STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055650	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center of Redlands	700 E Highland Ave Redlands, CA 92374

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) was obtained and maintained for two out of four sampled residents (Resident 4 and 68) receiving psychotropic medications (medications affecting brain activities associated with mental processes and behaviors). This failure had the potential for residents and/or their representatives to make treatment decisions without being fully informed of the risks, benefits, alternatives, and potential adverse effects associated with psychotropic medications. Findings:1. A review of Resident 4's Order Summary Report, indicated Resident 4 had a physician order, dated 4/13/26, for quetiapine (generic for Seroquel, a psychotropic medication to treat mental illness) 25 milligrams (mg - unit of measurement) by mouth two times a day for psychosis manifested by mood swing. During a concurrent interview and medical record review on 6/11/26 at 11:40 AM with the Medical Records Assistant (MRA), the MRA stated the facility was unable to provide documented informed consent for Resident 4's quetiapine. 2. A review of Resident 68's physician orders indicated Resident 68 received Seroquel (brand name for quetiapine) for schizophrenia (a mental illness that is characterized by disturbances in thought) manifested by hallucinations and delusional thoughts (having false or unrealistic beliefs). The Seroquel dose was increased on multiple occasions, including:On 10/1/25, Seroquel 200mg by mouth at bedtime was ordered, increased from 100 mg; On 3/24/26, Seroquel 300 mg by mouth at bedtime was ordered, increased from 250 mg; On 5/13/26, Seroquel 400 mg by mouth at bedtime was ordered, increased from 300 mg; [NAME] 6/6/26, Seroquel 100 mg by mouth in the morning was added to the existing regimen. A review of Resident 68's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/1/26 - 3/31/26 and 5/1/26 - 5/31/26, indicated Resident 68 had physician orders for Wellbutrin XL (brand name for Bupropion extended-release [ER - a tablet designed to release drug slowly over an extended period of time], a psychotropic medication used to treat depression) as follows:Wellbutrin XL 150 mg by mouth daily, dated 3/24/26; andWellbutrin XL 300 mg by mouth daily, dated 5/13/26, increased from 150 mg. During a concurrent interview and record review on 6/11/26 at 11:40 AM with MRA, the MRA stated the facility was unable to provide documented informed consents for Resident 68's Seroquel dose increases, the initiation of Wellbutrin XL 150 mg and the subsequent dose increase from 150 mg to 300 mg. During a concurrent interview and medical record review on 6/11/27 at 2:40 PM with the Director of Nursing (DON), the DON confirmed the facility was unable to provide documentation demonstrating Resident 4 and 68 and/or their representatives had been informed of the risks, benefits, and alternatives associated with the psychotropic medications and agreed to treatments. The DON stated the expectation was for physicians to educate the resident and/or representative regarding the risks and benefits of treatment, obtain informed consent, and for facility nursing staff to verify the informed consent process was completed. A review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated July 2022, indicated, .Residents, families and/or the representative are involved in the medication management process. Psychotropic medication (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	management includes: a. indications for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences.Residents (and/or representatives) have the right to decalin treatment with psychotropic medications.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' Minimum Data Set (MDS- a federally mandated resident assessment tool) assessments accurately reflected residents' status per Resident Assessment Instrument (RAI- comprehensive assessment and care planning process used by nursing home) guidelines for three of 24 sampled residents (Resident 68, 59, and 47) when:1. Resident 68's tobacco use in the annual comprehensive assessment was not accurately coded.2. Resident 59's restorative nursing program was not coded accurately in the recent quarterly assessment.3. Resident 47's visual abilities in the latest quarterly assessment were not accurately coded. These deficient practices had the potential for Resident 68, 59 and 47 not to receive the necessary care, treatment, and/or services to attain their highest practicable level of functioning.Findings: 1.A review of Resident 68's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 6/11/26, indicated the resident was admitted to the facility on [DATE] with diagnoses that included nicotine dependence (cigarettes). A review of Resident 68's Progress Notes, dated 6/5/26, indicated, Chief Complaint:.smoker. A review of the facility's Smoking List dated 6/8/26, indicated Resident 68's name. The list also indicated, Smoking times 8:30am, 10:00 am, 1:00pm, 4:00pm, and 8:00pm. Location: Station B Back Patio. During a smoking observation on 6/8/26, at 4:03 PM, in the station B back patio, Resident 68 was observed smoking cigarettes supervised by the Activities Assistant (AA) together with other residents. A review of the Quarterly Risk Data Collection Tool, dated 10/3/25, indicated, .V. Smoking Assessment A. Resident Smoking Status 1. Does resident smoke? .Yes. 2. Resident Uses: a. Tobacco (cigarettes, cigars, pipe) was checked off. A review of Resident 68's comprehensive annual MDS with an Assessment Reference Date (ARD- a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 10/3/25, indicated, Resident 68's J1300. Current Tobacco Use was coded as 0 (No). During a concurrent interview and record review on 6/10/26, at 3:27 PM, with the MDS Coordinator (MDSC), MDSC reviewed Resident 68's comprehensive annual MDS assessment with an ARD of 10/3/25, MDSC acknowledged that Resident 68 was a smoker and stated Sec. J1300 should have been coded as 1 (Yes). MDSC also stated that the MDS assessment was not coded accurately. MDSC added that her expectation was for staff to accurately assess residents, review resident clinical records and code MDS assessments accurately. MDSC stated that the MDS assessment should be reflective of the resident's health status which was important in developing the resident's plan of care. A review of Resident 68's Care Plan Report, initiated 2/21/25, indicated, Resident is at risk for noncompliance with smoking policy. Goal. Will maintain compliance r/t (related to) smoking policy daily.Interventions. Educate resident on the facility's smoking policy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Centers for Medicare & Medicaid Services (CMS)'s Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025, indicated .Chapter 3: MDS Items (J). J1300: Current Tobacco Use.Steps for Assessment.3.review the medical record and interview staff for any indication of tobacco use by the resident.Coding Instructions.Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. 2. A review of Resident 59's admission RECORD, dated 6/10/26, indicated the resident was admitted to the facility on [DATE] with diagnosis that included hemiplegia (paralysis of one side of the body) affecting left nondominant side, essential hypertension (high blood pressure), and muscle spasm. During an initial tour observation and interview on 6/8/26 at 9:30 AM inside Resident 59's room, with Resident 59, Resident 59 was awake, verbally responsive, with bilateral lower legs orthotics (medical devices designed to support, align, or correct the function of a body part on both sides) while lying in bed. Resident 59 stated she was paralyzed on the left side of her body. A review of Resident 59's quarterly MDS assessment with an ARD of 5/11/26, indicated, Resident 59's Brief Interview for Mental Status (BIMS) score was 15 (cognitively [relating to the mental processes of acquiring, processing, and understanding information] intact). A review of Resident 59's Order Summary Report, dated 6/10/26, indicated, Resident 59 had the following orders: A. RNA (Restorative Nursing Assistant) program to include: AAROM (Assisted Active Range of Motion) to RLE (Right Lower Extremity) to maintain strength, mobility for duration as tolerated x 15 mins (minutes), 5x/wk (five times per week) x 90 days. One time a day every Mon, Tue, Wed, Thu, Fri for RNA for 90 days order date 05/06/2026. B. RNA program to include: BLE (Bilateral Lower Extremity) splinting for proper positioning and further contractures 7x/wk (seven times per week) x 30 days order date: 4/14/26 end date: 5/14/26. C. RNA program to include: PROM to LLE (Left Lower Extremity) to maintain mobility, prevent contractures for duration as tolerated, 5x/wk x 4 wks. (weeks), one time a day every Mon, Tue, Wed, Thu, Fri for RNA order date: 05/06/2026 discontinued on 05/21/26. D. RNA PROM (Passive Range of Motion) to BUEs (Bilateral Upper Extremities) to prevent contractures and maintain joint mobility x 15 mins. (minutes) one time a day every Mon, Tue, Wed, Thu, Fri for RNA for 90 days order date 05/06/26. During a concurrent interview and record review on 6/11/26, at 8:37 AM with the MDSC, the MDSC reviewed Sec. (Section) O0500. Restorative Nursing Program of Resident 59's quarterly MDS assessment with an ARD of 5/11/26, MDSC stated that the look-back period for this section was from 5/5-11/26. MDSC acknowledged that Sec. O0500 A (Range of motion [passive] was coded as 0. Sec. O0500 B (Range of motion [active]) was coded as 3. Sec. O0500 C (splinting or brace assistance) was coded as 1. During a subsequent interview and record review on 6/11/26, at 8:41 AM with the MDSC, the MDSC reviewed Resident 59's RNA Documentation Survey Report (legal document used to track RNA services provided) for the month of May 2026. MDSC stated that based on the report, Resident 59's Sec. O0500 A (Range of motion [passive] should have been coded as 5, Sec. O0500 B (Range of (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2023, indicated Policy Interpretation and Implementation.6. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. 7. The interdisciplinary team uses the MDS form currently mandated by federal and state regulations to conduct the resident assessment.11. All persons who have completed any portions of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 12. Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews. A review of the facility's P&P titled Charting and Documentation, revised July 2017, indicated Policy Interpretation and Implementation.3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview and record review, the facility failed to ensure adequate and timely collaboration and coordination with the contracted hospice agency for one of two sampled residents (Resident 52) when:1. Resident 52's vaccines were not coordinated for timely administration.2. Resident 52's hospice nursing assessments in the hospice binder were not readily available to facility staff.3. The hospice agency did not have a copy of Resident 52's comprehensive plan of care from the facility.These failures resulted in the delay of care and had the potential to cause miscommunication among staff and unmanaged health concerns for Resident 52. Findings:1. A review of Resident 52's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 6/11/26, indicated the resident was readmitted to the facility on [DATE] with diagnoses that included unspecified dementia (loss of mental function such as thinking, memory, and reasoning skills), encounter for palliative care (specialized medical care for anyone living with a serious illness), and chronic obstructive pulmonary disease (a progressive lung disease which blocks air flow making breathing difficult).A review of Resident 52's History and Physical (H&P), dated 4/10/25, indicated, .Decision Making Capability: Resident is unable to make decisions concerning health care because of cognitive (relating to the mental processes of acquiring, processing, and understanding information) deficit and aphasia (disorder caused by brain damage that impairs one's ability to communicate).A review of Resident 52's Order Summary Report dated 6/11/26 indicated, Admit to [name of hospice agency] on routine level of care.order date 9/15/2025.During a concurrent observation on 6/11/26, at 10:43 AM, inside Resident 52's room, Resident 52 was awake, blinked her eyes but did not respond when spoken to while lying in bed.A review of Resident 52's quarterly MDS with an Assessment Reference Date (ARD- a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 3/12/26, indicated, .O0250. Influenza Vaccine (an annual immunization designed to protect against flu viruses).Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season? (O0250A) 0 - No.O0350. Resident's COVID-19 (contagious respiratory illness caused by a virus) vaccination is up to date.0 - No, patient is not up to date.During a concurrent interview and record review on 6/10/26, at 4:01 PM, with the Infection Preventionist (IP), the IP reviewed Resident 52's vaccination informed consents (a process in which a healthcare professional educates a resident/patient about the risks, benefits, and alternatives of a given procedure or intervention so the Resident can make an educated decision). The IP stated that the influenza, pneumococcal (bacterial infection of the lungs), and COVID-19 vaccination consents were obtained on 12/4/25. The IP added that she faxed the orders to the facility's pharmacy [name of pharmacy] but was informed that the hospice agency should be the provider of these vaccines. The IP also stated that she missed informing and following up with the hospice nurse until April 2026. (4 months later)A review of Resident 52's hospice PHYSICIANS ORDER dated 4/6/26, indicated, Pneumococcal vaccine administer 0.5 ML (Milliliter- unit of measure for volume) IM (Intramuscular- into the muscle) x 1 dose in deltoid muscle (muscle of the shoulder) for pneumococcal immunization, COVID-19 vaccine administer 0.3 ML IM x 1 dose in deltoid muscle for COVID-19 immunization, Influenza vaccine administer 0.5 ML IM x 1 dose to deltoid muscle for seasonal influenza prevention.A review of Resident 52's Immunization Audit Report dated 6/10/26, indicated that the Influenza and COVID-19 vaccines were administered on 4/20/26 while the Pneumococcal vaccine was given on 5/4/26.During a subsequent interview on 6/10/26, at 4:10 PM, with the IP, the IP stated it was not acceptable that there was no follow-up made to the hospice agency regarding the vaccine issues that resulted in the delay in administration. The IP also stated that the delay could put Resident 52 at increased risk of contracting respiratory infections especially during the winter season which was from September to March.During an interview on 6/10/26, at 4:16 PM, with the Registered Nurse 3 (RN 3), RN 3 stated staff were expected to administer vaccines (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the winter season. RN 3 also stated staff were expected to communicate and follow-up with the hospice agency on any concerns involving resident care needs in a timely manner. RN 3 stated the delay in administration could put Resident 52 at risk for infections.During an interview on 6/10/26, at 4:41 PM, with the Director of Nursing (DON), the DON stated the vaccines should have been administered to Resident 52 during the winter season to help prevent diseases. The DON also stated that staff were expected to administer the vaccines after the consents were obtained. The DON further stated that staff were also expected to communicate with the hospice agency in a timely manner.A review of Resident 52's Care Plan Report, undated, indicated The resident has altered respiratory status/Difficulty Breathing r/t (related to) Asthma, COPD.Interventions.Administer medications as ordered.A review of the facility's INFECTION PREVENTIONIST Job Description, undated, indicated, POSITION SUMMARY The Infection Preventionist is accountable for decreasing the incidence and transmission of infectious diseases between patients, staff, visitors and the community through strategic planning, leadership, and consultation, you will lead and direct a robust team in the identification and implementation of infection prevention goals and objectives throughout the facility.ESSENTIAL DUTIES AND RESPONSIBILITIES.Partners with the Medical Director develop, implement and evaluate annual infection prevention goals and action plan.Oversees the operations of the infection prevention, epidemiology and relevant safety programs.Accountable for surveillance of healthcare acquired and community acquired infections.A review of the facility's Policy & Procedure (P&P) titled Influenza Vaccine, revised March 2022, indicated Policy Statement All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza.Policy Interpretation and Implementation 1. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents.A review of the facility's P&P titled Pneumococcal Vaccine, revised October 2023, indicated Policy Statement All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation 2. Assessment of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission.A review of the facility's P&P titled Coronavirus Disease (COVID-19)- Vaccination of Residents, revised October 2025, indicated Policy Statement Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated. Policy Interpretation and Implementation 2. COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist.2. A review of Resident 52's hospice binder indicated the nursing assessment tab was empty.During a concurrent interview and record review on 6/11/26, at 11:01 AM, with Licensed Vocational Nurse 2 (LVN 2), LVN 2 reviewed Resident 52's hospice binder. LVN 2 stated Resident 52 was a hospice patient of [name of hospice]. She also stated that hospice nurses came almost every day and assessed the resident. LVN 2 acknowledged the nursing assessment tab in the hospice binder was empty and stated that hospice nurses should have put their assessments in the binder as these served as a communication tool between the hospice and facility staff.During a concurrent interview and record review on 6/11/26, at 11:34 AM, with the DON, the DON reviewed Resident 52's hospice binder and acknowledged the nursing assessment tab was empty. The DON stated it was his expectation the hospice nursing assessments be filed in the hospice binder. The DON stated these assessments should be accessible to facility staff to facilitate communication and coordination between the two entities.3. During an interview on 6/11/26, at 11:45 AM, with the Minimum Data Set (MDS - a federally mandated resident assessment tool) Coordinator (MDSC), the MDSC stated Resident 52's comprehensive care plan was completed by the facility and the MDSC was not sure if the hospice agency had a copy.During a concurrent interview and record review on 6/11/26, at 1:56 PM, with the hospice agency's Director of Patient Care Services (DPCS), the DPCS stated the agency did not have a copy of Resident 52's comprehensive care plan from the facility. The DPCS stated the expectation was for the hospice agency to have a copy of the comprehensive care plan because it served as a communication tool (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	between the two agencies and to ensure that the care and services needed by Resident 52 were provided. The DPCS stated the joint responsibilities/mutual promises stated in the hospice services agreement were not followed.During a concurrent interview and record review on 6/11/26, at 2:12 PM, with the DON, the DON reviewed Resident 52's hospice agreement and stated it was his expectation for the hospice agency to have a copy of the resident's comprehensive plan of care from the facility. The DON also stated the hospice agreement regarding mutual responsibilities