STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055570	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Elizabeth Healthcare Center	2800 N. Harbor Blvd. Fullerton, CA 92835

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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 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, facility document review, and facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed. * The RD's facial hair was not covered while inside the kitchen. * The kitchen utensils and equipment were not stored or kept in sanitary conditions. * The meat thawing process was not followed. These failures posed the risk for food borne illnesses in a highly susceptible residents population of 84 facility residents who received food prepared in the kitchen.Findings: Review of the facility matrix showed 84 of 88 residents who resided in the facility consumed food prepared in the kitchen. 1. Review of the facility's P&P titled Dress Code dated 2023 showed beards and mustaches (any facial hair) must wear a beard restraint. On 3/18/26 at 1100 hours, an observation and concurrent interview was conducted in the kitchen with the CDM Dietary Resource. The Registered Dietitian (RD) was observed in the kitchen without a beard restraint to cover his facial hair. The CDM Dietary Resource confirmed the RD was not wearing a beard restraint and stated it was the expectation all facial hair must be covered, while in the kitchen, with a beard restraint. 2. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas. On 3/17/26 at 0800 hours, during the initial tour of the kitchen, the following items were observed:- four of four heavily marred cutting boards On 3/18/26 at 1100 hours, during a tour of the kitchen and concurrent interview with the CDM Dietary Resource, four metal pans were observed stacked wet with dripping water. The CDM Dietary Resource confirmed the findings. On 3/18/2026 at 1455 hours an interview was conducted with Dietary Services Supervisor (DSS). The DSS confirmed that the the cutting boards had deep cuts and should have a smooth surface. 3. According to the USDA Food Code 2022, Section 3-501.13, showed freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/ or produce toxins. Review of the facility's P&P titled Thawing of Meats dated 2023 (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed thawing meat properly can be done.refrigerator at 41 degrees or cooler. Allow two to three days to defrost, depending on quality and total weight of meat. Label defrosting with a pull and use by date. On 3/17/26 at 0800 hours, during initial tour of kitchen, an observation of the reach-in refrigerator and concurrent interview was conducted with the Cook. The following items were observed:- Three 16 oz. sleeves of ground turkey in a hotel pan covered in plastic wrap dated of 3/9- One 10 lbs. box of diced beef dated of 3/13/26- One 10 lbs. box of ground beef with delivery date of 3/8 and received date of 3/6 The [NAME] verified the items identified were past their three days defrost and cook date. The items were disposed of in the trash. On 3/18/2026 at 1455 hours an interview was conducted with the DSS. The DSS stated the food from the freezer in the process of thawing should be labeled with the use by date and the freezer pull date and should be used within three days. The DSS verified the above findings.

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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, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infection. * The facility failed to ensure the transmission based precautions (additional infect control measures used in healthcare settings for the residents with known or suspected infections which can spread beyond standard precautions (minimum infection prevention practices that apply to all resident care, regardless of a resident's suspected or confirmed infection status)) were followed for Resident 63 when CNA 1 failed to sanitize the face shield after she removed the face shield, and before she hung on the hook placed outside the resident's room door in the hallway after she provided care to the resident. Additionally, the trash can inside the resident's room was overflowing with used PPE (Personal Protective Equipment-gloves, gown, mask, eye protection). * The facility failed to ensure a protective face mask was disposed of accordingly and was not left on Resident 35's night's stand with the respiratory equipment. * The facility failed to ensure the infection control practices were implemented when the clean linen storage protective curtain was left open. * The facility failed to ensure there was isolation cart with PPE at the doorway and failed to follow the facility's practice for signage showing EBP (Enhanced Barrier Precaution-infection control strategy for nursing homes requiring staff to wear gowns and gloves during high contact care for residents with, or at high risk of multi drug resistant organisms) for Resident 65. These failures posed the risk of not preventing the spread of infections in the facility and posed the risk of unsanitary environment.Findings: 1. Review of the facility's P&P titled IPCP (Infection Prevention and Control Plan) Standard and Transmission-Based Precautions (TBP) revised 10/2022 showed in part, Contact Precautions (Transmission-Based Precautions are used with a known infection that is spread by direct or indirect contact with the resident or the resident's environment. Patient-care equipment: It is preferred dedicated or disposable patient-care equipment be used. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient. Room and surface cleaning and disinfection. Rooms of patients on contact precautions are frequently cleaned and disinfected (e.g., at least daily or prior to use by another patient if outpatient setting) focusing on frequently touched surfaces and equipment in the immediate vicinity of the patient. Gloves and gown (don before room entry, doff before room exit; change before caring for another resident). Face protection may also be needed if performing activity with risk of splash or spray. Droplet Precautions (TBP) are used for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking (e.g. influenza). Use personal protective equipment (PPE) appropriately. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. Medical record review for Resident 63 was initiated on 3/17/26. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report dated 3/18/26, showed a physician's order dated 3/12/26, for transmission based precaution: droplet and contact every shift. Review of Resident 63's Plan of Care showed a focus problem for resident had an infection initiated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 3/11/26. In the intervention section, it showed to follow the facility's policy and procedures, transmission based precautions, respiratory, droplet and contact precautions. On 3/17/26 at 0928 hours, an observation of CNA 1 was conducted. CNA 1 was observed removing PPE by Resident 63's room. CNA 1 was observed to have removed the face shield and hung on the hook by the resident's door in the hallway. CNA 1 was not observed to have disinfected the face shield prior to placing it the hook. On 3/17/26 at 1000 hours, an interview and concurrent observation of Resident 63's room was conducted with CNA 1. The trash can in the resident's room was observed overflowing with soiled PPE. CNA 1 stated she will empty the trash and get a soiled PPE trash bin with a cover for the resident's room. CNA 1 verified Resident 63 was on TBP. CNA 1 stated she provided care to the resident prior removing the face shield earlier. CNA 1 verified she failed to disinfect the face shield prior to hanging the face shield on the hook because there was no disinfectant by the isolation cart. CNA 1 stated she should have disinfected the face shield. On 3/18/26 at 1632 hours, an interview was conducted with the DSD/IP. The DSD/IP stated the resident's room with TBP was supposed to have a trash bin with a cover for the staff to put used or soiled PPEs. It should be empty and not allowed to be overflowing. The DSD/IP further stated the expectation for the CNA was to disinfect the face shield after use and prior to hanging on the hook for infection control. On 3/19/26 at 1512 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings. 2. Review of the facility's P&P titled IPCP (Infection Prevention and Control Plan) Standard and Transmission-Based Precautions (TBP) revised 10/2022 showed in part, in the Enhanced Barrier Protection (EBP) section showed expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of Multi-drug Resistant Organisms (MDRO) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident for which the use of EBP applies are based on local epidemiology. Residents are not restricted to their rooms or limited from participation in group activities while on EBP. Although a private room is not required for residents on EBP, the following may be implemented: i. At least 3 feet of separation between beds; ii. Use of privacy curtains; iii. Frequent cleaning/disinfection of shared equipment and environmental surfaces; and iv. Changing PPE and performing hand hygiene between residents. Medical record review for Resident 35 was initiated on 3/17/25. Resident 35 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 35's H&P examination dated 1/28/26, showed the resident had no capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 35's Order Summary Report dated 3/18/26, showed: - an order dated 11/12/25, for Enhanced Barrier Precaution due to known and risk of multi drug-resistant organisms (MDRO) following any high contact resident care activities, dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of