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	055742	A. Building B. Wing	04/10/2026

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Harbor Villa Care Center	861 S. Harbor Blvd Anaheim, CA 92805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries for two of three final sampled residents (Residents 10 and104) reviewed for pressure injuries. * The facility failed to offload Resident 10's heels, as ordered by the physician and failed to provide a pressure relieving mattress with a pump as ordered by the physician. * The facility failed to offload Resident 104's heels as ordered by the physician. These failures had the potential for the residents to result in new pressure injuries, worsening of existing wounds, or other complications.Findings: Review of the facility's P&P titled Prevention of Pressure Injuries (undated) showed in part in the prevention skin care section to do not rub or otherwise cause friction on skin that is at risk of pressure injuries. Provide support devices and assistance as needed. Remind and encourage to change positions. Select appropriate support surfaces based the resident's risk factors, in accordance with current clinical practice. 1. Medical record review for Resident 10 was initiated on 4/7/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10' MDS assessment dated [DATE], showed the resident had intact cognition. Resident 10 was dependent on the staff with toilet hygiene, bathing, lower body dressing, sit to stand, and chair to bed or bed to chair transfer. In addition, Resident 10 required substantial to maximal assistance with bed mobility, rolling from left to right and sit to lying. Review of Resident 10's Order Summary Report showed the following physician's orders:- dated 1/4/26, to provide pressure-relieving mattress with a pump. Monitor for device function every shift for skin management. - dated 1/11/26, to offload or float bilateral heels at all times for skin management. - dated 4/1/26, to paint left and right heel diabetic ulcer (open sore, caused by nerve damage and poor circulation) with povidone iodine (antiseptic) and wrap with rolled gauze every day shift for wound care for 30 days. On 4/8/26 at 0745 hours, an observation of Resident 10 was conducted in the resident's room. Resident 10 was observed lying on the bed with a mattress without a pump, and both heels covered with dressings, which were resting directly on the mattress and not floated or offloaded. On 4/8/26 at 0923 hours, an interview and concurrent observation of Resident 10 was conducted with LVN 6 inside the resident's room. LVN 6 verified the resident did not have a pumpˆequipped mattress and the heels were not floated. LVN 6 stated Resident 10 had a pump on the mattress previously, however, another resident needed the pressure relieving mattress with a pump. LVN 6 verified Resident 10's physician's orders above. LVN 6 stated she could contact the physician to clarify the orders for skin management. LVN 6 further stated Resident 10 was at high risk for pressure injuries. On 4/9/26 at 0759 hours, an observation of Resident 10 was conducted inside the resident's room. Resident 10 was observed lying on the bed with both heels resting directly on the mattress without offloading. On 4/9/26 at 0822 hours, an interview and concurrent observation of Resident 10 was conducted with CNA 1. CNA 1 verified the heels were touching the mattress and stated she would reposition the resident and offload the heels. On 4/10/26 at 1408 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above. 2. Medical record review for Resident 104 was initiated on 4/7/26. Resident 104 was admitted to the facility on [DATE]. Review of Resident 104's Order Summary Report showed the following (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's orders: - dated 4/6/26, apply A&D (topical skin protectant used to treat and prevent minor skin irritations) ointment to the right and left heel blanchable redness every day shift for skin management for 30 days. - dated 4/6/26, to offload/float bilateral heels every shift for skin management. On 4/8/26 at 0807 hours, an observation of Resident 104 was conducted inside the resident's room. Resident 104 was observed lying in bed with both heels resting directly on the mattress and not floated. On 4/8/26 at 0912 hours, an interview and concurrent observation of Resident 104 was conducted with LVN 6. LVN 6 verified resident's heels were touching the bed mattress. LVN 6 stated she had not yet assessed the resident since the start of the shift. LVN 6 stated the resident was at risk for pressure injury and had a blanchable redness on both heels. On 4/8/26 at 1515 hours, an interview and concurrent observation of Resident 104 was conducted with RNA 1. RNA 1 verified Resident 104's heels were directly touching the mattress and not offloaded. RNA 1 stated she would reposition the resident. On 4/10/26 at 1310 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one two of four residents (Residents 6 and 44) observe for the medication administration were free from the significant medication errors. * LVN 1 administered the furosemide (medication to treat fluid retention) medication outside the physician's ordered parameter for Resident 6. * LVN 3 administered the heparin (blood thinner) medication without a physician's order for Resident 44. These failures posed the risk of adverse complication to the residents.Findings: Review of the facility's P&P titled Administering Medications (undated) showed the medications are administered in accordance with prescriber orders, including any required time frame. The P&P also showed the individual administering the medications checks the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 1. On 4/8/26 