STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055664	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York Healthcare & Wellness Centre	6071 York Blvd. Los Angeles, CA 90042

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor and temperature for three (3) of 3 sampled residents (Resident 9, 77 and 78) in accordance with the facility's policy and procedure titled Food Temperatures These failures had the potential to result in decreased meal consumption and negatively affect the health and well-being of residents receiving meals in the facility. Findings: During a review of the admission Record (AR), the AR indicated Resident 78 was originally admitted to the facility on [DATE], with diagnosis myocardial infarction (heart attack) , hemiplegia (loss of movement on one side of body) and hemiparesis (weakness on one side of the body) following cerebral infarction (Stroke) , and multiple sclerosis (chronic neurological disease where the immune system attacks the protective covering of nerves in the brain and spinal cord). During a review of Resident 78's Dietary profile - V7 dated 3/3/26, the profile indicated Resident 78 was on a regular texture, thin liquid diet (consists only of see-through fluids and foods that melt into clear liquids at room temperature) and identified as vegetarian (someone who does not eat meat, poultry, or seafood), with documented food preferences of fresh fruits, salads, muffins with cheese, and soups. During a review of Resident 78's care plan titled Nutritional status dated 12/4/2025, the care plan indicated resident 78's nutritional status care plan included a consistent carbohydrate diet with standard portions and regular texture. The care plan indicated Resident 78 was a vegetarian and had a dietary preference of fresh fruits, salads, muffins with cheese, and soups. During a review of Resident 78 Minimum Data Set (MDS a resident assessment tool) dated 5/2/2026, the MDS indicated the resident has moderate impaired cognition (some memory problems, with forgetfulness) and is independent with eating tasks such as able to use utensils and bring food and or liquids to mouth and swallow food and or liquids once the meal is placed before the resident. During a review of Resident 9's AR, the AR indicated Resident 9 was originally admitted to the facility on [DATE], with a diagnosis including aftercare following a surgical amputation (removal of body part) , and diabetes (chronic medical condition in which the body is unable to regulate blood sugar levels) . During a review of Resident 9's History and Physical (H&P) dated 12/4/2025, the H&P indicated Resident 9 is capable of participating in plan of care. During a review of Resident 9's MDS, dated [DATE], the MDS indicated the resident is cognitively intact (can understand and answer questions, express preferences and concerns and provide reliable information during interviews) and is independent (resident completes activities by themselves with no assistance from helper) for most activities of life (ADL's) such as eating and hygiene tasks. During a review of the AR, the AR indicated Resident 77 was originally admitted to the facility on [DATE], with a diagnosis to include Diverticulosis (small pouches develop in the wall of the intestines causing abdominal discomfort) of the intestine, diabetes (chronic condition in which the body has difficulty regulating blood sugar) , and atrial fibrillation (an irregular and often rapid heart rhythm). During a review of Resident 77's MDS, dated [DATE], the MDS indicated the resident has severe impaired cognition (memory problems, trouble with decision making). During an interview on 5/18/2026 at 9:15AM, with Resident 78, Resident 78 stated she was a vegetarian and reported concerns regarding the quality of the vegetables served. Resident 78 stated the vegetables were mushy and overcooked (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and that food served was not hot and was unpalatable (unpleasant taste). During an interview on 5/18/2026 at 9:59AM, in the presence of certified nurse assistant (CNA) 1 to assist in language translation Resident 77 stated she did not like her food and that the food was cold and mushy. During an interview on 5/18/2026 at 10:35 AM, with Resident 9, stated she is dissatisfied with the meal quality and stated that vegetables were frequently mushy, and she did not like the texture. Resident 9 further stated breakfast and afternoon meals were often served cold. During a concurrent observation and interview on 5/19/2026 at 12:32 PM with Dietary Supervisor (DS) and Certified Dietary Manager (CDM), a test tray (a process of tasting, temping, and evaluating the quality of the food) was observed being prepared. The DS was observed obtaining the temperature of the food items with the facility's food thermometer. The DS stated meatballs with apple glaze was 124 degrees Fahrenheit (F, degree of temperature) (hot foods held at 140 degrees Fahrenheit or higher), pasta - 121 F, peas 132 F, 3 bean salad (cold food item [held at 41 degrees Fahrenheit or below] 50 F, mouse (cold food item) 41 F. DS and CDM stated the peas served on a residents' meal tray was overcooked, pale green in color, and lacked consistency in texture and shape, and appeared soft and mushy rather than maintaining their intended form. The CDM stated resident may have an issue with texture, consistency and color of the peas being pale green and soggy, therefore the food would not appeal to the resident. The CDM further stated poor food texture and appearance could potentially impact meal intake and contribute to nutritional concerns. During a review of the facility's policies and procedure (P&P) titled Food Temperatures revised on 10/02/2025, indicated food should be served promptly to maintain safe and palatable temperatures. The policy further indicated acceptable serving temperatures include hot foods held at 140 degrees Fahrenheit or higher on the steam table and cold foods held at 41 degrees Fahrenheit or below at point of service. Additionally dietary staff should minimize the duration food is held on the tray line to maintain food temperature and quality.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed toˆstore, prepare, distribute and serve food in accordance with professional standards for food service safetyˆin accordance with theˆfacility's policies and procedures, titled Food Storage and Handling , Refrigerated Storage Guide, Produce Storage Guideline, and Ice Machine& Ice Storage Chest to prevent the outbreak of foodborne illnessˆ(an infection or irritation of the gastrointestinal tract caused by consuming food or beverages contaminated with bacteria, viruses, parasites, or chemical toxins)ˆfor 96ˆof 99ˆresidents receiving food fromˆthe kitchenˆ. The facility failed to:ˆ ˆ Discard 9 cucumbers beyond labeledˆuse-byˆdate 5/16/2026 stored in the refrigerator.ˆ Label and store one case of frozen boneless chicken thighs thatˆindicates Received date and use-by-date.ˆˆ Cover the opening of an opened carton of liquid whole egg when stored in the walk-in refrigerator. Keep the ice scoop/bin in a covered container when not in use. ˆ These deficient practices posing a risk for bacterial growth and foodborne illnessˆand a potential forˆfood contamination (transfer of harmful bacteria or other germs to food, surfaces, or utensils) had placed residents at risk for foodborne illness and lead to other serious medical complications and hospitalization.