STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055541	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Terrace Healthcare	1340 Highland Ave. Duarte, CA 91010

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled residents' (Residents 23 and 36) Minimum Data Set (MDS, a resident assessment tool) reflected an accurate assessment, by failing to: a. Ensure Resident 23's diagnosis of depression (feeling of deep sadness that made a resident lose interest in things they once enjoyed) was coded in MDS assessment dated [DATE]. b. Ensure Resident 36's use of antipsychotic medication was coded accurately in the MDS assessment dated [DATE]. These deficient practices resulted in inaccurate reporting to the Centers of Medicare and Medicaid (CMS, a federal agency that administered the Medicare program and worked with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential to result in Residents 23 and 36 not receiving interventions to address specific care concerns.Findings: a. During a review of Resident 23's admission Record (AR), the AR indicated the facility admitted Resident 23 on 1/27/2026 with diagnoses including secondary malignant neoplasm of brain (an aggressive, cancerous tumor in the brain) and depression. During a review of Resident 23's History and Physical (H&P) dated 1/29/2026, the H&P indicated Resident 23 lacked the capacity to make and understand medical decisions. During a review of Resident 23's Physician Order (PO) dated 3/31/2026, the PO indicated Resident 23 had an active order of mirtazapine (medication to treat depression) 7.5 milligrams (mg- unit of measurement) at bedtime for depression. During a review of Resident 23's MDS dated [DATE], the MDS indicated Resident 23 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 23 required maximal assistance (helper did more than half the effort) from staff with eating, oral hygiene, toileting hygiene, showering/ bathing, personal hygiene, and mobility. During a review of Resident 23's untitled Care Plan (CP) for depression, revised on 5/20/2026, the CP goal was to minimize Resident 23's behavioral episodes. The CP indicated a nursing intervention to anticipate and meet the resident's needs. During a review of Resident 23's Medication Administration Record (MAR) for 5/2026, the MAR indicated Resident 23 received 20 out of 20 doses of mirtazapine at bedtime for depression. During a concurrent record review and interview with MDS Director (MDSD) on 5/21/2026 at 11:29 AM, Resident 23's MDS dated [DATE] was reviewed. The MDSD stated the MDS dated [DATE] did not indicate Resident 23 had a diagnosis of depression and should have been. The MDSD stated Resident 23's MDS assessment was not accurate. The MDSD stated the MDSD should modify Resident 23's MDS assessment and resubmit it to CMS. The MDSD stated it was important to submit an accurate MDS assessment to CMS so that CMS would have the correct resident information. The MDSD stated the MDSD gathered resident's information by reviewing all of resident's medical records, interviewing the residents and/or the responsible party, and attending the interdisciplinary team (IDT, a team that worked together to plan a resident's care) meeting. The MDSD stated the Director of Nursing (DON) signed the MDS assessment to verify the accuracy. b. During a review of Resident 36's AR, the AR indicated the facility admitted Resident 36 on 3/9/2026 with diagnoses including psychosis (when a resident lost touch with reality) and depression. During a review of Resident 36's PO dated 3/9/2026, the PO indicated an order for Resident 36 to receive quetiapine fumarate 25 mg one tablet by mouth at bedtime for depression. During a review of Resident 36's H&P dated 3/11/2026, the H&P indicated (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 36 lacked the capacity to make and understand medical decisions. During a review of Resident 36's MDS dated [DATE], the MDS indicated Resident 36 had severely impaired cognition. The MDS indicated Resident 36 required setup assistance from staff with eating. The MDS indicated Resident 36 required supervision from staff with oral hygiene. The MDS indicated Resident 36 required moderate assistance (helper did less than half the effort) from staff with toileting hygiene, showering/bathing, personal hygiene, and bed-to-chair transferring. During a review of Resident 36's MAR for 3/2026, the MAR indicated Resident 36 received one dose of quetiapine fumarate at bedtime on 3/10/2026. During a concurrent record review and interview on 5/21/2026 at 11:43 AM with the MDSD, Resident 36's MDS dated [DATE] was reviewed. The MDSD stated the MDS indicated Resident 36 did not receive antipsychotic medication. The MDSD stated Resident 36's MDS was not an accurate assessment because quetiapine fumarate was an antipsychotic medication. The MDSD stated the MDS assessment should indicate Resident 36 received antipsychotics on a routine basis even if Resident 36 just took one dose of quetiapine fumarate. During an interview with the DON on 5/22/2026 at 9:28 AM, the DON stated the MDS assessment should be accurate. The DON stated the DON acknowledged the MDS assessment was accurate and completed upon submission to CMS by signing the MDS assessment. The DON stated the inaccurate MDS assessment was a discrepancy, and CMS did not receive accurate resident information. During a review of the facility's Policy and Procedure (P&P) titled, Accuracy of Resident Assessment Policy, revised in 5/2025, the P&P indicated the facility should ensure that all resident assessments, including the MDS, are accurate and reflective of the resident's condition during the applicable assessment period. The P&P indicated the staff completing any portion of the MDS or Resident Assessment Instrument (RAI) must accurately document and certify the information entered. The P&P further indicated that each person completed a section of the MDS should sign or electronically certify the accuracy of the information entered.