STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055364	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Healthcare Center	3401 Cedar Avenue Long Beach, CA 90807

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility did not ensure that staff assisted residents at eye level during feeding for two of the four sample residents (Resident 38 and Resident 40). These deficiencies had the potential to impact the residents' rights, particularly regarding dignity and respect, which could lead to feelings of inadequacy among the residents. Findings: a.During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dementia (a progressive state of decline in mental abilities), anxiety (a feeling of fear, dread, and uneasiness), cirrhosis of liver (a type of liver damage where healthy cells are replaced by scar tissue), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 38's History and Physical (H/P), dated 9/24/2024, the H/P indicated Resident 38 can make needs known but cannot make medical decisions. During a review of Resident 38's Minimum Data Set (MDS a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 38 was moderately impaired in cognitive (thinking process) skills. Resident 38 required set up assistance (helper sets up or cleans up while resident completes the activities) on self-care abilities with eating, required moderate assistance (helper does less than half the effort) with oral hygiene, personal hygiene, toileting hygiene, shower/bathe, and upper body dressing, was maximal assistance (helper does more than half the effort) with lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 38 required supervision assistance (helper provides verbal cues as resident completes activities) with rolling left and right, sitting to lying position, and lying to sitting on side of bed, required moderate assistance with sit to stand position, bed to chair transfers, and shower transfers. During an observation on 5/20/2025 at 12:59 p.m. in Resident 38's room, Resident 38 was being assisted up in bed by staff. After being assisted in a sitting up position, Resident 38 was ready to eat lunch. A staff member was standing in front of Resident 38 while feeding Resident 38. (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 - Few	b.During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), anemia (a condition where the body does not have enough healthy red blood cells), acute respiratory failure (lungs are unable to deliver enough oxygen to the blood, leading to low oxygen levels in the body), and benign prostatic hyperplasia with lower urinary tract symptoms (the non-cancerous enlargement of the prostate gland). During a review of Resident 40's H/P, dated 10/27/2024, the H/P indicated Resident 40 has the capacity to understand and make decisions. During a review of Resident 40's MDS dated [DATE], the MDS indicated Resident 40 was severely impaired in cognitive skills and required set up assistance on self-care abilities with eating, required maximal assistance (helper does more than half the effort) with oral hygiene, was dependent (helper does all of the effort) with personal hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 40 required maximal assistance with mobility ability such as rolling left and right, was dependent with sitting to lying position, lying to sitting on side of bed, bed to chair transfers, and shower transfers. During an observation on 5/20/2025 at 12:57 p.m. in Resident 40's room, Resident 40 was being assisted with his meal tray. After receiving assistance with his meal tray, Resident 40 was ready to eat lunch. Resident 40 attempted to feed himself, but due to hand tremors, the food fell off the utensil. A staff member entered the room to assist with feeding and stood in front of Resident 40 while providing assistance. During an interview on 5/20/2025 at 2:40 p.m., CNA 8 explained that staff should be seated at eye level when feeding residents. This position helps residents feel comfortable and ensures they chew their food correctly. If staff stand over residents while feeding them, it can make residents feel babied. During an interview on 5/23/2025 at 10:15 a.m. with the Director of Nursing (DON), the DON explained that feeding residents at eye level is important for maintaining their dignity. The DON noted that standing over residents while feeding them can make them feel inferior and may not provide the proper respect to the residents. During a review of the facility's policy and procedure (P/P) titled Quality of Life-Dignity, revised February 2020, indicated, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem . residents are treated with dignity and respect at all times. During a review of the facility's P/P titled Assistance with Meals, revised March 2022, indicated, residents shall receive assistance with meals in a manner that meets the individual needs of each resident facility staff will serve resident trays and will help residents who require assistance with eating. residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the licensed nursing staff failed to ensure the resident and/or responsible party (RP) were informed in advance of the risks and benefits of psychoactive medications (a drug that changes brain function and results in alterations, mood, consciousness, or behavior) for one of four sampled residents (Resident 38). This failure violated the residents' right to make an informed decision regarding the use of psychoactive medications. Findings: During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), mood disorder (a mental health condition that primarily affects your emotional state), and anxiety (a common emotion characterized by feelings of worry, fear, and unease). During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool) dated 11/29/2024, the MDS indicated Resident 38's cognition (ability to think, understand, learn, and remember) was severely impaired and required moderate assistance (helper does less than half the work) with personal hygiene, bathing, and dressing. During a review of Resident 38's Order Summary Report, the Order Summary report indicated an order was placed on 9/23/2024 for Ativan (medicine used to treat anxiety) 0.5 milligrams (mg- unit of measurement) three times a day for anxiety manifested by continuous yelling and screaming. The Order Summary Report indicated an order was placed on 8/30/2024 for Buspirone (medicine for anxiety) 10 mg once a day for anxiety manifested by continuous yelling. The Order Summary Report indicated an order was placed on 2/18/2025 for Lamictal (medicine to stabilize moods) 25 mg for mood disorder manifested by mood swings from calm to angry. During a review of Resident 38's History and Physical (H&P) dated 9/24/2024, the H&P indicated Resident 38 can make needs knows but cannot make medical decisions. During an interview on 5/22/2025 at 9:44 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 38 was confused, unable to make medical decisions, and should not be signing consents. LVN 2 stated it was important for the resident to understand what they were signing for accuracy and the residents safety. During a concurrent interview and record review on 5/22/2025 at 11:31 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 38 was confused and should not be signing consents because he was not aware of what he was signing. RNS 1 validated Resident 38 signed the psychoactive medication consents but because of his confusion, the signature was not valid and could potentially cause harm to Resident 38. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated Resident 38 was unable to make medical decisions and should not be signing consents. The DON stated Resident 38 should not have been asked to sign consents for psychoactive medications because he does not understand the risks and benefits and should have a conservatorship (when a judge appoints another person to act or make decisions for the person who needs help) to sign the consents. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, undated, the P&P indicated, Prior to initiating the use of psychotropic medications, the staff and physician will review the following with the resident/representative prior to obtaining documented consent: the potential risks and benefits and the resident's right to accept or decline the treatment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled resident (Resident 23) needs were accommodated when Resident 23's mattress was too small for Resident 23's bedframe. This failure resulted in Resident 23 needs not provided to make it a comfortable and homelike environment. Findings: During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), obesity (having too much body fat), and depression (a persistent state of sadness or lack of interest in things that you used to enjoy). During a review of Resident 23's Minimum Data Set (MDS- a resident assessment tool) dated 3/26/2025, the MDS indicated Resident 23's cognition (ability to think, understand, learn, and remember) was intact and was dependent (helper does all the effort) with toileting, bathing, and dressing. During a concurrent observation and interview on 5/20/2025 at 11:06 a.m., with Resident 23, Resident 23 stated he would prefer a larger mattress and had spoken with the social worker about getting one. Observed Resident 23 had a large bed frame with a small mattress. Resident 23 stated having a larger mattress would be more comfortable for him because he had a larger mattress at one point, but they removed it. During an interview on 5/21/2025 at 11:52 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 validated Resident 23's mattress was too small for the large bed frame he had in place, and he should in fact have a larger mattress for his safety and comfort. LVN 2 stated having a small mattress could cause Resident 23 to feel unsafe and uncomfortable. During an interview on 5/21/2025 at 12:03 p.m., with the Social Services Director (SSD), the SSD stated she was aware of Resident 23's mattress being too small for him but did not document this conversation. The SSD stated she spoke with the maintenance department about getting Resident 23 a larger mattress but did not follow up with them. The SSD stated Resident 23 should have a larger mattress because he has a large bed frame and having a small mattress could make him feel uncomfortable and possibly unsafe. During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated Resident 23 should have the correct size mattress because it was his right. The DON stated the resident has the right to feel comfortable and it was the facility's responsibility to ensure resident's feel their room was their own home. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated, Residents are provided with a safe, clean, and comfortable and homelike environment. Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Quality of Life- Accommodation of Needs, dated 9/2009, the P&P indicated, The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis. During a review of the facility's P&P titled, Resident Rights, dated 12/2021, the P&P indicated, Federal and state laws guarantee certain basic right to all residents of this facility. These rights include the resident's right to: a dignified existence.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility did not honor the choice and preferences of one of six sampled residents (Resident 90) to have a shower before a medical appointment. This failure had the potential to violate Resident 90's right to have a personal choice which could lead to frustration and anger. Findings: During a review of Resident 90's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (stroke)affecting left side and anxiety disorder(intense , excessive, and persistent worry and fear about everyday situations). During a review of Resident 90's Minimum Data Set (MDS-resident assessment tool) dated 4/3/2025, the MDS indicated Resident 90 had an intact cognition (ability to learn, remember, understand, and make decisions) and required partial/moderate assistance(helper does less than half the effort) with bathing, bed mobility, and transfer to and from a bed to chair. During interviews on 5/20/2025, at 2:49 p.m., and 5/22/2025, at 11:21 a.m., Resident 90 stated that CNA5 was preparing him for a medical appointment on 5/20/2025, at 5:20 a.m. Resident 90 told CNA 5 that CNA 7 would arrive early for a shower and informed RN 3 of his decision not to dress for the medical appointment. He expressed that this issue could have been avoided if staff had listened to him, and remarked that CNA 5 was in a hurry and did not heed his concern. During a telephone interview on 5/21/2025, at 4:24 p.m. with CNA 5, CNA 5 indicated that Resident 90 expressed a desire to take a shower prior to dressing for his medical appointment. CNA 5 stated the resident was getting mad at her because Resident 90 said no to changing his diaper and getting dressed up for his appointment in the morning. CNA 5 reported that Resident 90 expressed dissatisfaction because they felt it was too early to change their clothes. The resident preferred to shower before changing clothes in preparation for their morning medical appointment. During an interview on 5/22/2025, at 7:0& a.m. Licensed Vocational Nurse (LVN 7) reported that Resident 90 expressed a desire to have a shower before getting dressed for the medical appointment, and that CNA 7 would arrive early to assist with the shower. LVN 7 stated CNA 5 told her Resident 90 was refusing to get dressed because wanted to have a shower. LVN 7 stated it was important for a resident to have a choice because it's their rights and the resident would get upset if not provided a choice. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025, at 11:39 a.m. with CNA 7, CNA 7 stated on 5/19/2025 , Resident 90 was worried because he would like to take a shower before going to his medical appointment on 5/20/2025. CNA 7 stated she promised Resident 90 she would come early on Tuesday (5/20/2025) and would be the first resident to have a shower because of his early appointment. CNA 7 stated she gave the Resident 90 a shower at around 7:00 a.m. on Tuesday and was ready at the nursing station at 7:30 a.m. to be picked up for his appointment. During an interview on 5/22/2025, at 7:43 a.m. with Registered Nurse (RN3), RN3 stated she helped CNA 5 in dressing up Resident 90 because the resident was refusing to change his clothes at around 5:45 a.m. on 5/20/2025. RN 3 stated Resident 90 told her that he wanted a shower, and it was his shower day. RN 3 stated she told CNA 5 to give Resident 90 a shower but was told by CNA 5 that she has 4 more residents to change diapers. RN 3 stated Resident 90 should have been provided a shower when he requested to have one because it is a resident right to have a choice. During an interview on 5/22/2025, at 8:37 a.m. with Director of Staff Development (DSD), DSD stated it was important for the residents to have a choice so they will not feel unattended and upset. DSD stated it was important to listen and address resident's concern and the staff should have prioritized what need to be done on the Resident 90's care. During an interview on 5/22/2025, at 9:24 a.m. with the Administrator (ADM), ADM stated CNA 5 should have prioritized her workload and should have helped Resident 90 who was requesting for a shower. ADM stated resident should have a choice because it is their right and not being having a choice could make the resident upset and angry. During a review of facility's policy and procedure (P&P) titled, Resident Rights, revised 2020, the P&P indicated the resident should have the right to be supported by the facility in exercising his rights and right for self-determination(ability of an individual to make their own choices and control their lives).

