STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055737	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Hills Post Acute	12200 LA Mirada Blvd. LA Mirada, CA 90638

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within reach and/or not a proper call light for five of 18 sampled residents (Resident 31, Resident 44, Resident 95, Resident 48 and Resident 99). This deficient practice had the potential to negatively impact Residents 31, 44, 95, 48, and 99's psychosocial well-being and result in delayed provision of care and services. Findings: a. During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and depression (a medical illness causing feelings of sadness, or loss of interest in activities). During a review of Resident 31's Minimum Data Set (MDS - a resident assessment tool), dated 1/24/2026, the MDS indicated Resident 31's cognitive skills for daily decision making (the ability to think and process information) was moderately impaired. The MDS indicated Resident 31 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 31's care plan titled The resident has a communication problem related to difficulty hearing and Alzheimer's disease, dated 1/27/2026, the care plan indicated to provide a safe environment, including having the call light in reach. During an observation on 2/23/2026 at 9:20 a.m., at Resident 31's bedside, Resident 31 was observed lying in bed. The call light was located behind Resident 31's bed and not within reach. During a concurrent observation and interview on 2/23/2026 at 12:31 p.m., with Resident 31, at Resident 31's bedside, Resident 31 was observed sitting in bed visibly upset trying to reach the call light. Resident 31's call light was attached to the back side of her bed, not within reach. Resident 31 stated she needed assistance with using the restroom but was unable to call the nurse because she was not able to reach her call light. During a concurrent observation and interview on 2/23/2026 at 12:45 p.m., with Certified Nursing Assistant (CNA) 2, at Resident 31's bedside, Resident 31's call light was attached to the back of the resident's bed. CNA 2 stated the call light was not within reach. CNA 2 stated the call light should always be placed within Resident 31's reach so she could call for help when needed. CNA 1 stated not having the call light within reach placed Resident 31 at risk for unmet care needs, delayed assistance, increased risk for falls, and potential injury. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/2026 at 7:56 a.m., with the Director of Nursing (DON), the DON stated resident's call lights must be placed within the resident's reach at the bedside. The DON stated the call light was important for residents to be able to communicate their needs to staff. The DON stated licensed staff were responsible for ensuring residents' call lights were checked and positioned within reach at the bedside. The DON stated when a call light was not within reach, the resident would not be able to call for help, which was a safety issue. The DON stated this placed residents at risk for delayed care needs, and avoidable harm. b. During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE]. Resident 44' diagnoses included difficulty walking, dementia (a progressive state of decline in mental abilities), hypertensive heart disease (a heart disease caused by long-term high blood pressure) with heart failure (a condition in which the heart does not pump blood effectively to meet the body's needs), acute kidney failure (a sudden loss of kidney function in which the kidneys are unable to properly filter waste and fluids from the blood), stable burst fracture of the first lumbar vertebra (a broken bone in the lower spine caused by compression or pressure), unspecified fracture of T11-T12 vertebra (broken bones in the middle portion of the spine), and unspecified fracture of second lumbar vertebra (a broken bone in the lower spine). During a review of Resident 44's MDS, dated [DATE], the MDS indicated Resident 44's cognitive skills for daily decision making (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 44 required moderate assistance with toileting and bathing. The MDS indicated Resident 44 required maximal assistance (helper does more than half the effort) for transferring to and from bed and toilet and walking 10 feet and 50 feet. The MDS further indicated Resident 44 had a one fall since admission. During a review of Resident 44's History and Physical (H&P), dated 2/6/2026, the H&P indicated Resident 44 did not have the capacity to understand and make decisions. The H&P further indicated Resident 44 was identified as at risk for falls. During a review of Resident 44's Fall Risk assessment dated [DATE], the assessment indicated Resident 44 was at risk for falls. During a review of Resident 44's care plan titled Risk for falls, revised 2/5/2026, the care plan indicated to place Resident 44's call light within reach and encourage the resident to use for assistance as needed. During a concurrent observation and interview on 2/23/2026 at 9:58 a.m. with CNA 1, Resident 44's call light was observed hanging from a wall hook. CNA 1 stated the call light was not within reach. CNA 1 stated it was important for Resident 44 to have the call light accessible in case of an emergency. CNA 1 stated if the call light was not within reach, Resident 44 could attempt to get up without assistance and fall. During an interview on 2/25/2026 at 11:41 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 44 was on fall precautions and should have the call light within reach at all times. LVN 5 stated Resident 44 could attempt to reach for something and fall without a way to contact staff for assistance. c. During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE]. Resident 95's diagnoses included hemiplegia (total paralysis (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke – caused by a blockage that stops blood flow to part of the brain), aphasia (a disorder that makes it difficult to speak), apraxia (difficulty coordinating movements), anxiety disorder (a condition causing excessive worry, fear, or nervousness), and dysphagia (difficulty swallowing).During a review of Resident 95's MDS, dated [DATE], the MDS indicated Resident 95's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 95 required maximal assistance for eating and was dependent (staff does all the effort) for toileting, bathing, dressing, and personal hygiene. During a review of Resident 95's H&P, dated 2/16/2026, the H&P indicated Resident 95 did not have the capacity to make decisions. During a review of Resident 95's care plan titled Risk for falls, revised 1/26/2026, the care plan indicated to place Resident 95's call light within reach and encourage the resident to use for assistance as needed. During a concurrent observation and interview on 2/23/2026 at 10:51 a.m. with Resident 95, Resident 95 was observed in bed, awake and alert. Resident 95 attempted to speak but was unable to articulate understandable words. Resident 95 pointed to the picture call nurse on her communication board. The call light was observed hanging behind the resident's head on the bedpost. When asked if she was able to reach the call light, Resident 95 shook her head, indicating no. During a concurrent observation and interview on 2/23/2026 at 11:02 a.m. with CNA 3, in Resident 95's room, the call light was observed hanging on the bedpost behind the resident. CNA 3 stated the call light should have been within reach at all times so she could call for help if she was in pain, needed assistance, or during an emergency. CNA 3 stated she forgot to return the call light to the resident after checking on her earlier. During an interview on 2/25/2026 at 11:34 a.m. with LVN 5, LVN 5 stated it was important for Resident 95 to have the call light within reach for emergencies or when assistance was needed. LVN 5 stated residents could fall or experience an emergency and would not be able to summon help if the call light was not accessible. LVN 5 stated Resident 95 could not verbalize her needs, which made it more important for the call light to remain within reach. d. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE]. Resident 48's diagnoses included contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right elbow and wrist, functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), dysphagia (difficulty swallowing), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 48 had functional range of motion (ROM, the measure of the full, natural movement potential of a joint, such as how far it can bend or stretch) limitations to his upper and lower extremities (arm, legs). The MDS indicated Resident 48 was entirely dependent on staff for ADLs. During a review of Resident 48's care plan titled, At Risk for Falls, initiated 11/21/2024, the care plan (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated to keep the call light within reach, and ensure a safe environment with a working and reachable call light. During a concurrent observation and interview on 2/23/2026 at 1:50 p.m. with Resident 48, in Resident 48's room, Resident 48 was observed in bed with both wrists and elbows in a fixed, flexed (bent) position. A push button call light was observed. Resident 48 attempted to activate the call light but was unable to do so due to limited ROM in her elbows and wrists. Resident 48 stated she could not push the button. During an observation on 2/24/2026 at 12:09 p.m., in Resident 48's room, observed a push button call light at Resident 48's bedside. During a concurrent interview and record review on 2/24/2026 at 12:20 p.m. with Registered Nurse (RN) 1, a photo of Resident 48's call light, dated 2/24/2026 and timed at 12:09 p.m., was reviewed. RN 1 stated Resident 48 was capable of verbalizing her needs. RN 1 stated Resident 48's call light was not the most appropriate call light because she was unable to call or ask for help when needed. RN 1 stated Resident 48 would have benefitted from a call pad due to her presence of contractures to the wrist and elbows. RN 1 stated the incorrect call light placed Resident 48 at risk for delayed response to emergent or non-emergent care needs. e. During a review of Resident 99's admission Record, the admission Record indicated Resident 99 was admitted to the facility on [DATE]. Resident 99 diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), Alzheimer's (a disease characterized by a progressive decline in mental abilities), dysphagia, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and contractures of the right and left knees and ankles. During a review of Resident 99's H&P, dated 9/2/2025, the H&P indicated Resident 99 did not have the mental capacity to make decisions. During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99 cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 99 was dependent for ADLs. During an observation on 2/23/2026 at 10:39 a.m., at Resident 99's bedside, Resident 39 was observed lying in bed. The call light was on the floor under the bed. During an interview on 2/24/2026 at 2:02 p.m., with LVN 6, LVN 6 stated the the call light must always be kept within the resident's reach while the resident was in bed or seated. LVN 6 stated that the call light should never be placed on the floor or underneath the resident's bed. LVN 6 stated staff were responsible for ensuring the call light was accessible after providing care, repositioning the resident, or leaving the room. LVN 6 stated that maintaining the call light within reach was a basic safety measure and an expectation for all nursing staff to ensure resident safety and timely assistance. During an interview on 2/26/2026 at 10:23 a.m., with the DON, the DON stated the facility policy required call lights to be within all residents' reach at all times. The DON stated that it was the responsibility of nursing staff to ensure the call light was properly placed before exiting the residents' room. The DON stated that placing the call light on the floor or under the bed was not an acceptable (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practice and did not meet the facility's safety standards. The DON indicated that failure to maintain the call light within reach could prevent residents from summoning assistance in a timely manner and could increase the risk of falls, injury, or delayed care. During a review of the facility's policy and procedures (P&P) titled Call Lights: Accessibility and Timely Response, dated 12/19/2022, the P&P indicated the facility staff will ensure the call light is within reach of resident and secured. The P&P indicated the call system would be accessible to residents while in their bed or other sleeping accommodations within the resident's room. The P&P indicated each resident should, as much as possible, be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. The P&P further indicated special accommodations would be identified on the residents' person-centered plan of care and provided accordingly (examples include touch pads, larger buttons, bright colors, etc.).