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and implement specific, comprehensive, and individualized person-centered care plans (CP) to meet the residents' needs for two of two sampled residents (Residents 2 and 36) by failing to: a. Develop an individualized CP to address the diagnosis of depression (feeling of deep sadness that made a resident lose interest in things they once enjoyed) for Resident 2. b. Develop an individualized CP to address the diagnosis of dementia (a progressive state of decline in mental abilities) for Resident 36. These failures resulted in the residents not receiving individualized care to maintain the residents' highest practicable physical, mental, and psychosocial well-being.Findings: a. During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/22/2026 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and depression. During a review of Resident 2's History and Physical (H&P) dated 1/24/2026, the H&P indicated Resident 2 had full decision-making capacity. The H&P indicated Resident 2 had depression. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 5/1/2026, the MDS indicated Resident 2 had intact cognition (ability to understand). The MDS indicated Resident 2 felt depressed at least half of the 14ˆday lookˆback period, occurring between 7 and 11 days. The MDS indicated Resident 2 required setup assistance with eating and oral hygiene. The MDS indicated Resident 2 required supervision from staff with personal hygiene. The MDS indicated Resident 2 required maximal assistance (helper did more than half the effort) from staff with toileting hygiene, showering/bathing, and bed-to-chair transferring. During a concurrent record review and interview with the MDS Director (MDSD) on 5/21/2026 at 12:13 PM, Resident 2's entire care plans were reviewed. The MDSD stated there was no CP developed to address Resident 2's diagnosis of depression. The MDSD stated that even if Resident 2 was not taking any medication for depression, the licensed nurse should still develop a specific and individualized CP to address the diagnosis of depression. The MDSD stated staff should know the goal and intervention to address Resident 2's depression. During an interview with the Director of Nursing (DON) on 5/22/2026 at 9:54 AM, the DON stated there should be a specific CP to address Resident 2's depression. b. During a review of Resident 36's AR, the AR indicated the facility admitted Resident 36 on 3/9/2026 with diagnoses including dementia and depression. During a review of Resident 36's H&P dated 3/11/2026, the H&P indicated Resident 36 lacked the capacity to make and understand medical decisions. The H&P indicated Resident 36 had dementia. During a review of Resident 36's MDS dated [DATE], the MDS indicated Resident 36 had severely impaired cognition. The MDS indicated Resident 36 required setup assistance from staff with eating. The MDS indicated Resident 36 required supervision from staff with oral hygiene. The MDS indicated Resident 36 required moderate assistance (helper did less than half the effort) from staff with toileting hygiene, showering/bathing, personal hygiene, and bed-to-chair transferring. During a concurrent record review and interview with the MDSD on 5/21/2026 at 11:43 AM, Resident 23's entire care plans were reviewed. The MDSD stated there was no CP developed to address Resident 23's diagnosis of dementia. The MDSD stated the licensed nurse should develop and initiate the CP for new diagnosis, medication, treatments, and services. The MDSD stated the licensed nurse should initiate the CP when receiving a new order, no later than the end of the shift. The MDSD stated the CP identified the residents' problems and goals and indicated the interventions for specific care concerns. The MDSD stated the CP needed to be specific, individualized, and resident-centered to address each specific diagnosis, medications, and behavior to meet their needs. The MDSD stated staff could not meet the resident's goal without a specific CP. During an interview with the DON on 5/22/2026 at 9:47 AM, the DON stated there should be a specific CP to address dementia care for Resident 23. During a review of the facility's undated Policy and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedure (P&P) titled, Care Planning, dated 5/2025, the P&P indicated the facility should develop, implement, and maintain individualized, person-centered care plans to address each resident's physical, mental, psychosocial, safety, and functional needs in accordance with assessments, physician orders, resident preferences, regulations, and professional standards of practice. The P&P indicated the CP should include: Resident strengths, needs, and risks. Measurable goals. Interventions and services. Safety and supervision needs. Resident choices and preferences. Approaches to prevent avoidable decline and ad verse outcomes.