STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055430	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Hills Health Care Ctr	10426 Bogardus Ave Whittier, CA 90603

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an Advance Directives (AD-a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) were obtained and accessible in residents medical records for four of four sampled residents (Residents 1, 8, 16, 35, 95 and 201). This deficient practice had the potential for residents' medical treatment provisions to not be carried out, according to the resident's request during emergency situations and/or when a resident was incapacitated (the clinical state in which a patient is unable to participate in a meaningful way in medical decisions).ˆ Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated was readmitted to the facility on [DATE] with a diagnosis of encephalopathy (disease that affects the brain) and dementia (progressive brain disorder that impaired reasoning, memory and thinking). During a review of Resident 1's History and Physical (H&P)ˆsigned andˆdatedˆ[DATE], indicated that Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS – a federally mandated resident assessment tool) datedˆ[DATE], had a severely impaired cognition (thinking). 2. During a review of Resident 8's AR, the AR indicated Resident 8 was readmitted to the facility on [DATE] with a diagnosis of dementia and metabolic encephalopathy. ˆDuring a review of Resident 8's H&P signed andˆdatedˆonˆ[DATE], indicated that Resident 8 did not have capacity to understand and make decisions. 3.During a review of Resident 8's MDS dated ˆ[DATE], the MDS indicated the resident hadˆmoderately impaired cognition. During a review of Resident 16's AR, the AR indicated Resident 16 was admitted to the facility on [DATE] with a diagnosis of hypertension (HTN – high blood pressure) and depression (feeling severe sadness and hopelessness). (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ˆDuring a review of Resident 16's H&P signed andˆdatedˆonˆ[DATE], indicated that Resident 16 can make needs known but cannot make medical decisions. During a review of Resident 16's MDS dated ˆ[DATE], the MDS indicated the resident hadˆa moderately impaired cognition. 4. During a review of Resident 95's AR, the AR indicated Resident 95 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus (DM – high blood sugar) and HTN. ˆDuring a review of Resident 95's H&P signed andˆdatedˆonˆ[DATE], indicated that Resident 95 had the capacity to make decisions. During a review of Resident 95's MDS dated ˆ[DATE], the MDS indicated the resident hadˆa moderately impaired cognition. During a concurrent interview and record review with the Social Services Designee (SSD) on [DATE] at 3:50 PM, it was identified that Resident's 1, 8, 16 & 95 electronic medical chart did not have the advance directive notification form.ˆSSD stated that her initial assessment note indicated the advance directive notification form was located in Resident 1, 8, 16 & 95 hard chart. During a concurrent interview and record review with the SSD on [DATE] at 4 PM, it was identified that Resident's 1, 8, 16, & 95 hard chart did not have theˆadvance directive notification form. SSD stated that maintaining the AD notification form ensures compliance with the federal law, protects resident's rights and provides documentation that the resident or responsible party was properly informed of their medical care.ˆ A review of the facility's P&P titled Advance Directives and Associated Documentation revised 4/2025, indicated the policy of this facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. The facility recognizes and respects the resident's right to choose their treatment and make decisions about care to be received at the end of their life. The P&P indicated that the policy of this facility to implement the resident decisions and directives that are in compliant with State and/or Federal Law and the policies of this facility. The P&P indicated that the AD is written instruction that relates to the provision of health care when the individual is incapacitated, such as a Living Will, Durable Power of Attorney for Health Care or the Natural Death Act and these documents allow the individual to identify choices related to their medical treatment or designate someone to make treatment choices for them should they lose decision making capacity for themselves. 5. During a review of Resident 135's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included acute on chronic systolic (congestive) heart failure (chronic condition where the heart cannot pump blood efficiently, causing blood to back up and fluid to build up in the lungs, legs, and body), cellulitis (spreading skin infection) of right lower limb, and (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	muscle weakness. During a review of Resident 135's History and Physical (H&P), dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions.^ During a review of Resident 135's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated [DATE], the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses).^^^ During a review of Resident 135's Social Services Assessment/Evaluation dated [DATE] indicated Resident 135 had an Advance Health Care Directive in place. During a review of Resident 135's Physician Orders for Life Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatment that can or cannot be done at the end-of-life) dated [DATE], the POLST indicated the resident did not have an Advance Directive.^ The POLST indicated Resident 135 was a full code (a patient wants all available life-saving measures—including CPR, defibrillation, intubation, and mechanical ventilation—performed if their breathing or heart stops). During a concurrent interview and record review of Resident 135's medical chart on [DATE] at 3:21 PM, the Medical Records Director (MRD) confirmed there was no advance directive in Resident 135's chart. MRD stated if the advance directive should be in the chart. During a concurrent interview and record review of Resident 135's Social Services Assessment/Evaluation and POLST on [DATE] at 3:42 PM, the Social Services Director (SSD) stated Resident 135's assessment indicates resident has an advance directive. SSD could not find an advance directive on the electronic medical record. SSD stated the advance directive should be in the chart so that it will be easily accessible to facility staff. SSD stated she did not know why the Social Services Assistant (SSA) 1 would document there was an advance directive. SSD stated she would be checking SSA 1's work from now on. The SSD stated the importance of having the Advance Directive in the chart was to know what the resident wishes are and how to provide the care to them in case of an emergency.^^ 6. During a review of Resident 201's AR, the AR indicated the resident was admitted on [DATE] with diagnoses that included Chronic obstructive pulmonary disease (COPD, lung and airway diseases that restrict your breathing) with acute exacerbation, hypertension (high blood pressure), and difficulty in walking. During a review of Resident 201's History and Physical (H&P), dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions.^ During a review of Resident 201's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition. During a review of Resident 201's Social Services Assessment/Evaluation dated [DATE] indicated Resident 201 had an Advance Health Care Directive in place. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 201's POLST dated [DATE], the POLST indicated the resident did not have an Advance Directive.^ The POLST indicated Resident 201 is a DNR (Do not resuscitate) with selective treatment described as comfort focused treatment with hospitalization only if needs cannot be met in current location. During a concurrent interview and record review of Resident 201's medical chart on [DATE] at 3:23 PM, Admissions Coordinator (AC) stated the advance directive is usually found in the chart behind the POLST. AC stated when he interviewed the resident's representative for the POLST there was no advance directive at the time. AC stated the advance directive fulfills the resident's and family's wishes and should be in the physical chart. During a concurrent interview and record review of Resident 201's Social Services Assessment/Evaluation and POLST on [DATE] at 3:36 PM, the SSD stated Resident 201's assessment indicates resident has an advance directive. SSD confirmed and could not find an advance directive on the electronic medical record. SSD stated the advance directive should be uploaded on the electronic medical record if they have one. During a concurrent interview and record review of Resident 201's Social Services Assessment/Evaluation on [DATE] at 4:18 PM, SSA 1 stated it was an honest mistake that she selected Resident 201 had an advance directive. SSA 1 stated she believes Resident 201 was probably confused with the POLST and Advance Directive at the time. SSA 1 stated she should have followed up with AA to make sure both the POLST and Social Services Assessment matched. During an interview on [DATE] at 5:09 PM, the Director of Nursing (DON) stated the Advance directive should be in the resident's chart to indicate their wishes in the case of an emergency. A review of the facility's policy and procedure (P&P) titled Advance Directives and Associated Documentation dated 4/2025 indicated to obtain copy of the advance directive and conservatorship/guardianship documents and place in the resident health record.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess functional limitation in range of motion (limited ability to move a joint that interferes with daily functioning or places a resident at risk for injury) for three of four sampled residents (Resident 8, 12, and 49) reviewed for limited range of motion ([ROM] full movement potential of a joint) during their Minimum Data Set ([MDS] a federally mandated resident assessment tool) assessments. Specifically, (1) Resident 8's MDS assessments dated 10/15/2025 and 1/19/2026; (2) Resident 12's MDS assessments dated 10/16/2025 and 1/16/2026; and (3) Resident 49's MDS assessments dated 10/8/2025 and 1/8/2026 were inaccurately completed. These failures had the potential to affect the provision of Resident 8, 12, and 49's care, including the provision of activities of daily living ([ADLs] basic tasks that individuals perform to maintain their daily lives and independence) and ROM exercises, and provided inaccurate information to the Federal database. Findings: 1. During a review of Resident 8's Face Sheet (summary of a resident's information), the Face Sheet indicated the facility originally admitted Resident 8 on 10/10/2025 and readmitted on [DATE]. Resident 8's Face Sheet indicated Resident 8's diagnoses included dysphagia (difficulty swallowing) following a cerebral infarction (brain damage due to a loss of oxygen to the area), lack of coordination, and metabolic encephalopathy (disease that affects the brain, causing changes in its function). During a review of Resident 8's MDS, dated [DATE], the MDS indicated that Resident 8's arms and legs had no functional limitation in ROM. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had clear speech, expressed ideas and wants, usually understood verbal content, and had intact cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 8 required partial/moderate assistance (helper does less than half the effort) for eating and dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for toileting, showering, dressing, rolling to either side in bed, and transferring from lying to sitting on the side of the bed. The MDS indicated that Resident 8's arms and legs had no functional limitation in ROM. During a review of Resident 8's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 1/19/2026, the OT Evaluation indicated Resident 8 had within functional limits ([WFL] sufficient joint movement without significant limitation) ROM in the right arm and the left elbow. The OT Evaluation indicated Resident 8 had impaired ROM in the left shoulder, wrist and hand. During a review of Resident 8's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 1/19/2026, the PT Evaluation indicated Resident 8 had WFL ROM in both legs. The PT Evaluation indicated Resident 8 was dependent for rolling to either side in bed and transferring from lying to sitting on the side of the bed. During a review of Resident 8's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated recommendations for a Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) program. OT Discharge Summary indicated Resident 8's RNA program included ROM exercises to both arms, three times per week as tolerated. During a review of Resident 8's PT Discharge summary, dated [DATE], the PT Discharge Summary did not include RNA for ROM exercises. During a review of Resident 8's physician's orders, dated 1/30/2026, the physician's orders indicated RNA for ROM exercises to both arms, three times per week as tolerated. During a concurrent observation and interview on 2/25/2026 at 8:16 a.m. with Restorative Nursing Aide 1 (RNA 1) in the resident's room, Resident 8's RNA session was observed. Resident 8 was observed lying in bed and moving the right arm without any assistance. Resident 8's left arm was observed in complete elbow extension (straightened), wrist extension (bent upward), and the left-hand fingers positioned in a closed fist. RNA 1 was observed to physically move Resident 8's left arm for ROM exercises at the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shoulder, elbow, wrist, and hand joints. RNA 1 was observed placing a rolled towel in Resident 8's left hand. Resident 8 was observed asleep while RNA 1 provided ROM exercises on Resident 8's right arm. RNA 1 stated Resident 8 usually moves the right arm when Resident 8 was more awake but doesn't move that one (the left arm) at all. During a follow-up interview on 2/25/2026 at 8:45 a.m. with RNA 1, RNA 1 stated Resident 8 received ROM exercises to both arms. RNA 1 stated Resident 8 cannot move or assist with ROM exercises on the left arm. RNA 1 stated the rolled towel was placed in Resident 8's left hand to help open the fingers. RNA 1 stated Resident 8 did not have any ROM exercises for both legs. During an interview on 2/25/2026 at 11:46 a.m. with Physical Therapist 1 (PT 1), PT 1 stated Resident 8 should have received RNA for ROM exercises on both legs, especially the left leg which was weak. During an interview on 2/26/2026 at 12:06 p.m. with the MDS Nurse 1 (MDSN 1), MDSN 1 stated the MDS (in general) was an assessment to determine the care provided to the residents. MDSN 1 stated the MDS should be accurate to ensure residents were receiving the correct care. MDSN 1 stated the MDS included information gathered from the resident's clinical records, discussions with the residents and their family, and observations of the resident. MDSN 1 stated each resident's MDS was transmitted to the Federal database upon completion. During a review of Page GG-5 of the Resident Assessment Instrument ([RAI] full resident assessment which includes the MDS) User Manual, revised 10/1/2025, the RAI User Manual defined functional limitation in ROM as Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk for injury. During a concurrent interview and record review on 2/26/2026 at 12:30 p.m. with the MDSN 1 and MDS Nurse 2 (MDSN 2), Resident 8's MDS assessments, dated 10/15/2025 and 1/19/2026, and the RAI User Manual, revised 10/2025, were reviewed for functional limitation in ROM. MDSN 1 stated Resident 8's diagnoses included cerebral vascular accident ([CVA] stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and difficulty with coordination. MDSN 1 stated hemiplegia could result in weakness of one side of the body. MDSN 2 stated Resident 8's MDS assessments indicated Resident 8 had no functional limitation in ROM to both arms and legs. MDSN 2 reviewed the RAI User Manual's definition of functional limitation in ROM. MDSN 2 stated she did not know the definition of functional limitation in ROM as indicated in the RAI User Manual. MDSN 2 stated Resident 8's MDS assessments, dated 10/15/2025 and 1/19/2026, were inaccurate and should have indicated Resident 8 had functional limitation in ROM on one arm and one leg. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Associated Processes, revised 4/2025, the P&P indicated that the resident assessment will be comprehensive and accurate to develop, review, and revise the resident's comprehensive care plan. The P&P indicated Each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment. 2. During a review of Resident 12's Face Sheet, the Face Sheet indicated the facility admitted Resident 12 on 8/25/2025 and readmitted on [DATE]. The Face Sheet indicated Resident 12's diagnoses included malignant neoplasm (cancerous tissue growth) of the spinal cord and functional quadriplegia (paralysis from the neck down, including arms and legs, usually due to a spinal cord injury). During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12's arms and legs had no functional limitation in ROM. During a review of Resident 12's OT Evaluation and Plan of Treatment, dated 10/10/2025, the OT Evaluation indicated Resident 12 had WFL active range of motion ([AROM] performance of an exercise to move a joint without any assistance or effort of another person) in the right arm and WFL AROM in the left elbow, wrist, and hand. The OT Evaluation indicated Resident 12's passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) in the left shoulder was limited to 0-90 degrees (unit of joint measurement) for shoulder flexion (lifting the arm overhead, normal 0-180 degrees) and shoulder abduction (lifting the arm upward and away from the body, normal 0-180 degrees) due to pain. During a review of Resident 12's PT Evaluation and Plan of Treatment, dated 10/10/2025, the PT Evaluation indicated Resident 12 had WFL ROM and impaired strength in both (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	legs. During a review of Resident 12's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated recommendations for RNA to provide PROM exercises to both legs, three times per week as tolerated. During a review of Resident 12's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated recommendations for RNA to provide AROM to both arms and active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to the left shoulder, five times per week as tolerated. During a review of Resident 12's physician's orders, dated 12/1/2025, the physician's order indicated RNA for AROM to both arms and AAROM to the left shoulder, five times per week as tolerated. Another physician's order, dated 12/1/2025, indicated RNA for PROM exercises to both of Resident 12's legs, three times per week as tolerated. During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12 had clear speech, expressed ideas and wants, understood verbal contents, and had intact cognition. The MDS indicated Resident 12 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists only prior to or following the activity) for eating, personal hygiene, and oral hygiene. The MDS indicated Resident 12 was dependent for toileting, bathing, lower body dressing, rolling to either side in bed, transferring from lying to sitting on the side of the bed, and transferring from bed/chair-to-chair. The MDS indicated Resident 12's arms and legs had no functional limitation