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's consent for the administration of a psychotropic medication (drugs that affects behavior, mood, thoughts, or perception) was obtained from and verified with the resident's representative party (RP) for one out of two sampled residents (Resident 3).This deficient practice had the potential to place Resident 3 at risk for receiving psychotropic medications without the proper authorization and education regarding the risks and the benefits of the prescribed psychotropic medications.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (loss of blood flow to a part of the brain) affecting the right dominant side, hypertensive heart disease (high blood pressure), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), atrial fibrillation (irregular heart rhythm) and end stage renal disease (ESRD- irreversible kidney failure).During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 3's cognitive skills for daily decision making (ability to think and reason) was moderately impaired. The MDS indicated Resident 3 was dependent on staff's assistance with toileting, bathing, and upper/lower body dressing.During a review of Resident 3's History and Physical (H&P), dated 11/11/2025, the H&P indicated Resident 3 did not have the capacity to understand and make medical decisions.During a review of Resident 3's physician order dated 11/18/2025, the order indicated Lorazepam (a psychotropic medication) one milligram (mg, a unit of measurement) every six hours as needed for anxiety (feeling of unease).During a review of Resident 3's Medication Administration Record (MAR), dated 11/2025 through 12/2025, the MAR indicated from 11/18/2025 through 12/10/2025, Resident 3 was administered Risperidone (a psychotropic medication) 0.5 mg three times a day.During a concurrent interview and record review on 2/24/2026 at 12:20 p.m. with Registered Nurse (RN) 1, Resident 3's Psychotropic Consent Forms for Risperidone 0.5 mg and Lorazepam 1 mg, dated 11/16/2025, were reviewed. The consent forms indicated consent was obtained from Resident 3. RN 1 stated she was the nurse responsible for obtaining verification of informed consent for the administration of Resident 3's psychotropic medications. RN 1 stated because Resident 3 was deemed unable to make medical decisions, consent should have been verified with Resident 3's Representative Party and not Resident 3. RN 1 stated Resident 3's RP had the right to make informed, medical decisions on Resident 3's behalf and should have been made aware of the risks and the benefits of both psychotropic medications before their continued use within the facility. RN 1 stated this placed Resident 3 at risk for receiving psychotropic medications without the appropriate authorization, education regarding risks and benefits, and the opportunity for informed decision-making.During a review of the facility's policy and procedure (P&P) titled, Use of Psychotropic Medications, revised 3/17/2025, the P&P indicated prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative would be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medication advance of such initiation or increase. The P&P indicated the facility would document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options, and the preferred option to accept or decline.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify one of one sampled resident's (Resident 138) physician of scattered ecchymosis (bruising) on both of his arms upon his admission to the facility.This deficient practice resulted in Resident 138's ecchymosis being unmonitored and had the potential for worsening bruising and delay in care.Findings:During a review of Resident 138's admission Record, the admission Record indicated Resident 138 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of the vertebra in the lumbar region (infection in the spinal bones of the lower back), discitis in the lumbar region (infection of the disc space between the spinal bones), and spondylosis (age-related wear and tear of the spine).During a review of Resident 138's History and Physical (H&P), dated 2/20/2026, the H&P indicated Resident 138 had the capacity to understand and make decisions.During a review of Resident 138's physician orders, active on 2/25/2026, the physician orders indicated to inject heparin sodium (anticoagulant medication used to treat blood clots from forming in the blood vessels and the heart) injection solution 1000 units per milliliter (mL, unit of measurement), 0.5 mL subcutaneously (into the fat tissue) two times a day for deep vein thrombosis prophylaxis (method used to stop blood clots from forming in deep veins, usually in the legs, of at-risk individuals). The physician orders did not indicate to monitor Resident 138 for signs of bleeding. During a concurrent observation and interview on 2/23/2026 at 9:56 a.m., with Resident 138, in Resident 138's room, Resident 138 was observed lying in bed with scattered ecchymosis (bruising) on his arms. Resident 138 stated the bruises on his arms developed in the general acute care hospital (GACH) when he started on heparin. Resident 138 stated he did not have any other issues with bleeding.During a concurrent interview and record review, on 2/25/2026 at 9:24 a.m., with Registered Nurse (RN) 1, Resident 138's Skin Check, dated 2/20/2026, was reviewed. The Skin Check indicated Resident 138 had a pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) to his sacrum (area near the bottom of the spine) and an open wound to his left upper arm. The Skin Check did not indicate scattered ecchymosis on Resident 138's arms. RN 1 stated Resident 138 was admitted to the facility with scattered ecchymosis on his arms due to his heparin therapy. RN 1 stated the Skin Check should have indicated the scattered ecchymosis on Resident 138's arms to ensure Resident 138's physician was notified of the assessment.During a concurrent interview and record review, on 2/25/2026 at 9:27 a.m., with RN 1, Resident 138's Progress Notes, dated 2/19/2026 through 2/25/2026, were reviewed. The Progress Notes did not indicate Resident 138's physician was notified of the scattered ecchymosis on his arms. RN 1 stated Resident 138's physician was only notified of the pressure injury and open wound but was not informed of the scattered ecchymosis. RN 1 stated informing Resident 138's physician of the scattered ecchymosis upon admission was important to ensure Resident 138 was monitored for new or worsening ecchymosis on his arms and the rest of his body. RN 1 stated early notification upon admission would inform Resident 138's physician of the existing problem and to allow the physician to evaluate the necessity of the heparin treatment. RN 1 stated this placed Resident 138 at risk of undetected bleeding and delay in treatment.During a review of the facility's policy and procedure (P&P) titled, Notification of Changes, dated 12/19/2022, the P&P indicated the facility would promptly inform the resident's physician of any change requiring notification. The P&P indicated the physician was notified of circumstances that require a need to alter treatment such as a new treatment or discontinuation of current treatment due to adverse consequences or an acute condition.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete an accurate Minimum Data Set (MDS, a resident assessment tool) assessment for one of six sampled residents (Resident 50) oral and/or dental status.This deficient practice resulted in incorrect data transmitted to the Centers for Medicare and Medicaid Services (CMS, a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program) regarding Resident 50's missing natural teeth, and had the potential to negatively affect Resident 50s' plan of care and delivery of necessary care and services.Findings:During a review of Resident 50's admission Record, the admission Record indicated Resident 50 was originally admitted to the facility on [DATE] and re admitted on [DATE]. Resident 50's diagnoses included dysphagia (difficulty swallowing), chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), and depression (a medical illness causing feelings of sadness, or loss of interest in activities). During a review of Resident 50's History and Physical (H&P), dated 1/8/2026, the H&P indicated Resident 50 had the capacity to understand and make decisions. During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 50 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS did not indicate Resident 50 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 2/24/2026 at 1:10 p.m., at Resident 50's bedside, with Resident 50, Resident 50 was observed eating lunch. Resident 50 stated she did not have her upper and bottom natural teeth. During a concurrent interview and record review on 2/24/2026 at 3:30 p.m., with the MDS Nurse (MDSN), Resident 50's MDS, dated [DATE], section oral/dental status was reviewed. The MDS did not indicate Resident 50 was assessed as not having any oral and/or dental issues. The MDSN stated Resident 50's MDS oral/dental status assessment was coded incorrectly, as it did not reflect the resident's actual oral and/or dental status. The MDSN stated that because Resident 50 did not have her natural teeth, the MDS should have been coded to reflect that the resident was edentulous (toothless). The MDSN stated accuracy of the MDS assessment was important not only for outcome measures and quality indicators, but also for developing and individualizing a care plan based on the resident's actual needs. The MDSN stated inaccuracy of the MDS assessment had the potential to negatively impact the care provided, leading to inappropriate care planning and not meeting the residents' needs and services.During a review of the facility's policy and procedures (P&P) titled Resident Assessment-RAI, dated 12/19/2022, the P&P indicated the facility will conduct a comprehensive and accurate assessment of each resident's needs and health conditions, including dental status.During a review the facility's P&P titled MDS/CRC Coordinator-Job Description, undated, the P&P indicated the MDS coordinator was responsible for accurate completion of all MDS assessments.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASARR - a 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 was completed for one of eight sampled residents (Resident 11).This deficient practice resulted in Resident 11 not receiving a PASARR Level II evaluation, and had the potential to result in Resident 11 not receiving the specialized services needed to address serious mental illness while residing in the nursing facility.Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 11's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), anxiety disorder (a mental health condition involving persistent and excessive worry that interferes with daily activities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality).During a review of Resident 11's History and Physical (H&P), dated 12/7/2025, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 11's cognitive skills for daily decision making (ability to think, remember, and reason) were severely impaired. The MDS indicated Resident 11 was dependent (helper does all the effort) for toileting, bathing, dressing and personal hygiene. During a review of Resident 11's care plan report titled PASARR, revised 8/19/2025, the care plan indicated Resident 11's diagnoses included schizophrenia, bipolar disorder, psychosis, Parkinson's, and dementia. The interventions indicated to arrange referrals as indicated by PASRR Level II findings.During a review of Resident 11's PASARR Level I Screening, dated 7/24/2024, the PASARR Level I Screening indicated Resident 11 was screened as negative for serious mental illness or intellectual or developmental disability. The PASARR Level I Screening indicated a PASRR Level II evaluation (a more detailed assessment used to determine whether a resident requires specialized mental health or developmental disability services) was not required.During an interview on 2/25/2026 at 11:45 a.m., with the Social Services Director (SSD), the SSD stated the Social Services Department was not responsible for PASARR screenings. The SSD stated PASARR screenings were completed by the Admissions Department.During an interview on 2/25/2026 at 11:50 a.m. with the Admissions Coordinator (AC), the AC stated when a resident was admitted to the facility, the Admissions Department requested the PASARR from the hospital and uploaded the PASARR document into the resident's medical record. The AC stated the Admissions Department was not responsible for following up on the PASARR screening and only uploaded the document into the resident's medical file. The AC stated she was unsure which department was responsible for ensuring the PASARR screening was completed or followed through after admission.During an interview on 2/25/2026 at 12 p.m., with the Director of Nursing (DON), The DON stated upon admission the facility obtained the PASARR from the hospital . The Admissions Department uploaded the PASARR into the resident's medical record. The DON stated the PASARR remained part of the resident's medical record, and she reviewed the PASARR after admission to ensure the information was correct. The DON acknowledged Resident 11's PASARR did not indicate the resident had a serious mental illness; however, the resident's diagnosis report indicated diagnoses including schizoaffective disorder, bipolar type, bipolar disorder, and schizophrenia. The DON stated Resident 11's PASARR should have indicated the (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presence of serious mental illness based on the resident's diagnoses. The DON stated because the PASARR was coded incorrectly, Resident 11 did not receive an evaluation for services related to the resident's mental health needs. The DON stated Social Services was not involved in reviewing the PASARR. The DON acknowledged the facility policy indicated Social Services was responsible for PASARR review and stated she was unaware of that requirement.During a review of the facility's policy and procedure (P&P) titled Resident Assessment - Coordination with PASARR Program, revised 12/18/2023, the P&P indicated all applicants to the facility will be screened for serious mental disorders or intellectual disabilities through a PASARR Level I screening prior to admission. The P&P indicated a positive PASARR Level I screening requires a PASARR Level II evaluation by the state-designated authority to determine appropriate placement and specialized services. The P&P indicated the Social Services Director, or designee is responsible for maintaining each resident's PASARR screening status and referring residents to the appropriate authority when a serious mental disorder, intellectual disability, or related condition is identified.