at 0938 hours, a medication administration observation for Resident 6 was conducted with LVN 1. Prior to administering the medications for Resident 6, LVN 1 obtained the resident's BP reading using an automatic BP machine and the resident's BP reading was 103/68 mmHg. LVN 1 was then observed preparing and administering the following medications to Resident 6:- digoxin (used to increase the force of the heart contractions and slowing the heart) 125 mcg one tablet;- Drizalma sprinkle (antidepressant) 40 mg one capsule by mouth;- potassium chloride ER (supplement) 10 mEq one tablet by mouth;- furosemide 40 mg one tablet by mouth;- multivitamin with minerals (supplement) one tablet by mouth;- iron sulfate (supplement) 325 mg one tablet by mouth;-docusate sodium (stool softener) 100 mg one soft gel by mouth;- fluticasone propionate (used to prevent and treat seasonal allergies) 50 mcg nasal spray, one spray to each nostril;- ciclesonide (used to treat persistent asthma and allergic rhinitis) 80 mcg/inhalation, one puff orally; and- dabigatran etexilate (blood thinner) 110 mg one capsule by mouth. Medical record review for Resident 6 was conducted 4/7/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 2/1/26, showed the resident had the capacity to understand and make decisions. Review of Resident 6's Order Summary Report dated 4/8/26, showed a physician's order dated 4/5/26, to administer furosemide 40 mg one tablet by mouth one time a day for BLE edema (swelling); hold if SBP was less than 110 mmHg. On 4/8/26 at 1102 hours, an interview and concurrent medical record review for Resident 6 was conducted with LVN 1. LVN 1 verified he administered the furosemide medication to Resident 6 during the medication administration observation. LVN 1 further verified Resident 6's physician's order for the furosemide medication showed an ordered parameter to hold the medication if the SBP was less than 110 mmHg. LVN 1 stated he should not have administered the furosemide medication to Resident 6 because the resident's BP reading was 103 mmHg. On 4/8/26 at 1138 hours, a follow-up interview was conducted with LVN 1. LVN 1 stated he notified Resident 6's physician regarding the furosemide medication that was administered outside of the ordered parameter. LVN 1 stated the physician ordered to monitor the resident [NAME] hypotension (low blood pressure). On 4/8/26 at 1240 hours, an interview was conducted with the DON. The DON was informed of the above findings and stated the change of condition assessment was completed for Resident 6 and the resident's physician was notified. 2. On 4/9/26 at 0927 hours, an interview and concurrent medication administration observation for Resident 44 was conducted with LVN 3. LVN 3 was observed administering the heparin injection solution on the RUQ of Resident 44's abdomen. LVN 3 stated he would administer the heparin injection solution to the RUQ of the resident's abdomen because the previous dose was administered on the LUQ of the abdomen on 4/8/26. Medical record review for Resident 44 was conducted on 4/7/26. Resident 44 was readmitted to the facility on [DATE]. Review of Resident 44's H&P examination dated 3/30/26, showed Resident 44 had capacity to make medical decisions. Review of Resident 44's MAR for April failed to show a physician's order to administer the heparin injection solution to Resident 44. Review of Resident 44's Order Summary Report dated (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/9/26, failed to show a physician's order to administer the heparin injection solution to Resident 44. On 4/9/26 at 0950 hours, an interview and concurrent medical record review for Resident 44 was conducted with LVN 3. LVN 3 verified Resident 44 had no physician's order for the heparin injection solution. LVN 3 stated he made a mistake and administered the heparin injection solution to the wrong resident. On 4/9/26 at 1034 hours, a follow-up interview was conducted with LVN 3. LVN 3 stated Resident 44 was previously receiving the heparin injection solution, and he did not check the resident's MAR thoroughly prior to administering the heparin injection solution. LVN 3 stated when he checked for the last injection site for the heparin injection solution on the resident's MAR, he checked the last injection site for the Retacrit (used to treat low red blood cell count) injection instead. LVN 3 further stated he would check the resident's MAR to see what medications were due for the resident on his shift prior to administering the resident's medications. LVN 3 stated Resident 44's physician was notified the resident mistakenly received the heparin injection solution and the physician recommended to continue monitoring the resident. On 4/9/26 at 1051 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. On 4/9/26 at 1426 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure to prepare food by methods that conserve nutritive value and at safe and appetizing temperature for 11 residents that consumed pureed food and 45 residents on Regular Diet Texture. * The prepared pureed vegetables were left in the oven for more than one hour before the lunch food tray line. * The ham temperature was at 98 degrees Fahrenheit. These failures had the potential for the residents not to eat the food served and could affect the residents nutritional status. Findings: Review of the facility's P&P titled Food Preparation and Service (not dated) showed food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. Proper hot and cold temperatures are maintained during food distribution and service. 