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the physician when one of three sampled residents (Resident 22) laboratory (lab) tests were not successfully drawn by the laboratory for three days. This failure resulted in a delay in care and treatment for Resident 22. This failure resulted in Resident 22 to feel frustrated. Findings: During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool) dated 5/6/2025, the MDS indicated Resident 22's cognition (ability to think, understand, learn and remember) was intact and was dependent (helper does all the effort) with toileting, showering, and dressing. During a review of Resident 22's Order Summary Report, the Order Summary Report indicated an order was placed on 5/16/2025 for laboratory tests to be drawn every three months. During an interview on 5/20/2025 at 9:43 a.m., with Resident 22, Resident 22 indicated she felt frustrated because they have not been able to draw her blood the last two mornings. During a continued interview on 5/21/2025 at 8:35 a.m., with Resident 22, Resident 22 stated they were unable to draw her blood for the third time. During a concurrent interview and record review on 5/22/2025 at 1:42 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated licensed should have inform Resident 22's physician when Resident 22's blood draw was unsuccessful for the past three attempts (5/17/2025-5/19/2025) by the laboratory. LVN 1 stated the physician should be notified because the physician may be waiting on a specific lab result. During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated Resident 22's physician should have been notified that the lab was unsuccessful obtaining labs with three attempts from the laboratory. The DON stated it was important to communicate with the physician so it could be addressed, and the orders be carried out. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2/2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure privacy curtains were provided for one of one sampled resident (Resident 135). This failure had the potential to result in Resident 135 feeling embarrass and loss of dignity. Findings: During a review of Resident 135's admission Record, the admission Record indicated Resident 135 was admitted to the facility on [DATE] with diagnoses including broken right leg, broken hip, and encephalopathy (damage or disease that affects the brain). During a review of Resident 135's History and Physical (H&P), dated 4/21/2025, the H&P indicated Resident 135 had fluctuating capacity to understand and make decisions. During a review of Resident 135's Minimum Data Sheet (MDS - a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 135 needed partial to moderate assistance from nursing staff with toileting, showering, dressing and putting on and taking off footwear. The MDS indicated Resident 135 needed partial to moderate assistance from nursing staff with personal hygiene, rolling from left to right and sitting. The MDS indicated Resident 135 needed partial to moderate assistance from nursing staff with lying down and standing up, walking and transferring to a chair. During an observation on 5/20/2025 at 12:17 p.m., in Resident 135's room, Resident 135 was sitting up in bed. Resident 135 did not have any curtains, around his bed for privacy. During an interview on 5/22/2025 at 8:38 a.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated he assist Resident 135 with showering. CNA 2 stated he helps Resident 135 with rubbing lotion on his body. CNA 2 stated after he showers the residents, he brings them back to the bedside and closes the curtains to make sure the resident has privacy. CNA 2 stated Resident 135 does not have curtains. CNA 2 stated Resident 135 told him about the curtains last week. CNA 2 stated he did not document Resident 135 needed curtains in the Maintenance Log book. CNA 2 stated it was very important for the residents to have privacy curtains so the resident will not be exposed. During an interview on 5/22/2025 at 9:13 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated today she noticed Resident 135 did not have privacy curtains. LVN 5 stated she documented in the Maintenance Log book today. LVN 5 stated Resident 135 needs curtains for privacy during activities of daily living and for dignity. During an interview on 5/22/2025 at 10:51 a.m., with Registered Nurse (RN) 1, RN 1 stated she did not realized Resident 135 did not have privacy curtains. RN 1 stated without privacy curtains Resident 135 might not feel secure and his privacy will not be protected during activities of daily living and linen changes. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 8:44 a.m., with Maintenance Director (MTD), MTD stated he was responsible for repairs in the facility like making sure the beds work, tables, televisions, and call lights. MTD stated he makes repairs to anything in the facility that needs to be done. MTD stated he was also responsible for making sure the privacy curtains work properly. During an interview on 5/23/2025 at 12:06 p.m., with the Administrator (ADMIN), the ADMIN stated he was responsible for assigning the nurses to check the residents and the residents' rooms every morning during rounds for abnormalities and things that need to be repaired. ADMIN stated he had not heard anything about the Resident 135's bed needing privacy curtains. The ADMIN stated resident need privacy curtains to prevent exposure with changing dressing, and grooming. During a review of the facility's policy and procedure (P&P), titled Quality of Life - Dignity, dated 2/2020, the P&P indicated, .Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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	055364	A. Building B. Wing	05/23/2025

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Long Beach Healthcare Center	3401 Cedar Avenue Long Beach, CA 90807

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 96) was free of chemical restraints (use of medication to control a patient's behavior or restrict the patient's movement and not required to treat the medical symptom) by failing to: 1. Ensure Resident 96 was provided with non-pharmacological interventions(intervention that does not primarily use medicine) before administering a prn (as needed) psychotropic medication. 2.Ensure prn (as needed) psychotropic medication (any drugs that affects the brain activities associated with mental processes and behavior) use for Resident 96 did not exceed 14 days. These failures placed Resident 96 at risk for adverse consequences (unintended , harmful events attributed to the use of medication) due to unnecessary prolonged use of psychotropic medication. Findings: 1.During a review of Resident 96's admission Record, the admission Record indicated Resident 96 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to various areas of the brain)without behavioral disturbances, anxiety disorder(mental health conditions characterized by excessive and persistent worry, fear, and nervousness that interfere with daily life) and depression (emotional state that is marked by feelings of low self-worth and a reduced ability to enjoy life). During a review of Resident 96's Minimum Data Set (MDS- a resident assessment tool) dated 3/25/2025, the MDS indicated the resident had severely impaired cognitive skills (significant decline in thinking, remembering, and decision-making abilities impacting daily life), and was dependent on staff with bathing, toileting hygiene , lower dressing (ability to dress and undress below the waist), and chair/bed -to -chair transfer (transfer to and from a bed to a chair). During a review of Resident 96's Care Plan titled Behavior of restlessness as evidence by inability to sit still when up in a Geri-chair (padded chair that is designed to help seniors with limited mobility) related to the use of Ativan (medication used to treat anxiety and can induce sedation [state of calmness and sleepiness]) initiated 8/24/2024. The Care Plan goals indicated behaviors would be manageable for ninety days. The Care Plan's interventions include providing non-pharmacological interventions before administering Ativan. 2.During a review of Resident 96's Order Summary Report dated 4/15/2025 , the Order Summary Report indicated an active order of Ativan 1 milligram (mg.- unit of measurement) give one tablet by mouth every six hours as needed for restlessness. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/22/2025, at 4:32 p.m. with Licensed Vocational Nurse (LVN 6), Resident 96's electronic health record (EHR-electronic version of a patient's medical history and include clinical data relevant to that person's care under a particular provider) were reviewed. LVN 6 confirmed the order of Ativan 1 mg. every 6 hours prn (as needed) for restlessness was ordered on 4/15/2025 and non- pharmacological interventions were not documented by licensed nurses before administering Ativan 1 mg. LVN 6 stated the licensed nurses should have called the physician to reevaluate resident's behavior and obtain a new order of Ativan. LVN 6 stated physician order of Ativan used on a prn basis was only good for 14 days. LVN 6 stated administering Ativan without implementing first the non-pharmacological interventions could sedate (calm down and make sleepy) the resident unnecessarily and make the resident sleep too much which could affect his activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily). LVN 6 stated Ativan could act as a chemical restraint that could affect his quality of life. During a concurrent interview and record review on 5/23/2025, at 8:59 a.m. with LVN 7, Resident 96's Medication Administration Record dated 5/2025 (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and Order Summary Report (shows breakdown of all orders placed within specified time period) were reviewed. LVN 7 verified Ativan Order was indefinite and non- pharmacological interventions were not provided before administering Ativan. LVN 7 stated Ativan was ordered as a prn (as needed) and was a psychotropic medicine that should be given only for 14 days. LVN 6 stated renewal of Ativan order should be performed by a physician after resident's behavior was reevaluated. LVN 7 stated Ativan could make the resident sleepy and could cause side effects(unwanted and undesirable effects) that could affect resident's quality of life. During a concurrent interview and record review on 5/23/2025, at 11:30 a.m. with the Director of Nursing (DON), Resident 96's Order Summary Report was reviewed. The DON verified Resident 96's physician order of Ativan was more than 14 days. The DON agreed the licensed nurses should use non-pharmacological interventions first before administering Ativan because it was the least restrictive measure before utilizing chemical restraint. The DON stated Ativan could cause side effects like drowsiness , sleepiness which could affect their daily life. During a review of facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 2001, the P&P indicated prn orders for psychotropic medications are limited to 14 days. The P&P indicated residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. The P&P indicated behavioral and other non-pharmacological approaches are used to minimize or eradicate the need for medications and permit the lowest possible dose if indicated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an individualized care plan for two of four sampled residents (Resident 22 and Resident 90). This failure had the potential to result in a delay of the delivery of care and services. Findings: During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool) dated 5/6/2025, the MDS indicated Resident 22's cognition (ability to think, understand, learn and remember) was intact and was dependent (helper does all the effort) with toileting, showering, and dressing. During a review of Resident 22's Order Summary Report, the Order Summary Report indicated an order was placed 5/16/2025 for labs to be drawn every three months. During an interview on 5/20/2025 at 9:43 a.m., with Resident 22, Resident 22 indicated she felt frustrated because they have not been able to draw her blood the last two mornings. During a continued interview on 5/21/2025 at 8:35 a.m., with Resident 22, Resident 22 stated they were unable to draw her blood for the third time. During a concurrent interview and record review on 5/21/2025 at 2:39 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 validated a care plan was not implemented for Resident 22's unsuccessful lab draws, and a care plan should be done because it's a guideline to follow that is specific to each resident. LVN 1 stated a care plan for monitoring infection for the several unsuccessful lab draw attempts should have been implemented. During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated a care plan for Resident 22 should have been implemented because she is a hard stick. The DON stated a care plan is a guide for the nursing staff to identify resident problems that include interventions and the expected goals specific to that resident so the staff can better attend to their needs and care. During a review of Resident 90's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (stroke)affecting left side, anxiety disorder(intense , excessive, and persistent worry and fear about everyday situations) and hyperlipidemia(elevated level of fats in the blood). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 90's MDS dated [DATE], the MDS indicated the resident had an intact cognition (ability to learn, remember, understand, and make decisions) and required partial/moderate assistance(helper does less than half the effort) with bathing, bed mobility, and transfer to and from a bed to chair. During a review of Resident 90's Change in Condition (COC-a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) Evaluation dated 5/20/2025 and timed at 4:04 p.m., the COC Evaluation indicated Resident 90 had a concern regarding how a certified nursing assistant (CNA) turned and repositioned him last night. During an interview on 5/20/2024, at 2:49 p.m. with Resident 90, Resident 90 stated Certified Nursing Assistant (CAN 5)rolled him like a ragdoll while changing his diaper and put her finger into his butthole to ensure he would be compliant into what CNA5 was telling him to do. Resident 90 stated the incident happened around 5:20 a.m. on 5/20/2025 and CNA 5 wanted her to get ready early for his medical appointment. During a concurrent interview and record review of Resident 90's COC and Care Plan on 5/22/2025, at 7:07 a.m. with Licensed Vocational Nurse (LVN 7), LVN 7 confirmed the Care Plan did not address the alleged physical and sexual abuse and stated verbalization of Resident 90's concern being turned and repositioned. LVN7 stated Care plan addressing the alleged physical and sexual abuse is important so the resident can be monitored. During a concurrent interview and record review of Resident 90's Care Plan on 5/22/2025, at 7:43 a.m. with Registered Nurse (RN3), RN3 verified there was no care plan addressing Resident 90's alleged physical and sexual abuse. RN 3 stated Resident 90's care plan should address resident's alleged physical and sexual abuse to the resident was receiving the necessary care and treatment when the resident had a change in condition. During a concurrent interview and record review of Resident 90's Care Plan on 5/22/2025, at 9:24 a.m. and subsequent interview on 5/23/2025, at 10:36 a.m. with DON, DON agreed Resident 90's care plan was not specific and did not address the allegations of abuse. DON stated care plan is a guide in identifying the resident's problems with goals and interventions on how to care for the resident. DON stated Resident 90's care plan should be individualized to the resident's need. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: reflects currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition changes.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide one of three sampled residents (Resident 96) with an alternative communication method in a language that the resident could understand. This failure had the potential to place Resident 96 at risk of experiencing frustration, isolation, and inability to communicate their needs to the staff, which could lead to a delay in receiving appropriate care and services. Findings: During a review of Resident 96's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to various areas of the brain)without behavioral disturbances, anxiety disorder(mental health conditions characterized by excessive and persistent worry, fear, and nervousness that interfere with daily life) and depression (emotional state that is marked by feelings of low self-worth and a reduced ability to enjoy life). During a review of Resident 96's History and Physical (H&P), dated 12/13/2024, the H&P indicated the resident could make needs known but was unable to make medical decisions. During a review of Resident 96's Minimum Data Set (MDS- a resident assessment tool) dated 3/25/2025, the MDS indicated the resident had severely impaired cognitive skills (significant decline in thinking, remembering, and decision-making abilities impacting daily life), and was dependent on staff with bathing, toileting hygiene , lower dressing (ability to dress and undress below the waist), and chair/bed -to -chair transfer (transfer to and from a bed to a chair). During a review of Resident 96's Care Plan titled Resident Has Impaired Communication related to language barrier- Chinese Speaking Only, initiated 5/20/2025. The Care Plans goal indicated the resident will be able to communicate needs daily for three months. The Care Plans interventions included using alternative communication tools as needed such as communication board(a device that displays photos, symbols, or illustrations to help people with limited language skills express themselves), writing pad, signs and pictures. During an observation on 5/20/2025, at 4:07 p.m. in Resident 96's room, it was noted that Resident 96 was awake and conversing in a different language. No communication board or signage was observed to facilitate communication with the resident. During a concurrent observation and interview on 5/20/2025 at 4:16 p.m. in Resident 96's room, Registered Nurse (RN2) confirmed the presence of a communication board at the bedside, stating that it could help the resident express herself. RN 2 mentioned that the communication board should be at the resident's bedside. RN 2 indicated that they routinely contact a family member to translate for the resident. RN 2 noted that the resident's inability to express her needs due to a language barrier could impact the care and requirements of the resident. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025, at 12:49 p.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated she thinks Resident 96 speaks Chinese and she communicated with her the best she could by using hand gestures or movement. CNA1 stated Resident 96 had no picture or signage board for communication in her room. CNA 1 stated using hand gestures is not a reliable way to communicate to resident who cannot speak English. CNA 1 stated Resident 96 could get aggravated or frustrated if she cannot communicate what she needs. CNA1 stated communication is vital in Resident 96's care and treatment. During an interview on 5/22/2025, at 12:07 p.m. with Treatment Nurse (TN1), TN 1 stated doing hand gestures is not the correct way to communicate to a resident who does not speak English. TN 1 stated sometimes Resident 96 refused her treatment and became combative, and the facility would contact the FM to interpret because no one in the facility could speak Chinese. TN 1 stated Resident 96 inability to make her needs known to staff due to language barrier could affect her quality of life. During an interview on 5/23/2025, at 11:17 a.m. with Director of Nursing (DON), DON stated the facility was thinking of transferring the resident in a Chinese speaking facility. DON stated Resident 96's needs specific to her care will not be addressed and met because of the language barrier. During a review of facility's policy and procedure (P&P) titled, Quality of Life- Accommodation of Needs, dated 8/2009, the P&P indicated the staff will interact with the residents in a way to accommodate physical and sensory limitations of the resident , promotes communication and maintains dignity.