

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055608	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Primrose Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 515 Centinela Ave. Inglewood, CA 90302	
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 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 act upon recommendations from the Pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes), for two of five sampled residents (Resident 4 and Resident 7). This deficient practice placed Residents 4 and 7 at risk for receiving unnecessary medications. Findings: A. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 4's diagnoses included schizoaffective disorder (a mental illness that can affect thought, mood, and behavior), dementia (a progressive state of decline in mental abilities), and major depressive disorder (MDD, a mood disorder that cause a persistent feeling of sadness and loss of interest). During a review of Resident 4's History and Physical (H&P) dated 12/4/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4's Pharmacist Medication Regimen Review ([MRR] - a structured, comprehensive evaluation of a resident's entire medication list, conducted by a pharmacist to ensure safety and effectiveness) dated 3/12/2026, the MRR indicated Resident 4 was receiving Valproic Acid (drug classified as anti-convulsant and also functions as a mood stabilizer) 500 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) twice a day since 12/2025. The MRR indicated to consider a gradual dose reduction (tapering of a medication over time to determine the lowest effective dose to manage symptoms). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 6/3/2026, the MDS indicated Resident 4's had severe cognitive (ability to think and process) impairment. The MDS indicated, Resident 4 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, and dressing. During a review of Resident 4's Pharmacist MRR dated 6/16/2026, the Consultant MRR indicated, Resident 4 was receiving Mirtazapine (drug for treatment of depression) 30mg daily since 2/2025. The MRR indicated to consider a gradual dose reduction. During an interview on 7/9/2026 at 2:07 p.m., with the Director of Nursing (DON), the DON stated on 3/12/2026 and 6/16/2026 respectively, the Pharmacist recommended completing a GDR for Valproic Acid and Mirtazapine that were prescribed to Resident 4, and these recommendations were not addressed by the physician. The DON stated the facility failed to take any action on the pharmacist's recommendation by not informing Resident 4's physician. The DON stated the MRR should be acted upon by the licensed nursing staff within 7 days from the date the report was given. The DON stated the consultant pharmacist reviews residents' medications in order to follow the state and federal guidelines and to ensure that the facility was not giving unnecessary medication to the residents. B. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055608
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record indicated Resident 7's diagnoses included schizoaffective disorder, depression, and dementia. During a review of Resident 7's H&P dated 6/2/2026, the H&P indicated Resident 7 did not have the capacity to make medical decisions. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 7 was dependent on staff with oral hygiene, toileting hygiene, and dressing. During a concurrent interview and record review on 7/9/2026 at 2:15 p.m., with the DON, Resident 7's consultant pharmacist MRR, dated 6/16/2026, was reviewed. The consultant pharmacist MRR indicated Resident 7 was Mirtazapine 15 mg. daily since 10/2025 and to consider a GDR. The DON stated the MRR was not acknowledged and signed by the physician. The DON stated there was no documentation by the licensed nursing staff in the clinical records that the physician was notified regarding the Pharmacist's recommendation. The DON stated it was important to address and discuss all Pharmacist's recommendations with the resident's physician for the resident's safety. During a review of the facility's undated Policy and Procedure (P&P) titled, Medication Regimen Reviews, the P&P indicated upon receiving the MRR report from the pharmacist, the attending physician reviews, responds to the report and document in the resident's medical record that the pharmacist recommendations have been reviewed and what (if any) actions were taken to address them.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for one of five sampled residents (Resident 4) prior to administering psychotherapeutic medications (psychotropic, a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior). This deficient practice violated Resident 4's and their resident representative's (RR) right to make an informed decision regarding the use of psychotherapeutic medications. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included schizoaffective disorder (a mental illness that can affect thought, mood, and behavior), dementia (a progressive state of decline in mental abilities), and major depressive disorder (MDD, a mood disorder that cause a persistent feeling of sadness and loss of interest). During a review of Resident 4's Physician Order, dated 12/3/2025, the Physician Order indicated to administer Seroquel (drug used to treat schizoaffective disorder) 25 milligrams (mg, unit of measurement) by mouth twice a day for schizoaffective disorder manifested by screaming and visual hallucinations (perceptual experiences in the absence of real external sensory stimuli). During a review of Resident 4's History and Physical (H&P), dated 12/4/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4's Physician Order, dated 12/31/2025, the Physician Order indicated to administer Mirtazapine (drug for treatment of depression) 30 mg daily for depression manifested by poor oral intake. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 6/3/2026, the MDS indicated Resident 4's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 4 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and upper and lower body dressing. During a review of Resident 4's Medication Administration Record (MAR, a daily documentation record used by licensed nurse to document medications and treatments given to a resident) from 6/19/2026 to 7/7/2026, the MAR indicated Resident 4 received Seroquel 25 mg twice a day and Mirtazapine 30 mg daily. During a phone interview on 7/7/2026 at 12:48 p.m. with Resident 4's representative (RR 1), RR 1 stated she visited Resident 4 at the facility on 6/25/2026 and Registered Nurse 1 (RN 1) asked her to sign Resident 4's psychotherapeutic informed consent form. RR 1 stated she did not give verbal or written informed consent for the use of psychotherapeutic medications. RR 1 stated she did not have authority to give informed consent for psychotherapeutic medications. RR 1 stated she was allowed and only had the authority to give informed consent for medications used for treatment of dementia. During an interview on 7/8/2026 at 11:40 a.m. with RN 1, RN 1 stated it was the licensed nursing staff's responsibility to obtain psychotherapeutic informed consent from the resident or the resident representative and discuss the side-effects of the psychotherapeutic medications with the resident or the resident representative. RN 1 stated informed consent was required initially and if there was an increase in medication, and the consent needed to be renewed every 6 months. RN 1 stated RR 1 gave verbal consent to administer Seroquel and Remeron to Resident 4 on 6/19/2026. RN 1 stated Resident 4 was prescribed Seroquel for treatment of her schizoaffective disorder, not for dementia, and Remeron for treatment of her depression, not for dementia. RN 1 stated the facility staff could not initiate or administer psychotherapeutic medications without a valid informed consent. RN 1 stated psychotherapeutic medications were medications that help mitigate the resident's mood and behavior, which could affect their activities of daily living. RN 1 (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated psychotherapeutic medications have serious adverse reactions (undesired effect of a drug) such as shaking, weight loss, and unsteady gait that could jeopardize resident's health and well-being. During a review of the facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, undated, the P&P indicated prior to administration of a psychotropic medication, the prescribing clinician would obtain informed consent from the resident or resident representative and document the consent in the medical record. The P&P indicated the resident or resident representative had the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives options, and to choose the alternative or option he or she prefers. Cross Reference F757		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to notify the physician for one of five sampled residents (Resident 1), after Resident 1 had a change in condition and developed diarrhea on 6/26/26. This deficient practice had the potential to result in a delay in care, treatment and worsening of the resident's symptom. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnosis included gangrene (the death of body tissue caused by a lack of blood flow), chronic kidney disease (the progressive, irreversible loss of renal function), and diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical (H&P) dated 6/30/2026, the H&P indicated Resident 1 did not have the capacity to make decisions but was able to make needs known. During a review of Resident 1's Minimum Data Sheet ([MDS]- a resident assessment tool) dated 4/23/2026, the MDS indicated Resident 1's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) from staff for personal hygiene, showers, and dressing. During a review of Resident 1's Order Summary Report dated 6/14/2026, the Report indicated the physician ordered to administer loperamide (medication used to treat sudden diarrhea) two milligrams ([mg.] -a unit of measure for medication dosage) one tablet by mouth every 6 hours as needed for loose stool. During a review of Resident 1's Care Plan titled, .Resident has alteration in gastrointestinal r/t (related to) episodes of loose stools x 2 dated 6/14/2026, the Care Plan goal indicated resident will have normal, formed stool through review date, with target date of 10/20/2026. The Care Plan intervention indicated to notify the physician and responsible party. During a concurrent interview and record review on 7/8/2026 at 1:30 p.m., with Treatment Nurse (TN) 1, Resident 1's MAR dated 6/26/2026 was reviewed. The MAR indicated Resident 1 was given loperamide 2mg on 6/26/2026 due to diarrhea. During a concurrent interview and record review on 7/8/2026 at 1:41 p.m., with TN 1 Resident 1's Care Plan titled, Bowel: Resident has or is at risk for complications with gastrointestinal system (a continuous, twisting muscular tube that runs from the mouth to the anus) due to diarrhea dated 6/14/2026 was reviewed. TN 1 stated