STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055441	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Creek Healthcare & Wellness Centre	115 Bridge St. San Gabriel, CA 91775

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote dignity and respect for two (2) of two residents (Resident 54 and 104) reviewed for dignity, in accordance with the facility's policy when: 1. Facility staff did not address Resident 54 by the resident's preferred name and used the term [NAME] on 5/18/2026.2. Facility staff did not address Resident 58 by the resident's preferred name and used the term Mama on 5/19/2026. These deficient practices had the potential to affect Residents 54 and 58 senses of self-worth and self-esteem which could result in problems with emotional and mental well-being. Findings:1. During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), heart failure (a lifelong condition in which the heart muscle cannot pump enough blood to meet the body needs for blood and oxygen) and atrial fibrillation (Afib, is an irregular and often very rapid heartbeat) During a review of Resident 54's Minimum Data Set (MDS, a resident assessment tool) dated 3/26/2026, the MDS indicated Resident 54 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 54 was independent (resident completes the activity by themself with no assistance from a helper) eating and oral hygiene. The MDS also indicated Resident 54 needed partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, and lying to sitting on the side of the bed. During an observation on 5/18/2026 at 7:44 AM in Resident 54's room, Resident 54 finished eating his breakfast and called Certified Nurse Assistant 1 (CNA 1). CNA 1 came inside Resident 54's room and stated, Hello [NAME], are you finish eating breakfast? Resident 54 nodded to say yes to CNA 1. CNA 1 took away Resident 54's breakfast tray then went outside the room. During an observation on 5/18/2026 at 7:46 AM in Resident 54's room, CNA 1 went inside Resident 54's room, CNA 1 told Resident 54 Are you okay, [NAME]? CNA 1 stated she will change Resident 54's brief and the resident agreed. During an interview on 5/19/2026 at 4:09 PM with CNA 1, CNA 1 stated she remembered she addressed Resident 54 [NAME] when she was getting Resident 54 breakfast tray yesterday (5/18/2026). CNA 1 stated the staff should not be using labels like [NAME] or Mama when addressing residents to ensure that they treat the residents with respect and dignity. CNA 1 stated the facility staff should be using Resident 54's first or last name. 2. During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 58's diagnoses included COPD, gastroesophageal reflux disease (GERD, happens when stomach acid flows back up into the esophagus and causes heartburn [a painful, burning feeling in the middle of your chest]), and systemic inflammatory response syndrome (SIRS, is a severe, life-threatening medical emergency caused by the body's overwhelming response to a stressor) During a review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58's cognitive (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skills for daily decision making were severely impaired. The MDS indicated Resident 58 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, chair/ bed-to-chair transfer, and tub shower transfer. The MDS indicated Resident 58 also needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in oral hygiene, upper body dressing, personal hygiene, roll left and right, sit to lying, and lying to sitting on the side of the bed. During a concurrent observation on 5/19/2026 at 3:15 PM with Licensed Vocational Nurse 1 (LVN 1) and CNA 2 inside Resident 58's room, Resident 58 was being assessed by LVN 1 while CNA 2 was assisting Resident 58 to reposition. LVN 1 and CNA 2 were turning Resident 58 on the right side. CNA 2 stated Mama, we will turn you on the other side. After turning Resident 58, CNA 2 stated You are okay now Mama. During an interview on 5/19/2026 at 3:16 PM with CNA 2, CNA 2 stated it is not okay to use Mama to address Resident 58. CNA 2 also stated the staff must address the residents' with their first or last name, or the resident's preferred name. During an interview on 5/19/2026 at 3:17 PM with LVN 1, LVN 1 stated the staff were not supposed to use Mama or [NAME] on addressing the residents because they are not their parents. LVN 1 also stated the staff must address the residents by the resident's first and last name. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights revised 1/1/2012, the P&P indicated the facility will promote and protect those rights. The P&P also indicated residents have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations and applicable state and federal laws governing the protection of resident health and safety. The P&P indicated employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility did not ensure a homelike environment was established for 34 of 47 rooms (Rooms A, B, C, D, E, F, G, H, I, J, K, L, M, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG and HH) by failing to ensure the rooms were free from peeled wallpaper, missing paint on the walls and/or had functional drawers. These deficient practices can negatively affect the comfort and psychosocial wellbeing of the residents residing in the 34 rooms.Findings:During an interview on 5/20/2026 at 2:46 PM with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated a homelike environment should be provided for residents and if paint or wallpaper is missing from the walls in the residents' rooms, it should be fixed. CNA 4 further added, the wallpaper