in ROM. During a concurrent observation and interview on 2/24/2026 at 2:34 p.m. with Restorative Nursing Aide 3 (RNA 3) in the resident's room, Resident 12's RNA session was observed. Resident 12 was alert and awake. Resident 12 stated RNA 3 has been providing ROM due to Resident 12's inability to feel and move both legs. RNA 3 was observed providing PROM to both legs at the hip, knee, and ankle joints. RNA 3 was observed performing ROM exercises on Resident 12's left shoulder, elbow, wrist and hand. Resident 12 was observed following RNA 3's verbal cues for AROM exercises on the right shoulder, elbow, wrist, and hand. During an interview on 2/24/2025 at 3:27 p.m. with RNA 3, RNA 3 stated Resident 12 received PROM to both legs due to Resident 12's inability to move either leg. RNA 3 stated Resident 12 received AAROM to the left arm and performed AROM on the right arm. During an interview on 2/26/2026 at 12:06 p.m. with MDSN 1, MDSN 1 stated the MDS (in general) was an assessment to determine the care provided to the residents. MDSN 1 stated the MDS should be accurate to ensure residents were receiving the correct care. MDSN 1 stated the MDS included information gathered from the resident's clinical records, discussions with the residents and their family, and observations of the resident. MDSN 1 stated each resident's MDS was transmitted to the Federal database upon completion. During a review of Page GG-5 of the RAI User Manual, revised 10/1/2025, the RAI User Manual defined functional limitation in ROM as Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk for injury. During a concurrent interview and record review on 2/26/2026 at 12:30 p.m. with the MDSN 1 and MDSN 2, the RAI User Manual's definition of functional limitation in ROM was reviewed. MDSN 2 stated she did not know the definition of functional limitation in ROM as indicated in the RAI User Manual. During a concurrent interview and record review on 2/26/2026 at 12:56 p.m. with the MDSN 1 and MDN 2, Resident 12's MDS assessments, dated 10/16/2025 and 1/16/2026, were reviewed. MDSN 1 stated Resident 12's MDS assessments indicated Resident 12's arms and legs had no functional limitation in ROM. MDSN 1 stated Resident 12's MDS assessments were inaccurate because MDSN 1 did not know the RAI User Manual's definition of functional limitation in ROM. MDSN 1 stated Resident 12's MDS assessments should have indicated Resident 12 had functional limitation in ROM on one arm and both legs. During a review of the facility's P&P titled, Resident Assessment and Associated Processes, revised 4/2025, the P&P indicated that the resident assessment will be comprehensive and accurate to develop, review, and revise the resident's comprehensive care plan. The P&P indicated Each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment. 3. During a review of Resident 49's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 49 on 7/2/2023 and readmitted on [DATE]. The (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Face Sheet indicated Resident 49's diagnoses included the presence of a left artificial knee joint, infection of the left artificial knee joint, and muscle weakness. During a review of Resident 49's OT Evaluation and Plan of Treatment, dated 9/5/2025, the OT Evaluation indicated Resident 49 had WFL AROM in both arms. During a review of Resident 49's PT Evaluation and Plan of Treatment, dated 9/5/2025, the PT Evaluation indicated Resident 49 had a history of multiple left knee surgeries including a fusion (surgical procedure that joints the thigh bone and the shinbone to avoid any rotation and movement in the knee) of the left knee in 5/2025. The PT Evaluation indicated Resident 49 was found to have a midshaft fracture of the tibia (break in the central, narrowest portion of the shinbone) in the left leg which was immobilized with a cast. The PT Evaluation indicated Resident 49 had within normal limits ([WNL] normal joint movement) ROM in the right leg and the left hip. The PT Evaluation indicated Resident 49's left knee and ankle ROM were not assessed due to the presence of a cast. During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49's arms and legs had no functional limitation in ROM. During a review of Resident 49's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated recommendations for RNA to provide AROM to both arms, five times per week as tolerated. During a review of Resident 49's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated recommendations for RNA to provide AROM exercises to the right leg and the left hip, three times per week as tolerated. During a review of Resident 49's physician's orders, dated 12/1/2025, the physician's orders indicated RNA for AROM to both arms, five times per week as tolerated. Another physician's order, dated 12/31/2025, indicated RNA for AROM exercises to Resident 49's right leg and left hip, five times per week as tolerated. During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 had clear speech, had difficulty communicating some words, usually understood verbal content, and had severely impaired cognition. The MDS indicated Resident 49 was independent with eating, oral hygiene, personal hygiene, upper body dressing, and rolling to either side in bed. The MDS indicated Resident 49 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for lower body dressing and transferring from lying to sitting on the side of the bed. The MDS indicated Resident 49 required substantial/maximal assistance (helper does more than half the effort) for toileting and transferring from the bed/chair-to-chair. The MDS indicated Resident 49's arms and legs had no functional limitation in ROM. During an observation on 2/24/2026 at 2:04 p.m. with Restorative Nursing Aide 2 (RNA 2) in the resident's room, Resident 49's RNA session was observed. Resident 49 was observed awake, alert, and lying in bed with the head-of-bed elevated. Resident 49 was observed to follow RNA 2 demonstration and verbal cues for ROM exercises while Resident 49 performed AROM exercises to both shoulders, elbows, wrists, and hand joints. Resident 49 was observed with a cast on the left leg from the knee to the foot, exposing the left toes. Resident 49 was observed to follow RNA 2's verbal cues to perform AROM exercises to the right leg and the left hip. During an interview on 2/24/2026 at 2:17 p.m. with RNA 2, RNA 2 stated Resident 49 performed AROM of both arms, the right leg, and the left hip. During an interview on 2/26/2026 at 12:06 p.m. with MDSN 1, MDSN 1 stated the MDS (in general) was an assessment to determine the care provided to the residents. MDSN 1 stated the MDS should be accurate to ensure residents were receiving the correct care. MDSN 1 stated the MDS included information gathered from the resident's clinical records, discussions with the residents and their family, and observations of the resident. MDSN 1 stated each resident's MDS was transmitted to the Federal database upon completion. During a review of Page GG-5 of the RAI User Manual, revised 10/1/2025, the RAI User Manual defined functional limitation in ROM as Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk for injury. During a concurrent interview and record review on 2/26/2026 at 12:30 p.m. with the MDSN 1 and MDSN 2, the RAI User Manual's definition of functional limitation in ROM was reviewed. MDSN 2 stated she did not know the definition of functional limitation in ROM as indicated in the RAI User Manual. During a concurrent interview and record review on 2/26/2026 at 12:53 p.m. with MDSN (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 and MDSN 2, Resident 49's MDS assessments, dated 10/8/2025 and 1/8/2026, were reviewed. MDSN 1 stated Resident 49's MDS assessments should have indicated Resident 49 had functional limitation in ROM on one leg. During a review of the facility's P&P titled, Resident Assessment and Associated Processes, revised 4/2025, the P&P indicated that the resident assessment will be comprehensive and accurate to develop, review, and revise the resident's comprehensive care plan. The P&P indicated Each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure daily nursing staffing data was posted. On 2/23/2026, review of the posted Census and Daily Hours Per Patient Day (DHPPD, refers to the actual hours of work performed per patient day by a direct caregiver) and Nursing Staffing Assignment and Sign-In Sheet (NSA, a document to safeguard and ensure adequate, qualified staffing was present to provide resident care) revealed the most recent documents available were date 2/19/2026 and 2/20/2026, indicating the facility failed to post the required daily nursing staffing information for 2/21/2026, 2/22/2026, and 2/23/2026. This deficient practice had the potential to prevent resident's, staff, and visitors from having access to accurate daily staffing data. Findings: During an observation in the facility's lobby on 2/23/2026 at 8:22 AM, the DHPPD was dated for 2/19/2026 and the NSA was dated for 2/20/2026. During an interview on 2/23/2026 at 9:18 AM, the Director of Staff Development (DSD) stated the purpose of the DHPPD and NSA was to know the ratio of how many residents to licensed staff was needed to make sure all resident's needs were met. The DSD stated the DHPPD and NSA should have been posted daily and updated throughout the day depending on facility staff who call off or if there were any changes. The DSD stated the DHPPD and NSA was posted for anyone to see, including staff to know who was working and if there were enough staff to accommodate each resident. During a concurrent observation and interview on 2/23/2026 at 9:27 AM, the DSD stated the DHPPD and NSA posted was not correctly because the date was from last week. The DSD stated the DHPPD and NDS should have been updated because they should have been posted daily even on the weekends so the staff could have a realistic view of how many staff were in the facility. During an interview on 2/26/2026 at 11:20 AM, the Director of Nursing (DON) stated the purpose of the DHPPD and NSA was to make sure there was enough Certified Nursing Assistant's (CNA) to provide direct care, Licensed Vocational Nurses (LVN) to provide medication administration, and Registered Nurses (RN) to provide intravenous (IV) medication and do admissions/discharges for each resident in the facility. The DON stated the DHPPD and NSA should have been posted daily and as needed with any changes to ensure there were enough staff to take care of the residents. The DON stated the DHPPD and NSA were posted so family members and everyone could visibly see how many staff were in the building and how many nurses and CNAs were there in the facility taking care of the residents. During a review of the facility's policy and procedure (P&P) titled, Nursing Services/Posted Nurse Staffing Information dated November 2016, the P&P indicated It is the policy of this facility to post the nursing staffing data on a daily basis at the beginning of each shift. The nurse posting will be readily accessible to residents and visitors. The P&P indicated, The daily PPD will include the facility name, current date, total number and the actual hours worked by the following. The licensed and unlicensed nursing staff directly responsible for resident care per shift. 1. Registered Nurses. 2. LVN. 3. CNA. 4. Resident census.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper food handling and maintain the food service area in a clean and sanitary manner in accordance with the United States Food and Drug Administration (FDA) Food Code 2022 and the facility's policies and procedures (P&P) titled Storage of Food and Supplies, when: 1.The ground cinnamon spice container lid was partially open on the shelf above the food preparation area by the stove area. 2.The two hot water machine spouts (the part where the hot water flows into the pot or cup) were covered in a white chalky build-up. 3.The side salads and desserts on the lunch trays were not covered during transportation from the metallic delivery food cart to the resident's room. Findings: During an observation on 2/23/2026 at 8:15 AM in the facility's kitchen, the ground cinnamon spice container lid was observed partially opened on the shelf above the food preparation area by the stove area. During an observation on 2/23/2026 at 8:20 AM in the facility's kitchen, the two hot water machine spouts were covered in a white chalky build-up. During a concurrent observation and interview on 2/24/2026 at 12:15 PM with the Dietary Supervisor (DS), the DS stated that the ground cinnamon spice lid was not closed all the way and the two hot water machine spouts were covered in a white chalky build-up. The DS stated, all container lids were supposed to be closed all the way to prevent cross-contamination of the resident's foods. The DS stated, the hot water machine spouts were cleaned every day, and the chalky build-up was the hot water calcification (mineral deposits that settle out of hard water [water containing high mineral content] when heated) because the facility had hard water. During a concurrent record review and interview on 2/24/2026 at 12:30 PM with the Dietary Supervisor Assistant (DSA), the facility's kitchen Daily Cleaning Log, dated 2/22/2026 to 2/28/2026 was reviewed. The DSA stated that the coffee machines were cleaned on 2/22/2026 and 2/23/2026. The DSA stated, the daily cleaning of the coffee machine included cleaning the immediate surface area around the hot water machines, checking the exterior of the two hot water machines for visible cracks or dents, and wiping the two hot water machines down including the hot water spouts. During an observation on 2/24/2026 at 1 PM in the facility's boardroom, Registered Nurse (RN) 1 was observed delivering the regular diet test tray from the hallway to the boardroom, and the peach cobbler dessert was not covered. During a concurrent observation and interview on 2/25/2026 at 12:10 PM with Certified Nurse Assistant (CNA) 3 in Station 1's hallway by the metallic delivery food storage cart, CNA 3 stated, Resident 25's dessert bowl on her lunch tray was not covered. CNA 3 was observed delivering Resident 25's lunch tray from the metallic delivery food storage cart down the hallway to Resident 25's room. During another concurrent observation and interview on 2/25/2026 at 12:15 PM with CNA 4 in Station 1's hallway by the metallic delivery food storage cart, CNA 4 was observed carrying Resident 207's lunch tray from her room into the hallway to put inside the metallic delivery food storage cart. CNA 4 stated that Resident 207's salad cup and dessert bowel were not covered on her lunch tray. CNA 4 stated that the salad cup and dessert bowels were never covered on the food trays coming out of the metallic delivery food storage cart because the trays transported in the metallic delivery food storage cart from the kitchen. During an observation on 2/25/2026 at 12:21 PM in the hallway in front of the kitchen, the lunch trays inside the metallic food delivery food storage cart for Station 2 were observed, and the salad cups and dessert bowls on the lunch trays were not covered. During an interview on 2/25/2026 at 12:41 PM with the Dietary Supervisor (DS), the DS stated, the salads and desserts on the resident's trays were not usually covered because the CNAs transfer the trays from transportation cart directly to the resident's room. During a review of the United States Food and Drug Administration (FDA) Food Code, dated 2022, the Food Code indicated that foods shall be protected from cross contamination by storing the food in packages, covered containers, or wrapping. During a review of the FDA Food Code, dated 2022, the Food Code indicated that equipment that dispenses or vends liquids shall be designed that the delivery tube or chute and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orifices are protected dust, insects, rodents, and other contaminations. During a review of the facility's P&P titled Sanitation, dated 2023, the P&P indicated that all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas. During a review of the facility's P&P titled Storage of Food and Supplies, dated 2023, the P&P indicated dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc.) should be stored in seamless metal or plastic containers with tight covers or bins which easily sanitized.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facilityˆfailed toˆensure the Social Services Director (SSD) met the qualificationsˆrequiredˆfor a social worker in a facility with more than 120 residents bed capacity in the facility . The SSD who was hired by the facility on 9/15/2025 as SSD could not provideˆdocumentedˆevidence that at least one year of supervised social work experience in a healthcare setting and working directly with individualsˆprior to the start of employment at the facility.ˆ This deficient practice had the potential not to perform the necessary task of experienced SSD which could result improper discharge planning needs, not receiving medically related social services needs of the residents that could negativelyˆimpact the well being including the psychosocial well-being of all residents. Findings:ˆˆ During a review of the SSD's Employee File, indicated the SSD's date of hire at the facility was 8/15/2025 and had a Personnel Action/Change Form dated 9/15/2025. The Personnel Action/Change form indicated an employee status change of title from Medical Records Director (MRD) to SSD. The form indicated an employee status change of department from Medical Records to Social Services included Direct Support Professional 2, Case Manager, Program Manager, and Lead Case Manager. SSD's employee file indicated SSD held aˆBachelor of Science degree in Elementary Education withˆpreviousˆjob title of MRD prior to accepting the SSD position. The file also indicated the SSD had a Certificate of Completion for Social Service Designee dated 12/2/2024. A review of the SSD's Application for Employmentˆindicatedˆthe SSD previously held positions as Marketing Liason and MRD.ˆ During an interview on 2/26/2026 at 3:48 PM, the SSD stated she received training for Social Services Designee that was 45 hours long. The SSD stated she had a certification for counseling for 180 hours that was supervised by a social worker which the SSD and the facility could not provide documented evidence. The SSD stated she held Social Services positions at previous facility of 56 bed and 99 beds. The SSD stated she covered for the SSD when Social Services Designee was gone at previous facilities, which she considered as her experience as SSD. The SSD stated when she applied to facility she applied for medical records which was why she did not include Social Services positions on her application. The SSD stated when she accepted the position at facility for SSD on 9/15/2025 she did not sign a job description of SSD. The SSD stated she applied verbally for the SSD position with the Administrator (ADM) and the ADM hired her for the role. The SSD stated the facility was aware about her previous employment history. During an interview on 2/26/2026 at 4:26 PM, Administrator (ADM) stated SSD was initially hired as MRD. ADM stated when the position for SSD opened, SSD asked him she wanted to be considered for the position. ADM stated they hired SSD thinking it would be a good fit and they would be hiring internally. ADM stated he and Human Resources staff looked at SSD's previous job history and did not have her fill out a new application because she was already cleared for background check and in the software system. ADM stated although SSD was hired internally, a signed job description of the SSD role was not part of her employee file which should had been. ADM stated the purpose of having a signed job description was to make sure the employee understood the exact job description of their position/title. During a review of the facility's Job Description for Director of Social Services, the descriptionˆindicatedˆthe following qualifications:ˆ Education:ˆ Must have, as a minimum, a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to sociology, special education, rehabilitation counseling, and psychology.