STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055598	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bradley Gardens	980 West Seventh Street San Jacinto, CA 92582

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 food was stored, labeled, and maintained under sanitary conditions when multiple food items were not labeled or dated once opened, containers had food residue, and shelving inside the walk-in refrigerator showed signs of rust. These failures had the potential to result in cross-contamination, bacterial growth, and attraction of pests, placing resident at risk for food borne illness.Findings:On August 18, 2025, at 9 a.m., during a kitchen tour with the Dietary Supervisor (DS), the following were observed: a. One undated sandwich inside the refrigerator. b. One bag of breadcrumbs undated and unlabeled. c. One gallon container of balsamic vinegar open with no open date or use by date.d. One gallon container of soy sauce open with no open date or use by date, with residue on the outside of the bottle.e. Two bottles of honey without open or use by date, with sticky residue on the outside.f. A bag of pasta, opened and taped shut, without a label or open date.g. A flour container with excess flour spilled on the outside. h. A sugar container with excess sugar residue on the lid. i. The walk-in refrigerator contained a green shelf with brown discoloration resembling rust. During a concurrent interview with the DS, the DS stated, the following:a. The sandwich and breadcrumbs should have been labeled and dated. b. Once opened, vinegar and soy sauce containers should be dated, and bottles should be kept clean to prevent attracting pests. c. Honey bottles should be cleaned and free from residue. d. Pasta should be stored in a container once opened.e. Flour and sugar containers should be clean and free from residue to prevent pests.f. The walk-in refrigerator shelf appeared rusted and should be replaced.On August 21, 2025, at 3:07 p.m., during an interview with the Registered Dietitian (RD), the RD stated the storage shelves in the walk-in refrigerator should be rust free otherwise it is difficult to clean. The RD further stated that all food needs to have label and date, and shelves to be clean in order to prevent cross contamination, and bacterial growth.A review of the facility policy's titled Sanitization, dated November 2022, indicated .all kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.all utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning . A record review of the Food Code, 2022, the Food Code indicated, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris and the Equipment is cleaned at a frequency necessary to preclude accumulation of soil residues. In addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure proper disposal of garbage when one dumpster was overflowing with trash, and the lid was not closed.This failure had the potential to attract pests and rodents, which could cause food borne illness.Findings:On August 18, 2025, at 9:30 a.m., during an observation of the dumpster storage area outside the facility, one out of two dumpster lids was not closed, and trash was observed overflowing.On August 18, 2025, at 9:30a.m., a concurrent observation and interview were conducted with the Dietary Supervisor (DS) at the dumpster site. The DS stated the dumpster lids were open and should have been closed, and the trash should not have been overflowing in order to prevent pest infestations. On August 21, 2025, at 2:15 p.m., a concurrent observation and interview were conducted with the Maintenance Supervisor (MS) at the dumpsters. The MS stated, the staff throwing away trash were responsible for keeping the dumpster lids closed and the surrounding area clean. The MS further stated the dumpster lids should always be closed and the area free from trash to prevent attracting flied and rodents. A review of the facility policy and procedure titled Sanitization, dated November 2022, indicated, .kitchen wastes that are not disposed of by mechanical means are kept clean, leakproof, nonabsorbent, tightly closed containers and disposed daily.garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/ compactors with lids (or otherwise covered).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the monthly medication regimen review (MRR) for five of five sampled residents (Residents 5, 6, 10, 11 and 30) when the nursing staff did not monitor for signs and symptoms of adverse effects related to the use of blood thinning medications. Resident 5 and Resident 6 were receiving rivaroxaban (an anticoagulant, or blood thinning medication). Residents 10, 11, and 30 were receiving apixaban (an anticoagulant, or blood thinning medication). This failure had the potential for the medication not being optimized for best possible health outcome, and unnecessary or prolonged use of the medication which could lead to adverse effects such as bleeding or excessive bruising.During an interview on August 20, 2025 at 2:47 p.m., Licensed Vocational Nurse (LVN) 3 described the process for when a resident was admitted to the facility on a blood thinning medication as follows:Nursing staff should have monitored daily for adverse effects such as bleeding;Nursing staff should have documented monitoring in the medication administration record (MAR); andA care plan should have been developed. During an interview on August 20, 2025 at 2:50 p.m., LVN 1 stated when a resident was receiving anticoagulation therapy, nursing staff should have monitored for signs and symptoms of bleeding/bruising and should have documented monitoring in the MAR every day. LVN 1 further stated that any resident on anticoagulation therapy needed a provider's order to monitor for bleeding. LVN 1 stated nursing staff would have known what adverse reactions to monitor from reviewing the physician's orders and the care plan.1a. During a review of Resident 6's admission Record, dated August 20, 2025, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of chronic embolism (a blockage in a blood vessel) and thrombosis (blood clot) of unspecified deep veins of left lower extremity.A review of Resident 6's medical record indicated the following physician's orders:On December 13, 2024, Rivaroxaban Oral Tablet 20 milligram (mg, unit of measurement) Give 20 mg by mouth in the evening for DVT (deep vein thrombosis) prevention; [NAME] March 31, 