and paint should be complete so that residents are comfortable, feel safe and the resident will feel better having a pretty rooms. During an interview on 5/20/2026 at 3:08 PM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated a homelike environment allows for residents not to feel like patients but that they are regular people in their homes, and staff are to provide care and an environment for the residents that feels like home. LVN 3 stated that when paint is missing from the walls and white patches are left, it is not a homelike environment because residents see it and no one would want their own homes to look like that. During a concurrent observation of all the resident's room (47 rooms) and interview on 5/20/2026 from 3:18 PM through 3:57 PM with Maintenance Supervisor (MS). Rooms A, B, C, D, E, F, G, H, I, J, K, L, M, O, P, Q, R, S, T, U, V, W, X, Y, Z, AA, BB, CC, DD, EE, FF, GG and HH (34 rooms)were observed with peeled wallpaper, missing paint on the walls, white patches on the walls and/or broken drawers. MS stated the 37 residents' rooms were not homelike for the residents because of the missing paints, peeled wallpaper and broken drawers but it should be. MS further stated the walls and drawers should be fixed to create a good and homelike environment so that it looks good for the residents, and the residents will feel that staff care about their rooms. During an interview on 5/20/2026 at 4:30 PM with Administrator, Administrator stated the facility should provide a homelike, comfortable environment for residents that looks nice. Administrator stated resident rooms with missing paint, peeled wallpaper or broken drawers is not homelike, but all rooms should be homelike. During a review of the facility's policy & procedure (P&P) titled, Resident Rooms and Environment, revised 1/1/2012, the P&P indicated the facility will provide residents with a safe, clean, comfortable and homelike environment and staff will provide residents with a pleasant environment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate assessment of the Minimum Data Set (MDS, a resident assessment tool) for one of five sampled residents (Resident 11) reviewed for unnecessary medication reflect the resident's use of antipsychotic (AP, drug that works by altering brain chemistry to help reduce psychotic symptoms like hallucinations [an experience which a person sees, hears, feels, or smells something that does not exist], delusions [fixed false beliefs], and disordered thinking) medication on the Antipsychotic Medication Review (a structured, interprofessional evaluation of a resident's antipsychotic drug therapy to assess effectiveness, monitor side effects, and determine the need for continued use, dose reduction, or withdrawal) and its gradual dose reduction (GDR, a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) as indicated on the facility's policy. This deficient practice had the potential for the facility not to develop and implement an individualized care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives, interventions and timeframes to meet a resident's medical, nursing, and mental psychosocial needs) to monitor antipsychotic medication use and delivery of necessary care and services. Findings: During a review of Resident 11's admission Record, the admission record indicated Resident 11 was admitted to the facility on [DATE], with the diagnoses including but not limited to dementia (progressive brain disorder that slowly destroys memory and thinking skills), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and bipolar disorder (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]). During a record review of Resident 11's Order Summary Report, dated 2/26/2026, the Order Summary Report indicated a physician's order for Risperdal (antipsychotic medication used to treat schizophrenia) oral tablet 0.5 milligrams (mg, unit of measurement) 0.5 mg via gastrostomy tube (GT - a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) two times a day for unspecified schizophrenia manifested by visual hallucination of seeing people who are not there. During a review record review of Resident 11's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of February, March, and April 2026, the MAR indicated Resident 11 received Risperdal 0.5 mg twice daily. During a record review of a facility form titled, Psychotropic and Sedative/Hypnotic (class of drugs that work on the central nervous system to produce a calming or drowsy effect) Utilization By Resident, dated 4/21/2026, the record indicated Resident 11's last GDR was on 1/28/2026 for the use of Risperidone. During a record review of Resident 11's MDS, dated [DATE], the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 11 did not receive antipsychotics (which prompted to skip over if and when the last GDR was attempted and if the physician documented GDR as clinically contraindicated). During a concurrent record review of Resident 11's MDS dated [DATE] and interview on 5/21/2026 at 11:20 AM with the MDS Coordinator Nurse 1 (MDSN 1), MDSN 1 stated Resident 11 was taking an antipsychotic medication which was not reflected on the Antipsychotic Medication Review. MDSN 1 stated the MDS was not accurate, and the answer should have been documented as Yes antipsychotics were received on a routine basis only. MDSN 1 stated it was important to accurately assess the Antipsychotic Medication Review to ensure a gradual dose reduction is attempted as indicated. MDSN 1 stated the facility needed to monitor the resident's behavior to evaluate the need for AP medication and GDR. MDSN 1 added that the physician would need to taper or gradually discontinue the AP medication. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment Instrument (RAI) Process, revised 10/4/2016, the P&P indicated to provide (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident assessments that accurately depict the identify resident-specific issues and objective as required, while meeting state and federal guidelines and data submission requirements.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Preadmission Screening and Resident Review (PASARR - a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) Level 1 Screening (initial screening completed prior to admission to a nursing facility to identify individuals who have mental disorder [mental illness] or intellectual disability [ID, an individual with a level of retardation]) accurately for one (1) of two (2) sampled residents (Resident 43), reviewed for PASARR. This resulted in the inaccurate conclusion that Resident 43 did not require a Level 2 PASARR Evaluation (comprehensive evaluation conducted by the appropriate state-designated authority that determines whether an individual has MD, ID or a related condition, determines the appropriate setting for the individual, and recommends what, if any, specialized services and/or rehabilitative services the individual needs) completed, with the potential for Resident 43 not to receive the specialized mental health services the resident may need for overall wellbeing.Findings:During a review of Resident 43's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), anxiety (mental disorder involves persistent and excessive worry that can interfere with daily activities) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 3/21/2023, the MDS indicated Resident 43 with a diagnosis of anxiety. During a review of Resident 43's Diagnoses Report, (undated), the Diagnoses Report indicated Resident 43 with the diagnosis of anxiety, with an onset date of 3/14/2023 and unresolved. During a review of Resident 43's MDS, dated 3/18/2026, the MDS indicated Resident 43 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 43 required substantial/maximal assistance (helper does more than half the effort) with shower/bathing self, partial/moderate assistance (helper does less than half the effort) with oral, toileting and personal hygiene and setup or clean-up assistance (helper sets up or cleans up) with eating. The MDS also indicated Resident 2 had anxiety. During a review of Resident 2's PASARR Level 1 Screening, dated 3/15/2023, the PASARR Level 1 Screening indicated the Level 1 Screening was completed by facility staff who documented Resident 2 was not diagnosed with a serious mental illness (SMI) nor that Resident 2 was prescribed any psychotropic medications (medications that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). The PASARR Level 1 Screening also indicated with the submitted information, Resident 2 was negative for SMI and a Level 2 PASARR Evaluation was not required. During a concurrent interview and record review on 5/20/2026 at 9:41 AM with the Assistant Director of Nursing (ADON), Resident 43's PASARR Level 1 Screening, dated 3/15/2023, was reviewed. The PASARR Level 1 Screening indicated the Level 1 Screening was completed by the ADON who documented Resident 43 did not have any serious mental disorders [such as anxiety disorder]. The PASARR Level 1 Screening also indicated a negative Level 1 screening, and the case was closed with the reason being no serious mental illness. The ADON stated Resident 43 had an anxiety diagnosis at the time she completed the PASARR Level 1 screening and should have completed the PASARR to reflect that Resident 43 had a serious mental disorder. The ADON also stated it was important to ensure a PASARR Level 1 screening to determine if a Level 2 evaluation is needed for the residents. During an interview on 3/11/2026 at 10:51 AM with the MDS Nurse 2 (MDSN 2), the MDSN stated Resident 43 had a diagnosis of anxiety on admission to facility on 3/14/2023 and when Resident 2's PASARR Level 1 Screening was completed on 3/15/2023 so it was inaccurate. The MDSN also stated it was important that Resident 43's PASARR Level 1 Screening was completed accurately because a Level 2 screening would have been initiated, and she would have been evaluated for appropriate specialized services for her mental health disorders but was not. During a review of the facility Policy (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Procedure (P&P) titled, Pre-admission Screening Resident Review (PASRR), revised 4/25/2026, the P&P indicated all residents are to be screened for mental illness and ID or a related condition (RC). During a review of the facility's P&P titled, admission Screening Resident Review (PASRR), revised 4/24/2024, the P&P indicated the facility MDS Coordinator will be responsible for accessing and ensuring updates to the PASRR are completed per MDS guidelines. During a review of the facility's P&P titled, Completion & Correction, dated 3/25/2026, the P&P indicated medical records are to be complete and accurate and facility will work to complete and correct medical records to provide the highest quality and accuracy in documentation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) to address one (1) of 21 resident's (Resident 43) anxiety (mental disorder involves persistent and excessive worry that can interfere with daily activities). This failure had the potential for Resident 43 to receive care that was not personalized to meet the resident's specific needs for anxiety, which could