ˆ Findings: ˆ ˆ During an initial kitchen tour and a concurrent interview on 5/18/2026 from 8:25 AM to 8:45 AM with the Certified Dietary Manager (CDM), the following were observed in the freezer and the walk-in refrigerator:ˆˆ ˆˆ Nine (9) including three (3) partially peeled cucumbers labeled 5/11/2026 and use-by date 5/16/2026;ˆˆˆˆ ˆ One carton opened cage-free liquid whole egg with uncovered opening from the top; ˆ One case of unopened frozen boneless chicken thighs with no label of received date or use-by-date. ˆ ˆ Duringˆthe sameˆobservation and aˆconcurrent interview onˆ5/18/2026ˆatˆ8:40ˆAM, theˆCDMˆstatedˆtheˆfacilityˆreceived the chicken thighs around 5/15/2026 but the label was notˆplaced. The CDMˆstated thatˆstoring food in the freezerˆlackingˆexpirationˆor use-by-date, or not properly covering opened package of liquid egg that allowed anything to contaminate the food item was considered unsafe for resident's consumption.ˆThe CDMˆstated according to facility policy, the kitchen staffˆare required toˆproperlyˆlabel and date foods when storing food and supply and in a safe manner. The kitchen staffˆand cooks are also responsible forˆdisposing food thatˆisˆpast its use-by-dates. If foodsˆcontaminated or past use-by-date areˆprovided to theˆresidents, they could get sick.ˆˆ During a follow-up kitchen tour and a concurrent interview on 5/19/2026 at 11:35 AM with the Certified Dietary Manager (CDM), ice scoop was placed in a plastic container with no cover next to the ice machine. The CDM stated the old one that had a lid to cover was broken and he was supposed to follow the facility policy and replace the broken ice scoop and container with one that had cover to prevent contamination. The CDM stated residents could get sick from the ice if staff served the residents with a contaminated scoop. During a review of the facility's Policy and Procedures titled Produce Storage Guideline dated in 2023, the P&P indicated that cucumbers are stored in the refrigerator four to six days. During a review of the facility's P&P titled Food Storage and Handling dated 2022, the P&P indicated that storing frozen meat, poultry and food should be labeled and dated. During a review of the facility's P&P titled Ice Machine& Ice Storage Chests revised 10/1/2014, the P&P indicated that facility staff should take the following precautions to help prevent contamination of ice machine, ice storage chest/containers or ice: Keep the ice scoop/bin in a covered container when not in use.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the heating, ventilation, and air conditioning (HVAC) system was properly maintained to provide a safe and comfortable environment for 97 residents. The HVAC unit servicing the conference room malfunctioned and emitted a burnt plastic odor and white smoke into the facility. The malfunctioning HVAC unit had the potential to adversely affect resident health and safety by exposing residents to smoke and burnt odors, causing respiratory discomfort, anxiety, and the need for emergency response measures. During a review of the facility Maintenance Log titled Checking HVAC and Coils, changing filters dated 1/2026 to 5/2026, indicated that routine inspections that were documented for HVAC Units 1 through 9 were documented. During a review of the Heating & Air conditioning Invoice dated 5/20/2026, indicated that HVAC #6 had a bad contactor (electrical component) that needed to be replaced. During an observation on 5/21/2026 at 12:39 PM in the facility day room/conference room, surveyors detected a burning plastic odor emanating from the ceiling ventilation vents. [NAME] smoke was observed from the ceiling vent of the conference room for approximately one minute before dissipating. Facility staff were immediately notified of the odor and smoke. Administrator (ADM) was observed initiating the facility's Emergency Operations Plan for an internal fire event. The ADM was observed directing front desk staff to contact 911, instructed staff to close resident room doors and monitor residents for any safety concerns and directed the Maintenance Supervisor (MS) to inspect the HVAC unit located on the roof above the day room area. Facility staff opened the front entrance doors to improve ventilation, and an industrial air scrubber was placed in the day room to assist with air circulation and odor removal. During an interview on 5/21/2026 at 12:42 PM, the MS reported that electrical power to the HVAC unit had been shut off after a burnt plastic odor was detected originating from the unit. The MS stated there were no visible signs of fire, active smoke, or fire damage observed at the HVAC unit. The MS further stated that the HVAC system serviced only the day room and front lobby area. During an observation on 5/21/2026 at 12:45 PM, the local fire department arrived at the facility, including the Fire Chief (FC) and firefighters, in response to the reported burning plastic odor and smoke in the day room/conference room area. The FC was observed discussing the incident and the facility's response actions with the ADM. The Firefighters were observed inspecting the day room ventilation ducts and requested access to the rooftop HVAC unit for further evaluation. During an observation on 5/21/2026 at 1:00 PM, facility staff were observed monitoring residents and maintaining resident room doors closed during the inspection. Residents residing in Rooms 22-24 and 1-4 were interviewed and stated they were doing okay. Residents denied shortness of breath, coughing, respiratory distress, or other related symptoms. During a concurrent record review on 5/21/2026 at 1:20 PM with the MS, Maintenance records for HVAC inspections, coil cleaning, and filter changes from January through May 2026 were reviewed. MS stated that the facility had nine rooftop HVAC units and had received routine inspections, coil cleaning, and filter replacement. The MS identified HVAC Unit #6 as the unit servicing the day room and front lobby and confirmed it did not provide ventilation to resident rooms. During a concurrent record review on 5/21/2026 at 1:30 PM with the MS, Heating & Air conditioning Invoice dated 5/20/2026 was reviewed. MS stated that HVAC #6 had been inspected on 5/20/2026 and the invoice had indicated that the HAVC #6 had a bad electrical component that needed to be replaced. MS stated that this damaged electronic component could have caused the HVAC #6 not to work properly which caused the burnt plastic smell and white smoke to come from the conference room ventilation duct. During an interview on 5/21/2026 at 1:57 PM - Interview with Repairman (RM 1), RM [ROOM NUMBER] stated he inspected the HVAC unit on 5/20/2026 and determined the unit had a defective electrical component requiring replacement. RM [ROOM NUMBER] stated his inspection today 5/21/2026 revealed the (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HVAC compressor was damaged and required replacement. RM [ROOM NUMBER] stated the burnt plastic odor and white smoke originated from the damaged compressor. RM [ROOM NUMBER] stated there was no evidence of active fire damage upon inspection; however, the electrical components associated with the compressor were damaged. RM [ROOM NUMBER] further stated the damaged electrical component identified during the 5/20/2026 inspection could have contributed to the compressor malfunction and subsequent damage. ˆA review of the facility's P&P titled Maintenance Service revised 1/2012, indicated that the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times and maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. The P&P indicated that the director of maintenance is responsible for maintaining the following records/reports: inspection of building; work order requests and maintenance schedules. A review of the facility's P&P titled Resident Rooms and Environment revised 1/2012, indicated that the facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following: cleanliness and order; pleasant, neutral scents; comfortable levels of ventilation and comfortable temperatures.