1. Review of the facility's Diet Type Report dated 4/7/26, showed 11 residents consumed pureed food prepared in the kitchen. On 4/8/26 at 1004 hours, an observation of puree food preparation was conducted with [NAME] 1. [NAME] 1 was observed preparing pureed sweet potato yam. [NAME] 1 placed the sweet potato yam in the oven at 1007 hours. [NAME] 1 prepared the pureed ham and placed in the oven at 1011 hours. [NAME] 1 prepared the pureed braised cabbage and placed in the oven at 1016 hours. The oven was observed set at 200 degrees Fahrenheit. On 4/8/26 at 1120 hours, an observation and concurrent interview was conducted with [NAME] 2. [NAME] 2 verified the prepared pureed food was in the oven. [NAME] 2 verified the oven temperature was set at 200 degrees Fahrenheit. [NAME] 2 stated temperature could be lowered. On 4/8/26 at 1123 hours, an interview was conducted with the DSS. The DSS stated the food tray line would start at 1200 hours. The DSS stated the food temperatures need to be maintained and food should not been prepared more than one hour before tray line to prevent it from losing nutritional value. On 4/10/26 at 1302 hours, the DSS and Administrator were informed and acknowledged the above findings. 2. Review of the facility's Diet Type Report dated 4/7/26, showed 45 residents consumed Regular Diet Texture prepared in the kitchen. Medical record review for Resident 39 was initiated on 4/8/26. Resident 39 was admitted to the facility on [DATE]. Review of Resident 39's H&P examination dated 10/19/25, showed the resident was competent and was able to make decisions. Review of Resident 39's Order Summary Report showed a physician's order dated 8/27/25, for Resident 39 to have a fortified high protein no added salt regular texture, thin consistency diet with large portions at breakfast to increase caloric intake. On 4/7/26 at 0830 hours, an observation and concurrent interview was conducted with Resident 39. Resident 39 stated the facility food did not taste good and was served cold. On 4/8/26 at 1255 hours, a test tray inspection and concurrent interview was conducted with the DSS. The regular diet tray included ham. The ham temperature was observed at 98 degrees Fahrenheit. The DSS verified the temperature of the ham. The DSS stated the ham was not warm enough. On 4/10/26 at 1302 hours, the DSS and the Administrator was informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed for 81 of 87 residents who eat in the kitchen. * Food items used for residents' food were not properly stored, labeled and dated. * One expired bottle of opened ground ginger spice was not discarded. * The kitchen equipment and utensils were not maintained in a sanitary condition. * One cutting board was observed heavily marred and fuzzy with knife marks. * The pitchers were stored wet. * The hair restraint was not worn by one staff member preparing food in the kitchen. * Nonfood contact surfaces were not clean or in a cleanable condition. These failures had the potential to contaminate the food which could lead to foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen.Findings: 1. Review of the facility's Diet Type Report dated 4/7/26, showed 81 of 87 residents consumed the food prepared in the kitchen. On 4/7/26 at 0615 hours, during the initial tour of the kitchen with the DSS, the following was observed:- Oatmeal was observed in an aluminum container. The aluminum container lid was broken and would not close properly. The plastic liner of the container was torn; and- Ground cinnamon had no open date. The DSS verified the above findings. The DSS stated the oatmeal should have been stored in a sealed container and the cinnamon should have been stored, dated, and labeled accordingly. 2. On 4/7/26 at 0619 hours, during the initial tour of the kitchen with the DSS, an opened ground ginger spice was observed with a use by date of 3/27/26. The DSS verified the above finding and stated the above item should have been expired items and should have been discarded. 3. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C), nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. On 4/7/26 at 0625 hours, during the initial tour of the kitchen with the DSS, the following was observed:- two spatulas with red handle with chipped part;- a food strainer with brownish orange material resembling rust; and- one frying pan with inner deep scratches had lost the non-stick surface exposing the underlying metal. The DSS verified the above findings. The DSS stated the frying pan and the utensils will be replaced. 4. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, showed surfaces such as cutting blocks that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. On 4/7/26 at 0628 hours, during the initial tour of the kitchen with the DSS, one cutting board was observed heavily marred and fuzzy with knife marks. The DSS verified the findings. 5. According to USDA Food Code 2022, Section 4-901.11, equipment and utensils, air drying required, items must be allowed to drain and to air-dry before stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganisms can grow. On 4/7/26 at 0630 hours, during the initial tour of the kitchen with the DSS, eight water pitchers were observed stored wet. The surface of the shelf were the pitchers were stored were also wet. The DSS verified the observation and stated staff should have air dried the pitchers before storing. 