STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055480	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Californian Pasadena Healthcare	120 Bellefontaine Street Pasadena, CA 91105

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe, clean, comfortable sanitary and home-like environment for two (2) of three (3) sampled residents (Residents 37 and 41) reviewed for environment, by failing to ensure:The television (TV) of Resident 37 was functioning.The curtain in Resident 41's room above the sliding door was fully connected with the end of the curtain hanging down from the curtain rail. These failures have the potential to negatively affect Resident 37's well-being and quality of life and in addition had the potential to cause an unsafe environment for Resident 41 and staff to be placed at risk for injury.Findings: 1. During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was originally admitted to the facility on [DATE]. The admission record also indicated Resident 37's diagnoses included multiple fractures of pelvis (breaks in multiple bones between the lower abdomen and upper thighs), abnormalities of gait (manner of walking) and mobility (the ability to move or be moved freely and easily), and lack of coordination. During a review of Resident 37's Minimum Data Set (MDS – a resident assessment tool), dated 1/18/2026, the MDS indicated Resident 37 had modified independence (some difficulty in new situations only) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 37 was assessed to need setup or clean-up assistance (helper sets up or cleans up) with eating. The MDS indicated Resident 37 was assessed to need supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance) with oral and personal hygiene. The MDS indicated Resident 37 was assessed to need partial/moderate assistance (helper does less than half the effort) with upper body dressing. The MDS indicated Resident 37 was assessed to need substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunks or limbs and provides more than half the effort) with toileting, showering, lower body dressing, and putting on/taking off footwear. During a review of Resident 37's Social Services admission assessment dated [DATE], it indicated Resident 37 was able to verbally communicate needs. It also indicated Resident 37 functioned independently in all parts of life. During a concurrent observation and interview on 2/17/2026 at 2:19 PM in Resident 37's room, the TV was off. Resident 37 stated the TV in her room was not working (unable to recall since when). Resident 37 also stated she likes watching TV that Resident 37 told facility staff about the TV not working. During an interview on 2/19/2026 at 2:16 PM with Maintenance Supervisor (MS), MS stated it was never reported to him that Resident 37's TV was not functioning. MS stated, he was not made aware (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident 37's TV was not functioning until surveyor told him so. MS stated Resident 37 did not have a TV remote control to begin with. MS stated the facility's practice when resident's TV is not working/functioning is to verbally report to him if he is around and/ or record it on the maintenance logbook. MS stated Resident 37's TV issue was not recorded in the maintenance logbook and should have been recorded in the maintenance log. MS stated that any staff can log in the maintenance log. During an interview on 2/20/2026 at 3:14 PM with Director of Nursing (DON), the DON stated residents' TV should be functioning all the time and that all residents should be provided with TV remote control to use in turning on the TV. The DON stated residents' TV should be working so residents could use it at any time and enjoy the shows the residents want to watch. 2. During a review of Resident 41's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of hereditary (the passing of biological traits from the parents to their offspring through genetics or DNA) and idiopathic (spontaneous) neuropathy (damage to the nerves outside the brain and spinal cord, often causing pain, numbness, tingling, or weakness) and abnormalities of gait (unusual walking patterns) and mobility (impaired movement, coordination and balance). During a review of Resident 41'S MDS, dated [DATE], the MDS indicated the resident was moderately impaired (decisions poor; cues/supervision required) with cognitive skills for daily decision making. Resident 41 needed substantial/maximal assistance with going from sitting to standing, putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). Resident 41 needed partial/moderate assistance with chair/bed-to-chair transfers (the ability to transfer to and from a bed to a chair [or wheelchair]), upper body dressing (the ability to dress and undress above the waist). Resident 41 also needed setup or clean-up assistance with rolling left and right in bed and eating. During a concurrent observation and interview on 2/17/2026 at 9:13 AM with Resident 41 in the resident's room, the curtain above the sliding door next to Resident 41's bed was observed to be open and not securely attached to the curtain rail with the top right side of the curtain falling. Resident 41 stated she had complained about it to staff that the curtain is not fully blocking out the light at night, and it needs to be fixed. During an observation on 2/18/2026 at 8:51 AM inside Resident 41's room, the curtain above the sliding door next to Resident 41's bed was observed to be open and not be securely attached to the curtain rail with the top right side of the curtain falling. During an observation on 2/18/2026 at 2:40 PM inside Resident 41's room, the curtain above the sliding door to next to Resident 41's bed was observed to be open and not be securely attached to the curtain rail with the top right side of the curtain falling down.During an observation on 2/19/2026 at 7:20 AM inside Resident 41's room, the curtain above the sliding door next to Resident 41's bed was observed to be fully closed with the top right end of the curtain not securely attached to the curtain rail and falling down.During and observation on 2/19/2026 at 9:55 AM inside Resident 41's room, the curtain above the sliding door to next to Resident 41's bed was observed to be open and not be securely attached to the curtain rail with the top right side of the curtain falling down.During a concurrent observation and interview on 2/19/2026 at 11:12 AM with Resident 41 in her room, the curtain above the sliding door to next to Resident 41's bed was observed to be open and not be securely attached to the curtain rail with the right side of the curtain falling down. Resident 41 stated she has asked the staff to fix it and it still had not been done. During a concurrent observation and interview on 2/19/2026 at 1:22 PM with MS, the curtain above the sliding door to next to Resident 41's bed was observed to be open and not be securely attached to the curtain rail with the top right side of the curtain falling down. MS stated the curtain is falling and it should not be like that since it can pose a safety issue and potentially fall on the resident. During an interview on 2/20/2026 at 10:50 PM with Assistant Director of Nursing (ADON), ADON stated Resident 41's curtain should not have (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been falling off the curtain rail because it could potentially be a hazard and is not homelike. During an interview on 2/20/2026 at 3:16 PM with the DON, the DON stated Resident 41's curtain should have been fully secured to the curtain rail because it could have posed as a safety hazard.During a review of the facility's policy and procedure (P&P) titled, Safe and Homelike Environment, revised 3/20/2025, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The P&P also indicated the facility staff, and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. During a review of the facility's P&P titled, Television/TV revised April 2025, the P&P indicated: Ensure televisions are accessible and positioned for optimal viewing comfort. Maintenance Department will be responsible for any issues related to the use of television.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure competencies and skills sets to provide nursing and related services were completed for five (5) of 5 sampled employees in accordance with facility assessment and facility's policy and procedures (P&P). This deficient practice had the potential to cause an increased risk for improper resident assessments, and inadequate documentation which could negatively impact the quality of care to the residents.Cross referenced with 755Findings:During a concurrent review and interview on 2/19/2026 at 10:43 AM with Director of Staff Development (DSD), Certified Nurse Assistant 3's (CNA 3) employee records were reviewed. DSD stated CNA 3 was hired on 9/18/2017. DSD stated CNA 3 did not have documented evidence of completed skills competency evaluation upon hire and annually. DSD stated the facility has a form titled, Certified Nursing Assistant Skills Competency Log, which is used in evaluating the competency of the CNAs' skills upon hire, and yearly thereafter. DSD stated the skills competency log includes but is not limited to evaluating CNAs for activities of daily living, vital signs, feeding techniques, and resident's rights. During a concurrent record review and interview on 2/19/2026 at 10:44 AM with DSD, CNA 4's employee records were reviewed. DSD stated CNA 4 was hired on 9/8/2025. DSD stated CNA 4 did not have documented evidence of completed skills competency evaluation upon hire. During a concurrent record review and interview on 2/19/2026 at 10:45 AM with DSD, CNA 5's employee records were reviewed. DSD stated CNA 5 was hired on 8/21/2023. DSD stated CNA 5 did not have documented evidence of completed skills competency evaluation upon hire and annually. DSD stated it is important to evaluate CNA's skills competency before releasing them from orientation to know if the employee needs more training and to ensure resident's safety. During a concurrent record review and interview on 2/19/2026 at 10:51 AM with DSD, Licensed Vocational Nurse 3's (LVN 3) employee records were reviewed. DSD stated LVN 3 was hired on 12/23/2024. DSD stated LVN 3 did not have documented evidence of completed skills competency evaluation upon hire and annually. DSD stated the facility has a form titled, Licensed Nurse Core Clinical Competencies, which is used in evaluating the competency of the Licensed Nurses' skills upon hire, and yearly thereafter. DSD stated the skills competency log includes but is not limited to evaluating licensed nurses for blood sugar monitoring (the process of measuring the amount of sugar in the blood), medication administration, documentation of change of condition and care planning. DSD stated all employees should have completed and should be deemed competent for the skills required of them, upon hire and annually to ensure that the licensed nurses are capable of providing the necessary care for the residents. During a concurrent record review and interview on 2/19/2026 at 10:52 AM with DSD, Registered Nurse Supervisor 1's (RNS 1) employee records were reviewed. DSD stated RNS 1 was hired on 12/10/2025. DSD stated RNS 1 did not have documented evidence of completed skills competency evaluation upon hire. DSD stated the Director of Nursing (DON) was in charge of conducting the skills competency evaluation for registered nurses upon hire and annually. The DSD stated she files the completed competency skills evaluation in the RN's employee file once received from the DON.During a review of the Facility Assessment, updated 1/19/2026, the Facility Assessment indicated DSD and/or designee are following strictly the guidelines and facility's protocol in providing training and education to the newly hired facility staff, and current facility staff, monitoring the training progress and ongoing validation of the training. It also indicated skills competencies are done yearly and as needed.During a review of facility's P&P titled, Competency of Nursing Staff, revised May 2019, the P&P indicated facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.