the care plan intervention indicated to notify the physician for changes in bowel patterns. TN 1 stated there should have been a COC when Resident 1 had diarrhea, however, was not done. TN 1 stated COCs helped to maintain consistent monitoring and notification to the physician. TN 1 stated it was important to notify the physician in case he wanted to make changes to Resident 1's regimen (a systemic plan or routine designed to improve health routine). During a review of the facility's undated Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, The P&P indicated the facility was to promptly notify the physician of changes in the resident's medical conditions. The P&P indicated prior to notifying the physician provider, the nurse will make detailed observations and gather relevant information for the provider including information prompted by the interact Situation Background Assessment Recommendation (SBAR) form.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was completed accurately for two of 16 sampled residents (Resident 4 and Resident 7), who were coded for a diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid (CMS) and had the potential to negatively affect the plan of care and delivery of care and services for Residents 4 and 7. Findings: A. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 4's diagnoses included schizoaffective disorder (a mental illness that can affect thought, mood, and behavior), dementia (a progressive state of decline in mental abilities), and major depressive disorder (MDD, a mood disorder that cause a persistent feeling of sadness and loss of interest). During a review of Resident 4's History and Physical (H&P) dated 12/4/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4's cognitive (ability to think and process) skills for daily decision making were severely impaired. The MDS indicated Resident 4 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, and upper and lower body dressing. The MDS indicated, Resident 4 has no potential indicators of psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) such as hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). B. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 7's diagnoses included schizoaffective disorder, depression, and dementia. During a review of Resident 7's H&P dated 6/2/2026, the H&P indicated Resident 7 did not have the capacity to make medical decisions. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 7 was dependent on staff for oral hygiene, toileting hygiene and dressing. The MDS indicated Resident 7 had no potential indicators of psychosis such as hallucinations and delusions. During an interview on 7/9/2026 at 11:30 a.m., with the Physician Assistant (PA), the PA stated Residents 4 and Resident 7 had a diagnosis of schizoaffective disorder not schizophrenia. The PA also stated Residents 4 and Resident 7 did not have supporting documentation to justify a diagnosis of schizophrenia. There would have been documentation of the residents' long history of schizophrenia and persistent symptoms of behaviors that met the criteria of schizophrenia based on the Diagnostic and Statistical Manual of Mental Disorder (DSM 5, the primary handbook used by mental health professionals to diagnose psychiatric disorders). During a concurrent interview and record review on 7/9/2026 at 12:21 p.m., with the Minimum Data Set Nurse (MDSN), Resident 4's MDS dated [DATE] and Resident 7's MDS dated [DATE], were reviewed. The MDSN stated Residents 4 and Resident 7 MDS assessments were completed inaccurately. The MDSN stated Resident 4 and Resident 7 MDS Section I (Active Diagnoses) 6000 (schizophrenia) should not have been checked to indicate the resident's had a schizophrenia diagnosis. The MDSN stated the facility did not have supporting documentation or evidence that Resident 4 and Resident 7 had a diagnosis of schizophrenia. The MDSN stated inaccuracy of the MDS assessment could affect the plan of care of the residents. During a review of (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's undated Policy and Procedure (P&P) titled, Resident Assessments, the P&P indicated, all persons who have completed any portion of the MDS resident assessment must sign the document attesting to the accuracy of such information. The P&P also indicated information in the MDS assessment will consistently reflect information in the progress notes, plan of care, and resident observations and interviews.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure there was a one-to-one (1:1) feeder (a caregiver who was assigned to assist a resident with feeding for the duration of a meal) for one of five sampled residents (Resident 13) during meals. This deficient practice placed Resident 13 at risk for poor nutritional intake during meals. Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), muscle weakness (a reduction in a patient's capacity to generate force or activate existing muscle mass), and gastro-esophageal reflux disease (GERD, a digestive condition where stomach acid contents repeatedly flow back up into the esophagus). During a review of Resident 13's History and Physical (H&P), dated 2/6/2026, the H&P indicated Resident 13 did not have the capacity to make decisions but was able to make needs known. During a review of Resident 13's Minimum Data Sheet (MDS, a resident assessment tool), dated 5/12/2026, the MDS indicated Resident 13's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 13 was dependent (helper does all of the effort) on staff for personal hygiene, shower, and lower dressing. The MDS indicated Resident 13 required supervision (helper provides verbal cues to assist in completing the activity) from staff for eating. The MDS indicated Resident 13 was at risk for pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 13's physician order, dated 6/5/2026, the physician order indicated Resident 13 to have a 1:1 feeding for cueing. During an observation on 7/7/2026 at 12:40 p.m., in Resident 13's room, Resident 13 did not have a 1:1 feeder during lunch time. During an observation on 7/8/2026 at 12:53 p.m., in Resident 13's room, Resident 13 did not have a 1:1 feeder during lunch time. Resident 13 was moving food around on his lunch plate. During a concurrent observation and interview on 7/8/2026 at 1:02 p.m., with Treatment Nurse (TN) 1, in Resident 13's room, Resident 13 did not have a 1:1 feeder during lunch time. TN 1 stated there was no feeder assisting Resident 13 while he was trying to eat his lunch. TN 1 stated there should be a staff member sitting next to him while he was eating. TN 1 stated a feeder had to be with Resident 13 to make sure he was eating to prevent malnutrition (a deficiency, excess, or imbalance in person's intake of energy and /or nutrients). During a review of the facility's policy and procedures (P&P) titled, Assistance with Meals, undated, the P&P indicated residents shall receive assistance with meals in a manner that meets the individual needs of each resident. The P&P indicated nursing services or feeding assistants will help residents who require assistance with eating.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of five sampled residents (Resident 24) hair was washed and the resident's nails were trimmed during activity of daily living ([ADL]- activities such as bathing, dressing, and toileting a person performs daily) care. This deficient practice placed Resident 24 at risk for poor personal hygiene, skin irritation, and discomfort. Findings: During a review of Resident 24's admission Record, The admission Record indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 24's diagnosis included muscle sclerosis (chronic autoimmune disease of the central nervous system), hemiplegia (paralysis of one side of the body), and muscle wasting (involuntary loss of muscle mass and strength). During a review of Resident 24's History and Physical (H&P), dated 4/22/2026 the H&P indicated Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 5/6/2026, the MDS indicated Resident 24's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 24 was dependent (helper does all of the effort) on staff for personal hygiene, showering, and lower body dressing. During a review of Resident 24's Care plan titled, Skin dated 5/11/2025, the Care plan intervention indicated to keep the resident's skin clean and dry. During a concurrent observation and interview on 7/7/2026 at 12:06 p.m., in Resident 24's room, Resident 24 had large amounts of dandruff in his hair, on the resident's face and clothes. Resident 24 fingernails were not trimmed. Resident 24 stated he would like to have his nails trimmed and his hair washed. During a concurrent observation and interview on 7/8/2026 at 1:06 p.m., with Treatment Nurse (TN) 1, in Resident 24's room, TN 1 stated Resident 24's fingernails were not trimmed and the resident had large amounts of dandruff. TN 1 stated Resident 24's hair should be washed on his shower days, at least twice a week. TN 1 stated Resident 24's fingernails should be trimmed by the Certified Nursing Assistants (CNA). TN 1 stated it was important for the CNA to provide ADL care daily for Resident 24 so he would feel comfortable. TN 1 stated not having proper ADL care placed Resident 24 at risk for accumulation of dead skin and cause discomfort for the resident. During a review of the facility's undated policy and procedures (P&P) titled, Activities of Daily Living (ADL), Supporting, the P&P indicated residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good grooming, and personal hygiene.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of five sampled residents (Resident 13) Low Air Loss Mattress ([LALM]- a specialized medical bed used to prevent and treat pressure ulcers) was maintained in the correct setting. This deficient practice had the potential to place Resident 13 at risk for pressure ulcers (localized damage to the skin and /or underlying tissue usually over a bony prominence). Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), muscle weakness (a reduction in a patient's capacity to generate force or activate existing muscle mass), and gastro-esophageal reflux disease ([GERD] - a digestive condition where stomach acid contents repeatedly flow back up into the esophagus). During a review of Resident 13's History and Physical (H&P) dated 2/6/2026, the H&P indicated Resident 13 did not have the capacity to make decisions but was able to make needs known. During a review of Resident 13's Minimum Data Sheet ([MDS]- a resident assessment tool) dated 5/12/2026, the MDS indicated Resident 13's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 13 was dependent (helper does all of the effort) on staff for personal hygiene, shower, and lower dressing. The MDS indicated Resident 13 weighed 133 pounds ([lbs.] - a measurement of weight) and was at risk for pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 13's Braden Scale Assessment dated 5/12/2026, the Braden Scale Assessment indicated