ˆ Experience:ˆ Must have, as a minimum, 5 years of experience as a Social Worker, preferably in a hospital, long-term care facility, or other related health care facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to adhere to infection control practices for 1 of 3 residents (Resident 204) that were reviewed for Enhanced Barrier Precaution (Infection control measures that require all staff to wear Personal Protective Equipment (PPE-gown and gloves during high-contact resident care) in accordance to the facility infection control practice policy when two medical transportation personnel entered Resident 204's room without performing hand hygiene and while wearing gloves from a prior task. Resident 204 had Enhanced Barrier Precautions signage posted due to the presence of a dialysis catheter (medical device that give access into the blood stream to filter out waste products from the blood). This deficient practice had the potential to expose Resident 208, who has an invasive dialysis catheter, to harmful pathogens, increasing the risk for infection. Findings: During a review of Resident 204's admission Record (AR), the AR indicated Resident 204 was readmitted to the facility on [DATE] with a diagnosis of dementia (impaired thinking) and end stage renal disease (kidneys do not work anymore). ˆDuring a review of Resident 204's History and Physical (H&P)ˆsigned andˆdatedˆonˆ2/15/2026, indicated that Resident 204 did not have capacity to understand and make decisions. During a review of Resident 204's Minimum Data Set (MDS - a federally mandated resident assessment tool) datedˆ2/3/2026, the MDS indicated the resident hadˆa severely impaired cognition (thinking). During an observation on 2/26/2026 at 10:13 AM in Resident 204's room, a room designated as an EBP, two transportation staff entered the room wearing gloves did not perform hand hygiene prior to entry and did not don (put on) on isolation gown as required PPE. The transportation staff had made direct contact with Resident 204 to transfer her onto a gurney for a dialysis appointment. During an observation and interview on 2/26/2026 at 10:16 AM, the Infection Prevention Nurse (IPN) reported seeing two transportation staff in room [ROOM NUMBER], an Enhanced Barrier Precautions (EBP) room, transferring Resident 204 to a gurney without wearing gown and clean gloves. The IPN stated the staff used the same gloves worn upon entering the room and left the room without removing their gloves or performing hand hygiene. IPN explained that this practice increased infection risk for Resident 204, who has an indwelling dialysis catheter, and created a risk of crossˆcontamination. The IPN stated that organisms could be transferred to staff hands and clothing and subsequently spread to the dialysis center, transport vehicle, or other residents. During a review of the facility P&P titledˆ IPCP Standards and Transmission-Based Precautions revised 3/2024, indicated EBP: used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). The P&P indicated PPE: The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with: Indwelling medical devices include, but are not limited to central lines, peripherally inserted central catheter (PICC) lines, urinary catheters, feeding tubes, and tracheostomies. The P&P indicated Examples of high-contact resident care activities requiring gown and glove use include indwelling urinary catheter

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 23) with indwelling catheter (a flexible, hollow tube inserted into the bladder to continuously drain urine into an external drainage bag) drainage bag was covered to maintain privacy and dignity when the resident's catheter was visible to individuals walking past Resident 23's room. This deficient practice had violated the resident's rights for privacy and the potential to affect the resident's self-esteem and dignity. Findings: During a review of Resident 23's admission Record (AR), the AR indicated the facility admitted the resident on 2/6/2026, with diagnoses including disorders of urinary system (affecting how the body filtered waste and removed urine, often caused by infections, blockages, or chronic disease), type 2 Diabetes Mellitus (DM, a disorder characterized by difficult in blood sugar control and poor wound healing), and acute kidney failure (a sudden, often temporary, loss of kidney function that occurred over a few hours or days). During a review of Resident 23's History and Physical (H&P) dated 2/9/026, the H&P indicated the resident did not have the capacity to make medical or financial decisions. During a review of Resident 23's Physician's Order dated 2/9/2026 at 4:14 PM, the Physician's Order indicated indwelling catheter #16/10 milliliter (ml, unit of volume) to close drainage system for obstructive uropathy (a blockage in the urinary tract that prevented urine from flowing freely, causing urine to back up into the kidneys)/wound management, every shift. During a review of Resident 23's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 2/10/2026, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated the resident had an indwelling catheter. During an observation in Resident 23's room on 2/23/2026 at 2:16 PM, the resident's indwelling catheter was hanging on the right side of the bed without a cover. The resident's indwelling catheter had containing roughly approximately 250 ml of urine in the bag and could be seen while walking past the resident's room. During an interview on 2/25/2026 at 10:26 AM, Certified Nursing Assistant (CNA) 1 stated she ensured residents with an indwelling catheter had the catheter bag that was covered and the bag was placed in a basin. CNA 1 stated the indwelling catheter should have always been in a privacy bag to maintain privacy and dignity. CNA 1 stated if the indwelling catheter were not placed in a private bag the people who come in and out of the resident's room could see and the resident could have felt ashamed or uncomfortable. During an interview on 2/25/2026 at 11:07 AM, Licensed Vocational Nurse (LVN) 1 stated Resident 23's indwelling catheter should have always been covered with a dignity bag and placed on top of a basin to maintain infection control and hygiene. LVN 1 stated if the resident's indwelling catheter were not covered, that could affect the resident's dignity because they were unable to control their body and ability to urinate. During an interview on 2/26/2026 at 9 AM, the Director of Nursing (DON) stated Resident 23's indwelling catheter should have had a dignity bag covering the catheter to maintain the resident's dignity. The DON stated the indwelling catheter should have always been covered so the catheter would not be exposed or people could see the catheter. The DON stated if the indwelling catheter were not covered, that would be a dignity concern, and the resident could be embarrassed. During a review of the facility's policy and procedure (P&P) titled, Resident Rights: Dignity and Privacy dated November 2021, the P&P indicated, It is the policy of this facility that all residents be treated with kindness, dignity, and respect. The P&P indicated Resident's shall be examined and treated in a manner that maintains the privacy of their bodies. Privacy of a Resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident's safety. During a review of the facility's P&P titled, Indwelling Urinary Catheter Care dated December 2023, the P&P indicated, It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection. The P&P indicated, Cover the drainage bag with a privacy bag to maintain dignity.

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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 two of three residents (Resident 35 and Resident 8) received services in the facility with reasonable accommodation of resident needs to ensure that the call light (device used by residents to communicate needs to the nursing staff) was within reach and accessible to the resident, specifically placed on the resident's non-dominant side and out of reach. This deficient practice had the potential to limit Resident 35 and Resident 8's ability to request assistance, safety, and timely access to care. Findings: 1.During a review of Resident 35's admission Record (AR), the AR indicated the facility admitted the resident on 11/17/2022, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness or reduced motor function affecting one entire side of the body, including the arm, leg, and sometimes the face), contracture (a stiffening/shortening at any joint, that reduced the joint's range of motion) – left hand, and degenerative disease of nervous system (incurable, progressive conditions where nerve cells in the brain or spial cord lose function and die over time). During a review of Resident 35's Occupational Discharge summary dated [DATE] to 3/18/2024, the Discharge Summary indicated the resident's Functional Skills Assessment showed a self-care score of zero (from zero to 12; 12 being the highest [function]) and a mobility function score of zero (from zero to 12; 12 being the highest [function]). During a review Resident 35's Physician's Order dated 7/26/2024 at 3:05 PM, the Physician's Order indicated Restorative Nursing Assistant (RNA, a specialized Certified Nursing Assistant [CNA] who helped resident's regain or maintain their physical strength and independence after an illness or injury) to apply bilateral resting hand splints (a rigid or flexible device used to immobilize, support, and protect injured bones, joints, or tissues while they healed) and right elbow extension splint five times a week every day, up to five hours. During a review of Resident 35's History and Physical (H&P) dated 7/22/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 35's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 12/31/2025, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated the resident was dependent (helper did all of the effort and the resident did none of the effort to complete the activity) on facility staff for all self-care areas including mobility. During a review of Resident 35's Limited Physical Mobility to Press Call Light related to Contractures Care Plan dated 2/25/2026, the Care Plan goal indicated the resident would demonstrate the appropriate use of adaptive devices to increase mobility and interventions included providing supportive care and assistance with mobility as needed. During a concurrent observation and interview in Resident 35's Room on 2/23/2026 at 1:54 PM, the resident's left hand was in a closed position unable to open or move fingers. The resident's call light (continued on next page)

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	055430	A. Building B. Wing	02/26/2026

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Whittier Hills Health Care Ctr	10426 Bogardus Ave Whittier, CA 90603

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was observed not within reach and tucked behind the resident's left shoulder. Resident 35 stated the call light should have been in front of me and not being able to reach the call light made her feel awful because she was unable to call facility staff. During a concurrent observation and interview in Resident 35's Room on 2/23/2026 at 2:05 PM, CNA 2 stated the call light should have been right next to Resident 35 where the resident could reach the call light otherwise the resident would not be able to call the facility staff and something could happen to the resident. During an interview on 2/25/2026 at 11:03 AM, the Licensed Vocational Nurse (LVN) 1 stated the resident's call light should have been within reach to be able to use the call light. LVN 1 stated if the resident needed help, using the call light was the most important way to call the facility staff. LVN 1 stated Resident 35 was unable to use her left arm and the resident's call light should have been near her dominant hand to be able to press the call light if she needed anything. During an interview on 2/26/2026 at 8:40 AM, the Director of Nursing (DON) stated the resident's call light should have been within the resident's reach to be able to call facility staff if Resident 35 needed help. 2. During a review of Resident 8's admission Record (AR), the facility admitted Resident 8 on 10/10/2025, and was readmitted on Resident 8 on 1/17/2026 with diagnoses that included metabolic encephalopathy (reversible brain dysfunction caused by chemical imbalance), dementia (a progressive state of decline in mental abilities), and lack of coordination and memory deficit (memory loss) following a cerebral infarction (CVA [cerebrovascular accident], stroke, loss of blood flow to a part of the brain). During a review of Resident 8's care plan, revised 1/10/2026, the care plan indicated Resident 8 was at risk for fall and injury related to left frontal cavernoma (irregularly formed and leaky blood vessels located at the front of the brain), CVA with left-sided weakness and impaired mobility. The care plan's interventions included ensuring the call light was within reach and encouraging Resident 8 to use it to call for assistance as needed, keeping need items with reach, and ensuring a safe environment by having clutter-free floors and a working and reachable call light. During a review of Resident 8's Minimal Data Set (MDS, a resident's assessment), dated 1/19/2026, the MDS indicated Resident's 8 cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 8 was dependent (helper does all the effort) on the facility's staff for ADLs such as performing toileting hygiene and bathing. The MDS indicated Resident 8 was dependent on facility's staff for repositioning in bed and transferring from a lying to sitting position or from chair/bed to chair. The MDS indicated Resident 8 was frequently incontinent (loss of control) of bowel. During a review of Resident 8's history and physical (HP), dated 1/20/2026, the HP indicated Resident 8 did not have the capacity to understand and make decisions. During a concurrent observation and interview on 2/23/2026 at 10:35 AM in Resident 8 room, Resident (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8 was observed lying in bed with the call light clipped to her pillow on the Resident 8 stated she had pressed the button for staff but did not know where the button was. Resident 8 attempted to reach for it with her right hand to her crossing over her body and had difficulty accessing it. Resident 8 stated she had pressed the button for staff but did not know where the button was. During a concurrent observation and interview on 2/23/2026 at 10:45 AM in Resident 8's room with Certified Nurse Assistant (CNA) 5. CNA 5 stated that Resident 8 was lying in bed and the call light was by the left side of her head and clipped to her pillow. CNA 5 stated Resident 8 could not move her left arm, but she was able to use her right arm to reach and press the call light. During an interview on 2/26/2026 at 12:23 PM with Registered Nurse (RN), 1 RN 1 stated that the call light should be within reach of the resident to call for assistance such as calling for assistance to change their adult diaper, asking for pain medications, or asking for assistance to the restroom. RN 1 stated, if the resident had one-sided weakness or difficulty moving one side of the body, the call light should be past mid-line of the body and closer to the more functional side of the body. RN 1 stated, if a resident cannot reach the call light, it may lead to a delay in care. During a review of the facility's policy and procedure (P&P) titled, Routine Procedures: Call Light/Bell dated May 2017, the P&P indicated It is the policy of this facility to provide the resident a means of communication with nursing staff. The P&P indicated, Leave the resident comfortable. Place the call device within resident's reach before leaving room.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on observation, interview, and record review, the facility failed to provide one of 29 sampled residents (Resident 17) with an admission agreement (legally binding contract between a resident and a nursing facility, detailing the rights, responsibilities, services, and costs for care) in Resident 17's preferred language. This deficient practice had the potential for preventing Resident 17 from being informed of their rights, including contact information for the Ombudsman (trained advocates who investigate complaints, protect rights, and improve quality of life for residents) and the State agency. Findings: During a review of Resident 17's Face Sheet (summary of a resident's information), the Face Sheet indicated the facility admitted Resident 17 on 9/7/2025 with diagnoses including difficulty walking, dysphagia (difficulty swallowing) following a cerebral infarction (brain damage due to a loss of oxygen to the area), and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body). During a review of Resident 17's Minimum Data Set ([MDS] a resident assessment tool), dated 12/5/2025, the MDS indicated Resident 17's preferred language was Spanish. The MDS indicated Resident 17 had clear speech, understood verbal content, expressed ideas and wants, and had moderately impaired cognition (ability to think, understand, learn, and remember). During a concurrent observation and interview on 2/24/2026 at 1:20 p.m. in the dining room, Resident 17 did not know how to contact the Ombudsman and State agency. The dining room was observed without any posted Ombudsman and State agency information. During a concurrent interview and record review on 2/26/2026 at 10:23 a.m. with the admission Coordinator (AC), Resident 17's admission agreement, dated 9/7/2025, was reviewed. The AC stated Resident 17 signed the admission agreement, which included the Ombudsman and State Agency contact information. The AC stated Resident 17's preferred language was Spanish and stated Resident 17's admission agreement was written in English. The AC stated it would be difficult for Resident 17 to refer to the admission agreement for the Ombudsman and State agency information since it was not in Resident 17's preferred language. During a concurrent interview and record review on 2/26/2026 at 2:23 p.m. with the Director of Marking and Admissions (DOMA), the DOMA stated the residents (in general) should receive an admission agreement in their preferred language to easily understand the information. During a review of the facility's policy and procedure (P&P) titled, Resident Rights and Responsibilities, dated 4/2025, the P&P indicated the facility informed residents both orally and in writing of their rights as a resident. The P&P also indicated the facility will inform the resident of their rights and responsibilities in a language that is both clear and understandable to the resident.