central line, urinary catheter, feeding tube and wound care any chronic skin opening, requiring a dressing around the resident every shift related to presence of Gastrostomy tube every shift. - an order dated 11/12/25, for may have suction at bedside for oral care. - an order dated 2/4/26, for may suction as needed for increased secretion. - an order dated 1/27/26, to administer albuterol sulfate (a short acting bronchodilator medication, relaxes airway muscles to quickly treat spasm in the bronchus, wheezing and chest tightness) inhalation nebulization solution 2.5 mg/3 ml 0.083% to inhale orally via nebulizer every four hours as needed for shortness of breath. - an order dated 2/5/26, to administer albuterol sulfate inhalation nebulization solution 2.5 mg/3 ml 0.083% to inhale orally via nebulizer every six hours for shortness of breath. On 3/17/26 at 0920 hours, during the initial tour of the facility, an observation of Resident 35 in the resident's room was conducted. Resident 35 was lying in bed. Resident 35's nightstand was observed with a suction machine, a nebulizer machine, a nebulizer medication receptacle or container on a tissue paper and a protective face mask closed to the nebulizer medication receptable in between the suction machine and the nebulizer machine. On 3/17/26 at 0926 hours, an interview and concurrent observation of Resident 35 was conducted with LVN 2. LVN 2 verified Resident 35's nightstand had an exposed, open protective face mask was placed close to the nebulizer medication receptable in between the suction machine and the nebulizer machine. LVN 2 stated the face mask should have been disposed appropriately. LVN 2 further stated he will dispose the face mask and change the nebulizer medication container. On 3/19/26 at 1513 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Review of the facility's P&P titled Clean Linen revised 5/2007 showed in part, it is the policy of this facility to use the following guidelines with clean linen. Daily excess linen shall be stored on shelves and covered. On 3/18/26 at 0950 hours, the clean linen closet was observed with the curtain left open. On 3/18/26 at 1006 hours, a concurrent observation of the clean linen closet and an interview was conducted with the DON. The DON verified the clean linen curtain to cover the linen shelves was open. The DON stated the curtain should be closed to prevent the contamination of the clean linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/26 at 0820 hours, the clean linen closet was observed with curtain left open. On 3/19/26 at 0825 hours, a concurrent observation of the clean linen closet and an interview was conducted with the DSD/IP. The DSD/IP verified the clean linen curtain to cover the linen shelves was open. The DSD/IP stated there were a lot of people getting linen at the time and they must have forgotten; however, had given an in-service yesterday to make sure to close the linen closet curtain. The DSD/IP stated the facility will try to find another system to address the linen closet curtain to remain closed. 4. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precaution, Infection Control revised 10/2022 showed in part, it is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions in Long Term Care. It is appropriate to individualize decisions regarding resident placement, balancing infection risk with the need for more than one occupant in the room, the presence of risk factors that increase the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized resident. Under Enhanced Barrier Protection (EBP)- expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs (Multi Drug Resistant Organism- bacteria that becomes resistant to multiple antibiotics making infections difficult to treat) to staff hands and clothing then indirectly transferred to resident or from resident to resident, residents with wounds and indwelling medical devices are at high risk acquisition of and colonization with MDRO. On 3/17/26 at 0939 hours, an observation was conducted in Resident 65's room. Resident 65 was lying in bed, with an indwelling catheter connected to the urinary drainage bag. Resident 65's wife and daughter were inside the room and not wearing any PPEs while wiping Resident 65's face with a face cloth. There was no EBP signage and isolation cart in front of Resident 65's door. Medical record review for Resident 65 was initiated on 3/17/26. Resident 65 was admitted to the facility on [DATE]. Review of Resident 65's Order Summary Report showed an active physician's order dated 3/15/26, for Enhanced Barrier Precaution due to known risk of MDRO: following any high contact resident care activities, dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: Central line, urinary catheter, feeding tube and wound care: any chronic skin opening Requiring a dressing around the resident's room and Therapy Gym. Every shift related to presence of indwelling catheter every shift. On 3/17/26 at 1010 hours, an interview and concurrent observation of Resident 65's room was conducted with LVN 3. LVN 3 verified there was no EBP signage and isolation cart in front of Resident 65's door. On 3/17/26 at 1542 hours, an interview was conducted with the DON. The DON verified the findings and stated there should be a red dot opposite to the resident's name which meant EBP, and the staff should have placed an isolation cart with PPEs, and the EBP signage with the description of PPEs along the resident's headboard. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/26 at 0915 hours, an interview was conducted with the DSD/IP . The DSD/IP verified the findings and stated, We missed it, one of our lapses that we have to correct.

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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, medical record review, and facility P&P review, the facility failed to promote the dignity and respect for two of 19 final sampled residents (Residents 14 and 65) for indwelling urinary catheter (a flexible tube inserted through the urethra (transports urine from the bladder to the outside of the body) or abdominal wall into the bladder to continuously drain urine) use. * Residents 14 and 65's indwelling urinary catheter drainage bags were exposed and not placed inside dignity bags. These failures had the potential to affect the privacy and dignity of the residents. Findings: Review of facility's P&P titled Dignity and Privacy dated 11/2021 showed it is the policy of this facility that all residents be treated with kindness, dignity and respect. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from by passers. 1. On 3/17/26 at 0840 hours, during the initial tour of the facility, an observation of Resident 14 in the resident's room was conducted. Resident 14 was observed lying on his bed with indwelling urinary catheter drainage bag placed in a basin with resident's urine visible to others. Medical record review for Resident 14 was initiated on 3/17/26. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's H&P examination dated 3/10/26, showed the resident had cognitive communication deficit. Review of Resident 14's Order Summary Report dated 3/16/26, showed a physician's order dated 3/17/26, for indwelling catheter size French 16/10 ml attached to bedside. On 3/17/26 at 0843 hours, an observation of Resident 14 in the resident's room and a concurrent interview was conducted with the DON. The DON verified the resident's urine was visible from the urinary drainage bag. The DON stated the resident's urinary drainage bag should have been enclosed in a urinary dignity bag for Resident 14's privacy. On 3/19/26 at 1520 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above. 2. On 3/17/26 at 0939 hours, Resident 65 was observed in bed with the urinary catheter drainage bag on the left side of the bed, uncovered, containing 100 ml of yellowish urine. Medical record review for Resident 65 was initiated on 3/17/26. Resident 65 was admitted to the facility on [DATE], with a diagnosis of urinary retention (inability to completely or partially empty the bladder). Review of Resident 65's Order Summary Report showed a physician's order dated 3/15/26, for indwelling catheter size French 16/10 ml attached to bedside for diagnosis of urinary retention. On 3/17/26 at 1006 hours, an interview was conducted with LVN 3. LVN 3 stated Resident 65 had urinary catheter drainage bag and verified Resident 65 had no privacy bag. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/26 at 1535 hours, an interview with DON was conducted. The DON stated the facility provided privacy bags to all the residents with an indwelling urinary catheter. The DON verified the findings.