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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 practices in accordance with the facility's policy and procedure (P&P) by failing to ensure: Three (3) individually prepared ice cream bowls were labeled with use by date.An open gallon container of ice cream, opened on 2/18/2026 has a use by date of 6 months after open date.Kitchen freezer 1 (KF1) was clean, without crumbs and ice-build up. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing food borne illness (food poisoning- with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) which could lead to other serious medical complications and hospitalization.Findings:1.During the initial tour on 2/17/2026 at 8:08 AM, in the facility's kitchen, 3 individually prepared ice creams were observed with a label date of 2/16/2026. During an interview on 2/19/2026 at 1:59 PM with the Facility Chef (FC), the FC stated 3 individually prepared ice creams dated 2/16/2026 were missing a useˆby date label. The FC stated 2/16/26 date on the 3 individually prepared ice creams was the preparation date. The FC stated serving food without a useˆby date is not safe for residents, may cause confusion among kitchen staff, and could result in untimely disposal if foods are not properly labeled with a useˆby date. 2. During an observation in the kitchen on 2/19/2026 at 6:24 AM, Kitchen Freezer 2 (KF2) was observed with one gallon of ice cream, with open date of 2/18/2026, and use by date of 10/15/2026 (approximately eight months from open date). During an interview on 2/19/2026 at 7:25 AM with FC, FC stated the one gallon of ice cream was opened yesterday, 2/18/2026, and kitchen staff (unknown) labeled the ice cream incorrectly. use by date according to manufacturer's use by date of 10/15/2026. During a concurrent observation, policy review and interview on 2/19/2026 at 8 AM with Dietary Service Supervisor (DSS), DSS stated the facility's P&P titled. Freezer Storage Guidelines, dated 2023, indicated that the ice cream can be kept in the freezer for 6 months. The DSS stated that the 1 gallon of ice cream's use by date should have been labeled 8/18/2026, and not 10/15/2026. 3. During an observation in the kitchen on 2/19/2026 at 6:25, KF 1 was observed dirty with crumbs and ice built up that dripped down to the bottom of KF1. During a concurrent observation and interview on 2/19/2026 at 2 PM with the FC, FC verified that the KF1 was not clean. FC stated the bottom level of KF1 was dirty with crumbs and was also observed with a pool of frozen liquid that dripped from the top part of the freezer. FC stated there was ice built up on the top portion of KF1. FC stated a dirty freezer was not acceptable because it can cause food contamination (introducing harmful or unwanted substances) which was harmful to the residents that could possibly cause sickness such as diarrhea. During an interview on 2/20/2026 at 2:13 PM with DSS, the DSS stated she did not know why there was pool of frozen liquid on the bottom of KF1. DSS stated the water must have dripped from the top part of KF1 where there were some ice-built ups. The DSS stated this was unsanitary because it can contaminate the food that was stored in KF1 which could cause residents to get sick. During a review of facility's P&P titled, Refrigerators and Freezers, revised November 2022, the P&P indicated the facility will ensure safe refrigerator and freezer maintenance, temperatures and sanitation, and will observe food expiration guidelines. During a review of facility's P&P titled Food Receiving and Storage, revised November 2024, the P&P indicated all foods stored in the refrigerator or freezer are covered, labeled and dated use by date).

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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, interview and record review, the facility failed to follow its infection control policies and procedures by failing to ensure:Staff donned (putting on) full personal protective equipment (PPE; clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments such as a gown, gloves and mask) prior to entering Resident 16's room and staff performed proper hand hygiene by washing their hands with soap and water after leaving Resident 16's room who was under contact isolation (a transmission based precautions to stop germs from spreading through direct touch with a patient or indirect touch with contaminated objects in their environment) for Clostridium Difficile (C. diff; a highly contagious bacterial infection that causes an infection of the colon [the longest part of the long intestine]) infection. A documented evidence for daily water temperature control monitoring for the facility's water management program.Resident 48's breathing treatment mask and tubing (deliver aerosolized medication directly to the lungs. It includes vinyl mask, medication cup and plastic tube) and respiratory set up bag were changed every seven (7) days per facility's policy. These failures had the potential to result in spread of infection to other residents in the facility.Findings: During a review of Resident 16's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of hemiplegia (severe or complete paralysis affecting one vertical side of the body, often including the arm, leg and face) and hemiparesis (partial weakness or reduced motor function affecting one entire side of the body) following cerebral infarction (stroke - the death of brain tissue as a result of ischemia [when blood flow and oxygen is reduced in a part of the body]) affecting the right dominant side and enterocolitis (the inflammation of both the small intestine and the colon [large intestine] often causing severe abdominal pain, diarrhea, fever and vomiting) due to C.diff. During a review of Resident 16'S Minimum Data Set (MDS – a resident assessment tool), dated 1/29/2026, the MDS indicated the resident had severe impairment (never/rarely made decisions) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 16 needed substantial/maximal assistance (helper does more than half the effort) with putting on/taking off footwear, lower body dressing (the ability to dress and undress below the waist) and toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having bowel movements). The MDS also indicated Resident 16 needed partial/moderate assistance (helper does less than half the effort) with going from sitting to standing, upper body dressing (the ability to dress and undress above the waist) and personal hygiene. It indicated, Resident 16 also needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with rolling left and right in bed and going from lying down to sitting on the side of the bed and needed setup or clean-up assistance (helper sets up or cleans up; resident complete activity) with eating. During a review of Resident 16's Order Summary Report dated 2/17/2026 to 2/19/2026, Resident 16's Order Summary Report indicated an order initiated on 2/16/2026 to observe contact isolation secondary to resident being C.diff positive and all activities of daily living (ADLs; activities such as bathing, dressing and toileting a person performs daily), activities, skilled rehabilitation services, and dining services will be provided in the resident's room.During a review of Resident 16's Care Plan, dated 2/17/2026, Resident 16's Care Plan indicated Resident 16 required contact isolation precautions related to C.diff and indicated interventions including to observe contact isolation secondary to Resident 16 being C.diff positive with all ADLs, activities, skilled rehabilitation services and dining services being provided inside the resident's room and to perform hand washing before patient care, if hands are soiled and after patient care.During an observation on 2/17/2026 at 9:08 AM in the hallway outside of Resident 16's room, a contact precautions sign was observed outside the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	door indicating to stop, see the nurse before entering the room and to clean hands, wear a gown and gloves on room entry and to clean hands when exiting.During an observation on 2/17/2026 at 10:53 AM inside Resident 16's room, Housekeeping (HK) was observed entering Resident 16's room without donning PPE and removed the glove box on the wall to the right of Resident 16's bed and changed it with a new box of gloves. HK was then observed exiting Resident 16's room without washing her hands.During an interview on 2/17/2026 at 11:03 AM with Infection Preventionist (IP), IP stated she observed HK enter Resident 16's room earlier who is on contact isolation precautions for C.diff without donning PPE or washing her hands after she exited the room.During an interview on 2/18/2026 at 2:51 PM with IP, IP stated on 2/17/2026 IP on 2/17/2026 at around 10:53 AM, IP had observed HK walk into Resident 16's room who was on contact isolation for C.diff without donning PPE, then changed the glove box in the resident's room, and HK exited the room without washing her hands. IP stated HK should have stopped and checked to see what isolation Resident 16 had prior to entering the room, washed her (HK) hands, donned PPE and gloves and then stepped into the room. IP also stated, HK should have washed her hands prior to exiting the room. IP further stated it is important to follow the facility's proper infection control protocol prior to entering a