negatively affect her overall wellbeing.Findings:During a review of Resident 43's admission Record, the admission Record indicated Resident 2 was readmitted to the facility on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities), anxiety and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 43 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 43 was substantial/maximal assistance (helper does more than half the effort) with shower/bathing self, partial/moderate assistance (helper does less than half the effort) with oral, toileting and personal hygiene and setup or clean-up assistance (helper sets up or cleans up) with eating. The MDS also indicated Resident 2 had anxiety. During a concurrent interview and record review on 5/20/2026 at 10:41 AM with Assistant Director of Nursing (ADON) and the Minimum Data Set Nurse 2 (MDSN 2), Resident 43's electronic medical chart, dated 5/20/2025 through 5/20/2026 was reviewed. Resident 43's electronic medical chart failed to indicate a developed care plan for Resident 43's anxiety. ADON stated there was no active care plan for Resident 43's anxiety. MDSN 2 stated there should be a care plan to address Resident 43's anxiety diagnosis so that staff providing care to the resident would know what Resident 43's behaviors or manifestation of anxiety were and how to manage them and provide person-centered care. During an interview on 5/21/2026 at 2:20 PM with the Director of Nursing (DON), the DON stated Resident 43 should have a developed care plan for anxiety because it is still an active diagnosis for the resident and a care plan would help staff know what interventions are in place for the resident's anxiety and so staff can monitor the effectiveness of the interventions. During a review of the facility policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary (collaborative approach where professionals from various health and social care fields work together to treat a resident) care that reflects best practice standards for meeting health, safety, psychosocial (having to do with the mental, emotional, social, and spiritual effects), behavioral, and environmental needs of residents of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. The P&P also indicated the purpose was to ensure that a comprehensive person-centered care plan was developed for each resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Activities of Daily Living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) were provided for two (2) of 2 sampled residents (Residents 4 and 72) reviewed for ADL care area by failing to ensure:1. Resident 4's fingernails on both hands were kept clean.2. Resident 72 received oral care as needed to prevent the resident's lips from becoming chapped (a condition where the lips become dry, cracked, and peeling). These failures had the potential for Residents 4 and 72 to develop skin breakdown and infection, which would negatively affect Resident 4 and 72's wellbeing. Findings 1. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 4's diagnoses included diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities) During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 2/20/2026, the MDS indicated Resident 4 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in shower/ bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on the side of the bed, and tub/ shower transfer. During an observation on 5/18/2026 8:25 AM inside Resident 4's room, Resident 4 was awake and lying on her bed. Resident 4's fingernails on both hands were dirty and with brown discoloration around the nail edges. During an observation on 5/19/2026 at 9:19 AM inside Resident 4's room, Resident 4 was lying on her bed sleeping. Resident 4's fingernails on both hands were dirty and with brown discoloration around the nail edges. During a concurrent observation and interview on 5/20/2026 at 8:01 AM with Infection Preventionist Nurse (IPN) inside Resident 4's room, Resident 4 picked her nose with her right index finger. IPN stated Resident 4 fingernails were dirty, it has brownish to blackish discoloration. The staff should clean Resident 4's fingernails all the time when they provide care for the residents. The staff should keep Resident 4'w fingernails clean because of infection control. During an interview on 5/20/2026 at 10:52 AM with Director of the Staff Development (DSD), DSD stated Resident 4 fingernails had debris around and under the resident's fingernails. The staff should clean the residents' fingernails daily. It was part of their morning care. It was not acceptable to have dirt under Resident 4 fingernails because Resident 4 can get sick from the debris under her fingernails. During review of the facility's policy and procedure (P&P) titled, Grooming Care of the Fingernails and Toenails revised on 10/11/2021, the P&P indicated nail care is given to clean the nail bed and keep the nails trimmed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: 2. During a review of Resident 72's admission Record, the admission indicated Resident 72 was readmitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) to the left and right side and dysphagia (difficulty swallowing). During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72 had severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 72 required partial/moderate assistance (helper does less than half the effort) with eating, oral and personal hygiene and dependent with toileting hygiene and shower/bathing self. During a review of Resident 72's History & Physical (H&P), dated 4/29/2026, the H&P indicated Resident 72 does not have