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 22 and Resident 78) fingernails were trimmed and free from accumulation of unknown substances underneath their fingernails. This failure had resulted in Resident 22 and 78 fingernails to be long with an accumulation of unknown substances underneath the fingernails. This failure had the potential to cause infection and impaired skin integrity. Findings: During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool) dated 5/6/2025, the MDS indicated Resident 22's cognition (ability to think, understand, learn and remember) was intact and was dependent (helper does all the effort) with toileting, showering, and dressing. During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted to the facility 4/17/2024 with diagnoses including legal blindness (medical and legal definition that refers to a severe visual impairment) and intracerebral hemorrhage (a type of stroke that causes bleeding in your head). During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78's cognition was intact and was dependent activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a concurrent observation and interview on 5/20/2025 at 12:09 p.m., with Resident 78, Resident 78 was observed to have long fingernails. Resident 78 stated he would like them to be shorter. During a concurrent observation and interview on 5/20/2025 at 12:18 p.m., with Certified Nurse Assistant (CNA) 3, CNA 3 validated Resident 78's nails were long and required trimming. CNA 3 stated keeping resident nails clean and trimmed was important for infection control and prevent resident from scratching themselves, possibly breaking skin. During a concurrent observation and interview on 5/22/2025 at 8:412 a.m., in Resident 22's room, Resident 22 was feeding herself with her hands and her nails were observed to be long and unclean. Resident 22 stated she would like them to be cut but did not know they could do it for her. Resident 22 stated she was concerned she may scratch her scalp and break skin because her nails were long. During an interview 5/22/2025 at 8:26 a.m., with CNA 1, CNA 1 stated she does not always have time to clean and trim resident nails. CNA 1 stated she should make time to clean and trim resident nails for infection prevention and to prevent the resident from scratching themselves. CNA 1 stated she will make sure to clean and trim Resident 22's nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 9:18 a.m., with the Infection Prevention Nurse (IPN), the IPN stated it was important to keep resident nails trimmed and clean because they use their hands to eat and if they were not clean, bacteria can accumulate under their nails, causing the resident to get sick and putting their health at risk. The IP stated not keeping resident nails clean and trimmed can result in the resident feeling embarrassed and ashamed. During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated it was important to keep resident nails clean and trimmed because if not it can cause skin issues if they scratch themselves or an infection if they eat with their hands. The DON stated a resident could feel uncomfortable and not care for if their personal hygiene needs were not being met. During a review of the facility's policy and procedure (P&P), titled Fingernails/Toenails, Care of, dated 2/2018, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care includes daily cleaning and regular trimming. Proper nails care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During a review of Resident 90's admission Record, the admission Record indicated Resident 90 the was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (damage to the brain from interruption of its blood supply) affecting left side, anxiety disorder(intense , excessive, and persistent worry and fear about everyday situations) and hyperlipidemia(elevated level of fats in the blood). During a review of Resident 90's MDS dated [DATE], the MDS indicated Resident 90 had an intact cognition (ability to learn, remember, understand, and make decisions) and required partial/moderate assistance(helper does less than half the effort) with bathing, bed mobility, and transfer to and from a bed to chair. During a review of Resident 90's Change in Condition (COC-a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) Evaluation dated 5/20/2025 and timed at 4:04 p.m., the COC Evaluation indicated Resident 90 had a concern regarding how a certified nursing assistant (CNA) turned and repositioned him. During a review of Resident 90's COC Evaluation dated 5/22/2025 timed at 10:09 a.m., the COC indicated Resident 90 had open area or fissure (linear cut) measuring 0.2 centimeter (cm.- unit of measurement) by 1. 1 cm. in the sacro coccyx area (bottom of the spine). During an interview on 5/20/2024, at 2:49 p.m. with Resident 90, Resident 90 stated Certified Nursing Assistant (CNA 5) rolled him like a ragdoll while changing his diaper and put her finger into his butthole to ensure he would be compliant into what CNA 5 was telling Resident 90. Resident 90 stated the incident happened around 5:20 a.m. on 5/20/2025 and CNA 5 wanted her to get ready early for his medical appointment. During a concurrent interview and record review of Resident 90's electronic health record (EHR-digital version of a patient's medical chart) on 5/22/2025, at 8:37 a.m., with Director of Staff Development (DSD), DSD stated skin assessment was not performed after the allegations of physical and sexual abuse that happened on 5/20/2025. DSD stated Resident 90's COC Evaluation dated 5/20/2025 indicated skin assessment was not applicable and was not documented. During an interview on 5/22/2025, at 11:54 a.m. with Treatment Nurse (TN 1), TN 1 stated she was asked by LVN 5 to come and do skin check on Resident 90 on 5/22/2025 at around 10:00 a.m. with LVN 5. TN 1 stated there was a fissure (linear cut) in the coccyx (tailbone) area measuring 0.2 centimeter (cm.-unit of measurement) by 0.1 cm. TN 1 stated a head-to-toe skin assessment should have been done after an allegation of physical and sexual abuse to prevent delay of care and treatment. TN 1 stated the facility will not know the cause of any skin breakdown and necessary treatment will not be initiated if head to toe skin assessment was not performed in a timely manner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2025, at 9:14 a.m. and subsequent interview on 5/22/2025, at 9:24 a.m. with the DON, the DON stated they did not perform a body check and skin assessment after the resident complained about an allegation of physical and sexual abuse against staff member, because she was focused on the emotional state of Resident 90. The DON stated not doing a body check and skin assessment will cause a delay in treatment and care. The DON stated it was important to perform body check and skin assessment to identify any injury or any change in condition after an alleged abuse so they can initiate treatment in a timely manner. 3.During a review of Resident 96's admission Record, the admission Record indicated Resident 96 was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to various areas of the brain) without behavioral disturbances, anxiety disorder(mental health conditions characterized by excessive and persistent worry, fear, and nervousness that interfere with daily life), depression (emotional state that is marked by feelings of low self-worth and a reduced ability to enjoy life) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 96's History and Physical (H&P) dated 12/13/2024, the H&P indicated Resident 96 could make needs known but was unable to make medical decisions. During a review of Resident 96's MDS dated [DATE], the MDS indicated the resident had severely impaired cognitive skills, and was dependent on staff with bathing, toileting hygiene , lower dressing (ability to dress and undress below the waist), and chair/bed -to -chair transfer (transfer to and from a bed to a chair). During a review of Resident 96's Order Summary Report, the Order Summary Report dated 12/11/2024, indicated a physician order of Insulin Lispro (rapid acting medication used to manage blood sugar with diabetes and is administered subcutaneously[SC- under the skin]) inject as per sliding scale (amount of insulin to be administered changes or slides up and down based on the resident's blood sugar) SC four times a day for DM ac meals(before meals) and at HS (bedtime): if blood sugar is 151- 200 give 2 units (amount of insulin); bs 201- 250- give 4 units , bs 251-300 give 6 units; bs 301-350 give 8 units; 351-400 give 10 units; greater than 400 give 12 units and call the physician. During a review of Resident 96's Progress Notes dated 5/6/2025, the Progress Notes indicated Resident 96's blood sugar was ranging from high 300 to 400. The Progress Notes indicated the physician was notified on 5/6/2025 and Lantus (long-acting insulin used to control high blood sugar)10 units at bedtime was started. During a review of Resident 96's Medication Administration Report (MAR) dated 5/5/2025, the MAR indicated Lantus 10 units SC at bedtime at bedtime for DM and was ordered on 5/5/2025. During a review of Resident 96' MAR dated 5/18/2025 to 5/22/2025, the MAR indicated the following blood sugar readings before meals with sliding scale of Lispro insulin: On 5/18/2025 at 1:00 p.m. bs was 308 milligrams/deciliter (mg./dl- unit of measurement used to express the concentration of sugar in the blood), and at 5:00 p.m. 396 mg/dl. On 5/19/2025 at 9:00 a.m. bs was 286 mg/dl, at 1:00 p.m. 347 mgs/dl, and at 5:00 p.m. 373 mg/dl. (continued on next page)

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	055364	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Healthcare Center	3401 Cedar Avenue Long Beach, CA 90807

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/2025 at 9:00 a.m. bs was 400 mg/dl, at 1:00 p.m. 270 mg/dl, and at 5:00 p.m,282 mg/dl. On 5/21/2025 at 9:00 a.m. bs was 400 mg/dl, at 1:00 p.m.400 mg/dl, and at 5:00 p.m. 376 mg/dl. On 5/22/2025 at 9:00 a.m. bs was 400 mg/dl, at 1:00 p.m. 400mg/dl and at 5:00 p.m. 3:57 mg/dl. During a concurrent interview and record review on 5/22/2025, at 4:32 p.m. with Licensed Vocational Nurse (LVN 6), Resident 96's EHR were reviewed. LVN 6 agreed Resident 96's bs had been high ranging over 300 to 400 mg/dl since 5/19/2025 to 5/22/2025 and blood sugar was not stable and controlled. LVN 6 stated the licensed nurses should have called the physician to obtain new orders to manage the elevated blood sugar of Resident 96 or readjust the doses of insulin. LVN 6 stated Resident 96's treatment for high blood sugar was not effective and needed to be reevaluated by the physician. During a concurrent interview and record review on 5/23/2025, at 11:30 a.m. with LVN 7, Resident 96's EHR were reviewed. LVN 7 confirmed resident's blood sugar readings had been elevated and abnormal for the past three days. LVN 7 stated there was a change in condition (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) documented on 5/5/2025 for high bs and Lantus 10 units SC was started on Resident 96 for blood sugar control. LVN 7 stated the licensed nurses should have notified the physician because Resident 96's blood sugar was still uncontrolled and high. LVN 7 stated Resident 96 could be at risk of getting hospitalized and diabetic coma(serious, and potentially life -threatening condition where someone becomes unconscious due to blood sugar being dangerously high or low requiring emergency medical treatment) if blood sugar is not controlled and managed. During an interview on 5/22/2025, at 9:14 a.m. and subsequent interview on 5/22/2025, at 9:24 a.m. with the DON, the DON stated the physician only comes once a month and the licensed nurses should have notified the physician about the high blood sugar despite the addition of Lantus in her treatment. The DON stated Resident 96 could have hyperglycemic episodes (the body has too much glucose in the bloodstream) and if left untreated could increase her risk of hospitalization. During a review of facility's policy and procedure (P&P) titled Change in Condition or Status, revised 2/2021, the P&P indicated The facility will promptly notify the resident, his or her attending physician, and the resident representative of changes in medical/ mental condition. The P&P indicated the nurse will notify the resident's attending physician or physician on call when there is a need to alter the resident's medical treatment significantly and a significant change in resident's physical, emotional and mental conditions. Based on observation, interview and record review, the facility failed to ensure three of 12 sampled residents(Resident 22, Resident 90 and Resident 96) received necessary care and services by failing to: 1. Document a change in condition (COC a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral or functional condition) for Resident 22's missed laboratory blood draw. 2. Assess and perform full body skin assessment when Resident 90 verbalized allegation of physical and sexual abuse against a certified nursing assistant. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Identify Resident 96's episodes of hyperglycemia (high blood sugar) and notify the physician when Resident 96's blood sugar readings was persistently abnormal and elevated from 5/19/2025 to 5/22/2025. These failures had the potential to place Resident 22, Resident 90 and Resident 96 at risk for delay of care and treatment. Findings: 1.During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool) dated 5/6/2025, the MDS indicated Resident 22's cognition (ability to think, understand, learn and remember) was intact and was dependent (helper does all the effort) with toileting, showering, and dressing. During a review of Resident 22's Order Summary Report, the Order Summary Report indicated an order was placed on 5/16/2025 for laboratory tests to be drawn every three months. During an interview on 5/20/2025 at 9:43 a.m., with Resident 22, Resident 22 indicated she felt frustrated because they have not been able to draw her blood the last two days (5/19/2025 to 5/20/2025). During a continued interview on 5/21/2025 at 8:35 a.m., with Resident 22, Resident 22 stated they were unable to draw her blood for the third time. During a concurrent interview and record review on 5/21/2025 at 2:39 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 22's physician was not notified that her blood draw was unsuccessful the last three days nor was a COC documented but should have been done. LVN 1 stated a COC was done so the nursing staff were aware of changes with the residents and how and what to monitor for. During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated COC's should have been done and documented when Resident 22's ordered laboratory tests were not done due to unsuccessful blood draws for three days. The DON stated the COC was documented for monitoring purposes when something changes with the resident.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of 2 sampled residents (Resident 53) ophthalmology (focused on the diagnosis, treatment, and surgery of eye diseases and disorders) referral was followed up. This failure had the potential to negatively affect Resident 53's quality of life. Findings: During a review of Resident 53's admission Record the admission Record indicated Resident 53 was admitted to the facility on [DATE] with diagnosis including glaucoma (a group of eye conditions that damage the optic nerve which connects the eye to the brain), muscle weakness, and anxiety (intense, excessive, and persistent worry and fear about everyday situations. During a review of Resident 53's History and Physical (H&P) dated 12/31/24, the H&P indicated Resident 53 had the capacity to understand and make decisions. During a review of Resident 53's Minimum Data Set (MDS - a resident assessment tool) dated 3/11/2025, the MDS indicated Resident 53 had severely impaired cognition (ability to think, understand, learn, and remember). The MDS also indicated Resident 53 needed partial to moderate assistance (helper does half the work) with activities of daily living (ADLs- activities such as bathing, and dressing and toileting a person performs). The MDS also indicated Resident 53 vision was impaired (sees large print, but not regular print in newspaper/books and does not wear corrective lenses. During a review of Resident 53's Order Summary Report dated 5/22/25 the Order Summary Report indicated Resident 53 was prescribed latanoprost ophthalmic emulsion (medication used to reduce elevated eye pressure) 0.005% instill one drop in both eyes in the evening for glaucoma and timolol maleate gel (used to lower pressure inside the eye) forming solution 0.5% instill one drop in both eyes two times a day for glaucoma. During a review of Resident 53's Care Plan titled Impaired Visual Function dated 6/20/2022, the Care Plan indicated to ensure vision aids are available to support resident's participation in activities, store eyeglasses in a safe place where they can be reached if necessary. During a concurrent observation and interview on 5/20/2025 at 3:36 p.m., with Resident 53 in his room. Resident 53 was sitting on his bed with no eyeglasses. Resident 53 stated he was blind in his left eye, and he needed glasses for his right eye. Resident 53 stated he could still see a little out on Resident 53's right eye and would really like to read. Resident 53 asked the surveyor if she could you help. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/23/2025 at 9:05 a.m., with Social Services (SS) 1 reviewed Resident 53's Ophthalmology Consultation dated 3/6/2023. The SS1 stated Resident 53 was referred to an eye specialist for his glaucoma and for cataract (a clouding of the lens inside the eye, causing blurry, hazy, or faded vision) removal surgery. SS1 stated she was not working at the facility on 3/6/2025 at the time of the referral. SS1 stated that it was the role the SS to follow up on this type of referral and that Resident 53 should have been seen by the specialist and he was not. SS 1 stated Resident 53 could feel isolated and depressed and should have seen eye specialist. During an interview on 5/23/25 at 12:10 p.m., with the Director of Nursing (DON). The DON stated Resident 53 should have been sent to the eye specialist when the referral was made back min 3/6/25. The DON stated it was Resident 53's right to see the eye specialist and the facility should have accommodated the resident's needs. During a review of the facility's Policy & Procedure (P&P) titled Referrals, Social Services dated 12/2008, the P&P indicated Social services personnel shall coordinate most resident referrals with outside agencies. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physicians. Social services will help arrange transportation to outside agencies, clinic appointments, etc., as appropriate.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to improve and/or prevent a decline in range of motion (ROM, full movement potential of a joint) for one of nine sample residents (Resident 112) by failing to provide Resident 112 with passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to the left leg in accordance with Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) recommendations on 2/7/2025. This deficient practice had the potential to cause Resident 112 to have a decline in ROM leading to contracture (loss of motion of a joint) development and have a decline in physical functioning and mobility (ability to move). Findings: During a review of Resident 112's admission Record, the admission Record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following an intracerebral hemorrhage (bleeding in the brain), abnormal posture, and muscle weakness. During a review of Resident 112's PT Evaluation and Plan of Treatment (PT Eval), dated 11/5/2024, the PT Eval indicated Resident 112 had no strength in the left hip, knee, and ankle. During a review of Resident 112's Physical Therapy Discharge summary, dated [DATE], the PT Discharge Summary indicated discharge recommendations for a Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) program for PROM exercises to Resident 112's left leg and active assistive range of motion (AAROM, use of muscles surrounding the joint to perform the exercise but required some help from a person or equipment) exercises to Resident 112's right leg. During a review of Resident 112's Minimum Data Set (MDS, a resident assessment tool), dated 4/27/2025, the MDS indicated Resident 112 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 112 required set-up or clean up assistance for eating, partial/moderate assistance for oral and personal hygiene, substantial/maximal assistance for upper body dressing, and total assistance for toileting hygiene, bathing, and bed to chair transfers. The MDS indicated Resident 112's sit-to-stand transfers were not attempted. The MDS indicated Resident 112 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand) and one leg (hip, ankle, knee, foot). During a review of Resident 112's May 2025 RNA Documentation Survey Report (RNA flowsheet, daily record of RNA services provided for each month), the RNA flowsheet did not have an RNA task for PROM exercises to Resident 112's left leg. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/20/2025 at 9:42 am, in Resident 112's room, Resident 112 was lying in bed. Resident 112's left elbow and left wrist were bent, and the fingers of the left hand were in a fist. Resident 112's left leg was rotated outwards with the knee bent and the toes pointing downwards. Resident 112 stated he was unable to move his left arm and left leg on his own. During a concurrent interview and record review on 5/21/2025 at 2:20 p.m., RNA 1 reviewed Resident 112's May 2025 RNA tasks and confirmed Resident 112 did not have an RNA task for left leg PROM exercises. RNA 1 stated she was aware Resident 112 did not have left leg PROM exercises included in the RNA program but put Resident 112 on the motorized exercise bicycle anyway to get Resident 112's left leg moving since he was unable to move the leg on his own. During a concurrent interview and record review on 5/22/2025 at 1:21 pm, Physical Therapist 1 (PT 1) reviewed Resident 112's PT Discharge summary, dated [DATE], and confirmed the PT recommendations for the RNA program were for AAROM of Resident 112's right leg and PROM of Resident 112's left leg. PT 1 reviewed Resident 112's May 2025 RNA tasks and confirmed the RNA task for left leg PROM was not implemented as recommended. PT 1 stated she forgot to input the RNA task for PROM exercises to Resident 112's leg. PT 1 stated it was important Resident 112 received left leg PROM exercises with RNA because he was paralyzed on the left side of the body, could not move his left leg on his own, and could potentially develop contractures and a functional decline if he did not receive ROM exercises. During an interview on 5/23/2025 at 3:00 p.m., the Director of Nursing (DON) stated it was important residents who were identified as having ROM limitations and/or were at risk for contracture development received treatment and services to maintain their function to prevent contractures and functional declines. During a review of the facility's Policy and Procedure (P&P), titled Resident Mobility and ROM, revised 7/2017, the P&P indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM would receive treatment and services to increase and/or prevent a further decrease in ROM.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to prevent unplanned weight loss (a weight loss greater than 5 % in one month) of 29 pounds ([lbs.] 18.59 % percent [%] in 6 months) from 1/2025 to 5/25 for one of three sampled residents (Resident 116). The facility failed to: 1. Ensure Registered Dietician's (RD- expert on diet and nutrition) recommendations for Resident 116's weekly weights, protein supplement (boost protein [nutrients body needed] intake), double portions for breakfast, appetite stimulant (medication that stimulates appetite) and to have a blood test done for a complete metabolic panel (CMP- blood test that measures 14 different substances in the blood) and a prealbumin (blood test used to indicate nutritional deficiencies) were carried out. 2. Ensure a Change of Condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) for severe weight loss was completed on 1/2025 when Resident 116 had a weight loss of 10 lbs. (6.4 % loss), on 2/2025 when Resident 116 had a weight loss of 8 lbs. (11.5% loss), 4/2025 when Resident 116 had a weight loss of 9 lbs. (17.3% loss) and on 5/2025 when Resident 116 had a weight loss of 2 lbs. (18.59% loss), total of 29 lbs. in 6 months. 3. Ensure facility's staff followed Resident 116's care plan titled, Altered in Nutrition dated 3/14/2025 to monitor and report Resident 116's weight loss and poor oral intake to the physician. 4. Ensure there were weekly interdisciplinary team (IDT- a group of professionals from different disciplines who work together to achieve a common goal) weight variance meetings from 1/2025 through 5/2025 to address Resident 116 weight loss. 5. Develop a comprehensive care plan with interventions to prevent Resident 116's weight loss. These failures resulted in Resident 116's severe weight loss of 29 lbs. (18.59 % of body weight) in 6 months. Findings: During a review of Resident 116's admission Record, the admission Record indicated Resident 116 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), kidney transplant (replaces a failing kidney with a healthy one from a living or deceased [dead] donor) legally blind (vision loss), gastro-esophageal reflux (GERD- burning sensation in chest, heartburn). Resident 116 was discharge from the facility on 2/5/2025 to the general acute care hospital (GACH) due to altered mental status (a change in a person's mental function or level of consciousness, encompassing a range of symptoms from mild confusion to coma [a deep state of unconsciousness, where a person is alive but unable to respond to their environment]) and readmitted back on 2/10/2025. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 116's Registered Dietician (RD) Food and Nutrition Assessment initiated on 12/10/2024 and completed on 12/30/2024, the Food and Nutrition assessment indicated Resident 116's weight was 156 lbs. on 12/7/2024 and the resident was consuming 76% to 100% of her breakfast, lunch and dinner. Resident 116's re-admission weight on 2/10/2025 was 140 lbs. The RD's Food and Nutrition assessment also indicated Resident 116 should have been consuming 1775 to 2125 calories (a unit of energy used to measure the energy content of food) per day to maintain her admission weight. The RD's Food and Nutrition assessment also indicated that Resident 116 had a low pre albumin level and RD's recommendation was to start 30 milligrams (mg - unit of measurement) of sugar free protein supplement two times a day (BID). During a review of Resident 116's Order Summary Report dated 2/10/2025, the Order Summary Report indicated an order for Fortified (a diet in which certain essential nutrients have been added to foods to improve their nutritional value) Consistent Carbohydrate Diet (CCHO- diet f or resident with diabetes). During a review of Resident 116's History and Physical (H&P) dated 2/11/2025, the H&P indicated Resident 116 had the capacity to understand and make decisions. During a review of Resident 116's Minimum Data Set (MDS - a resident assessment tool) dated 4/13/2025, the MDS indicated Resident 116 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 116 needed partial to moderate assistance (helper does half the work) with activities of daily living (ADLs- activities such as bathing, and dressing a person performs). The MDS indicated Resident 116 height was 62 inches (unit of measurement) and weighed 138 lbs. The MDS indicated Resident 116 was on a therapeutic diet (specialized meal plans designed to treat or manage specific medical conditions by controlling nutrient intake) and the resident had no weight loss of 5% in the last month or loss of 10 % or more in the last six months. During a review of Resident 116's Weights and Vitals Summary from 12/2024 through 5/2025, the Weights and Vitals Summary indicated Resident 116's weight was as follows: 1.On 12/7/2024 Resident 116 weight was 156 lbs. 2.On 12/16/24 Resident 116 weight was 150 lbs. (3.85 % weight loss). 3.On 1/1/2025 Resident 116 weight was 146 lbs. (6 .4 % weight loss). 4.On 2/4/2025 Resident 116 weight was 138 lbs. (11.5 % weight loss). 5. On 2/10/2025 (readmission weight) Resident 116 weight was 140 lbs. (9.7 % weight loss). 6. On 4/3/2025 Resident 116 weight was 129 lbs. (17.31 % weight loss). 7. On 5/22/2025 Resident 116 weight was 127 lbs. (18.59 % weight loss). During a review of Resident 116's RD's recommendations dated 3/6/2025, the RD recommendation indicated to have the resident's weekly weights for two weeks. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 116's RD's recommendations dated 3/10/2025, the RD recommended was to discontinue Health Shakes (beverage, intended to be a healthy addition to a diet) and, provide snack three times a-day (TID) and to give 30 milliliters (ml-unit of measurement) of liquid protein (essential nutrient for the structure, function, and regulation of the body's tissues and organs) daily. During a review of Resident 116's RD's Weight Change Note dated 3/10/2025 the RD's Weight Change Note indicated Resident 116 weight was stable at 138 lbs. and it was discussed in IDT meeting. RD's recommendation indicated to have the resident's weekly weights for two weeks. During a review of Resident 116's RD's recommendations dated 3/11/2025, the RD's recommendation indicated to check CMP and prealbumin, weekly weights for two weeks and double portions at breakfast. During a review of Resident 116's Multidisciplinary Quarterly Care Conference dated 3/12/2025, the Multidisciplinary Quarterly Care Conference indicated Resident 116 was consuming between 26% to 50% of her breakfast, lunch and dinner. Resident 116's weight goal was 150 lbs., and she weighed 138 lbs., and that the family had requested for the resident to have a snack three times a day. During a review of Resident 116's care plan titled Alteration in Nutrition dated 3/14/2025 and revised on 5/22/2025 the care plan focus indicated that Resident 116 had lost 9.0 lbs. between 3/2025 through 4/2025. The care plan goal indicated for Resident 116 to consume 75% of her meals. The care plan interventions indicated to notify Resident 116's doctor and family of weight gain or loss of 5% or 5 lbs. in one month. On 5/19/2025 Resident 116 was started on Glucerna (nutritional shake) one time a day, ordered on 5/18/2025. During a review of Resident 116's Situation, Background, Assessment, and Recommendations ([SBAR] a technique which is used to facilitate prompt and appropriate communication within the care team) communication form dated 3/31/25, the SBAR indicated Resident 116 had no appetite and had lost nine lbs. in two month (2/4/2025- 4/3/2025). The SBAR indicated to have recommendation from Resident 116's primary doctor and RD consult. During a review of Resident 116's RD's recommendations dated 4/7/2025, the RD's recommendation was to do weekly weights for four weeks, check CMP, prealbumin and to call the medical doctor (MD) for an appetite stimulant. During a review of Resident 116's RD's Weight Change Note dated 4/07/2025 the RD's Weight Change Note indicated Resident 116's weight was 129 lbs. and that she was refusing meals and had a significant weight loss for in one month and three months. The RD's Weight Change Note indicated Resident 116 was at risk for further weight loss due to her refusal of meals and poor food intake. The RD's Weight Change Note indicated the RD attempted to discuss appetite and meal refusal and weight loss with Resident 116 on 4/7/2025, but she was asleep, and Resident 116's response was I know speak English. The RD informed Resident 116 she would have a Spanish speaking staff follow up with her. The RD's Weight Change Note also indicated that further weight loss would be undesirable. The RD recommendations were to do weekly weights for four weeks, check CMP, prealbumin and to call the medical doctor (MD) to request an appetite stimulant. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 116's Order Summary Report (summary of active, completed, discontinued, on hold or struck out physician orders) from 12/01/2024 through 5/31/2025, the Order Summary Report indicated Resident 116 was started on a protein supplement on 1/30/2025 which was discontinued on 2/10/2025. The Order Summary Report indicated Resident 116 was started on Glucerna on 5/19/2025. During a review of Resident 116's Medication Administration Record (MAR) dated 2/31/2025, the MAR indicated that Resident 116 had an order dated for a protein supplement 30 ml two times a day to start on 1/30/25 and was discontinued on 2/10/2025. During a review of Resident 116's, CMP results report dated 4/7/2025, the CMP results report indicated Resident 116's albumin was 3.0 grams per deciliter (g/dL-reference range is 3.5 to 5.7 g/dL). During an interview on 5/20/2025 at 11:28 a.m., with Resident 116's Family Member 1 (FM1), FM1 stated Resident 116 had lost a lot of weight since her admission to the facility on [DATE]. FM 1 stated they had been bringing Resident 116 lunch and dinner every day because she does not like the food at the facility as it was too sweet and she has DM. FM 1 stated the facility has not told them how much weight Resident 116 had lost but FM 1 knows it was a lot because last month (April) her eyes were sunken in prior to Resident 116's doctor discontinued a medication (unknown). FM 1 stated he had informed someone in the facility (unknown) that Resident 116 wanting a protein shake in the morning because she refuses to take her medication without food. FM 1 stated they live very far from the facility and cannot bring her breakfast that was the reason they requested a protein shake because Resident 116 will not take her medications until FM 1 bring her food. During a concurrent interview and record review on 5/22/2025 at 7:47 a.m., with the Assistant Director of Nurses (ADON) Resident 116's clinical record (Weights and Vitals Summary, COC documentation and IDT meeting notes) were reviewed, from 12/2024 through 5/2025. The ADON stated that in December Resident 116's admission weight was 156 lbs. and that in April the resident's weight was 129 lbs. The ADON stated the only documentation she could find was a COC that was done on 3/31/2025 for a 9.0 lb. weight loss. The ADON stated there should have been a COC done in 1/2025, 2/2025, and 4/2025 when Resident 116 continued to have a weight loss. The ADON stated Resident 116 should have had IDT meetings for weight loss and a comprehensive care plan should have been developed when Resident 116 started losing weight in 1/2025. The ADON stated the RD should have brought this resident's weight loss to IDT weight variance meetings in 1/2025 when Resident 116 had a 10 lbs. weight to discuss interventions to prevent the resident's future weight loss and to keep a better track of the resident's condition. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/22/2025 at 9:15 am with the RD, Resident 116's weights and RD's recommendations from 12/2024 through 5/2025 were reviewed. The RD stated that Resident 116 did have a weight loss of 10 lbs. in 1/2025 and had lost 6.4% of her body weight with no RD recommendations. The RD stated that in 2/2025, Resident 116 had lost another 9.0 lbs. and lost 11.5% of her body weight with no RD recommendations. The RD stated she did not know about the resident's weight loss until 3/2025 when Resident 116 weighed 138 lbs. and that was the reason why nothing was done for Resident 116's weight loss in 1/2025 and 2/2025. On 3/6/2025 RD's recommendation for weekly weights for two weeks was not done. On 3/10/2025 RD's recommendation to give 30 ml of a protein supplement TID was not done. On 3/11/2025 RD recommendation for weekly weights for two weeks, double portions for breakfast and a blood work for CMP and pre albumin, were not done. RD stated that in 4/2025 Resident 116 had lost another 9.0 lbs. and had lost 17.3% of her body weight. RD stated she had recommended on 4/7/2025 to do weekly weights for four weeks, give an appetite stimulant and to do a pre-albumin level and those intervention were not done. The RD stated a weight loss of 5 % in one month 7.5 % in three months and 10% in 6 months constitute a significant weight loss, and a weight loss greater than 7.5% in 3 months and greater than 10% was a severe weight loss. The RD stated Resident 116 was receiving 300 calories a day less than estimated needs in 1/2025, 160 calories a day less in 2/2025 and 70 calories a day less in 4/2025. The RD stated she did not talk to Resident 116 or FM 1 regarding her weight loss because Resident 116 could not speak English. RD stated there were no IDT meetings done for Resident 116's weight loss and that there should have been IDT meetings starting 1/2025 when the weight loss was first identified to prevent further weight loss. The RD stated there was no comprehensive care plan for Resident 116's weight loss and that there should have been one. The RD stated Resident 116's weight loss was preventable, sadly the facility dropped the ball with Resident 116's care. During an interview on 5/23/25 at 11:50 a.m., with the Director of Nurses (DON), the DON stated she was informed of Resident 116's weight loss on 3/31/2025, and she had been trying to find any documentation regarding Resident 116 weight loss. The DON stated that Resident 116 had significant weight loss from 12/2024 through 4/2025. The DON stated that there should have been a COC done for Resident 116's weight loss to inform Resident 116 doctor and the family member. The DON stated that Resident 116 should have had a comprehensive care plan put in place in 1/2025 when Resident 116 lost 10 lbs. The DON stated that RD was responsible for addressing Resident 116's weigh loss during weekly IDT weight variance meetings and her failure to do so resulted in Resident 116's weight loss going unnoticed. The DON also stated that Resident 116 weight loss could have been prevented if appropriate interventions had been implemented. During a review of the facilities Policy and Procedure (P&P) titled, Weight Assessment and Intervention dated 3/2022, the P&P indicated residents are weighed upon admission and at intervals established by the interdisciplinary team .Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time .Undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met .The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia (loss of appetite) , weight loss or increasing the risk of weight loss .Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of the facilities P&P titled, Care Plans Comprehensive Person Centered dated 3/2022, the P&P indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan, includes measurable objectives and timeframes .When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. During a review of the facilities P&P titled, Change in a Resident's Condition or Status dated 7/2017, the P&P indicated, the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc. 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an), significant change in the resident's physical/emotional/mental condition; a need to alter the resident's treatment significantly. During a review of the facilities P&P titled ,Resident Food Preferences dated 2/2021, the P&P indicated, individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes .The Dietitian and nursing staff, assisted by the Physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences. The Dietitian will discuss with the resident or representative the rationale of any prescribed therapeutic diet. During a review of the facilities P&P titled, Nutritional Assessment dated 10/2017, the P&P indicated, as part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. The nutritional assessment will be conducted by the multidisciplinary team.