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to determine if bilateral bolster pillows functioned as a physical restraint, for one of two residents reviewed for restraints (Resident 12). * Resident 12 sustained a fall from bed, and the facility implemented bilateral bed bolster (a long, narrow, and firm cushion designed to provide enhanced support, improve spinal alignment, and reduce muscle strain) pillows. Resident 12 stated the bolster pillows prevented him from repositioning himself in bed and they restricted his movement. Resident 12 stated he could not sleep well at night due to the bolster pillows restricting his movement. Resident 12 stated he could not remove the bolster pillows. This failure posed the risk for further loss of sleep (associated physical and psychosocial results from a loss of sleep), loss of autonomy, and restriction of freedom of Resident 12's movement. Findings: Review of the facility's P&P titled Restraints (undated) showed it is the policy of the facility that residents have the right to be free from physical restraints imposed for purposes of convenience, and not required to treat a resident's medical symptoms. A physical restraint is defined as equipment adjacent to the resident's body that the resident cannot remove easily, which restricts freedom of movement or normal access to the resident's body. A physician's order is necessary for the use of a physical restraint. The use of physical restraint must first be explained to the resident. Potential negative outcomes of restraints include a loss of autonomy, dignity, and self-respect. Medical record review for Resident 12 was initiated on 3/17/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's Care Plan Report showed a care plan focus initiated 3/5/25, titled ADL (Activities of Daily Living) Self Care Performance Deficit related to limited mobility, musculoskeletal impairment, fatigue, impaired balance, and acute stroke with history of right sided weakness. Review of Resident 12's Care Plan Report showed a care plan focus revised 2/3/26, titled At Risk for Falls related to recent closed fracture of the right femur and generalized weakness. The care plan interventions included recommend use of the bolster pillows to define (bed) perimeter and to maintain spatial awareness. Review of Resident 12's Order Summary Report showed a physician's order dated 3/1/26, for bilateral bolster pillows to define (bed) perimeter. On 3/17/26 at 0900 hours, an observation and concurrent interview was conducted with Resident 12. Resident 12 was observed lying in his bed with bilateral bolster pillows attached to his bed. Resident 12 stated he recently fell out of bed and onto the floor. Resident 12 stated the facility then implemented the bolster pillows. Resident 12 stated he hated the bolster pillows because they prevented him from repositioning himself in bed and they restricted his movement. Resident 12 stated he could not sleep well at night due to the bolster pillows restricting his movement. Resident 12 stated he could not remove the bolster pillows. On 3/19/26 at 1051 hours, an observation and concurrent interview for Resident 12 was conducted with RN 1. Resident 12 was observed lying in his bed with bilateral bolster pillows attached to his bed. Resident 12 conveyed his feelings regarding the bolster pillows to RN 1. Resident 12 stated the bolster pillows prevented him from repositioning himself in bed, and as a result he could not sleep well. Resident 12 stated he could not remove the bolster pillows from his bed. RN 1 was asked to describe the facility's process specific to the use of physical restraints. RN 1 stated before the use of a physical restraints, a restraint assessment must be performed. RN 1 stated a physical restraint assessment would include determining if the equipment (including bolster pillows) placed adjacent to a resident's body could be removed easily by the resident, and if the equipment restricted the resident's freedom of movement. RN 1 stated if the equipment could not be easily removed by a resident and restricted the resident's freedom of movement, the equipment could be considered as a physical restraint. RN 1 stated a physician's order was required for the use of physical restraints. RN 1 reviewed Resident 12's medical record and verified a physical restraint assessment was not conducted to determine if the bilateral bolster (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pillows were a physical restraint. RN 1 verified there was no physician's order for the use of a physical restraint for Resident 12.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the PASRR (Preadmission Screening and Resident Review) Level 1 screening (identifies if a resident has a suspected mental illness or intellectual/developmental disability or related condition) contained accurate information for two of three residents (Residents 7 and 56) reviewed for PASRR. * Resident 7 had a diagnosis of depression and PTSD (Post Traumatic Stress Disorder); however, the PASRR Level 1 screening showed Resident 7 had no diagnosed mental illness. * Resident 56 had a diagnosis of mood disorder and PTSD; however, the PASRR Level 1 screening showed Resident 56 had no diagnosed mental illness. These failures posed the risk for inappropriate placement in a long-term care nursing home, if a PASRR Level 2 (determines if a resident can benefit from specialized mental health services) mental health evaluation was necessary, and the facility subsequently could not provide the residents with the necessary mental health services.Findings: 1. Medical record review for Resident 7 was initiated on 3/17/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Psychological Consult and Progress Note dated 1/20/26, showed Resident 7 had a diagnosis of PTSD and depression. Review of Resident 7's Care Plan Report showed a care plan focus problem revised 1/7/26, titled At Moderate Risk for Depression and Re-traumatization related to PTSD. Review of Resident 7's PASRR Level 1 screening dated 2/11/26, showed Resident 7 had no diagnosis of mental illness. The PASRR Level 1 screening was negative, and a PASRR Level 2 mental health evaluation was not required, for reasons which included Resident 7 did not have a mental illness. On 3/18/26 at 1157 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DSD. The DSD verified Resident 7 had a diagnosis of PTSD and depression; however, the PASRR Level 1 screening showed Resident 7 did not have a diagnosed mental illness. The DSD verified the information contained on Resident 7's PASRR Level 1 screening was inaccurate which could potentially prevent Resident 7 from receiving a PASRR Level 2 mental health evaluation. 2. Medical record review for Resident 56 was initiated on 3/17/26. Resident 56 was admitted to the facility on [DATE]. Review of Resident 56's Psychiatric Progress Notes dated 12/5/25, showed Resident 56 had a diagnosis of mood disorder. Review of Resident 56's Care Plan Report showed a care plan focus problem initiated 6/5/25, titled At Risk for Re-traumatization related to a history of PTSD. Review of Resident 56's Care Plan Report showed a care plan focus problem revised 3/18/26, titled Potential for Mood Problem, with a diagnosis of mood disorder related to a history of trauma. Review of Resident 56's PASRR Level 1 screening dated 6/4/25, showed Resident 56 had no diagnosis of mental illness. The PASRR Level 1 screening was negative, and a PASRR Level 2 mental health evaluation was not required, for reasons which included Resident 56 did not have a mental illness. On 3/18/26 at 1159 hours, an interview and concurrent medical record review for Resident 56 was conducted with the DSD. The DSD verified Resident 56 had a diagnosis of mood disorder and PTSD; however, the PASRR Level 1 screening showed Resident 56 did not have a diagnosed mental illness. The DSD verified the information contained on Resident 56's PASRR Level 1 screening was inaccurate which could potentially prevent Resident 56 from receiving a PASRR level 2 mental health evaluation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P, the facility failed to ensure the Plan of Care was revised for one of 19 final sampled residents (Resident 14). * The facility failed to ensure Resident 14's Plan of Care was revised to address the physician's order dated 3/16/26, to change the resident's enteral (a method of delivering nutrients directly into the stomach or small intestine when a person cannot eat or swallow safely) feeding rate and enteral water flush. This failure posed the risk for Resident 14 to not receive the person-centered care and services required to attain or maintain her highest level of physical and mental well-being.Findings: Review of the facility's P&P titled Enteral Feeding revised 10/2007 showed it is the policy of this facility to provide enteral feeding according to the physician's orders. Medical record review for Resident 14 was initiated on 3/17/26. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's H&P examination dated 3/10/26, showed the resident had cognitive communication deficit. Review of Resident 14's Order Summary Report dated 3/16/26, showed the following physician's orders: - to administer Jevity (calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long or short-term tube feeding) 1.5 via Gastrostomy tube (GT, a small tube placed through the abdominal wall into the stomach, used to provide feeding formula and/or administer medications) per pump kit to infuse at 60 ml/ hour over 20 hours or until volume limit is completed. Restart at 1400 hours. - to flush GT tubing with 20-30 ml of water before and after medications- to flush GT tubing with 30 ml of water every four hours Review of Resident 14's Plan of Care showed a care plan problem initiated 3/3/26, addressing the nutritional problem or potential nutritional problem. The care plan showed to administer enteral regimen order for Jevity1.5 at 70 ml for twenty hours and flush with water 175 ml every four hours. On 3/19/26 at 1201 hours, an interview and concurrent medical record review for Resident 14 was conducted with RN 1. RN 1 verified Resident 14's Plan of Care showed a care plan problem initiated 3/3/26, addressing the nutritional problem or potential nutritional problem, and the interventions showed to administer enteral regimen order for Jevity1.5 at 70 ml for twenty hours and flush with water 175 ml every four hours. RN 1 stated the care plan should have been updated when the changed of order for enteral feeding was prescribed by the physician on 3/16/26. On 3/19/26 at 1455 hours, an interview was conducted with the DON. The DON stated the licensed nurse should have updated Resident 14's Plan of Care upon receiving the physician's order to change the resident's enteral feeding and water flushes. Cross reference F693.