the capacity to understand and make decisions. During a review of Resident 72's care plan titled, Resident is at Risk for Oral/Dental Health Problems, revised 4/15/2026, the care plan indicated staff are to provide assistance with mouth care as per ADL personal functional status and to monitor/document/report as needed any signs and symptoms of oral/dental problems needing attention: lips cracked or bleeding. During a concurrent observation and interview on 5/21/2026 at 7:46 AM with Certified Nursing Assistant 3 (CNA 3), at Resident 72's bedside, Resident 72 was observed laying in bed with crusted skin on the bottom lip and inner upper lip and red/brown discolorations on the resident's inner upper and lower lips. CNA 3 stated Resident 72's lips looked dirty, dry and scabbing. CNA 3 stated Resident 72 needed total oral care assistance from staff and could not provide oral care to himself. During a concurrent observation and interview on 5/21/2026 at 7:51 AM with Licensed Vocational Nurse 1 (LVN 1), at Resident 72's bedside, Resident 72 was observed laying in bed with crusted skin on the bottom lip and inner upper lip and red/brown discolorations on the resident's inner upper and lower lips. LVN 1 stated Resident 72 had dryness to his upper and lower lips, with lip peeling and brown/red discolorations. LVN 1 stated Resident 72 should be receiving oral care whenever staff notice the resident's mouth and lips are dry and the resident should not have dry, scabbing, peeling or discolored lips. During an interview on 5/21/2026 at 8:10 AM with Registered Nurse 2 (RN 2), RN 2 stated it was important for staff to provide oral care to maintain moisture in Resident 72's mouth to prevent further mouth sores and bacteria that can cause infections and to prevent Resident 72 from feeling uncomfortable from the lip dryness. During an interview on 5/21/2026 at 2:25 PM with the Director of Nursing (DON), the DON stated dry lips occur when lips are not moist and chapping occurs when there is a cut and bleeding may occur. The DON stated it was important to make sure oral care was provided to Resident 72's lips to prevent dryness which could lead to sores and discomfort. During a review of the facility's policy & procedure (P&P) titled, Oral Care, revised 1/1/2012, the P&P indicated the purpose that all residents receive appropriate oral care daily. The P&P indicated it was the responsibility of each staff member within the nursing department to ensure good oral care for each resident.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) for two (2) of six (6) sampled residents (Residents 4, and 31) reviewed for unnecessary medications (any drug when used without adequate monitoring, and without adequate indication for use) and insulin use as indicated on the residents' care plan by failing to monitor: 1. Resident 4 for signs and symptoms (s/s) of hypoglycemia (an abnormally low level of sugar [glucose] in the blood) and hyperglycemia (a condition where the blood glucose [sugar] levels are abnormally high), while on Lantus Solostar (Insulin Glargine [Lantus, a type of long-acting insulin]) and Novolin R (Regular human Insulin, a short-acting insulin) from 4/30/2026 to 5/21/2026. 2. Resident 31 for s/s of hypoglycemia and hyperglycemia while on Lantus Solostar and Humulin R (is a short-acting human insulin) from 2/28/2026 to 5/21/2026. This deficient practice had the potential for Residents 4 and 31 to experience episodes of hypoglycemia, and hyperglycemia without proper monitoring while on insulin, which may result in harm, hospitalization, and diabetic coma (is a medical emergency caused by a blood sugar level that was too low or too high).Findings: 1. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 4's diagnoses included diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities) During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 2/20/2026, the MDS indicated Resident 4 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in shower/ bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on the side of the bed, and tub/ shower transfer. The MDS also indicated Resident 4 received 7 insulin injections during the last 7 days. During a record review on Resident 4's Care Plan (CP) for diabetes, revised 3/11/2026 the CP interventions indicated:Monitor/document/report as needed (PRN) any s/s of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul (breathing a deep, rapid, and labored breathing pattern), acetone breath (smells fruity), stupor (barely responsive and can only be roused by intense, repeated physical or verbal stimulation), coma.Monitor/document/report PRN any s/s of hypoglycemia: sweating, tremor (an involuntary, rhythmic shaking movement in one or more parts of your body), increased heart rate (tachycardia), pallor (paleness), nervousness, confusion, slurred speech (when words sound mumbled, jumbled, or blended together, making them difficult to understand), lack of coordination (poor muscle control that causes clumsy, jerky movements), staggering gait(an unsteady, uncoordinated walking pattern characterized by irregular steps, lateral swaying, and a tendency to stumble) During a concurrent interview and record review on 5/21/2026 at 9:30 AM with MDS Nurse 1 (MDSN 1), Resident 4's Physician Orders (PO) dated 5/7/2025 to 4/30/2026 were reviewed. The PO indicated:1. Lantus Solostar (Insulin Glargine) Subcutaneous (SQ, a shot that delivers medicine into the fatty tissue layer just under the skin, above the muscle, using a short, small needle for slow, steady absorption) Solution 100 units per milliliter (ML, measure of volume) inject 30 units SQ at bedtime for diabetes. Hold if Blood Sugar (BS) is less than (<) 100. 