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 15 and 2) oxygen nasal cannula (a small plastic tube, which fits into the person's nostril for providing supplemental oxygen) tubing with the date and change every seven (7) days, or as needed while receiving oxygen therapy and oxygen humidifier (medical device used to humidify supplemental oxygen) were labeled and dated for Resident 2. This failure had the potential for resident harm, as the possibly over-extended use of unchanged nasal cannulas placed Resident 15 at high risk of developing a respiratory infection. Findings: 1.During a review of Resident 15's admission Record dated 5/22/2025, the admission Record indicated, the facility initially admitted Resident 15 on 9/3/2021, then readmitted on [DATE], with admitting diagnoses that included chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 4/19/2025, the MDS indicated, Resident 15 did not have cognitive impairments (a decline in mental abilities like memory, language, problem-solving, and attention). The MDS indicated, Resident 15 also required substantial/maximal assistance from staff for dressing himself and personal hygiene. The MDS indicated, Resident 15 also required set up or clean-up assistance performing activities of oral hygiene, eating, and he required dependent assistance with shower/bathe, and movement while in and out of bed. During on observation on 5/20/2025 at 9:01 a.m. at Resident 15's bedside, there was a blank, undated label on Resident 15's nasal cannula oxygen tubing. Resident 15 was observed to be receiving oxygen therapy at three liters (3L - a unit of measurement) per minute (amount of oxygen delivered within a minute) through the unlabeled nasal cannula. During a concurrent observation and interview on 5/20/2025 at 9:10 a.m. with Licensed Vocational Nurse 4 (LVN 4), LVN 4 observed Resident 15 receiving oxygen therapy via nasal cannula tubing that was not labeled with a date. LVN 4 stated, she did not see any date labeled on the oxygen tubing and stated it should have been labeled with a date, to prevent the spread of infection. During an interview on 5/22/2025 at 9:12 a.m. with the Infection Prevention Nurse (IPN), the IPN stated the oxygen tubing should be changed weekly, and the oxygen tubing needed to be dated. LVN 4 and Respiratory Therapist (RT) needed to follow policy and procedure to prevent infection, contamination, and acquired respiratory infection. During a concurrent observation and interview on 5/22/2025 at 9:37 a.m. with RT at Resident 15's bedside , there was no dated labeling on Resident 15's oxygen tubing. RT stated, oxygen tubing should be labeled. RT stated, the nurses probably forgot to do this and should have been done every week. RT stated, changing and dating the oxygen tubing was part of their responsibilities. RT stated, there was a risk of contamination and infection if the date was not applied to the oxygen tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025at 12:40 p.m. with the Director of Nursing (DON), the DON stated, the staff needs to label the oxygen tubing with a date every week to prevent contamination and spread of respiratory infection. During a review of Resident 15's Order Summary Report dated 4/25/2025 indicated, Oxygen at 2-3 L/minute through nasal cannula, every night shift, every Sunday. Change oxygen tubing every week, date tubing During a review of Resident 15's Care Plan Report initiated on 5/16/2025 for Resident 15's oxygen therapy indicated, shortness of breath was to be managed by giving oxygen, and the interventions included to change oxygen tubing weekly, or as needed. 2. During a review of Resident 2's admission Record, the admission record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included pleural effusion (buildup of fluid between the tissues that line the lungs and chest), disorders of lung and history of Covid 19 (active Covid 19 illness[highly contagious respiratory disease]). During a review of Resident 2's MDS dated [DATE],the MDS indicated Resident 2 had severely impaired cognitive skills (significant decline in thinking, remembering, and decision-making abilities impacting daily life) and was dependent on staff with oral hygiene, toileting hygiene, bathing, dressing,1 personal hygiene and bed mobility. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated an order for oxygen at two liters per minute (L/min.- unit of measurement that expresses flowrate) via nasal cannula to keep oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage). During an observation on 5/20/2025, at 4:27 p.m. in Resident 2's room with Registered Nurse (RN 2), RN 2 confirmed Resident 2's nasal cannula and oxygen humidifier were not labeled and dated. RN 2 stated the facility changed the oxygen humidifier and nasal cannula every week to prevent respiratory infection. During an interview on 5/22/2025, at 12:59 p.m. with Respiratory Therapist (RT), RT stated they labeled and dated nasal cannula and oxygen humidifier every Wednesday and as needed to prevent infection. RT stated it was a shared responsibility with licensed nurses and does not need a physician order to change the oxygen humidifier and nasal cannula because it was the standard of practice and care. During an interview on 5/23/2025, at 10:27 a.m. with the DON, the DON stated nasal cannula and oxygen humidifier are changed by RT and licensed vocational nurses every Wednesday or weekly. The DON stated not labeling and dating nasal cannula and oxygen humidifier could spread infection among residents and staff because no one would know when to change them. During a review of facility's P&P titled, Departmental (Respiratory Therapy) Prevention of Infection, revised 11/2011, the P&P indicated Change the oxygen cannula and tubing every seven days or as needed. The P&P indicated to use distilled water for humidification and mark the bottle with date and initials upon opening and discard after 24 hours.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure pain medication was reordered to pharmacy in a timely manner for one of one sampled resident (Resident 77). This failure had the potential for Resident 77 to experience pain and delay in treatment. Findings: During a review of Resident 77's admission Record, the admission Record indicated, Resident 77 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including bilateral breast cancer (a disease where abnormal cells in the breast grow uncontrollably, forming tumors), bilateral leg neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet) and hypertension (HTN-high blood pressure). During a review of Resident 77's Minimum Data Set (MDS - a resident assessment tool), dated 3/15/2025, the MDS indicated Resident 77 had the ability to express ideas and wants. The MDS indicated Resident 77 had the ability to understand others. The MDS indicated Resident 77 was dependent on the nursing staff for toileting, showering, sitting, and lying down. The MDS indicated Resident 77 was dependent on the nursing staff for transferring, lower body dressing, putting on and taking off footwear. The MDS indicated Resident 77 needed substantial to maximal assistance from nursing staff with upper body dressing, personal hygiene, and rolling from left to right. The MDS indicated Resident 77 needed substantial to maximal assistance from nursing staff with standing and walking. During an interview on 5/20/2025 at 12:03 p.m., with Resident 77, Resident 77 stated she received Norco for pain due to breast cancer. Resident 77 stated she had to wait for Norco (medication used to manage moderate to moderately severe pain) when she complained of pain to her bilateral (both) breast, with a pain level of eight over 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable) . Resident 77 stated she waited two days (unknown dates) for pain medication. Resident 77 stated she was told by the licensed nurses she had to wait for the doctor's approval before receiving pain medication. Resident 77 stated she had to call her power of attorney (the authority to act for another person in specified or all legal or financial matters) to get the facility to give her pain medication from the emergency kit (a kit designed to help nursing facilities provide medication to their residents during emergency situations). During an interview on 5/22/2025 at 9:43 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 77 takes Norco 10 milligram (mg- unit of measurement) every six hours as needed for severe pain related to Resident 77 breast cancer. LVN 5 stated when the Norco has a three-day supply left, the licensed nurse will call for an authorization from the doctor. LVN 5 stated the doctor's authorization usually takes an hour. LVN 5 stated when pain medication was administered from the emergency medication kit, it means the medication has run out. LVN 5 stated the licensed nurses will call the pharmacy to get a code to open the emergency medication kit and administer pain medication as ordered from the emergency medication kit. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/23/2025 at 2:02 p.m., with the Director of Nursing (DON), reviewed Resident 77's Nursing Progress Notes, dated 3/8/2025 and 3/13/2024. The Nursing Progress Notes indicated on 3/8/2025 at 6:37 p.m., a Licensed Vocational Nurse (LVN 8) documented a call was made to the pharmacy regarding Resident 77's Norco 10 mg and a code was given to the licensed vocational nurse on 3/8/2025 at 2:17 p.m., to get Norco from the emergency medication kit. The Nursing Progress Notes indicated Resident 77 was given Norco 10 mg for complained of severe pain on 3/8/2025 at 6:36 p.m. The DON stated when the medication was down to a three-day supply, the medication nurse will call the pharmacy then wait for the delivery of the medication. The DON stated the prescribing doctor needs to sign for authorization of the medication. The DON stated authorization could take up to 24 hours. The Nursing Progress Notes indicated on 3/13/2025 at 3:01 p.m., Resident 77 was concerned about her pain medication not being filled on 3/8/2025. The Nursing Progress Notes indicated the doctor did not receive the request for Norco authorization faxed to Resident 77's doctor. The Nursing Progress Notes indicated a new request for Norco authorization refaxed on 3/13/2025 at 3:01 p.m. The DON stated on 3/8/2025 Resident 77's Norco 10 mg ran out and the licensed nurses did not re-order when Resident 77's Norco 10 mg was down to a three-day supply. The DON stated the medication was not filled on 3/8/2025 and the doctor did not receive a fax. The DON stated when the residents were not medicated for pain in a timely manner the comfort of the resident will be altered, and the resident will have no relief of pain. During a review of Resident 77's Order Summary, dated 1/7/2025, the order Summary indicated, Resident 77 had an order for Norco 10-325 mg by mouth every six hours as needed for severe pain. During a review of the facility's Controlled Drug Record, the Controlled Drug Record indicated on 3/7/ 2025 there was one tablet of Norco remaining and administered at 4:03 p.m. During a review of the facility's Controlled Drug Record, the Controlled Drug Record indicated on 3/8/ 2025, there was no documentation for Norco 10 mg. During a review of Resident 77's MAR dated March 2025, the MAR indicated Resident 77 did not received any pain medication after 3/13/2025 at 9:50 p.m., to 3/15/2025 at 12:15 a.m. During a review of Resident 77's pain assessment, Resident 77 had no pain level assessment after 3/13/2025 at 9:50 p.m., to 3/15/2025 at 12:15 a.m. During a review of the facility's Controlled Drug Record, the Controlled Drug Record indicated on 3/14/ 2025, there was no documentation of Norco 10 mg. During a review of the facility's Order Audit Report, the Order Audit Report indicated the facility reordered Norco 10 mg on 3/14/2025. During a review of the facility's policy and procedure (P&P) titled, Emergency Medications, dated 4/2021, the P&P indicated, The facility shall maintain a supply of medications typically used in emergencies. The emergency medication kit will include medications and biologicals that are essential in providing emergency treatment. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, undated, the P&P indicated, The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Restorative Nursing Aide program (RNA, nursing aide program that helps residents maintain any progress after therapy intervention to maintain their function) was modified by qualified and competent staff when Restorative Nursing Assistant 1 (RNA 1) modified Resident 112's RNA program independently. This deficient practice placed the residents in the facility at risk for harm and injury and had the potential to result in inaccurate and inappropriate provision of necessary care and services, assessments, and interventions. Findings: During a review of Resident 112's admission Record, the admission Record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following an intracerebral hemorrhage (bleeding in the brain), abnormal posture, and muscle weakness. During a review of Resident 112's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge summary, dated [DATE], the PT Discharge Summary indicated discharge recommendations for an RNA program for passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises for Resident 112's left leg and active assistive range of motion (AAROM, use of muscles surrounding the joint to perform the exercise but required some help from a person or equipment) exercises to Resident 112's right leg. During a review of Resident 112's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Discharge summary, dated [DATE], the OT Discharge Summary indicated discharge recommendations for an RNA program for PROM exercises to Resident 112's left arm, three (3) times a week as tolerated. During a review of Resident 112's Minimum Data Set (MDS, a resident assessment tool), dated 4/27/2025, the MDS indicated Resident 112 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 112 required set-up or clean up assistance for eating, partial/moderate assistance for oral and personal hygiene, substantial/maximal assistance for upper body dressing, and total assistance for toileting hygiene, bathing, and bed to chair transfers. The MDS indicated Resident 112's sit-to-stand transfers were not attempted. The MDS indicated Resident 112 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm (shoulder, elbow, wrist, hand) and one leg (hip, ankle, knee, foot). During a review of Resident 112's RNA Documentation Survey Report (RNA flowsheet, daily record of RNA services provided for each month), dated 5/2025, the RNA flowsheet indicated RNA Tasks for RNA to: 1) provide AAROM exercises to Resident 112's right leg and right arm, 3 times a week, and 2) provide PROM exercises to Resident 112's left arm, 3 times a week. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/20/2025 at 9:42 a.m., in Resident 112's room, Resident 112 was lying in bed. Resident 112's left elbow and left wrist were bent, and the fingers of the left hand were in a fist. Resident 112's left leg was rotated outwards with the knee bent and the toes pointing downwards. Resident 112 stated staff assisted with bicycle exercises for both of his arms and legs and practiced sit-to-stand exercises, 3 times a week, for many months. During an observation of an RNA session on 5/21/2025 at 1:42 p.m., in Resident 112's room, Resident 112 was lying in bed. RNA 1 positioned a wheelchair next to Resident 112's bed. RNA 1 removed Resident 112's blankets and put shoes on Resident 112's both feet. RNA assisted Resident 112 into a sitting position by moving Resident 112's both legs off the bed, hugging the upper body, and lifting Resident 112's upper body into an upright position. RNA 1 placed a gait belt (safety device worn around the waist that can be used to help safely transfer a person from one surface to another or while walking) on Resident 112's waist. Resident 112 tried to stand with RNA 1 assistance but could not. RNA 1 grabbed Resident 112's gait belt and assisted Resident 112 to stand a second time and helped pivot Resident 112 into the wheelchair next to the bed. While seated in the wheelchair, RNA 1 assisted Resident 112 into a standing position two times while holding onto the gait belt where Resident 112 stood momentarily and assisted Resident 112 back down into sitting. RNA 1 transported Resident 112 into the Therapy gym, placed Resident 112's wheelchair in front of a motorized exercise bicycle (motorized exercise device for the arms and/or legs to help patients strengthen muscles, improve ROM, and increase endurance), placed Resident 112's both feet on the foot pedals, and placed Resident 112's right hand on the handlebar of the exercise bicycle. Resident 112's left elbow was fully bent with the hand in a fist and was not placed on the handlebar of the bicycle. RNA 1 set the timer on the exercise bicycle for 15 minutes and told Resident 112 to inform her when the timer was complete. After five minutes, Resident 112 stated he felt nauseous and wanted to return to bed. RNA 1 removed Resident 112's feet from the pedals and the right arm from the handlebar and transported Resident 112 back to his room. Once back in Resident 112's room, RNA 1 fully assisted Resident 112 into standing by grabbing Resident 112's upper body and the gait belt and pivoted Resident 112 back into sitting on the edge of the bed. RNA 1 fully assisted Resident 112 back into the bed to lay on his back and provided PROM to Resident 112's left arm. During a concurrent interview and record review on 5/21/2025 at 2:20 p.m., RNA 1 stated the therapy department created and modified the RNA program as needed. RNA 1 stated the specific types of exercises RNAs were supposed to carry out with the residents were written on the RNA task. RNA 1 stated Resident 112 required a lot of physical assistance for all RNA activities. RNA 1 reviewed Resident 112's May 2025 RNA tasks and confirmed Resident 112 had RNA tasks for AAROM exercises to Resident 112's right arm and right leg and PROM to Resident 112's left arm. RNA 1 confirmed Resident 112 did not have RNA tasks for left leg ROM exercises, sit-to-stand transfers, and the motorized exercise bicycle. RNA 1 stated she was aware Resident 112 did not have RNA tasks for left leg ROM, sit-to-stand transfers, and the motorized exercise bike but implemented the activities anyway. RNA 1 stated the RNAs were supposed to follow exactly what the RNA tasks indicated and were not allowed to modify the RNA program because RNAs were not qualified to do so. RNA 1 stated the PT and OT were the only staff qualified to modify the RNA program because they had the training and qualifications to do so. RNA 1 stated she should have notified the Therapy Department and/or licensed nurse and waited for therapy to re-assess Resident 112 and modify the RNA program and RNA tasks as appropriate if she wanted to modify the RNA program but did not. RNA 1 stated if RNAs did not follow the RNA program and tasks as indicated and modified the RNA program without the proper qualifications, it could potentially cause harm to the residents. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2024 at 1:02 p.m., Occupational Therapist 1 (OT) stated PT and/or OT established and modified the RNA program as needed. OT 1 stated specific RNA exercises and equipment were recommended for each resident for a reason based on the therapist's assessment and the resident's functional abilities. OT 1 stated RNAs were supposed to carry out the RNA program as ordered and could not modify the RNA program because they were not qualified to do so. OT 1 stated if an RNA modified the RNA program independently, it could potentially cause harm and injury to the residents in the facility. During a concurrent interview and record review on 5/22/2025 at 1:21 p.m., Physical Therapist 1 (PT 1) stated PT and/or OT created and modified the RNA programs as needed. PT 1 stated specific RNA exercises and equipment were recommended for each resident for a reason based on the therapist's assessment and the resident's functional abilities. PT 1 stated RNAs were supposed to carry out the RNA program as listed on the RNA tasks and could not modify the RNA program because they were not qualified to do so. PT 1 reviewed Resident 112's PT Discharge summary, dated [DATE], and confirmed the PT recommendations for the RNA program were for AAROM of Resident 112's right arm and right leg and PROM of Resident 112's left leg. PT 1 stated she did not recommend sit-to-stand exercises and/or the motorized exercise bicycle because Resident 112 was not appropriate for those specific exercises for RNA at the time of discharge from PT because he had impulsive behavior and required maximal assistance (required 51-75% physical assistance to perform tasks) to stand. PT 1 stated if RNAs modified the RNA program independently, it could jeopardize the safety of the residents in the facility and could lead to accidents and/or harm. During an interview on 5/23/2025 at 3:00 p.m., the Director of Nursing (DON) stated the RNA treatment plan was determined by the licensed therapists and implemented by the RNAs as ordered on the RNA tasks. The DON stated the RNAs were supposed to follow exactly what the RNA order indicated. The DON stated if an RNA program required modification, the RNA must notify a licensed nurse, PT, and/or OT who in turn would re-assess the resident and modify the RNA program if appropriate based on the resident's needs. The DON stated RNAs were not qualified and competent to modify an RNA program because they did not have the proper training and expertise. The DON stated if RNAs modified the RNA program independently, it could negatively impact the safety of the residents and staff in the facility. During a review of the facility's Policy and Procedure (P&P), titled Specialized Rehabilitative Services, revised 12/2009, the P&P indicated once a resident met his or her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either Nursing or RNA would implement to assure the resident maintained his/her functional and physical status. During a review of the facility's P&P, titled Staffing, revised 10/2017, the P&P indicated the facility provided sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. During a review of the facility's Job Description, titled Restorative Nursing Assistant, revised 9/2020, the RNA Job Description indicated RNA would assist the resident to restore, improve, or maintain bodily functions to the highest degree practicable in accordance with the resident's assessment, care plan, and as directed by supervisors.