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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 observation, interview, and record review, the facility failed to notify the physician when two of three sample residents (Resident 8 and 194) with significant change in condition by failing to: 1.Resident 8 had pain and discoloration on her left foot's second toe and pain from her hemorrhoid (swollen veins in the anus and lower rectum [temporary storage chamber for stool before allowing the stool to pass through the anal canal to exit the body]). These failures resulted in the lack of and delay in Resident 8 medical management and coordination which did not address Resident 8 issues regarding her left foot second toe pain and discoloration and her hemorrhoid pain and follow up until the recertification survey team (from 2/23/2026 to 2/26/2026) conducted an investigation on 2/24/2026 into Resident 8's medical care. 2. For Resident 194 the facility failed to inform the Medical Director when the primary physician did not respond to the call or text when the resident complained of 3 out of 10 right hip and shoulder pain on the numerical pain scale (a tool used to quantify pain intensity, from 0 - no pain to 10 - worst pain experienced), and had a skin tear on the back of the right shoulder and right ear pain after the fall on 1/29/2026 at the facility. As a result of this deficient practice, Resident 194 did not receive care and services to evaluate the cause of ear pain, shoulder and hip pain from 1/29/2026 at the time of fall to 2/2/2026. Findings: 1.During a review of Resident 8's admission Record, the facility admitted Resident 8 on 10/10/2025 and the facility readmitted Resident 8 on 1/17/2026 with diagnoses that included metabolic encephalopathy (reversible brain dysfunction caused by chemical imbalance), dementia (a progressive state of decline in mental abilities), and memory deficit (memory loss) following a cerebral infarction (CVA [cerebrovascular accident], stroke, loss of blood flow to a part of the brain). During a review of Resident 8's care plans, revised on 12/28/2025, the care plan indicated Resident 8 was at risk for alteration in gastro-intestinal status related to hemorrhoids. The care plans interventions, initiated on 1/17/2026, indicated to apply Procotozone -HC External Cream 2.5% (prescription topical steroid cream used to temporarily relieve pain, swelling, and itching from hemorrhoids) to the rectum topically every 24 hours as needed for hemorrhoids and to apply after bowel movements. During a review of Physician 1's Convalescent Podiatry Care Evaluation and Treatment, dated 11/3/2025 and 1/5/2026, Physician 1 indicated Resident 8's five toenails on her left foot were thickened, discolored, brittle with subungual debris (collection of blood trapped underneath the toenail) and were painful upon palpation. Physician indicated that Resident 8 had 10 mycotic (fungal), hypertrophic (thicken nails), painful, and incurvated toenails (a severely curved, rounded, or C-shaped toenail that curls downwards, often leading to pain, pressure, and, if it punctures the skin, an ingrown nail). Physician 1 had trimmed Resident 8 nails with a nail clipper and Dremel (a small handheld motorized tool to grind and smooth down nails) and recommended to apply Clotrimazole 1% cream (antifungal skin cream to treat skin infections caused by fungus) topically to the affected area daily. During a review of Resident 8 Order Summary Report, the order, dated 1/17/2026, indicated to apply Proctozone - HC External Cream 2.5% to the rectum topically every 24 hours as needed for hemorrhoids after bowel movement. During a review of Resident 8 Order Summary Report, the order, dated 1/18/206, indicated Resident 8 may be seen and treated by a Podiatrist (physician specializing in diagnosing, treating, and preventing conditions of the foot, ankle, and lower leg). During a review of Resident 8's Minimal Data Set (MDS, a resident assessment tool), dated 1/19/2026, the MDS indicated that Resident 8's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 8 was dependent (helper does all the effort) on the facility staff for her activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and dependent on the facility staff for repositioning in bed and transferring from a sitting to lying position and from chair or bed to chair transfer. The MDS indicated that Resident 8 was frequently incontinent (loss of control of bowel or bladder) of bowel. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 8's History and Physical (HP), dated 1/20/2026, the HP indicated Resident 8 did not have the capacity to understand and make decisions. During an observation on 2/25/2026 at 8:16 AM with Restorative Nurse Assistant (RNA) 1 in Resident 8's room, RNA 1 removed the Resident 8's left sock, the second toe appeared red near the nail bed. RNA 1 touched the toe, causing the resident to scream in pain, and the resident again expressed pain when the sock was replaced. RNA 1 told the resident she would notify the nurse about the pain. During a concurrent observation and interview on 2/26/2026 at 8:11 AM in Resident 8's room, Resident 8 was observed pointing to her left foot with her pointer stick and stated pain on my 2nd finger, and stated, sometimes it hurts in the morning or sometimes in hurts in the afternoon. Resident 8 stated she did not know how long her left second toe had been hurting. During a concurrent observation and interview on 2/26/2026 at 8:20 AM with Treatment Nurse (TN) 2, in Resident 8's room, while TN 1 was providing maintenance treatment to Resident 8's Sacro coccyx area (tailbone area), she stated that Resident 8 has active hemorrhoids sometimes like today. RN 2 stated, Resident 8 currently has a small pink and reddish hemorrhoid, and the way to treat it was to push it back in. TN 1 was observed applying A&D ointment (skin barrier cream) to her finger and pushing Resident 8's hemorrhoid back into the lower rectum area. During a concurrent observation and interview on 2/26/2026 at 8:36 AM with Certified Nurse Assistant (CNA) 5, in Resident 8's room, CNA 5 removed the resident's left sock and noted that her second toenail was longer than the others with discoloration at the nail bed. When the sock was put back on, Resident 8 grimaced, yelled that her 2nd finger hurts, and asked for it to be removed while pointing to her left foot. After CNA 5 removed the sock again, the resident calmed down. CNA 5 stated he would notify the nurse about the resident's pain for medication. During a concurrent observation and interview on 2/26/2026 at 12:15 PM with CNA 5 and CNA 6, in Resident 8's room, CNA 5 and CNA 6 were observed cleaning and changing Resident 8's adult briefs. Resident 8 was observed repeatedly stating that her butthole hurts. CNA 6 was observed applying A&D ointment to her finger and told Resident 8 that she will apply cream to help her. During a concurrent interview and record review on 2/26/2026 at 12:50 PM with Registered Nurse (RN) 1, Resident 8 Skilled Nursing Evaluation form, dated 2/18/2026, 2/22/2026, 2/24/2026, and 2/25/2026 were reviewed. RN 1 stated, there was no documented evidence about Resident 8's left 2nd toenail pain or hemorrhoids. RN 1 stated, she was not aware of Resident 8's complaint of pain on the toenail pain or had active hemorrhoids. RN 1 stated, since she was not aware of Resident 8's change of condition (CoC) regarding her left 2nd toenail and hemorrhoids, Resident 8's Primary Care Physician was not notified. RN 1 stated, since there was no CoC, there would be no care plan related to Resident 8's active toenail pain and hemorrhoids. During the same interview on 2/26/2026 at 1:05 PM with RN 1, RN 1 stated, the licensed nurses were expected to do a thorough head-to-toe assessment upon shift change including removing resident's socks. RN 1 stated, on shower days, CNAs were expected to do a observe the resident's skin for any changes either in the shower or during sponge baths and that included moving the resident's socks. RN 1 stated, Resident 8's PCP needed to be notified about Resident 8's CoC for further orders and instructions related to Resident 8's medical care. During a review of the facility's policies and procedures (P&P) titled Change in Condition, dated April 2025, the P&P indicated that the facility needed to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being. The P&P indicated that it, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware examples included change in medical condition. 2. During a review of Resident 194's General Acute Care Hospital (GACH) 1's Discharge Summary record, the record indicated that Resident 194 was admitted to the hospital on [DATE] for altered mental status and was brought into the GACH emergency department for further evaluation. On 1/24/2026 Resident 194 was discharged from the GACH and admitted to the facility for rehabilitation care. During a review of Resident 194's admission Record, the facility admitted Resident on 1/24/2026 with diagnoses that included Acute Respiratory (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Failure (ARF, condition where the lungs cannot provide enough oxygen to the resident of the body's tissues) with hypoxia (the body's tissues does not receive enough oxygen to function properly), type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and lobar pneumonia (PNA, an infection/inflammation in the lungs). The AR indicated that Resident 194 passed away on 2/2/2026 (nine days after admitted to the facility). During a review of Resident 194's Minimal Data Set (MDS, a resident assessment), dated 1/29/2026, the MDS indicated that Resident 194's cognitive (a resident's thought process) skills were moderately impaired. The MDS indicated that Resident 194 needed substantial assistance (helper does more than half the effort) with toileting hygiene and showering, functional mobility such as repositioning self in bed, transferring from a lying to sitting position, and transferring from bed/chair to chair. During a review of Resident 194's History and Physical (HP), dated 1/24/2026, the HP indicated that Resident 194 was alert and oriented to person, time, place, and situation, with clear speech and was able to make her needs known but cannot make medical decisions. During a review of Resident 194's Change of Condition Evaluation (CoC) record, dated 1/29/2026 timed at 11:15 PM, the CoC record indicated Resident 194 had fallen on the night of 1/29/2026. The CoC record indicated that Resident 194 had no changes in mental status, complained of 3 out of 10 right hip and shoulder pain on the numerical pain scale (a tool used to quantify pain intensity, from 0 - no pain to 10 - worst pain experienced), and had a skin tear on the back of the right shoulder. The CoC record indicated that the facility contacted PA 1 on 1/29/2026 at 11:39 PM, and pending response. During a review of Resident 194's Nursing PN, dated 1/29/2026 timed at 11:40 PM, the PN indicated that upon entering the room CNA found Resident 194 lying on her right side, and when interviewed Resident 194 stated she was trying to stand up and fell down. The PN indicated that Resident 194 complained of right shoulder, right hip, and right ear pain. During a review of Resident 194's Fall Risk Evaluation record, dated 1/29/2026, the record indicated that Resident 194 had one (1) or two (2) falls within the past three (3) months and was considered a fall risk. During a review of Resident 194's care plan, date initiated on 1/29/2026, the care plan indicated that Resident 194 had an unwitnessed fall. The care plan's interventions, initiated on 1/29/2026, included placing a fall mat by bedside, keeping the bed in low position, and monitoring/documenting/reporting as needed for 72 hours to the physician signs and symptoms of pain, bruising, change in mental status, new onset of confusion/inability to maintain posture or agitation. During a review of Resident 194's care plan, date initiated on 1/30/2026, the care plan indicated that Resident 194 had alteration in musculoskeletal status related to complaints of weakness and dizziness. The care plan's interventions, initiated on 1/30/2026, included anticipating resident's needs and monitoring for fatigue. During a review of Resident 194's PT Treatment Encounter Note(s), dated 1/30/2026, the record indicated that nursing advised not to get resident up to due episode of passing out. The record indicated that Resident 194 was responsive during therapy but seemed weak. During a review of the Skin/Wound Note PN dated 1/30/2026, timed at 4:16 PM, indicated a follow up skin assessment of Resident 194's wound after the fall with right shoulder skin abrasion measuring 3-centimeter (cm) X 3 cm with light bleeding. During a review of the Skin/Wound Note, dated 1/31/2026 at 10:44 PM, indicated Skin issue has not been evaluated on the front right shoulder abrasion that was acquired in-house. During a review of the PN dated 2/2/2026 timed at 11:02 AM, PA 1 informed of Resident 194's condition and RR asking to hold off on hospital transfer, per PA 1 continue to monitor the resident and report any new changes. During a review of COC report dated 2/2/2026 at 1:30 PM, indicated IDT met on 2/1/26 to discuss resident fall with the RR that on 1/29/26 at approximately 11:15PM CNA reported to LVN and RN that resident was on the floor. LVN and RN went to residents' room immediately and noted resident on the floor laying on her right side of bed with her back against the bed frame. RN assessed resident for ROM and was at baseline, noted with skin scrape to right shoulder. First aid was provided to right shoulder. Resident 195 complained of mild pain to right shoulder and right hip. LVN medicated resident for pain as ordered. Resident 195 was transferred back to bed by 2 staff assist. Resident 195 stated she was trying to stand up and fell (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	down. During an interview on 2/25/2026 at 4:45 PM with Family Member (FM) 1, FM 1 stated the morning of 1/30/2026, she received a notification from the facility that Resident 194 had fallen the night prior (1/29/2026). FM 1 stated, she went to visit Resident 194 that morning (1/30/2026), and Resident 194 told FM 1 that she did not feel good and was having pain, but cannot recall the location of Resident 194's pain. FM 1 stated, facility did not mention to her what may have caused Resident 194 to fall on the night of 1/29/2026 and cannot recall if Resident 194 had an x-ray (medical imaging) after the fall. During the same concurrent interview and record review on 2/26/2026 at 1:15 PM with RN 1, Resident 194's CoC evaluation, dated 1/29/2026, was reviewed. RN 1 stated, Resident 194's CoC indicated that the facility attempted to notify PA 1 at 1/29/2026 at 11:39 PM, but the documented evidence of primary care physician (PCP) recommendation indicated Pending response from (PA 1). RN 1 stated, there was no documented evidence that Licensed Vocational Nurse (LVN) 3 attempted to notify PA 1 three times within the 11 PM to 7 AM shift on 1/29/2026 and no documented evidence of additional follow up notification during the 7 AM to 3 PM shift on 1/30/2026. RN 1 stated, because LVN 3 was not able to notify PA 1, LVN 3 needed to go up the chain of command and notify the Medical Director of Resident 194's CoC. RN 1 stated, if LVN 3 could not contact Resident 194's PCP or the On-Call Physician, Resident 194 should have been transferred to the GACH for further evaluation. During the same concurrent interview and record review on 2/26/2026 at 1:30 PM with RN 1, Resident 194's PN, dated 1/29/2026 timed at 11:40 PM, and Order Summary Report were reviewed. RN 1 stated, the PN indicated that Resident 194 complained of right shoulder, right ship, and right ear pain. RN 1 stated, there was no documented evidence of PA 1's recommendations such as orders for x-ray or imaging of Resident 194's right shoulder or hip or orders regarding Resident 194's right ear pain. RN 1 stated, Resident 194's new orders post-fall included to place Resident 194 in a low bed, place floor mats on bilateral sides of the bed, and wound care treatments for Resident 194's right shoulder abrasion. During a concurrent interview and record review on 2/26/2026 at 2:45 PM with the Assistant Director of Nursing (ADON), Resident 194's CoC Evaluation record, dated 1/29/2026 and PNs dated 1/29/2026 timed at 11:40 PM, 1/30/2026 timed at 6:55AM, 1/30/2026 timed at 11:01 AM, and 1/30/2026 timed at 11:10 AM, were reviewed. The ADON stated, the CoC indicated a pending response from PA 1, and the reviewed PN did not have any documented evidence of additional follow-up notification to PA 1. The ADON stated, because LVN 3 could not contact PA 1, it was the facility's standard of practice to notify the Director of Nursing (DON) and the Medical Director for further orders and evaluation. During the same concurrent interview and record review on 2/26/2026 at 3:55 PM with the DON, Resident 194's Order Summary Report was reviewed. The DON stated the only order from PA 1 was Resident 194's wound care treatment orders for her right should abrasion and no order for transfer to the hospital when the resident complained of shoulder pain, ear pain, weakness and dizziness. The DON stated, there was no need for x-rays because [Resident 194's] range of motion was at baseline. During the same concurrent interview and record review on 2/26/2026 at 4:05 PM with the DON, Resident 194's PN dated 1/29/2026 timed at 11:40 PM was reviewed. The DON stated that Resident 194 complained of right shoulder, right hip, and right ear pain. The DON stated, upon the facility's investigation on 2/1/2026, the DON stated she could not explain the reason for Resident 194 experience of right ear pain. The DON stated she was not informed by the license nurses that they were not able to get a hold of PA 1 or the other physician to report Resident 1's complaints of pain. During an interview on 2/26/2026 at 4:10 PM with PA 1, PA 1 stated he was Resident's 194's PA. PA 1 stated, since Resident 194 fell on 1/29/2026 during the 11 PM to 7 AM shift, PA 1 stated I was not the on-call provider at that time. PA 1 stated, I am not sure if they contacted another provider. PA 1 stated, he would have ordered an x-ray of [Resident 194's] right shoulder and hip because she was complaining of right shoulder and hip pain. PA 1 stated, he was not aware that Resident 194 was complaining of right ear pain. PA 1 stated, based on the LN ?s assessment at the time of the fall, if the PCP cannot be reached, the LN should have consulted with the DON and the Medical Director for further instructions. During a review of the facility's policy and (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedures (P&P) titled Fall Management System, dated April 2025, the P&P indicated that it was the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. During a review of the same facility's P&P titled Fall Management System, dated April 2025, the P&P indicated that when a resident sustains a fall, the Attending Physician shall be notified of the fall and the resident's status, provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. During a review of the facility's same P&P titled Change in Condition, dated April 2025, the P&P indicated if at any time the team recognized the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware, such as new complaints of pain or worsened pain. The P&P indicated in circumstances where immediate attention is warranted, the nurse shall use her clinical judgement and inform the physician based on the urgency of the situation. The Medical Director shall be notified if the primary physician or on-call physician could not be reached.