room on contact isolation for C.diff helps prevent cross contamination and prevents the spread of infection.During an observation on 2/19/2026 at 6:20 AM in the hallway outside of Resident 16's room, Medical Records (MR) was observed doffing PPE and using the alcohol based hand sanitizer upon exiting Resident 16's room. MR was not observed to wash her hands with soap and water. During an interview on 2/19/2026 at 5:23 AM with MR and the Director of Nursing (DON), MR stated she did not wash her hands with soap and water upon exiting Resident 16's room and only used the alcohol- based hand sanitizer. The DON stated, MR should have washed her hands with soap and water upon exiting Resident 16's room since the resident is on contact isolation precautions for C.diff.During a concurrent observation and interview on 2/19/2026 at 6:25 AM with the DON, in the hallway outside of Resident 16's room, Certified Nursing Assistant 2 (CNA 2) was observed entering Resident 16's room without donning PPE and touched the gloves inside the room to the right of Resident 16's bed. The DON stated CNA 2 should have donned full PPE prior to entering Resident 26's room and touching anything from the resident's environment or room.During an interview on 2/20/2026 at 2:52 PM with the DON and Assistant Director of Nursing (ADON), both the DON and ADON stated it is the expectation of all staff to wear proper PPE prior to entering Resident 16's room because the resident is on contact isolation for C.diff and the proper PPE includes wearing a mask, gown and gloves and upon exiting need to doff (remove) their PPE and do hand washing with soap and water and not just the alcohol based hand sanitizer. Both the DON and ADON further stated if this protocol is not followed there is a risk for the infection to spread to others in the facility. During a review of the facility's policy and procedure (P&P) titled, Standard Precautions (the minimum, baseline infection control practices used by healthcare workers for all patients, regardless of their suspected or confirmed infection status), Enhanced Barrier Precautions (EBP; infection control measures in nursing homes requiring staff to wear gowns and gloves during high-contact care [e.g. (in example) bathing, dressing, changing linens and wound care] for residents with wounds, medical devices or known antibiotic resistant germ colonization [the process where bacteria or other microbes settle, grow and multiply on body surfaces without causing infection]) and Transmission Based Precautions (used in addition to standard precautions as a second-level of infection control), revised 5/20/2025, the P&P indicted its purpose was to provide guidelines for infection control practices to reduce the potential for transmission of pathogens and multi-drug resistant organisms and viruses. The P&P also indicated under Contact Precautions that, Contact Precautions are an extension of Standard Precautions it is required that gowns and gloves are worn for all contact with body fluids as well as contact with environmental surfaces in the patient's/resident's room. During a review of the facility's P&P titled, Clostridium Difficile, revised October 2024, the P&P (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, Measures are taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. Precautions are taken while caring for residents with C. difficile to prevent transmission to other residents. The P&P also indicated: The primary reservoirs for C. difficile are infected people and surfaces. Spores can persist on resident-care items and surfaces for several months and are resistant to some common cleaning and disinfection methods. Steps toward prevention and early intervention include frequent hand washing with soap and water by staff and residents. 2. During an interview on 2/18/2026 at 1:52 PM with Maintenance Supervisor (MS), MS stated the control measures (actions that can be taken to reduce the potential of exposure to a hazard) for the water management program is checking water temperatures of random rooms at the facility every day. MS stated since he just started two (2) months ago, he is still trying to figure out his own system and does not have a log but would look for the previous Maintenance Supervisor's log.During an interview on 2/18/2026 at 2:25 PM with MS, MS stated he has been checking the water temperatures everyday for the last 2 months but has not been documenting the temperatures in a log. MS also stated he could not find any water temperature log previously kept by the Maintenance Supervisor before him. MS further stated it is important to document the daily water temperature checks in a log to show that it is being done since checking the water temperatures are for the resident's safety.During an interview on 2/20/2026 at 2:29 PM with MS, MS stated there was no log kept documenting the results of the daily water temperature checks since he started as MS and stated he could not find any water temperature log from the previous Maintenance Supervisor.During an interview on 2/20/2026 at 3:29 PM with the DON, the DON stated it is important to keep a log of the daily water temperature checks to ensure the water management controls are within range. During a review of the facility's P&P titled, Legionella (a bacterium which cases legionnaires' disease [a severe form of pneumonia – lung inflammation usually caused by infection]) Water Management Program, revised 5/22/2025, the P&P indicated, the water management program includes the following elements: the control limits or parameters that are acceptable and that are monitored, a system to monitor limits and the effectiveness of control measures and documentation of the program.During a review of the facility's P&P titled, Water Temperatures, Safety of, revised December 2020, the P&P indicated, maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log and maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log. 3. During a review of Resident 48's admission Record indicated Resident 48 was admitted to the facility on [DATE], with diagnoses that included unspecified asthma, uncomplicated (chronic inflammatory lung disease characterized by narrowed, mucus-filled airways that cause wheezing, coughing, chest tightness, and shortness of breath, a chronic respiratory condition, representing a diagnosis where specific details are not fully documented), generalized muscle weakness (a widespread reduction in physical strength affecting muscles throughout the body rather than a single, isolated area), and presence of cardiac (an electronic device that is implanted in the body to monitor heart rate and rhythm). During a review of the MDS- dated 1/29/2026, indicated Resident 48 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 48 is dependent, (helper does all of the effort) with the toilet transfer, sit to stand, shower/bathe self, lower body dressing, and putting on/ taking off footwear. The MDS also indicated Resident 48 needed substantial/maximal (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Californian Pasadena Healthcare	120 Bellefontaine Street Pasadena, CA 91105

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance in toileting hygiene, upper body dressing, and sit to lying. Resident 48 needed partial or moderate assistance, with eating, oral hygiene and personal hygiene. During a review of Resident 48's Physician Orders, dated 1/28/2026, it indicated Resident 48 has an order for Albuterol Sulfate Nebulization solution (a sterile, preservative-free, short-acting bronchodilator solution used in a nebulizer machine [a medical device that converts liquid medication into a fine mist, allowing it to be inhaled directly into the lungs through a mouthpiece or face mask], to treat acute asthma attacks, wheezing, and COPD symptoms by opening airways) 2.5 milligram (mg a unit of measurement)/3 milliliter, (ml- a metric unit for measuring liquid volume) inhale orally via nebulizer every six hours as needed for shortness of breath and wheezing (an uncomfortable feeling of not getting enough air, and a high-pitched whistling sound caused by narrowed airways). During an observation on 2/17/2026 at 9:55 AM in Resident 48's room, observed Resident 48's breathing treatment mask and tubing was stored inside a respiratory/patient set up bag dated 2/1/2026. There was no date on the breathing treatment mask nor the tubing beside the date on the respiratory/patient set up bag. During an interview on 2/17/2026 at 1:45 PM with Licensed Vocational Nurse (LVN1), LVN 1 stated Resident 48's breathing treatment mask, tubing and respiratory/ patient set up bag are supposed to be changed every seven days by night shift nurses to help prevent infection. LVN 1 stated, the label on the respiratory/ patient set up bag was dated 2/1/2026 and the breathing treatment mask and respiratory/ patient set up bag should have been changed on 2/8/2026 but it was not changed. During an interview on 2/18/2026 at 4:25 PM with Registered Nurse 1(RN1), RN 1 stated Resident 48's breathing treatment mask, tubing and the respiratory set up bag are supposed to be changed every seven days per facility's policy, and it is to prevent the accumulation of bacteria and germs that can cause lung infection if not changed accordingly. During an interview on 2/20/2026 at 11:14 AM with Infection Preventionist Nurse (IP), IP nurse confirmed the breathing treatment mask and tubing is supposed to be stored inside a clean respiratory set up bag with date of first use to determine when it needs to be changed with a new set. IPN also stated it is important to change the breathing treatment mask, tubing and respiratory set up bag every seven days to prevent infection and cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During a record review of the facility's policy and procedure titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2024, the policy indicated the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The policy also indicated the following steps for the use of the device: When equipment is completely dry, store it in a plastic bag with the resident's name and the date on it. Change equipment and tubing every seven days, or according to facility protocol.