was not followed when Resident 52's care plan was not provided to the hospice agency.A review of Resident 52's Hospice Services Agreement, signed 9/3/25, indicated, .III. SERVICES TO BE PROVIDED BY HOSPICE.3.6 Professional management includes assessing, planning, monitoring, directing and evaluating the Patient's hospice care.IV. SERVICES TO BE PROVIDED BY FACILITY.4.6.Facility shall ensure that services rendered by Hospice meet the needs of the Patient in a timely manner.V. JOINT RESPONSIBILITIES/MUTUAL PROMISES 5.1 Development and Implementation of Plan of Care.Hospice and Facility shall each maintain a copy of each Patient's Plan of Care in their respective clinical records.EXHIBIT A HOSPICE SERVICES.II. Nursing Services.1. Assessment of Patient/family total care needs.EXHIBIT E DELINEATION OF NURSING AND AIDE SERVICES HOSPICE RN RESPONSIBILITIES: 3. Collaboration with Facility Staff in delivery and updating Plan of Care.6. Communication and coordination of patient care services of Facility Staff and Hospice interdisciplinary team.FACILITY RN/LVN RESPONSIBILITIES.1. Cooperation with hospice Staff in implementing and updating of Plan of Care.6. Communication with Hospice RN regarding needs for medication refills, new medication orders, and supply needs.A review of the facility's Policy & Procedure (P&P) titled Hospice Program, revised July 2017, indicated Policy Interpretation and Implementation.5. Hospice providers who contract with this facility: a. must have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency; and b. are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility.10. In general, it is the responsibility of the facility to.d. Communicating with the hospice provider to ensure that the needs of the resident are addressed.13. Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for 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 needed treatment and services were provided to maintain range of motion (ROM- full movement potential of a joint) for one of four sampled residents (Resident 59) when Resident 59's Restorative Nursing Program (a nursing-driven service in long-term care settings that helps residents maintain or improve their functional abilities to their highest possible level) orders were not followed in accordance with Resident 59's plan of care.These failures had the potential to cause further decline in functional mobility, ROM, and quality of life for Resident 59.Findings:During an initial tour observation on 6/8/26, at 9:30 AM, inside Resident 59's room, Resident 59 was awake, verbally responsive, with bilateral lower leg orthotics (medical devices designed to support, align, or correct the function of a body part on both sides) while lying in bed. Resident 59 stated she was paralyzed on the left side of her body.A review of Resident 59's admission RECORD dated 6/10/26, indicated the resident was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) affecting left nondominant side, polyneuropathy (condition where multiple nerves throughout the body malfunction simultaneously causing widespread numbness, tingling, pain and muscle weakness), and muscle spasm.A review of Resident 59's Minimum Data Set (MDS- a federally mandated resident assessment tool) with an Assessment Reference Date (ARD- a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 5/11/26, indicated, Resident 59's Brief Interview for Mental Status (BIMS) score was 15 (cognitively [relating to the mental processes of acquiring, processing, and understanding information] intact). The MDS assessment also indicated that Resident 59 had impairment on one side of the body for functional limitation in range of motion.A review of Resident 59's Order Summary Report, dated 6/10/26, indicated, Resident 59 had the following orders:A. RNA (Restorative Nursing Assistant) Program for PROM (Passive Range of Motion) to BLEs (Bilateral Lower Extremities) to maintain mobility, contracture (permanent or prolonged stiffening of muscles, tendons, skin or other soft tissues that restricts normal joint movement) prevention QD (every day), 5x/wk. (5 times per week) x 90 days. One time only for 90 days- order date: 05/28/26B. RNA Program to include: AAROM (Assisted Active Range of Motion) to RLE (Right Lower Extremity) to maintain strength, mobility for duration as tolerated x 15 mins (minutes), 5x/wk x 90 days. One time a day every Mon, Tue, Wed, Thu, Fri for RNA for 90 days- order date: 05/06/2026C. RNA Program to include: BLE splinting for proper positioning and further contractures 7x/wk x 30 days- order date: 4/14/26, end date: 5/14/26D. RNA Program to include: PROM to LLE (Left Lower Extremity) to maintain mobility, prevent contractures for duration as tolerated, 5x/wk x 4 wks., one time a day every Mon, Tue, Wed, Thu, Fri for RNA- order date: 05/06/26, discontinued on 05/21/26E. RNA Program to include: donning (the act of putting on an item) and doffing (the act of taking off or removing an item) of BLE orthotics for prevention of contracture and proper positioning QD, 7x/wk- order date: 05/28/26F. RNA PROM to BUEs (Bilateral Upper Extremities) to prevent contractures and maintain joint mobility x 15 mins, one time a day every Mon, Tue, Wed, Thu, Fri for RNA for 90 days. Order date: 05/06/26During an interview on 6/10/26, at 8:56 AM, with the RNA, the RNA stated that services provided to residents included splinting, active and passive ROM exercises. The RNA also stated RNAs were expected to document the services provided to residents in the cloud-based electronic health record on the same day or before the shift ended.During an interview on 6/10/26, at 9:37 AM, with the Registered Nurse (RN) 1, RN 1 stated it was her expectation for staff to follow doctor's orders and document before the shift ended because if it was not documented, it meant it was not done. RN 1 also added that this was important to ensure accuracy of the services provided to the resident.During an interview on 6/10/26, at 9:49 AM, with the Director of Rehabilitation (DOR), the DOR stated it was her expectation for RNAs to perform the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the Long-Term Care Ombudsman of a resident discharge for one of three sampled discharged residents (Resident 80).This failure had the potential to limit ombudsman involvement and advocacy related to Resident 80's discharge. Findings:A review of Resident 80s admission Record indicated Resident 80 was admitted to the facility on [DATE], with the following diagnoses, acute respiratory failure with hypoxia (Lungs cannot adequately transfer oxygen into the blood stream),Type II Diabetes Mellitus (a long term condition that causes