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the reason for resident's discharge and notice of proposed discharge was completed for one of three sampled residents (Resident 193) reviewed for closed records as indicated in the facility's policy and procedure titled Criteria for Transfer and Discharge, This deficient practice had the potential to result in inappropriate information communicated to the receiving health care institution or provider. Findings: During a review of Resident 193's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included type 2 diabetes mellitus (chronic condition where the body resists insulin [hormone produced by the pancreas that regulates blood sugar by moving glucose [sugar] from the bloodstream into cells for energy] or fails to produce enough, causing high blood sugar), other schizoaffective disorders (chronic mental health condition combining schizophrenia symptoms [hallucinations, delusions, disorganized thinking] with mood disorder episodes [mania or depression]), and seizures. The AR indicated Resident 193 was discharged on 12/5/2025. During a review of Resident 193's Discharge summary dated [DATE] indicated Resident 193's Transfer/Discharge was necessary due to: the health and safety of individuals in the facility would be endangered. The summary indicated Resident 193 was transferred to hospital due to aggressive behavior. During a review of Resident 193's Notice of Proposed Transfer/discharge date d 12/5/2025 indicated resident's transfer/discharge was made for the following reason: the transfer or discharge was appropriate because resident's health had improved sufficiently and no longer required services provided by the facility. The Notice of Proposed Transfer/Discharge did not indicate a Resident/Representative Signature. During a concurrent interview and record review of Resident 193's Discharge Summary and Notice of Proposed Transfer/discharge on [DATE] at 4:58 PM, the Director of Nursing (DON) confirmed the reason of discharge on the discharge summary and notice of proposed transfer/discharge did not match. The DON stated the summary, and notice should match so that it gives the correct information about resident's reason for discharge. The DON confirmed there was no resident/representative signature on the Notice of Proposed Transfer/Discharge. The DON stated the form should be completed and include the correct information. A review of the facility's policy and procedure (P&P) titled Criteria for Transfer and Discharge, dated 4/2025 indicated when the facility transfers or discharges a resident, the facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the minimum data set (MDS, a standardized assessment and care screening tool) was completed and transmitted to Centers of Medicare and Medicaid Services (CMS) timely for 2 of 3 sampled residents (Resident 32 and Resident 71). This deficient practice failed to provide CMS specific resident information for quality care measure purposes and had the potential to affect the quality of care provided to the resident. Findings: During a review of Resident 32's admission Record (AC), the AC indicated the resident was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (your body does not use insulin properly), muscle weakness (when muscles aren't as strong as they should be). During a review of Resident 32's History and Physical (H&P) dated 11/14/2025 indicated Resident 32 has the capacity to understand and make decisions. A review of Resident 32's MDS, dated [DATE] indicated this was a 5-day scheduled assessment. A review of facility's CMS submission Report indicated Resident 32's was last submitted on 3/10/2025. During a review of Resident 71's admission Record (AC), the AC indicated the resident was admitted to the facility on [DATE] with diagnoses that included Acute Respiratory Failure with hypoxia (when you don't have enough oxygen in your blood), Type 2 diabetes mellitus (your body does not use insulin properly). During a review of Resident 71's History and Physical (H&P) dated 10/24/2025 indicated Resident 71 has the capacity to make their needs known but cannot make medical decisions. A review of Resident 71's MDS, dated [DATE] indicated this was a 5-day scheduled assessment. A review of facility's CMS submission Report indicated Resident 71's was last submitted on 2/24/2026. On 2/25/2026 at 2:15 PM, during an interview and concurrent record review of Resident 32'Smds. MDS nurse stated and Resident 71's 5 day scheduled assessment dated [DATE] with MDS coordinator, MDS coordinator stated she was responsible for completing Resident32's and Resident 71's 5-day MDS assessment and transmitting it to CMS. MDS coordinator stated, I forgot to complete transmit the MDS for Resident 32 and for Resident 71, I hadn't realized it until now. MDS coordinator stated MDS should be completed upon admission and transmitted within 14 days for both residents 32 and 71 per federal regulations and our faclity practice. During a review of the facility's policy and procedure (P&P) titled Resident assessment and associated processes with a revision date of 4/2025. The P&P indicated The facility will electronically encode, accurate, and complete MDS data to the Centers for Medicare & Medicaid Services system as soon as possible.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care and services to prevent skin injury (a skin damage due to prolonged unrelieved pressure and friction) to ensure the resident's low air loss mattress was set according to the physician's order and within the appropriate weight range for one of two sampled residents (Resident 75). This deficient practice had the potential to place Resident 75 at risk for developing pressure injuries, impaired pressure redistribution, and potential skin breakdown. Findings: During a review of Resident 75's admission Record (AR), the AR indicated the facility admitted the resident on 7/21/2024, with diagnoses including pressure ulcer (localized, damaged areas of skin and underlying tissue caused by prolonged, unrelieved pressure - or pressure combine with shear - that cuts off blood flow) of right hip, abnormal posture, and adult failure to thrive (a decline caused by chronic diseases and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 75's Physician's Order dated 7/22/2024 at 4:45 PM, the Physician's Order indicated for the resident to have low air loss mattress (a therapeutic hospital mattress that used a pump to push air through tiny holes in the fabric, creating a cool, dry, floating sensation) for skin management, setting according to resident weight and check function every shift. During a review of Resident 75's History and Physical (H&P) dated 5/4/2025, the H&P indicated the resident did not have the capacity to understand and make decisions but could make needs known. During a review of Resident 75's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 1/21/2026, the MDS indicated the resident had severe cognitive impairment (Problems with a person's ability to think, learn, remember, use judgement, and make decisions) and was at risk of developing pressure ulcer/injuries and treatments included: pressure reducing device for chair, pressure reducing device for bed, nutrition/hydration intervention, and applications of ointments/medications. During a review of Resident 75's At Risk for Pressure Ulcer Development Care Plan revised 1/21/2026, the Care Plan indicated for the resident to have intact skin, free of redness, blisters (small, painful, fluid-filled bubbles that formed under the top layer of skin, usually on hands or feet) or discoloration with interventions that included administering treatments as ordered and monitoring for effectiveness, daily body checks, and having low air loss mattress for skin management setting according to resident weight and check function every shift. During a review of Resident 75's Weight Summary dated 2/23/2026, the Weight Summary indicated the resident's weight while sitting was 114 pounds. During an interview on 2/25/2026 at 11:17 AM, the Treatment Nurse (TN) 1 stated the TNs were in charge of setting the low air loss mattress setting for each resident and should have been consistent with each resident's weight. TN 1 stated for Resident 75, the resident had a history of wounds and needed to have a special mattress to protect the resident's skin and prevent skin break down. During a concurrent interview and record review of Resident 75's Physician's Order on 2/25/2026 at 11:29 AM, TN 1 stated the facility staff were not following the Physician's Order but should have been. TN 1 stated the resident's low air loss mattress setting should have been set to Resident 75's weight for the resident's safety. TN 1 stated if the setting was not correct the resident could have redness or skin breakdown because of the pressure from the mattress. During an interview on 2/26/2026 at 8:36 AM, the Director of Nursing (DON) stated the low air loss mattress setting should have been set according to the resident's weight. The DON stated having a low air loss mattress for Resident 75 was important because the resident was prone to skin breakdown and if the settings were not correct, the resident would be uncomfortable. During a concurrent interview and record review of Resident 75's Physician's Order on 2/26/2026 at 8:40 AM, the DON stated the facility staff did not follow the Physician's Orders for the mattress setting which could result in too firm and not comfortable, likely changing the skin or having skin irritation for Resident 75. During a review of the undated Low Air Loss Mattress User Manual, the User Manual indicated the Product Function: Analog Pressure Dial (adjusts how firm or soft the air-filled mattress felt by controlling the air pump (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure) - Adjust the dial to correspond to the patient's appropriate weight setting or comfort level. During a review of the facility's policy and procedure (P&P) titled, Continuum of Care: Admission dated 2/7/2025, the P&P indicated, Note and initiate physician orders. Initiate medications and treatment. During a review of the facility's P&P titled, Skin and Wound Monitoring and Management dated April 2025, the P&P indicated, It is the policy of this facility that a resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. The P&P indicated In order to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement the following approaches as an appropriate and consistent with the resident's care plan: use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses), licensed nurse to document presence of pressure reducing devices on Treatment Administration Records as ordered. The P&P indicated, Confirm all orders have been implemented as ordered.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide range of motion ([ROM] full movement potential of a joint) intervention for two of four sampled residents (Resident 8 and 96) reviewed for ROM limitations. 1. For Resident 8, the facility failed to: -Measure Resident 8's left hand during the Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation, dated 1/19/2026, in accordance with professional standards of practice. -Provide Resident 8 with ROM exercises for both legs from 1/24/2026 to 2/25/2026. -Perform AAROM to Resident 8's left arm in accordance with the physician's orders, dated 1/30/2026. 2. For Resident 96, the facility failed to provide ROM exercises to both arms and legs from 2/18/2026 to 2/26/2026 (nine days) following Resident 96's admission to hospice (interdisciplinary care that is designed to provide physical, emotional, social, and spiritual comfort of an individual in the last phases of life due to a terminal disease). This failure was not in accordance with the facility's policy and procedures (P&P) titled, ROM and Contracture Prevention, revised 5/2019, and End of Life Care; Hospice and/or Palliative Care, revised 4/2025. These failures had the potential for Resident 8 to experience an undetected decline in ROM of the left hand, decreased strength in the left arm, and decline in ROM of both legs. These failures also had the potential for Resident 96 to experience a decline in ROM of both arms and legs, which could lead to the development of contractures (stiffening/shortening at any joint that reduces the joint's range of motion). Findings: 1.During a review of Resident 8's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 1/19/2026, the MDS indicated Resident 8 had clear speech, expressed ideas and wants, usually understood verbal content, and had intact cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 8 required partial/moderate assistance (helper does less than half the effort) for eating and dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for toileting, showering, dressing, rolling to either side in bed, and transferring from lying to sitting on the side of the bed. During a review of Resident 8's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 1/19/2026, the OT Evaluation indicated Resident 8 had within functional limits ([WFL] sufficient joint movement without significant limitation) ROM in the right arm and the left elbow. The OT Evaluation indicated Resident 8 had impaired ROM in the right shoulder, wrist, and hand. The OT Evaluation indicated Resident 8's right shoulder had 0-80 degrees (unit of joint measurement) of flexion (lifting the arm overhead, normal ROM measurement 0-180 degrees), right wrist had 0-40 degrees of extension (bending the wrist upward, normal ROM measurement 0-90 degrees) and 0-40 degrees of wrist flexion (bending the wrist downward, normal ROM measurement 0-90 degrees). The OT Evaluation indicated Resident 8's right thumb, index finger, middle finger, ring finger, and little finger were impaired but did not include measurements of each finger. During a review of Resident 8's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 1/19/2026, the PT Evaluation indicated Resident 8 had within functional limits ([WFL] sufficient joint movement without significant limitation) ROM in both legs. The PT Evaluation indicated Resident 8 was dependent for rolling to either side in bed and transferring from lying to sitting on the side of the bed. During a review of Resident 8's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated recommendations for a Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) program. The OT Discharge Summary indicated Resident 8's RNA program included active range of motion ([AROM] performance of an exercise to move a joint without any assistance or effort of (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another person) exercises for the right arm and active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) for the left arm, three times per week as tolerated. During a review of Resident 8's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated recommendations to continue with PT to promote increased muscle strength, balance, and safety