6. According to the USDA Food Code 2022, Section 2-402.11 Effectiveness (A), Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils. Review of the facility's P&P titled Foodborne Illness - Employee hygiene and Sanitary Practices not dated, showed food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Hair nets or caps and/ or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. On 4/7/26 at 0645 hours, an observation of Dietary Aide 1 and concurrent interview was conducted with the DSS. Dietary Aide 1 was observed with hairy arms with no covering preparing pancake syrup in the kitchen. The DSS verified the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation of Dietary Aide 1's arms. The DSS stated Dietary Aide 1 should wear arm sleeves to keep hair from contacting the food. 7. According to the USDA Food Code 2022, Section 4-601.11 Food Contact Surfaces, Nonfood Contact Surfaces, and Utensils (A) Equipment, food contact surfaces and utensils shall be clean to sight and touch, (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. On 4/7/26 at 1002 hours, an observation of the water pipe in the kitchen behind the dishwasher and concurrent interview was conducted with the Maintenance Director. The water pipe in the was observed peeling off with brownish orange material resembling rust. The Maintenance Director confirmed the findings. On 4/10/26 at 1302 hours, the DSS and Administrator was informed and acknowledged the above findings.

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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, medical record review, and facility's P&P review, the facility failed to ensure the residents or their representatives were informed in advance of the proposed treatment regarding the use of psychotropic medications (medications affecting brain activity) for two of five residents (Residents 3 and 4) reviewed for unnecessary medications. * The facility failed to have separate informed consent and nonpharmacological interventions for Resident 4's use of the clonazepam (a prescription medication used to treat seizure disorders and panic disorder by acting as a central nervous system depressant), lorazepam (a medication used for short-term management of anxiety disorders, insomnia, acute seizures (status epilepticus), and pre-anesthetic sedation) and aripiprazole (medication used to treat mental health conditions by balancing dopamine (critical neurotransmitter and chemical messenger in the brain that regulates pleasure, reward, motivation, memory, and motor control). In addition, the aripiprazole medication was classified as antidepressant in the resident's informed consent. * The facility failed to ensure the informed consents for the olanzapine (a medication for mental disorders including schizophrenia and bipolar disorder) and mirtazapine (antidepressant medication) medications were signed by Resident 3's physician. In addition, the facility failed to have separate informed consent and nonpharmacological intervention for Resident 3's use of the mirtazapine and olanzapine medications. These failures had the potential to compromise the residents' and/or their designated representatives' right to be fully informed regarding the psychotropic medication and its possible nonpharmacological interventions in order to make an informed decision.Findings: 1. Medical record review for Resident 4 was initiated on 4/7/26. Resident 4 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed the resident had moderate cognitive impairment. Review of Resident 4's Informed Consent-Psychoactive Medication – V3 dated 3/4/26 showed the facility used one informed consent form for the aripiprazole, clonazepam, and lorazepam medications. In addition, the aripiprazole was classified as an antidepressant medication. There was no documented evidence a separate informed consents and nonpharmacological interventions for Resident 4's use of the aripiprazole, clonazepam, and lorazepam medications were completed. Review of Resident 4's Order Summary Report dated 4/9/26, showed the following physician's orders: - dated 9/30/25, to administer clonazepam 1 mg tablet by mouth every 12 hours for anxiety manifested by undirectable verbal aggressive behavior. Institute nonpharmacological approach prior to administration of pain medication: (1) Repositioning, (2) Dim lights/quiet environment (3) Hot/cold applications and (4) Relaxation techniques; - dated 1/6/26, to administer lorazepam 1 mg tablet mouth every 12 hours as needed for anxiety manifested by verbalization of anxiety/ post-traumatic stress for 90 days not to exceed 2 grams per day. Institute nonpharmacological approach prior to administration: (1) Reorientation, (2) Music/TV, (3) Re-direction/ Diversion, (4) Reassurance, (5) Quiet environment, (6) Encourage vent feelings, (7) food/drink; and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 1/12/26, to administer aripiprazole 10 mg tablet by mouth at bedtime for Bipolar Disorder (a chronic mental health condition characterized by extreme mood swings, alternating between intense highs -mania/hypomania- and lows - depression) manifested by loose and disorganize thoughts. Institute nonpharmacological approach prior to administration: (1) Reorientation, (2) Music/TV, (3) Re-direction/Diversion, (4) Reassurance, (5) Quiet environment, (6) Encourage vent feelings, (7) food/drink. On 4/9/26 at 1600 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 4's Informed Consent-Psychoactive Medication – V3 dated 3/4/26, showed the facility used one informed consent form for the aripiprazole, clonazepam, and lorazepam medications. In addition, RN 1 verified the aripiprazole was classified as an antidepressant medication on the informed consent. On 4/10/26 at 0900 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated she was not aware the informed consent should have only one medication listed. The SSD further stated she would implement the use of one informed consent per each medication. On 4/10/26 at 1324 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 3 was initiated on 4/7/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 3's Informed Consent-Psychoactive Medication – V2 dated 11/14/25, and Informed Consent-Psychoactive Medication – V3 dated 2/12/26, failed to show