Resident 13 was at high risk for skin breakdown. During a review of Resident 13's Order Summary Report dated 2/5/2026, the physician orders indicated to provide Resident 13 with a LALM and to have the settings per resident's weight. During a concurrent observation and interview on 7/8/2026 at 12:38 p.m., with Treatment Nurse (TN) 1, in Resident 13's room, TN 1 stated Resident 13 weighed 133 lbs. and the LALM was set at 180 lbs. During a concurrent interview and record review on 7/8/2026 at 12:43 p.m., with TN 1, Resident 13's Physician's order dated 2/5/2026 was reviewed. The TN stated, the Physician's order indicated to set Resident 13's LALM per the resident's weight. TN 1 stated the LALM should have been set closer to Resident 13's weight of 133 lbs. TN 1 stated not having the correct LALM settings placed the resident at risk for pressure ulcers. During a review of the facility's undated policy and procedure (P&P) titled, Low Air Loss Mattress General Procedure, the P&P indicated LALM are therapeutic support surfaces designed to assist in the prevention and treatment of pressure injuries. The P&P indicated pressure setting shall be determined based on the resident's weight.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:1. Three Hoyer lifts (a mechanical device used to transfer non-ambulatory individuals between surfaces from a bed to a wheelchair and vice versa without manual lifting) were not blocking a fire alarm in the facility's hallway.2. One of five sampled residents (Resident 39) had a physician order for going out on pass (OOP, temporary permission to leave a confined facility) and was signed out before going OOPThis deficient practice had the potential to result in safety hazards for residents, staff members, and visitors and placed Resident 39 at risk for medical complications.Findings: 1. During an observation on 7/7/2026 at 2:39 p.m., three Hoyer lifts were observed blocking one of the facility's fire alarms and posted signs. The sign indicated, Do not park anything in front of fire pull box at any time, keep area clear. in the facility's hallway. During a concurrent observation and interview on 7/9/2026 at 10:26 a.m. with Licensed Vocational Nurse 2 (LVN 2), three Hoyer lifts were blocking one of the facility's fire alarms and posted signs. LVN 2 stated the facility had do not park signs around the facility to keep the area safe for residents, visitors and staff members. LVN 2 stated mechanical equipment, linen carts, trash cans, and any other items should not be parked in front of the signs in the hallway. LVN 2 stated the three Hoyer lifts should not have been parked at the signage area. LVN 2 stated it was a safety hazard to not keep an area with a fire alarm and posted signage clear, which could result in possible injuries for residents, visitors and staff. During a review of the facility's policy and procedures (P&P), titled Accidents and Incidents-Investigating and Reporting, undated, the P&P indicated the facility was in compliance with current rules and regulations governing accidents and/or incidents involving a medical device. 2. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses including toxic encephalopathy (neurologic disorder characterized by brain dysfunction caused by exposure to toxic substances), muscle weakness (a reduction in a patient's capacity to generate force or activate existing muscle mass), and gastro-esophageal reflux disease (GERD, a digestive condition where stomach acid contents repeatedly flow back up into the esophagus) During a review of Resident 39's History and Physical (H&P), dated 5/8/2026, the H&P indicated Resident 39 had the capacity to make medical decisions. During a review of Resident 39's Minimum Data Sheet (MDS, a resident assessment tool), dated 5/8/2026, the MDS indicated Resident 39's cognition (ability to think and process) was moderately impaired. The MDS indicated Resident 39 was dependent (helper does all of the effort) on staff for personal hygiene, shower, and lower dressing. The MDS indicated Resident 39 was dependent on staff for mobility and used a wheelchair. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2026 at 10:26 a.m. with the Business Office Manager (BOM), the BOM stated on 6/17/2026, she escorted Resident 39 to a check cashing place to cash her check. The BOM stated she did not use the OOP log to sign the resident out of the facility. The BOM stated she had thought the resident could just leave without clinical or medical clearance. During a concurrent interview and record review on 7/10/2026 at 10:35 a.m. with Director of Nursing (DON), the sign-out log sheet and physician orders were reviewed. The sign-out log sheet did not indicate Resident 39 was signed out on 6/17/2026. The physician orders indicated there were no OOP orders (on 6/17/2026) for Resident 39. The DON stated for Resident 39 to go OOP, the facility had to obtain an OOP physician order and sign Resident 39 out when she left the facility. The DON stated the purpose of this process was to keep track of Resident 39 and keep Resident 39 safe. The DON stated Resident 39's safety was at risk because the BOM was not aware of Resident 39's medical conditions. During a review of the facility's P&P titled, Signing Residents Out, dated 8/2006, the P&P indicated all residents leaving the premises must be signed out. The P&P indicated registers must indicate the resident's expected time of return. The P&P indicated residents must be signed in upon return to the facility.		