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to close the privacy curtain (fabric barrier suspended from ceiling tracks to divide shared rooms, providing patients with immediate visual privacy, dignity, and a sense of security during examinations or treatment) to provide privacy for one (1) of twenty-three sampled residents (Resident 9), who was only wearing a diaper when the resident was returning to her bed from the bathroom. This failure violated the resident's right to be treated with dignity and respect which can affect Resident 9 's psychological, emotional, and physical well-being During a review of Resident 9's admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included dementia in other diseases classified elsewhere (cognitive decline caused by underlying conditions rather than primary Alzheimer's or vascular dementia [brain damage or disease, resulting in a severe, progressive decline in cognitive function memory, reasoning, and behavior, that interferes with daily life]), hypertensive heart disease without heart failure (the early-to-intermediate stage of structural heart damage caused by chronic, uncontrolled high blood pressure), and other abnormalities of gait and mobility (walking patterns or movement difficulties that do not fit into specific classifications like shuffling, limping, or stumbling). During a review of the Minimum Data Set (MDS- a resident assessment tool) dated 12/19/2025, indicated Resident 9 is severely impaired (never/ rarely made decisions) for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS also indicated Resident 9 needs setup or clean-up assistance (helper sets up or cleans up) with eating, and Resident 9 needs supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for oral hygiene, personal hygiene, roll left and right, sit to lying and sit to stand. The MDS indicated, Resident 9 needs substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) for toileting hygiene, shower, bathe self, lower body dressing, putting on/ taking off footwear. During an observation on 2/18/2024 at 12:20 PM near Nursing Station 1 and the front lobby area, Resident 9 was visible from outside the resident's room while Resident 9 is walking back to her bed from the bathroom (inside the resident's room) without being covered with a towel or clothing, and the resident was wearing a diaper. Registered Nursing Supervisor (RNS) 1 was present in the room assisting Resident 9, and Resident 9's privacy curtain was not closed. During an interview on 2/18/2024 at 12:35 PM, RNS 1 stated he should have provided privacy to Resident 9 by properly covering the reisdent and making sure the privacy curtain was closed while RNS 1 assisted Resident 9 back to the resident's bed. RNS 1 stated it is essential to protect Resident 9's dignity and treat the reisdent with respect. During an interview on 2/20/2026 at 1:35 PM with the Director of Nursing (DON), the DON stated it is very important to provide privacy to residents in the facility. The DON also stated respecting patient privacy is foundational to ethical, patient-centered care and respecting individual's autonomy. During a review of the facility's Policy and Procedure titled Quality of Life - Dignity , dated February 2020, indicated the following:Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.Residents are always treated with dignity and respect. Demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to treat cognitively impaired residents with dignity and sensitivity.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one (1) of five (5) sampled residents (Resident 38) reviewed for unnecessary medication have a specific indication for the use of valproic acid (a prescription medication used primarily to prevent and treat seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and a mood stabilizer) as indicated on the facility's policy. This deficient practice had the potential to place Resident 38 at risk for significant adverse consequences (serious negative outcomes resulting from an event, action, or situation) from the use of unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior), which could result in impairment or decline in the residents' mental, physical condition, functional, and psychosocial status.Findings: During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE]. Resident 38's diagnoses included dementia (a progressive state of decline in mental abilities), metabolic encephalopathy (temporary or permanent brain dysfunction), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2025, the MDS indicated Resident 38 had moderately impaired (decisions poor, sues/supervision required) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 38 had symptoms of feeling down, depressed and hopeless. The MDS indicated Resident 38 required substantial/maximal assistance (helper does more than half the effort) with eating and personal hygiene. The MDS indicated Resident 38 was dependent (helper does all of the effort) with oral and toileting hygiene, shower, upper and lower body dressing and putting on/off footwear. The MDS indicated Resident 38 was taking antipsychotic medications (primarily used to treat psychosis [a condition that affects how a person perceives reality]). During a review of Resident 38's Progress Notes, dated 12/12/2025, by Psychiatric Nurse Practitioner (PNP, an advanced practice registered nurse, authorized to assess, diagnose, and treat individuals with mental health disorders), the Progress Notes indicated to continue Depakote (valproic acid) regimen for mood stabilization. The Progress Notes indicated Resident 38's current diagnoses were dementia and depression. Resident 38's Progress Notes did not indicate a diagnosis of mood disorder (also called an affective disorder, a category of mental health conditions where the primary disruption involves a person's emotional state, causing significant deviation from their usual mood patterns). During a review of Resident 38's Order Summary Report, dated 2/18/2026, the Order Summary Report indicated Valproic acid oral solution 250 milligrams (mg, unit of measurement) per five (5) milliliters (ml, unit of measurement), give 5 ml by mouth every eight (8) hours for mood disorder manifested by mood swings from pleasant to irritable, ordered on 12/2/2025. During a concurrent record review and interview on 2/20/2026 at 8:04 AM with Assistant Director of Nursing (ADON), Resident 38's Valproic acid order was reviewed. ADON verified Resident 38 has an order for Valproic acid for mood disorder, ordered on 12/2/2025. ADON stated the diagnosis of mood disorder as an indication for the use of Valproic Acid was incorrect because Resident 38 was not diagnosed with mood disorder. Resident 38's medical records did not indicate any diagnosis of mood disorder. During an interview on 2/20/2026 at 3:11 PM, with the Director of Nursing (DON), the DON stated it was important to have an accurate diagnosis as an indication for use of any medication to ensure the resident receives the correct medication for the correct indication. The DON stated psychotropic medication orders should have a resident's diagnosis and the behavior that resident is manifesting, to ensure the medication is necessary for the resident. The DON stated the PNP Progress Notes did not indicate that Resident 38 has a diagnosis of mood disorder. Therefore, the use of valproic acid was unnecessary. During a review of Facility's Policy (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Procedure (P&P) titled, Unnecessary Medication/Medication Therapy, revised April 2007, the P&P indicated each resident's medication regimen shall include only those medications necessary to treat existing conditions. Medication use shall be consistent with an individual's condition. All medication orders will be supported by appropriate care processes and practices.