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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 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 and implement a comprehensive, person-centered care plan for two of 12 sampled residents (Resident 50 and Resident 31), by failing to:1. Develop a care plan to address Resident 50's oral status and lack of teeth. 2. Implement interventions related to Resident 31's indwelling catheter (a flexible tube inserted into the bladder to drain urine into a bag), including monitoring and documenting urinary output.These deficient practices placed Residents 50 and 31 at risk for delayed care, nutrition risks and needs, continuity of care, and overall health status. Findings:a. During a review of Resident 50's admission Record, the admission Record indicated Resident 50 was originally admitted to the facility on [DATE] and re admitted on [DATE]. Resident 50's diagnoses included dysphagia (difficulty swallowing), chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing), and depression (a medical illness causing feelings of sadness, or loss of interest in activities). During a review of Resident 50's History and Physical (H&P), dated 1/8/2026, the H&P indicated Resident 50 had the capacity to understand and make decisions.During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool), dated 1/10/2026, the MDS indicated Resident 50's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 50 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) assistance from staff for activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 2/24/2026 at 1:10 a.m., with Resident 50, at Resident 50's bedside, the resident was observed sitting in bed eating lunch. Resident 50 stated she did not have her upper and lower natural teeth. During a concurrent interview and record review on 2/24/2026 at 3:30 p.m., with the MDS Nurse (MDSN), Resident 50's medical records were reviewed. The medical records did not indicate a care plan related to Resident 50's edentulous (having no teeth) status. The MDSN stated a care plan for missing natural teeth should have been developed to indicate specific interventions, including nutritional needs, safe eating, oral health needs, and monitoring Resident 50 for complications related to her edentulous status. During an interview on 2/26/2026 at 7:56 a.m., with the Director of Nursing (DON), the DON stated residents without natural teeth should have an individualized care plan to ensure the residents' needs were addressed, communicated and coordinated with staff for continuity of care and services. b. During a review of Resident 31's admission Record, the admission Record indicated Resident 31 was admitted to the facility on [DATE] with diagnoses included obstructive and reflux uropathy (a blockage in the urinary tract preventing proper urine flow, urinary retention), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities).During a review of Resident 31's MDS, dated [DATE], the MDS indicated Resident 31's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 31 required moderate (helper does less than half the effort) assistance from staff for ADLs. During a review of Resident 31's care plan titled The resident has indwelling catheter ., the dated 1/22/2026, the care plan indicated to monitor and document Resident 31's intake and output. During a concurrent interview and record review on 2/24/2026 at 2:01 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 31's care plan titled The resident has indwelling catheter . dated 1/22/2026, and Electronic Medical Record (EMR) titled Monitor Record, dated 1/22/2026 through 2/24/2026, were reviewed. The EMR did not indicate documented evidence that Resident 31's intake and out was monitored as indicated in the care plan. LVN 3 stated there was no urinary output recorded from 1/22/2026 through 2/24/2026. LVN 3 stated urinary output was required for residents with indwelling catheter to assess urinary function and identify potential complications such as decreased output, pain, and/or signs of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection. During an interview on 2/26/2026 at 7:59 a.m., with the Director of Nursing (DON), the DON stated indwelling catheter monitoring and documenting intake and output was a required intervention as indicated in the care plan. The DON stated Resident 31's care plan interventions were not implemented. The DON stated urinary output monitoring was necessary to ensure resident safety and timely medical intervention. During a review of the facility's policy and procedures (P&P) titled Comprehensive Care Plans, dated 1/19/2022, the P&P indicated the facility would develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive 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 revise the comprehensive fall prevention care plan following a resident's fourth fall for one out of six sampled residents (Resident 74).This deficient practice had the potential to result in additional falls and bodily injury for Resident 74.Findings:During a review of Resident 74's admission Record, the admission Record indicated Resident 74 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 74's diagnoses included muscle weakness, diabetes (poor blood sugar control), hypertensive (high blood pressure) heart disease, and urinary tract infection (UTI- an infection in the bladder/urinary tract).During a review of Resident 74's Minimum Data Set ([MDS], a resident assessment tool), dated 12/19/2025, the MDS indicated Resident 74's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 74 required maximal assistance (helper does more than half of the effort) for showering, dressing and taking off footwear and moderate assistance (helper does less than half the effort) for toileting.During a review of Resident 74's Interdisciplinary Notes (IDT, group of different disciplines working together towards a common goal of a resident), dated 9/22/2025, 1/5/2026, and 2/10/2026, the IDT Notes indicated Resident 74 had three unwitnessed falls on 9/19/2025, 1/5/2026, and 2/9/2026.During an observation on 2/23/2026 at 9:23 a.m., in Resident 74's room, Resident 74 was observed in bed without fall mats on either side of the bed.During a concurrent interview and record review on 2/24/2026 at 3:29 p.m. with Registered Nurse (RN) 2, Resident 74's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 2/19/2026, and all of Resident 74's care plans, dated in 2026, were reviewed. The SBAR indicated Resident 74 had an unwitnessed fall on 2/19/2026. There were no care plan intervention revisions to Resident 74's fall care plan since his fall on 2/19/2026. RN 2 stated she was the assigned RN during Resident 74's fall on 2/19/2026. RN 2 stated that the normal process following a fall was to assess the resident, notify the physician, and modify the care plan to implement different or additional interventions to prevent reoccurrence. RN 2 stated Resident 74's care plans were not modified after the fall and the lack of revision, especially given Resident 74's history of frequent falls, placed Resident 74 at risk for another fall.During a concurrent interview and record review on 2/25/2026 at 3:43 p.m. with the Director of Nursing (DON), all of Resident 74's care plans, dated in 2026, were reviewed.The care plans indicated no revisions to the interventions after Resident 74's latest fall on 2/19/2026. The DON stated the care plan should have been reviewed and revised to evaluate the effectiveness of current interventions and to implement additional measures. The DON stated that if the care plan had been revised, floor mats would have been added as an intervention. The DON stated the lack of revisions to the interventions placed Resident 74 at risk for another fall.During a review of the facility's policy and procedure (P&P) titled, Care Plan Revisions Upon Status Change, revised 12/19/2022, the P&P indicated the comprehensive care plan would be reviewed and revised as necessary, when a resident experiences a status change.During a review of the facility's P&P titled, Fall Prevention Program revised 12/28/2023, the P&P indicated the comprehensive care plan would be reviewed, and revised as necessary, when a resident experiences a status change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided necessary assistance with activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) for one of eight sampled residents (Resident 22), who required assistance with transfers (help from one or more staff members to safely move a resident between two positions, such as from a bed to a chair, a chair to a wheelchair, or standing up) and dressing.This deficient practice had the potential to result in decline in mobility (ability to move freely), muscle weakness, development of pressure injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and decreased psychosocial well-being from remaining in bed for prolonged periods. Findings:During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 22's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke - caused by a blockage that stops blood flow to part of the brain), muscle weakness, history of falling, and Stage 2 pressure ulcer (partial-thickness loss of skin, presenting as a shallow open sore or wound) of the sacral region (lower back). During a review of Resident 22's History and Physical (H&P), dated 9/22/2025, the H&P indicated Resident 22 had the capacity to make decisions. During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 22's cognitive skills for daily decision making (ability to think, remember, and reason) were moderately impaired. The MDS indicated Resident 22 required set up and clean up assistance for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 22 required maximal assistance (helper does more than half the effort) for toileting, bathing, and dressing and required moderate assistance (helper does less than half the effort) for transferring to and from bed and toilet. The MDS indicated Resident 22 was at risk for pressure ulcers.During a review of Resident 22's care plan titled, Restorative Nursing Program: passive range of motion (PROM, the movement of a joint through its full range by an external force without any muscle contraction or effort from the patient), assistive range of motion (AAROM, the maximum distance and direction a joint can move voluntarily using an individual's own muscle strength, without any outside assistance), revised 1/23/2026, the care plan indicated Resident 22 had potential for decline in range of motion (ROM, the amount of movement that a particular joint or series of joints can achieve in a specific direction) and functional activity tolerance related to cerebrovascular accident (CVA - stroke, loss of blood flow to a part of the brain). The care plan indicated Resident 22 would be able to adapt and adjust to living as independently and safely as possible; enable good hygiene and promote functional mobility; decrease risk for skin breakdown; and improve posture and enable the resident to sit up in a wheelchair for meals and activities, as needed. The interventions included to monitor Resident 22 for any changes and refer to nursing and/or rehabilitation as indicated; provide PROM exercises to bilateral lower extremities (legs) five times per week or as tolerated; provide AAROM exercises to bilateral upper extremities (arms); and promote mobility and positioning to support functional activity.During a review of Resident 22's care plan titled, Limited Physical Mobility related to weakness, bilateral knee pain, revised 1/23/2026, the care plan indicated Resident 22 had limited physical mobility related to weakness and bilateral knee pain. The goals indicated Resident 22 would remain free of complications related to immobility, including contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion), thrombus formation (blood clot development), skin breakdown, and fall-related injury through the next review date; and would minimize contracture formation, skin breakdown, and fall-related injury. The interventions included monitoring for signs and symptoms of pain associated with mobility and attempting non-pharmacological interventions; inviting the resident to activity (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	programs that encourage physical mobility; providing gentle range of motion as tolerated with daily care; providing supportive care and assistance with mobility as needed; and documenting assistance provided; and initiating physical therapy (PT) and occupational therapy (OT) referrals, as needed.During a review of Resident 22's ADLs Transfer Flow Sheet dated 1/26/2026 through 2/26/2026, the ADL Transfer Flow Sheet indicated Not Applicable for transfers on 2/23/2026, 2/24/2026, 2/25/2026, and 2/26/2026.During a concurrent observation and interview on 2/23/2026 at 11:13 a.m., in Resident 22's room, Resident 22 was observed lying in bed awake and alert. The low air loss mattress (LALM - a therapeutic mattress used to reduce pressure and prevent skin breakdown) was set at 240. Resident 22 was dressed in a gown and covered with a jacket while lying in bed. Resident 22 stated staff did not get her out of bed. Resident 22 stated staff told her the nurses were female and unable to get her up. Resident 22 stated she had to wait for