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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, and record review the facility failed to ensure one of five sampled residents (Resident 11) received continuous oxygen (O2) at two liters per minute ([L/min]- a metric unit of volume used to measure liquids and gases) according to the physician's order. This deficient practice had the potential for Resident 11 not to receive adequate O2 and cause respiratory distress (difficulty breathing) to the resident. Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 11's diagnoses included respiratory failure (occurs when your lungs cannot get enough oxygen into your blood), dysphagia (difficulty swallowing), and cerebral infarction (a medical term for tissue death in the brain). During a review of Resident 11's History and Physical (H&P) dated 3/16/2026, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Sheet ([MDS]- a resident assessment tool) dated 5/12/2026, the MDS indicated Resident 11's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 11 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) on staff for personal hygiene, dressing, bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on bed) and transfers. The MDS indicated Resident 11 was receiving O2 therapy.During a review of Resident 11's Order Summary Report dated 6/3/2026, the Report indicated the physician ordered to administer O2 2 L/min continuously to Resident 11 via nasal cannula ([N/C] a small plastic tube, which fits into the person's nostrils for providing supplemental O2) per concentrator tank (a medical device that delivers a continuous stream of concentrated oxygen to a patient) every shift.During an observation on 7/7/2026 at 11:13 a.m., in Resident 11's room, Resident 11 was observed without the N/C on and the O2 set at zero.During a concurrent observation and interview on 7/8/2026 at 12:28 p.m., with Minimum Data Set Nurse (MDSN), in Resident 11's room, Resident 11 was observed with the O2 set at zero. The MDSN stated Resident 11 should be on continuous O2 therapy and should be set at 2 L/min, and not at zero. The MDSN stated not administering the correct O2 therapy as ordered could cause shortness of breath to the resident and lead to hypoxia (a state of inadequate oxygen supply to the body's tissues and cells).During a review of the facility's undated Policy and Procedure (P&P) titled, Oxygen Administration, the P&P indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. The P&P indicated to verify the physician's order, turn on the oxygen, start the flow of oxygen at the rate of two or three liters per minute and adjust so that it is the proper flow of oxygen being administered.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 48) was evaluated by the physician at least every 60 days and documented in the resident's clinical records. This deficient practice had the potential for a delay in the assessment of Resident 48's medical condition and receiving necessary care and treatment. Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 84 was admitted to the facility on [DATE] with diagnoses included cerebral infarction (type of stroke, loss of blood flow to a part of the brain), Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 48's History and Physical (H&P) dated 11/22/2025, the H&P indicated Resident 48 had the capacity for medical decision making. During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool) dated 5/8/2026, the MDS indicated Resident 48's cognition (ability to think and process) was intact. The MDS indicated Resident 48 was dependent (helper does all of the effort) on staff for toileting hygiene and dressing. During an interview on 7/7/2026 at 9:37 a.m., with Resident 48, Resident 48 stated she seldom saw her physician. Resident 48 stated her physician made a short visit to see her on 3/2026 (date unspecified). Resident 48 stated she needed to talk to her physician regarding her left knee pain. During a concurrent interview and record review on 7/9/2026 at 8:54 a.m., with the Director of Nursing (DON), Resident 48's Progress Notes dated 1/11/2026 to 7/3/2026 were reviewed. The DON stated Resident 48 was visited by a Nurse Practitioner ([NP] - a nurse who has advanced clinical education and training) on 1/11/2026, 1/27/2026, 2/8/2026, 3/13/2026, 3/27/2026, 4/8/2026, 4/20/2026, 5/4/2026, 6/2/2026, 6/19/2026, and 7/3/2026, and was not seen by the physician. The DON stated the Physician saw Resident 48 once this year on 3/3/2026 (in approximately 4 months [120 days]). The DON stated the physician should visit Resident 48 at least once a month and could alternate visits with the NP. The DON stated a physician had more extensive training and knowledge to assess and diagnose residents properly compared to NP. The Physician would document his findings in the Progress Notes about the resident's condition and treatment plan every time he completed his visit and evaluation of the resident. During a review of the facility's undated Policy and Procedure (P&P) titled, Physician Visits, the P&P indicated The attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every (60) days thereafter. The P&P also indicated the attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. During a review of the Facility Assessment Tool (a process for evaluating a facility's resident population and identifying the resources needed to provide care and services) dated 3/31/2026, the Facility Assessment Tool under Physician Services, indicated the attending physicians are required to evaluate their patients within 72 hours of admission and at least every 30 days following their initial visit or based on the patient's medical needs.		