2025, Monitor/document/report adverse reactions of anticoagulant therapy: bleeding such as: Nosebleeds that happen often, unusual bleeding from gums, menstrual bleeding that is heavier than normal, or vaginal bleeding, bleeding that is severe or you cannot control, red, pink, or brown urine, bright red or black stools, coughing up blood or blood clots, vomit blood or vomit looks like coffee grounds, headaches, feeling dizzy or weak, pain, swelling, or new drainage at wound sites, every shift write progress note and notify physician of identified drug side effect(s).A review of Resident 6's medical record, including the MARs dated December 14, 2024 to March 30, 2025, indicated Resident 6 was administered rivaroxaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy. 1b. During a review of Resident 30's admission Record, dated August 20, 2025, the admission Record indicated Resident 30 was admitted to the facility on [DATE]. A review of Resident 30's Acute Hospital Records, dated November 23, 2024, indicated Resident 30 had a DVT.A review of Resident 30's medical record indicated the following physician's orders:On November 23, 2024, Apixaban Oral Tablet 5 mg Give two tablets by mouth two times a day for DVT for 7 days;On November 30, 2024, Apixaban Oral Tablet 5 mg Give one tablet by mouth two times a day for DVT prevention; [NAME] February 28, 2025, Monitor/document/report adverse reactions of anticoagulant therapy: bleeding such as: Nosebleeds that happen often, unusual bleeding from gums, menstrual bleeding that is heavier than normal, or vaginal bleeding, bleeding that is severe or you cannot control, red, pink, or brown urine, bright red or black stools, coughing up blood or blood clots, vomit blood or vomit looks like coffee grounds, headaches, feeling dizzy or weak, pain, swelling, or new drainage at wound sites, every shift write progress note and notify physician of identified drug side effect(s).A review of Resident 30's medical record, including the MARs dated November 23, 2024 to February 27, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025, indicated Resident 30 was administered apixaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy. 1c. During a review of Resident 10's admission Record, dated August 21, 2025, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of acute embolism and thrombosis of unspecified deep veins of left lower extremity. A review of Resident 10's medical record indicated a physician's order on July 16, 2025, for Apixaban Oral Tablet 5 mg Give 5 mg by mouth two times a day for acute embolism and thrombosis of unspecified deep veins of left lower extremity. A review of Resident 10's medical record indicated there was no documented evidence of a physician's order for Monitor/document/report adverse reactions of anticoagulant therapy between July 16, 2025 to August 20, 2025. A review of Resident 10's medical record, including the MARs dated July 16, 2025 to August 20, 2025, indicated Resident 10 was administered apixaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy. During a concurrent interview and record review on August 20, 2025 at 2:53 p.m., with LVN 1, Resident 10's medical record, including physician's orders and MARs dated July 16, 2025 to August 20, 2025, were reviewed. LVN 1 confirmed Resident 10 started taking apixaban on July 16, 2025, there were no physician orders for monitoring adverse reactions of anticoagulation therapy, and there was no documentation of monitoring for bleeding during apixaban use. LVN 1 stated there should have been physician orders for monitoring adverse reactions of anticoagulation therapy and nursing staff should have documented the monitoring daily. 1d. During a review of Resident 5's admission Record, dated August 21, 2025, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of acute embolism and thrombosis of unspecified deep veins of left lower extremity. A review of Resident 5's medical record indicated a physician's order on May 20, 2025, for Rivaroxaban Oral Tablet 20 mg Give 20 mg by mouth one time a day for acute embolism and thrombosis of unspecified deep veins of left lower extremity. Further review of Resident 5's medical record indicated he had been administered rivaroxaban since January 8, 2025. A review of Resident 5's medical record indicated there was no documented evidence of a physician's order for Monitor/document/report adverse reactions of anticoagulant therapy between January 8, 2025 to August 20, 2025. A review of Resident 5's medical record, including the MARs dated January 8, 2025 to August 20, 2025, indicated Resident 5 was administered rivaroxaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy. During a concurrent interview and record review on August 20, 2025 at 2:56 p.m., with LVN 1, Resident 5's medical record, including physician's orders and MARs dated January 8, 2025 to August 20, 2025, were reviewed. LVN 1 confirmed Resident 5 started taking rivaroxaban on January 8, 2025, there were no physician orders for monitoring adverse reactions of anticoagulation therapy, and there was no documentation of monitoring for bleeding during rivaroxaban use. LVN 1 stated there should have been physician orders for monitoring adverse reactions of anticoagulation therapy and nursing staff should have documented the monitoring daily. 1e. During a review of Resident 11's admission Record, dated August 20, 2025, the admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnosis of acute embolism and thrombosis of unspecified deep veins of right lower extremity. A review of Resident 11's medical record indicated a physician's order on May 11, 2025, for Apixaban Oral Tablet 5 mg Give one tablet by mouth two times a day related to acute embolism and thrombosis of unspecified deep veins of right lower extremity. Further review of Resident 11's medical record indicated he had been administered apixaban since May 2, 2025. A review of Resident 11's medical record indicated there was no documented evidence of a physician's order for Monitor/document/report adverse reactions of anticoagulant therapy between May 2, 2025 to August 20, 2025. A review of Resident 11's medical record, including the MARs dated May 2, 2025 to August 20, 2025, indicated Resident 11 was administered apixaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy. During a concurrent interview and record review on August 20, 2025 at 3:04 p.m., with LVN 1, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 11's medical record, including physician's orders and MARs dated May 2, 2025 to August 20, 2025, were reviewed. LVN 1 confirmed Resident 11 started taking apixaban on May 2, 2025, there were no physician orders for monitoring adverse reactions of anticoagulation therapy, and there was no documentation of monitoring for bleeding during apixaban use. LVN 1 stated when the anticoagulant medication was ordered for Resident 11, the adverse effect monitoring should have been entered but it was not done. During an interview on August 20, 2025 at 3:09 p.m., the Registered Nurse (RN) 1 stated residents on anticoagulation therapy required daily monitoring for side effects such as bleeding/bruising symptoms. RN 1 stated nursing staff were expected to document daily monitoring of side effects in the MAR and if there was an issue with bleeding, nursing staff should have documented in the health status notes. Additionally, RN 1 stated a care plan should have been initiated anytime a new medication such as anticoagulation therapy was started. During an interview on August 20, 2025 at 3:33 p.m., the Director of Nursing (DON) stated the process for anticoagulation therapy was as follows: The physician would have written an order for anticoagulation therapy; The nurse that received the order should have written a corresponding order for side effect monitoring such as bleeding/bruising; andThe nurse should have initiated a care plan for anticoagulation therapy. During the same interview on August 20, 2025 at 3:33 p.m., the DON stated nursing staff were expected to document monitoring for bleeding under the Monitoring MAR during every shift. A review of the consultant pharmacist's (CP) monthly MRRs from November 2024 to July 2025 for Resident 5, 6, 10, 11, and 30 indicated there were no recommendations from the CP related to the need for potential adverse effect monitoring during anticoagulant therapy. During a follow-up interview on August 21, 2025 at 3 p.m., the DON stated it was important to monitor side effects during blood thinner use because bleeding could cause complications for the residents if not identified in a timely manner. Additionally, the DON stated the irregularity should have been identified and reported by the CP in the monthly MRR between November 2024 - July 2025 for Residents 5, 6, 10, 11, and 30 who were receiving anticoagulant therapy. A review of the manufacturer's instructions for apixaban tablets, dated May 2024, retrieved from DailyMed (The contents of DailyMed is provided and updated daily by the U.S. Food and Drug Administration.), indicated, Warnings and precautions .Apixaban can cause serious, potentially fatal, bleeding. Promptly evaluate signs and symptoms of blood loss. A review of the manufacturer's instructions for rivaroxaban tablets, dated July 2025, retrieved from DailyMed, indicated, Warnings and precautions.Risk of bleeding: Rivaroxaban can cause serious and fatal bleeding. A review of the facility's policy and procedures (P&P), titled Medication Regimen Reviews, dated May 2019, indicated, The consultant pharmacist reviews the medication regimen of each resident at least monthly.The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example.inadequate monitoring for adverse consequences.An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice.It may also include the use of medication without adequate monitoring. A review of the facility's P&P, titled Anticoagulation - Clinical Protocol, dated November 2018, indicated, Assess for any signs or symptoms related to adverse drug reactions due to the medication .The staff and physician will monitor for possible complications in individuals who are being anticoagulated .if an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing or spitting up blood from the respiratory tract), or other evidence of bleeding, the nurse will discuss the situation when the physician before giving the next scheduled dose of anticoagulant.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure five of five sampled residents (Residents 5, 6, 10, 11 and 30) were free from unnecessary medications when the nursing staff did not monitor for signs and symptoms of adverse effects related to the use of blood thinning mediations. Resident 5 and Resident 6 were receiving rivaroxaban (an anticoagulant, or blood thinning medication). Residents 10, 11, and 30 were receiving apixaban (an anticoagulant, or blood thinning medication).This failure had the potential to result in unnecessary use of medications for Residents 5, 6, 10, 11 and 30; and for side effects of these medications (such as bleeding or excessive bruising) to go undetected or recognized for timely intervention.Findings:During an interview on August 20, 2025 at 2:47 p.m., Licensed Vocational Nurse (LVN) 3 described the process for when a resident was admitted to the facility on a blood thinning medication as follows: Nursing staff should have monitored daily for adverse effects such as bleeding; Nursing staff should have documented monitoring in the medication administration record (MAR); andA care plan should have been developed. During an interview on August 20, 2025 at 2:50 p.m., LVN 1 stated when a resident was receiving anticoagulation therapy, nursing staff should have monitored for signs and symptoms of bleeding/bruising and should have documented monitoring in the MAR every day. LVN 1 further stated that any resident on anticoagulation therapy needed a provider's order to monitor for bleeding. LVN 1 stated nursing staff would have known what adverse reactions to monitor from reviewing the physician's orders and the care plan.1a. During a review of Resident 6's admission Record, dated August 20, 2025, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of chronic embolism (a blockage in a blood vessel) and thrombosis (blood clot) of unspecified deep veins of left lower extremity. A review of Resident 6's medical record indicated the following physician's orders:On December 13, 2024, Rivaroxaban Oral Tablet 20 milligram (mg, unit of measurement) Give 20 mg by mouth in the evening for DVT (deep vein thrombosis) prevention; [NAME] March 31, 2025, Monitor/document/report adverse reactions of anticoagulant therapy: bleeding such as: Nosebleeds that happen often, unusual bleeding from gums, menstrual bleeding that is heavier than normal, or vaginal bleeding, bleeding