two male staff to assist her with getting out of bed. Resident 22 stated she had been in bed for approximately five months and had only been out of bed twice. Resident 22 stated when she was receiving physical therapy she was getting out of bed and felt she was getting stronger. Resident 22 stated after therapy ended, staff attempted to get her up out of bed with a Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). Resident 22 stated staff used the Hoyer lift incorrectly, which caused her pain, and since that time staff had not attempted to get her up again except on two occasions when male staff were available. Resident 22 stated when she asked staff to get her out of bed, staff told her she must wait for two male staff because the female staff were not strong enough to assist her out of bed. Resident 22 stated her physician told staff she needed to get out of bed and that there were special staff who could assist with getting her up. Resident 22 stated she remained in bed every day and did not get dressed. Resident 22 stated she wore a gown and covered herself with a jacket while lying in bed. Resident 22 stated she wanted to get up and go to activities, including the Sunshine Room, but staff would not get her out of bed. Resident 22 stated staff provided exercises to her legs while in bed but did not get her out of bed for activities.During observations on 2/23/2026 at 11:13 a.m., 2/24/2026 at 9:26 a.m., 12:35 p.m., and 4:25 p.m., 2/25/2026 at 9:30 a.m. and 11:45 a.m., and 2/26/2026 at 9:26 a.m., Resident 22 was observed lying in bed wearing a hospital gown and covered with a jacket.During a concurrent observation and interview on 2/24/2026 at 12:35 p.m., with Resident 22, Resident 22 was observed lying in bed awake and alert. Resident 22 stated she wanted to get out of bed, but staff told her the female staff were unable to lift her, and she needed to wait for male staff to assist her out of bed.During an interview on 2/26/2026 at 9:40 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated it was her responsibility to wake residents in the morning, assist with dressing, and assist residents out of bed in preparation for breakfast. CNA 3 acknowledged Resident 22 did not get out of bed from 2/23/2026 through 2/26/2026. CNA 3 stated Resident 22 complained the Hoyer lift hurt her leg the last time staff attempted to get her up, and since that time Resident 22 had refused to get out of bed and get dressed. CNA 3 stated she had been documenting Not Applicable instead of Resident Refused on the ADL Flow Sheet. CNA 3 acknowledged refusals should have been documented as Resident Refused so there would be a record of the resident's refusal to get out of bed. CNA 3 further acknowledged she had not reported the refusals to get out of bed to the charge nurse. CNA 3 stated it was important for Resident 22 to get dressed and participate in activities and maintain mental well-being. CNA 3 stated residents generally felt presentable and happier when they were dressed and out of bed. CNA 3 stated she had not personally assisted Resident 22 out of bed but would use the Hoyer lift with two staff if the resident requested assistance.During an interview on 2/26/2026 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 22 typically only got out of bed when two male staff assisted her because the resident reported the Hoyer lift caused her pain. LVN 5 stated Resident 22 reported experiencing pain when staff attempted to transfer her using the Hoyer lift. LVN 5 stated mobility and ADLs should have been addressed daily. LVN 5 acknowledged she did not get the resident out of bed the previous day and did not administer pain medication prior to attempting a transfer. LVN 5 stated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staffing should not have been a reason a resident remained in bed throughout the day. LVN 5 stated Resident 22 was weight-bearing, could pivot during transfers, and required a two-person assist. LVN 5 stated Resident 22 was not bedbound and there was no clinical reason for the resident to remain in bed throughout the day. LVN 5 stated if a resident refused to get out of bed, the refusal should have been documented, addressed in the care plan, and the physician and responsible party should have been notified so alternate methods of assisting the resident out of bed could have been explored. LVN 5 stated the charge nurse, and CNAs were responsible for ensuring care plans addressing mobility were followed to promote activity. LVN 5 stated remaining in bed throughout the day could place the resident at risk for pressure ulcers, depression, and loss of mobility, which could negatively impact the resident's quality of life. LVN 5 stated there were no orders for bedrest or mobility restrictions for Resident 22. During an interview on 2/26/2026 at 11:10 a.m., with Director of Nursing (DON), the DON stated she was aware Resident 22 reported discomfort when using the Hoyer lift. The DON stated if a resident experienced discomfort with a transfer method, staff should have explored alternative methods to assist the resident out of bed. The DON stated if a resident refused care, the refusal should have been documented in the progress notes and addressed through the care plan and interdisciplinary team (IDT - a group of healthcare staff from different departments who work together to plan and coordinate a resident's care). The DON stated if a resident was not receiving care related to mobility, the lack of care and any refusals should have been documented. The DON stated remaining in bed for extended periods could place Resident 22 at risk for contractures, pressure ulcers, and decline in well-being.During a review of the facility's policy and procedure (P&P) titled ADL Care of Dementia Unit Residents, dated 12/19/2022, the P&P indicated the facility will provide appropriate treatment and services related to ADLs to ensure residents' ADL needs are met while attaining or maintaining the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated each resident's physical functioning will be assessed in accordance with the facility's assessment procedures, the level of assistance needed for ADL activities will be included in the resident's plan of care, and care plan interventions will be monitored on an ongoing basis for effectiveness and revised as necessary. The P&P further indicated referrals may be made if current interventions are ineffective or if the resident shows a decline in physical functioning.During a review of the facility's P&P titled Safe Resident Handling/Transfers, dated 12/19/2022, the P&P indicated the facility will ensure residents are handled and transferred safely to prevent or minimize the risk of injury and to provide a safe and comfortable experience for residents while keeping employees safe in accordance with current standards and guidelines. The P&P indicated the IDT, or designee will evaluate and assess each resident's individual mobility needs. The P&P indicated mechanical lifting equipment or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies. The P&P further indicated two staff members must be utilized when transferring residents using mechanical lifts and resident lifting and transferring will be performed according to the resident's individual plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the placement of bilateral (pertaining to both) floor mats and padded siderails for two of eight sampled residents (Residents 44 and 37), who were on fall and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) precautions. These deficient practices had the potential to result in Resident 44 sustaining an injury from a fall, and Resident 37 sustaining an injury during seizure activity. Findings: a. During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses which included difficulty walking, dementia (a progressive state of decline in mental abilities), stable burst fracture of the first lumbar vertebra (a broken bone in the lower spine caused by compression or pressure), unspecified fracture of the T11-T12 vertebra (broken bones in the middle portion of the spine), and unspecified fracture of the second lumbar vertebra (a broken bone in the lower spine). During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool), dated 11/6/2025, the MDS indicated Resident 44's cognitive skills for daily decision making (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 44 required moderate assistance (helper does less than half the effort) for toileting and bathing. The MDS indicated Resident 44 required maximal assistance (helper does more than half the effort) for transferring to and from bed and toilet and walking 10 feet and 50 feet. The MDS further indicated Resident 44 had a one fall with no injury since admission. During a review of Resident 44's History and Physical (H&P), dated 2/6/2026, the H&P indicated Resident 44 did not have the capacity to understand and make decisions. The H&P indicated Resident 44 was identified as at risk for falls. During a review of Resident 44's Fall Risk assessment dated [DATE], the assessment indicated Resident 44 was at risk for falls. During a review of Resident 44's care plan titled Risk for falls, revised 2/5/2026, the care plan indicated Resident 44 was at risk for falls. The interventions indicated to provide bilateral floor mats at the bedside. During a review of Resident 44's Order Summary Report dated 2/26/2026, the Order Summary Report indicated bilateral floor mats. During an observation on 2/23/2026, at 9:55 a.m., while in Resident 44's room, Resident 44 was observed sleeping. A fall mat was observed to the right side of the bed. No fall mat was observed to the left side of the bed. During an interview on 2/23/2026, at 10:15 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 44 was supposed to have two floor mats. CNA 1 stated she confirmed with the charge nurse that Resident 44 required bilateral floor mats. During an interview on 2/25/2026 at 11:41 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 (continued on next page)

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Sunny Hills Post Acute	12200 LA Mirada Blvd. LA Mirada, CA 90638

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 44 was on fall precautions. LVN 5 stated Resident 44 should have fall mats on both sides of the bed, and the bed should be in the lowest position and locked. LVN 5 stated having only one fall mat could be an issue because Resident 44 could fall from the opposite side of the bed where no fall mat was in place and there was no way to determine which direction Resident 44 could fall. During a review of the facility's policy and procedure (P&P) titled Fall Prevention Program, revised 12/28/2023, the P&P indicated the nurse and/or interdisciplinary team would initiate interventions on the resident's care plan in accordance with the resident's level of risk. The P&P further indicated fall interventions would be implemented as appropriate and that each resident's risk factors and environmental hazards would be evaluated when developing the resident's comprehensive care plan. The P&P indicated care plan interventions would be monitored for effectiveness and revised as needed. b. During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that included epilepsy (a chronic brain disorder characterized by a tendency to have recurrent, unprovoked seizures) and dementia (a progressive state of decline in mental abilities). During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37's cognition was moderately impaired. The MDS indicated Resident 37 required supervision or touching assistance with oral hygiene, upper body dressing, and personal hygiene.During a review of Resident 37's H&P, dated 3/27/2025, the H&P indicated Resident 37 could make his needs known but could not make medical decisions.During observations on 2/23/2026 at 10:08 a.m. and on 2/24/2026 at 8:36 a.m., in Resident 37's room, Resident 37 was observed lying in bed. The grab bars were unpadded. During a concurrent observation and interview on 2/24/2026 at 1:04 p.m., with LVN 2, in Resident 37's room, Resident 37's bed was observed with unpadded bilateral grab bars. LVN 2 stated Resident 37 did not have any padding on his grab bars.During a concurrent interview and record review on 2/24/2026 at 1:05 p.m., with LVN 2, Resident 37's Orders, active on 2/24/2026, were reviewed. The Orders indicated to apply padded grab bars for seizure precautions. LVN 2 stated Resident 37 had a history of seizures and should have had padding added to his grab bars. LVN 2 stated padded grab bars were used as a safety precaution if Resident 37 had a seizure with jerking, involuntary movement. LVN 2 stated without padded grab bars, Resident 37 was at risk for injury during a seizure.During an interview on 2/25/2026 at 1:54 p.m., with the Director of Nursing (DON), the DON stated Resident 37 had a history a seizures and seizure precautions, such as medication treatment and padded side rails, should be in place to prevent seizure occurrence and injury. During a review of the facility's P&P titled, Seizure Precautions, dated 12/19/2022, the P&P indicated, It is the policy of this facility to ensure a resident is protected from injury and managed in the event of a seizure according to current standards of practice.