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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, medical record review, document review, and facility P&P review, the facility failed to ensure the necessary care and services were provided for one of 19 final sampled residents reviewed with low air loss mattress. * The low air loss mattress setting was not consistent with Resident 11's weight and was on static mode setting. This failure had the potential for the resident to not benefit from the therapy provided from using the low air loss mattress.Findings: Review of the facility's P&P titled Guidelines to Prevent and Manage Pressure Injury: Repositioning and Early Mobilization revised 12/2023 showed to reposition all the individuals at risk of, or with existing pressure ulcers, unless contraindicated. Consider the condition of the individual and the pressure redistribution support surface in use when deciding if repositioning should be implemented as a prevention strategy. Consider the pressure redistribution support surface in use when determining the frequency of repositioning. Review of the facility's P&P titled Skin and Wound Monitoring and Management revised 4/2025 showed in order to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: use pressure relieving or reducing and redistributing devices including but not limited to low air loss mattresses, wedges, pillows, etc. Licensed nurse to adjust the settings of LAL (Low Air Loss) mattress based on resident's weight and/ or comfort and follow manufacturer's guidelines. Review of the Med-Aire 8 Alternating Pressure Mattress Replacement System with Low Air Loss Operator's Manual (undated) showed it has been specifically designed for prevention of bedsores and offers an affordable solution to 24-hour pressure area care. In static mode, the mattress provides a firm surface that makes it easier for the patient to transfer or reposition. The static mode prevents the patient from bottoming out when in a sitting position. On 3/17/26 at 0859 hours, during the initial tour of the facility, Resident 11 was observed positioned on her back and lying on a LAL mattress on static mode with the normal pressure level set between 80 to 160-pound weight. On 3/18/26 at 1004 hours, Resident 11 was observed positioned on her back and lying on a LAL mattress on static mode with the normal pressure level set between 80 to 160 pounds weight. Medical record review for Resident 11 was initiated on 3/17/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 6/19/25, showed Resident 11 had no capacity to understand and make decisions. Review of the Significant Change in Status MDS dated [DATE], showed Resident 11 had memory problems and had severely impaired cognitive skills for daily decision making. Further review of the MDS showed Resident 11 was dependent on staff for the activities of daily living. Review of Resident 11's Order Summary Report for 3/2026 showed a physician's order dated 11/20/25, for LAL mattress related to wound care management. Review of Resident 11's Weights and Vitals Summary showed on 3/17/26, Resident 11 had a weight of 93 pounds. On 3/18/26 at 1053 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 11 used the LAL mattress and setting was checked by the licensed nurses during their rounds. On 3/19/26 at 1041 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 was informed of the above findings. LVN 5 acknowledged the findings and stated the LAL mattress was monitored by the licensed nurses daily and setting was based on the resident's weight and comfort, the static mode was essentially used for bed mobility and transfers, and the incorrect setting could cause potential risk for further skin issues. On 3/19/26 at 1453 hours, an interview and concurrent medical record review was conducted with the DSD/IP. The DSD/IP was informed of the above findings. The DSD/IP acknowledged the findings and stated the purpose of the LAL mattress was to relieve pressure. In addition, the DSD/ IP stated the LAL mattress was used for the residents with Stage 3 and above pressure injury; the licensed nurses were responsible in checking the setting daily; the setting was based on the resident's weight and comfort; incorrect setting defeated the purpose of the use of the LAL mattress. On 3/19/26 at 1649 hours, the DON was informed and verified the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate treatment and services for one of 19 final sampled residents (Resident 14) reviewed with enteral (a method of delivering nutrients directly into the stomach or small intestine when a person cannot eat or swallow safely) feeding orders. * The facility failed to ensure Resident 14's enteral feeding was labeled with the resident's name, date, time, and initials by the nurse per facility policy. This failure posed the risk for Resident 14 to potentially affect the resident's clinical condition. Findings: Review of the facility's P&P titled Enteral Feeding revised on October 2007 showed it is the policy of this facility to provide enteral feeding according to the physician orders. The procedures section showed document initials, date and time the formula was hung or administered, and initial that the label was checked against the order in the formula label. On 3/17/26 at 0842 hours, during the initial tour of the facility, an observation of Resident 14 in the resident's room was conducted. Resident 14 was observed lying on his bed with Jevity (a fiber-fortified, high-protein tube-feeding formula and oral supplement designed for short or long-term therapeutic nutrition) 1.5 infusing at 60 ml/hour via enteral pump. The Jevity 1.5 formula container label was observed with no resident's name, infusion rate, date, time and nurse's initial documented. The container had little less than 400 ml of formula left. Medical record review for Resident 14 was initiated on 3/17/26. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's H&P examination dated 3/10/26, showed the resident had cognitive communication deficit. Review of Resident 14's Order Summary Report dated 3/16/26, showed the following physician's orders: - to administer Jevity 1.5 via Gastrostomy tube (GT, a small tube placed through the abdominal wall into the stomach, used to provide feeding formula and/ or administer medications) per pump kit to infuse at 60 milliliter/ hour over 20 hours or until volume limit is completed. Restart at 1400 hours. - to flush GT tubing with 20-30 ml of water before and after medications.- to flush GT tubing with 30 ml of water every four hours. On 3/17/26 at 0845 hours, an observation of Resident 14 in the resident's room and a concurrent interview was conducted with the DON. The DON verified Resident 14's GT feeding formula was not labeled as above. The DON stated the resident's feeding formula should have been labeled by the licensed nurse when it was hung according to the facility policy. The DON further stated she will get another formula to hang and make sure she will label the container. On 3/19/26 at 1455 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV (intravenous-through the vein) therapy for one of 19 final sampled resident (Resident 63) reviewed with hydration orders. * Resident 63 was not provided with the sodium chloride (a sterile solution used to replenish body water and electrolytes, treat low salt, and provide a vehicle for other medication infusions) 0.9% IV solution 1000 ml as ordered by the physician. This failure posed the risk of Resident 63 not to receive the required treatment in accordance with the resident's plan of care and the physician's order which may potentially affect the resident's clinical condition. Findings: Review of the facility's P&P titled Administration of Intravenous Therapy revised May 2021 showed it is the policy of this facility to provide intravenous fluids and medications according tophysician orders. The procedures section showed:1. Follow the rights to medication administration.2. Confirm intravenous access for location/site, patency and signs and symptoms of infiltration like pain, redness, swelling.3. Prepare the intravenous medications or intravenous fluids according to pharmacy instructions. Verify intravenous medication bag or intravenous fluid label against the physician orders and IV MAR (Medication Administration Record).4. Change and label intravenous tubing according to policy and procedures.5. Flush intravenous line according to physician orders; and6. Document intravenous administration in the resident's medication administration record. Medical record review for Resident 63 was initiated on 3/17/26. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report dated 3/18/26, showed:- an order dated 3/15/26 a administer one liter of Sodium Chloride Solution 0.9 % to infuse 60 ml/hr intravenously for IV hydration and nutrition secondary to constipation for one day. - an order dated 3/15/26, discontinue IV when completed.