2. Novolin R Injection Solution 100 unit/ ML, inject SQ before meals and at bedtime for DM II. Notify Physician if BS <60 or greater than (>) 400.Inject per sliding scale (method of adjusting medication doses, most commonly insulin, based on the resident's blood glucose level [amount of sugar present in the blood at a given time]):If 60 to 199 = 0; may give orange juice, sugar water (a mixture of water and dissolved sugar) or (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oral glucose gel (an over-the-counter medication, consisting primarily of dextrose [concentrated sugar] and water) if BS <60.200 to 250 = 2 units;251 to 300 = 4 units;301 to 350 = 6 units;351 to 400 = 8 units;BS > 400 give 10 Units, SQ before meals and at bedtime for DM2.Notify Physician if BS <60 or >400. During a concurrent interview and record review on 5/21/2026 at 9:36 AM with MDSN 1, Resident 4's Nurses Progress Notes (NPN) dated 5/1/2026 to 5/21/2026 were reviewed. MDSN 1 stated the licensed staff did not have a documented evidence that Resident 4 was monitored for s/s of hypoglycemia or hyperglycemia in the NPN. During a concurrent interview and record review on 5/21/2026 at 9:44 AM with MDSN 1, Resident 4's Medication Administration Record (MAR), dated 5/1/2026 to 5/21/2026 and medical records were reviewed. MDSN 1 stated Resident 4's BS level was ranging from 200s to 300s, which considered the resident hyperglycemic. MDSN 1 stated since there was no documentation of the staff monitoring Resident 4 for s/s hypoglycemia and hyperglycemia, this means the monitoring was not done.During a concurrent interview and record review on 5/21/2026 at 9:51 AM with MDSN 1, Resident 4's Care Plan (CP) for diabetes revised 3/11/2026 was reviewed. The CP interventions indicated:Monitor/document/report PRN any s/s of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul, acetone breath, stupor, coma.Monitor/document/report PRN any s/s of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait.MDSN 1 stated Resident 4's CP was not implemented because the staff did not monitor Resident 4 for s/s of hyperglycemia and hypoglycemia. MDSN 1 stated it was important that Resident 4 was not monitored for hypoglycemia or hyperglycemia because Resident 4 can suffer from cardiac problems like stroke (occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts/ruptures), diabetic coma (is a medical emergency caused by a blood sugar level that was too low or too high), and diabetic ketoacidosis (DKA, is a life-threatening, emergency complication of diabetes caused by a severe lack of insulin). 2. During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 31's diagnoses included diabetes, chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should), urinary tract infection (UTI, is an infection in any part of the urinary system), transient ischemic attack (TIA, is a temporary blockage of blood flow to the brain), and cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) without residual deficits. During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 31 partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) on eating, oral hygiene, upper body dressing, and Personal hygiene. Resident 31 also needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) on toileting hygiene, and shower/ bathe self, lower body dressing, putting on/taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed, Sit to stand, and Chair/bed-to-chair transfer. The MDS also indicated Resident 31 received 7 insulin injections during the last 7 days. During a record review of Resident 31's CP for diabetes, dated 5/19/2026, the CP interventions indicated: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Dietary consultation for nutritional regimen and ongoing monitoring. Fasting Serum Blood Sugar (a test that measures the amount of sugar [glucose] in your blood after you have not eaten or consumed anything but water for at least eight hours) as ordered by doctor. If infection is present, consult doctor regarding any changes in diabetic medications. Offer substitutes for foods not eaten. During a concurrent interview and record review on 5/21/2026 at 9:56 AM with MDSN 1, Resident 31's PO dated 2/28/2026 was reviewed. The PO indicated:1. Lantus Solostar (Insulin Glargine) SQ Solution 100 unit/ML Inject 15 units SQ one time a day for DM, Hold if BS< 90. 2. Humulin R Injection Solution 100 unit/ ML, Inject SQ before meals and (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at bedtime for DM II .Notify Physician if BS <60 or >450. May give orange juice, sugar water, or glucose gel; if BS <60.Inject per sliding scale: If 60 to 199 = 0; 200 to 250 = 2 units;251 to 300 = 4 units;301 to 350 = 6 units;351 to 400 = 8 units ;401 to 450 = 10 units,BS >450 give 12 units, SQ before meals and at bedtime for DM II. Notify Physician if BS <60 or >450. During a concurrent interview and record review on 5/21/2026 at 9:57 AM with MDSN 1, Resident 31's CP for diabetes, dated 5/19/2026 was reviewed. The CP interventions indicated:Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.Dietary consultation for nutritional regimen and ongoing monitoring.Fasting Serum Blood Sugar as ordered by doctor. If infection is present, consult doctor regarding any changes in diabetic medications.Offer substitutes for foods not eaten.MDSN 1 stated Resident 1 should have added interventions to monitor Resident 31's diabetes or insulin use, including to monitor s/s of hyperglycemia or hypoglycemia. MDSN 1 stated Resident 1's CP was