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to monitor new onset of penile swelling as indicated on the care plan for one (1) out of 1 sampled resident (Resident 49) reviewed for edema. This failure resulted in the nursing staff not monitoring Resident 49's penile swelling daily for worsening or improvement and had the potential to negatively affect Resident 49's physical comfort and psychosocial (the interaction between a person's psychological [mental/emotional] state and their social environment [relationships, culture and surroundings] as it affects their health) well-being. During a review of Resident 49's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted with diagnoses of hemiplegia (severe or complete paralysis affecting one vertical side of the body, often including the arm, leg and face) and hemiparesis (partial weakness or reduced motor function affecting one entire side of the body) following cerebral infarction (stroke - the death of brain tissue as a result of ischemia [when blood flow and oxygen is reduced in a part of the body]) affecting the left dominant side and epilepsy (a chronic brain disorder characterized by a tendency to have recurrent, unprovoked seizures [a sudden, temporary surge of uncontrolled electrical activity in the brain that disrupts normal function causing changes in behavior, movements, feelings and levels of consciousness]). During a review of Resident 49'S Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2025, the MDS indicated the resident was moderately impaired (decisions poor; cues/supervision required) with cognitive (ability to think, remember, and reason) skills for daily decision making. The MDS indicated Resident 49 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of two [2] or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers, going from sitting to standing, toilet transfers and with toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). The MDS also indicated Resident 49 also needed substantial/maximal assistance (helper does more than half the effort) with going from sitting to lying down, rolling left and right in bed, putting on/taking off footwear, upper and lower body dressing (the ability to dress and undress above and below the waist) and needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During an interview on 2/17/2026 at 10:12 AM with Resident 49, Resident 49 stated the head of his penis had been swollen for a month and was causing him pain.During a review of Resident 49's Situation, Background, Assessment and Recommendation (SBAR; a structured, four-step communication framework used by healthcare professionals to quickly and clearly share vital patient information) documentation dated 2/12/2026 written by Registered Nurse Supervisor 2 (RNS 2), Resident 49's SBAR documentation indicated on 2/12/2026 around 9:50 PM, an unknown Certified Nursing Assistant (CNA) while changing Resident 49 observed that Resident 49 had swelling in the penile area. The SBAR also indicated RNS 2 went to assess Resident 49 and the area was noted to have swelling in the resident's shaft area. At 10:00 PM Resident 49's physician (MD) was notified, who gave an order to send Resident 49 to the hospital if the resident was in a lot of pain in the penis area and if not in pain to monitor. During a review of Resident 49's Care Plan dated 2/16/2026 created by RNS 2, Resident 49's Care Plan indicated Resident 49 was at risk for impaired skin integrity (the skin's overall health) related to penile swelling and indicated interventions for assessing penile swelling daily and to document size, color, temperature and skin integrity and to monitor for any redness, infection, open areas, drainage or foul odor. During a concurrent interview and record review on 2/19/2026 at 12:52 PM with Licensed Vocational Nurse 5 (LVN 5), Resident 49's Electronic Medical Record (EMR; a digital version of a patient's paper chart, containing their medical history, diagnosis, medications and treatment plans) dated 8/13/2025 to 2/19/2026 was reviewed. Resident 49's EMR indicated one day of documented monitoring for Resident 49's penile swelling on 2/15/2026. LVN 5 stated there was an SBAR created (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for resident's penile swelling on 2/12/2026 and a daily 72-hour monitoring every shift should have been implemented to monitor Resident 49's swelling as indicated in the resident's care plan for risk for impaired skin integrity. LVN 5 also stated there was no documentation of daily monitoring on resident's Medication Administration Record (MAR) or Treatment Administration Record (TAR) and daily 72-hour monitoring of Resident 49's penile swelling and it should have been implemented to see if the swelling was improving or worsening. During a concurrent interview and record review on 2/19/2026 at 1:57 PM with RNS 2, Resident 49's SBAR documentation dated 2/12/2026 and Care Plan dated 2/16/2026 were reviewed. Resident SBAR documentation indicated Resident 49 was assessed for penile swelling and MD had ordered to monitor and Resident 49's Care Plan for penile swelling indicated an intervention to assess penile swelling daily and to document size, color, temperature and skin integrity and to monitor for any redness, infection, open areas, drainage or foul odor. RNS 2 stated when she called the MD on 2/12/2026, MD had told RNS 2 to monitor Resident 49's penile area daily for redness, burning or difficulty urinating and an order should have been initiated for monitoring the area so the other nursing staff would be aware to monitor the area as well. RNS 2 stated she had initiated the care plan for Resident 49's penile swelling but forgot to input the order which resulted in no daily monitoring of Resident 49's penile swelling being done to know whether Resident 49's penile swelling was getting better or worse. During a concurrent interview and record review on 2/20/2026 at 10:36 AM with Assistant Director of Nursing (ADON), Resident 49's SBAR documentation dated 2/12/2026 and Care Plan dated 2/16/2026 were reviewed. ADON stated according to the care plan RNS 2 had created a care plan with custom interventions to address Resident 49's penile swelling but did not create an order for monitoring to implement the care plan intervention. ADON stated only two nursing notes for monitoring Resident 49's penile swelling were documented in Resident 49's medical records on 2/15/2026 but nothing else. During the same interview on 2/20/2026 at 10:36 AM with ADON, ADON stated an order for monitoring Resident 49's penile swelling daily should have been implemented with an additional order to report to the MD if the condition worsens. ADON further stated Resident 49's penile swelling should have been monitored daily from 2/12/2026 so they would be able to assess if the swelling was getting better or worse and to notify the MD of the progress and because it was not monitored, it could have led to bigger consequences. During an interview on 2/20/2026 at 2:56 PM with ADON, ADON stated Resident 49's interventions for his penile swelling should have been implemented as indicated on his care plan. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2024, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P also indicated each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to receive the services and/or items included in the plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure to provide assistant devices to prevent accident for one (1) of three (3) sample residents (Resident 48) reviewed for fall by failing to provide floor mat (a protective, cushioned device placed on the floor beside a bed or in high-risk areas to reduce the severity of injuries-such as fractures or bruises-if a resident falls or rolls out of bed) after the resident has a fall in the facility. This failure placed Resident 48 at risk for another fall that may result to serious injury and hospitalization. During a review of Resident 48's admission Record indicated Resident 48 was admitted to the facility on [DATE], with diagnoses that included unspecified asthma, uncomplicated (chronic inflammatory lung disease characterized by narrowed, mucus-filled airways that cause wheezing, coughing, chest tightness, and shortness of breath, a chronic respiratory condition, representing a diagnosis where specific details are not fully documented), generalized muscle weakness (a widespread reduction in physical strength affecting muscles throughout the body rather than a single, isolated area), presence of cardiac (an electronic device that is implanted in the body to monitor heart rate and rhythm), and history of falling (a documented record or self-report of past incidents where an individual has stumbled, lost balance, or collapsed, signaling a high risk for future falls and injury). During a review of the Minimum Data Set (MDS- a resident assessment tool) dated 1/29/2026, indicated Resident 48 had moderately impaired (decisions poor: cues/supervision required) for cognitive skills (mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS indicated Resident 48 is dependent, (helper does all of the effort) with the toilet transfer, sit to stand, shower/bathe self, lower body dressing, and putting on/ taking off footwear. It also indicated, Resident 48 needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunks or limbs but provides more than half the effort) in toileting hygiene, upper body dressing, and sit to lying. Resident 48 needed partial or moderate assistance, (helper does less than half the effort) with eating, oral hygiene and personal hygiene. During a review of Resident 48's Situation, Background, Assessment, Recommendation (SBAR, a structured, four-step communication framework, used primarily in healthcare to ensure concise, accurate, and rapid exchange of information), communication form general dated 2/13/2026, it indicated Resident 48 has an actual fall without injury due to poor balance and unsteady gait on 2/13/2026. During a review of Resident 48's care plan report dated 2/13/2026, the care plan intervention for episode of