awareness. During a review of Resident 8's physician's orders, dated 1/30/2026, the physician's orders indicated RNA for AROM exercises on the right arm and AAROM exercises on the left arm, three times per week as tolerated. During an interview on 2/24/2026 at 8:31 a.m. with the Director of Rehabilitation (DOR), the DOR stated the purpose of RNA (in general) was to maintain a resident's mobility to prevent any decline. The DOR stated the purpose of ROM exercises included to maintain a resident's mobility and prevent the development of contractures (stiffening/shortening at any joint that reduces the joint's range of motion). During a concurrent observation and interview on 2/25/2026 at 8:16 a.m. with Restorative Nursing Aide 1 (RNA 1) in the resident's room, Resident 8's RNA session was observed. Resident 8 was observed lying in bed and agreeable to the RNA exercises. Resident 8 was observed actively moving the right arm. Resident 8's left elbow was completely extended, the left wrist was extended, and the left hand was positioned in a closed fist. RNA 1 physically moved Resident 8's left arm for ROM exercises at the shoulder, elbow, wrist, and hand joints. Resident 8 complained of pain during elbow flexion (bending) but tolerated the exercises after RNA 1 decreased the degree of ROM provided. RNA 1 positioned a rolled towel in Resident 8's left hand. RNA 1 then moved to the right side of Resident 8's bed. RNA 1 physically moved Resident 8's right arm for ROM exercises at the shoulder, elbow, wrist, and hand joints since Resident 8 fell asleep. RNA 1 stated Resident 8 usually helps with the right arm when Resident 8 was more awake but doesn't move that one (the left arm) at all. RNA 1 stated Resident 8's RNA program included ROM exercises to both arms and did not include both legs. Resident 8 was observed moving the right leg to straighten the knee. Resident 8's left leg was fully extended on the bed. During a follow-up interview on 2/25/2026 at 8:45 a.m. with RNA 1, RNA 1 stated Resident 8 received AROM on the right arm and AAROM on the left arm. RNA 1 stated AAROM exercises (in general) meant a resident could help with the exercises. RNA 1 stated Resident 8 cannot move or assist with ROM exercises on the left arm. RNA 1 stated Resident 8 did not have RNA for ROM exercises to both legs. RNA 1 stated she placed the rolled towel in Resident 8's left hand to help open the fingers. RNA 1 stated Resident 8's left hand could develop contractures if it was constantly positioned in a closed fist. During a concurrent interview and record review on 2/25/2026 at 11:26 a.m. with the DOR, Resident 8's OT Discharge summary, dated [DATE], and PT Discharge summary, dated [DATE], were reviewed. The DOR stated the OT Discharge recommendations included RNA to provide Resident 8 with AROM to the right arm and AAROM to the left arm, three times per week. The DOR stated the PT Discharge recommendation indicated for Resident 8 to continue with PT services. The DOR reviewed Resident 8's PT documentation and stated Resident 8 did not receive additional PT services after the PT discharge on [DATE]. During a concurrent interview and record review on 2/25/2026 at 11:46 a.m. with Physical Therapist 1 (PT 1), Resident 8's PT Discharge summary, dated [DATE], was reviewed. PT 1 stated Physical Therapist 3 (PT 3) provided Resident 8's PT services when PT 1 was on vacation. PT 1 stated Resident 8 had minimal improvement with PT services. PT 1 stated Resident 8 required AAROM on the right leg and passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) on the left leg. PT 1 stated Resident 8's initial discharge plan was to return home with the family, but the family decided for Resident 8 to remain in the facility. PT 1 stated PT 3 should have notified the DOR regarding the recommendations for Resident 8 to continue therapy services. PT 1 stated Resident 8 did not receive any ROM intervention to both legs for approximately one month from PT discharge on [DATE] to today (2/25/2026). PT 1 stated Resident 8 should have received ROM exercises to both legs to prevent contractures and atrophy (loss of muscle), especially on Resident 8's left side which was weak. During a concurrent interview and record review on 2/25/2026 at 1:28 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m. with Occupational Therapist 1 (OT 1), Resident 8's OT Evaluation, dated 1/19/2026, and OT Discharge summary, dated [DATE], were reviewed. OT 1 stated ROM limitations (in general) were measured with a goniometer (instrument used to measure angles of joint movement). OT 1 stated the OT Evaluation included measurements for Resident 8's PROM on the left shoulder and wrist. OT 1 stated the OT Evaluation indicated Resident 8's PROM on the left hand was impaired but did not include measurements. OT 1 stated Resident 8's left hand did not have a baseline (starting points used for comparison) measurement for ROM. OT 1 stated Resident 8 had some movement in the left arm and recommended RNA for AAROM exercises. OT 1 stated AAROM exercises allowed Resident 8 to contribute to the movement, decrease pain, and prevent Resident 8 from being completely dependent on the left arm. OT 1 stated the RNAs have not reported any changes with Resident 8's RNA program. During a review of the textbook titled, Occupational Therapy for Physical Dysfunction: 7th Edition, published in 2014, Chapter 7 titled, Assessing Abilities and Capacities: Range of Motion, Strength, and Endurance, the textbook indicated the OT used assessments to establish a patient's baseline abilities including specific measurements of joint ROM where limitations were noted. The textbook's Chapter 7 indicated a goniometer is the most common tool used for measuring joint motion of the arms. 2. During a review of the facility's P&P titled, End of Life Care; Hospice and/or Palliative Care, revised 4/2025, the P&P indicated the facility will continue to provide necessary care and services to assist the resident to achieve his or her highest practicable well-being. During a review of Resident 96's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 96 on 2/2/2023 and readmitted on [DATE]. The Face Sheet indicated Resident 96's diagnoses included atherosclerotic (thickening and hardening of the blood vessels) heart disease, acquired absence of the left toes, muscle weakness, and dysphagia (difficulty swallowing). During a review of Resident 96's MDS, dated [DATE], the MDS indicated Resident 96 had clear speech, had difficulty communicating some words or finishing thoughts but able if prompted or given time, and usually understood most of the conversation. The MDS indicated Resident 96 had severely impaired cognition. The MDS indicated Resident 96 required substantial/maximal assistance (helper does more than half the effort) for eating and dependent for oral hygiene, toileting, dressing, transferring from lying to sitting on the side of the bed, and char/bed-to-chair transfers. During a review of Resident 96's Joint Mobility Evaluation ([JME] brief assessment of a resident's range of motion in each joint of both arms and legs), dated 7/11/2025, the JME indicated Resident 96's intervention included RNA for PROM exercises to both arms and legs, three times per week as tolerated. The JME indicated Resident 98 had minimum ROM limitations (75-100 percent [%] of range intact) in both shoulders and severe ROM limitation (0-25% of range intact) in the left fingers. The JME indicated Resident 96 experienced a ROM decline in the left hand. During a review of Resident 96's physician's orders, dated 7/31/2025, the physician's orders indicate for the RNA to provide gentle PROM to both arms, three times per week as tolerated. Another physician order, dated 7/31/2025, indicated for the RNA to provide PROM to both legs, three times per week as tolerated. During a review of Resident 96's OT Evaluation and Plan of Treatment, dated 8/12/2025, the OT Evaluation indicated Resident 96 had WFL ROM in the right arm, left elbow, and left wrist. The OT Evaluation indicated Resident 96's left shoulder flexion was limited to 90 degrees, and the left hand had a clenched fist (formed by tightly curling the fingers into the palm) contracture at rest. The OT Evaluation indicated Resident 96 had a history of refusing a splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) and will continue to utilize joint mobilization techniques (skilled, manual therapy used to treat stiffness and restricted ROM) as tolerated to reduce Resident 96's further risk of contracture. During a review of Resident 96's PT Evaluation, dated 8/12/2025, the PT Evaluation indicated Resident 96 had WFL ROM in both hips and ankles. Resident 96's PT Evaluation indicated both knees extended to 90 degrees (bent into a right-angle position). During a review of Resident 96's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated recommendations for the RNA to provide gentle PROM to both arms, three times per week or (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as tolerated. During a review of Resident 96's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated both of Resident 96's knees improved to 15 degrees of extension. Resident 96's PT Discharge Summary indicated recommendations for RNA to provide ROM to both legs. During a review of Resident 96's unsigned admission Orders/Hospice Certification, dated 2/16/2026, the admission Orders/Hospice Certification indicated Resident 96 was admitted to hospice care with a diagnosis of atherosclerotic heart disease. During a review of Resident 96's physician's orders, dated 2/17/2026, the physician's orders indicated to discontinue RNA for gentle PROM to both arms, three times per week as tolerated, due to Resident 96's hospice care. During a review of another physician's order, dated 2/18/2026, the physician's order indicated to discontinue Resident 96's RNA for PROM to both legs, three times per week as tolerated. During a review of Resident 96's JME, dated 2/24/2026, the JME indicated Resident 96 had a change in condition. The JME indicated Resident 96's interventions included nursing under hospice care. The JME indicated Resident 96 had minimum ROM limitations in both shoulders and severe ROM limitations in the left fingers. During an interview on 2/24/2026 at 8:31 a.m. with the DOR, the DOR stated the purpose of RNA (in general) was to maintain a resident's mobility to prevent any decline. The DOR stated the purpose of ROM exercises included to maintain a resident's mobility and prevent the development of contractures (stiffening/shortening at any joint that reduces the joint's range of motion). During an observation on 2/24/2026 at 12:14 p.m. in the dining room, Resident 96 was observed sitting upright in a Geri chair (chair that allows someone to get out of bed and sit comfortably in different positions while fully supported) for lunch. Resident 96 had a cup of ice cream placed on Resident 96's chest. Resident 96 used the left wrist to steady the cup against Resident 96's chest. Resident 96's left-hand fingers were bent at all joints into a nearly closed fist. Resident 96 scooped and ate the ice cream using the right arm. During an observation on 2/24/2026 at 12:17 p.m., Restorative Nursing Aide 4 (RNA 4) sat in front of Resident 96 to hold the cup while Resident 96 continued to use the right arm to eat the entire cup of ice cream. RNA 4 uncovered Resident 96 lunch plate which contained a scoop of white rice and shredded beef with vegetables. Resident 96 was observed using the right hand to eat the beef and rice with a fork. Resident 96 did not move the left arm during lunch. During an interview on 2/25/2026 at 8:45 a.m. with RNA 1, RNA 1 stated Resident 96 had RNA for ROM exercises to both arms and legs. RNA 1 stated Resident 96's RNA program was discontinued for the past week (2/17/26 and 2/18/26) since Resident 96 was admitted to hospice care [on 2/16/26]. During an observation on 2/25/2026 at 9:00 a.m. in the resident's room, Resident 96 was observed sleeping in bed. During an interview on 2/25/2026 at 9:53 a.m. with RNA 1, RNA 1 stated Resident 96 did not complain of any pain when Resident 96 was receiving RNA for ROM exercises prior to its discontinuation. During an observation on 2/26/2026 at 8:00 a.m. in the resident's room, Resident 96 was observed sleeping while turned to the right side. Resident 96 did not wake up with verbal cues. During an interview on 2/26/2026 at 8:46 a.m. with RNA 1, RNA 1 stated that prior to the discontinuation of RNA exercises, Resident 96 did not refuse ROM exercises but preferred RNA in the afternoon. RNA 1 stated Resident 96 was happy and had conversations during the ROM exercises. RNA 1 stated Resident 96 had more ROM limitations in the left arm and both legs. RNA 1 stated there was an order to discontinue RNA for Resident 96 last week (2/17/26 and 2/18/26). During a telephone interview on 2/26/2026 at 11:11 a.m. with Resident 96's Responsible Party (RP 1), RP 1 stated Resident 96 had stroke (loss of blood flow to part of the brain) a long time ago (unspecified period of time) affecting the left side of the body. RP 1 stated the facility did not ask and RP 1 did not request to stop Resident 96's RNA services for ROM exercises. During a concurrent interview and record review on 2/26/2026 at 12:11 p.m. with Physical Therapist 2 (PT 2) and Occupational Therapist 2 (OT 2). Resident 96's physician orders to discontinue RNA, dated 2/17/2026 and 2/18/2026, and JME, dated 2/24/2026, were reviewed. PT 2 stated RNA services (in general) allowed the residents to maintain their progress achieved during therapy intervention and prevented the development of contractures. PT 2 stated joint contractures affected a resident's mobility and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	function, including activities of daily living ([ADLs] basic tasks that individuals perform to maintain their daily lives and independence). PT 2 stated Resident 96's JME, dated 2/24/2026, indicated Resident 96 had minimal ROM limitations in both shoulders and severe ROM limitations on the left fingers. OT 2 stated the DOR notified the therapists of Resident 96's transition to hospice services and to discontinue RNA services. PT 2 and OT 2 stated they did not contact the family regarding the discontinuation of RNA services. During an interview on 2/26/2026 at 1:30 p.m. with the Director of Nursing (DON), the DON stated the facility's nursing staff should continue to provide services to a resident on hospice care with the added services of the hospice staff. The DON stated the provision of RNA services, including ROM exercises, application of splints, and ambulation (the act of walking), was under nursing services to prevent contractures, stiffness, and maintain a resident's mobility. The DON stated Resident 96 had ROM limitations and could experience a decline in ROM and increased stiffness without RNA services. The DON did not know the reason Resident 96 was discharged from RNA services. During a telephone interview on 2/26/2026 at 1:35 p.m. with the Hospice Medical Director (Hospice MD), the Hospice MD stated residents on hospice care (in general) should not have any limitation in receiving ROM and movement within the resident's tolerance. During a concurrent interview and P&P review on 2/26/2026 at 1:50 p.m. with the DON, Resident 96's physician orders to discontinue RNA services, dated 2/17/2026 and 2/18/2026, and the facility's P&P titled, ROM and Contracture Prevention, revised 5/2019, were reviewed. The DON stated Resident 96 has not received RNA for ROM to both arms (since 2/17/2026) for nine days and ROM to both legs for eight days (since 2/18/2026). Resident 96 could experience increased stiffness and contractures to both arms and legs without RNA services. The DON reviewed the facility's P&P titled, ROM and Contracture Prevention, and stated every resident, including residents on hospice services, should receive services to prevent ROM decline. During a review of the facility's P&P titled, ROM and Contracture Prevention, revised 5/2019, the P&P indicated the facility ensured residents received services, care, and equipment to assure that: Every resident maintains, and/or improves to his/her highest level of range of motion (ROM) and mobility, unless a reduction is clinical unavoidable; and Every resident with limited range of motion and mobility maintains or improves function unless reduced Range of Motion (ROM)/mobility is unavoidable based on the resident's clinical condition. During a review of the facility's policy and procedure (P&P) titled, ROM and Contracture Prevention, revised 5/2019, the P&P indicated the facility ensured that residents receive services and care to assure that Every resident maintains, and/or improves to his/her highest level of range of motion (ROM) and mobility, unless a reduction is clinically unavoidable. During a review of Resident 8's Face Sheet (summary of a resident's information), the Face Sheet indicated the facility admitted Resident 8 on 10/10/2025 and readmitted on [DATE]. Resident 8's Face Sheet indicated Resident 8's diagnoses included dysphagia (difficulty swallowing) following cerebral infarction (brain damage due to a loss of oxygen to the area), lack of coordination, and metabolic encephalopathy (disease that affects the brain, causing changes in its function).