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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 interview and record review, the facility failed to ensure care and services related to urinary Foley catheter (a flexible tube inserted through the urethra [a hollow tube that lets urine leave the body] into the bladder to drain urine into a collection bag) management were provided for one of six sampled residents (Resident 39), who had sediment (matter that settles to the bottom of a liquid), cloudiness and blood in the urine.This deficient practice had the potential to result in urinary catheter obstruction, urinary tract infection (UTI- an infection in the bladder/urinary tract) and a decline in Resident 39's health status.During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 39's diagnoses included dysphagia (difficulty swallowing), bradycardia (low heart rate), and hepatic encephalopathy (a serious brain dysfunction caused by liver failure) and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury).During a review of Resident 39's History and Physical (H&P), dated 12/03/2025, the H&P indicated Resident 39 was not able to make medical or financial decisions.During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 12/8/2025, the MDS indicated Resident 39's cognitive skills for daily decision making (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 39 was dependent for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 39's physician order dated 12/3/2025, the physician order indicated indwelling Foley catheter size 18. Change for blockage, leaking, pulled out, excessive sediment.During an interview on 2/24/2026 at 1:37 p.m., with Licensed Vocational Nurse (LVN) 8, LVN 8 stated that normal urine should be yellow in color, clear, and free from cloudiness, sediment, blood, or foul odor. LVN 8 stated that the particles observed in the urine were most likely sediment. LVN 8 stated that this finding represented a change in condition and that a change-of-condition assessment should have been initiated and the physician notified in accordance with the resident's care plan. LVN 8 stated that the resident was unable to feel sensations below the waist due to a diagnosis of quadriplegia. LVN 8 stated it was important to closely monitor Resident 39 for signs and/or symptoms of a UTI.During an interview on 2/26/2026 at 10:23 a.m., with the Director or Nursing (DON), the DON stated that urine should be clear, yellow in color, and free from sediment, cloudiness, blood, or foul odor. The DON stated that the presence of sediment or cloudy urine indicated an abnormal finding and constituted a change in the resident's condition. The DON stated that nursing staff were required to initiate a change-of-condition assessment and notify the physician per the facility policy. The DON stated that residents with quadriplegia may be unable to feel pain or discomfort related to urinary issues, which placed them at increased risk for an undetected UTI. The DON stated that staff were responsible for closely monitoring such residents for non-verbal signs and symptoms of infection and ensuring timely documentation and physician notification.During a review of the facility's policy and procedure (P&P) titled, Notification of Changes dated 12/19/2022, the P&P indicated The purpose of this policy is to ensure the facility promptly informs the resident, the resident's physician when there is a change requiring notification. Circumstances requiring notification include significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include life-threatening conditions, or Clinical complications.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to change one of one sampled resident's (Resident 138) peripherally inserted central catheter (PICC, a thin, flexible tube inserted into the vein in the upper arm and guided into a large vein near the heart) line dressing and securement device (a sterile tool to hold the PICC in place on the skin) in accordance with the physician's orders.These deficient practices resulted in Resident 138's PICC line dressing and securement device remaining unchanged for 11 days which had the potential to result in avoidable bloodstream infection.Findings:During a review of Resident 138's admission Record, the admission Record indicated Resident 138 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of the vertebra in the lumbar region (infection in the spinal bones of the lower back), discitis in the lumbar region (infection of the disc space between the spinal bones), and spondylosis (age-related wear and tear of the spine).During a review of Resident 138's History and Physical (H&P), dated 2/20/2026, the H&P indicated Resident 138 had the capacity to understand and make decisions.During a review of Resident 138's Order Summary Report, active on 2/25/2026, the Order Summary Report indicated to:1. Change Resident 138's peripherally inserted central catheter (PICC, a thin, flexible tube inserted into the vein in the upper arm and guided into a large vein near the heart) line securement device (a sterile tool to hold the PICC in place on the skin) upon admission and every seven days during the evening shift.2. Change Resident 138's PICC line transparent dressing (a clear, sticky bandage placed over the PICC line insertion site), per sterile technique, upon admission and every seven days during the evening shift.During a concurrent observation and interview on 2/23/2025 at 9:56 a.m., with Resident 138, in Resident 138's room, Resident 138 was observed with a PICC line to the right upper arm. The dressing was dated 2/13/2026. Resident 138 stated the PICC line was inserted during his admission at the general acute care hospital (GACH) for antibiotic treatment (medication administered to treat an infection). Resident 138 stated the facility had not changed his PICC line dressing since his admission on [DATE].During an interview on 2/24/2026 at 8:50 a.m., with Registered Nurse (RN) 3, RN 3 stated, on 2/19/2026, Resident 138 was admitted to the facility with a PICC line inserted to his right upper arm. RN 3 stated Resident 138's PICC line dressing and securement device should have been changed upon his admission. RN 3 stated Resident 138's PICC line dressing and securement device were last changed on 2/13/2026 and the longest they should be in place was seven days. RN 3 stated Resident 138's PICC line dressing and securement device were present on Resident 138 for 11 days. RN 3 stated changing Resident 138's PICC line dressing and securement device was important to ensure the licensed nurses were aware of the last change date and to trust the facility's licensed nurses changed the dressing and securement device competently. RN 3 stated while Resident 138 was admitted to the facility, Resident 138 was under their care and the facility was responsible for ensuring the dressing and securement device change were done correctly. RN 3 stated due to Resident 138's dressing and securement device being unchanged for 11 days, Resident 138 was at risk for bloodstream infection. During a concurrent interview and record review on 2/24/2026 at 3:46 p.m., with RN 2, Resident 138's IV Administration Report, dated 2/1/2026 through 2/28/2026, was reviewed. The IV Administration Report indicated securement device change on 2/20/2026 and 2/23/2026, and PICC line transparent dressing change on 2/20/2026, 2/22/2026, and 2/23/2026. RN 2 stated checkmarks on the IV Administration Report indicated the order was completed. RN 2 stated, on 2/22/2026 and 2/23/2026, she documented Resident 138's PICC line transparent dressing was changed, and on 2/23/2026, she documented Resident 138's PICC line securement device was changed. RN 2 stated she was confused and thought the order was to assess the PICC line dressing and securement device to see if they needed to be changed. RN 2 stated on 2/22/2026 and 2/23/2026, she did not change Resident 138's PICC line dressing and securement device. RN 2 stated Resident 138's PICC line dressing and securement (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	device were not changed upon admission.During an interview on 2/25/2026 at 2:24 p.m., with the Director of Nursing (DON), the DON stated Resident 138's PICC line dressing and securement device should have been changed upon his admission to the facility. The DON stated having the PICC line dressing and securement on for 11 days would allow the adhesive to begin to peel off and expose the insertion site to air and other bacteria. The DON stated if bacteria were to enter through the PICC insertion site, it would enter the blood and could potentially reach the heart, causing a very serious infection.During a review of the facility's Policy and Procedure (P&P) titled, PICC/Midline/Central Vascular Access Device Dressing Change (CVAD- a tube inserted into a vein or artery to deliver medications and fluids), dated 12/19/2026, the P&P indicated to change PICC, midline, or central venous access device (CVAD) dressing, weekly or if soiled, in a manner to decrease potential for infection and/or cross contamination.

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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 provide oxygen (a medical gas used to help with breathing) therapy in accordance with the facility policy and physician orders for one of three sampled residents (Resident 137). This deficient practice had the potential to result in hyperoxygenation (too much oxygen) which could result in respiratory failure (sudden onset condition where the lungs cannot bring enough oxygen into the blood). Findings:During a review of Resident 137's admission Record, the admission Record indicated Resident 137 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 137's diagnoses included acute respiratory failure with hypoxia (sudden onset condition where the lungs cannot bring enough oxygen into the blood), pneumonia (an infection/inflammation in the lungs), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing).During a review of Resident 137's Minimum Data Set (MDS- a resident assessment tool), dated 2/7/2026, the MDS indicated Resident 137's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 137 depended on staff with oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 137 received oxygen (a medical gas used to help with breathing) therapy.During a review of Resident 137's History and Physical (H&P), dated 1/10/2026, the H&P indicated Resident 137 did not have the mental capacity to make decisions.During an observation on 2/23/2026 at 9:45 a.m., 2/23/2026 at 1:43 p.m., and 2/24/2026 at 8:54 a.m., in Resident 137's room, Resident 137 was observed lying in bed. Resident 137 was receiving oxygen at 5 liters per minute (LPM, unit of volume measurement) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen).During a concurrent observation and interview on 2/24/2026 at 12:47 p.m., with Registered Nurse (RN) 1, in Resident 137's room, Resident 137 was observed lying in bed. Oxygen was infusing at 5 LPM via nasal cannula. RN 1 lowered Resident 137's oxygen to 2 LPM and checked his oxygen saturation (measurement of the percentage of oxygen in the blood). RN 1 stated Resident 137's oxygen should not be infusing at 5 LPM.During a concurrent interview and record review on 2/24/2026 at 12:49 p.m., with RN 1, Resident 137's Orders, active on 2/24/2026, were reviewed. The Orders indicated to administer oxygen at 2 LPM via nasal cannula to maintain Resident 137's oxygen saturation above 92 percent (%). RN 1 stated Resident 137's oxygen should not be above 2 LPM based on Resident 137's physician order. RN 1 stated Resident 137 had COPD and his need for oxygen was lower compared to a resident who did not have COPD. RN 1 stated giving Resident 137 too much oxygen could cause the resident to lose his drive to breathe and could cause respiratory failure. During an interview on 2/25/2026 at 1:56 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses were responsible for administering oxygen therapy per the physician's order. The DON stated Resident 137 required oxygen therapy, however, Resident 137 had COPD. The DON stated residents with COPD had a lower oxygen saturation threshold (normal oxygen saturation is between 95 to 100%) and providing too much oxygen would be harmful. The DON stated Resident 137 was at risk of hyperoxygenation which could reduce Resident 137's lung function and cause respiratory failure.During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, dated 12/10/2022, the P&P indicated, Oxygen is administered under orders of a physician.