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide social services for two of six sampled residents by failing to: 1.Follow up with Resident 23's request for a larger mattress. 2.Request conservatorship (when a judge appoints another person to act or make decisions for the person who needs help) for Resident 38 who was unable to make medical decisions on his own. This failure resulted in a delay in necessary care and services for Resident's 23, and 38. Findings: During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), obesity (having too much body fat), and depression (a persistent state of sadness or lack of interest in things that you used to enjoy). During a review of Resident 23's Minimum Data Set (MDS- a resident assessment tool) dated 3/26/2025, the MDS indicated Resident 23's cognition (ability to think, understand, learn, and remember) was intact and was dependent (helper does all the effort) with toileting, bathing, and dressing. During a concurrent observation and interview on 5/20/2025 at 11:06 a.m., with Resident 23, Resident 23 stated he would prefer a larger mattress and had spoken with the social worker about getting one. Observed Resident 23 had a large bed frame with a small mattress. Resident 23 stated having a larger mattress would be more comfortable for him because he had a larger mattress at one point, but they removed it. During an interview on 5/21/2025 at 11:52 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 validated Resident 23's mattress was too small for the large bed frame he had in place, and he should in fact have a larger mattress for his safety and comfort. LVN 2 stated having a small mattress could cause Resident 23 to feel unsafe and uncomfortable. During an interview on 5/21/2025 at 12:03 p.m., with the Social Services Director (SSD), the SSD stated she was aware of Resident 23's mattress being too small for him but did not document this conversation. The SSD stated she spoke with the maintenance department about getting Resident 23 a larger mattress but did not follow up with them. The SSD stated Resident 23 should have a larger mattress because he has a large bed frame and having a small mattress could make him feel uncomfortable and possibly unsafe. During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated Resident 23 should have the correct size mattress because it's his right. The DON stated the resident has the right to feel comfortable and it's the facility's responsibility to ensure resident's feel their room is their own. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated, Residents are provided with a safe, clean, and comfortable and homelike environment. Staff provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. During a review of the Director of Social Services Job Description dated 9/2020, the Director of Social Services Job Description indicated the Director of Social Services duties and responsibilities included, Ensures that all residents are treated fairly, with kindness, dignity, and respect, and their rights are protected at all times. Ensures ongoing evaluations for dental, vision, and mental health exams and follow up. Directs and coordinates resident's appointments including transportation. During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), mood disorder (a mental health condition that primarily affects your emotional state), and anxiety (a common emotion characterized by feelings of worry, fear, and unease). During a review of Resident 38's (MDS dated [DATE], the MDS indicated Resident 38's cognition (ability to think, understand, learn, and remember) was severely impaired and required moderate assistance (helper does less than half the work) with personal hygiene, bathing, and dressing. During a review of Resident 38's Order Summary Report, the Order Summary report indicated an order was placed 9/23/2024 for Ativan (medicine used to treat anxiety) 0.5 milligrams (mg- unit of measurement) three times a day for anxiety manifested by continuous yelling and screaming. The Order Summary Report indicated an order was placed on 8/30/2024 for Buspirone (medicine for anxiety) 10mg once a day for anxiety manifested by continuous yelling. The Order Summary Report indicated an order was placed 2/18/2025 for Lamictal (medicine to stabilize moods) 25mg for mood disorder manifested by mood swings from calm to angry. During a review of Resident 38's History and Physical (H&P) dated 9/24/2024, the H&P indicated Resident 38 can make needs knows but cannot make medical decisions. During an interview on 5/22/2025 at 9:44 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 38 was confused, unable to make medical decisions, and should not be signing consents. LVN 2 stated its important for the resident to understand what they are signing for accuracy and resident's safety. During a concurrent interview and record review on 5/22/2025 at 11:31 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated Resident 38 was confused and should not be signing consents because he was not aware of what he was signing. RNS 1 validated Resident 38 signed the psychoactive medication consents but because of his confusion, the signature was not valid and could potentially cause harm to Resident 38. During an interview on 5/22/2025 at 12:07 p.m., with the SSD, the SSD stated Resident was unable to make medical decisions and should have a conservatorship. The SSD stated she was not sure as why she has not looked into obtaining a conservatorship for Resident 38. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated Resident 38 was unable to make medical decisions and should not be signing consents. The DON stated Resident 38 should not have been asked to sign consents for psychoactive medications because he does not understand the risks and benefits and should have a conservatorship to sign the consents. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, undated, the P&P indicated, Prior to initiating the use of psychotropic medications, the staff and physician will review the following with the resident/representative prior to obtaining documented consent: the potential risks and benefits and the resident's right to accept or decline the treatment. Cross reference F552 and F558

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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 blood pressure parameters for blood pressure medications prior to administration for one out of four sampled residents (Resident 342). This deficient practice has the potential to result in low blood pressure which can cause light-headedness, dizziness, and fatigue for Resident 342. Findings: During a review of Resident 342's admission Record, the admission Record indicated Resident 342 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension ([HTN], high blood pressure), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 342's History and Physical (H/P) dated 4/25/2025, the H/P indicated has the capacity to understand and make decisions. During a review of Resident 342's Minimum Data Set ([MDS], a resident assessment tool), dated 5/11/2025, the MDS indicated Resident 342 had intact cognitive (thinking process) skills, and required set up assistance (helper sets up as resident completes the activity) with self-care abilities with eating, and oral hygiene, was supervision assistance (helper provides verbal cues as resident completes activity) with upper body dressing and personal hygiene, required moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 342 required moderate assistance with mobility with rolling left and right, sitting to lying position, lying to sitting on side of bed, sit to stand position, bed to chair transfers, toilet transfers, and was dependent (helper does all of the effort) with shower transfers. During a review of Resident 342's Order Summary Report, the Order Summary Report indicated amlodipine besylate oral tablet (pill) 10 milligram ([mg], a unit of measurement), give one tablet by mouth one time a day for hypertension, furosemide oral tablet 20 mg give one tablet by mouth one time a day for extra body fluid, and lisinopril oral tablet 40 mg give one tablet by mouth one time a day for hypertension. During a review of Resident 342's Medication Administration Record ([MAR], to document medications taken by each individual) for May 2025, the MAR indicated amlodipine besylate oral tablet 10 mg give one tablet by mouth one time a day for hypertension was administered for the month, furosemide oral tablet 20 mg give one tablet by mouth one time a day for extra body fluid was administered for the month, and lisinopril oral tablet 40 mg give one tablet by mouth one time a day for hypertension was administered for the month to Resident 342. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/21/2025 at 9:34 a.m. The Licensed Vocational Nurse (LVN) was at Resident 342's doorway while preparing medication for the resident. The Licensed Vocational Nurse (LVN) indicated that there were no established parameters for the administration of blood pressure medications. However, she noted that she would withhold the medication if the patient's blood pressure fell below a certain threshold. The LVN mentioned that she needed to call the medical doctor to confirm whether she could administer the blood pressure medication, which would delay the medication administration process. She noted that there should have been parameters in place to hold the blood pressure medication if the blood pressure falls below a certain threshold. Without such parameters, she would have to administer the medication as ordered, even if the blood pressure was below that threshold. During an interview on 5/23/2025 at 10:15 a.m. The Director of Nursing stated that staff should take residents' blood pressure before administering medication to ensure safety and adherence to hold parameters. The DON stated it was important to have parameters for blood pressure medication so staff can identify the need for the medication administration that was ordered by the medical doctor. DON stated if a staff gave a blood pressure medication to a resident whose blood pressure was already low, the resident could become hypotensive (low blood pressure) that could lead to a change in condition and possible hospital transfer. During a review of the facility's policy and procedure (P/P) titled, Administering Medications, revised April 2019, indicated, medications are administered in accordance with prescriber orders, including any required time frame the following information is checked/verified for each resident prior to administering medications: allergies to medications; and vital signs, if necessary. During a review of the facility's P/P titled Medication Utilization and Prescribing - Clinical Protocol, no dated, indicated, the staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to determine if the medication and doses are still relevant and are not causing undesired complications .the staff and physician will monitor the progress of anyone with a probable adverse drug reaction and anyone for whom medications have been adjusted because of the possibility of an adverse drug reaction .if the physician has stopped, tapered, or changed an existing medication, the staff will monitor for, document, and report any return of symptoms. During a review of the facility's P/P titled Medication and Treatment Orders, revised July 2016, indicated, orders for medications must include: a. Name and strength of the drug; . b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration; e. Clinical condition or symptoms for which the medication is prescribed; and f. Any interim follow-up requirements (pending culture and sensitivity reports, repeat labs, therapeutic medication monitoring, etc.).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the physician of consultant pharmacist's (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) recommendation for one of one sampled residents (Resident 69) related to administration of sertraline (medication used to treat depression [a serious mental disorder characterized by persistent sadness, loss of interest, and changes in thinking, sleeping, eating, and acting]). This deficient practice possibly resulting in medication side effects (a secondary, typically undesirable effect of a drug or medical treatment) and leading to a decrease in resident's physical, mental, or psychosocial well-being. Findings: During a review of Resident 69's admission Record, the admission Record indicated Resident 69 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia(a mental illness that is characterized by disturbances in thought), and chronic kidney disease (kidneys that are damaged and not working properly to filter blood). During a review of Resident 69's History and Physical (H&P), dated 2/7/2024, the H&P indicated Resident 69 had the capacity to understand and make decisions. During a review of Resident 69's Order Summary, dated 4/24/2025, the Order Summary indicated, sertraline 50 (medication used to treat depression [a serious mental disorder characterized by persistent sadness, loss of interest, and changes in thinking, sleeping, eating, and acting]) milligram (mg-unit of measurement) by mouth one time a day for depression manifested by feeling depressed. During a concurrent interview and record review at 5/23/2025 at 11:02 a.m., with Assistant Director of Nursing (ADON), the pharmacist's Note to Attending Physician/Prescriber, dated 4/30/2025 was reviewed. The Note to Attending Physician/Prescriber indicated, Resident 69 had been receiving sertraline 50 mg once a day for depression since 4/10/2024. The Note to Attending Physician/Prescriber indicated to please evaluate for discontinuation or gradual dose reduction per federal nursing facility regulations. The ADON stated Resident 69 was receiving sertraline 50 mg by mouth one time a day for depression manifested by feeling depressed. The ADON stated The Note to Attending Physician/Prescribe, dated 4/30/2025, with recommendations for sertraline were not given to the doctor and not reviewed by the doctor for Resident 69. The ADON stated a gradual dose reduction was done to slowly wean the resident off psychotropic medications, so the resident will not stay on the psychotropic medication for too long. ADON stated she could not find any documentation of Resident 77 receiving a gradual dose reduction. During an interview on 5/23/2025 at 3:05 PM with the Director of Nursing (DON), the DON stated Resident 69 could have a change in mental status, behavior and a potential risk for receiving unnecessary medication if the doctor does not receive the Note to Attending Physician/Prescriber with pharmacist medication recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled, Psychotropic Medication Use, dated 2001, Residents on psychotropic medication receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, to determine whether the continued use of the medication is benefitting the resident, to find an optimal dose, or in an effort to discontinue the medication.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Healthcare Center	3401 Cedar Avenue Long Beach, CA 90807

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two of two sampled residents (Resident 69 and Resident 129) had dental services. This failure had the potential to lead to weight loss for Resident 69 and Resident 129. Findings: During a review of Resident 69's admission Record, the admission Record indicated Resident 69 was re-admitted to facility on 2/6/2024, with diagnoses including severe protein- calorie malnutrition (a state of inadequate intake of both protein and calories), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia(a mental illness that is characterized by disturbances in thought), and chronic kidney disease (kidneys that are damaged and not working properly to filter blood). During a review of resident 69's Order Summary, dated 2/6/2024, the Order Summary indicated, Resident 69 may have a dental consult and treatment as indicated. During a review of Resident 69's History and Physical (H&P), dated 2/7/2024, the H&P indicated Resident 69 had the capacity to understand and make decisions. During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 69 needed supervision or touching assistance from nursing staff with oral hygiene, eating, and personal hygiene. During a review of Resident 129's admission Record, the admission Record indicated, Resident 129 was admitted to the facility with diagnoses including diabetes mellitus, and seizures (temporary disruption of the brain's normal electrical activity). During a review of Resident 129's History and Physical (H&P), dated 3/12/2025, the H&P indicated Resident 69 had the capacity to understand and make decisions. During a review of Resident 129's MDS dated [DATE], the MDS indicated Resident 129 needed supervision or touching assistance from nursing staff with oral hygiene, eating, and personal hygiene. During an interview an interview on 5/20/25 at 1:21 p.m., with Resident 69, Resident 69 stated she had all her teeth removed and has not received dentures in six weeks. During a record review of Resident 69's Onsite Mobile Dental report, dated 12/18/2024, the Onsite Mobile Dental report indicated, Resident 69 had 20 teeth extractions. The Onsite Mobile Dental report indicated, Resident 69 was receiving treatment for front upper dentures and partial lower dentures. During a review of Resident 69's Onsite Mobile Dental report, dated 1/7/2025, the Onsite Mobile Dental report indicated, Resident 69 needed dental x-rays before taking impressions for dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 69's Onsite Mobile Dental report, dated 1/16/2025, the Onsite Mobile Dental report indicated, Resident 69 had full mouth dental x-rays done. During an interview on 5/21/2025 at 9:04 a.m., with Resident 129, Resident 129 stated her dentures were not fitting right. Resident 129 stated she had problems with chewing food. Resident 129 stated she had not seen a dentist in three weeks. During a review of Resident 129's Onsite Mobile Dental report, dated 4/15/2025, Resident 129 had a recommendation for new dentures. The Onsite Mobile Dental report indicated, Resident 129 needed a full mouth dental x-ray. During an interview on 5/21/2025 at 12:31 p.m., with the Social Services Director (SSD), SSD stated it was her responsibility to document on the MDS if the resident has missing teeth. SSD stated she did not pay attention to Resident 69's and Resident 129's teeth when she initially spoke to them. SSD stated she does not know how to read the dental recommendations and did not follow up on the doctor's recommendations for Resident 69 and Resident 129. During an interview on 5/22/2025 at 10:15 a.m., with Registered Nurse (RN) 1, RN 1 stated there was no follow up on the dental recommendations for Resident 69 and Resident 129. RN 1 stated Resident 69 and Resident 129 can have a negative effect on the residents' nutrition, and they cannot chew their food well. The RN 1 stated it was important to follow up on dental recommendations so the residents' dental condition can improve. During an interview on 5/23/2025 at 3:04 p.m., with the Director of Nursing, The DON stated dental recommendations need to be followed because it could lead to issues with chewing, nutrition and a potential for weight loss. During a review of the facility's policy and procedure (P&P), titled Dental Examination/ Assessment, dated 12/2013, the P&P indicated .Upon conducting a dental examination, a resident needing dental services will be promptly referred to a dentist.