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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 interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the responsible party, for one of five sampled resident's (Resident 4), prior to administering psychotropic medications (drugs that changes brain function and results in alterations in perception, mood, consciousness or behavior) to the resident. This deficient practice had the potential to result in the use of unnecessary psychotropic medication that could cause harm to Resident 4. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 4's diagnoses included schizoaffective disorder (a mental illness that can affect thought, mood, and behavior), dementia (a progressive state of decline in mental abilities), and major depressive disorder (MDD, a mood disorder that cause a persistent feeling of sadness and loss of interest). During a review of Resident 4's Physician Order dated 12/3/2025, the Physician Order indicated to administer Seroquel (drug used to treat schizoaffective disorder) 25 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount) by mouth twice a day to Resident 4, for schizoaffective disorder manifested by screaming and visual hallucinations (perceptual experiences in the absence of real external sensory stimuli). During a review of Resident 4's History and Physical (H&P) dated 12/4/2025, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions. During a review of Resident 4's Physician's Order dated 12/31/2025, the Physician's Order indicated, to administer Mirtazapine (drug for treatment of depression) 30 mg. daily to Resident 4, for depression manifested by poor oral intake to Resident 4. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 6/3/2026, the MDS indicated Resident 4 had severe cognitive (ability to think and process) impairment. The MDS indicated Resident 4 was dependent (helper does all the effort) on staff for oral hygiene, toileting hygiene, and dressing. During a review of Resident 4's Medication Administration Record dated 6/19/2026 to 7/7/2026, the MAR indicated Resident 4 received Seroquel 25 mg. twice a day and Mirtazapine (Remeron) 30mg daily. During a review of Resident 4's Psychotherapeutic Drug Informed Consent Forms for Mirtazapine and Seroquel dated 6/19/2026, the Forms indicated verbal consent was documented under section for Resident/ Resident's Representative Name and section for Resident/Resident's Representative Signature was blank. During a phone interview on 7/7/2026 at 12:48 p.m., with Resident 4's representative (RR 1), RR 1 stated she visited Resident 4 at the facility on 6/25/2026 and Registered Nurse (RN) 1 asked her to sign an informed consent for psychotropic medication for Resident 4. RR 1 stated she did not give verbal nor written informed consent for the use of psychotherapeutic medications because she did not have authority to do so. During an interview on 7/8/2026 at 11:40 a.m., with RN 1, RN 1 stated it was the responsibility of the licensed nursing staff to obtain informed consent from the resident or his/her representative prior to administering psychotropic medications. RN 1 stated it was also the responsibility of the licensed nursing staff to discuss the side-effects of the psychotherapeutic medications to the resident or his/her representative. RN 1 stated informed consent for psychotropic medications was required if there was an increase dosage in the medication, and it needed to be renewed every 6 months. RN 1 stated on 6/19/2026, RR 1 gave verbal consent to administer Seroquel and Remeron to Resident 4. Resident 4 was prescribed Seroquel for treatment of schizoaffective disorder and Remeron for treatment of depression. RN 1 stated the facility staff could not initiate or administer any (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotherapeutic medications without a valid informed consent. RN 1 stated psychotropic medications were medications that help mitigate resident's mood and behavior that could ultimately affect their activities of daily living. RN 1 stated the side-effects of psychotherapeutic medications would cause a significant change in resident's health condition. RN 1 stated without a proper or valid informed consent, it was considered as unnecessary medication. During interviews on 7/8/2026 at 2:36 p.m. and 7/10/2026 at 8:25 a.m., with the Director of Nursing (DON), the DON stated psychotropic medications should have a valid informed consent from the resident or resident representative to ensure that the facility did not give inappropriate medication. There was no valid informed consent obtained for Resident 4's Seroquel and Mirtazapine. During a review of the facility's undated Policy and Procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, the P&P indicated, prior to administration of a psychotropic medications, the prescribing clinician will obtain informed consent from the resident or resident representative and document the consent in the medical record. The P&P also indicated the resident or resident representative has the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives options, and to choose the alternative or option he or she prefers		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During observation, interview and record review, the facility failed to ensure staff (Physical Therapist [PT] 1) performed hand hygiene (washing hands or using an alcohol-based hand sanitizer) after PT 1 picked up gloves from the floor, prior to obtaining clean gloves from the glove dispenser, donning (putting on) new gloves and providing care to one of five sampled residents (Resident 37). This deficient practice had the potential to lead to cross contamination (the physical transfer of harmful bacteria or viruses from one person or object to another) and the spread of infection to Resident 37, other residents and staff. Findings: During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 