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to effectively manage one of two sampled residents' (Resident 30) pain, after Resident 30 complained of severe pain (pain rated seven to ten on a 10-point scale). Resident 30 was administered Norco (an opioid medication used to treat pain), which was ordered for moderate pain (pain rated four to six on a 10-point scale).This deficient practice resulted in Resident 30's pain being mismanaged which left Resident 30 feeling frustrated with his pain management regimen.Findings:During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke - caused by a blocked blood vessel in the brain) affecting the right side and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).During a review of Resident 30's Minimum Data Set (MDS- a resident assessment tool), dated 1/6/2026, the MDS indicated Resident 30's cognition (process of thinking) was intact. The MDS indicated Resident 30 required moderate assistance (helper does less than half the effort) with toileting, bathing, and lower body dressing. The MDS indicated Resident 30 received opioid medication (medication used to treat pain).During a review of Resident 30's History and Physical (H&P), dated 8/29/2025, the H&P indicated Resident 30 did not have the mental capacity to make decisions.During a review of Resident 30's Order Summary Report, active on 2/24/2026, the Order Summary Report indicated to administer Norco (an opioid medication) 10-325 milligrams (mg, a unit of measurement), by mouth, every six hours as needed for moderate pain (pain rated four to six on a 10-point scale).During a review of Resident 30's Care Plan titled, Resident is on Pain Medication Therapy, dated 11/13/2024, the care plan indicated to administer pain medication as ordered by the physician.During an interview on 2/23/2026 at 9:35 a.m., with Resident 30, Resident 30 stated he had pain in his right shoulder, right hip, and lower back. Resident 30 stated he could receive Norco every six hours as needed. Resident 30 stated his pain was usually about an eight out of ten (on a scale from 0-10). Resident 30 stated Norco began to decrease his pain after 30 minutes but returned after two hours. Resident 30 stated he was frustrated because his pain would return and he had to wait four more hours until the next Norco dose.During an interview on 2/24/2026 at 1:07 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 30 requested Norco regularly to treat his pain. LVN 2 stated Resident 30 usually rated his pain an eight out of ten and she would administer Norco.During a concurrent interview and record review on 2/24/2026 at 1:10 p.m., with LVN 2, Resident 30's Medication Administration Record (MAR), dated 2/1/2026 through 2/28/2026, was reviewed. The MAR indicated Resident 30 was administered Norco 10-325 mg for his reports of severe pain. LVN 2 stated Resident 30 received Norco however, the order was to administer for moderate pain and not severe pain. LVN 2 stated administering the ordered dose of Norco for Resident 30's reports of severe pain would not be as effective in ensuring the resident's pain was managed effectively. The MAR indicated Resident 30 was administered Norco on the following dates and times for the following pain levels: - 2/6/2026 at 8:42 p.m. - pain level of 7.- 2/7/2026 at 3:37 a.m. - pain level of 7.- 2/7/2026 at 4:22 p.m. - pain level of 7.- 2/8/2026 at 7:21 p.m. -pain level of 8.- 2/9/2026 at 8:11 a.m. - pain level of 8.- 2/9/2026 at 8:11 p.m. - pain level of 8.- 2/10/2026 at 8 a.m. - pain level of 8.- 2/11/2026 at 5:08 p.m. - pain level of 7.- 2/12/2026 at 6:38 a.m. - pain level of 8.- 2/12/2026 at 9:40 p.m. - pain level of 7.- 2/13/2026 at 10:21 a.m. - pain level of 7.- 2/13/2026 at 4:10 p.m. - pain level of 8.- 2/15/2026 at 8:26 p.m. - pain level of 8.- 2/16/2026 at 4:38 a.m. - pain level of 7.- 2/16/2026 at 2:29 p.m. - pain level of 8.- 2/17/2026 at 8:29 a.m. - pain level of 8.- 2/17/2026 at 5:06 p.m. - pain level of 7.- 2/18/2026 at 8:30 a.m. - pain level of 8.- 2/18/2026 at 3:57 p.m. - pain level of 8.- 2/19/2026 at 2:41 a.m. - pain level of 7.- 2/19/2026 at 4:04 p.m. - pain level of 8.- 2/20/2026 at 8:36 p.m. - pain level of 8.- 2/21/2026 at 8:25 a.m. - pain level of 8.- 2/21/2026 at 3:57 p.m. - pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	level of 8.- 2/22/2026 at 10:10 a.m. - pain level of 8.- 2/23/2026 at 7:59 a.m. - pain level of 8.- 2/24/2026 at 7:30 a.m. - pain level of 8.During an interview on 2/25/2026 at 1:49 p.m., with the Director of Nursing (DON), the DON stated Norco was a pain medication administered as needed with a specific time duration and based on a pain scale. The DON stated the licensed nurses were responsible for assessing Resident 30's pain and administering Norco according to the physician's order. The DON stated Resident 30 reported having severe pain but was administered Norco for moderate pain. The DON stated Resident 30's pain would not be managed effectively because the licensed nurses were under-medicating him according to his pain scale. The DON stated under-medicating Resident 30 would cause Resident 30 to continue to be in pain.During a review of the facility's policy and procedure (P&P) titled, Pain Management, dated 12/19/2022, the P&P indicated, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the hemodialysis (treatment to cleanse the blood of waste and extra fluid artificially through a machine when the kidney(s) have failed) emergency kit ([E-kit]- a readily set of supplies for immediate use in the event of dialysis-related complications) was at the bedside for one of two sampled residents (Resident 45), who was receiving hemodialysis treatment. This deficient practice had the potential to result in lack of necessary treatment and services in the event of an emergency, such as bleeding for Resident 45. Findings: During a review of Resident 45's admission Record, the admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (irreversible kidney failure) dependent on renal dialysis (a medical treatment that replaces some of the functions of the kidneys).During a review of Resident 45's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2026, the MDS indicated Resident 45's cognition (the ability to think and process information) was intact. The MDS indicated Resident 45 required moderate (helper does less that half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 45's physician order, dated 1/4/2026, the physician order indicated Resident 45 was to received Hemodialysis on Mondays, Wednesdays, and Fridays. During a review of Resident 45's care plan titled The resident needs hemodialysis related to renal failure, date initiated 11/6/2024, and revised 1/4/2026, the care plan indicated the resident must have a bedside hemodialysis emergency kit. The interventions indicated to check the hemodialysis emergency kit every shift. During an observation on 2/23/2026 at 10:50 a.m., and 2/24/2026 at 11:43 a.m., at Resident 45's bedside, there was no E-kit present observed or readily accessible. During a concurrent observation and interview on 2/24/2026 at 1:48 p.m., with Licensed Vocational Nurse (LVN) 7, at Resident 45's bedside, Resident 45's bedside and surrounding storage areas were inspected. There was no dialysis E-kit observed. LVN 7 stated residents receiving dialysis should have a dialysis E-Kit available at the bedside for immediate use in the event of dialysis- related complications such as bleeding. During an interview on 2/26/2026 at 7:59 a.m., with the Director of Nursing (DON), the DON stated residents receiving dialysis were at risk for bleeding from the access site. The DON stated a dialysis E-Kit should be kept at the bedside and readily available in case of an emergency. The DON stated failing to ensure a dialysis E-kit was readily available at Resident 45's bedside placed the resident at risk for uncontrolled bleeding from the access site, delayed emergency intervention, and potential life-threatening complications. During a review of the facility's policy and procedure (P&P) titled Hemodialysis, dated 12/19/2022, the P&P indicated the facility will provide the necessary care and treatment consistent with the comprehensive person-centered care, and the implementation of appropriate intervention.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Registered Nurse (RN) 2 was competent regarding peripherally inserted central catheter (PICC, a thin, flexible tube inserted into the vein in the upper arm and guided into a large vein near the heart) line dressing changes for one of one sampled resident (Resident 138).This deficient practice resulted in Resident 138's PICC line dressing not being changed upon admission and placed Resident 138 at risk for avoidable bloodstream infection.Cross Reference F694 and F842Findings:During a review of Resident 138's admission Record, the admission Record indicated Resident 138 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of the vertebra in the lumbar region (infection in the spinal bones of the lower back), discitis in the lumbar region (infection of the disc space between the spinal bones), and spondylosis (age-related wear and tear of the spine).During a review of Resident 138's History and Physical (H&P), dated 2/20/2026, the H&P indicated Resident 138 had the capacity to understand and make decisions.During a review of Resident 138's Order Summary Report, active on 2/25/2026, the Order Summary Report indicated to:1. Change Resident 138's peripherally inserted central catheter (PICC, a thin, flexible tube inserted into the vein in the upper arm and guided into a large vein near the heart) line securement device (a sterile tool to hold the PICC in place on the skin) upon admission and every seven days during the evening shift.2. Change Resident 138's PICC line transparent dressing (a clear, sticky bandage placed over the PICC line insertion site), per sterile technique, upon admission and every seven days during the evening shift.During a review of the facility's In-Service Lesson Plan and Attendance Record titled, Intravenous (IV, medical technique to deliver fluids and medication into a vein) Maintenance, Tubing, Site Checks, PICC and Midline (a thin, flexible tube inserted into the vein in the upper arm with the tip ending near the armpit) Dressing Changes, dated 12/29/2025, the In-Service's objectives indicated, Insurance licensed staff demonstrates safe, competent, and compliant care of all vascular access devices (a tube inserted into a vein or artery to deliver medications and fluids) to prevent infection, complication, and medication effort: IV therapy, tubing, site changes, and care of midline [and] PICC line. The In-Service indicated Registered Nurse (RN) 2 attended the in-service. During a concurrent observation and interview on 2/23/2025 at 9:56 a.m., with Resident 138, in Resident 138's room, Resident 138 was observed with a PICC line to the right upper arm. The dressing was dated 2/13/2026. Resident 138 stated the PICC line was inserted during his admission at the general acute care hospital (GACH) for antibiotic treatment (medication administered to treat an infection). Resident 138 stated the facility had not changed his PICC line dressing since his admission on [DATE].During a concurrent interview and record review on 2/24/2026 at 3:44 p.m., with RN 2, the facility's Policy and Procedure (P&P) titled, Intravenous Therapy, dated 12/19/2022, the P&P indicated, IV sites are changed every seventy-two (72) hours unless otherwise ordered by the physician. RN 2 stated based on the P&P, the RNs had 72 hours from admission to change the resident's PICC line dressing then every seven days moving forward, based on the physician's order. RN 2 stated she was confused and thought the IV Therapy P&P applied to all IVs, PICC lines or regular peripheral intravenous line (PIV, a short, flexible tube inserted into a small vein). RN 2 stated she realized the P&P was not relevant to PICC line dressing changes because only PIV sites were changed every 72 hours. During a concurrent interview and record review on 2/24/2026 at 3:46 p.m., with RN 2, Resident 138's IV Administration Report, dated 2/1/2026 through 2/28/2026, was reviewed. The IV Administration Report indicate securement device change on 2/20/2026 and 2/23/2026, and PICC line transparent dressing change on 2/20/2026, 2/22/2026, and 2/23/2026. RN 2 stated checkmarks on the IV Administration Report indicated the order was completed. RN 2 stated, on 2/22/2026 and 2/23/2026, she documented Resident 138's PICC line transparent dressing was changed, and on 2/23/2026, she documented (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 138's PICC line securement device was changed. RN 2 stated she was confused and thought the order was to assess the PICC line dressing and securement device to see if they needed to be changed. RN 2 stated on 2/22/2026 and 2/23/2026, she did not change Resident 138's PICC line dressing and securement device. RN 2 stated Resident 138's PICC line dressing and securement device were not