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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 ensure Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) services provided were accurately documented for three of nine sampled residents (Residents 3, 116, and 121). 1.For Residents 3, the facility failed to ensure RNA daily documentation accurately reflected RNA services provided. 2.For Resident 116, the facility failed to ensure RNA daily documentation accurately reflected RNA services provided. 3.For Resident 121, the facility failed to ensure the RNA daily documentation prompts (questions or cues used to direct the write on the specific focus or task) pertained to the RNA task of services provided. These deficient practices had the potential to negatively impact the provision of necessary care and services due to the inaccurate reflection of services provided. Findings: 1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including a left femur (thigh bone) fracture (broken bone) and gout (form of arthritis that occurs when uric acid builds up in the blood and causes joint inflammation). During a review of Resident 3's January 2025 RNA Documentation Survey Report (RNA flowsheet, daily record of RNA services provided for each month), the RNA flowsheet indicated RNA tasks for RNA to assist Resident 3 with walking exercises using a front wheeled walker (FWW, mobility device with two wheels in the front used for support when standing or walking), three times a week, and for RNA to provide active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) exercises to Resident 3's both arms, three times a week. The RNA flowsheet indicated the following prompts under the RNA task for walking exercises: 1) Amount of minutes spent training and skill practice in walking, 2) Distance walked (in feet), 3) Did the resident complain of or show signs of pain of discomfort? The RNA flowsheet indicated the letters n, n, n on the following dates for the RNA task of ambulation: 1/21/2025, 1/23/2025, 1/28/2025, and 1/30/2025. The RNA flowsheet indicated the following prompts under the RNA task for AAROM exercises to both arms: 1) Amount of minutes spent providing ROM and 2) Did the resident complaint of or show signs of pain or discomfort? The RNA flowsheet indicated the letters n, n on the following dates for the RNA tasks of AAROM to both arms: 1/22/2025, 1/24/2025, and 1/29/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Minimum Data Set (MDS, resident assessment tool), dated 5/13/2025, the MDS indicated Resident 3 had severely impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 3 required substantial/maximal assistance for eating, oral hygiene, and upper body dressing and was dependent for toileting hygiene, bathing, lower body dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 3 had functional range of motion (ROM) limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both legs. During an observation on 5/22/2025 at 9:00 am, in Resident 3's room, Resident 3 was lying in bed. Resident 3's both legs were rotated to the right side of the body. Resident 3's left hip and left knee were fully bent and resting on the chest. Resident 3's right leg was straight with a slight bend in the knee. During a concurrent interview and record review on 5/23/2025 at 9:38 a.m., Restorative Nursing Aide 2 (RNA 2) stated the RNAs documented on the electronic medical record by answering a series of prompts related to the RNA task. RNA 2 reviewed Resident 3's RNA flowsheets and stated the letter n meant not applicable. RNA 2 stated she documented n, n, n or n, n when the prompts asked did not pertain to the RNA task or if the resident was not seen for RNA treatment that day. During a concurrent interview and record review on 5/23/2025 at 12:22 p.m., the Assistant Director of Nursing (ADON) stated she assisted with RNA supervision and support, particularly with RNA documentation. The ADON reviewed Resident 3's January 2025 RNA flowsheet and stated she did not know what n, n, n and n, n represented on the RNA flowsheet. The ADON stated the letters on the RNA flowsheet were confusing and it was unclear if RNA services were provided or missed. The ADON stated it was important that documentation was clear and accurate to avoid confusion and to ensure the residents were receiving the appropriate services. During a concurrent interview and record review on 5/23/2025 at 1:25 pm, Restorative Nursing Assistant 1 (RNA 1) and Restorative Nursing Assistant 3 (RNA 3) stated the RNA documentation process was confusing. RNA 1 and RNA 3 reviewed Resident 3's January 2025 RNA flowsheet and stated the letter n meant not applicable. RNA 1 and RNA 3 stated they documented n, n, n or n, n when the prompts did not pertain to the RNA task or if the RNAs were verbally told to discontinue RNA services, but the RNA task was never discontinued in the electronic system and was still active. RNA 1 and RNA 3 stated Resident 3's January 2025 RNA flowsheets were confusing because it was unclear if Resident 3 received or missed RNA sessions on 1/21/2025 to 1/24/2025 and 1/28/2025 to 1/30/2025. During a concurrent interview and record review on 5/23/2025 at 3:00 p.m., the Medical Records Director (MRD) stated she audited the RNA flowsheets to ensure RNA documentation was accurate and RNA services were provided as indicated. The MRD reviewed Resident 3's January 2025 RNA flowsheet and stated she did not know what the letters n, n, n and n, n meant and did not know if RNA services were provided or missed on 1/21/2025 to 1/24/2025 and 1/28/2025 to 1/30/2025. The MRD stated she did not pay attention to the letters and assumed RNA services were provided since the box was not blank. The MRD stated it was important that documentation was accurate to ensure the facility had the correct assessment of the resident and to ensure all necessary services were being provided. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/23/2025 at 3:18 p.m., the Director of Nursing (DON) reviewed Resident 3's January 2025 RNA flowsheets and stated the documentation was unclear and inaccurate. The DON stated she did not know what n, n, n or n, n meant and did not know if RNA services were provided or missed on 1/21/2025 to 1/24/2025 and 1/28/2025 to 1/30/2025. The DON stated it was important all RNAs documented consistently, and RNA documentation guidelines were clear to avoid confusion. The DON stated if documentation was unclear and inaccurate, it could result in confusion, missed services, and an inaccurate reflection of services provided. 2. During a review of Resident 116's admission Record, the admission Record indicated Resident 116 was admitted to the facility on [DATE] with diagnoses including right-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following an intracerebral hemorrhage (bleeding in the brain), legal blindness, and sepsis (illness caused by the body's response to an infection). During a review of Resident 116's MDS, dated [DATE], the MDS indicated Resident 116 had moderately impaired cognition. The MDS indicated Resident 116 required supervision or touching assistance for eating, partial/moderate assistance for upper body dressing and personal hygiene, substantial/maximal assistance for bathing, lower body dressing, rolling to both sides, and sit to stand transfers, and was dependent for toileting hygiene and transfers. The MDS indicated Resident 116 had functional ROM limitations in both arms and both legs. During a review of Resident 116's February 2025 RNA flowsheet, the RNA flowsheet indicated an RNA task for RNA to assist Resident 116 with walking exercises using a FWW, three times a week. The RNA flowsheet indicated the following prompts under the RNA task for walking exercises: 1) Amount of minutes spent training and skill practice in walking, 2) Distance walked (in feet), 3) Did the resident complain of or show signs of pain of discomfort? The RNA flowsheet indicated the letters n, n, n on the following dates for the RNA task of ambulation: 2/3/2025, 2/17/2025, 2/19/2025, 2/21/2025, and 2/26/2025. During a concurrent observation and interview on 5/20/2025 at 3:53 pm, in Resident 116's room, Resident 116 was lying in bed. Resident 116 had difficulty bending the right knee and stated the right side of the body was weaker than the left side of the body. Resident 116 stated staff inconsistently assisted with exercises to both arms and both legs. Resident 116 stated staff assisted with exercises about three times a week but sometimes did not show up for an entire week. During a concurrent interview and record review on 5/23/2025 at 9:38 a.m., RNA 2 stated the RNAs documented on the electronic medical record by answering a series of prompts related to the RNA task. RNA 2 reviewed Resident 116's February 2025 RNA flowsheets and stated the letter n meant not applicable. RNA 2 stated she documented n, n, n or n, n when the prompts asked did not pertain to the RNA task or if the resident was not seen for RNA treatment that day. During a concurrent interview and record review on 5/23/2025 at 12:22 p.m., the ADON stated she assisted with RNA supervision and support, particularly with RNA documentation. The ADON reviewed Resident 116's February 2025 RNA flowsheets and stated she did not know what n, n, n and n, n represented on the RNA flowsheet. The ADON stated the letters on the RNA flowsheet were confusing and it was unclear if RNA services were provided or missed. The ADON stated it was important documentation was clear and accurate to avoid confusion and to ensure the residents were receiving the appropriate services. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/23/2025 at 1:25 p.m., RNA 1 and RNA 3 stated the RNA documentation process was confusing. RNA 1 and RNA 3 reviewed Resident 116's February 2025 RNA flowsheets and stated the letter n meant not applicable. RNA 1 and RNA 3 stated they documented n, n, n or n, n when the prompts did not pertain to the RNA task or if the RNAs were verbally told to discontinue RNA services, but the RNA task was never discontinued in the electronic system and was still active. RNA 1 and RNA 3 stated Resident 116's February RNA flowsheets were confusing because it was unclear if Resident 116 received or missed RNA sessions on 2/3/2025, 2/17/2025, 2/19/2025, 2/21/2025, and 2/26/2025. During a concurrent interview and record review on 5/23/2025 at 3:00 p.m., the MRD stated she audited the RNA flowsheets to ensure RNA documentation was accurate and RNA services were provided as indicated. The MRD reviewed Resident 116's February 2025 RNA flowsheets and stated she did not know what the letters n, n, n and n, n meant and did not know if RNA services were provided or missed on 2/3/2025, 2/17/2025, 2/19/2025, 2/21/2025, and 2/26/2025. The MRD stated she did not pay attention to the letters and assumed RNA services were provided since the box was not blank. The MRD stated it was important documentation was accurate to ensure the facility had the correct assessment of the resident and to ensure all necessary services were being provided. During a concurrent interview and record review on 5/23/2025 at 3:18 p.m., the DON reviewed Resident 116's February 2025 RNA flowsheets and stated the documentation was unclear and inaccurate. The DON stated she did not know what n, n, n or n, n meant and did not know if RNA services were provided or missed on 2/3/2025, 2/17/2025, 2/19/2025, 2/21/2025, and 2/26/2025. The DON stated it was important all RNAs documented consistently, and RNA documentation guidelines were clear to avoid confusion. The DON stated if documentation was unclear and inaccurate, it could result in confusion, missed services, and an inaccurate reflection of services provided. 3. During a review of Resident 121's admission Record, the admission Record indicated Resident 112 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including liver cirrhosis (condition in which the liver is scarred and permanently damaged) and cervical (region of the neck) and spinal stenosis (condition that occurs when the spaces in the spine narrow and put pressure on the spinal cord and nerve roots). During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121 was cognitively intact. The MDS indicated Resident 121 required substantial/maximal assistance for eating and was dependent for hygiene, bathing, dressing, and rolling to both sides. The MDS indicated Resident 121 had functional ROM limitations in both arms and one leg. During a review of Resident 121's March 2025 RNA flowsheet, the RNA flowsheet indicated an RNA task for RNA to apply a splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to Resident 121's right elbow, for up to two hours, as tolerated. The RNA flowsheet indicated the following prompts under the RNA task: 1) Amount of minutes spent training and skill practice in walking, 2) Distance walked (in feet), 3) Did the resident complain of or show signs of pain of discomfort? The RNA flowsheet indicated the letters n, n, n on the following dates: 3/13/2025, 3/18/2025, 3/20/2025, and 3/22/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/20/2025 at 10:09 a.m., in Resident 121's room, Resident 121 was lying in bed with both elbows bent, both writs bent, and both hands open. Resident 121 stated he was unable to move both shoulders, could minimally bend and straighten both elbows, and was unable to move both wrists and both hands on his own. Resident 121 stated he used to get exercises to both arms and both legs but did not anymore. During a concurrent interview and record review on 5/23/2025 at 9:38 am, RNA 2 stated the RNAs documented on the electronic medical record by answering a series of prompts related to the RNA task. RNA 2 reviewed Resident 121's March 2025 RNA flowsheets and stated the letter n meant not applicable. RNA 2 stated she documented n, n, n or n, n when the prompts asked did not pertain to the RNA task or if the resident was not seen for RNA treatment that day. RNA 2 stated n, n, n was likely documented because the prompts about walking distance and time spent walking did not apply to Resident 121's RNA task for application of the elbow splint. During a concurrent interview and record review on 5/23/2025 at 1:25 p.m., RNA 1 and RNA 3 stated the RNA documentation process was confusing. RNA 1 and RNA 3 reviewed Resident 121's March 2025 RNA flowsheets and stated the letter n meant not applicable. RNA 1 and RNA 3 stated they documented n, n, n or n, n when the prompts did not pertain to the RNA task or if the RNAs were verbally told to discontinue RNA services, but the RNA task was never discontinued in the electronic system and was still active. RNA 1 and RNA 3 stated Resident 121's March RNA flowsheets were confusing because it was unclear if Resident 121 was seen for treatments or missed treatments since n, n, n was likely documented since the prompts about walking distance and time spent walking were not applicable to the RNA task for splinting. During a concurrent interview and record review on 5/23/2025 at 3:00 p.m., the MRD stated she audited the RNA flowsheets to ensure RNA documentation was accurate and RNA services were provided as indicated. The MRD reviewed Resident 121's March 2025 RNA flowsheets and stated she did not know what the letters n, n, n and n, n meant and did not know if RNA services were provided or missed on 3/13/2025, 3/18/2025, 3/20/2025, and 3/22/2025. The MRD confirmed the prompts on the RNA documentation related to walking did not match the RNA task for splinting. The MRD stated she did not pay attention to the letters, tasks, or prompts and assumed RNA services were provided since the box was not blank. The MRD stated it was important documentation was accurate to ensure the facility had the correct assessment of the resident and to ensure all necessary services were being provided. During a concurrent interview and record review on 5/23/2025 at 3:18 p.m., the DON reviewed Resident 121's March 2025 RNA flowsheets and stated the documentation was unclear and inaccurate. The DON confirmed the prompts on the RNA documentation related to walking did not match the RNA task for splinting. The DON stated mismatched RNA tasks and prompts could result in confusion and inaccurate documentation. The DON stated she did not know what n, n, n or n, n meant and did not know if RNA services were provided or missed on 3/13/2025, 3/18/2025, 3/20/2025, and 3/22/2025. The DON stated if documentation was unclear and inaccurate, it could result in confusion, missed services, and an inaccurate reflection of services provided. During a review of the facility's policy and procedure (P&P), titled Charting and Documentation, revised 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The P&P indicated documentation in the medical record would be objective, complete, and accurate.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review the facility failed to effectively use its Quality Assessment and Performance Improvement (QAPI) program to identify and address resident care concerns, such as weight loss. a. The facility did not monitor or identify the resident's weight loss. b. The facility did not follow the Restorative Nursing Assistant Program exercises as recommended by Physical Therapy. c. The facility did not ensure accurate documentation by Restorative Nursing Assistant Services. d. The facility did not observe infection control practices. e. The facility failed to ensure staff is not standing over while feeding a resident. f. The facility did not follow up on a missed outpatient appointment. These failures had the potential to negatively impact residents ' care and could lead to a delay of care and treatment to the residents. Findings: During an interview on 5/23/2025, at 2:47 p.m. with Assistant Director of Nursing (ADON), ADON stated she did not know what the specific deficient practices from last standard health survey. ADON stated they did not identify any weight loss on Resident 116 or any weight loss on other residents as a problem. ADON stated the facility did not look at the actual comprehensive care plan of the affected resident and did not address the problem. ADON stated the facility should have conducted an interdisciplinary team(IDT- team of healthcare professionals who discuss and manage resident's care)meeting addressing the progressive weight loss of Resident 116. ADON stated last April 2025, the facility was working on falls and skin and wound management. ADON stated it is important to have an effective QAPI Plan to ensure repeated deficiencies will resolve or will not reoccur and to ensure residents' safety and quality of care. During a review of the facility's policy and procedure titled Quality Assurance and Performance Improvement (QAPI) Program, revised February 2020, it was indicated that the facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program focused on the indicators of care and quality of life for the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death) and epilepsy (disorder that causes episodes of seizures or altered consciousness). During an observation on 5/22/2025 at 2:30 p.m., in the hallway in front of the Therapy gym, Resident 24 was sitting in a wheelchair facing the wall with a cloth gait belt around the waist. OT 1 assisted Resident 24 with sit to stand exercises using the handrail on the wall. Once the therapy session was complete, OT 1 removed Resident 24's cloth gait belt, wiped down the cloth gait belt with a disinfectant wipe, and placed the cloth gait belt on a rack in the back of the Therapy gym. During an interview on 5/22/2025 at 2:57 p.m., OT 1 stated she cleaned and disinfected the cloth gait belt with Super Sani-Cloth disinfectant wipes (disposable wipes used to disinfect surfaces) after working with Resident 24. OT 1 stated cloth gait belts were made of fabric, a porous (having small spaces or holes through which liquid or air may pass) material. OT 1 stated it was important shared equipment was disinfected properly to prevent the spread of infection. During an interview and record review on 5/23/2025 at 1:06 p.m., the Infection Preventionist Nurse (IPN) stated cloth gait belts were cleaned and disinfected using Super Sani-Cloth disinfectant wipes before and after resident use. The IPN stated cloth gait belts were made of porous material. The IPN reviewed the Super Sani-Cloth manufacturer instructions and confirmed the instructions indicated the disinfectant wipes were to be used on non-porous, hard surfaces only. The stated Super Sani-Cloth disinfectant wipes were ineffective because cloth gait belts were made of porous materials. The IPN stated the only way to properly clean and disinfect cloth gait belts was to launder them after each resident use. The IP stated it was important to clean and disinfect shared equipment properly to prevent the spread of infection and avoid cross contamination. (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products). During an interview on 5/23/2025 at 3:18 p.m., the DON stated it was important shared equipment was disinfected properly and according to manufacturer guidelines before and after resident use to prevent the spread of infection. During a review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 9/2022, the P&P indicated Resident care equipment, including reusable items and durable medical equipment would be cleaned and disinfected according to current Center for Disease Control and Prevention (CDC- organization that protects the public's health) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA-a U.S. government agency that sets and enforces workplace safety and health standards) Bloodborne Pathogens Standard. The P&P indicated reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Super Sani-Cloth Germicidal Wipes Safety Data Sheet, revised 9/7/2023, the Safety Data Sheet indicated the wipes were to be used as a disinfectant on hard, non-porous surfaces and must only be used according to label instructions. 