documented evidence the informed consents for the mirtazapine and olanzapine medications were signed by Resident 3's physician. In addition, the facility failed to have a separate informed consent and nonpharmacological interventions for Resident 3's use of mirtazapine and olanzapine medications. Review of Resident 3's Order Summary Report dated 4/9/26, showed the following physician's order: - dated 1/12/26, to administer mirtazapine oral tablet 30 mg, give one tablet by mouth at bedtime for depression manifested by poor oral intake less 50%. Institute nonpharmacological approach prior to administration: 1. Reorientation, 2. Music/TV, 3. Re-direction/Diversion, 4. Reassurance, 5. Quiet environment, 6. Encourage vent feelings, 7. food/drink; and - dated 1/12/26, to administer olanzapine oral tablet 5 mg, give one tablet by mouth at bedtime for schizoaffective episodes manifested by outburst without reason. Institute nonpharmacological approach prior to administration: 1. Reorientation, 2. Music/TV, 3. Re-direction/Diversion, 4. Reassurance, 5. Quiet environment, 6. Encourage vent feelings, 7. food/drink. On 4/10/26 at 0903 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 3's Informed Consent-Psychoactive Medication -V2 dated 11/14/25, and the Informed Consent-Psychoactive Medication V-3 dated 2/12/26, had two psychotropic medications in each informed consent. RN 2 acknowledged both informed consents were not signed by Resident 3's (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician and the nonpharmacological approach for the mirtazapine and olanzapine medications were not separated. RN 2 stated there should have been separate informed consent and nonpharmacological approaches to make sure it was clear which nonpharmacological approach was specific for each medication. RN 2 stated the licensed nurses should make sure Resident 3's physician signed the informed consent. On 4/10/26 at 1317 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 87 residents (nonsampled resident, Resident 91) was assessed to self-administer of medication. The facility failed to ensure there was a physician's order and self-administration assessment for the Vicks VapoRub (cough suppressant and topical analgesic) ointment medication found at the resident's bedside. This failure had the potential to impact Resident 91's safety and well-being and an increased risk of improper medication use. Findings: Review of the facility's P&P titled Self-Administration of Medications (undated) showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. On 4/7/26 at 0816 hours, during the initial tour of the facility, Resident 91 was observed sitting in bed and watching TV. A container of Vicks VapoRub ointment was observed inside an open drawer of the resident's bedside cabinet. Medical record review for Resident 91 was initiated on 4/7/26. Resident 91 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 91's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 91's Order Summary Report for April 2026 failed to show a physician's order for the Vicks VapoRub ointment medication. Further review of Resident 91's medical record did not show Resident 91 had been assessed to self-administer the Vicks VapoRub ointment medication. On 4/7/26 at 0843 hours, an observation and concurrent interview was conducted with Resident 91. A Vicks VapoRub ointment was observed inside the resident's opened bedside drawer. Resident 91 stated she used the Vicks VapoRub ointment two days ago. On 4/7/26 at 0849 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified the Vicks VapoRub ointment was inside the opened drawer of Resident 91's bedside drawer. CNA 3 stated Resident 91 was not allowed to have medication in her cabinet and/or bedside table. On 4/7/26 at 0853 hours, an observation and concurrent interview was conducted with RN 3. RN 3 verified the Vicks VapoRub ointment was present at Resident 91's bedside. RN 3 stated the ointment should not be at the bedside because it was considered a medication. On 4/7/26 at 0917 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified there was no physician's order and no self-administration assessment for Resident 91's Vicks VapoRub ointment. LVN 1 stated Resident 91's drawers should have been checked and the facility staff or the resident should have notified the charge nurse if there was medication kept at the bedside. LVN 1 further stated there should have been a physician's order and self-administration assessment for Resident 91's Vicks VapoRub ointment in place. On 4/10/26 at 1317 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure a safe environment for the residents, staff, and visitor was provided in one of four hallways. * One of four hallways was observed with a handrail that was sharp to the touch. This failure posed the risk of injury to the residents, staff, and visitors.Findings: On 4/7/26 at 0709 hours, the handrail in Hallway A was observed with an uneven surface. The paint on the handrail was peeling, exposing the wooden surface underneath. The handrail felt sharp to the touch. On 04/7/2026 at 1346 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified the above findings.