not person centered because the CP interventions were incomplete. During a concurrent interview and record review on 5/21/2026 at 10:05AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Medication Administration- General Guidelines dated 11/2021 was reviewed. The P&P indicated monitoring of side effects or medication-related problems occurs continually, but particularly after medication administration and especially after the first few doses of a new medication. The DON stated the licensed staff should always monitor the residents who received insulin for s/s of hypoglycemia and hyperglycemia and document in their nurses' progress notes every shift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for two (2) of three (3) sampled residents (Residents 4 and 10) reviewed for tube feeding (enteral nutrition, delivers liquid nutrition through a flexible tube that goes in through the nose or directly into the stomach or small intestine) in accordance with the facility's policy and procedure when: 1. Resident 4's tube feeding machine (enteral feeding pump which delivers liquid nutrition /formula directly into the stomach or small intestine via a feeding tube) had beige - colored stains and the resident's intravenous pole (IV pole, is a slender, portable medical stand used in healthcare settings to hold bags or bottles of fluids, medications, or nutrients) where the TF machine was attached had brown and beige - colored stains. 2. Licensed Vocational Nurse 2 (LVN 2) failed to change gloves in between tasks during medication administration via gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) to Resident 10 . These deficient practices have potential to contaminate clean items and can place the residents at risk for infection.Findings1. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 4's diagnoses included diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities) During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 2/20/2026, the MDS indicated Resident 4 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in shower/ bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on the side of the bed, and tub/ shower transfer. The MDS also indicated Resident 4 was on feeding tube for nutrition. During an observation on 5/18/2026 8:25 AM inside Resident 4's room, Resident 4 was awake and lying in bed. The tube feeding (TF) machine was turned off and there were beige colored stains all over the TF machine. During an observation on 5/19/2026 at 9:19 AM inside Resident 4's room, Resident 4 was lying in bed sleeping. Resident 4's TF machine was turned off and TF machine had beige colored stains. Resident 4's IV pole where resident's TF machine was attached was also observed with brown and beige colored stains. During a concurrent observation and interview on 5/20/2026 at 7:59 AM with Infection Preventionist Nurse (IPN) inside Resident 4's room. Resident 4 was lying in bed sleeping. Resident 4's TF machine had beige colored stains. IPN stated the IV pole had grime and beige colored splatter stains from the TF formula. IPN stated Resident 4's TF machine and IV pole were dirty and should have been cleaned before starting each TF administration for infection control. During review of the facility's Policy and Procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment revised on 1/1/2012, the P&P indicated Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC, is the national public health agency of the United States) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA, is a U.S. federal agency under the Department of Labor that ensures safe working conditions by setting and enforcing standards, providing training, and offering assistance to employers and workers) Blood-borne Pathogens Standard. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. 2. During a review of Resident 10's admission Record, the admission record indicated Resident 10 was admitted (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the facility on [DATE] and re-admitted on [DATE]. Resident 10's diagnoses included hemiplegia (paralysis of one side of the body) hemiparesis (weakness on one side of the body) cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting right side of the body, functional quadriplegia (is the condition in which both the arms and legs are paralyzed and lose normal motor function) and dementia During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 10 was dependent on toileting hygiene, and shower/ bathe self. Resident 10 also needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) on lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair transfer and tub/shower transfer. The MDS also indicated Resident 10 was on feeding tube for nutrition. During an observation on 5/20/2026 at 8:23 AM with LVN 2 inside Resident 10's room, LVN 2 changed her gloves, then touched Resident 10's linen cover and clothing (shirt) and removed the towel covering Resident 10's Gˆtube. LVN 2 then connected the flush syringe, aspirated Resident 10's gastric residual volume (GRV, refers to the amount of fluid remaining in the stomach after a meal or during tube feeding), flushed the Gˆtube, and began administering medications through Resident 10's Gˆtube. During an interview on 5/20/2026 at 8:32 AM with LVN 2, LVN 2 stated she should have changed her gloves after touching Resident 10's clothing and towel to maintain proper infection control before checking Resident 10's G- tube residual and administering Resident 10's medications. During a review of the facility's Policy and Procedure (P&P) titled, General Guidelines for Medication Administration, dated 11/2021, the P&P indicated the person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, and before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations and medications given via enteral tubes. Examination gloves are worn when necessary. During a review of the facility's P&P titled Medication-Administration revised 6/6/2025, the P&P indicated all medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner.