changed upon admission. During an interview on 2/25/2026 at 9:15 a.m., with RN 1, RN 1 stated the licensed nurses received in-service trainings regarding PIV and PICC lines at least annually to ensure they were competent with providing IV therapy, changing PIV sites, and changing PICC line dressings. RN 1 stated when a resident arrived to the facility with a PICC line, the dressing was changed upon admission, then every seven days and as needed. RN 1 stated care of PIV and PICC lines were different because PIV sites were changed every 72 hours unless ordered by the physician. RN 1 stated being competent with the care of all vascular devices was necessary to prevent bloodstream infection. During an interview on 2/25/2026 at 2:13 p.m., with the Director of Nursing (DON), the DON stated, on 12/29/2025, she conducted an in-service for the licensed nurses regarding the care of vascular access devices. The DON stated she reviewed the P&P titled, IV Therapy and PICC/Midline/Central Vascular Access Device (CVAD) Dressing Change with the licensed nurses to cover care of vascular access devices and IV tubing.During a concurrent interview and record review, on 2/25/2026 at 2:15 p.m., with the DON, the facility's P&P titled, PICC/Midline/CVAD Dressing Change, dated 12/19/2022, was reviewed. The P&P indicated, to change PICC, midline, or central venous access device (CVAD) dressing, weekly or if soiled, in a manner to decrease potential for infection and/or cross contamination. The DON stated PICC lines were changed upon admission then every seven days. The DON stated PICC lines and PIV care differed from each other because PIV sites were changed every 72 hours while the PICC line's access site does not change, however, the RNs were responsible for changing the PICC line dressing per the physician's order. The DON stated RN 2's competency related to the care of PICC lines was important to ensure Resident 138's PICC line dressing was changed on time to prevent Resident 138 from contracting a bloodstream infection. During a review of the facility's Registered Nurse Job Description, undated, the Job Description duties and responsibilities included providing direct care skills with IV administration in accordance with current policies and procedures.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor signs and symptoms of bleeding for one of five sampled residents (Resident 138), who was receiving heparin (anticoagulant medication used to treat blood clots from forming in the blood vessels and the heart).This deficient practice had the potential to result in undetected bleeding and had the potential to result in delay in care.Findings:During a review of Resident 138's admission Record, the admission Record indicated Resident 138 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis of the vertebra in the lumbar region (infection in the spinal bones of the lower back), discitis in the lumbar region (infection of the disc space between the spinal bones), and spondylosis (age-related wear and tear of the spine).During a review of Resident 138's History and Physical (H&P), dated 2/20/2026, the H&P indicated Resident 138 had the capacity to understand and make decisions.During a review of Resident 138's Order Summary Report, active on 2/25/2026, the Order Summary Report indicated to inject heparin sodium (anticoagulant medication used to treat blood clots from forming in the blood vessels and the heart) injection solution 1000 units per milliliter (mL, unit of measurement), 0.5 mL subcutaneously (into the fat tissue) two times a day for deep vein thrombosis prophylaxis (method used to stop blood clots from forming in deep veins, usually in the legs, of at-risk individuals).During a concurrent interview and record review on 2/24/2026 at 1:21 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 138's Orders, active on 2/24/2026, was reviewed. The orders did not indicate to monitor for signs of bleeding related to heparin. LVN 2 stated Resident 138 did not have orders to monitor for signs of bleeding. LVN 2 stated Resident 138 was on heparin therapy to prevent blood clots. LVN 2 stated heparin sodium increased Resident 138's risk for bleeding. LVN 2 stated without the necessary monitoring, Resident 138 could have undetected bleeding which could result in a delay in treatment.During an interview on 2/25/2026 at 2:06 p.m., with the Director of Nursing (DON), the DON stated Resident 138 was at a high risk for bleeding and should have been monitored every shift for signs of bleeding. The DON stated without the necessary monitoring, Resident 138 was at risk of complications such as hematuria (blood in the urine), gastrointestinal bleed (bleeding in the digestive tract), nose bleeds, and other signs of internal bleeding. The DON stated all symptoms of bleeding would be considered a change in condition and quick intervention.During a review of the facility's policy and procedure (P&P) titled, High Risk Medications-Anticoagulants, dated 12/19/2022, the P&P indicated, The resident's plan of care shall alert staff to monitor for adverse consequences

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of six sampled residents (Residents 3 and 4) were free from significant medication error (one which caused the resident discomfort or jeopardizes his or her health and safety) when:1. Resident 4 was administered midodrine (medication used to treat low blood pressure) outside of the ordered parameter (specific instructions that dictate whether the medication is safe to administer) 17 times in January 2026 and 19 times in February 2026.2. Resident 3 was administered metoprolol (medication used to treat high blood pressure) outside of the ordered parameters on 1/10/2026, 2/16/2026, 2/19/2026, and 2/21/2026.This deficient practice increased Resident 4's risk of headache, chest pain, and stroke (loss of blood flow to the brain), and increased Resident 3's risk of hypotension (low blood pressure) and bradycardia (slowed heart rate) that could cause dizziness, fainting, weakness, or sudden cardiac arrest.Findings:a. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke - caused by a blocked blood vessel in the brain) affecting the left side and hypertensive heart disease with heart failure (chronic high blood pressure that causes the heart muscle to weaken leading to an inability to pump blood efficiently).During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 1/10/2026, the MDS indicated Resident 4's cognition (process of thinking) was intact. The MDS indicated Resident 4 was dependent on staff's assistance with toileting, bathing, and upper/lower body dressing.During a review of Resident 4's Order Summary Report, order dated 1/11/2026, the Order Summary Report indicated to give midodrine (medication used to treat low blood pressure) 5 milligrams (mg, a unit of measurement), by mouth three times a day, for hypotension (low blood pressure) and hold (not give) if systolic blood pressure (SBP, the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood out) was greater than 110 millimeters of mercury (mm Hg, unit of pressure measurement).During an interview on 2/24/2026 at 3:12 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated prior to administering midodrine, she was responsible for checking Resident 4's blood pressure and checking the hold parameters (specific instructions that dictate whether the medication is safe to administer) in the orders. LVN 1 stated if Resident 4's blood pressure was within the parameters, she would administer midodrine, however, if Resident 4's blood pressure was higher than 110 mm Hg, she would hold the midodrine. LVN 1 stated whether midodrine was administered or held, she was responsible for documenting accurately on the MAR. LVN 1 stated she was familiar with Resident 4 and most of the time giving [midodrine] to him.During a concurrent interview and record review on 2/24/2026 at 3:18 p.m., with LVN 1, Resident 4's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/1/2026 through 1/31/2026 and 2/1/2026 through 2/28/2026, were reviewed. The MARs indicated Resident 4 was administered midodrine 5 mg for the following SBP readings:1. 1/13/2026 - SBP of 117 mm Hg2. 1/14/2026 - SBP of 116 mm Hg3. 1/15/2026 - SBP of 121 mm Hg4. 1/16/2026 - SBP of 117 mm Hg5. 1/17/2026 - SBP of 141 mm Hg6. 1/18/2026 - SBP of 118 mm Hg7. 1/18/2026 - SBP of 128 mm Hg8. 1/19/2026 - SBP of 117 mm Hg9. 1/20/2026 - SBP of 114 mm Hg10. 1/21/2026 - SBP of 121 mm Hg11. 1/22/2026 - SBP of 121 mm Hg12. 1/23/2026 - SBP of 145 mm Hg13. 1/24/2026 - SBP of 134 mm Hg14. 1/26/2026 - SBP of 139 mm Hg15. 1/27/2026 - SBP of 132 mm Hg16. 1/28/2026 - SBP of 116 mm Hg17. 1/31/2026 - SBP of 123 mm Hg18. 2/1/2026 - SBP of 115 mm Hg19. 2/2/2026 - SBP of 117 mm Hg20. 2/3/2026 - SBP of 115 mm Hg21. 2/6/2026 - SBP of 116 mm Hg22. 2/7/2026 - SBP of 114 mm Hg23. 2/8/2026 - SBP of 116 mm Hg24. 2/8/2026 - SBP of 113 mm Hg25. 2/9/2026 - SBP of 118 mm Hg26. 2/12/2026 -SBP of 116 mm Hg27. 2/13/2026 - SBP of 121 mm Hg28. 2/14/2026 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- SBP of 118 mm Hg 29. 2/14/2026 - SBP of 121 mm Hg30. 2/15/2026 - SBP of 113 mm Hg31. 2/18/2026 - SBP of 115 mm Hg32. 2/19/2026 - SBP of 124 mm Hg33. 2/19/2026 - SBP of 122 mm Hg34. 2/20/2026 - SBP of 132 mm Hg35. 2/21/2026 - SBP of 113 mm Hg36. 2/22/2026 - SBP of 115 mm HgLVN 1 stated she administered midodrine to Resident 4 when the midodrine should have been held. LVN 1 stated Resident 4 had a history of a stroke and administering midodrine when Resident 4's SBP was higher than 110 mm Hg had the potential to increase Resident 4's blood pressure and increased Resident 4's risk of another stroke. During an interview on 2/25/2026 at 1:44 p.m., with the Director of Nursing (DON), the DON stated midodrine was administered when Resident 4's SBP was below 110 mm Hg. The DON stated midodrine would assist in increasing the SBP. The DON stated midodrine will always have hold parameters and the licensed nurse was responsible for holding midodrine if the SBP was outside the parameters. The DON stated if Resident 4 was administered midodrine when his SBP was above 110 mm Hg, Resident 4 was at risk of becoming hypertensive (elevated blood pressure) and could experience headache, chest pain, and/or another stroke. b. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, hypertensive heart disease, heart failure, atrial fibrillation (irregular heart rhythm) and end stage renal disease (ESRD- irreversible kidney failure). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was moderately impaired. The MDS indicated Resident 3 was dependent on staff's assistance with toileting, bathing, and upper/lower body dressing. During a review of Resident 3's Order Detail Report, dated 1/28/2026, the report indicated to administer metoprolol (a medication used to treat high blood pressure and lower the heart rate) 25 mg, by mouth every six hours and to hold if SBP was less than 110 mm Hg and if heart rate (HR) was less than 60 beats per minute (bpm). During a concurrent interview and record review on 2/26/2026 at 9:24 a.m., with Registered Nurse (RN) 1, Resident 3's MAR, dated 1/1/2026 through 1/31/2026, and 2/1/2025 through 2/26/2026, and Order Detail Report, dated 1/28/2026, were reviewed. The MARs indicated Resident 3 was administered metoprolol 25 mg outside the medication parameters on the following dates: 1. 1/10/2026 - HR of 59. 2. 2/16/2026- HR of 56 3. 2/19/2026 - HR of 56 4. 2/21/2026 - HR of 56 The MARs did not indicate additional documentation to indicate the reason metoprolol was administered outside of the medication parameters. RN 1 stated metoprolol was used to help control blood pressure and lowered the heart rate. RN 1 stated if Resident 3 was administered metoprolol outside of the parameters, Resident 3 was at risk of developing a slowed heart rate, or cardiac arrest. During a concurrent observation, interview, and record review on 2/26/2026 at 10:05 a.m. with LVN 3, Resident 3's AM bubble pack, dated 2/19/2026, was observed and Resident 3's MAR, dated 2/2026, was reviewed. The bubble pack indicated eight tablets were removed. The MAR indicated Resident 3 was administered metoprolol 25 mg eight times. LVN 3 stated that it was important to ensure accurate medication administration documentation and parameters were followed to ensure Resident (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3 did not exhibit cardiac related issues, especially because Resident 3 was on multiple blood pressure medications and Amiodarone (a medication used to control abnormal heart rhythm). During a review of the facility's policy and procedure (P&P), titled, Medication Administration, dated 12/19/2022, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician. The P&P indicated, Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.