that is severe or you cannot control, red, pink, or brown urine, bright red or black stools, coughing up blood or blood clots, vomit blood or vomit looks like coffee grounds, headaches, feeling dizzy or weak, pain, swelling, or new drainage at wound sites, every shift write progress note and notify physician of identified drug side effect(s).A review of Resident 6's medical record, including the MARs dated December 14, 2024 to March 30, 2025, indicated Resident 6 was administered rivaroxaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy.1b. During a review of Resident 30's admission Record, dated August 20, 2025, the admission Record indicated Resident 30 was admitted to the facility on [DATE]. A review of Resident 30's Acute Hospital Records, dated November 23, 2024, indicated Resident 30 had a DVT.A review of Resident 30's medical record indicated the following physician's orders:On November 23, 2024, Apixaban Oral Tablet 5 mg Give two tablets by mouth two times a day for DVT for 7 days;On November 30, 2024, Apixaban Oral Tablet 5 mg Give one tablet by mouth two times a day for DVT prevention; [NAME] February 28, 2025, Monitor/document/report adverse reactions of anticoagulant therapy: bleeding such as: Nosebleeds that happen often, unusual bleeding from gums, menstrual bleeding that is heavier than normal, or vaginal bleeding, bleeding that is severe or you cannot control, red, pink, or brown urine, bright red or black stools, coughing up blood or blood clots, vomit blood or vomit looks like coffee grounds, headaches, feeling dizzy or weak, pain, swelling, or new drainage at wound sites, every shift write progress note and notify physician of identified drug side effect(s).A review of Resident 30's medical record, including the MARs dated November 23, 2024 to February 27, 2025, indicated Resident 30 was administered apixaban and there was no documented evidence of monitoring for adverse reactions of (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anticoagulant therapy. 1c. During a review of Resident 10's admission Record, dated August 21, 2025, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of acute embolism and thrombosis of unspecified deep veins of left lower extremity. A review of Resident 10's medical record indicated a physician's order on July 16, 2025, for Apixaban Oral Tablet 5 mg Give 5 mg by mouth two times a day for acute embolism and thrombosis of unspecified deep veins of left lower extremity. A review of Resident 10's medical record indicated there was no documented evidence of a physician's order for Monitor/document/report adverse reactions of anticoagulant therapy between July 16, 2025 to August 20, 2025. A review of Resident 10's medical record, including the MARs dated July 16, 2025 to August 20, 2025, indicated Resident 10 was administered apixaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy. During a concurrent interview and record review on August 20, 2025 at 2:53 p.m., with LVN 1, Resident 10's medical record, including physician's orders and MARs dated July 16, 2025 to August 20, 2025, were reviewed. LVN 1 confirmed Resident 10 started taking apixaban on July 16, 2025, there were no physician orders for monitoring adverse reactions of anticoagulation therapy, and there was no documentation of monitoring for bleeding during apixaban use. LVN 1 stated there should have been physician orders for monitoring adverse reactions of anticoagulation therapy and nursing staff should have documented the monitoring daily. 1d. During a review of Resident 5's admission Record, dated August 21, 2025, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of acute embolism and thrombosis of unspecified deep veins of left lower extremity. A review of Resident 5's medical record indicated a physician's order on May 20, 2025, for Rivaroxaban Oral Tablet 20 mg Give 20 mg by mouth one time a day for acute embolism and thrombosis of unspecified deep veins of left lower extremity. Further review of Resident 5's medical record indicated he had been administered rivaroxaban since January 8, 2025. A review of Resident 5's medical record indicated there was no documented evidence of a physician's order for Monitor/document/report adverse reactions of anticoagulant therapy between January 8, 2025 to August 20, 2025. A review of Resident 5's medical record, including the MARs dated January 8, 2025 to August 20, 2025, indicated Resident 5 was administered rivaroxaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy. During a concurrent interview and record review on August 20, 2025 at 2:56 p.m., with LVN 1, Resident 5's medical record, including physician's orders and MARs dated January 8, 2025 to August 20, 2025, were reviewed. LVN 1 confirmed Resident 5 started taking rivaroxaban on January 8, 2025, there were no physician orders for monitoring adverse reactions of anticoagulation therapy, and there was no documentation of monitoring for bleeding during rivaroxaban use. LVN 1 stated there should have been physician orders for monitoring adverse reactions of anticoagulation therapy and nursing staff should have documented the monitoring daily. 1e. During a review of Resident 11's admission Record, dated August 20, 2025, the admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnosis of acute embolism and thrombosis of unspecified deep veins of right lower extremity. A review of Resident 11's medical record indicated a physician's order on May 11, 2025, for Apixaban Oral Tablet 5 mg Give one tablet by mouth two times a day related to acute embolism and thrombosis of unspecified deep veins of right lower extremity. Further review of Resident 11's medical record indicated he had been administered apixaban since May 2, 2025. A review of Resident 11's medical record indicated there was no documented evidence of a physician's order for Monitor/document/report adverse reactions of anticoagulant therapy between May 2, 2025 to August 20, 2025. A review of Resident 11's medical record, including the MARs dated May 2, 2025 to August 20, 2025, indicated Resident 11 was administered apixaban and there was no documented evidence of monitoring for adverse reactions of anticoagulant therapy. During a concurrent interview and record review on August 20, 2025 at 3:04 p.m., with LVN 1, Resident 11's medical record, including physician's orders and MARs dated May 2, 2025 to August 20, 2025, were reviewed. LVN 