high blood sugar levels) without complications , Essential Hypertension (high blood pressure that does not have a single identifiable medical cause).During a concurrent interview and record review on 06/11/26, at 9:15 AM, with Registered Nurse (RN 2), Resident 80's discharge records, dated 04/28/26, were reviewed. The discharge records indicated Notification Information- the facility must send a copy of this notice to a representative of the Office of the State Long Term Care Ombudsman. RN 2 stated Resident 80 was discharged home on [DATE] and discharge arrangements included home health services and durable medical equipment (DME).During a concurrent interview and record review on 06/11/26, at 12:05 PM, with the Medical Records Director (MRD), MRD stated nursing staff were responsible for faxing the notification for discharge to the Ombudsman and providing the transmittal notification to medical records. MRD stated that he was unable to locate the documentation that verified that the notification for discharge was faxed to the Ombudsman for Resident 80.During an interview on 6/11/26, at 2:45 PM, with the Director of Nursing (DON), the DON stated a discharge notification should have been faxed to the Long-Term Care Ombudsman upon discharge, as indicated in the Notice of Transfer or Discharge.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely completion and transmission of the Minimum Data Set (MDS - a federally mandated resident assessment tool) assessments in accordance with the Centers of Medicare and Medicaid Services (CMS) federal completion timeframes for two of three sampled residents (Resident 33 and 72) reviewed for Resident Assessments when:1. Resident 33's discharge MDS assessment was not done.2. Resident 72's quarterly MDS assessment was not transmitted after completion. These failures had the potential to result in inadequate monitoring of Residents 33 and 72's progress and decline, and the lack of resident specific information to CMS for payment and quality measure monitoring.Findings:1. A review of Resident 33's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 6/11/26, indicated the resident was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (a severe brain disorder in which people interpret reality abnormally), chronic obstructive pulmonary disease (COPD- a progressive lung disease which blocks air flow making breathing difficult), and essential hypertension (high blood pressure).A review of Resident 33's Physician Telephone order dated 2/22/26, indicated, Order Summary: May transfer resident to [name of hospital] for further evaluation.During a concurrent interview and record review on 6/11/26, at 8:52 AM, with the MDS Coordinator (MDSC), MDSC reviewed Resident 33's MDS assessments and stated Resident 33 had the following MDS Assessments:1. Quarterly MDS Assessment with an Assessment Reference Date (ARD- a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 1/3/26. MDSC stated this assessment was completed on 1/15/2026 and accepted by CMS on 1/16/26.2. Quarterly MDS Assessment with an ARD of 10/03/2025. MDSC stated this assessment was completed on 10/15/2025 and accepted by CMS on 10/16/2025. 3. admission MDS Assessment with an ARD of 7/4/2025. MDSC stated this assessment was completed on 7/7/2025 and accepted on 7/8/2025.The MDSC stated that Resident 33 was transferred to the hospital on 2/22/26 and did not come back. MDSC added that a discharge MDS assessment should have been done when the resident was discharged .The Centers for Medicare & Medicaid Services (CMS)'s Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025, indicated .Chapter 2: Assessments for the RAI.2.5 Assessment Types and Definitions.Item Set refers to the MDS items that are active on a particular assessment type or tracking form. There are 9 item subsets for nursing homes.Discharge (ND) Item Set. This is the set of items active on a standalone OBRA (Omnibus Budget Reconciliation Act of 1987) Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility. OBRA-Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include:.Discharge (return not anticipated or return anticipated).2. A review of Resident 72's admission RECORD dated 6/11/26, indicated the resident was readmitted to the facility on [DATE] with diagnoses that included toxic encephalopathy (a neurological disorder caused by brain damage, disease, or malfunction resulting from exposure to poisonous substances), chronic obstructive pulmonary disease (COPD- a progressive lung disease which blocks air flow making breathing difficult), and essential hypertension (high blood pressure).During a concurrent interview and record review on 6/11/26, at 9:00 AM, with the MDSC, MDSC reviewed Resident 72's MDS assessments and stated that Resident 72's latest MDS assessment was a quarterly MDS with an ARD of 4/27/26. MDSC stated that this assessment was completed on 5/1/26 but was not transmitted. MDSC added it was missed. MDSC stated that the assessment should have been (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transmitted within 14 days after the completion of the MDS assessment per RAI guidelines.The Centers for Medicare & Medicaid Services (CMS)'s Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025, indicated .Chapter 2: Assessments for the RAI.2.6 Required OBRA Assessments for the MDS.RAI OBRA-required Assessment Summary.Quarterly (Non-Comprehensive). Transmission Date No Later Than MDS Completion Date + 14 calendar days.A review of the facility's MDS Coordinator Job Description, undated, indicated, .ESSENTIAL DUTIES AND RESPONSIBILITIES.3. Perform healthcare assessments and reassessments.11. Utilize the Minimum Data Set (MDS) to code and record assessment data gathered from resident healthcare documentation review, including visual observations, discussions with direct care staff, and interviews with resident and family members. 12. Assess the content of each resident's MDS and medical record to ensure completeness and thoroughness of documentation.16.maintain all necessary documentation and resident records. Complete medical forms, charts, and reports in an accurate and timely manner.A review of the facility's Policy and Procedure (P&P) titled Resident Assessments, revised October 2023, indicated Policy Interpretation and Implementation.1. OBRA-Required Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include: b. Quarterly Assessments;.6. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments.15. All residents admitted to the facility are notified that the data from the MDS is transmitted to and maintained in a federal data repository, the Internet Quality Improvement Evaluation System (iQIES).