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F 0692 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review, the facility did not ensure that two of three sample residents' (Resident 70 and Resident 204) fluid intake was not monitored to restrict fluid intake at 1000 milliliters (mL, unit of weight) per 24 hours while on hemodialysis (dialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) as ordered by the physician and in accordance with the facility's policy and procedures titled Licensed Nurse Procedures: Fluid Restrictions, 1.Resident 70's total fluid intake was within the fluid restrictions parameters on 2/3/2026, 2/4/2026, 2/17/2026, 2/18/2026, and 2/24/206. 2.Resident 204's total fluid intake was accurately documented and fluid restrictions parameters on 2/13/2026 to 2/25/2026. These failures had the potential to place Resident 70 and Resident 204 at risk for altered hydration status which may lead to severe dehydration or fluid overload which may result in a hypotensive (low blood pressure) or hypertensive (high blood pressure) blood pressure emergency, edema (swelling), shortness of breath, heart failure (heart cannot effectively pump blood to the rest of the body) and may ultimately lead to hospitalization. Findings: 1.During a review of Resident 70's admission Record, the facility admitted Resident 70 on 11/8/2024, and the facility readmitted Resident 70 on 12/12/2025 with diagnoses that included Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with Diabetic Chronic Kidney Disease (disease where high blood sugar and blood pressure damage the kidney's blood vessels over time causing the kidneys to stop working properly), End Stage Renal Disease (ESRD, irreversible kidney failure), and dependence on renal dialysis. During a review of Resident 70's History and Physical (HP), dated 9/12/2025, the HP indicated that Resident 70 can make her needs known but cannot make medical decisions. During a review of Resident 70's care plan, dated 1/29/2026, the care plan indicated that Resident 70 was at risk for renal insufficiency related to ESRD. The care plan's interventions included to monitor for signs and symptoms of fluid overload such as swelling, difficulty breathing, and weight gain over 2 pounds (lbs, unit of weight) over a day, and to monitor Resident 70 fluid intakes and output every shift with a fluid restriction of 1000 mL per 24 hours. During a review of Resident 70's care plan, dated 1/29/2026, the care plan indicated Resident 70 was dependent on renal dialysis related to ESRD. The care plan's interventions included monitoring vital signs and weight, and to monitor Resident 70 fluid intake and output every shift with a fluid restriction of 1000 mL per 24 hours. During a review of Resident's 70 Minimal Data Set (MDS, a resident assessment), dated 2/6/2026, the MDS indicated that Resident 70's cognitive (a resident's thought process) skills were moderately impaired and received a therapeutic diet (a physician prescribed diet). The MDS indicated that Resident 70 received dialysis. During a review of Resident 70's Order Summary Report, the order, dated 1/29/2026, the order indicated to monitor Resident 70 for intake and output each shift for a fluid restriction of 1000mL per 24 hours. The order indicated the following: Nursing: Day shift - 300mL, PM shift - 120mL, NOC shift - 100mL; Dietary: Breakfast -240mL, Lunch - 120mL, and Dinner 120mL. 2. During a review of Resident 204's admission Record, the facility admitted Resident 204 on 2/12/2025, and the facility readmitted Resident 204 on 2/10/2026 with diagnoses that include DM with Diabetic Chronic Kidney Disease, ESRD, and dependence on renal dialysis. During a review of Resident 204's MDS, dated [DATE], the MDS indicated that Resident 204's cognitive skills were moderately impaired. The MDS indicated that Resident 204 was on a therapeutic diet and received dialysis. During a review of Resident 204's care plan, initiated 2/10/2026, the care plan indicated Resident 204 was at risk for complications related to ESRD and hemodialysis. The care plan's interventions included monitoring and reporting any signs and symptoms of renal insufficiency such as changes in level of consciousness and changes in heart and lunch sounds, and monitoring Resident 204's intake and output with a fluid restriction of 1000mL per 24 hours. During a review of Resident 204's Order Summary Report, order, dated 2/10/2026, indicated (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to monitor Resident 204's intake and output every shift. During a review of Resident 204's care plan, initiated on 2/11/2026, the care plan indicated Resident 204 had the potential for nutritional problems related to her ESRD on dialysis three times a week, and DM. The care plan's interventions included providing therapeutic carbohydrate consistent renal diet (CCHO diet), monitoring intake at every meal, and monitoring Resident 204's intake and output with a fluid restriction of 1000mL per 24 hours. During a review of Resident 204's HP, dated 2/13/2026, the HP indicated that Resident 204 did not have the capacity to understand and make decisions. During a review of Resident 204's Order Summary Report, the order, dated 2/24/2026, indicated to monitor Resident 204 Intake and Output each shift for a fluid restriction of 1000mL per 24 hours. The order indicated the following: Nursing: Day shift - 300mL, PM shift - 120mL, NOC shift - 100mL; Dietary: Breakfast - 120mL, Lunch - 120mL, Dinner - 240mL. During a concurrent observation and interview on 2/26/2026 at 8:43 AM in Resident 70's room, Resident 70 was observed sitting in her wheelchair with three partially consumed 8ˆoz water bottles on her overbed table (an adjustable table with lockable wheels designed to roll over a bed or chair and provide a flat and stable surface). Resident 70 stated, she could not remember when she received the water bottles and was unsure how much water she drank today and stated that she just takes sips of water. During an interview on 2/26/2026 at 12:45 PM with Registered Nurse (RN) 1, RN 1 explained that it is important to monitor a dialysis resident's fluid intake to prevent fluid overload, which can cause increased blood pressure, abnormal lung sounds, and swelling. RN 1 stated the resident's fluid restriction is divided into two parts: nursing (fluids given with medications or between meals, monitored by licensed nurses) and dietary (fluids provided on meal trays, with Certified Nurse Assistants (CNAs) responsible for documenting intake during meals). During an interview and record review on 2/26/2026 at 1 PM, RN 1 reviewed Resident 70's MAR and Point of Care fluidˆintake records for February 2026. RN 1 stated that on 2/3/2026, 2/4/2026, 2/17/2026, 2/18/2026, and 2/24/2026, documentation showed Resident 70's fluid consumption exceeded more than the 1000 mL perˆday fluid restriction. RN 1 explained that CNAs typically report how much the resident drinks during meals, and licensed nurses are responsible for ensuring the resident's total daily fluid intake stays within the ordered limit. During a concurrent interview and record review on 2/26/2026 at 2:35 PM with the Assistant Director of Nursing (ADON), Resident 204's MAR from 2/13/2026 to 2/25/2026, the MAR did not document the resident's shiftˆbyˆshift fluid intake. The ADON explained that without numerical values, licensed nurses cannot determine the resident's actual fluid intake, and therefore Resident 204 may have exceeded her 1000 mL perˆday fluid restriction. During a review of the facility's policies and procedures (P&P) titled Licensed Nurse Procedures: Fluid Restrictions, revised May 2007, the P&P indicated it was important to ensure fluid needs are met while not exceeding limits established by the physician. The P&P indicated that nursing will note fluid restrictions and will complete Intake and Output.

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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 observation, interview, and record review, the facility failed to assess the pain level for one of two sampled residents (Resident 203), who verbalized pain during medication pass. This has the potential to result in Resident 203's unmet needs affecting the residents' quality of life. Findings: During a review of Resident 203's admission Record (AC), the AC indicated the resident was admitted to the facility on [DATE] with diagnoses that included During a review of Resident 203's History and Physical (H&P) dated 2/12/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 203's Order Summary Report dated 2/26/2026, the Order Summary Report indicated a medication order for: 1.Acetaminophen/Tylenol (a medication used to treat pain) oral tablet 325 milligrams (mg a unit of measurement), give 2 tablet by mouth every 6 hours as needed for mild pain (1-3) with an order start date of 2/17/2026. 2.Tramadol HCL (a medication used to treat pain) oral tablet 50 mg (Tramadol HCL) give 1 tablet by mouth every 6 hours as needed for moderate pain (4-6) During a medication pass observation on 2/25/2026 at 8:48 AM with Licensed Vocational Nurse (LVN 2), Resident 203 asked LVN 2 for pain medication as his stomach hurt when he eats. LVN 2 reviewed the resident's medications, took out Tylenol and Tramadol, and asked the resident which one he preferred. Resident 203 chose Tramadol, stating he hadn't taken it in a while. LVN 2 then administered one tablet of Tramadol 50 mg. During a follow up interview with LVN 2 on 2/25/2025 at 8:55 AM, LVN 2 stated she forgot to assess Resident 203s pain. LVN 2 stated it is facility and nursing practice to ask a resident to rate their pain level from 1-101=lowest amount, 10=most painful) and ask questions as onset of pain, what makes it worst. LVN 2 stated, she forgot to conduct the pain assessment before administering the Tramadol HCL 50mg to Resident 203. LVN 2 stated it was important to ask the numeric pain level so that she could choose the appropriate pain medication for Resident 203's pain as he had a few different options based on his pain level. During an interview on 2/26/2025 at 1:39 PM, the Director of Nursing (DON) stated that when a resident verbalizes pain, nurses are required to perform a pain assessment first. This includes identifying the location of the pain, obtaining a numeric pain rating, and using that information to select the appropriate medication. The DON explained that failing to assess pain properly can lead to incorrect dosing or overmedicating a resident by not following the physicianˆordered parameters. During a review of the facility's policy and procedure (P&P) titled Pain Recognition and Management, with a revision date of 4/2025, the P&P indicated Pain will be identified and documented in the electronic health record (HER) using a scale 1-10 is most common

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow physician's orders for one of one sampled resident (Resident 4) who was receiving Hydrocodone (medication used to treat severe, chronic pain) as needed for moderate and severe pain. This deficient practice increased the risk of Resident 4 to experience adverse effects (unwanted and dangerous side effect of medications) that could lead to health complications, such as severe respiratory depression [breathing problems], coma, addiction, and severe low blood pressure. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included toxic encephalopathy (brain dysfunction caused by exposure to toxins like solvents, heavy metals, industrial chemicals, drugs, or poisons), specified disorders of urinary system (include urinary tract infections, kidney stones, bladder control) , and extended spectrum beta lactamase (enzymes produced by bacteria that breakdown and cause resistance to common antibiotics that make infections hard to treat). During a review of Resident 4's History and Physical (H&P), dated 1/30/2026, the H&P indicated the resident had the capacity to make medical and financial decisions. During a review of Resident 4's Order Summary Report indicated the following orders: Dated 1/30/2026, indicated a physician order was made for HYDROcodone-Acetaminophen Oral Tablet 5-325 milligrams (mg, unit of measure) (Hydrocodone-Acetaminophen) Controlled Drug,ˆ Give 1 tablet by mouth every 4 hours as needed for moderate pain (4-7). Dated 2/2/2026, indicated a physician order was made for HYDROcodone-Acetaminophen Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen) Controlled Drug * Give 2 tablet by mouth every 4 hours as needed for Pain Management, Give 2 by mouth every 4 hours as needed for severe pain (8-10) per Physician's Assistant (PA). During a review of Resident 4's Medication Administration Record (MAR) for February 2026 indicated that Resident 4 was administered Hydrocodoneˆ Acetaminophen Oral Tablet 5ˆ325 mg, a controlled medication, with physician orders to administer one tablet every 4 hours as needed for moderate pain (4-7) and two tablets every 4 hours as needed for severe pain (8-10), as ordered by the Physician Assistant (PA). The MAR reflected the following administrations in which two tablets were given despite the resident reporting a pain level below 8-10, which was inconsistent with the physician's order: On 2/2/2026 at 4:30 PM, pain level 7 On 2/2/2026 at 8:57 PM, pain level 7 On 2/3/2026 at 8:14 PM, pain level 0 On 2/5/2026 at 6:21 PM, pain level 4 On 2/5/2026 at 10:32 PM, pain level 7 On 2/6/2026 at 7:15 PM, pain level 4 On 2/7/2026 at 11:58 PM, pain level 7 On 2/8/2026 at 4:18 AM, pain level 6 On 2/8/2026 at 8:45 AM, pain level 7 On 2/10/2026 at 8:36 PM, pain level 7 On 2/11/2026 at 6:35 PM, pain level 4 On 2/13/2026 at 1:10 AM, pain level 7 On 2/13/2026 at 2:35 PM, pain level 6 During a concurrent interview and record review of Resident 4's MAR on 2/26/2026 at 1:39 PM, the Director of Nursing (DON) stated the nurses should have followed the physician's orders because it indicates the parameters for the pain medication. The DON stated if the physician orders are not followed the resident could get sedated, drowsy, and overmedicated. During a concurrent interview and record review of Resident 4's MAR on 2/26/2026 at 2:04 PM, the Assistant DON (ADON) confirmed he gave Resident 4 two tablets of Hydrocodone for a pain level of 6 because the resident mentioned she wanted Hydrocodone and knew she was due for pain medication. The ADON stated if the physician order is not followed the resident could experience dizziness or sleepiness. A review of the facility's policy and procedure (P&P) titled Six Rights of Medication Administration, dated 5/2018 indicated the six rights of medication administration are as follow in order to ensure safety and accuracy of administration: Right Resident - Resident is identified prior to medication administration Right Time - Medications are administered within prescribed time frames. Right Medication order- Medications are checked against the order before they are given. Right Dose-Medications are administered according to the dose prescribed Right Route - Medications are administered according to the route prescribed Right Documentation - Document administration or refusal of the medication after the administration (continued on next page)

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Whittier Hills Health Care Ctr	10426 Bogardus Ave Whittier, CA 90603