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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 initiate a comprehensive care plan for one out of four sampled residents (Resident 4) when the Resident 4's foley catheter (a thin hollow tube that is inserted through the opening of the urinary tract into a person's bladder and is used to drain the bladder into an external collection bag) was changed as a result of a change in condition due to significantly cloudy urine in accordance with the facility's policy and procedure titled Person-Centered Care Planning and Change in Condition. This deficient practice had the potential for Resident 4 to be at risk for complications related to the use of foley catheter such as infection and injury due to accidental removal of the catheter if notFindings: During a review of Resident 4's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included benign prostatic hyperplasia (enlargement of the prostate gland that commonly leads to difficulty in emptying the bladder), dysphagia (difficulty in swallowing), and muscle weakness. During a review of Resident 4's History and Physical (H&P), dated 4/2/2026, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/9/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). During a review of Resident 4's Change in Condition (CIC), dated 4/24/2026, timed at 1:09 PM, signed by Registered Nurse (RN) 2, the CIC indicated that the resident had significantly cloudy urine. The CIC also indicated that a new foley catheter was being placed by the treatment nurse. During a review of Resident 4's entire care plans, it did not include a care plan to indicate that a new foley catheter was placed on or around 4/24/2026. During a concurrent interview and record review on 5/20/2026 at 11:28 AM with the Treatment nurse (TN) 1, Resident 4's medical records were reviewed, including the care plans. TN 1 stated that there is no care plan or documentation to indicate that a new foley catheter was inserted on 4/24/2026. During an interview on 5/21/2026 at 11:31 AM with the Director of Nursing (DON), the DON stated that care plans are use as the basis on how [the facility] care for the resident. The DON added that the care plan should have a focus or problem, a goal that the facility wants to achieve, and interventions or actions on how to achieve that goal. The DON stated that for Resident 4, if the foley catheter was changed because of the CIC on 4/24/2026, then a new care plan should have been initiated for the insertion of a new foley catheter with interventions such as for the nurses to monitor the resident for signs of infection and to keep the foley catheter bag below the bladder. The DON further stated that if there is no care plan, the facility would not be able to effectively track the resident's care. During a review of the facility's policy and procedure (P&P) titled, Change in Condition, effective 8/25/2022, the P&P indicated that as part of the documentation of a change in condition, the nurse will update the care plan to reflect the resident's current status. During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, effective 5/22/2025, the care plan indicated that a person-centered care plan means that the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. The P&P also indicated that interventions are actions, treatments, procedures, or activities designed to meet an objective. The P&P also indicated that the care plan must describe services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. The P&P further indicated that care plans must be reviewed and revised by the facility after each assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update the comprehensive care plan for one out of three sample residents (Resident 39) to address the interventions and goals needed for Resident 39's was ordered to receive prednisone (a medication that suppresses the immune system and reduce inflammation) in accordance with policy and procedure titled Person-Centered Care Planning and Adverse Drug Reactions. This deficient practice placed Resident 39 at risk of not to be monitored and receive immediate care for the potential side effects of the medication, such as the risk of infections. Findings: During a review of Resident 39's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included muscle weakness, inflammatory polyarthropathy (clinical term describing inflammation in five or more joints), and hemiparesis (partial weakness, numbness, or reduced control on one entire side of the body). During a review of Resident 39's History and Physical (H&P), dated 9/4/2024, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2026, the MDS indicated that the resident has moderately impaired cognition (the ability to process thoughts and emotions). During a review of Resident 39's Change in Condition (CIC) Note, dated 5/11/2026, timed at 3:13 PM, the IC indicated that the resident complained of pain of the left hand near the knuckle. During a review of Resident 39's care plans, it included a care plan for the resident [complaint of] left hand pain, initiated on 5/11/2026. The care plan included an intervention to [follow up] with new orders, initiated on 5/11/2026. The care plan did not have documented evidence to address the interventions and goals needed for Resident 39's who was receiving prednisone. During a review of Resident 39's nurses progress notes, an entry, dated 5/11/2026, timed at 8:48 PM, indicated that a medication order was entered for prednisone oral tablet 20 MG (milligram, a unit of measuring weight) give 1 tablet by mouth one time a day for Rheumatoid Arthritis (a disorder that causes painful swelling, stiffness, and potential deformity of joints). During a review of Resident 39's physician's order, dated 5/11/2026, that indicated for Resident 39 to receive prednisone. During a concurrent interview and record review on 5/21/2026 at 11:31 AM with the Director of Nursing (DON), Resident 39's medical records were reviewed, including the resident's CIC, physician's orders, and care plans. The DON stated that Resident 39's care plan for left hand pain, initiated on 5/11/2026, does not include the medication prednisone. The DON stated that the care plan should have been updated to reflect the medication that was ordered by the physician to manage the resident's left-hand pain. The DON added that updating the care plan was important because some medications, such as prednisone that could have side effects that must be monitored. The DON further added that for prednisone, the nurses should be monitoring for infections, because prednisone can suppress the resident's ability to fight infections. During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, effective 5/22/2025, the care plan indicated that a person-centered care plan means that the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. The P&P also indicated that interventions are actions, treatments, procedures, or activities designed to meet an objective. The P&P also indicated that the care plan must describe services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. The P&P further indicated that care plans must be reviewed and revised by the facility after each assessment. During a review of the facility's P&P titled, Change in Condition, effective 8/25/2022, the P&P indicated that as part of the documentation of a change in condition, the nurse will update the care plan to reflect the resident's current status. During a review of the facility's P&P titled, Adverse Drug Reactions, effective 8/19/2025, the P&P indicated that the facility will monitor, promptly identify, document, report, and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriately address adverse drug reactions. The P&P indicated for staff to update the care plan for any new precautions or monitoring requirements.