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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 observation, interview and record review, the facility failed to develop a care plan for oxygen administration for one of 25 sampled residents (Resident 82).This failure had the potential to prevent Resident 82 from receiving individualized respiratory care and treatment.Findings:A review of Resident 82's admission Record (demographic information), indicated Resident 82 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure with hypoxia (inadequate oxygen supply in the blood), pneumonia (infection/inflammation in lungs) and pleural effusion (when the fluid collects in the space around the lungs).A review of Resident 82's Order Summary Report (physician's orders) dated 6/2/26, indicated, Oxygen at 4 liter/minute [LPM- a unit that expresses flow rate] via nasal cannula [a flexible tube that delivers oxygen through the nose] continuously every shift.A review of Resident 82's Medication Administration Record for the month of June, indicated the oxygen at 4 LPM via nasal cannula was administered for Resident 82 from 6/3/26 to 6/8/26 on all shifts.A review of Resident 82's quarterly Minimum Data Set (MDS - a resident assessment tool), dated 6/6/26, section C1 Oxygen Therapy, indicated Resident 82's oxygen therapy was administered.During a concurrent observation and interview on 6/8/26, at 10:06 AM, with Licensed Vocational Nurse 3 (LVN 3), in Resident 82's room, Resident 82 was wearing a nasal cannula and had an oxygen concentrator set at 3 LPM. LVN 3 confirmed Resident 82's oxygen was set at 3 LPM. During an interview with the Medical Records Assistant (MRA) on 6/11/26, at 6:15 PM, MRA confirmed Resident 82 had no care plan for oxygen therapy. MRA also confirmed the licensed nurses were responsible for making the care plan for residents.A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. A review of another facility P&P titled, Oxygen Administration, revised 10/2010, indicated, Preparation . 2. Review the resident's care plan to assess for any special needs of the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional standards of practice were followed when:1. For one of five residents observed during medication administration (Resident 84), nursing staff failed to identify and clarify a physician order for enoxaparin (an anticoagulant [blood thinner]) that specified intramuscular (injected into a muscle) administration, which was inconsistent with manufacturer instructions for subcutaneous (injection into the fatty tissue beneath the skin) administration.This failure had the potential to result in unresolved medication order discrepancies and inaccurate clinical documentation regarding the route of administration, and medication administration inconsistent with the physician order and manufacturer instructions. The incorrect intramuscular order also had the potential to increase the risk of bleeding and hematoma (a collection of blood under the skin or within tissue that may cause swelling, bruising, and pain) formation if administered by the intramuscular route.2. For one of four residents reviewed for psychotropic medication use (Resident 6), nursing staff entered and utilized a diagnosis of psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality) without supporting clinical documentation.This failure had the potential to result in inaccurate clinical documentation, care planning, behavioral monitoring, and clinical decision-making based on unsupported diagnosis. Findings:During a medication administration observation on 6/9/26 9:43 AM, in Resident 84's room, Licensed Vocational Nurse (LVN) 2 administered seven medications, including enoxaparin (generic name for Lovenox, anticoagulant [blood thinner]) 40mg/0.4mL (milligram per milliliter - unit of measurement) by subcutaneous injection to Resident 84's left lower abdomen. A review of Resident 84's hospital record titled, Active Medication Interfacility Transfer Report, undated, indicated, Resident 84's home medications, including enoxaparin 40mg subcutaneously once daily with a documented start date of 2/25/26. A review of Resident 84's physician order, dated 6/5/26, indicated, Enoxaparin Sodium Injection Prefilled Syringe Kit 40 MG/0.4ML, inject 40 mg [milligram - unit of measurement] intramuscularly one time a day for PPX [prevention] DVT [deep vein thrombosis - blood clot]. A review of Resident 84's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/1/26 - 6/30/26, indicated nursing staff documented administration of enoxaparin as intramuscular on 6/6/26, 6/7/26, 6/8/26, and 6/9/26. During a concurrent interview and record review on 6/9/26, at 12:43 PM, LVN 2 acknowledged the physician order specified intramuscular administration. LVN 2 stated she administered the medication subcutaneously to Resident 84 because she knew enoxaparin should be administered by the subcutaneous route. LVN 2 acknowledged the physician order incorrectly specified intramuscular administration and confirmed nursing staff did not contact the physician to clarify the order. During a concurrent interview and record review on 6/9/26, at 2:11PM, with the Director of Nursing (DON), the DON reviewed Resident 84's physician order and MAR, and stated nursing staff should have clarified the physician order and corrected the route of administration. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for enoxaparin sodium injection, dated 1/2026, retrieved from Dailymed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs) indicated: .Do not administer enoxaparin sodium injection by intramuscular injection. Administer enoxaparin sodium injection by subcutaneous injection only. A review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, indicated: .If.a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. 2. A review of Resident 6's admission Record (a document showing a summary of the resident's information) indicated the resident was admitted to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility on [DATE] with diagnoses, including depression. A review of Resident 6's MAR, dated 4/1/26 - 4/30/26, indicated a physician order, dated 4/10/26, for aripiprazole (an antipsychotic medication to treat mental illness) 30 mg by mouth at bedtime for depression manifested by persistent low mood. A review of Resident 6's medical record titled, IDT [interdisciplinary] Behavior Management, dated 4/13/26, indicated the current medication aripiprazole 30 mg by mouth at bedtime for depression manifested by persistent low mood. A review of Resident 6's medical record titled, Preadmission Screening and Resident Review ([PASRR] - federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) level I screening, dated 4/18/26, indicated .Serious Mental Illness.Specify the diagnosis or describe the symptoms: Depression. A review of Resident 6's Care Plan Report, dated 4/22/26, indicated .the resident has depression. A review of Resident 6's Minimum Data Set ([MDS] - a standardized assessment tool) Assessment, Section I - Active Diagnoses, dated 5/16/26, indicated depression was documented as an active diagnosis. The MDS did not identify a psychotic disorder. A review of Resident 6's physician orders in the MAR, dated 6/1/26 - 6/30/26, indicated the diagnosis associated with aripiprazole was changed on 6/3/26 from depression manifested by persistent low mood to psychosis manifested by persistent low mood. A review of Resident 6's clinical record indicated the diagnosis of psychosis was subsequently incorporated into the resident's diagnosis list, care plan, PASRR documentation, and behavioral monitoring, as follows:Resident 6's medical record titled, Medical Diagnosis, undated, indicated a new diagnosis of Psychosis was added to Resident 6's medical record on 6/8/26 with date of diagnosis documented as 4/10/26 and the classification documented as present on admission. Resident 6's Care Plan Report, dated 6/8/2026, indicated the care plan for aripiprazole was updated on 6/8/26: .Potential for adverse side effects secondary to psychotropic drug use (Aripiprazole) secondary to (psychosis) manifested by the target behavior of (persistent low mood) .Administer Antipsychotic medication per order. Resident 6's PASRR level I screening, dated 6/8/26, indicated Schizophrenia/schizoaffective disorder or symptoms of psychosis was selected under the Serious Mental Illness section. Resident 6's MAR, dated 6/1/26 - 6/30/26, indicated a physician order, dated 6/4/26, for .Monitor behavior(s) of Psychosis q (every) shift for use of Aripiprazole. A review of Resident 6's clinical record did not identify documentation supporting a diagnosis of psychosis at the time the diagnosis was entered and utilized, including a physician assessment, psychiatric evaluation, consultation, or other clinical documentation supporting such diagnosis. During a concurrent interview and medical record review on 6/11/26, at 9:58 AM, with the DON, the DON stated Registered Nurse (RN) 3 mistakenly associated aripiprazole with a diagnosis of psychosis and entered the diagnosis without obtaining clarification regarding the resident's diagnosis from the physician. A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated July 2017, indicated: .The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. A review of the facility's P&P titled, Psychotropic Medication Use, dated July 2022, indicated: .Residents will not receive medications that are not clinically indicated to treat a specific condition.Psychotropic medication management includes.indications for use.Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record.