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of care for three of three sampled residents (Residents 2, 7, and 36) when:a. The facility did not document the blood sugar level on Resident 2's medical record. b. The facility did not rotate the insulin (a hormone that helped a resident's body use sugar for energy) administration site for Resident 2.c. The facility did not document the psychotropic medication monitoring every shift when Resident 36 was taking citalopram hydrobromide (medication for depression [feeling of deep sadness that made a resident lose interest in things they once enjoyed]) and quetiapine fumarate (medication for psychosis [when a resident lost touch with reality]). d. The facility did not rotate the insulin administration site for Resident 7. These failures had the potential to compromise Residents 2, 7, and 36's health and safety. Findings: a. During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/22/2026 with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and depression. During a review of Resident 2's History and Physical (H&P) dated 1/24/2026, the H&P indicated Resident 2 had full capacity on decision making. During a review of Resident 2's Physician Order (PO) dated 1/26/2026, the PO indicated Resident 2 had an active order for licensed staff to administer lantus (a longˆacting insulin that helped a resident control blood sugar) 100 unit/milliliter (ml- unit of measurement) inject 10ml subcutaneously (the fatty tissue area located just beneath the skin at bedtime. The order indicated to hold lantus when Resident 2's blood sugar level was less than 100. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 5/1/2026, the MDS indicated Resident 2 had intact cognition (ability to understand). The MDS indicated Resident 2 required setup assistance with eating and oral hygiene. The MDS indicated Resident 2 required supervision from staff with personal hygiene. The MDS indicated Resident 2 required maximal assistance (helper did more than half the effort) from staff with toilet hygiene, showering/bathing, and bed-to-chair transferring. During a review of Resident 2's Blood Sugar Summary (BSS) for 5/2026, the BSS indicated no blood sugar reading/level documented at bedtime on 5/2/2026, 5/3/2026, 5/4/2026, 5/5/2026, 5/6/2026, 5/7/2026, 5/8/2026, 5/9/2026, 5/10/2026, 5/11/2026, 5/12/2026, 5/16/2026, and 5/17/2026. During a concurrent record review and interview on 5/21/2026 at 12:13 PM with the MDS Director (MDSD), Resident 2's Medication Administration Record (MAR) for 5/2026 was reviewed. The MDSD stated there was no blood sugar reading/levels documentation for the lantus administration on Resident 2's MAR at bedtime on 5/2/2026, 5/3/2026, 5/4/2026, 5/5/2026, 5/6/2026, 5/7/2026, 5/8/2026, 5/9/2026, 5/10/2026, 5/11/2026, 5/12/2026, 5/16/2026, and 5/17/2026. The MDSD stated it was the facility's practice to check the blood sugar before administering insulin whether it was short-acting or long-acting. The MDSD stated the licensed nurse should document the blood sugar level on resident's MAR to prevent hypoglycemia (low blood sugar). During a concurrent record review and interview on 5/22/2026 at 9:54 AM with the Director of Nursing (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(DON), Resident 2's Nurses' Progress Notes (NPP) for 5/2026 were reviewed. The DON stated there were no bedtime blood sugar reading/levels documented on Resident 2's NPP for 5/4/2026, 5/5/2026, 5/10/2026, 5/11/2026, 5/16/2026, and 5/17/2026. The DON stated the NPP indicated the licensed nurse only documented Resident 2's blood sugar level at bedtime on 5/2/2026, 5/3/2026, 5/6/2026, 5/7/2026, 5/8/2026, 5/9/2026, and 5/12/2026. The DON stated it was important to check and document the blood sugar level before insulin administration. The DON stated the physician would review the documented blood sugar level to adjust the resident's insulin dosage. The DON stated the license nurse should document the blood sugar level on the resident's medical record upon the administration of insulin. The DON stated documentation was proof of action. The DON stated the resident could become hypoglycemia or hyperglycemia (high blood sugar) with uncontrolled sugar. b. During a review of Resident 2's MAR for 5/2026, the MAR indicated Resident 2 received 20 out of 20 doses of lantus at bedtime. During a concurrent record review and interview on 5/21/2026 at 12:13 PM with the MDSD, Resident 2's Administration History (AH) for lantus dated from 5/2/2026 to 5/16/2026 was reviewed. The MDSD stated the AH indicated Resident 2 received lantus in left lower abdomen for three consecutive days on 5/3/2026 to 5/5/2026 and 5/9/2026 to 5/11/2026. The MDSD stated Resident 2's AH indicated Resident 2 received lantus in left lower abdomen for two consecutive days on 5/15/2026 and 5/16/2026. The MDSD stated it was the facility's practice that the licensed nurse should rotate the insulin administration site to minimize discoloration, pain, and wound for the resident. c. During a review of Resident 36's admission Record (AR), the AR indicated the facility admitted Resident 36 on 3/9/2026 with diagnoses including psychosis and depression. During a review of Resident 36's H&P dated 3/11/2026, the H&P indicated Resident 36 lacked the capacity to make and understand medical decisions. During a review of Resident 36's MDS dated [DATE], the MDS indicated Resident 36 had severely impaired cognition. The MDS indicated Resident 36 required setup assistance with eating. The MDS indicated Resident 36 required supervision from staff with oral hygiene. The MDS indicated Resident 36 required moderate assistance (helper did less than half the effort) from staff with toilet hygiene, showering/bathing, personal hygiene, and bed-to-chair transferring. During a review of Resident 36's Physician Order (PO) dated 3/9/2026, the PO indicated for licensed staff to administer citalopram hydrobromide 10 milligrams (mg-unit