1 confirmed (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 11 started taking apixaban on May 2, 2025, there were no physician orders for monitoring adverse reactions of anticoagulation therapy, and there was no documentation of monitoring for bleeding during apixaban use. LVN 1 stated when the anticoagulant medication was ordered for Resident 11, the adverse effect monitoring should have been entered but it was not done. During an interview on August 20, 2025 at 3:09 p.m., the Registered Nurse (RN) 1 stated residents on anticoagulation therapy required daily monitoring for side effects such as bleeding/bruising symptoms. RN 1 stated nursing staff were expected to document daily monitoring of side effects in the MAR and if there was an issue with bleeding, nursing staff should have documented in the health status notes. Additionally, RN 1 stated a care plan should have been initiated anytime a new medication such as anticoagulation therapy was started. During an interview on August 20, 2025 at 3:33 p.m., the Director of Nursing (DON) stated the process for anticoagulation therapy was as follows: The physician would have written an order for anticoagulation therapy; The nurse that received the order should have written a corresponding order for side effect monitoring such as bleeding/bruising; andThe nurse should have initiated a care plan for anticoagulation therapy. During the same interview on August 20, 2025 at 3:33 p.m., the DON stated nursing staff were expected to document monitoring for bleeding under the Monitoring MAR during every shift. During a follow-up interview on August 21, 2025 at 3 p.m., the DON stated it was important to monitor side effects during blood thinner use because bleeding could cause complications for the residents if not identified in a timely manner. A review of the manufacturer's instructions for apixaban tablets, dated May 2024, retrieved from DailyMed (The contents of DailyMed is provided and updated daily by the U.S. Food and Drug Administration.), indicated, Warnings and precautions .Apixaban can cause serious, potentially fatal, bleeding. Promptly evaluate signs and symptoms of blood loss. A review of the manufacturer's instructions for rivaroxaban tablets, dated July 2025, retrieved from DailyMed, indicated, Warnings and precautions.Risk of bleeding: Rivaroxaban can cause serious and fatal bleeding. A review of the facility's policy and procedures (P&P), titled Anticoagulation - Clinical Protocol, dated November 2018, indicated, Assess for any signs or symptoms related to adverse drug reactions due to the medication .The staff and physician will monitor for possible complications in individuals who are being anticoagulated .if an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing or spitting up blood from the respiratory tract), or other evidence of bleeding, the nurse will discuss the situation when the physician before giving the next scheduled dose of anticoagulant.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure dignity was provided for two of two residents reviewed for dignity (Residents 5 and 38) when Resident 5 and 38's lunch tray was not provided at the same time at their tables.This failure had the potential to negatively affect Residents 5 and 38's self-worth and self-esteem. Findings:1a. On August 18, 2025, at 12:18 p.m., an observation was conducted in the dining room with Resident 5. Resident 5 was seated at a table with another resident, who was served his meal and began eating. Resident 5 did not receive his lunch for approximately five minutes and was observed looking over his right shoulder until his meal arrived. On August 18, 2025, at 12:30 p.m., an interview was conducted with Resident 5. Resident 5 stated that it has happened before that he had to wait for his meal while other residents at his table were already eating.1b. On August 18, 2025, at 12:50 p.m., an observation was conducted in the dining room with Resident 38. Resident 38 was seated at a table with two other residents, who were served their meals and began eating. Resident 38 did not receive his lunch for approximately eight minutes and was observed watching the other two residents eat. The other two residents were nearly finished with their meal trays before Resident 38 received his.On August 18, 2025, at 12:56 p.m., a concurrent observation and interview was conducted with the Director of Staff Development (DSD). The DSD stated Resident 38's meal was delayed due to room change. On August 18, 2025, at 1:02 p.m., an interview was conducted with Resident 38. Resident 38 stated that he will just watch the other residents eat their food while he waits for his food. On August 21, 2025, at 4:23 p.m., an interview was conducted with the DSD. The DSD stated that the meal trays should be served one table at a time, so the residents are not waiting and watching others eat, in order to respect residents' rights.On August 21, 2025, at 2:40 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated residents seated together were expected to receive their meals at the same time as a group. The RD stated serving meals separately could make residents feel left out and affect their sense of dignity.A review of the facility Policy and Procedure titled, Dignity, dated February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level or satisfaction with life, feeling of self-worth and self-esteem .Residents are treated with dignity and respect at all times .