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or attempt and note any concerns A review of the facility's P&P titled Pain Recognition and Management, dated 4/2025 indicated pain management was provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the residents' goals and preferences.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate hospice (interdisciplinary care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual in the last phases of life due to a terminal disease) services to one of one residents (Resident 96) on hospice care by failing to: 1. Designate a member of the interdisciplinary team fully aware of the role as the hospice coordinator. 2. Ensure Resident 96 received a hospice physician assessment upon admission to hospice on 2/16/2026. 3. Ensure a physician signed the physician's orders, dated 2/16/2026, for Resident 96's admission to hospice. 4. Ensure Resident 96 received chaplain and Certified Home Health Aide ([CHHA] certified nursing assistants who are trained specifically for hospice care) services as indicated in Resident 96's admission Orders/Hospice Certification, dated 2/16/2026. 5. Ensure Resident 96 had a 60-day hospice certification (hospice medical director or physician member of the hospice interdisciplinary group who certifies the patient's terminal condition). These failures prevented Resident 96 from receiving well-coordinated hospice services to meet the resident's need with end of life. Findings: During a review of Resident 96's Face Sheet (summary of a resident's information), the Face Sheet indicated the facility originally admitted Resident 96 on 2/2/2023 and readmitted on [DATE]. The Face Sheet indicated Resident 96's diagnoses included atherosclerotic (thickening and hardening of the blood vessels) heart disease, acquired absence of the left toes, muscles weakness, and dysphagia (difficulty swallowing). During a review of Resident 96's Minimum Data Set ([MDS] a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 96 had clear speech, had difficulty communicating some words or finishing thoughts but able if prompted or given time, and usually understood most of the conversation. The MDS indicated Resident 96 had severely impaired cognition (ability to think, understand, learn, and remember) that required substantial/maximal assistance (helper does more than half the effort) for eating and dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for oral hygiene, toileting, dressing, transferring from lying to sitting on the side of the bed, and char/bed-to-chair transfers. During a review of Resident 96's admission Orders/Hospice Certification, dated 2/16/2026, the admission Orders/Hospice Certification indicated Resident 96 was admitted to hospice care with a diagnosis of atherosclerotic heart disease. Resident 96's admission Orders/Hospice Certification was not signed by a physician for authorization of admission orders. The admission Orders/Hospice Certification indicated the hospice staff frequency during the initial weekly included a nurse, social worker, chaplain, and CHHA. During a review of Resident 96's handwritten physician's orders, dated 2/16/2026, the physician's Orders indicated to admit Resident 96 to hospice care. The handwritten physician's orders for Resident 96's admission to hospice care were signed by the Hospice Registered Nurse (Hospice RN) without a physician's signature. During a review of Resident 96's hospice binder (three-ringed binder containing documents related to the resident's hospice care), the hospice binder did not include a Physician's Certification for Hospice Benefit. Resident 96's hospice binder included a Flow Sheet with visits signed by the Hospice RN, dated 2/16/2026, and signed by the Social Worker, dated 2/17/2026. Resident 96's Hospice Flow Sheet also indicated unidentified hospice staff completed Resident 96's skin assessment, dated 2/17/2026, and observed Resident 96 eating dinner while sitting upright, dated 2/24/2026. During an observation on 2/24/2026 at 12:14 p.m. in the dining room, Resident 96 was observed sitting upright in a Geri chair (chair that allows someone to get out of bed and sit comfortably in different positions while fully supported) for lunch. Resident 96 had a cup of ice cream placed on Resident 96's chest. Resident 96 used the left wrist to steady the cup against Resident 96's chest. Resident 96's left-hand fingers were bent at all joints into a nearly closed fist. Resident 96 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scooped and ate the ice cream using the right arm. During an observation on 2/25/2026 at 9:00 a.m. in the resident's room, Resident 96 was observed sleeping in bed. During an interview on 2/25/206 at 9:37 a.m. with the Social Services Director (SSD), the SSD stated the Director of Nursing (DON) was the coordinator between the hospice and the facility. During an interview on 2/25/2026 at 9:41 a.m. with the Registered Nurse Supervisor (RNS), the RNS stated the SSD was the facility's hospice coordinator. During an interview on 2/25/2026 at 9:43 a.m. with the DON, the DON stated the SSD was the facility's hospice coordinator. During an interview on 2/25/2026 at 2:09 p.m. with the SSD, the SSD stated she was verbally informed regarding the designation as the hospice coordinator upon hire. The SSD stated the hospice coordinator responsibilities included providing the hospice agency information to the residents and the family, speaking to the residents and family about hospice care, and contacting the hospice to perform a hospice evaluation. The SSD stated the DON arranged Resident 96's hospice services. During a concurrent interview and record review on 2/25/2026 at 2:20 p.m. with the DON and the SSD, Resident 96's hospice admission Orders/Hospice Certification, dated 2/16/2026, and the handwritten physician's orders, dated 2/16/2026, were reviewed. The DON stated the SSD was the hospice coordinator who arranged the interdisciplinary (IDT) meetings with the facility, the hospice, and family. The DON stated the SSD's role as the hospice coordinator (in general) included receiving the hospice paperwork within three days of a resident's admission to hospice and arranging hospice services for the chaplain, social worker, and other hospice staff as needed for the resident. The DON and SSD reviewed Resident 96's admission Orders/Hospice Certification and stated a physician did not sign the certification. The DON stated it was important for a physician to certify Resident 96's provision of hospice care. The DON stated the admission Order/Hospice Certification indicated Resident 96 was supposed to receive a weekly visit from the nurse, chaplain, social worker, and CHHA. The DON reviewed Resident 96's Hospice Flow Sheet and stated the nurse and social worker visited Resident 96. The DON stated the Flow Sheet did not indicate the CHHA provided care to Resident 96. The DON reviewed Resident 96's handwritten physician's orders, dated 2/16/2026, and stated Resident 96's physician's orders for hospice care were not signed by a physician. The DON stated Resident 96's hospice records did not include a physician assessment. The DON stated the SSD was responsible for ensuring Resident 96 received the necessary hospice services and assessments. During an interview on 2/25/2026 at 2:48 p.m. with the SSD, the SSD stated she was not informed of the hospice coordinator's duties until today (2/25/2026). During a concurrent interview and record review on 2/25/2026 at 3:05 p.m. with the SSD, the SSD provided Resident 96's 60-day Physician Certification for Hospice Benefit for 2/16/2026 to 4/16/2026. The SSD stated the facility received Resident 96's 60-day Physician Certification for Hospice benefit today (2/25/2026) which should have already been placed in Resident 96's hospice binder. During a telephone interview on 2/26/2026 at 11:11 a.m. with Resident 96's Responsible Party (RP 1), RP 1 stated the hospice was supposed to assess Resident 96 but stated nobody has provided any additional information about Resident 96's hospice services. The RP stated there was a meeting scheduled for today (2/26/2026) at 1:00 p.m. with the facility and the hospice regarding Resident 96's services. During a review of the facility's policy and procedure (P&P) titled, End of Life Care; Hospice and/or Palliative Care, revised 4/2025, the P&P indicated the resident and family members will be an active part of the care planning team, and they will be kept informed about who is responsible for care, what they can expect, and who they can look to for information and assistance. The P&P also indicated Hospice services will be offered as appropriate and as ordered by the physician. During a review of the Hospice Services Agreement, effective 9/1/2025, between the facility and Resident 96's hospice, the Hospice Services Agreement indicated the facility shall designate a member of the Facility's interdisciplinary team who is responsible for working with the Hospice to coordinate care provided by the Facility staff and Hospice staff to any resident under Hospice's care. Such interdisciplinary team member shall be responsible for the following: (i) collaborating with Hospice and coordinating Facility Hospice's care; (ii) communicating (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Hospice and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions to ensure quality of care for the Resident and the family; (iii) ensuring that Facility communicates with the Hospice medical director, the Resident's attending physician, and other practitioners participating in the provision of care to the Resident as needed to coordinate the hospice care with medical care provided by other physicians; (iv) obtaining the following information from Hospice: (A) the most recent hospice plan of care specific to each Resident; (B) hospice election form; (C) physician certification and recertification of the terminal illness specific to each Resident.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure therapy equipment was maintained in safe operating condition for one of two adjustable height therapy mats. An adjustable therapy mat in the Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) room was observed with a slanted, uneven surface due to a malfunctioning heightˆadjustment mechanism. This failure had the potential to create a safety hazard for residents using the mat for therapy interventions. Findings: During a concurrent observation and interview on 2/24/2026 at 9:01 a.m. in the OT room with the Director of Rehabilitation (DOR), a therapy mat was observed in a slanted position. The DOR stated the therapy staff did not report any problems with the therapy mat. The DOR was observed lowering and increasing the height of the therapy mat. The side of the therapy mat, which was closer to the wall, did not lift as the DOR increased the height of the therapy mat, creating a slanted position. The DOR stated the residents would be imbalanced if sitting on the therapy mat. During a review of the facility's policy and procedure (P&P) titled, Equipment Maintenance, revised 5/2016, the P&P indicated the facility ensured equipment remains in good working order for residents and staff safety.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light system (a communication tool that allows residents to immediately signal for assistance) was maintained in proper functioning for two of four sample residents (Resident 8 and Resident 96) in accordance to the facility's policy and procedure titled Physical Environment: Equipment Maintenance. Resident 8 call light (a button that allows the resident to communicate their need of assistance from the nursing staff) did not light up when pressed. In addition the nurse call dome light indicator (a visual signaling device above the resident's room in the hallways to immediately alert nursing staff for assistance) above the room and centralized call light panel (an audio and visual central display in the nursing station that lights up to indicate which resident needs assistance) located at the nursing station was not functioning properly. This deficient practice had the potential for unmet resident's needs especially in an event of emergency when needed assistance that may cause negative outcomes such as accidents/injury and/or anxiety (fear of the unknown), Findings: 1. During a review of Resident 8's admission Record (AR), the facility admitted Resident 8 on 10/10/2025, and the facility readmitted Resident 8 on 1/17/2026 with diagnoses that included metabolic encephalopathy (reversible brain dysfunction caused by chemical imbalance), dementia (a progressive state of decline in mental abilities,) and lack of coordination and memory deficit (memory loss) following a cerebral infarction (CVA [cerebrovascular accident], stroke, loss of blood flow to a part of the brain).). During a review of Resident 8's care plan, revised 1/10/2026, the care plan indicated Resident 8 was at risk for fall and injury related to left frontal cavernoma (irregularly formed and leaky blood vessels located at the front of the brain), Cerebral Vascular Accident (CVA, nterruption of blood flow in the brain) with left-sided weakness and impaired mobility. The care plan's interventions included ensuring the call light was within reach and encouraging Resident 8 to use it to call for assistance as needed, keeping need items with reach, and ensuring a safe environment by having clutter-free floors and a working and reachable call light. During a review of Resident 8's Minimal Data Set (MDS, a resident's assessment), dated 1/19/2026, the MDS indicated Resident's 8 cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 8 was dependent (helper does all the effort) on the facility's staff for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) such as performing toileting hygiene and bathing. The MDS indicated Resident 8 was dependent on facility's staff for repositioning in bed and transferring from a lying to sitting position or from chair/bed to chair. The MDS indicated Resident 8 was frequently incontinent (loss of control) of bowel. During a review of Resident 8's history and physical (HP), dated 1/20/2026, the HP indicated Resident 8 did not have the capacity to understand and make decisions. 2. During a review of Resident 96's admission Record, the facility admitted Resident 96 on 2/2/2023 and readmitted Resident 96 on 6/16/2025 with diagnoses that included chronic kidney disease (progressive damage and loss of function in the kidneys), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle wasting and atrophy (muscle loss). During a review of Resident 96's HP, dated 6/16/2025, the HP indicated that Resident 96 can make her needs known but cannot make medical decisions. During a review of Resident 96's care plan, initiated on 6/16/2025, the care plan indicated Resident 96 was at risk for fall/injury related to limited mobility, bowel and bladder incontinence, and history of falls. The care plan's interventions included ensuring the call light was within reach, encouraging the use of the call light for assistance, and ensuring a safe environment by having clutter-free floors and a working and reachable call light. During a review of Resident 96's MDS, dated [DATE], the MDS indicated Resident 96's cognitive skills were severely impaired. The MDS indicated that Resident 96 was dependent on the facility's staff to perform ADLs and for repositioning in bed and transferring from chair/bed to chair. During a concurrent observation and interview on 2/23/2026 at 10:35 AM in (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 8 room, Resident 8 was observed lying in bed with the call light clipped to her pillow and by the left side of her head. Resident 8 was observed reaching over the midline of her body with her right hand to her left shoulder and had difficulty reaching for the call light by the left side of her head. Resident 8 stated, she pressed the button for the nurses but did not know where the button was. Resident 8's in-room call light indicator located on the wall at the end of the bed lite up. During the same observation on 2/23/2026 at 10:39 AM outside Resident 8's room, the nurse call dome light above Resident 8 and Resident 96's room was not turned on. During the same observation and interview on 2/23/2026 at 10:41 AM in the nurse's station with Registered Nurse (RN) 1, the call light panel was observed. RN 1 stated, currently, at 10:41 AM, there was no call light indicated on the call light panel to show that a call light was pressed within the last five minutes. During an observation and interview on 2/23/2026 at 10:44 AM, Certified Nurse Assistant (CNA) 5 tested the bedside call lights for Residents 8 and 96. CNA 5 stated that although the inˆroom call light indicators was turned on, the hallway nurseˆcall dome light above the door did not light up. CNA 5 stated that because the hallway indicator did not light up, he was unaware that Resident 8 had activated her call light. CNS 5 also stated he did not know how long the call lights for Residents 8 and 96 had not been working. During an interview and record review on 2/26/2026 at 8:53 AM, the Maintenance Supervisor (MS) reviewed the facility's Nursing Call System Testing records dated 1/7, 1/12, 1/19, 1/27, 2/10, and 2/16 of 2026. He stated that on those dates, the bedside call lights, inˆroom indicators, hallway indicators, and station panels were all tested and functioning properly. The MS also stated he was not aware that the call lights for Residents 8 and 96 were malfunctioning until CNA 5 reported the issue on 2/23/2026. During the same concurrent interview and record review on 2/26/2026 at 9 AM with the MS, the facility's Preventative Maintenance Task Sheet, dated 1/5/2026 and 2/6/2026 were reviewed. The MS stated that the call light indicators inside and outside the room and at the nurse's stations were properly functioning on these dates. During a review of the facility policies and procedures (P&P) titled Routine Procedures: Call Light/Bell, May 2017, the P&P indicated if the call light/bell is defective, immediately report this information to the supervisor. During a review of the facility's P&P titled Physical Environment: Equipment Maintenance, dated May 2022, the P&P indicated that the facility was to establish procedures for routine and non-routine care of equipment and to ensure that it remains in good working order for resident and staff safety. During a review of the facility's P&P titled Physical Environment: Equipment Maintenance, dated May 2022, the P&P indicated the Maintenance Supervisor or Designee will carry out routine maintenance on specified program equipment.