of measurement) daily to Resident 36 for depression. During a review of Resident 36's PO dated 3/9/2026, the PO indicated for licensed staff to administer quetiapine fumarate at bedtime to Resident 36 for depression. During a concurrent record review and interview on 5/21/2026 at 11:43 AM with the MDSD, Resident 36's MAR for 3/2026 was reviewed. The MAR indicated Resident 36 received 22 out of 22 doses of citalopram hydrobromide daily. The MAR indicated Resident 36 received 1 out of the 2 doses of quetiapine fumarate at bedtime. The MDSD stated there were no documentation for citalopram hydrobromide and quetiapine fumarate monitoring in Resident 36's MAR for 3/2026. The MDSD stated it was the standard of practice to document on the resident's MAR every shift for psychotropic medication monitoring. The MDSD stated when the resident was on antipsychotic/ antidepressant, staff should monitor the resident's behavior every shift. The MDSD stated resident's behavior could (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be triggered anytime, and the licensed nurse should notify the doctor for any medication adjustment. The MDSD stated it was important to monitor residents on psychotropic medication to ensure medication effectiveness and behavior management. The MDSD stated the psychotropic medication monitoring was for everyone's safety including the staff, residents, and visitors. The MDSD stated staff could not identify the resident's behavior pattern without the psychotropic medication monitoring. During an interview on 5/22/2026 at 9:47 AM with the DON, the DON stated the licensed nurse should monitor the resident's behavior every shift and tally with hashmark on the resident's MAR. The DON stated the licensed nurse should start monitoring the resident's behavior upon admission and when they start taking the psychotropic medication. The DON stated the licensed nurse who received the psychotropic medication order should transcribe the order in the MAR along with the side effect monitoring of the psychotropic medication. The DON stated the licensed nurse should continue to monitor the resident's behavior and document on the MAR every shift and no later than the end of shift. The DON stated this would ensure continuity of necessary care to meet the resident's needs. During a review of the facility's Policy and Procedure (P&P) titled Insulin Administration, revised 5/2025, the P&P indicated the facility should ensure safe insulin administration in accordance with physician orders and accepted nursing practices. The P&P indicated the facility should check and document the blood sugar levels prior to insulin administration in the medical record and MAR. The P&P indicated the licensed nurse should rotate insulin injection sites according to accepted standards of practice. During a review of the facility's P&P titled Psychotropic Medication Management, revised 5/2025, the P&P indicated the facility should ensure safe use of psychotropic medications for residents in accordance with regulatory requirements and accepted standards of practice. The P&P indicated the facility should ensure residents receiving psychotropic medications are monitored for therapeutic effectiveness, behavioral response, adverse reactions or side effects, changes in cognition, mood, appetite, sleep, functional status, and signs of over-sedation or medication d. During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 on 4/23/2025 and readmitted on [DATE] with diagnoses included type 2 diabetes mellitus, chronic kidney disease (when the kidneys are damaged and cannot filter the blood properly), and hemiplegia (the loss of muscle function and/or sensation of one entire side of the body). During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 required moderate assistance for toileting hygiene, shower/bathe, and dressing. During a review of Resident 7's Order Summary Report (OSR) dated 4/29/2026, the OSR indicated for licensed staff to administer Insulin Asparte Injection Solution (a fast-acting, man-made insulin used to control blood sugar in people with diabetes mellitus) to Resident 7, to be injected subcutaneously before meals and at bedtime depending on Resident 7's blood sugar levels. The OSR indicated to rotate injection site each time an insulin injection was given. During a review Resident 7's Location of Administration Report, dated 3/2026, the Location of Administration Report indicated insulin was administered to Resident 7 at the same injection sites and not rotated on the following dates: 3/6/2026, 3/7/2026, 3/9/2026, 3/12/2026, 3/13/2026, 3/14/2026, 3/15/2026, and 3/17/2026. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review Resident 7's Location of Administration Report, dated 5/2026, the Location of Administration Report indicated insulin was administered to Resident 7 at the same injection sites and not rotated on the following dates: 5/6/2026, 5/7/2026, 5/9/2026, 5/10/2026, 5/17/2026, 5/18/2026, 5/19/2026 and 5/20/26. During a concurrent interview and record review on 5/22/2026 at 8:22 a.m. with the Director of Nursing (DON), Resident 7's Location of Administration Report for the months of 3/2026 and 5/2026 were reviewed. The DON stated it is professional nursing practice to inject insulin into subcutaneous tissue, usually in the abdomen or behind the arms. The DON stated licensed nurses should rotate sites after each injection to prevent bruising and to also prevent making the subcutaneous tissue in a particular site harden, which could delay the insulin's absorption rate in the body (an adverse effect when the body takes longer