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	055650	A. Building B. Wing	06/11/2026

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Highland Care Center of Redlands	700 E Highland Ave Redlands, CA 92374

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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 follow the physician's order for oxygen administration and place an oxygen in use sign outside the room, in accordance with the oxygen administration policy for one of 25 sampled residents (Resident 82).This failure had the potential to result in ineffective oxygen therapy, potential respiratory distress, or compromised safety for Resident 82. Findings:A review of Resident 82's admission Record (demographic information), indicated Resident 82 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure with hypoxia (inadequate oxygen supply in the blood), pneumonia (infection/inflammation in lungs) and pleural effusion (when fluid collects in the space around the lungs).A review of Resident 82's Order Summary Report (physician's orders) dated 6/11/26, indicated an order for Oxygen at 4 liter/minute [LPM- a unit that expresses flow rate] via nasal cannula [tubing that delivers oxygen through the nose] continuously every shift on 6/2/26.A review of Resident 82's Medication Administration Record for the month of June, indicated the oxygen at 4 LPM via nasal cannula was administered for Resident 82 from 6/3/26 to 6/8/26 on all shifts.A review of Resident 82's quarterly Minimum Data Set (MDS - a resident assessment tool) dated 6/6/26 section C1 Oxygen Therapy, indicated Resident 82's oxygen therapy was administered.During a concurrent observation and interview on 6/8/26, at 10:06 AM, with Licensed Vocational Nurse 3 (LVN 3), in Resident 82's room, Resident 82 had a nasal cannula attached to oxygen concentrator (a device that provides extra air oxygen) set at 3 LPM and with no oxygen in use sign outside Resident 82's room. LVN 3 confirmed Resident 82's oxygen was set at 3 LPM instead of 4 LPM and no oxygen in use sign was found outside Resident 82's room.A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 10/2010, indicated, Preparation 1. Verify that there is a physician's order for this procedure . Steps in Procedure . 2. Place Oxygen in Use sign on the outside of the room entrance door.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 24 sampled residents (Resident 52) was assessed for the appropriate use of grab bars (safety devices anchored to bed to provide stability, maintain balance and prevent falls) based on acceptable standards of practice and per facility policy.This failure placed Resident 52 at risk for entrapment (an event in which resident was caught, trapped, or entangled in the tight spaced around the bed) and injury from the use of the affixed grab bars.Findings:A review of Resident 52's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 6/11/26, indicated the resident was readmitted to the facility on [DATE] with diagnoses that included unspecified dementia (loss of mental function such as thinking, memory, and reasoning skills), encounter for palliative care (specialized medical care for anyone living with a serious illness), and chronic obstructive pulmonary disease (a progressive lung disease which blocks air flow making breathing difficult).A review of Resident 52's History and Physical, H&P dated 4/10/25, indicated, .Decision Making Capability: Resident is unable to make decisions concerning health care because of cognitive (relating to the mental processes of acquiring, processing, and understanding information) deficit and aphasia (disorder caused by brain damage that impairs one's ability to communicate).A review of Resident 52's quarterly MDS with an Assessment Reference Date (ARD- a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 3/12/26, indicated, Resident 52 was dependent on staff for eating, toileting, oral hygiene, personal hygiene, and rolling in bed.A review of Resident 52's latest Side Rail Utilization Assessment, dated 3/19/26, indicated, A. Side Rail Usage 1. Type of Assessment c) Quarterly 2. Are siderails currently in use or being requested? C. Not in use or requested.During an initial tour observation on 6/8/26, at 12:08 PM, inside Resident 52's room, Resident 52 was asleep lying in bed. Resident 52's bed was placed in low position and with bilateral padded grab bars.During a concurrent observation and interview on 6/11/26, at 10:43 AM, inside Resident 52's room, with Resident 52, Resident 52 was awake, able to slightly move both upper extremities but did not respond when spoken to. Resident 52's bed was in low position and with bilateral padded grab bars.During an interview on 6/11/26, at 2:20 PM, with the MDS Coordinator (MDSC), the MDSC stated that residents were assessed for side rail/grab bar use using the Side Rail Utilization Assessment form during admission, quarterly, and as needed. MDSC also stated that an assessment, doctor's order, consent, and care plan were needed whenever side rails or grab bars were used.During a concurrent observation and interview on 6/11/26, at 2:34 PM, inside Resident 52's room, with the MDSC, the MDSC acknowledged Resident 52 had bilateral padded grab bars affixed to the bed.During a subsequent interview and record review on 6/11/26, at 2:40 PM, with the MDSC, the MDSC reviewed resident 52's electronic health record and stated there were no doctor's orders, informed consent, or care plan for the use of grab bars. MDSC also stated that since the resident could not use grab bars based on her ADL levels, the grab bars should not have been installed. MDSC added that the grab bars could place the resident at risk for entrapment and potential injury.During an interview on 6/11/26, at 2:55 PM, with the Director of Nursing (DON), the DON stated that residents using siderails/grab bars needed to have a doctor's order, consent, risk assessment, and care plan. The DON also stated that based on these findings, the facility's policy and procedure was not followed for Resident 52.A review of the facility's Policy and Procedure (P&P) titled Bed Safety and Bed Rails, revised August 2022, indicated Policy Statement. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Policy Interpretation and Implementation.2. Consideration is given to the resident's safety, medical conditions,.as well as input from the resident and family.Use of Bed Rails 1. Bed rails are adjustable metal or rigid plastic bars (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that attach to the bed. For the purpose of this policy :bed rails include:.c. grab/assist bars.The use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met, including.informed consent.5. The interdisciplinary evaluation includes:.d. consultation with the attending physician.8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure accurate accountability of controlled substances (medications with a high potential for abuse and dependence) for one of five randomly selected residents reviewed for controlled substance accountability (Resident 83). The facility's Controlled Drug Record (CDR - inventory records used to document receipt, use, and count of controlled substances did not match the Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident).This failure resulted in inaccurate accountability of a controlled substance and had the potential to result in diversion (controlled substances used by someone other than the resident for whom the medication was prescribed) or misuse of controlled substances and compromised resident medication safety. Findings:During an inspection of Medication Cart 1 at Nursing Station A on 6/9/26 at 1:01 PM in the presence of Licensed Vocational Nurse (LVN) 1, Resident 83's blister card (a type of medicine packaging where individual doses of medication are sealed in small, clear plastic bubbles (blisters) and attached to a rigid card or foil backing) for tramadol (an opioid medication used to treat moderate to moderately severe pain) 50 mg (milligram - unit of measurement) and corresponding records were reviewed. A review of Resident 83's physician orders, dated from 6/1/26 through 6/5/26 indicated the resident had multiple tramadol 50 mg orders, including as-needed and routine dosing schedules. A review of Resident 83's CDR, dated 6/3/26 through 6/9/26, indicated nursing staff removed one tramadol 50 mg tablet from the blister card on 6/8/26 at 1:30 PM and documented the removal in the CDR. A review of Resident 83's June 2026 MAR did not identify corresponding documentation that nursing staff administered the tramadol dose removed from the blister card on 6/8/26 at 1:30 PM. The MAR also did not identify corresponding pain assessments associated with that dose. During a concurrent interview and record review on 6/9/26 at 1:01 PM with LVN 1, LVN 1 stated Resident 83 had multiple changes to tramadol 50 mg orders, including changes to the as-needed dosing frequency and the addition of a routine tramadol 50 mg order. LVN 1 stated the pharmacy instructed nursing staff to continue using the tramadol 50 mg blister card already stored in the medication cart because the medication and strength remained the same. LVN 1 reviewed the CDR entry dated 6/8/26 at 1:30 PM and stated she removed the tramadol tablet from the medication cart, recorded the removal in the CDR and administered the medication to Resident 83. LVN 1 further stated, I don't know why I didn't document it in the MAR. LVN 1 confirmed the CDR and MAR did not match. During a concurrent interview and record review on 6/9/26 at 1:50 PM with the Director of Nursing (DON), the DON reviewed the records and confirmed the discrepancy between the CDR and the MAR for Resident 83. The DON further stated the expectation was for nursing staff to document removal of controlled substances in the CDR and document administration in the MAR after administering the medication. A review of the facility's policy and procedures (P&P) titled, Administering Medications, dated April 2019, indicated: .the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered.e. any complaints or symptoms for which the drug was administered; f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug.

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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 remove a discontinued medication from active medication storage in one of two medication rooms (Nursing Station A Medication Room).This failure had the potential to result in inadvertent administration of a discontinued medication. Findings: During a medication room inspection on 6/9/26 at 12:13 PM in the presence of the Director of Nursing (DON), a prefilled syringe of Spikevax 2025-2026 (COVID-19 vaccine) labeled for Resident 17 was observed in the medication refrigerator located in Nursing Station A Medication Room with a date of 5/14/26. A review of Resident 17's physician's telephone order, dated 5/13/26, indicated, Moderna COVID-19 Bivalent (a vaccine formulated to protect against two virus strains or variants) Intramuscular (injected into a muscle) Suspension (a liquid medication) 50 MCG/0.5ML (microgram per milliliter - unit of measurement).Inject 0.5 ml intramuscularly one time only for COVID VACCINE until 05/14/2026 23:59 (11:59 PM). A review of Resident 17's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/1/26 - 5/31/26, indicated nursing staff did not administer the vaccine to Resident 17 on 5/14/26. A review of Resident 17's clinical record did not identify documentation indicating staff obtained a subsequent physician order for COVID-19 vaccination or made additional attempts to administer the vaccine after 5/28/26. During a concurrent interview and clinical record review on 6/9/26 at 12:23 PM with the DON, the DON confirmed the order was a one-time order that ended on 5/14/26 and the order status was discontinued. The DON stated nursing staff should have removed the vaccine from the medication refrigerator and medication storage area. A review of the facility's policy and procedure titled, Discontinued Medications, dated November 2022, indicated, .Staff shall destroy discontinued medications.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to keep the lids of two of three dumpsters closed which exposed the trash inside.This failure had the potential to attract pests to the premises which could spread disease to residents and staff in the facility.Findings:During a concurrent observation tour and interview on 6/8/26, at 8:53 AM, with the Dietary Supervisor (DS), in the facility's outside garbage area, two of three metal dumpsters were open. Several trash bags were exposed inside one dumpster and trash was observed in the other. The DS confirmed the lids of two metal dumpsters were left open and needed to be closed at all times to prevent harboring of pests. A review of the facility's policy and procedure (P&P) titled, Food-Related Garbage and Refuse Disposal, revised 10/2017, indicated, 7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.