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 3 and 4) reviewed for unnecessary medications were free from unnecessary psychotropic medications. * The facility failed to ensure Resident 3 was properly monitored for orthostatic blood pressures (measure the blood pressure while laying down or sitting and again upon standing up) as ordered by the physician. * The facility failed to ensure Resident 3's monthly behavior summary for the use of olanzapine (a medication for mental disorders including schizophrenia and bipolar disorder) and mirtazapine (antidepressant medication) were completed. * The facility failed to ensure a gradual dose reduction (GDR) was attempted for Resident 4 when the facility failed to follow the psychiatrist's order to discontinue the clonazepam medication. These failures had the potential for adverse health outcomes to the residents related to the effects of psychotropic medications.Findings: Review of the facility's P&P titled Psychotropic Medication Use (undated) showed residents will not receive medications that are not clinically indicated to treat a specific condition. The P&P further showed: - Use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. - Residents on the psychotropic medications receive gradual dose reductions (coupled with nonpharmacological interventions), unless clinically contraindicated, in an effort to discontinue these medications. - Residents receiving psychotropic medications are monitored for adverse consequences, including cardiovascular effects: irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure and orthostatic hypotension. Review of the facility's P&P titled Charting and Documentation (undated) showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Under the Policy Interpretation and Implementation section showed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 1. Medical record review for Resident 3 was initiated on 4/7/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. a. Review of Resident 3's Order Summary Report dated 4/9/26, showed the following physician's orders: - dated 11/14/25, to monitor orthostatic BP when laying every Sunday; and - dated 11/14/25, to monitor orthostatic BP when sitting every Sunday. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3's MARs for February and March 2026 showed orthostatic BP (lying and sitting) were scheduled to be monitored every Sunday. However, Resident 3's BP readings for lying and sitting were identical on multiple dates: - On 2/1/26, the BP readings were 125/67 mmHg for lying position and 125/67 mmHg for sitting position. - On 3/8/26, the BP readings were 122/65 mmHg for lying position and 122/65 mmHg for sitting position. - On 3/15/26, the BP readings were 125/67 mmHg for lying position and 125/67 mmHg for sitting position. - On 3/22/36, the BP readings were 133/72 mmHg for lying position and 133/72 mmHg for sitting position. - On 3/29/26, the BP readings were 119/72 mmHg for lying position and 119/72 mmHg for sitting position. On 4/9/26 at 1130 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 3's orthostatic BP were the same for laying and sitting position on the above dates. RN 1 stated Resident 3's BP should have been checked in correct positions. RN 1 stated accurate orthostatic readings were necessary to identify hypotension and report concerns to the physician. RN 1 stated the psychotropic medication could affect Resident 3's BP and required monitoring. b. Review of Resident 3's Order Summary Report dated 4/9/26, showed the following physician's orders: - dated 1/12/26, to administer mirtazapine 30 mg oral tablet, give one tablet at bedtime for depression manifested by poor oral intake less than 50%. -dated 1/12/26, to administer olanzapine 5 mg oral tablet, give one tablet by mouth at bedtime for schizoaffective episodes manifested by outburst without reason. However, further review of Resident 3's medical record showed no monthly behavior summary reports for January through March 2026 were completed for the olanzapine and mirtazapine medications. On 4/9/26 at 1339 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified no monthly behavior summary reports from January to March 2026 for the use of the olanzapine medication were completed for Resident 3. RN 1 stated the monthly summaries were needed to assess behavioral response and determine whether medication adjustments were needed. On 4/9/26 at 1422 hours, a follow-up interview and concurrent medical record review was conducted with RN 1. RN 1 no monthly behavior summary reports from January to March 2026 for the use of mirtazapine for Resident 3 were completed. RN 1 stated the reports were necessary to determine medication effectiveness and whether dose reduction was appropriate. On 4/10/26 at 1317 hours, an interview was conducted with the DON. The DON was informed and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged the above findings. 3. Medical record review for Resident 4 was initiated on 4/7/26. Resident 4 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed the resident had moderate cognitive impairment. Review of Resident 4's Order Summary Report dated 4/9/26, showed the following physician's order: - dated 9/30/25, to administer clonazepam 1 mg tablet by mouth every 12 hours for anxiety manifested by undirectable verbal aggressive behavior. - dated 1/6/26, to administer lorazepam 1 mg tablet mouth every 12 hours as needed for Anxiety manifested by verbalization of anxiety/ post-traumatic stress for 90 days. - dated 1/12/26, to administer aripiprazole 10 mg tablet by mouth at bedtime for Bipolar Disorder (a chronic mental health condition characterized by extreme mood swings, alternating between intense highs -mania/hypomania- and lows - depression) manifested by loose and disorganize thoughts. Review of Resident 4's Consultant Pharmacist's Recommendation to Inter-Disciplinary Team (IDT) dated 2/18/26, showed the need to assess if clinically appropriate to consider a GDR for either one or both of the agents. Review of Resident 4's Psych Progress Notes dated 3/3/26, showed GDR would be attempted. The physician documented to discontinue the clonazepam 1 mg in the progress notes. However, further review of Resident 4's Order Summary Report failed to show the clonazepam 1 mg was discontinued. On 4/9/26 at 0816 hours, an