to react to the injected insulin). The DON stated licensed nurses should check the resident's medication administration record which documented the previous site that was used to inject insulin. During an interview on 5/22/2026 at 9:35 a.m. with Registered Nurse 1 (RN 1), RN 1 stated prior to administering insulin, the licensed nurse needed to check the resident's blood sugar and the doctor's order to determine if an insulin injection could be given. RN 1 stated insulin injections should be administered at the subcutaneous tissue. RN 1 stated it was nursing practice to rotate the insulin injection sites. RN 1 stated licensed nurses should not repeatedly inject insulin at the same site because the area can become irritated, painful, and/or swollen. During a review of the facility's Policy and Procedure (P&P) titled, Insulin Administration Policy, dated 5/2025, the P&P indicated the facility shall ensure insulin is administered safely, accurately, and in accordance with physician orders, infection control standards, and accepted nursing practices. The P&P further indicated that insulin injection sites shall be rotated according to accepted standards of practice.

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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 safe food storage practices in one of one facility kitchen, by failing to: a. Discard five cups of vanilla ice cream dated 5/18/2026 that had spilled over in the kitchen Refrigerator 1. b. Discard one pitcher of prune juice with a use by date of 5/14/2026 in the kitchen Refrigerator 1. These deficient practices had the potential to result in food-borne illnesses (illness caused by ingesting contaminated food or beverages) for the residents.Findings: During an observation in the facility kitchen in the presence of [NAME] 1 on 5/19/26 at 8:43 AM, there were five cups of vanilla ice cream dated 5/18/26 that had spilled over in the kitchen Refrigerator 1. [NAME] 1 stated there was no expiration date on any of the cups and since they had spilled over and were overflowing, these items should have been removed from the refrigerator and thrown out. During a concurrent observation and interview with [NAME] 1 on 5/19/26 at 8:53 AM, there was one pitcher of brown liquid with a use by date of 5/14/26 in Refrigerator 1. [NAME] 1 stated the brown liquid inside the pitcher was prune juice and it should not be stored inside the refrigerator because it was expired. During an interview with the Dietary Supervisor (DS) on 5/20/26 at 1:50 PM, the DS stated there should not be any expired food items inside the kitchen refrigerators because it could make the residents sick. The DS stated all kitchen staff were responsible to check there were no expired items in the kitchen and refrigerators. The DS stated that if there was an expired item inside the kitchen's refrigerator, it should be removed and thrown away. During an interview with the Director of Nursing (DON) on 5/22/2026 at 9:29 AM, the DON stated there should not be any expired food inside the kitchen's refrigerator. The DON stated the DS was responsible for ensuring there was no expired food inside the kitchen refrigerator. The DON stated if there was any expired food inside the kitchen refrigerator, the food item should be thrown out in the trash. The DON stated expired food could make the residents sick. During a review of the facility's Policy and Procedure (P&P) titled Kitchen Refrigerator and Freezer Policy, revised May 2025, the P&P indicated, The facility shall maintain kitchen refrigerators and freezers in a safe, clean, and sanitary condition to ensure proper food storage and prevent foodborne illness.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to ensure safe handling and storage of food brought into the facility in one of one resident's refrigerator, by failing to: a. Discard one container of peanut butter and chocolate chip frozen dessert and one container of strawberry ice cream with no name or expiration date. b. Discard one cup of vanilla ice cream with no name or expiration date that was sealed with a plastic wrap. These deficient practices had the potential to result in food-borne illnesses (illness caused by ingesting contaminated food or beverages) for the residents.Findings: During an observation and interview on 5/19/26 at 9:04 AM with the facility's [NAME] 1 (Cook 1) inside the employee's lounge where the resident's refrigerator was located, Cook1 stated the resident's refrigerator should not have items that were not labeled with a name and expiration date. One container of peanut butter and chocolate chip frozen dessert and a strawberry ice cream with no name or expiration date was observed inside the resident's refrigerator. [NAME] 1 stated nursing staff were responsible for checking and cleaning out the resident's refrigerator. During an interview with the Dietary Supervisor (DS) on 5/20/26 at 1:50 PM, the DS stated the resident's refrigerator was located inside the staff's break room. The DS stated nursing staff collect food brought in by family for the residents and place it inside the resident's refrigerator. The DS stated there was no resident food brought in by the family that was kept in the kitchen area. The DS stated food brought in by family should be labeled including the resident's name, room number and expiration date or date the food was placed inside the resident's refrigerator. The DS stated expired or non-labeled foods in the resident's refrigerator should be discarded. During an interview with License Vocational Nurse 3 (LVN 3) on 5/20/2026 at 2:11 PM, LVN 3 stated outside food