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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 one of eight sampled residents (Resident 2) who was unable to carry out activities of daily living (ADL) received the necessary services to maintain good oral hygiene as indicated in the facility's policy and procedure titled ?Oral Care. This deficient practice had the potential to result in discomfort, pain, impaired oral health, and a decline in overall well- being. Findings: During a review of Resident 2' s admission Record (AR), the AR indicated Resident 2 was admitted on [DATE], with a diagnoses that included dysphagia (difficulty swallowing) quadriplegia(unable to move all four limbs and is completely dependent on others for mobility and activities of daily living) , and atherosclerotic heart disease(a form of heart disease caused buildup of plaque or fatty deposits in the arteries that supply blood to the heart). During a review of Resident 2's History and Physical dated 2/27/2026, indicated Resident 2 does not have the capacity the capacity to make medical decisions (decline in memory, thinking, reasoning, judgment, and the ability to perform everyday activities that is severe enough to interfere with daily life). During a review of Resident 2's Minimum Set Data (a resident assessment and care planning tool) dated 3/5/2026, indicated the resident was cognitively intact (minimal or mild difficulty in memory) and dependent on staff for all activities of daily living (ADLs) including oral hygiene. During an observation on 5/18/2026 at 12:46 PM in Resident 2's room, Resident 2 was observed sleeping in bed, breathing with mouth open, and dry lips were with brown scabbed areas present on the lower lip and debris was within the oral cavity. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 1, a regular facility staff assigned to Resident 2 on 5/18/2026 at 1:06 pm the resident was observed lying in bed breathing through his mouth. CNA1 confirmed the resident's lips were dry, cracked, and had brown scabs. CNA 1 stated that he provides oral care, brushing the residents' teeth once daily. During a concurrent observation and interview on 5/18/2026 at 1:11PM, with Director of Nursing (DON) in Resident 2's room, DON stated the resident's lips were dry and cracked with brown scabs. DON stated, the reason Resident 2's lips were dry was because, the resident breaths through his mouth and keeps his mouth open for a long period. The DON further stated staff should be providing oral care as needed. The DON did not indicate if Resident 2's was consistently provided oral care. DON did not identify any additional interventions being implemented to address the residents' dry, cracked lips and oral condition. During an observation on 5/18/2026 at 3:50PM in Resident 2's room, the resident was lying in bed, breathing with mouth open wide. Resident 2's lip was visible with brown scab. During a concurrent observation and interview on 5/18/2026 at 3:55PM with Registered Nurse (RN1) in Resident 2's room, RN1 stated, Resident 2 was breathing through his mouth with dry lips, cracked, and have brown scabbed areas. RN 1 stated that the resident should have lip balm (wax like substance to keep lips moisturized) applied to his lips and receive frequent oral swabbing. RN1 further stated Resident 2 appeared dry and dehydrated. During a concurrent interview and Record review on 5/20/2026 at 9:03AM, Resident 2's care plans were reviewed. DON stated the resident does not have a care plan created for oral care needed related to the resident's mouth breathing. DON further stated he should have a care plan that indicates specific interventions that staff must implement, including frequent swabbing of mouth and provide lip moisturizer. During a concurrent interview and record review on 5/20/2026 at 9:05 AM resident 2's Activities of Daily living (ADL) look back for oral hygiene from 4/1/26 - 4/14/26 was reviewed. DON stated the record indicated Resident 2 received oral care one time during the day shift and one time during the night shift. DON stated he should be receiving oral care as needed. During a review of the facility's policy and procedure titled, ?Oral Care revised on November 2015, indicated all residents receive appropriate oral care daily. The policy stated nursing staff are responsible for ensuring good oral care for each resident, assessing the oral cavity and teeth upon admission and as needed, (continued on next page)

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	055664	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York Healthcare & Wellness Centre	6071 York Blvd. Los Angeles, CA 90042

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observing adverse oral conditions such as bleeding , swelling, unusual mouth odor, pain, discomfort, or other abnormalities, and reporting identified concerns to the charge nurse. The policy further indicated oral care should be provided to dependent residents as necessary, measures should be taken to maintain oral hygiene and lip integrity, and oral care and pertinent observations are to be documented in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 resident receives care consistent with professional standard of practice to prevent pressure ulcers (a skin breakdown due to unrelieved pressure and friction to the skin) for one of one sampled resident (Resident 22), who was a high risk to develop pressure ulcer, with a waffle mattress (mattress to prevent pressure ulcer) overlay setting at 140 (firmness setting of the mattress 80 [soft] - 280 [firm]) as per physicians order. This deficient practice had the potential to result in development of pressure ulcer and/or skin breakdown, which could negatively affect Resident 22's quality of life. Findings: During a review of Residents 22's admission Record indicated the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's disease (brain condition that causes problems with movement), peripheral vascular disease (progressive circulation disorder), and muscle weakness. During a review of Minimum Data Set (MDS, a resident assessment tool), dated 4/1/2026, indicated Resident 22's cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated Resident 22 was dependent with all activities of daily living (ADLs). During a review of Resident 22's Braden Scale for Predicting Pressure Sore (ulcer) Risk dated 1/8/2026 indicated Resident 22 was completely immobile and high risk for pressure ulcer. During a review of Resident 22's Braden Scale for Predicting Pressure Sore Risk dated 4/2/2026 indicated Resident 22 was completely immobile and high risk for pressure ulcer. During a review of Resident 22's Order Summary report (OSR) (Physician Orders) dated 5/19/2026 indicated use of waffle mattress overlay to prevent pressure injury/ skin breakdown. Settings: 140. During a review of Resident 22's care plan (CP) revised on 5/17/2026, indicated, the resident had a wound management device: Waffle mattress an overlay (pad on top of mattress) to prevent pressure injury and skin breakdown. The intervention included to monitor for accurate settings (setting:140). During a concurrent observation and interview on 5/18/2026 at 9:35 AM with Licensed Vocational Nurse (LVN) 2 in Resident 22's room, Resident 22 was in bed on a waffle mattress with the setting was at 170. LVN 2 stated, the physicians order indicated the waffle mattress setting should be at 140, not 170. LVN 2 stated, the waffle mattress was being used for the prevention of pressure ulcer and/or skin breakdown, and not following the right setting defeats the purpose of the mattress and potentially could result in pressure ulcer and/ or skin breakdown. During an interview on 5/19/2025 at 10:05 AM with Director of Nurses (DON), DON stated, Resident 22 needs the waffle mattress because she's immobile and high risk for pressure ulcer. DON stated, it was the licensed nurse responsibility to follow physicians order, which indicated the waffle mattress setting should be at 140 not 170. DON stated, not following the setting reduces the effectiveness of the mattress, which potentially could result in pressure injury and/or skin breakdown. A review of the facility's policy and procedure (P&P) titled, Mattresses, dated 1/1/2012, indicated, the facility will provide mattresses capable of meeting needs of residents to provide pressure reduction to resident s at risk of skin breakdown, and an air mattress is used under the direction of an attending physician's order. A review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention, dated 7/31/2024, indicated a) complete a skin risk evaluation, develop a plan of care for the resident's risk factor, and implement intervention identified which include pressure redistributing devices for bed.