- monitor intake every shift include oral fluid intake, enteral feeding and flush, IV fluids and IV antibiotics every shift for 30 days. Further review of Resident 63's Order Summary Report failed to show any physician's order to discontinue sodium chloride solution 0.9 % to infuse 60 ml/hr intravenously prior to completion of the IV therapy. Review of Resident 63's MAR dated 3/1 - 3/21/26, showed the resident's intake showed:- on 3/15/26, PM (1500-2300 hours) shift 240 ml- on 3/16/26, NOC shift 200 ml- on 3/16/26, AM shift 600 ml- on 3/16/26, PM shift 500 ml Review of Resident 63's IV MAR dated 3/1 - 3/31/26, showed one liter of sodium chloride solution 0.9 % to infuse 60 ml/hour intravenously for IV hydration and nutrition secondary to constipation for one day was not initialed on 3/15/26 on PM (1500-2300 hours) shift. Further review of Resident 63's IV MAR dated 3/1 - 3/31/26, showed sodium chloride solution 0.9 % to infuse 60 ml/hr intravenously was marked checked and initialed by the NOC (2300 - 0700 hours) shift, and day (0700-1500 hours) shift on 3/16/26. Review of Resident 63's Task: Fluid Intake showed:- on 3/15/26, 2129 hours, 120 ml- on 3/16/26, 0607 hours, 120 ml- on 3/16/26, 0724 hours, 520 ml - on 3/16/26, 2221 hours, 480 ml Review of Resident 63's Plan of Care initiated on 3/15/26, showed a focused care plan problem to address the resident's IV fluids related to constipation. The interventions included to administer treatment as ordered/tolerated, observe, document, and report to the physician as needed for signs of infiltration at the site. Review of Resident 63's Progress Notes failed to any documentation regarding discontinuing the IV fluids. On 3/17/26 at 0928 hours, during the initial tour of the facility, an observation of Resident 63 in the resident's room and a concurrent interview with Resident 63 was conducted. Resident 63 was observed lying on his bed. A sodium chloride 0.9% IV solution which appeared to be full was observed hung in a pole beside the resident. The sodium chloride 0.9% solution IV bag was observed labeled with Resident 63's name, room number, sodium chloride 0.9% 1 liter, dated 3/15 at 2200 hours with RN initials was hooked up to an IV tubing with no label and was not hooked to the resident for administration. Additionally, there was no cap to protect the IV tubing port. Resident stated he thought he was given the IV solution the other night because he was constipated. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 63 further stated he did not realize the IV fluid bag was still hung at his bedside. On 3/17/26 at 1007 hours, an observation of Resident 63 in the resident's room and a concurrent interview was conducted with the DON. The DON stated she was the RN responsible to take care of the IV therapy for today. The DON verified the findings for the sodium chloride 0.9% IV solution and IV tubing as above. The DON stated the IV tubing should be covered with protective cap for the control of infection. The DON further stated she will find out why the IV solution dated 3/15/26, two nights ago was still full. On 3/18/26 at 1147 hours, an interview and concurrent record review for Resident 63 was conducted with RN 1. RN 1 verified Resident 63's IV MAR failed to show a nurse's initial to indicate the IV therapy was initiated on 3/15/26 at 2200 hours. RN 1 stated the IV MAR should have been initialed when the sodium chloride 0.9% was hung. RN 1 verified the intake and output as above. RN 1 stated the intake should reflect in resident's MAR which accounted for the total of the oral intake consumed by the resident as reported by the CNA, and in addition the fluids given by the licensed nurse orally upon administration of medication and the IV fluids consumed during the shift. On 3/18/26 at 1431 hours, an interview and concurrent record review for Resident 63 was conducted with the DON. The DON verified Resident 63's IV MAR failed to show a nurse's initial to indicate the IV therapy was initiated on 3/15/26 at 2200 hours, and the resident's intake record as above. The DON stated she was not sure what happened why the bag of sodium chloride 0.9% was still in the resident's room on 3/17/26, and appeared to be not infused to the resident. The DON stated her expectation for the licensed nurses was to follow the physician's order. Resident 63 should have received the sodium chloride 0.9% as ordered. The DON further stated the licensed nurses were expected to document the resident's intake accurately including all fluid intake. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services to two of 19 final sampled residents (Residents 34 and 65) reviewed with oxygen orders. * The facility failed to administer the oxygen as ordered by the physician to Resident 34. Resident 34 had an order for continuous oxygen at 2 LPM (liters per minute); however, it was not administered as ordered. * The facility failed to ensure Resident 65's oxygen tubing was dated. These failures posed the risk of developing complications as result of inadequate oxygen therapy, and had the potential to negatively impact the residents' medical condition.Findings: 1. Review of the facility's P&P titled Oxygen Therapy revised 2/2012 showed in part, it is the policy of this facility to administer oxygen in a safe manner. The resident's preliminary and comprehensive assessment should address that oxygen is needed and how often oxygen is to be administered. Medical record review for Resident 34 was initiated on 3/17/26. Resident 34 was admitted to the facility on [DATE]. Review of Resident 34's H&P examination dated 10/29/25, showed Resident 34 had a history of COPD (Chronic Obstructive Pulmonary Disease- a progressive treatable lung disease that makes breathing difficult). Review of Resident 34's Order Summary Report showed a physician's order dated 10/30/25, to administer oxygen at 2 LPM via NC (nasal canula- a lightweight, flexible tube with two prongs inserted into the nostrils used to deliver oxygen to residents with breathing difficulties) continuously every shift for respiratory failure related to COPD. Review of Resident 34's Plan of Care showed a care plan problem dated 10/28/25, for the resident has COPD. The interventions included to give oxygen therapy as ordered by the physician. On 3/17/26 at 1230 hours, an observation and concurrent interview for Resident 34 was conducted with LVN 4. Resident 34 was observed in the dining room, in his wheelchair, already eating lunch. Resident 34 was observed without oxygen. LVN 4 verified Resident 34 did not have an oxygen from the time Resident 34 went inside the dining room. On 3/17/26 at 1255 hours, while still in the dining room, Resident 34 was observed to have oxygen per nasal canula using portable oxygen tank set at 2 LPM. LVN 4 stated the DON administered the oxygen in the dining room. On 3/17 26 at 1305 hours, an interview was conducted with the DON. The DON verified Resident 34 had no oxygen when he came to the dining room, and the DON verified she administered the oxygen. 2. On 3/17/26 at 0942 hours, an observation and concurrent interview for Resident 65 was conducted with LVN 3. Resident 65 was observed in bed with the oxygen tubing connected to the oxygen concentrator (a medical device that filters nitrogen from the air to deliver concentrated medical grade oxygen to users with breathing conditions) at 2 LPM per nasal cannula. Resident 65's connector and all oxygen tubing were not dated. LVN 3 verified the above findings and stated the tubing should have been dated. Medical record review for Resident 65 was initiated on 3/17/26. Resident 65 was admitted to the facility on [DATE]. Review of Resident 65's Order Summary Report showed a physician's order dated 3/15/26, for oxygen at 2 LPM via NC continuously every shift. On 3/17/26 at 1547 hours, an interview was conducted with the DON. The DON verified the findings and stated the staff were supposed to date the oxygen tubing using the yellow stickers.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility P&P review, facility document review, and the California Code of Regulations review, the facility failed to ensure a staff member was onsite during the night shift who could provide the respiratory care and services to the residents, in accordance with the residents' plan of care. * For the night shift, the facility failed to ensure a staff member was on site at the facility who could provide the respiratory care and services to the residents with oxygen titration (the process of adjusting a resident's supplemental oxygen flow rate to main the target oxygen saturation levels) orders. This failure had the potential to result in negative health outcomes to the residents. Findings: Review of the California Code of Regulations, Title 16, section 1399.365, showed the respiratory care services LVNs may perform in the long-term care setting. Respiratory services LVNs may not perform included the initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration. Review of the 2026 Facility Assessment revised 1/27/26, showed the following resident respiratory conditions can be cared for by the facility: Acute and chronic respiratory failure, pulmonary edema, COPD, dyspnea, postsurgical aftercare, hypoxemia, sleep apnea, obstructive sleep apnea, asthma, cystic fibrosis and dependence on or supplemental oxygen therapy. The Facility Assessment showed the average number of residents who received respiratory system care and services over a six-month period: January 2025, 32 residents, February 2025, 21 residents, March 2025, 16 residents, April 2025, 11 residents, May 2025, 12 residents, and June 2025, five residents. The Facility Assessment documented the facility's staffing plan. The staffing plan would be used to create the baseline staffing plan that will address resident needs, expected outcomes, quality