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one resident reviewed (Resident 38) was free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when Resident 38 was administered risperidone (an anti-psychotic medication used for schizophrenia) without adequate monitoring. This failure resulted in unnecessary medications for Residents 38, which increased the potential for medication interactions, adverse reactions, and unidentified risks associated with the use of psychotropic medications that included but not limited to sedation, respiratory depression, constipation, anxiety, agitation, and memory loss.Findings:A review of Resident 38's admission Record dated August 21, 2025, indicated he was admitted to the facility on [DATE], with diagnoses which included paranoid schizophrenia (mental illness).A review of Resident 38's Order Listing Report dated August 21, 2025, indicated the following physician's orders were ordered on June 19, 2025: Risperdal Oral tablet 3 mg (milligrams - a unit of measurement) Give 3 mg by mouth two times a day for PARANOID SCHIZOPHRENIA . Anti-Psychotic Monitor of episodes of PARANOID SCHIZOPHRENIA AEB (as evidenced by): paranoid ideations. Drug: RisperDaL .every shift . A review of Resident 38's Care Plan Report indicated Focus .admitted with antipsychotic medication r/t (related to) Medical Diagnosis: PARANOID SCHIZOPHRENIA AEB: paranoid ideations. Medication: Risperdal. At risk for adverse drug reaction .Approaches .Monitor/record occurrence of target behavior symptoms(s) AEB paranoid ideations . were initiated on June 20, 2025.A review of Resident 38's Medication Administration Record (MAR) for the period of June 19 to August 21, 2025, indicated the resident received risperidone as ordered by the physician.A review of Resident 38's Monitoring Record indicated the resident was monitored for episodes of paranoid schizophrenia aeb paranoid ideations as follows:1. For the period of June 19 to 30, 2025, the resident did not have any episode for morning, evening and night shifts.2. For the period of July 1 to 32, 2025, the resident had six episodes in the morning shift on July 19, 22, 25-28, 2025, four episodes in the evening shift on July 26, 27, 29 and 30, 2025, and none in the night shift.3. For the period of August 1 to 21, 2025, the resident had 17 episodes in the morning shift on August 1, 3-13, 15-19, 2025, and none in the evening and night shifts. A review of resident 38's e-Mar (electronic MAR) - Medication Administration Note and Health Status Note for the period of June 19, 2025, to August 21, 2025, did not indicate any documented evidence that Resident 38's episodes of paranoid ideations were described when it was observed on July 19, 25, 28, August 1, 3-13, 15-19, 2025.On August 18, 2025, at 11:30 a.m., Resident 38 was observed in the hallway asking for his medication.On August 18, 2025, at 4:00 p.m., Resident 38 was observed in the hallway asking for his medication.On August 21, 2025, at 9:47 a.m., during a concurrent interview with Licensed Vocational Nurse (LVN) 1 and record review of Resident 38's physician's orders, LVN 1 stated Resident 38 was being monitored for his paranoid ideations. LVN 1 stated Resident 38's paranoid ideations are asking for his medications and missing smoke break. LVN 1 stated there was no specific monitoring of Resident 38's paranoid ideations and it should be indicated on the monitoring so that it will be clear what behavior is exactly being monitored. On August 21, 2025, at 10:19 a.m., during an interview, the Behavioral Health Nurse Director (BHND) stated he ensures there is behavior monitoring for every psychotropic medication that a resident is on. The BHND stated he does not tailor behavior monitoring because residents' behavior can change. The BHND stated Resident 38's paranoid ideation is asking for Tylenol (a pain medication). The BHND stated it was tricky and behavior monitoring does not have to be tailored to the resident because the nurses will only focus on one behavior and leave other behaviors out, so the behavior monitoring is left broad and general. The BHND stated the expectation was if a resident was observed with frequent behavior changes through out the day, the nurses should describe it in their progress notes by creating a Health Status Note.On (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	August 21, 2025, at 11:21 a.m., during an interview, the Director of Nursing (DON) stated the practice was every resident behavior is monitored. The DON stated her expectation was for the nurses to document Resident 38's behavior in the Health Status Note to be able to identify if his behaviors are frequent. On August 21, 2025, at 12:55 p.m., during a follow up interview, the BHND stated Resident 38's behavior of paranoid ideation is specific to the resident. The BHND stated they are not going to have monitoring for all behaviors and that is hard. On August 21, 2025, at 1:30 p.m., during an interview, LVN 2 stated paranoid ideation is when a resident says someone's out to get me or is afraid of something. LVN 2 stated paranoid ideation can be different for every resident. On August 21, 2025, at 3:03 p.m., during a follow up interview, the DON stated behavior monitoring should be resident specific. The DON stated it is important to monitor target behaviors specific to each resident to adjust doses if needed or appropriate, to evaluate for the effectiveness or ineffectiveness of the medication, and to identify changes of conditions or new behaviors. A review of the facility's policy and procedure (P&P) titled Behavioral Assessment, Intervention, and Monitoring dated February 2025 indicated .Behavioral symptoms are identified using facility-approved behavioral screening tools and the comprehensive assessment .The nursing staff identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including .onset, duration, intensity, and frequency of behavioral symptoms .The IDT [Interdisciplinary team, a group of healthcare professionals from different disciplines] thoroughly evaluates new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition .If psychotropic medications are prescribed for behavioral symptoms, documentation includes .specific target behaviors and expected outcomes .monitoring for efficacy.The IDT monitors for and documents any new, worsening, or improved symptoms in the resident's behavior.A review of the facility's P&P titled Psychotropic Medication Use, dated February 2025 indicated, Residents receiving psychotropic medication are monitored and the response to treatment is documented.Monitoring may include.behavior flow sheets, medication administration records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive care plan (specific interventions to provide effective and person-centered care to meet the resident's needs) was initiated according to the facility's policy when two of five sampled residents (Resident 5 and 6) received anticoagulant therapy with rivaroxaban (an anticoagulant, or blood thinning medication). This failure had the potential to result in delays in treatment and care for Residents 5 and 6. During an interview on August 20, 2025 at 2:47 p.m., Licensed Vocational Nurse (LVN) 3 described the process for when a resident was admitted to the facility on a blood thinning medication as follows: Nursing staff should have monitored daily