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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 a functional call light (used in healthcare facilities as an alerting device for nurses or other nursing personnel to assist a resident when in need) for one (1) of four (4) sampled residents (Resident 58) reviewed for environment as indicated in the facility's policy and procedure. This deficient practice had the potential not to meet Resident 58's needs, which could negatively affect the resident's overall wellbeing. Findings:During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 58's diagnoses included chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), gastroesophageal reflux disease (GERD, condition when stomach acid flows back up into the esophagus and causes heartburn [a painful, burning feeling in the middle of the chest]), and Systemic Inflammatory Response Syndrome (SIRS, is a severe, life-threatening medical emergency caused by the body's overwhelming response to a stressor). During a review of Resident 58's Minimum Data Set (MDS, a resident assessment tool), dated 3/26/2026, the MDS indicated Resident 58 was severely impaired with cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 58 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, chair/ bed-to-chair transfer, and tub shower transfer. The MDS indicated Resident 58 also needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in oral hygiene, upper body dressing, personal hygiene, roll left and right, sit to lying, and lying to sitting on the side of the bed. During an observation on 5/18/2026 at 8:48 AM inside Resident 58's room, Resident 58 was lying in bed awake, moaning, scratching the right side of her chest, and rocking back and forth to scratch her back. The surveyor pressed Resident 58's call light to request assistance from facility staff; however, the light on the wall indicating that Resident 58's call light had been activated was off. During an observation on 5/18/2026 at 8:52 AM outside Resident 58's room, while Resident 58's call light was activated, the light above the resident's door, which indicates a call light was activated inside Resident 58's room, remained off. During an observation on 5/19/2026 at 9:01 AM inside Resident 58's room, Resident 58 was lying in bed sleeping. The surveyor pressed Resident 58's call light to check if it was functioning. The wall indicator light, which should illuminate when the call light is triggered, did not turn on. During an observation on 5/19/2026 at 9:04 AM outside Resident 58's room, the surveyor pressed Resident 58's call light. The light above the door, which indicates a call light was activated inside Resident 58's room, remained off. During an observation on 5/19/2026 at 3:08 PM with the Director of Nursing (DON) inside Resident 58's room, the DON pressed Resident 58's call light. The wall indicator light did not illuminate to show the call light had been activated. The DON then unplugged the call light cord from the wall and plugged it back in, after which the wall indicator light turned on. During an observation and interview on 5/19/2026 at 3:09 PM with the DON inside Resident 58's room, the DON again pressed Resident 58's call light, and the wall indicator light did not turn on. The DON stepped out of the room and checked the bulb above the door, which lights up when the call light is activated from inside the room, and it was also off. The DON stated Resident 58's call light was broken and needed to be replaced. During an interview on 5/19/2026 at 3:10 PM with the DON, the DON stated if Resident 58's call light was not functioning properly, Resident 58 would not be able to call for help if she needed assistance. During an interview on 5/19/2026 at 3:28 PM with the Maintenance Director (MTD), the MTD stated they check the residents' call lights monthly and also check designated areas of the facility each week, which results in call lights being checked daily. The purpose of the call light system is for residents to call staff when they need help. If a call light is not working, the resident (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cannot request assistance. During a concurrent interview and record review on 5/19/2026 at 3:53 PM with the MTD, the Call Light Check Sheet dated 4/2026 was reviewed. The MTD stated that N/A means the call light was not checked during that week. The record indicated Resident 58's call light was last checked on 4/3/2026. The MTD stated that on Thursday, 5/14/2026, Resident 58's room was painted, and all items were removed and then returned afterward, but the call light was not rechecked to ensure it was functioning properly. During a review of the facility's Policy and Procedure (P&P) titled, Communication - Call System revised 8/24/2024, the P&P indicated if the call alert system is defective, it will be reported to maintenance for immediate repair. During a review of the facility's P&P titled, Communication -Call System revised 8/29/2024, the P&P indicated the facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities. To ensure that residents have a means of contacting Facility staff for assistance.