measures, and acuity at any given time in the facility. Based on the facility's resident population and their care needs, the facility has made a good faith effort and approach to ensure sufficient and qualified staff met the needs of the residents at any given time. The facility staffing plan showed the number of RNs assigned to each shift. Day shift two RNs, evening shift one RN, and night shift no RNs. Review of the facility's P&P titled Respiratory Nurse Training revised 12/2025 showed it is the policy of the facility to provide a pathway for training of a respiratory nurse, who once qualified, can deliver skilled nursing services within the State Practice Guidelines for respiratory assessment, respiratory data collection, interventions, resident education, and documentation of the care and treatment provided. Review of the facility's P&P titled Oxygen Therapy revised 2/2012 showed it is the policy of the facility to administer oxygen in a safe manner. The resident's preliminary and comprehensive assessment should address: That oxygen therapy is needed, how often oxygen is to be administered, and any restrictions as to when oxygen should not be administered. The resident's plan of care should be addressed: That oxygen is to be administered, when and how often oxygen is to be administered, who is responsible for administering oxygen, and the type of oxygen device to use (i.e., mask, nasal). A list of residents with active physician's orders for oxygen therapy was requested from the facility. Review of the Order Listing Report dated 3/19/26, showed 13 residents had active physician's orders for supplemental oxygen continuously and/or as needed. Residents 38 and 35 were included on the list and had orders for supplemental oxygen which required titration as needed. 1. Medical record review for Resident 38 was initiated on 3/17/26. Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's active physician's orders showed an order dated 2/6/26, to monitor the oxygen saturation every shift. Additionally, Resident 38 had a physician's order dated 2/6/26, for oxygen via nasal cannula at a rate of 2 liters per minute, if Resident 38's oxygen saturation was less than 90%. Review of Resident 38's H&P examination dated 2/7/26, showed Resident 38 was admitted to the facility for several conditions which included pneumonia and bilateral pleural effusion (an abnormal build up of fluid in the space between the lungs and chest cavity, often causing shortness of (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breath, chest pain, and coughing) , status post thoracentesis (a procedure that removes excess fluid from the pleural space between the lungs and chest wall to relieve shortness of breath and diagnose the cause of the fluid buildup). Further review of Resident 38's H&P examination showed the resident had the capacity to understand and make decisions. Review of Resident 38's Care Plan Report showed a care plan focus revised 3/9/26, titled At Risk for Respiratory Complications related to recent pneumonia, respiratory failure, and pleural effusion. The care plan interventions included monitoring Resident 38's oxygen saturation and administering oxygen via nasal cannula at a rate of 2 liters per minute, if Resident 38's oxygen saturation was less than 90%. Review of Resident 38's Oxygen Saturation Summary showed Resident 38 intermittently received supplemental oxygen therapy. An example being on 3/16/26 at 0253 hours, Resident 38's oxygen saturation was measured at 97% while receiving supplemental oxygen therapy via nasal cannula. On 3/16/26 at 0400 hours, Resident 38's oxygen saturation was measured at 94% on room air (no supplemental oxygen provided). On 3/16/26 at 1049 hours, Resident 38's oxygen saturation was measured at 95%, while receiving supplemental oxygen therapy via nasal cannula. On 3/18/26 at 1516 hours, an observation and concurrent interview was conducted with Resident 38. Resident 38 was observed lying in his bed. Resident 38 was not observed receiving supplemental oxygen therapy. Resident 38 stated he was recently readmitted to the facility after receiving treatment for pneumonia in the acute care hospital. Resident 38 stated the nurses monitored his oxygen saturation every shift and if his oxygen saturation was low (less than 90%) the nurses would then apply his continuous oxygen via nasal cannula (at a rate of 2 liters per minute). Resident 38 stated he had received supplemental oxygen on all shifts when needed. 2. Medical record review for Resident 35 was initiated on 3/17/26. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 1/28/26, showed Resident 35 had no capacity to understand and make decisions. Further review of Resident 35's H&P examination showed he had a diagnosis of aspiration pneumonitis (an acute lung injury caused by inhaling gastric contents (vomit), resulting in chemical burns to the airways) and a history of COPD. Review of Resident 35's Care Plan Report showed a care plan focus titled COPD revised 3/18/26. The care plan interventions included monitoring Resident 35's oxygen saturation and administering oxygen via nasal cannula at a rate of 2 liters per minute, if Resident 35's oxygen saturation was less than 90%. Additional interventions showed to use an oxygen mask as needed, at a rate of 5 liters per minute when Resident 35 was asleep. Review of Resident 35's active physician's orders showed an order dated 2/4/26, to monitor the oxygen saturation every shift. Additionally, Resident 35 had an order dated 2/6/26, for oxygen via nasal cannula at a rate of 2 liters per minute if the oxygen saturation was less than 90%. The order showed may use an oxygen mask at a rate of 5 liters per minute as needed, when Resident 35 was asleep. Review of Resident 35's Oxygen Saturation Summary showed Resident 35 intermittently received supplemental oxygen therapy. Examples included 1/29/26 at 0637 hours, Resident 35's oxygen saturation was measured at 98%, while receiving oxygen via mask at a rate of 3 liters per minute. On 2/6/26 at 0639 hours, Resident 35's oxygen saturation was measured at 93%, while receiving oxygen via mask at a rate of 2 liters per minute. On 2/24/26 at 2000 hours, Resident 35's oxygen saturation was measured at 97%, while receiving oxygen via nasal cannula. On 3/18/26 at 1537 hours, an interview and concurrent record review was conducted with the DON. The DON verified the 2026 Facility Assessment showed the facility could provide respiratory services to the residents, in accordance with the physicians' orders and the residents' plan of care. The DON then verified the 2026 Facility Assessment was accurate specific to RN staffing on the night shift. The DON stated for the last year the facility did not have a RN assigned to work the night shift at the facility. The DON stated LVNs were assigned to work the night shift. The DON was asked what respiratory services the LVNs could provide to the residents on the night shift. The DON stated the LVNs could provide basic respiratory tasks and services and administer oxygen in emergent situations. The DON stated the LVN basic respiratory tasks and services did not include the adjustment or titration of oxygen liter flow or oxygen concentration, in (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-emergent situations. The DON verified on the night shift, the facility did not have a nurse on site who could provide respiratory services to the residents with oxygen titration orders. The DON stated from this point forward, the facility would ensure a nurse was assigned to the night shift, who could provide respiratory services to the residents who required adjustment or titration of oxygen therapy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services for one of 19 final sampled residents who was receiving dialysis care. * The facility failed to administer Resident 3's medications per the physician's orders when Resident 3 had scheduled dialysis appointments. The medication were as follows: ascorbic acid (dietary supplement), cholecalciferol (a fat-soluble vitamin used to treat or prevent Vitamin D deficiency and support bone health, immune function, and calcium absorption), cyanocobalamin (a synthetic form of vitamin B12 used to support red blood cell production, proper metabolism, and nerve function), furosemide (medication to treat fluid retention), and zinc sulfate (dietary supplement used to treat zinc deficiency). This failure had the potential to negatively impact the resident's health outcomes.Findings: Review of the facility's P&P titled Medication Administration revised 8/2021 showed medications shall be administered as prescribed by the attending physician. When a medication is withheld, refused, or given other than the scheduled time it should be appropriately documented on the Medication Administration Record (MAR). Medical record review for Resident 3 was initiated on 3/18/26. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 3 had diagnoses which included End Stage Renal Disease (irreversible kidney failure) and had dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys failed). Review of Resident 3's H&P examination dated 11/19/25, showed Resident 3 had a limited capacity to make decisions. Review of Resident 3's Order Summary Report showed the following physician's orders:- dated 11/18/25, a dialysis schedule at a dialysis center for Tuesdays, Thursdays, and Saturdays; - dated 11/25/25, to administer ascorbic acid 250 mg two tablets by mouth once a day for skin integrity;- dated 11/25/25, to administer zinc sulfate 220 mg one tablet by mouth once a day for zinc deficiency and skin integrity; - dated 1/2/26, to administer cholecalciferol 125 mcg one tablet by mouth once a day for supplement; - dated 1/2/26, to administer cyanocobalamin 500 mcg one tablet by mouth once a day for supplement; and- dated 1/2/26, to administer furosemide 40 mg one tablet by mouth once a day for bilateral upper extremity edema (fluid retention). Review of Resident 3's MAR for March 2026 showed the following medications were not administered to Resident 3 and were coded the number 8, indicating Resident 3 was absent from the facility:- on 3/3, 3/5, 3/10, 3/12, 3/14, 3/17 and 3/19/26 at 0900 hours, ascorbic acid, cholecalciferol, cyanocobalamin, furosemide, and zinc sulfate were not administered to Resident 3. Further review of Resident 3's medical failed to show documentation the medications were administered at a different time. On 3/19/26 at 1159 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Resident 3 should have been administered the medications when he returned to the facility from the dialysis center. On 3/19/26 at 1514 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON verified the above findings. The DON stated Resident 3's medication administration times should have been adjusted according to his dialysis schedule. The DON further stated Resident 3's medications should be administered before or after his scheduled dialysis appointments.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure appropriate pain medication was provided for one of five final sampled residents (Resident 63) reviewed for unnecessary medications. * Resident 63 was administered with hydrocodone-acetaminophen {combination medication used to treat severe pain by combining an opioid (hydrocodone) with a non-opioid pain reliever (acetaminophen)} as ordered for severe pain when the resident complained of moderate pain. This failure may have contributed to Resident 63's constipation and potentially affect the resident's clinical condition. Findings: Review of the facility's P&P titled Pain Recognition and Management revised 4/2025 showed it is the policy of this facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the residents' goals and preferences. Review of the facility's P&P titled Physician Orders revised 1/2016 showed it is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses. Medical record review for Resident 63 was initiated on 3/17/26. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report dated 3/18/26, showed: - an order dated 3/11/26, to administer hydrocodone-acetaminophen 5-325 mg one tablet by mouth every four hours as needed for severe pain.- an order dated 3/11/26, to monitor pain level using the following scale: scale 0 means no pain, scale 1-3 means mild, scale 4-6 means moderate, scale 7-10 means severe every shift.- an order dated 3/11/26, to administer acetaminophen (a pain relieving medication) 325 mg tablet, give two tablets by mouth every four hours as needed for pain Review of Resident 63's MAR dated 3/1 - 3/31/26, showed hydrocodone-acetaminophen 5-325 mg one tablet by mouth every four hours as needed for severe pain was administered on 3/13/26 at 2146 hours, when the resident complained of pain level of 6 (moderate). Review of Resident 63's Plan of Care showed:- a focus problem initiated on 3/11/26, for at risk of pain or discomfort with interventions written to administer analgesia medication as per orders and to follow pain scale to medicate as ordered.- a focus problem initiated on 3/15/26, for potential for fluid deficit related to constipation. On 3/17/26 at 0937 hours, an interview was conducted with Resident 63 in his room. Resident 63 stated he got constipated and it was very uncomfortable feeling for him. Resident 63 stated he was given hydrocodone pills for management of his pain and would not really wanted to take it because it made him constipated. On 3/18/26 at 1142 hours, an interview and a concurrent record review for Resident 63 was conducted with RN 1. RN 1 verified hydrocodone-acetaminophen 5-325 mg one tablet by mouth every four hours as needed for severe pain was administered on 3/13/26 at 2146 hours, when the resident complained of pain level of 6. RN 1 stated the hydrocodone-acetaminophen 5-325 mg one tablet should not have been given to the resident because the resident complained of moderate pain. RN 1 further stated the resident should have been given acetaminophen or the physician could have been called for the proper medication prescription. On 3/18/26 at 1442 hours, an interview was conducted with the DON. The DON stated her expectation was for the licensed nurse to assess the resident's level of pain, medicate the resident according to the pain scale, and to follow the orders as prescribed by the physician. On 3/19/26 at 1505 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage of the medications. * The facility failed to ensure the expired supplies were removed from Treatment Cart A and from the central supply room. * The facility failed to ensure the hydrophilic (water-miscible, topically applied formulations designed to absorb moisture (exudate) while maintaining a moist environment for skin healing) cream and zinc oxide (a topical skin protectant used primarily to treat and prevent diaper rash, minor burns, cuts, and skin irritations by creating a protective, moisture-resistant barrier) cream were not left unattended by the licensed nurse on top of Resident 14's nightstand. These failures had the potential to negatively impact the residents' well-being and posed the risk for the occurrence of errors in the administration of skin treatments.Findings: Review of the facility's P&P titled Medication Access and Storage revised 2/2019 showed contaminated or those in containers that are cracked, soiled, or without secure closures are immediately removed from stock and disposed of. 1a. On [DATE] at 1134 hours, an inspection of Treatment Cart A and concurrent interview was conducted with LVN 5. During the inspection of Treatment Cart A, the following was observed: - one opened bottle of Stomahesive protective powder, with an expiration date of [DATE] LVN 5 verified the above findings and removed the bottle of Stomahesive protective powder from Treatment Cart A. On [DATE] at 1511 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. b. On [DATE] at 1217 hours, an inspection of the Central Supply room and concurrent interview was conducted with LVN 5. During the inspection of the Central Supply room, the following was observed: - one opened bottle of Skin-Prep protective spray, with an expiration date of [DATE] LVN 5 verified the above findings and removed the bottle of Skin-Prep protective spray from the Central Supply room. On [DATE] at 1511 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above finding. 2. Review of the facility's P&P titled Medication Access and Storage revised 2/2019 showed the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, medication and treatment carts, and medication supplies are locked or attended by persons with authorized access. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Physician Orders revised 1/2016 showed it is the policy of this facility that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs. No drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses. Medical record review for Resident 14 was initiated on [DATE]. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's H&P examination dated [DATE], showed the resident had cognitive communication deficit. Review of Resident 14's Order Summary Report dated [DATE], failed to show a physicians order for the hydrophilic cream and zinc oxide cream. On [DATE] at 0840 hours, during the initial tour of the facility, an observation was conducted with Resident 14. Resident 14 was observed lying in bed in her room. A plastic bag containing hydrophilic cream and zinc oxide cream was observed on top of the resident's nightstand. On [DATE] at 0850 hours, an interview and concurrent observation of Resident 14 in the resident's room was conducted with LVN 1. LVN 1 verified the plastic bag containing hydrophilic cream and zinc oxide cream was on top of the resident's nightstand. LVN 1 stated it was the policy of the facility to have a physician's order for any skin treatment and an order for may leave medications at bedside as needed by the resident. LVN 1 stated he will check if there was any physician's order for the resident and will remove the creams from the resident's nightstand for safety. On [DATE] at 1205 hours, an interview and concurrent medical record review for Resident 14 was conducted with RN 1. RN 1 verified Resident 14 medical record failed to show physician's orders for the use of hydrophilic cream and zinc oxide cream. RN 1 stated the hydrophilic cream and zinc oxide cream should not have been left at resident's nightstand for safety. On [DATE] at 1444 hours, an interview was conducted with the DON. The DON stated Resident 14 probably have came with the hydrophilic cream and zinc oxide cream from the acute care hospital and the creams should not have been left at the resident's nightstand for safety reasons. The DON was informed and acknowledged the above findings.