post fall is to use of injury prevention devices such as floor mats and low bed. During multiple observations (three times) on 2/18/2026 from 10:55 AM to 3:12 PM in Resident 48's room, there were no floor mats found as listed in the 2/13/2026 care plan report's intervention for post fall injury prevention. During a concurrent interview and record review on 2/19/2026 at 3:55 PM with Licensed Vocational Nurse (LVN) 2, Resident 48's care plan report dated 2/13/2026 was reviewed. The care plan report indicated floor mats will be used as injury prevention device for Resident 48 to prevent future fall injury. LVN 2 stated she did not call physician to order floor mats for Resident 48 and there was no other licensed nurse that obtained the order from Resident 48's physician for the use of floor mat so it was not implemented. LVN 2 stated it is very important to implement all fall injury precautions to prevent future fall injuries, and this is to prevent long term disability and maintain resident independence. During an interview on 2/19/2026 at 4:25 PM with Registered Nurse (RN) 2, RN 2 stated she did not see any floor mats in Resident 48's room at all. RN 2 stated it is very important to implement all fall injury precautions to prevent future fall injuries, and this is to prevent long term disability. During an interview on 2/20/2026 at 2:00 PM with the Director of Nursing (DON),he DON stated it is very important to implement all fall injury precautions such as providing floor mat to the resident to prevent life-altering injuries, such as hip fracture (break in the bone) and this is to prevent long term (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disability, maintain resident independence and prevent injury related death. During a record review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2024, the policy indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. During a record review of the facility's policy and procedure titled, Falls - Clinical Protocol, revised September 2024, the policy indicated the staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. The policy also indicated, if the residents continue to fall, the staff will re-evaluate the situation and consider other possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions.

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The Californian Pasadena Healthcare	120 Bellefontaine Street Pasadena, CA 91105

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide trauma-informed care (an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma [trauma (results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being)]) by failing to identify trauma triggers (a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening) and develop and implement a treatment plan to address a diagnosis of post-traumatic stress disorder (PTSD- a mental health disorder that develops in some people who have experienced a shocking, scary, or dangerous event) for one (1) of two (2) sampled residents (Resident 6) reviewed for behavior. This deficient practice had the potential to cause re-traumatization (when stress reactions experienced as a result of a previous traumatic event are relived when faced with a new similar incident) which could result in Resident 6 to experience increased anxiety (intense, excessive, and persistent worry and fear about everyday situations disorder), depression (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities), and relive the trauma causing grief, panic, or terror.Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included PTSD, amputation (surgical removal of the entire or portion of the leg or arm), and phantom limb syndrome with pain (pain felt in the part of a limb that was removed after an amputation). During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 6 had modified independence (some difficulty in new situations only) with cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 6 had symptoms of feeling down, depressed, hopeless, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy and feeling bad about self. The MDS indicated Resident 6 required setup or clean-up assistance (helper sets up or cleans up) with eating. The MDS indicated Resident 6 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying assistance) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 6 required partial/moderate assistance (helper does less than half the effort) with shower, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 6 required substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunks or limbs and provides more than half the effort) with toileting hygiene. The MDS also indicated Resident has a diagnosis of PTSD. During a review of Resident 6's Social Service admission assessment dated [DATE], indicated Resident 6 responded No to all the following questions in the brief trauma questionnaire:Have you ever served in a war or served in non-combat job that exposed you to war related casualties?Have you ever been in a serious car accident, work accident, or any other accident?Have you been in a natural disaster, i.e. tornado, fire, earthquake, hurricane, chemical spill?Have you had a life-threatening illness, cancer, heart attack, etc?Have you been physically punished by a caregiver prior to the age of 18 to the point of injury or bruising?Have you been a victim of physical attack, mugged or assaulted?Have you had unwanted sexual advances?Have you been in other situations in which you were injured or situation in which you feared you might be seriously injured or killed?Has a close family member or friend died from a violent situation, ie. car crash, crime, attack, natural disaster?Have you ever witnessed a situation in which someone was seriously injured or killed? During a review of Resident 6's Care Plan (CP), initiated on [DATE], the CP indicated Resident 6 is at risk for emotional distress related to PTSD, CP goal indicated for Resident 6 not to exhibit signs and symptoms of psychosocial or emotional distress. The CP interventions included the (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following:Provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated.Encourage Resident 6 to report pain, fear, feeling of anxiety, anger at onset.Monitor behavior and notify Doctor (MD) if it interferes with functioning.Monitor for sleep pattern disturbance (e.g. disruptive change in sleep pattern as related to one's biological and emotional needs.)Monitor resident every shift for sigh and symptoms of psychosocial distress such as verbalization of fear, withdrawal, crying, verbalization of fearfulness, anger.Refer for Psychiatric (a medical doctor who specializes in mental health, including substance use disorders) consult as indicated.Social Service Director (SSD) will make frequent room visits and provide relief from any psychosocial distress. During a concurrent record review and interview on [DATE] at 9:18 AM with Assistant Director of Nursing (ADON), Resident 6's medical records were reviewed. ADON stated Resident 6 was admitted to the facility with diagnoses of PTSD, and the initial psychiatric consult conducted on [DATE] by Psychiatric-Mental Health Nurse Practitioner 1 (PMHNP 1, an advanced practice registered nurse licensed to assess, diagnose, and treat individuals with mental health disorders) did not and should have indicated Resident 6's diagnosis of PTSD and identified triggers to trauma. ADON stated Resident 6 has a CP for PTSD that was developed on [DATE], but the CP was not Resident 6 specific since Resident 6's trauma triggers were not identified. During a concurrent record review and interview on [DATE] at 9:18 AM with ADON, Resident 6's risk for emotional distress related to PTSD care plan and medical records were reviewed. ADON stated Resident 6's care plan was not implemented because there was no documented evidence that the staff monitored the resident for sleep pattern disturbances and psychosocial distress such as verbalization of fear, withdrawal, crying, verbalization of fearfulness and anger. ADON stated she did not know exactly what Resident 6's past trauma was. ADON stated, It's probably due to the resident's (Resident 6) amputation. ADON stated, it was important to identify trauma triggers for residents with diagnosis of PTSD to provide holistic care. ADON added that by preventing residents from encountering triggers that may cause re-traumatization, the facility staff can help ensure that the resident's PTSD is properly managed. ADON also stated if PTSD is not managed, residents may decline and become at risk for hospitalization. During an interview on [DATE] at 3:06 PM with the Director of Nursing (DON), the DON stated, it was necessary to identify the triggers of each resident with PTSD, including Resident 6, in order to know how to care for them and promote their mental well-being. The DON stated PMHNP 1 did not and should have identified Resident 6's trauma triggers for the facility staff to better develop specific interventions to address Resident 6's diagnosis of PTSD. The DON stated, Triggers can be anything, it can be sensory or situational, and most manifestations are avoidance behaviors, anger and flashbacks. The DON stated the facility policy on Trauma Informed Care did not and should have included identification of triggers for residents with PTSD to be able to provide the care they need. During a review of facility's Policy and Procedure (P&P) titled, Trauma Informed Care, revised in [DATE], the P&P indicated the facility supports a culture of emotional well-being and physical safety for staff, residents and visitors. The P&P indicated as part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. Reduce or eliminate unnecessary stimuli (noise, lighting, unwanted or sudden physical contact, etc.).