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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 provide a safe and hazard free environment in accordance with the facility's policy and procedure titled Resident Safety and Maintenance Service for one of three sampled residents (Resident 1), who was observed lying in bed under his overhead light fixture with plastic cover sagging and not properly secured. This deficient practice had the potential for the light fixture plastic cover to fall on to Resident 1 and cause injury. Findings: During a review of Resident 1's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included wedge compression fracture the lumbar vertebra (a broken bone in the lower back), bilateral hip osteoarthritis (the smooth cartilage that cushions the ends of your bones gradually wears away over time, causing bones to rub against each other and resulting in pain, stiffness, and swelling), and generalized muscle weakness. During a review of Minimum Data Set (MDS, a resident assessment tool), dated 4/20/2026, indicated Resident 1's cognitive skills (ability to make daily decisions) moderately impaired. The MDS indicated Resident 1's required supervision or touching assistance (Helper provides verbal cues and or touching steadying) with eating and personal hygiene, and substantial/maximal assistance (helper does more than half the effort) with toileting, bathing and dressing. During a concurrent observation and interview on 5/18/2026 at 9:00 AM with Licensed Vocational Nurse (LVN) 1, In Resident 1's room. Resident 1 was lying in bed under his overhead light fixture with plastic cover sagging and not properly secure. LVN 1 stated, she did not notice it, but the sagging cover of the light fixture potentially could fall on to Resident 1 and cause injury, it should be fixed immediately and secured properly. During an interview on 5/18/2026 at 9:15 AM with the Maintenance Supervisor (MS), In Resident 1's room. MS stated, he not aware that the Resident 1's light fixture cover was not secured properly and sagging. MS stated, the light fixture cover could fall on the patient and cause injury. During an interview on 5/19/2026 at 10:01 AM with the Director of Nurses (DON), DON stated, it is the responsibility of nursing as well as the maintenance supervisor to ensure Resident 1 had a hazard free environment. DON stated, the light fixture cover of Resident 1 should have been secured properly and not sagging, because it potentially could fall on to the Resident 1 and cause injury. A review of the facility's policy and procedure (P&P) titled Resident Safety dated 4/2021, indicated, purpose is to provide a safe and hazard free environment and to observe the safety and wellbeing of the Residents. A review of the facility's policy and procedure (P&P) titled Maintenance Service, dated 1/1/2012, indicated, the maintenance department maintains all areas of the building, and equipment's, and keep the building in good repairs and free from hazards.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 34 and 4) received appropriate treatment and services for urinary care in accordance with the professional standard of practice and facility's policy and procedures titled Indwelling Catheter, Guideline for Prevention of Catheter-Associated Urinary Tract Infection (2009) (CAUTI, a catheter associated UTI (an infection of the urinary tract that includes urethra, ureters, bladder and kidneys resulting when microorganism gets into the urine and travels to the urinary tract) and Suprapubic Catheter Re-insertion and Management. The facility failing to: 1. For Resident 4, the foley catheter (a thin hollow tube that is inserted through the opening of the urinary tract into a person's bladder and is used to drain the bladder into an external collection bag) was not monitored for use and no date when the catheter was inserted following a change in condition when the resident's urine was observed cloudy. 2. For Resident 34, the suprapubic catheter (SPC-an indwelling urinary catheter inserted surgically through the abdominal wall into the bladder for continuous urinary drainage) was not monitored for signs and symptoms of infection such as cloudiness and sediments (particles such as bacteria, crystals, blood cells and mucus in the urine. This deficient practice had the potential for Resident 4 and 34 to have delayed or not received care and interventions, and/or treatments to prevent catheter-associated urinary tract infection and other catheter associated complications such as dislodgement of the catheter and bladder discomfort from catheter blockage due to sediment buildups. Findings: 1. During a review of Resident 4's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included benign prostatic hyperplasia (enlargement of the prostate gland that commonly leads to difficulty in emptying the bladder), dysphagia (difficulty in swallowing), and muscle weakness. During a review of Resident 4's History and Physical (H&P), dated 4/2/2026, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/9/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). During a review of Resident 4's Change in Condition (CIC), dated 4/24/2026, timed at 1:09 PM, signed by Registered Nurse (RN) 2, the CIC indicated that the resident had significantly cloudy urine. The CIC also indicated that a new foley catheter was being placed by the treatment nurse. During a review of Resident 4's Treatment Administration Record (TAR) for April 2026, the TAR did not indicate documented evidence that a new foley catheter was inserted on 4/24/2026, as indicated in the CIC, dated 4/24/2026. During a review of Resident 4's entire care plans, the care plan did not include a care plan to indicate documented evidence that a new foley catheter was inserted on or around 4/24/2026. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's progress notes for the month of April 2026, the progress notes did not indicate documented evidence that a new foley catheter was inserted on or around 4/24/2026. During a review of Resident 4's Surveillance Data Collection Form (SDC) for Urinary Tract Infections, dated 4/27/2026, signed by the Infection Preventionist Nurse (IPN), the SDC did not indicate documented evidence of when Resident 4's foley catheter was inserted. During a review of Resident 4's Surveillance Data Collection Form (SDC) for Urinary Tract Infections, dated 5/5/2026, signed by IPN, the SDC did not indicate documented evidence of when Resident 4's foley catheter was inserted. During a concurrent interview and record review on 5/20/2026 at 11:28 AM with the Treatment nurse (TN) 1, Resident 4's medical records were reviewed, including the resident's care plans, progress notes, and TAR for April 2026. TN 1 stated that there was no care plan or documentation in the TAR and progress notes to indicate that a new foley catheter was inserted on 4/24/2026. TN 1 stated that he is not certain if he inserted a new foley catheter, but if he did, he stated that he might have forgotten to document it. During an interview on 5/20/2026 at 3:30 PM with RN 2, RN 2 stated that on 4/24/2026, TN 1 inserted a new foley catheter on Resident 4. RN 2 stated that she would expect that TN 1 to document the insertion of the new foley catheter immediately after he finished. RN 2 also stated that it was important to know when the foley catheter was inserted. During a concurrent interview and record review on 5/21/2026 at 11:11 AM with the Infection Preventionist Nurse (IPN), the SDC's, dated 4/27/2026 and 5/5/2026, were reviewed. The IPN stated that the SDC's does not include a date of when the foley catheter was inserted because there is no documented evidence that the foley catheter was inserted at the facility. The IPN also indicated that it was important for the facility to know the insertion date of the foley catheter because it is part of the facility's interventions to prevent the development of catheter-associated urinary tract infections (CAUTI). During a concurrent interview and record review on with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Indwelling Catheter, and resource titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, were reviewed. The DON stated that the facility's P&P indicate that catheter use and CAUTI's will be monitored. The DON also stated that the facility's resource for the prevention of CAUTI indicated that the date of catheter insertion must be documented. During a review of the facility's P&P titled, Indwelling Catheter- Insertion, Maintenance, and Discontinuation of, effective 8/19/2025, the P&P indicated for staff to document the following after the insertion of a foley catheter: Type and size of catheter inserted. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date and time of catheter insertion. Urine return and characteristics, color, and odor, if any. Any difficulties or discomfort. During a review of the facility's P&P titled, Indwelling Catheter, effective 8/19/2025, the P&P indicated that residents will be periodically assessed for the need for continued catheter use and/or any complications associated with catheter use. The P&P indicated that catheter use and CAUTIs will be included in the facility's monthly infection control surveillance. The P&P further indicated that the facility uses the resource titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infection (2009). During a review of the facility's resource for the prevention of CAUTI titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infection (2009), updated 6/6/2019, the resource indicated that the facility is to consider implementing a system for documenting the indication for catheter insertion, date and time of catheter insertion, individual who inserted catheter, and date and time of catheter removal. The resource also indicated that performance measures in preventing CAUTIs include compliance with documentation of catheter insertion and removal dates 2. During a review of Resident 34's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included UTI, acquired absence of other parts of the urinary tract (a missing part of urinary system), chronic kidney disease (CKD) (kidneys are damaged and cannot filter blood as well as they should), calculus of kidney (kidney stone) and neuromuscular dysfunction of the bladder/neurogenic bladder (lacks bladder control). During a review of Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2026, indicated Resident 34's cognitive skills (ability to make daily decisions) was intact. The MDS indicated, Resident 34 required setup and clean-up assistance (helper sets up and cleans up; resident completes activity), substantial/maximal assistance (helper does more than half the effort) with bathing and dependent (helper does all the effort) with toileting and dressing. During a review of Resident 34's Order Summary report (OSR) dated 5/19/2026 indicated to a) SPC via gravity drainage for neurogenic bladder, and b) assess urinary drainage for signs and symptoms of infection noting cloudiness and sediments. During a review of Resident 34's CP revised 5/18/2026, indicated Resident 34 had a SPC related to neurogenic bladder at risk for infection/UTI with intervention to assess urinary drainage for sign and symptoms of infection, noting cloudiness, color and sediments, and monitor and report to MD sign and symptoms of UTI including cloudiness. During a concurrent observation and interview on 5/18/2026 at 9 AM with Resident 34, in Resident 34's room. Resident 34 in bed, with SPC tubing and drainage bag cloudy with some sediments. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 34 stated, he feels fine, reporting not having any discomfort and no concerns. During a concurrent observation and interview on 5/18/2026 at 2PM (5 hours after first observation of Resident 34's SPC drainage bag) with Licensed Vocational Nurse (LVN) 2, in Resident 34's room. Resident 34 in bed, with SPC tubing and drainage bag cloudy with some sediments. LVN 2 stated, he did not assess the urinary drainage bag earlier, and it is cloudy and had sediments. LVN 2 stated, he though Treatment Nurse (TN) 1 assessed Resident 34's urinary drainage bag this morning. LVN 1 stated, monitoring of Resident 34's urinary drainage bag should be ongoing, because Resident was at risk for infection and/or UTI, not addressing the symptoms earlier had the potential to delay intervention of treatment for possible UTI. During an interview on 5/18/2206 at 3 PM with the TN 1, TN 1 stated, he did not notice the sedimentation and the cloudy urine in Resident 34's SPC tubing and urinary drainage bag at 7 AM this morning, but monitoring should be ongoing. TN 1 stated, it was the responsibility of the LVN and the TN to assess Resident 34's urinary drainage bag and should be ongoing. TN 1 stated, not addressing the sign and symptoms of possible UTI had the potential for delayed of intervention and treatment. During an interview on 5/19/2206 at 10:01 AM with the Director of Nurses (DON), DON stated, assessment of Resident 34's urinary drainage bag should be assessed by both LVN 1 and TN 1 and should be ongoing because of the risk for infection and/or UTI. DON stated, delay reporting of signs and symptoms of infection had the potential to result in delayed of intervention and/or treatment of possible UTI that could negatively affect Resident 34's quality of life. A review of the facility's policy and procedure (P&P) titled, Suprapubic Catheter Re-insertion and Management, dated 1/30/2026, indicated under monitoring and ongoing assessment, nursing staff shall monitor for and promptly report signs of infection (i.e. cloudy or foul-smelling urine). A review of the facility's policy and procedure (P&P) titled, Infection Control – Policies and Procedures, dated 6/21/2022, indicated objective includes to prevent, detect, investigate and control infections in the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to insure one out of eight sampled residents (Resident 2) offered and received the sufficient fluid intake to maintain proper hydration as recommended by the Registered Dietitian (RD) baseline daily fluid intake (calculated fluid a resident should consume each day) to ensure proper hydration. This deficient practice had the potential to result in Resident 2's continued dehydration (fluid deficit), impaired oral health, kidney damage, urinary tract infections, hospitalizations, and could result in a decline in the resident's overall condition. Findings: During a review of Resident 2' s admission Record (AR), the AR indicated Resident 2 was admitted on [DATE], with a diagnoses that included dysphagia (difficulty swallowing) quadriplegia (unable to move all four limbs and is completely dependent on others for mobility and activities of daily living) , and atherosclerotic heart disease (a form of heart disease caused by the buildup of plaque and fatty deposits) in the arteries that supply blood to the heart). During a review of Resident 2's History and Physical dated 2/27/2026, indicated Resident 2 does not have the capacity the capacity to make medical decisions (decline in memory, thinking, reasoning, judgment, and the ability to perform everyday activities that is severe enough to interfere with daily life). During a review of Resident 2's Minimum Set Data (a resident assessment and care planning tool) dated 3/5/2026, indicated the resident was cognitively (thought process) intact and dependent on staff for all activities of daily living (ADLs) including oral hygiene. During an observation on 5/18/2026 at 12:46 PM in Resident 2's room, Resident 2 was observed sleeping in bed, breathing with mouth open with dry observed dry lips and brown scabbed areas present on the lower lip and debris was within the oral cavity. During a review of Resident 2's Change of Condition (COC) report dated 5/18/2026, indicated resident had poor appetite and dry mouth due to mouth breather, physician and resident representative notified. During a review of Resident 2's Order Summary report dated 5/19/2026, indicated Resident 2 was transferred to General Acute Care Hospital (GACH) for further evaluation due to weakness and poor oral intake. During a concurrent interview and record review on 5/20/2026 at 10:05 AM with Director of Nursing (DON) of Resident 2's Nutritional Risk Assessment dated 2/27/2026, the Nutritional Risk Assessment indicated Registered Dietitian (RD) estimated the resident's fluid need was 1,269 ml to 1731 ml (5.3 to 7.2 cups) every day with the goal to have no signs or symptoms of dehydration. During a concurrent interview and