4. During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (weakness of the heart that leads to buildup of fluid in the lungs and other parts of the body) and Parkinson's Disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement). During a review of Resident 82's Order Summary Report, the Order Summary Report indicated a physician's order for Enhanced Barrier Precautions (EBP, an approach of targeted gown and glove use during high contact care activities to reduce transmission of infections) to prevent MDRO (MRDO, bacteria resistant to many antibiotics) infection due to the presence of a gastronomy tube (G-tube, a tube placed directly into the stomach for long-term feeding), indwelling catheter (thin, flexible tube inserted into the bladder through the urethra to drain urine), and pressure injury (injuries to the skin and underlying tissue resulting from prolonged pressure on the skin). During an observation on 5/20/2025 at 10:40 a.m., a sign was posted outside of Resident 82's room which indicated Resident 82 was on EBP precautions. The sign indicated every person must clean his/her hands, including before entering and when leaving the room. An additional sign was posted in the hallway outside of Resident 82's room which indicated staff must practice hand hygiene before and after contact with high touch surfaces. In Resident 82's room, Resident 82 was lying in bed. CNA 9 entered Resident 82's room, put on gloves, removed Resident 82's blankets, adjusted the position of Resident 82's bed, moved Resident 82's tray and bedside table in front of the resident's body, placed Resident 82's call light within reach, placed blankets onto Resident 82's body, removed both gloves, exited Resident 82's room, walked down the hall, sat down on a stool, and documented on the touchscreen device hanging on the wall using her hands. CNA 9 did not perform hand hygiene after exiting Resident 82's room. During an interview on 5/20/2025 at 10:56 a.m., CNA 9 confirmed she touched high contact surfaces areas such as the bed, blankets, call light, and bedside table in Resident 82's room. CNA 9 stated staff must perform hand hygiene before entering a resident's room, after touching the resident and/or items in the resident's room and upon exiting a resident's room to prevent the spread of infection. During an interview on 5/23/2025 at 1:06 p.m., the IPN stated all staff must perform hand hygiene before entering a resident's room, before and after providing care to a resident, after touching high touch surfaces in a resident's room, and upon exiting a resident's room. The IPN stated it was important staff performed hang hygiene as indicated to prevent the spread of infection and cross contamination. During an interview on 5/23/2025 at 3:18 p.m., the DON stated all staff must perform hand hygiene upon exiting a resident's room and when touching high contact surface areas in a resident's room to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised 10/2023, the P&P indicated hand hygiene was considered the primary means to prevent the spread of infection and healthcare-associated infection. The P&P indicated hand hygiene was indicated after touching the resident's environment. Based on observation, interview, and record review, the facility failed to maintain and observe infection control practices by: 1.Failing to ensure Resident 91's curtains were clean and free of stains. 2.Staff failed to perform hand hygiene when entering and exiting resident's room (Resident 38 and 40) when done with providing care. 3.Failing to ensure Occupational Therapist 1 (OT 1) used the appropriate cleaning agent to effectively clean and disinfect a cloth gait belt after providing occupational therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) services to Resident 24. 4. Failing to ensure Certified Nursing Assistant 9 (CNA 9) performed hand hygiene after touching high contact surfaces in Resident 82's room. These failures had the potential to result in cross contamination (physical, movement or transfer of harmful bacteria from one person, object, or place to another) and place residents at risk for spread of infection. Findings: 1.During a review of Resident 91's admission Record, the admission Record indicated Resident 91 was admitted to the facility on [DATE] with diagnoses including depression (a persistent states of sadness or lack of interest in things that you used to enjoy) and hypertension (HTN- elevated blood pressure). During a review of Resident 91's Minimum Data Set (MDS- a resident assessment tool) dated 4/28/205, the MDS indicated Resident 91's cognition (ability to think, understand, learn, and remember) was moderately impaired and was dependent (helper does all the effort) with activities of daily living (ADLS- activities such as bathing, dressing, and toileting a person performs daily). During a concurrent observation and interview on 5/20/2025 at 11:14 a.m., in Resident 91's room, multiple unknown brownish colored stains were observed on the curtains and Resident 91 stated the stains on the curtains made her feel dirty and she would prefer they were clean. During a concurrent observation and interview on 5/20/2025 at 11:42 a.m., with Licensed Vocational Nurse (LVN) 3, in Resident 91's room, LVN 3 validated Resident 91's curtains were stained with multiple unknown brownish colored stains. LVN 3 stated curtains should be changed when visibly soiled as it can make the resident feel filthy and vulnerable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/2025 at 8:47 a.m., with the Housekeeping Supervisor (HKS), the HKS stated resident curtains should be clean, free of stains and tears, and changed if they are not presentable. HKS stated keeping the resident curtains clean was for the residents dignity as this was their home. During an interview on 5/23/2025 at 9:18 a.m., with the Infection Prevention Nurse (IPN), the IPN stated the resident curtains should remain clean and without stains for infection control purposes because the curtains accumulate bacteria. IPN stated this facility was the residents home and when the curtains were dirty, it may cause the resident to feel uncomfortable. During an interview on 5/23/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated resident curtains should be kept clean and without stains because facility was their home and if they were not clean, it can potentially affect their dignity and make them feel uneasy. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated, Residents are provided with a safe, clean, comfortable, and homelike environment; The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting, including a clean, sanitary, and orderly environment. 2a. During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dementia (a progressive state of decline in mental abilities), anxiety (a feeling of fear, dread, and uneasiness), cirrhosis of liver (a type of liver damage where healthy cells are replaced by scar tissue), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 38's History and Physical (H&P), dated 9/24/2024, the H&P indicated Resident 38 can make needs known but cannot make medical decisions. During a review of Resident 38's MDS, dated [DATE], the MDS indicated Resident 38 was moderately impaired in cognitive skills. Resident 38 required set up assistance (helper sets up or cleans up while resident completes the activities) on self-care abilities with eating, required moderate assistance (helper does less than half the effort) with oral hygiene, personal hygiene, toileting hygiene, shower/bathe, and upper body dressing, was maximal assistance (helper does more than half the effort) with lower body dressing, and putting on/taking off footwear. During an observation on 5/20/2025 at 12:55 p.m. near Resident 38's room, Certified Nursing Assistant (CNA) 4 went into Resident 38's room, and did not perform hand hygiene before assisting Resident 38 up in bed for lunch. After being assisted in a sitting up position, Resident 38 was ready to eat lunch. CNA 4 did not perform hand hygiene before preparing the meal tray for Resident 38 and proceeded to feed Resident 38. 2b. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), anemia (a condition where the body does not have enough healthy red blood cells), and acute respiratory failure (lungs are unable to deliver enough oxygen to the blood, leading to low oxygen levels in the body). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's H&P, dated 10/27/2024, the H&P indicated Resident 40 has the capacity to understand and make decisions. During a review of Resident 40's MDS dated [DATE], the MDS indicated Resident 40 was severely impaired in cognitive skills and required set up assistance on self-care abilities with eating, required maximal assistance (helper does more than half the effort) with oral hygiene, was dependent (helper does all of the effort) with personal hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, and putting on/taking off footwear. During an observation on 5/20/2025 at 12:58 p.m. near Resident 40's room, CNA 8 walked into Resident 40's room to assist Resident 40 with his meal tray. CNA 8 did not perform hand hygiene before assisting Resident 40 with meal tray, preparing the utensils and removing the covers off the plates and bowls. After being assisted with his meal tray, Resident 40 was ready to eat lunch. CNA 8 walked out of Resident 40's room but did not perform hand hygiene. Resident 40 was trying to feed himself, but his hand was shaking too much, the food ended up falling off the utensil onto his chest. CNA 8 came back after a minute, did not perform hand hygiene before helping feed Resident 40 with his lunch. During an interview on 5/20/2025 at 2:50 p.m., with CNA 8, CNA 8 stated staff were supposed to perform hand hygiene before going into a resident's room and after coming out of a resident's room. CNA 8 stated the importance of performing hand hygiene was to prevent the spread of infection. CNA 8 stated if staff were not performing hand hygiene, staff can spread the infection to others and everyone would get sick. During an interview on 5/21/2025 at 4:01 p.m., with the Director of Staff Development (DSD), the DSD stated staff should be performing hand hygiene by using the hand sanitizer before entering and exiting the resident's room. The DSD stated hand washing was recommended to prevent infection, but if not able to hand wash, hand sanitizing the hands to prevent the spread of infection works. The DSD stated if staff do not perform hand hygiene, staff can spread the infection to other residents, the visitors and their family members. During an interview on 5/22/2025 at 3:04 p.m. with the Infection Prevention Nurse (IPN), the IPN stated staff are to use hand sanitizer before entering a resident's room and before exiting a resident's room. IPN stated staff are supposed to perform hand hygiene before they go into a resident's room and when they come out of a resident's room, they are supposed to perform hand hygiene again. IPN stated if staff were not performing hand hygiene, there was a risk of spreading the infection to others. During an interview on 5/23/2025 at 10:15 a.m., with the Director of Nursing (DON), the DON stated the importance of performing hand hygiene as it was the standard precaution to prevent the spread of infection. The DON stated if staff was not performing hand hygiene, staff can spread the infection to other residents and the safety of the residents are at risk.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain electrical therapy (services given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) equipment for three (3) of 3 devices for resident use during therapy treatment in the therapy gym. These failures jeopardized resident and staff safety and had the potential to cause harm and injury to residents using the therapy equipment during electrical therapy treatment. Findings: During a concurrent observation and interview on 5/20/2025 at 1:45 p.m., in the therapy gym, the Director of Rehabilitation (DOR) stated the rehabilitation department (Rehab) had three types of electric equipment for resident use during therapy treatment: a motorized electrical bicycle for the arms and legs (TE1), a recumbent cross trainer (TE2, exercise machine used in a sitting position with foot pedals and handlebars), and recumbent stepper (TE3, exercise machine used in a sitting position with foot pedals). TE 1, TE 2, and TE 3 were observed in the back of the therapy gym. The DOR stated Rehab did not inspect and/or perform any maintenance or preventative maintenance on any of the three types of therapy equipment. During a concurrent interview and record review on 5/22/2025 at 1:21 p.m., the DOR reviewed the User Manuals (UM) for TE1, TE2, and TE3. The DOR confirmed Rehab did not inspect and perform any maintenance as instructed in all 3 UMs. During an interview on 5/22/2025 at 3:28 pm, the Maintenance Director (MTD) stated the Maintenance Department did not perform any routine inspections, maintenance, or preventative maintenance on any of the equipment in the therapy gym. The MTD stated it was important the facility performed routine inspections of equipment and preventative maintenance of all equipment to ensure the equipment was working properly to prevent any injuries to the residents and/or staff and to avoid costly, preventable repairs. During an interview on 5/23/2025 at 3:18 pm, the Director of Nursing (DON) stated it was important to maintain the rehabilitation equipment because the residents used the equipment to regain strength and mobility. The DON stated rehab equipment needed to be maintained and safe for resident use. During a review of TE 1's UM, dated 10/2007, the UM indicated under Safety Precautions that users must ensure the following: .the screw knob fixing supporting the module of the handlebar or arm/upper body trainer is tightened and the legs and arms are secured properly, the screws of all adjustable parts of the device were tightened and intact before every training session, suitable clothing must always be worn, and security related controls according to the medicine product operator regulation (Medical Devices Act) must be carried out at least every second year. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Maintenance Service, revised 12/2009, the P&P indicated maintenance services shall be provided to all areas of the building, grounds, and equipment. The P&P indicated the Maintenance Director was responsible for developing and maintaining a schedule of maintenance services to assure the buildings, grounds, and equipment were maintained in a safe and operable manner. The P&P indicated maintenance personnel shall follow manufacturer's recommended maintenance schedule. During a review of TE 2's UM, dated 10/2010, the UM indicated under Safety Instructions that the device must be examined regularly. The UM indicated under Break-In Period and Preventative Maintenance Intervals that users were recommended to follow preventative maintenance intervals according to the amount of usage the device receives. The UM indicated to clean the covers of the arms, seat, and display and wipe off perspiration, dirt, and dust monthly (if used less than 10 hours per week), weekly (if used 10 to 40 hours per week), and daily (if used more than 40 hours per week). The UM indicated to replace the batteries of the device every 12 months (if used less than 10 hours per week), every 3 months (if used 10 to 40 hours per week), and every one month (if used more than 40 hours per week). The UM indicated to check drive belts for signs of wear every 12 to 24 months (if used less than 10 hours per week), every six to twelve months (if used 10 to 40 hours per week), and every 3 to six months (if used more than 40 hours per week). During a review of TE 3's undated UM, the UM indicated any mechanical or electrical work conducted within the main body must be recalibrated. The UM indicated the generic maintenance schedule should be applied to both medical and non-medical products: covers, seat, handlebars and consoles should be cleaned with a damp cloth daily, the screen should be cleaned with a damp cloth weekly, the battery should be checked with a voltmeter (device used to measure voltage) every six months, the seat, base frame roller guide and adjustment pan should be cleaned with a damp cloth every two weeks, the connections should be checked bimonthly (for high use) and every six months (for low use), and the inner handlebars should be cleaned with a silicone spray as needed.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review , the facility failed to meet the required room size measurement of 80 square feet per resident in rooms with multiple residents. This deficient practice had the potential for inadequate space for each resident's privacy and safe nursing care. Findings: During a review of the facility room waiver request letter dated 5/23/2025, indicated the following rooms did not meet the 80 square (sq. ft.) per resident requirement in multiple bedrooms: 1.room [ROOM NUMBER] had 3 beds which measured 215.5 square feet (sq. ft.- unit of measurement). 2.room [ROOM NUMBER] had 3 beds which measured 215.5 square feet. 3.room [ROOM NUMBER] had 4 beds which measured 292.2 square feet. 4.room [ROOM NUMBER] had 4 beds which measured 296.3 square feet. 5.room [ROOM NUMBER] had 4 beds which measured 292.2 square feet. 6.room [ROOM NUMBER] had 4 beds which measured 292.2 square feet. 7.room [ROOM NUMBER] had 4 beds which measured 296.3 square feet . 8.room [ROOM NUMBER] had 4 beds which measured 297.7 square feet. 9.room [ROOM NUMBER] had 4 beds which measured 297.7 square feet. 10.room [ROOM NUMBER] had 3 beds which measured 262.6 square feet. 11.room [ROOM NUMBER] had 3 beds which measured 262.6 square feet. 12.room [ROOM NUMBER] had 2 beds which measured 186.96 square feet. 13.room [ROOM NUMBER] had 2 beds which measured 192.5 square feet. 14.room [ROOM NUMBER] had 2 beds which measured 157.9 square feet. 15.room [ROOM NUMBER] had 2 beds which measured 157.9 square feet. 16.room [ROOM NUMBER] had 2 beds which measured 160.1 square feet. 17.room [ROOM NUMBER] had 2 beds which measured 157.1 square feet. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	18.room [ROOM NUMBER] had 2 beds which measured 157.1 square feet. 19.room [ROOM NUMBER] had 2 beds which measured 157.8 square feet. 20.room [ROOM NUMBER] had 3 beds which measured 266 square feet. 21. room [ROOM NUMBER] had 2 beds which measured 153.4 square feet. 22. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 23. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 24. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 25. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 26. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 27. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 28. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 29. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 30. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 31. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 32. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 33. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 34. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 35. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 36. room [ROOM NUMBER] had 4 beds which measured 234.7 square feet. 37. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 38. room [ROOM NUMBER] had 3 beds which measured 220.7 square feet. 39. room [ROOM NUMBER] had 4 beds which measured 386.7 square feet. 40.room [ROOM NUMBER] had 3 beds which measured 222.6 square feet. 41. room [ROOM NUMBER] had 3 beds which measured 222.6 square feet. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	42. room [ROOM NUMBER] had 3 beds which measured 222.6 square feet. 43. room [ROOM NUMBER] had 3 beds which measured 222.6 square feet. 44. room [ROOM NUMBER] had 3 beds which measured 224.6 sq. ft. 45. room [ROOM NUMBER] had 3 beds which measured 346. 8 sq.ft. 46. room [ROOM NUMBER] had 3 beds which measured 222.6 sq.ft. 47. room [ROOM NUMBER] had 3 beds which measured 222.6 sq.ft 48. room [ROOM NUMBER] had 3 beds which measured 224.6 sq. ft. 49. room [ROOM NUMBER] had 3 beds which measured 224.6 sq. ft. 50. room [ROOM NUMBER] had 3 beds which measured 224.6 sq. ft. 51.room [ROOM NUMBER] had 3 beds which measured 224.6 sq.ft. During an interview on 5/20/2025, at 12:11 p.m. in room [ROOM NUMBER] D with Resident 1, Resident 1 stated if there is a fire in the facility his bed would be in the way and the door would not be able to close. During an interview on 5/23/2025, at 12:13 p.m. with Administrator (ADM), ADM stated Resident 1's bed blocking the door could cause a hazard and he would prefer to not have anything blocking the door or any doors to ensure prompt entry and exit at anytime and not only during an emergency. During a review of facility's policy and procedure (P&P) titled, Homelike Environment, revised 2/2021, the P&P indicated the residents are provided with a safe, clean, comfortable and homelike environment.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review the facility failed to ensure one of one sampled resident (Resident 1's) room remained safe from fire hazards. This failure had the potential to result in significant harm during a facility fire. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated, Resident 1 was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with diagnoses of but not limited to multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN-high blood pressure). During a record review of Resident 1's History and Physical, dated 8/14/2024, indicated that Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), the MDS indicated, Resident 1 was dependent on nursing staff for showering, toileting, transferring, and putting on and taking off footwear. The MDS indicated Resident 1 needed substantial to maximal assistance from nursing staff with dressing, rolling from left to right, sitting, and lying down. The MDS indicated Resident 1 used a wheelchair. During a concurrent observation and interview with Resident 1 on 5/20/2025 at 12:11 pm, it was noted that Resident 1's bed obstructed the entrance to their room. Resident 1 expressed concerns that in the event of a fire, the bed would impede access and prevent the door from closing properly. During an interview on 5/22/2025 at 11:28 AM, RN 1 explained that placing a bed in front of the door creates a fire hazard. The door must be able to close, and the entrance to the residents' room cannot be obstructed. During an interview on 5/23/2025 at 8:44 AM with the Maintenance Director (MTD), the MTD stated awareness of Resident 1's bed blocking the door. The MTD explained that Resident 1 moves his bed to fit on the other side. The MTD mentioned speaking to the Administrator (ADM), who assured him it would be addressed. The MTD added that in case of emergencies like a fire, it is necessary to shut the door to isolate the fire. During an interview on 5/23/2025 at 12:13 PM, the Administrator (ADMIN) stated that they move beds to accommodate residents' belongings. Resident 1 refused to move his items, stating the room was too small for another bed. The ADMIN mentioned that Resident 1's bed blocks the door, creating a potential hazard and hindering staff access. The ADMIN prefers to keep doors clear to ensure prompt entry and exit at all times, not just during emergencies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055364	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Healthcare Center	3401 Cedar Avenue Long Beach, CA 90807

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled, Maintenance Service, undated, the P&P indicated .Functions of maintenance personnel include, but are not limited to: .Maintaining the building in good repair and free from hazards.