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure medications were administered and supervised as ordered when Licensed Vocational Nurse 3 (LVN 3) left medications on the bedside table for one (1) of 23 sampled residents (Resident 2). This failure had the potential to result in diversion (medications being misused, stolen, or not given to the right person as prescribed) or accidental ingestion of the medications by other residents that could lead to adverse outcomes and compromise the residents' health and safety.Findings: During a review of Resident 22's admission Record by, the admission Record indicated the facility admitted Resident 22 on 1/30/2026 with diagnoses that included but not limited to chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), presence of prosthetic heart valve (a man-made or tissue valve that helps the heart pump blood the right way when the original valve no longer works), and rheumatoid arthritis (a long-term disease where the body's immune system attacks the joints, causing inflammation and pain.) During a review of Resident 22's Admission/readmission Initial Assessment, dated 1/31/2026, the assessment indicated Resident 22 did not want to self-administer his medications. During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool), dated 2/1/2026, the MDS indicated Resident 22 had moderately intact cognitive (ability to think, reason, and function) skills for daily decision making. The MDS indicated Resident 22 required supervision with oral hygiene and personal hygiene and substantial/maximal assistance with toileting and showering. During a review of Resident 22's Physician's Order dated 2/18/2026, the Physician's Order indicated Resident 22 was ordered the following medications: -Acetaminophen (a medication used to treat mild pain) 325 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), give two (2) tablets every four (4) hours as needed.-Folic acid (a vitamin used to help the body make new healthy blood and cells) 1 mg, give 1 tablet one time a day.-Norvasc (a medication used to treat hypertension [HTN- high blood pressure]), 10 mg, give 1 tablet one time a day.-Spironolactone (a medication used to treat HTN), 25 mg, give 1 tablet by mouth one time a day.-Simethicone (a medication used to relieve gas and bloating), 80 mg, give 1 tablet by mouth every 6 hours as needed. During a concurrent observation and interview on 2/18/2026 at 8:09 AM with Resident 22 inside Resident 22's room, Resident 22 was lying in bed resting and on top of the resident's bedside table, in a medication cup, had 4 white tablets and 1 yellow tablet. Resident 22 stated the medications were blood pressure medications. Resident 22 stated the medications were placed on the bedside table 5 minutes ago. During a concurrent interview and record review on 2/18/2026 at 1:27 PM with LVN 3, Resident 22's physician's orders, dated 1/30/2026 to 2/18/2026 were reviewed. The orders did not indicate Resident 22 may self-administer (to take one's own medication by yourself without someone else giving it to you) medications. LVN 3 stated there is no order for Resident 22 to self-administer his medications, and the medications should not have been left at Resident 22's bedside. LVN 3 stated that residents must take their medications in the presence of a licensed nurse to ensure the medications were administered and will be effective. During a concurrent interview and record review on 2/18/2026 at 4:01 PM with LVN 3 and the Director of Nursing (DON), Resident 22's Medication Administration Record (MAR), dated 2/18/2026 was reviewed. The MAR indicated on 2/18/2026, LVN 3 administered Resident 22's medications. LVN 3 stated she gave all the morning medications to Resident 22. The DON stated LVN 3 should not have left the medications at the bedside because other residents/staff can get the medication potentially harming the residents and/or staff. During a review of the facility's Policy and Procedure titled, Storage of medications, biologicals and medical supplies, dated 10/2024, the P&P indicated, Medications shall not be kept by the bedside unless the resident may self-administer.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate Medication Regimen Review (MRR, review is a thorough, systematic evaluation of a patient's entire medication list) for one (1) of 23 sampled residents (Resident 38) by failing to reflect the correct diagnosis for the resident's use of valproic acid (a prescription medication used primarily to prevent and treat seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] and a mood stabilizer) on the December 2025 and January 2026 MRR reports, which were in the resident's medical records. This deficient practice had the potential for the facility's pharmacy consultant (PC, perform medication regimen reviews based on a patient's health history to evaluate the appropriateness, safety, benefits, risks, and cost-effectiveness of medication therapy), to fail to identify irregularities (refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services.) which may result in Resident 38 experiencing adverse consequences (serious negative outcomes resulting from an event, action, or situation) from the use of unnecessary medication.Findings: During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was initially admitted to the facility on [DATE]. Resident 38's diagnoses included dementia (a progressive state of decline in mental abilities), metabolic encephalopathy (temporary or permanent brain dysfunction), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2025, the MDS indicated Resident 38 had moderately impaired (decisions poor, sues/supervision required) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 38 has symptoms of feeling down, depressed and hopeless. The MDS indicated Resident 38 required substantial/maximal assistance (helper does more than half the effort) with eating and personal hygiene. The MDS indicated Resident 38 was dependent (helper does all of the effort) with oral and toileting hygiene, shower, upper and lower body dressing and putting on/off footwear. The MDS indicated Resident 38 was taking antipsychotic medications (primarily used to treat psychosis). During a review of Resident 38's Progress Notes, dated 12/12/2025, by Psychiatric Nurse Practitioner (PNP, an advanced practice registered nurse, authorized to assess, diagnose, and treat individuals with mental health disorders), the Progress Notes indicated to continue Depakote (valproic acid) regimen for mood stabilization. During a review of Resident 38's Order Summary Report, dated 2/18/2026, the Order Summary Report indicated Valproic acid oral solution 250 milligrams (mg, unit of measurement) per five (5) milliliters (ml, unit of measurement), give 5 ml by mouth every eight (8) hours for mood disorder manifested by mood swings from pleasant to irritable, ordered on 12/2/2025. During a review of a facility form titled, Psychoactive and Sedative/Hypnotic Utilization by Resident for Record Updated Between 12/1/2025 and 12/17/2025, the form indicated Resident 38's Valproic acid was for psychosis manifested by mood swings from pleasant to irritable, as documented by the PC. There were no recommendations listed for Resident 38's Valproic acid. During a review of a facility form titled, Psychoactive and Sedative/Hypnotic Utilization by Resident for Record Updated Between 1/1/2026 and 1/15/2026, the form indicated Resident 38's Valproic acid was for psychosis manifested by mood swings from pleasant to irritable, as documented by the PC. There were no recommendations listed for Resident 38's Valproic acid. During a concurrent record review and interview on 2/20/2026 at 8:05 AM with Assistant Director of Nursing (ADON), Resident 38's Valproic acid order and MMR for December 2025 and January 2026 were reviewed. ADON verified Resident 38 has an order of Valproic acid for mood disorder, ordered on 12/2/2025. ADON stated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 38's MMR done by PC for December 2025 and January 2026 indicated valproic acid order was for psychosis, which was inaccurate. ADON stated the MRR reports are scanned, uploaded and are a part of the resident's records. ADON stated it was important for MRR to be accurate to ensure residents are provided with correct/necessary medications to prevent harm. The ADON stated, Resident may not need the medication. It may cause harm and drug adverse side effects that could lead to death. During an interview on 2/20/2026 at 3:12 PM, with the Director of Nursing (DON), the DON stated he did not know why PC documented psychosis on December 2025 and January 2026's MRR report for Resident 38's Valproic acid. The DON verified that there were no recommendations for Resident 38's valproic acid for December 2025 and January 2026. During a review of Facility's Policy and Procedure (P&P) titled, Medication Regimen Review, revised on May 2019, the P&P indicated PC reviews the medication regimen of each resident at least monthly. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medications related problems, mediation errors and other irregularities. During a review of Facility's P&P titled, Charting and Documentation, revised in July 2025, indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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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 pancake style call light (soft touch call light - a specialized patient-assistance button designed for individuals with limited mobility, poor dexterity, or weak grip strength and only requires minimal, gentle pressure to activate) for one (1) of three (3) sampled residents (Resident 44) reviewed for environment was functioning properly.This failure had the potential to put Resident 44 at risk for experiencing a delay in receiving assistance from facility staff which could lead to a fall or accident.During a review of Resident 44's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of hemiplegia (severe or complete paralysis affecting one vertical side of the body, often including the arm, leg and face) and hemiparesis (partial weakness or reduced motor function affecting one entire side of the body) following cerebral infarction (stroke - the death of brain tissue as a result of ischemia [when blood flow and oxygen is reduced in a part of the body]) affecting the right dominant side and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 44'S Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2026, the MDS indicated the resident was severely impaired (never/rarely made decision) with cognitive (ability to think, remember, and reason) skills for daily decision making. The MDS also indicated Resident 44 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two [2] or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers, rolling left and right in bed, going from lying down to sitting on the side of the bed, upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear and personal hygiene. During a review of Resident 44's Care Plan dated 2/9/2026, Resident 44's Care Plan indicated Resident 44 had severely impaired cognition and was rarely/never understood and unable to reliably use a standard call light due to the resident's cognitive limitations and had been provided a pancake style call light. The Care Plan also indicated an intervention to ensure the pancake call light is clearly visible, functional and appropriately positioned.During a review of Resident 44's Care Plan dated 5/20/2024, Resident 44's Care Plan indicated Resident 44 had an Activities of Daily Living (ADL; activities such as bathing, dressing and toileting a person performs daily) self-care and/or mobility performance deficit related to stroke and indicated an intervention for the pancake style call light to be in place. During an observation on 2/19/2026 at 6:54 AM inside Resident 44's room, Resident 44 was observed lying down with a pancake style call light observed on the resident's left side. When the pancake style call light was pressed, the call light was observed to turn on and when the pressure on the call light was released, the call light turned off. During a concurrent observation and interview on 2/19/2026 at 6:57 AM with Admissions Director (AD) and Payroll (PR) inside Resident 44's room. Resident 44 was observed lying down in bed with the pancake style call light on the resident's left side. The pancake style call light was pressed to turn it on and when the pressure was released, the call light turned off. Both AD and PR stated with the pancake style call light, pressure needed to be held onto the call light to keep it on. During a concurrent observation and interview on 2/19/2026 at 7:10 AM with Licensed Vocational Nurse 6 (LVN 6) inside Resident 44's room, Resident 44 was observed lying down in bed with the pancake style call light on the resident's left side. The pancake style call light was pressed to turn it on and when the pressure was released, the call light turned off. LVN 6 stated the pancake style call light would only stay on when pressure was held on top of it and stated it should not be like that and once the pancake style call light is pressed, it should stay on without having to keep pressure on top of it. During a concurrent observation and interview on 2/19/2026 at 7:12 AM with the Director of Nursing (DON) inside Resident 44's room, Resident 44 was observed lying down in bed with the pancake style call light on the resident's left side. The call light was observed to not stay on once pressure was (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	released. The DON stated Resident 44's call light was not functioning properly because it would not stay on when the pressure was released from the pads. The DON further stated the call light should stay on once it is pressed and the broken pancake style call light needed to be changed. During an interview on 2/19/2026 at 7:14 AM with Maintenance Supervisor (MS), MS stated for the soft touch or pancake style call lights, once it is pressed, it should stay on and pressure should not have to be held on the call light to keep it on. During an interview on 2/20/2026 at 10:44 AM with the Assistant Director of Nursing (ADON), the ADON stated the purpose of a call light is for resident to alert staff that they are in need of assistance and the way a soft touch or pancake style call light works is once pressure is applied on it, it turns the call light on and stays on. The ADON stated Resident 44 should not have to keep pressure on the pancake style call light to keep the call light on. The ADON further stated if the call light is not functioning properly, it can pose a risk for unmet needs and a risk for falls and injury to the resident. During a concurrent interview and record review on 2/20/2026 at 2:54 PM with the DON and ADON, the facility's policy and procedure (P&P) titled, Call Light revised 2/20/2026 was reviewed. The P&P indicated, The purpose of this procedure is the respond to the resident's requests and needs, and also indicated the call light is to be plugged in at all times and if a call light malfunctions it shall be reported to the maintenance supervisor promptly and the residents will be provided with a call bell and provided close staff monitoring (as indicated) until the call light is fixed. The DON and ADON stated the facility's P&P indicated, the resident's call light should always be functioning properly.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure the facility's staffing information was posted and placed in a visible and prominent area on 2/17/2026, 2/18/2026, and 2/19/2026 in accordance with the facility's policies and procedures (P&P). This deficient practice had the potential for the residents, staff, and visitors not to be informed of the actual number of nurses providing direct care for the residents.Findings: During an observation at the facility's basement entrance lobby door, on 2/17/2026 at 7:55 AM, a visitor's log was observed on top of a table right beside the door. There was no staffing information posted. During an observation at the facility's basement entrance lobby door, on 2/18/2026 at 8 AM, a visitor's log was observed on top of a table right beside the door. There was no staffing information posted. During a concurrent observation and interview on 2/19/2026 at 9:40 AM with Director of Staff Development (DSD), the posted staffing information dated 2/19/2026 was observed in Nursing Station 1, near the front lobby, and facility's main entrance. The posted staffing information reflected the facility census (the total number of residents living in the facility) of 61 for 2/19/2026, 7 AM to 3 PM shift, two (2) Registered Nurses (RN), five (5) Licensed Vocational Nurses (LVNs) and 12 Certified Nursing Assistants (CNAs). During a concurrent observation at the facility's basement entrance door and interview on 2/19/2026 at 9:43 AM with DSD, a visitor's log was observed on top of a table right beside the door. There was no staffing information posted. DSD stated some visitors enter through the basement entrance lobby door and would access the elevator to go up to Nursing Station 2. DSD stated visitors who usually use the basement entrance have residents to visit in Nursing Station 2. DSD stated posted staffing information should be placed in the basement entrance. The DSD stated that it was important to post the staffing information that consists of the census, the total number of RNs, LVNs and CNAs working each shift. DSD added that this posting should be easily seen and read by residents, visitors, and staff. During an interview, on 2/20/2026 at 3:24 PM, with Director of Nursing (DON), the DON stated he did not know why the facility never practice posting the facility's staffing information in the basement entrance lobby door. The DON stated that they only posted the shift staffing information that consists of the census, the total number of RN, LVN and CNA's working each shift in Nursing Station 1, in the front entrance. The DON added that this posting should be easily seen and read by residents, visitors, and staff. The DON stated that it should be posted on both floors (basement and front lobby) of the building. During a review of Facility's P&P titled, Posting Direct Care Daily and Staffing , revised on 3/20/2025, the P&P indicated within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.