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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, medical record review, and facility P&P review, the facility failed to ensure the medical record was accurately maintained for two of 19 final sampled residents (Residents 12 and 21). * The facility failed to ensure Resident 12's H&P examination was uploaded accordingly into the resident's electronic health record. Resident 12's H&P examination was uploaded in Resident 2's electronic health record. * The facility failed to ensure Resident 21's Restraint/Enabling Device/Safety Device Evaluation was accurately completed. These failures had the potential for the residents' care needs not being met as the medical records were inaccurate.Findings: 1.a. Medical record review for Resident 2 was initiated on 3/17/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. b. Medical record review for Resident 12 was initiated on 3/18/25. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. On 3/18/26 at 1103 hours, while the medical record review for Resident 2 was being conducted, Resident 12's H&P examination record was included in Resident 2's electronic medical record. On 3/18/26 at 1455 hours, a medical record review of Resident 2 and a concurrent interview was conducted with the MRD. The MRD verified Resident 12's H&P examination was uploaded in Resident 2's electronic health record. The MRD stated Resident 12's H&P examination should not be in Resident 2's electronic health record. The MRD further stated she will remove Resident 12's H&P examination record from Resident 2's electronic health record. 2. Review of the facility's P&P titled Documentation revised 5/2007 showed the resident's clinical record is a concise and accurate account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. It is also necessary to include data needed for identification and communication with family and friends. Complete history of the resident and present illness is required under current law and regulations at the time of admission. Medical record review for Resident 21 was initiated on 3/17/26. Resident 21 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 21's Restraint/ Enabling Device/ Safety Device Evaluation dated 2/2/26, showed under the device recommended, may install bilateral grab bar as an enabler for bed mobility, turning, repositioning and transfers. LAL mattress for comfort. Review of Resident 21's Order Summary Report for 3/2026 did not show a physician's order for LAL mattress. On 3/19/26 at 1259 hours, an interview and concurrent medical record review for Resident 21 was conducted with RN 1. RN 1 verified the findings and stated there was no physician's order for a LAL (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mattress for Resident 21. On 3/19/26 at 1426 hours, an interview and concurrent medical record review for Resident 21 was conducted with the DSD/IP. The DSD/IP was informed of the above findings. The DSD/IP acknowledged the findings and stated there was no order for a LAL mattress, and the previous order was discontinued on 11/18/24, and should not be included in the assessment. On 3/19/26 at 1649 hours, the DON was informed and verified the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the essential equipment in a safe operating conditions. * The facility failed to ensure the ice machine was cleaned and sanitized as per the manufacturer's instructions. * The facility failed to ensure the glucometers (a device which measures the amount of sugar in the blood) in Medication Carts A and Cart B were calibrated and quality control was performed for two days in October 2025. These failures had the potential for the residents to receive ice from the kitchen not clean for consumption; and had the potential for the residents requiring blood glucose checks to have inaccurate readings.Findings: 1. Review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2023 showed the internal components cleaned monthly or per manufacturer's recommendations.information about the operation, cleaning and care of the ice machine can be obtained from the owner's manual. Review of the facility's document titled Ice Machine Cleaning and Sanitizing Log dated 2025 showed the ice machine was cleaned once a month. Review of the ice machine's manufacturer guidelines titled Service Manual (undated) showed the interior of the ice storage bin is in contact with food products, ICE, and should be cleaned and sanitized regularly. Once a week, sanitize it with a commercial food grade sanitizer in compliance with the manufacturer's instructions. On 3/17/26 at 0519 hours, an interview was conducted in the kitchen with the Director of Maintenance and RD Dietary Resource. The Director of Maintenance was asked how the ice machine was cleaned. The Director of Maintenance stated the ice machine was turned off, emptied of all ice, and the bin was cleaned with soap and water, then the machine was turned on. Once the ice filled up in the bin, the ice in the bin was emptied and cleaned with Sani Tech. This cleaning procedure was completed two times per quarter by Director of Maintenance. The third month, the ice machine was cleaned by a service company. The RD Dietary Resource verified according to the Director of Maintenance and the Ice Machine Cleaning and Sanitizing Log, the ice machine bin was cleaned once a month. The RD Dietary Resource also verified the Service Manual showed the ice machine bin was to be cleaned weekly. 2. Review of the facility's P&P titled Glucometer Calibration revised 1/2018 showed it is the policy of the facility to ensure that glucometers are calibrated correctly. Licensed nurses will calibrate glucometer daily. Test results for calibration will be recorded on the appropriate form that is kept in the glucometer logbook. Check the meter serial number. Check the meter chem strip lot number, test expiration date and log in the form. Review of the facility document titled Blood Glucose Monitoring Quality Control Log dated 10/2025 for Medication Cart A and Cart B showed no documented evidence the glucometers were calibrated and had quality control check on 10/19 and 10/20/25. Furthermore, the above normal control and high control results were not observed on the glucometers with the serial number of 1040-4347198 and 1040-4469963. On 3/18/26 at 1219 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 stated the licensed nurses on the 11-7 shift (2300 to 0700 hours) calibrated the glucometer and performed the quality control test. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055570	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Elizabeth Healthcare Center	2800 N. Harbor Blvd. Fullerton, CA 92835

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition, on 3/18/26 at 1245 hours, a follow-up interview and concurrent record review was conducted with LVN 3. LVN 3 acknowledged the findings and stated it was important to calibrate the glucometers to ensure accurate blood sugar readings for the residents. On 3/19/26 at 1649 hours, the DON was informed and verified the above findings.