record review on 5/20/2026 10:05 AM with Director of Nursing (DON) Resident 2's intake and output record from 5/1/2026 to 5/14/2026 indicated the resident's fluid intake was not consistently maintained within the Registered Dietitian's estimated daily fluid requirement of 1,269ml to 1731ml per day. The intake and output Record indicated the following daily fluid intakes.: 5/01/2026: intake 720ml; Output 1700 ml 5/02/2026: intake 960ml; output1390 ml 5/03/2026: intake 1200 ml; output 1340 ml 5/04/2026: intake 900ml; output 1300 ml 5/5/2026: intake 720 ml; output 750 ml 5/06/2026: intake 1200 ml; output 1640ml 5/07/2026: intake 720 ml; output 1500 ml 5/08/2026: intake 640 ml; output 1400ml 5/09/2026: intake 3120 ml; output 1540ml 5/10/2026: intake 960 ml; output 1120 ml 5/11/ 2026: intake 480 ml; output 1000 ml 5/12/2026: intake 960 ml; output 1640ml 5/13/2026: intake 1200ml; output 1200ml 5/14/2026: intake 1200ml; output 1680ml During a continued interview and record review on 5/20/2026 at 10:05 AM DON further stated the facility has a dashboard for clinical alerts for each resident; however, it did not appear that any alert had been generated regarding Resident 2's inadequate fluid intake. The DON stated there was no specific monitoring process in place. The DON explained the Certified Nursing Assistants (CNAS) were expected to encourage residents to take in fluids, but no specific care plan had been created or Physicians order placed related to Resident 2's dehydration problem. During a concurrent interview and record review on 5/21/2026 at 8:55AM with the DON, stated the physician had not been notified regarding Resident 2's fluid requirements not being met until yesterday 5/20/2026, at which time the physician ordered intravenous fluids (liquids (continued on next page)

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	055664	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
York Healthcare & Wellness Centre	6071 York Blvd. Los Angeles, CA 90042

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that are delivered directly into a person's bloodstream through a vein using a small tube inserted into a vein. During a review of the facility's policy and procedure titled, Hydration Program revised November 2015, indicated the facility will provide residents with fluids to minimize episodes of dehydration. The policy further indicated that a Registered Dietitian (RD) will determine a recommended baseline daily fluid need for all residents and that a plan of care will be developed for resident who trigger dehydration or have the potential for fluid imbalance based on diagnosis or medical history. The policy indicated that nursing staff will document fluid intake and notify nursing staff when a resident is not consuming sufficient fluids or exhibits signs and symptoms of dehydration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that two out of three medication rooms (MR), did not contain medications that were past the discard by date in accordance with the policy MR 2 contained two bags of Ertapenem (an antibiotic, medication that is used to treat infections) that were past the discard date. MR 3 contained one syringe of Enbrel (a medication used to reduce inflammation and swelling) that was past the discard date. This deficient practice had the potential for residents to be administered expired medications, which could lack the intended efficacy to treat the residents' diseases. Findings: a. During a review of Resident 69's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included hypotension (low blood pressure), muscle weakness, and diabetes mellitus (condition characterized by high blood sugar levels). During a review of Resident 69's History and Physical (H&P), dated 4/2/2026, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 69's Minimum Data Set (MDS, a resident assessment tool), dated 3/6/2026, the MDS indicated that the resident has moderately impaired cognition (the ability to process thoughts and emotions). During a review of Resident 69's physician's orders, dated 4/30/2026, indicated an order for Resident 69 to receive Ertapenem Sodium Infection Solution Reconstituted Use 500 MG (milligram, a unit of measuring weight) intravenously in the evening for [right] hip [hardware infection]. During a medication storage inspection on 5/20/2026 at 2:51 PM with the Assistant Director of Nursing (ADON), the facility's MR 3 was inspected. The MR 3's medication refrigerator was observed containing two bags of Resident 69's Ertapenem with a label that indicated to Discard After 5/17/2026. The ADON stated that the two bags of Ertapenem should not have been in the refrigerator because they are past the discard by date. b. During a review of Resident 43's AR, the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included muscle weakness, dysphagia (difficulty in swallowing), and dementia (a decline in mental ability-such as memory loss, impaired judgment, and confused thinking). During a review of Resident 43's H&P, dated 9/15/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 43's MDS, dated [DATE], the MDS indicated that the resident has severely impaired cognition. During a review of Resident 43's physician's orders since the resident's admission from 12/28/2024 to 5/21/2026, indicated no physician order for Resident 43 to receive Enbrel. During a medication storage inspection on 5/20/2026 at 3:09 PM with the ADON, the facility's MR 2 was inspected. The MR 2's medication refrigerator was observed containing one syringe of Resident 43's Enbrel with a label that indicated to Discard After 5/9/2026. The ADON stated that the syringe of Enbrel should not have been in the refrigerator because it is past the discard by date. During a follow up interview on 5/20/2026 at 3:13 PM with the ADON, the ADON stated that it was the responsibility of the nurses to remove expired medications from the medication because the medications could potentially be administered to the residents. The ADON added that the medications could be ineffective or could possibly be contaminated with bacteria if past the discard date. During a concurrent interview and record review on 5/21/2026 at 11:31 AM with the Director of Nursing (DON), Resident 43's medical records were reviewed, including the resident's physician's orders from 12/28/2024 to 5/21/2026. The DON stated that Resident 43 did not have an order for Enbrel. The DON stated she does not know why there was a syringe of Enbrel if the resident never had an order for the medication. The DON further stated that the medication should have been discarded because it was never in the resident's medication regimen. During the same interview on 5/21/2026 at 11:31 AM with the DON, the DON stated that it is the nurses' responsibility to inspect the stocked medications for (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any medications that are expired. The DON stated that if expired medications are not discarded before their expiration, there is a risk that the nurses might mistakenly administer the expired medication. The DON further added that expired medications could lead to the ineffective treatment of the residents' disease. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, revised 1/2018, the P&P indicated that it is the facility's policy that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The P&P indicated that outdated medications are immediately removed from the inventory, disposed of according to procedures for medication disposal. The P&P further indicated that all expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the accuracy of documentation for two out of four sampled residents (Resident 9 and Resident 94) who were observed during medication administration in accordance with the facility's policy and procedures titled Medication Administration- General Guidelines, by failing to ensure: 1. Licensed Vocational Nurse (LVN) 2 did not document the administration of Resident 94's meclizine (a medication used to treat dizziness) prior to the administration of the medication. 