or food that the resident ordered via delivery should be placed inside the resident's refrigerator located inside the employee's break room. LVN 3 stated when LVN 3 received outside food for the residents, LVN 3 would label the food item with the resident's name, room number and date of when the food item was placed inside the resident's refrigerator. LVN 3 stated the food item inside the resident's refrigerator should have the expiration date. LVN 3 stated if a resident ate expired food, it would make them sick. LVN 3 stated the Infection Control Nurse (IPN) was responsible in checking the food items inside the resident's refrigerator. During an interview with the Director of Nursing (DON) on 5/22/2026 at 9:30 AM, the DON stated the resident's family could bring food from home for the resident. The DON stated resident's food could be stored inside the resident's refrigerator. The DON stated the food items inside the resident's refrigerator should be labeled with the resident's room and day when the food was placed inside the refrigerator. The DON stated the food could only stay inside the resident's refrigerator for a certain amount of time. The DON stated the staff (nurses and CNA's) were responsible for checking the resident's refrigerator for any expired food. The DON stated if there were food items inside the resident's refrigerator that were not labeled with a date of when it was received or at least an expiration date, then the item should be removed from the resident's refrigerator and discarded. The DON stated the housekeeping staff were responsible for ensuring the resident's refrigerator was kept clean. During a review of the facility's Policy and Procedures (P&P) titled, Food Received From Outside Sources Policy, revised May 2025, the P&P indicated, the facility shall promote safe handling, storage and consumption of food brought into the facility by resident's families, visitors or outside sources to reduce the risk of foodborne illness and maintain resident safety. 3. Food items stored in the facility shall be labeled with: a. Residents' name b. Date received c. Food item description4. Expired, spoiled, unlabeled, or unsafe food items shall be discarded.

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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. Based on observation, interview, and record review, the facility failed to implement infection control practices in accordance with its policy and procedure, when: a. Two of two unlabeled wash basins were stacked on top of each other and placed on the floor underneath the sink located in the shared bathroom between Rooms A and B. b. The resident's urinal (container used for urination) was placed on the nightstand for one of one sampled resident (Resident 58). These deficient practices had the potential to spread infection in the facility. Findings: a. During an observation on 5/19/2026 at 10:36 AM inside the shared bathroom between Rooms A and B, two empty wash basins were stacked on top of each other and placed on the floor underneath the bathroom sink. The two wash basins were both unlabeled. The shared bathroom has two doors, with one door leading to Room A and another door leading to Room B. During a concurrent observation and interview on 5/19/2026 at 10:38 AM with Certified Nursing Assistant 2 (CNA 2) inside the shared bathroom between Rooms A and B, CNA 2 stated the two wash basins should each be labeled with a resident's name and be placed at the resident's bedside. CNA 2 stated the two wash basins should not be on the floor of the shared bathroom for Rooms A and B because it could be contaminated with germs and spread infection. CNA 2 stated CNA 2 does not know who placed the two wash basins on the bathroom floor under the sink. During an interview on 5/22/2026 at 8:22 AM with the Director of Nursing (DON), the DON stated the facility had bathrooms that were shared between two resident rooms. The DON stated it was possible that numerous residents will use the same bathroom, depending on various factors such as how many residents were assigned to a room and whether the residents were continent (ability to control the release of urine and stool). The DON stated personal items that the facility provided the resident, such as bed pans and wash basins were specifically given to one resident and should not be shared in order to prevent the transmission (spread) of infection. The DON stated personal items such as wash basins should be labeled with a resident's name or initials and resident's room number. The DON stated wash basins should be kept at the resident's bedside area and should not be left in a shared bathroom, which could lead to the spread of infection. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Policy, revised 5/2025, the P&P indicated The facility is committed to maintaining an effective Infection Prevention and Control Program to help prevent, identify, investigate, and control infections and communicable diseases in accordance with CMS regulations, CDC guidelines, and applicable state requirements. The P&P further indicated the facility shall implement infection prevention and control practices to reduce the risk of transmission of infections among residents, staff, visitors, and vendors. b. During a review of Resident 58's admission Record (AR), the AR indicated the facility admitted Resident 58 on 5/10/26 with diagnoses including encephalopathy (a brain dysfunction caused by infection and/or brain injury), respiratory failure (lungs could not supply oxygen to the blood) and urinary tract infection (infection in the urine). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 58's History and Physical (H&P) dated 5/11/26, the H&P indicated Resident 58 was alert but intermittently confused. During a review of Resident 58's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 5/17/26, the MDS indicated Resident 58 had moderately impaired cognition (ability to understand) and was dependent (helper does all of the effort) for toileting hygiene, shower, lower body dressing, putting on and taking off footwear and personal hygiene. During an observation and interview inside Resident 58's room on 5/19/26 at 11:02 AM, Resident 58 was sitting in a wheelchair watching TV. A urinal was observed next to Resident 58, hanging from Resident 58's nightstand drawer that was opened. There was Resident 58's food items inside the drawer. Resident 58 stated Resident 58 used the urinal and then placed it back on the drawer because Resident 58 did not have a urinal holder. Resident 58 stated Resident 58 had not been offered one. Resident 58 stated Resident 58 had no other place to put the urinal. During an observation inside Resident 58's room on 5/20/26 at 10:23 AM, Resident 58's side table had a urinal containing yellow liquid inside. Some of the yellow liquid was dripping on the outside of the urinal landing on Resident 58's side table. During an observation and interview with License Vocational Nurse 3 (LVN3) on 5/20/26 at 2:08 PM, LVN 3 stated Resident 58's urinal should not be placed on top of Resident 58's side table or hanging from the nightstand drawer. LVN 3 stated the urinal should not be hanging from the drawer because it's not sanitary. LVN 3 stated having a urinal filled with urine on top of the resident's side table was an infection control issue. LVN 3 stated having a urinal filled with urine on top of the resident's side table or nightstand drawer could cause bacteria to spread to Resident 58's food or drink. During an interview with the Infection Prevention Nurse (IPN) on 5/21/26 at 2:30 PM, the IPN stated a urinal placed on top of a resident's side table was an infection control issue because it was not sanitary and could potentially contaminate the resident's food. The IPN stated the urinal should be kept inside the blue urinal holder that should be hanging from the side of the bed of the resident. The IPN stated if staff noticed there was no urinal holder, they should request it from central supply. The IPN stated having a urinal filled with urine on Resident 58's side table posed a risk of spillage and contaminating areas on Resident 58's table. During an interview with the Director of Nursing on 5/22/2026 at 9:34 AM, the DON stated the resident's urinal should not be placed on the nightstand. The DON stated the urinal should be kept inside the urinal holder that should be attached to the side of the resident's bed. The DON stated it was not sanitary to keep the urinal on the nightstand. The DON stated it was an infection control issue for the residents. The DON stated the urinal should be labeled with the resident's room number and removed if soiled. The DON stated the urinal should be emptied as soon as the resident was done urinating and should not be kept with urine inside for long periods of time since it could tip over and the urine could spill. The DON stated the Certified Nursing Assistants (in general) and licensed nurses were responsible for emptying the urinal and to ensure the urinal was placed in an area that the resident would not be at risk of spilling the urine. During a review of the facility's P&P titled, Urinal Labeling and Storage, revised May 2025, the P&P indicated, urinals shall not be stored on floors, bedside meal trays, windowsills, or other inappropriate surfaces.

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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, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced dignity and respect for one of one sampled resident (Resident 4) when Licensed Vocational Nurse 3 (LVN 3) failed to feed Resident 4 at eye-level on 5/19/2026 during Resident 4's lunch meal. This deficient practice resulted in the violation of Resident 4's right to a dignified existence and had the potential to affect Resident 4's feelings of self-worth and self-respect Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 3/14/2026 and re admitted on [DATE] with diagnoses including protein-calorie malnutrition (when a resident does not eat enough protein and calories to meet nutritional needs), dysphagia (difficulty swallowing), and generalized muscle weakness (loss of overall physical strength). During a review of Resident 4's doctor's progress note (DPN) dated 3/16/2026, the DPN indicated Resident 4 had full decision-making capacity. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 3/21/2026, the MDS indicated Resident 4 had moderately impaired cognition (ability to understand) and was dependent for eating, toileting hygiene, and upper/lower body dressing. During an observation on 5/19/2026 at 12:50 PM inside Resident 4's room, Resident 4 was awake and sitting in bed with a tray table placed across Resident 4's chest. LVN 3 was standing by the left side of Resident 4 and feeding Resident 4 with a spoon. There was no chair observed near Resident 4's bedside. During an interview on 5/19/2026 at 12:54 PM with LVN 3 outside of Resident 4's room, LVN 3 stated LVN 3 fed Resident 4 while LVN 3 was standing up because Resident 4 needed just standby assist (a level of care where a caregiver remains within arm's reach of a resident to ensure their safety, step in, or prevent injury while the resident performs the