interview was conducted with Resident 4. Resident 4 stated her medications made her sleepy sometimes. However, she needed to take the medications and her pain medication to control her pain. On 4/9/26 at 1530 hours, an interview and concurrent record review was conducted with the SSD. The SSD verified Resident 4's Psych Progress Notes dated 3/3/26, showed GDR would be attempted and the physician's order to discontinue the clonazepam. The SSD stated she did not know why the psychiatrist order was not carried out and that the RN in charge of the psychotherapeutic medication lead the GDR meetings and the SSD supervised. On 4/9/26 at 1545 hours, a telephone interview was conducted with the Psychiatrist. The Psychiatrist verified he discontinued the clonazepam 1 mg on 3/3/26, as per the pharmacy recommendation for GDR. The Psychiatrist stated he discussed the GDR order with the nurse in charge of the psychotherapeutic medications. The Psychiatrist further stated his expectation was for the RN to follow the order to discontinue the clonazepam. The Psychiatrist stated he was not aware the clonazepam was not discontinued. On 4/9/26 at 1600 hours, an interview and concurrent record review was conducted with RN 1. RN 1 verified the clonazepam medication for Resident 4 was not discontinued as ordered by the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Psychiatrist. RN 1 stated the clonazepam medication should have been discontinued, however, she did not know why the clonazepam medication was not discontinued. On 4/10/26 at 1324 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the PASARR recommendations were followed up and incorporated into the resident's care for one of seven final sampled residents (Resident 8) reviewed for PASARR. * The facility failed to ensure the PASARR Level II recommendations were followed and incorporated into Resident 8's care. This failure had the potential for Resident 8 not to receive the adequate care that was recommended by the PASARR Level II evaluation report that completed by an appropriate state-designated authority.Findings: Medical record review for Resident 8 was initiated on 4/7/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 3/4/25, showed Resident 8 was competent and able to make decisions. Review of Resident 8's admission Records dated 4/9/26, showed Resident 8 had diagnoses which included schizophrenia. Review of Resident 8's Order Summary Report showed a physician's order dated 3/16/26, to administer haloperidol (antipsychotic) oral tablet 1 mg, give one tablet by mouth at bedtime for schizoaffective disorder. Review of the Department of Health Care Services (DHCS) letter sent to Resident 8 dated 12/16/19, showed the PASARR Level II evaluation was conducted on 10/01/19, by a licensed clinical psychologist from the DHCS. The letter further showed the personalized care recommendation were based on Resident 8's medical and social history, strength, and personal goals. Cultural and religious preferences should be considered when providing care. The recommendation showed the following:Psychotropic Medication and Education MonitoringMental Health Rehabilitation ActivitiesActivities of Daily Living (ADL) Training/ReinforcementSupportive ServicesPsychotherapy/CounselingSubstance Rehabilitative ServicesPsychiatry ConsultationNeuropsychology ConsultationInternal Medicine ConsultationOptometry ConsultationSocial Worker ConsultationPain Services ConsultationSleep Specialist ConsultationSmoking CessationSafety monitors for falling and harm to self or others However, further review of Resident 8's medical record did not show if the recommendations from the PASARR Level II evaluation was followed up and incorporated into the resident's care. Review of Resident 8's plan of care failed to show a care plan was developed to address the recommendations from the PASARR Level II evaluation. On 4/8/26 at 1514 hours, an interview and a concurrent medical record review for Resident 8 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated she could not find documented evidence to show the recommendations from the PASARR Level II evaluation were followed up. The MDS Coordinator reviewed the resident's plan of care and stated she could not find the care plan problem addressing the recommendation for specialized services as per the PASARR Level II evaluation report. The MDS Coordinator stated Resident 8 was receiving services recommended from PASARR Level II evaluation and were already part of Resident 8's care plan. However, the MDS Coordinator stated the care plan did not address the PASSAR Level II evaluation and the result. The MDS Coordinator acknowledged there was a possibility the recommendation from the PASSAR level II evaluation could have been missed. On 4/10/26 at 1020 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the treatment and care in accordance with the professional standards of practice for one of four final sampled residents (Resident 10) reviewed for unnecessary medications and one nonsampled resident (Resident 87). * The facility failed to ensure the insulin injection site was rotated for Resident 10. * The facility failed to ensure the insulin injection site was rotated for Resident 87. The facility failed to ensure Resident 87's insulin was administered accurately as ordered by the physician. The insulin Regular Human injection (medication to lower blood sugar levels) solution was not administered to Resident 87 when the sliding scale (amount of insulin to be administered based on the blood sugar results) showed to administer 1 unit of insulin Regular Human injection solution. These failures had the potential for the residents not to receive appropriate care and treatment.Findings: Review of the facility's P&P titled Insulin Administration (undated) showed to provide guidelines for the safe administration of insulin to residents with diabetes. The Steps in the Procedure (Insulin Injections via Syringe) section showed select an injection site: a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately two inches around the navel. b. Injection sites should be rotated preferably within the same general area (abdomen, thigh, upper arm). 