2. LVN 1 did not document the administration of Resident 9's acetaminophen (a medication used to control pain) prior to the administration of the medication. This deficient practice had the potential to cause inaccuracies in the residents' records, which could cause the misadministration of medications. Findings: 1. During a review of Resident 94's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included diabetes mellitus (high blood sugar levels), dizziness, and hypertension (high blood pressure levels). During a review of Resident 94's History and Physical (H&P), dated 10/3/2025, the H&P indicated that the resident has fluctuating capacity to understand and make decisions. During a review of Resident 94's Minimum Data Set (MDS, a resident assessment tool), dated 3/26/2026, the MDS indicated that the resident has intact cognition During a review of Resident 94's physician's orders, dated 10/29/2024, indicated for Resident 94 to receive Meclizine HCL oral tablet 25 MG (milligram, a unit of measuring weight) give 25 MG by mouth every 8 hours as needed for dizziness. During a medication administration observation on 5/19/2026 at 9:13 AM inside Resident 94's room, Licensed Vocational Nurse (LVN) 2 was observed preparing Resident 94's meclizine. LVN 2 placed Resident 94's meclizine tablet inside of a medication cup. After placing the meclizine tablet inside of the medication cup, LVN 2 was observed documenting in the MAR that meclizine was administered. During the same medication administration observation on 5/19/2026 at 9:14 AM inside Resident 94's room, LVN 2 administered Resident 94's meclizine. During a follow up interview on 5/19/2026 at 9:18 AM, LVN 2 stated that the correct process of medication administration is to document after the medication has been administered, and not before. LVN 2 further stated that he documented the administration of the medication before the medication was administered because he believed that there is no way that the resident will refuse the medication. 2. During a review of Resident 9's AR, the AR indicated that the resident was originally admitted on [DATE] with diagnoses that included 11/23/2025. During a review of Resident 9's H&P, dated 12/4/2025, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 9's MDS, dated [DATE], the MDS indicated that the resident has intact cognition (the ability to process thoughts and emotions). During a review of Resident 9's physician's orders, dated 5/14/2026, indicated for Resident 9 to receive acetaminophen oral tablet 500 MG give 2 tablets by mouth every 6 hours as needed for moderate pain. During a medication administration observation on 5/19/2026 at 9:32 AM inside Resident 9's room, LVN 1 was observed preparing Resident 9's acetaminophen. LVN 1 placed Resident 9's acetaminophen tablet inside of a medication cup. After placing the acetaminophen tablet inside of the medication cup, LVN 1 was observed documenting in the MAR that acetaminophen tablet was administered During the same medication administration observation on 5/19/2026 at 9:33 AM inside Resident 9's room, LVN 1 administered Resident 9's acetaminophen. During a follow up interview on 5/19/2026 at 9:45 AM, LVN 1 stated that the correct process of administering medications is for the nurse to document the administration of medication after the medication has been administered. LVN 1 stated that she made a mistake in documenting the administration of medication before she had administered the medication. During an interview on 5/21/2026 at 11:31 AM with the Director of Nursing (DON), the DON stated that the correct process for staff was to document in the MAR the administration of medication after the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication has been administered, and not prior to administration. The DON stated that documenting before the medication has been administered is not accurate because the resident could still refuse the medication. During a review of the facility's policy and procedure (P&P) titled, Medication Administration- General Guidelines, updated 11/2021, the P&P indicated that medications are administered as prescribed in accordance with good nursing principles and practices. The P&P also indicated that the individual who administers the medication dose records the administration on the resident's [Medication Administration Record] after the medication [administration] is completed.

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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** Based on observation, interview and record review, the facility failed to implement the facility's policy and procedure for infection control by failing to ensure a safe and sanitary environment to prevent transmission of diseases and infections for one of three sampled resident (Resident 8), who was observed on 5/20/2026 with a suction cannister (a medical receptacle used with suction machines to collect bodily fluids-such as mucus, and secretion) dated 5/18/2026 half-filled with cloudy secretions. This deficient practice can result in the suction cannister to harbor bacteria and/or virus (microscopic germs that can invade the body and cause infections) which potentially can get Resident 8 and negatively affect her quality of life. Findings: During a review of Resident 8's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included asthma (a condition that causes airways become swollen, narrow, and clogged with mucus), respiratory failure (a condition where the respiratory system fails to maintain adequate gas exchange), dependence on supplemental oxygen, and on palliative care (medical care for anyone living with a serious illness, focused on providing relief from symptoms). During a review of Minimum Data Set (MDS, a resident assessment tool), dated 4/14/2026, indicated Resident 8's cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated, Resident8 was dependent with all activities of daily living (ADL's). During a review of Resident 8's care plan (CP) revised 4/6/2026, indicated the resident required oxygen therapy related to respiratory illness. The interventions included to suction resident as needed for excess secretions and at risk for infection, with intervention that included to monitor for sign and symptoms of distress and monitor to Medical Doctor (MD). During a review of Resident 8's Order Summary Report dated 5/21/2026 indicated to administer oxygen at two liters (a metric unit of volume flow rate) via nasal cannula (flexible plastic device used to deliver supplemental oxygen) for respiratory failure and may suction excess oral secretions as needed. During a concurrent observation and interview on 5/20/2026 at 8:15 AM with MDS Nurse (MDSN), in Resident 8's room, observed at Resident 8's bedside a suction cannister dated 5/18/2026 half-filled with cloudy secretions. MDSN stated, the suction cannister should have been replaced after it was used to prevent infection. During an interview on 5/20/2026 at 2:25 PM with the Registered Nurse (RN) 1, RN 1 stated, Resident 8's oral suctioning are only done by RN, and she did not suction Resident 8 today so the secretions in the cannister must be old. RN 1 added, she would replace the suction cannister whenever she suctions Resident 8. RN 1 stated, suction cannister needs to be replaced after each use, because secretions could harbor bacteria and/or virus when it just sits there and Resident 8 could get sick from an infection. During an interview on 5/20/2026 at 3:21 PM with the Director of Nurses (DON), DON stated, the facility did not have a specific policy to when to dispose of a dirty suction cannister, though facility's suction cannister such as the one used by Resident 8 was a single-use item so it should have been disposed of after used. DON stated, since the suction cannister was dirty and dated 5/18/2026, it could have harbored bacteria and/ or virus that could potentially result in Resident 8 getting sick from an infection. A review of the facility's policy and procedure (P&P) titled, Infection Control - Policies and Procedure, (6/21/2022) indicated objectives includes prevent and control infections and maintain a safe and sanitary environment for personnel, residents, visitors and public. A review of the facility's policy and procedure (P&P) titled, Cleaning & Disinfecting of Residents Care Equipment, (1/1/2012) indicated semi- critical items consist of items that come in contact with mucous membrane (i.e. respiratory equipment), and single use items are disposed of after single use.