37's diagnoses included muscle weakness (a reduction in a patient's capacity to generate force or activate existing muscle mass), atrial fibrillation (irregular and very fast heartbeat) and dementia (a progressive state of decline in mental abilities). During a review of Resident 37's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 4/29/2026, the MDS indicated Resident 37's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 37 was dependent (helper does all of the effort) on staff for personal hygiene, showering, and dressing. During an observation on 7/7/2026 at 12:06 p.m., PT 1 dropped gloves on the floor, was observed picking up the gloves from the floor, proceeded to obtain and don new gloves from the glove dispenser, then provided care for Resident 37 without performing hand hygiene. During an interview on 7/7/2026 at 2:12 p.m., with PT 1, PT 1 stated she dropped gloves on the floor. She picked up the gloves and threw them in the trash. PT 1 stated she obtained another pair of gloves (from the clean glove dispenser) without washing her hands. PT 1 stated the surface of the floor was considered dirty and she should have washed her hands after picking up the gloves off the floor and prior to donning the clean gloves. Hand hygiene practices were important to prevent cross contamination and the spread of infection. During a review of the facility's undated Policy and Procedure (P&P) titled, Handwashing/Hand Hygiene, the P&P indicated this facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents and visitors. The P&P indicated to perform hand hygiene after contact with contaminated surfaces, after touching the resident's environment and immediately prior to touching a resident.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post the recent California Department of Public Health (CDPH, state licensing and certification agency) annual survey results for 2024 and 2025 in the areas of the facility that are prominent and accessible to the residents, resident representatives, family members, and visitors. This deficient practice placed the residents, family members, and visitors at risk of not knowing the status of the facility's non-compliance outcome results and past performance history. Findings: During an observation on 7/7/2026 at 8:25 a.m. at facility hallway, there was one survey binder hanging on the wall. The survey binder contained the Complaint and Facility Reported Incidents and the result of the last standard survey, dated 2/11/2022. During a concurrent interview and record review on 7/7/2026 at 8:45 a.m. with the Administrator (ADM), the survey binder was reviewed. The ADM stated the survey binder was incomplete and not updated. The ADM stated the facility had an annual recertification survey (an unannounced, comprehensive inspection conducted on-site by CDPH to evaluate nursing home's compliance with federal health and safety compliance) in 2024 and 2025. The ADM stated he was responsible for putting the survey results for the past 3 preceding years in the survey binder. The ADM stated the updated survey results should be available and accessible to the public for transparency. The ADM stated the survey binder contained the statement of deficiencies identified by the CDPH and the facility's plan of correction. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, undated, the P&P indicated Federal and State laws guarantee certain basic rights to all residents of this facility and these rights include the right to examine survey results. During a review of the facility's admission packet, titled California Standard admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities, revised 8/2025, on page 63 and 64 indicated the resident has the right to examine the results of the most recent survey of the facility conducted by Federal and State surveyors and any plan of correction in effect with respect to the facility and should post in a place readily accessible to resident, and family members and legal representative of residents.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post the updated daily nurse staffing information that included the facility name, current date, total number and the actual hours worked by nursing staff directly responsible for resident care per shift along with the resident census, at the beginning of each day. This deficient practice had the potential to affect the care of the residents in the facility and for residents needs to go unmet. Findings: During a concurrent observation and interview on 7/7/2026 at 8:50 a.m., with the Infection Preventionist Nurse (IPN) at Station A, the staffing information, dated 7/6/2026 was observed to be posted. The IPN stated the nurse staffing information for the day, dated 7/7/2026 was not posted and updated. The IPN stated the nurse staffing information should include the projection and the actual hours worked by licensed nurses and CNA's that would be providing direct care and services to residents and the actual total number of residents living in the facility. The IPN stated the daily nurse staffing information should be prepared the day before and posted before the beginning of the shift. The IPN stated the nurse staffing information should be updated daily so the residents, staff, and visitors would know whether there were enough staff present to provide care and accommodate the residents' needs. During an interview on 7/8/2026 at 2:40 p.m., with the Director of Nursing (DON), the DON stated it was important for the nurse staffing information to be updated and posted daily to show that the facility was in compliance with regulations and to show how many staff the facility planned based on the census to take care and manage the residents living in the facility. During a review of the facility's undated Policy and Procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, the P&P indicated, The facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents.		