task). LVN 3 stated LVN 3 was supposed to sit in a chair when feeding the resident at eye-level. LVN 3 stated the purpose of using a chair and feeding at eye-level was for the residents to be fed properly and to make the residents feel comfortable. During an interview on 5/22/2026 at 8:22 AM with the Director of Nursing (DON), the DON stated nursing staff needed to sit next to residents when feeding them to respect the residents' dignity. The DON stated nursing staff should show respect to the residents, which included feeding them at eye-level. The DON stated that when a staff member fed a resident while standing above or over the resident, the resident would feel intimidated (scared, nervous, uncomfortable) or felt disrespected by staff. During a review of the facility's Policy and Procedure (P&P) titled, Dignity Policy, dated 5/2025, the P&P indicated, The facility is committed to ensuring that all residents are treated with dignity, respect, compassion, and individuality at all times. The P&P indicated residents shall be treated in a manner that promotes self-worth, independence, privacy, and quality of life. The P&P further indicated all staff are responsible for promoting and protecting resident dignity at all times.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 60) who was admitted in the facility with pressure induced deep tissue damage (damaged skin caused by staying in one position for too long) received care and services to promote wound healing by failing to accurately monitor and assess the correct settings of the low air loss mattress (LALM - tiny laser made air holes in the mattress top surface continually blow out air causing the patient to float, designed to prevent and treat pressure sores, or pressure ulcers) according to Resident 60's weight. This deficient practice placed Resident 60 at risk of poor wound healing and deterioration of current pressure induced deep tissue damage. Findings: During a review of Resident 60's admission Record (AR), the AR indicated the facility admitted Resident 60 on [DATE] with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), pressure induced deep tissue damage of the sacral region (base of the spine, just above the buttocks) and contracture (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the forearm. During a review of Resident 60's Weights and Vital Summary (WVS) dated [DATE], the WVS indicated Resident 60's weight was 118 lbs. (pounds-a unit of measurement). During a review or Resident 60's Order Summary Report (OSR) dated [DATE], the OSR indicated LALM to bed, set according to resident weight, check mattress every shift for proper setting and function and may adjust to resident comfort level every shift for wound management. During a review of Resident 60's untitled Care Plan Report (CPR) initiated on [DATE], the CPR indicated Resident 60 had potential/actual impairment to skin integrity and the interventions included LAL mattress as ordered. During an observation inside Resident 60's room on [DATE] at 10:21 AM, Resident 60 was resting in bed with LALM. Resident 60's LALM was set to approximately 160-170 lbs. normal pressure. During a concurrent observation inside Resident 60's room on [DATE] at 12:31 PM, Resident 60's LALM settings had been changed to approximately 100 lbs. During a review of Resident 60's History and Physical (H&P) dated [DATE], the H&P indicated Resident 60 lacked full medical decision-making capacity due to cognitive impairment (unable to make decisions). During an interview with License Vocational Nurse 3 (LVN 3) on [DATE] at 1:58 PM, LVN 3 stated the LALM settings were done by the treatment nurse, and it should be set to the resident's current weight. LVN 3 stated the LALM should be set according to the resident's weight and physician's (MD) order. LVN 3 stated that if the LALM was not set according to the resident's weight, the pressure could increase the risk of skin breakdown potentially causing more harm to the resident. During an interview with Treatment Nurse 1 (TN1) on [DATE] at 11:19 AM, TN1 stated the LALM settings were set according to the resident's weight. TN1 stated if the LALM was too firm it would defeat the purpose of offloading on the resident's skin. TN1 stated that if the LALM was too soft, the weight would touch the bottom of the bed and could cause an ulcer to the area. TN1 stated TN1 was responsible in setting the LALM and during rounds to ensure the LALM settings were according to the resident's weight. TN1 stated it was not acceptable to have inaccurate setting on a LALM that was supposed to provide comfort and support to the resident's pressure areas. During an interview with the facility's Director of Nursing (DON) on [DATE] at 9:38 AM, the DON stated the LALM should be set to the resident's weight. The DON stated staff needed to follow the doctors' orders. The DON stated the purpose of the LALM was to prevent any type of skin issues such as pressure ulcers in bed bound residents or those at high risk for skin breakdown. The DON stated the licensed nurses and the treatment nurse were responsible for ensuring the correct LALM settings were in place. During a review of the facility's Policy and Procedure (P&P) titled Low Air Loss Mattress revised [DATE], the P&P indicated, The facility shall provide and monitor low air loss mattresses for residents who require pressure redistribution and skin protection to help prevent or manage pressure injuries in accordance with (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders and resident care needs. Settings are appropriate for the resident's weight and condition.