for adverse effects such as bleeding; Nursing staff should have documented monitoring in the medication administration record (MAR); andA care plan should have been developed. During an interview on August 20, 2025 at 2:50 p.m., LVN 1 stated when a resident was receiving anticoagulation therapy, nursing staff should have monitored for signs and symptoms of bleeding/bruising and should have documented monitoring in the MAR every day. LVN 1 further stated that any resident on anticoagulation therapy needed a provider's order to monitor for bleeding. LVN 1 stated nursing staff would have known what adverse reactions to monitor from reviewing the physician's orders and the care plan.1a. During a review of Resident 6's admission Record, dated August 20, 2025, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of chronic embolism (a blockage in a blood vessel) and thrombosis (blood clot) of unspecified deep veins of left lower extremity. A review of Resident 6's medical record indicated a physician's order on December 13, 2024, for Rivaroxaban Oral Tablet 20 milligram (mg, unit of measurement) Give 20 mg by mouth in the evening for DVT (deep vein thrombosis) prevention.A review of Resident 6's MARs dated December 14, 2024 to April 7, 2025, indicated Resident 6 was administered rivaroxaban as prescribed by the physician.A review of Resident 6's Care Plan Reports dated December 14, 2024 to April 7, 2025, indicated there was no documented evidence of a care plan developed for anticoagulation therapy use and management after rivaroxaban was ordered and administered. A review of Resident 6's Care Plan Report dated April 8, 2025, approximately 3.5 months after anticoagulant therapy was initiated, indicated Focus - Anticoagulant therapy r/t (related to) chronic embolism and thrombosis of unspecified deep veins of left lower extremity. At risk for abnormal bleeding or hemorrhage. Medication: Rivaroxaban. 1b. During a review of Resident 5's admission Record, dated August 21, 2025, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of acute embolism and thrombosis of unspecified deep veins of left lower extremity. A review of Resident 5's medical record indicated a physician's order on May 20, 2025, for Rivaroxaban Oral Tablet 20 mg Give 20 mg by mouth one time a day for acute embolism and thrombosis of unspecified deep veins of left lower extremity. Further review of Resident 5's medical record indicated he had been administered rivaroxaban since January 8, 2025. A review of Resident 5's MARs dated January 8, 2025 to May 29, 2025, indicated Resident 5 was administered rivaroxaban as prescribed by the physician. A review of Resident 5's Care Plan Reports dated January 8, 2025 to May 29, 2025, indicated there was no documented evidence of a care plan developed for anticoagulation therapy use and management after rivaroxaban was ordered and administered. A review of Resident 5's Care Plan Report dated May 30, 2025, approximately 5 months after anticoagulant therapy was initiated, indicated Focus - Anticoagulant therapy r/t (related to) acute embolism and thrombosis of unspecified deep veins of L (left) . At risk for abnormal bleeding or hemorrhage. Medication: Rivaroxaban. During an interview on August 20, 2025 at 3:09 p.m., the Registered Nurse (RN) 1 stated a care plan should have been initiated anytime a new medication such as anticoagulation therapy was started. During an interview on August 20, 2025 at 3:33 p.m., the Director of Nursing (DON) stated the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process for anticoagulation therapy was as follows: The physician would have written an order for anticoagulation therapy; The nurse that received the order should have written a corresponding order for side effect monitoring such as bleeding/bruising; andThe nurse should have initiated a care plan for anticoagulation therapy. During the same interview on August 20, 2025 at 3:33 p.m., the DON stated a care plan should have been initiated for new medication orders and the care plan gets revised if medications are discontinued. A review of the facility's policy and procedures (P&P), titled Care Plans, Comprehensive Person-Centered, dated March 2022, indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set, an assessment tool] assessment (Admission, Annual, or Significant Change In Status), and no more than 21 days after admission.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely communication and implementation of a hospice physician's medication order (Prednisone - to reduce inflammation) for one of one resident reviewed for hospice (medical care provided to individuals with terminal illnesses) (Resident 3).This failure resulted in Resident 3 receiving Prednisone four days after it was ordered by the hospice physician, which had the potential to cause unnecessary delay in treatment and comfort.Findings: A review of Resident 3's admission Record indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD- a chronic respiratory problem) and Alzheimer's disease (progressive loss of memory). Resident 3 was admitted to hospice services on April 28, 2025.A review of Resident 3's History and Physical Examination dated May 9., 2025, indicated .Mentally Capable of Understanding - No.A review of Resident 3's hospice physician's order dated August 8, 2025, indicated .Prednisone 20 mg (milligram- unit of measurement) 2 tablets daily for five days.A review of Resident 3's e-MAR (electronic MAR - medication administration record) indicated Prednisone was first administered on August 12, 2025 - four days after the order was written.On August 21, 2025, at 9:55 a.m., during a concurrent interview and record review of Resident 3's hospice physician order, LVN 2 stated she was not aware of the Prednisone order. LVN 2 stated the standard practice was for a medication ordered on August 8, 2025, to be available within the same day or by the following day, and to be administered as soon as it became available.On August 21, 2025, at 4:15 p.m., during an interview with the Director of Nursing (DON), the DON stated it was the expectation that any change in condition or new medication order must be communicated with her by the hospice physician or hospice nurse. The DON further stated she was not aware of the Prednisone order.On August 21, 2025, at 2:22 p.m., during a concurrent interview and record review with Hospice Registered Nurse (HRN), she