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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 licensed nurses accurately and completely documented the administration of intravenous (IV) antibiotics (medications administered directly into the blood stream to treat an infection), and the peripherally inserted central catheter (PICC- a thin, flexible tube that delivers medications through a vein) line dressing change for two out of three sampled residents (Resident 78 and Resident 138).These deficient practices had the potential to place Resident 78 at risk for altered peak and trough levels (blood tests used in therapeutic drug monitoring to ensure medication effectiveness and safety), which had the potential to result in subtherapeutic dosing leading to ineffective treatment of Resident 78's infection, or elevated levels that could lead to toxicity, and placed Resident 138 at an increased risk for catheter-related blood stream infection and systemic complications.Cross Reference F694 and F726. Findings: a. During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was initially admitted to the facility on [DATE]. Resident 78's diagnoses included acute osteomyelitis (bone infection) of the right tibia and fibula (bones of the lower leg), infection and inflammatory reaction due to internal right knee prosthesis (artificial limb). During a review of Resident 78's Minimum Data Set (MDS, resident assessment tool) dated 2/12/2026, the MDS indicated Resident 78's cognition was moderately impaired (ability to think and reason). The MDS indicated Resident 78 required moderate assistance (helper does less than half of the effort) with toileting, showering, and upper body dressing. During a review of Resident 78's Order Summary, dated 11/1/2025 through 2/28/2026, the Order Summary indicated the following: 1. Amikacin (antibiotic) Sulfate Injection Solution 400 milligram (mg, a unit of measurement) intravenously (IV) one time a day. 2. Tygacil (antibiotic) Intravenous Solution Reconstituted 50 mg (Tigecycline) one dose intravenously every 12 hours. 3. Cefoxitin (antibiotic) Sodium Intravenous Solution Reconstituted 2 grams (a unit of measurement) one dose intravenously every 12 hours. 4. Flush IV line with normal saline (a solution of salt and water) 10 milliliters (ml, a unit of measurement) before and after IV dose every shift for maintenance. During a concurrent interview and record review on 2/25/2026 at 3:49 p.m. with the Director of Nursing (DON), Resident 78's IV Medication Administration Record (MAR), dated 1/2026 through 2/2026, was reviewed. The DON stated that she was the assigned registered nurse (RN) on 1/3/2026 for the 7 a.m. to 3 p.m. shift and did not document the administration of Resident 78's morning doses of IV antibiotics. The DON stated that she recalled being busy during the shift and forgot to document the administration. The DON stated IV antibiotic administration must be accurately documented to ensure treatments were completed as ordered and to clearly reflect the care provided. The DON (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the administration of Amikacin was especially important to accurately document because peak and trough blood levels were monitored. The DON stated inaccurate or missing documentation had the potential to result in altered peak and trough levels and could affect therapeutic effectiveness of the antibiotic. The DON stated this placed Resident 78 at risk for ineffective treatment and further infection progression. The IV MAR was left blank on the following dates and times, indicating the orders were not performed: 1. 1/3/2026 at 9:00 a.m. - Amikacin Sulfate (an antibiotic). 2. 1/3/2026 at 8:00 a.m. and 8:00 p.m. -Tigeycline (Tygacil). 3. 2/20/2026 at 8:00 p.m. - Tigecycline. 4. 2/21/2026 11 p.m. to 7 a.m. shift - IV flush. 5. 2/22/2026 6:00 a.m. - Cefoxitin. b. During a review of Resident 138's admission Record, the admission Record indicated Resident 138 was admitted to the facility on [DATE]. Resident 138's diagnoses included osteomyelitis of the vertebra in the lumbar region (infection in the spinal bones of the lower back), discitis in the lumbar region (infection of the disc space between the spinal bones), and spondylosis (age-related wear and tear of the spine).During a review of Resident 138's History and Physical (H&P), dated 2/20/2026, the H&P indicated Resident 138 had the capacity to understand and make decisions.During a review of Resident 138's Order Summary Report, dated 2/25/2026, the Order Summary Report indicated to:1. Change Resident 138's PICC line securement device (a sterile tool to hold the PICC in place on the skin) upon admission and every seven days during the evening shift.2. Change Resident 138's PICC line transparent dressing (a clear, sticky bandage placed over the PICC line insertion site), per sterile technique, upon admission and every seven days during the evening shift. During a concurrent observation and interview on 2/23/2025 at 9:56 a.m., with Resident 138, in Resident 138's room, observed Resident 138's PICC line to the right upper arm. The PICC line dressing was dated 2/13/2026. Resident 138 stated the PICC line was inserted during his admission at the general acute care hospital (GACH) for antibiotic treatment. Resident 138 stated since his admission to the facility, no one changed his PICC line dressing.During a concurrent interview and record review on 2/24/2026 at 3:46 p.m., with Registered Nurse (RN) 2, Resident 138's IV Administration Report, dated 2/1/2026 through 2/28/2026, was reviewed. The report indicated the PICC line dressing was changed on 2/20/2026, 2/22/2026, and 2/23/2026, and the securement device was changed on 2/20/2026 and 2/23/2026. RN 2 stated checkmarks on the IV Administration Report indicated the order was completed. RN 2 stated, on 2/22/2026 and 2/23/2026, she documented Resident 138's PICC line transparent dressing was changed, and on 2/23/2026, she documented Resident 138's PICC line securement device was changed. RN 2 stated she was confused and thought the order was to assess the PICC line dressing and securement device. RN 2 stated on 2/22/2026 and 2/23/2026, she did not change Resident 138's PICC line dressing and securement device.During an interview on 2/25/2026 at 2:27 p.m., with the DON, the DON stated documentation on the IV Administration Record was to communicate to the other RNs the accurate date Resident 138's PICC line dressing and securement device were changed. The DON stated this would allow the RNs to coordinate Resident 138's care and to change the PICC line dressing and securement device immediately because it was not changed upon admission. The DON stated as a result, Resident 138's PICC line dressing and securement device were not changed, placing Resident 138 at risk for infection.During a review of the facility's Policy and Procedure (P&P) titled, Documentation in Medical Record, dated 12/19/2022, the P&P (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055737	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Hills Post Acute	12200 LA Mirada Blvd. LA Mirada, CA 90638

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated documentation of services provided to the resident must be accurate, relevant, and complete.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 infection (the invasion and multiplication of microorganisms[like bacteria, viruses] in body tissues, potentially causing illness or harm) control practices for one of six residents (Resident 7), when Resident 7's indwelling catheter (a flexible tube inserted into the bladder to drain urine into a bag) drainage bag was observed touching the floor.This deficient practice placed Resident 7 at risk for infection and had the potential to spread bacteria through cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment).Findings:During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7's diagnoses included benign prostatic hyperplasia (BPH- enlargement of the prostate), dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic kidney disease ([CKD]- when kidneys were damaged and could not filter blood properly, leading to a buildup of waste and fluid in the body). During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 2/13/2206, the MDS indicated Resident 7's cognition (the ability to think and process information) was intact. The MDS indicated Resident 7 required maximum (helper does more than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 7's care plan tilted The resident has indwelling Foley catheter ., dated 1/9/2026, the care plan indicated Resident 7 was to have no signs and symptoms of urinary infection. The interventions indicated to keep the catheter below the level of the bladder. During an observation on 2/23/2026 at 12:57 p.m., and 2/24/2026 at 1:29 p.m., at Resident 7's bedside, Resident 7 was observed lying in bed. The indwelling catheter drainage bag was observed on the right side of Resident 7's bed, touching the floor. During a concurrent observation and interview on 2/24/2026 at 1;51 p.m., with Licensed Vocational Nurse (LVN) 7, at Resident 7's bedside, Resident 7 was observed lying in bed. The indwelling catheter drainage bag was directly on the floor on the right side of the bed. LVN 7 stated the catheter drainage bag should be kept off the floor and below the level of the bladder to prevent contamination and backflow of the urine. LVN 7 stated the catheter bag should not have been touching the floor because of infection control. LVN 7 stated when the bag was on the floor, bacteria from the floor could contaminate the drainage bag and travel into Resident 7's urine. During an interview on 2/26/2026 at 7:59 a.m., with the Director of Nursing (DON), the DON stated the indwelling catheter drainage bag should be kept off the floor and placed in a clean basin (container) when the resident was in bed. The DON stated failing to ensure Resident 7's catheter drainage bag was kept off the floor exposed the drainage bag to contamination. The DON stated this placed the resident at risk for infection, development of a catheter-associated urinary tract infection [(UTI]- an infection in the bladder/urinary tract), and other preventable infection-related complications. During a review of the facility's policy and procedure (P&P) titled Infection Prevention and Control Program, dated 12/19/2022, the P&P indicated the facility will provide and maintain a sanitary environment to help prevent the development and transmission of infections. During a review of the facility's P&P titled Appropriate Use of Indwelling Catheters, dated 12/19/2022, the P&P indicated indwelling urinary catheters will be utilized with interventions to prevent complications such as urinary tract infection.