stated on August 8, 2025, the Nurse Practitioner evaluated Resident 3 and issued the Prednisone order. The HRN stated she sent the order to the facility via e-fax and also called the facility pharmacy. The HRN stated she should have verified with the facility staff that the order was received. The HRN further stated that not communicating and implementing the order could cause delay in treatment and comfort for Resident 3. On August 21, 2025, at 2:28 p.m., in an interview with LVN 3, LVN 3 stated she saw the delivered Prednisone tablets on her medication cart for Resident 3 on August 12, 2025. LVN 3 stated she contacted the hospice and the physician for the order, at which time the physician authorized initiation of the medication. A review of the facility undated document titled Hospice Program, indicated .Hospice services are available to residents at the end of life.Hospice Providers who contract with the facility: Are held responsible for meeting the same professional standards and timeliness of service.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility had a medication error rate of 6.9% when two medication errors occurred out of 29 opportunities during medication administration for one of nine residents (Resident 29). The facility did not administer Resident 29's stool softener (used for constipation) and laxative (used for constipation) medications according to the physician's orders.This failure had the potential to result in Resident 29 not receiving the full therapeutic benefit of their medication or experiencing side effects (such as diarrhea) from receiving the wrong dosage of a laxative.Findings:On August 19, 2025, at 8:40 a.m., during a medication administration observation with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed preparing six medications for Resident 29, including one docusate (a stool softener) 100 mg soft gel capsule and 30 ml (milliliters, unit of measurement) lactulose (a laxative) oral solution. A review of Resident 29's medical record indicated the following physician's orders: On April 11, 2025, Lactulose Oral Solution 20GM/30ML give 15 mL by mouth one time a day for constipation; [NAME] June 11, 2025, DSS oral capsule 100 mg, give 200 mg by mouth two times a day for supplement (hold for loose stool).On August 19, 2025, at 10:01 a.m., during a concurrent interview and record review of Resident 29's electronic medication administration record (e-MAR) with LVN 1, LVN 1 stated Resident 29 had an order for docusate 200 mg by mouth, she only gave one docusate soft gel which is 100mg instead of two soft gels (200mg). LVN 1 stated Resident 29 had an order for lactulose 15 ml, she administered 30 ml. LVN 1 stated, she should have administered 15 ml.On August 19, 2025, at 1:24 p.m., during an interview, the Director of Nursing (DON) stated LVN 1 should have done the triple check process for medication administration which is comparing the physician's order on the computer screen with the bubble pack, checking the resident's name, and the expiration date. The DON stated they are not supposed to take short cuts because they are dealing with human life.A review of the facility's policy and procedure titled Administering Oral Medications dated October 2010 indicated .Steps in the Procedure .Check the label on the medication and confirm the medication name and dose with the MAR . Check the medication dose. Re-check to confirm the proper dose .Prepare the correct dose of the medication .For liquid medications .Place cup on a level surface and read the poured amount at eye level to check accuracy .For tablets or capsules from a bottle .pour the desired number into the bottle cap and transfer to the medication cup .

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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. Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when two opened and expired refrigerated multi-dose vials (MDV) of Tuberculin Purified Protein Derivative (PPD- test agent used in the diagnosis of tuberculosis, a serious illness that mainly affects the lung) were not discarded according to the manufacturer's specifications and the facility's policy.This failure had the potential for residents to receive unsafe and ineffective medications (reduced potency) from being used past their discard (expiration) date and not being removed from active stock.Findings:On August 18, 2025, at 9:24 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN) 2 in the medication room, there were two opened refrigerated MDV of PPD 5 TU (test unit) per 0.1 ml (milliliter- a unit of measurement) with an open date label that indicated the vials were opened on July 12, 2025. LVN 2 stated the vials were good for 30 days when opened and both vials expired on August 11, 2025 (7 days ago). LVN 2 stated expired medications should have been discarded.On August 19, 2025, at 1:24 p.m., during an interview, the Director of Nursing (DON) stated she expected the licensed nurses to go through all the medications in the refrigerator to check for expired medications. A review of the PPD vial manufacturer's instructions dated October 2021, indicated, .A vial of [PPD] which has been entered and in use for 30 days should be discarded .A review of the facility's policy and procedure titled Medication Labeling and Storage dated February 2023 indicated .Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial .

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the two resident bedrooms (rooms [ROOM NUMBERS]) did not accommodate more than four residents per room.This failure had the potential to have an adverse effect on the residents' safety and wellbeing.Findings:During the facility survey on August 18 to August 21, 2025, rooms [ROOM NUMBERS] were observed to have five beds which can accommodate five residents in each room. room [ROOM NUMBER] was observed to have five beds occupied by five residents. room [ROOM NUMBER] was observed to have five beds and currently being occupied by five residents.During the facility survey days on August 18 to August 21, 2025, no adverse effects impacting the quality of life of the residents residing in rooms [ROOM NUMBERS] were observed. On August 21, 2025, at 4:15 p.m. the Director of Nursing (DON) was interviewed. The DON stated, there was no complain from the residents regarding having five residents in the room. The DON stated, there was no quality of life issues.