1. Medical record review for Resident 10 was initiated on 4/7/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's Order Summary Report showed the following physician's orders: - dated 3/12/26, to administer glargine (a long-acting insulin used once daily used to treat diabetes by controlling blood sugar for 24 hours) insulin, inject 10 units subcutaneously (administered into the fatty tissue layer between the skin and muscle, often in the abdomen or upper arm) at bedtime. Hold if blood sugar is less than 100 mg/dL. - dated 2/1/26, to administer regular human insulin (medication to lower blood sugar levels) to inject as per sliding scale (amount of insulin to be administered based on the blood sugar results) before meals and at bedtime. Review of Resident 10's Location of Administration dated 4/1 through 4/30/26, showed the glargine insulin and the regular human insulin were administered consecutively on the same injection sites on the following dates and times: - on 4/3/26 at 0630 hours, regular insulin was administered to the LUQ of the abdomen; - on 4/3/26 at 2100 hours, regular insulin was administered to the LUQ of the abdomen; - on 4/3/26 at 2100 hours, glargine insulin was administered to the LUQ of the abdomen; - on 4/4/26 at 0630 hours, regular insulin was administered to the LLQ of the abdomen; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 4/4/26 at 2100 hours, glargine was administered to the LLQ of the abdomen; - on 4/4/26 at 2106 hours, regular insulin was administered to the LLQ of the abdomen; - on 4/5/26 at 1630 hours, regular insulin was administered to the LLQ of the abdomen; - on 4/6/26 at 2100 hours, glargine insulin was administered to the LLQ of the abdomen; - on 4/7/26 at 0630 hours, regular insulin was administered to the LLQ of the abdomen; - on 4/7/26 at 1630 hours, regular insulin was administered to the LUQ of the abdomen; and -on 4/7/26 at 2100 hours, regular insulin was administered to the LUQ of the abdomen. On 4/10/26 at 1045 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 7. LVN 7 verified the above findings and stated the insulin injection site should be rotated with each insulin administration. On 4/10/26 at 1406 hours, an interview was conducted with the DON. The DON stated the nursing staff were expected to rotate the insulin injection sites to prevent fat tissue buildup and ensure proper insulin absorption. The DON was informed and acknowledged the findings as above. 2. Medical record review for Resident 87 was initiated on 4/7/26. Resident 87 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 87's MDS assessment dated [DATE], showed the resident had moderate cognitive impairment. a. Review of Resident 3's Order Summary Report dated 4/8/26, showed a physician's order dated 5/14/25, to administer insulin Regular Human injection solution, to inject as per sliding scale subcutaneously before meals and at bedtime. Review of Resident 3's Location of Administration Report dated 2/1 through 4/7/26, showed the insulin Regular Human injection was administered consecutively on the same site on the following dates, times, and locations of administration: - On 2/1/26 at 0549 and at 1150 hours, the location of administration was RLQ; - On 2/11/26 at 0549 and 1256 hours, the location of administration was LUQ; - On 2/21/26 at 0655 and 1300 hours, the location of administration was RLQ; - On 2/22/26 at 0615 and 1046 hours, the location of administration was LLQ; - On 2/24/26 at 2057 and 2/25/26 at 0541 hours, the location of administration was LLQ; - On 2/26/26 at 1038 and 1701 hours, the location of administration was LUQ; - On 3/3/26 at 1636 and 3/3/26 at 2102 hours, the location of administration was RLQ; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/12/26 at 2038, 3/13/26 at 0540 and 1134 hours, the location of administration was LLQ; - On 3/16/26 at 0543, 1157, and 2124 hours, the location of administration was RLQ; - On 3/22/26 at 0624 and 1216 hours, the location of administration was LUQ; - On 3/26/26 at 1630 and 2130 hours, the location of administration was LUQ; - On 3/29/26 at 1234 and 1612 hours, the location of administration was LUQ; - On 4/1/26 at 2045 and 4/2/26 at 0554 hours, the location of administration was RLQ; - On 4/3/26 at 0537 and 1213 hours, the location of administration was LUQ; and - On 4/7/26 at 0544 and 1158 hours, the location of administration was RLQ. On 4/10/26 at 0926 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the location of administration for Resident 87's insulin regular human injection solution was not rotated multiple times in February, March, and April 2026. LVN 2 stated the licensed nurse should have rotated the site of administration of Resident 87's insulin regular. LVN 2 further stated the location of administration should be rotated to prevent complication on the skin. LVN 2 stated failure to rotate the injection site could cause skin complications including hardening and scar tissue formation. b. Further review of Resident 87's medical record review showed the insulin Regular Human injection solution was not administered when the sliding scale showed to administer 1 unit of insulin Regular Human injection solution on the following dates and times: - On 2/9/26 at 0630 hours; - On 2/28/26 at 1130 hours; - On 3/7/26 at 1130 and 1630 hours; and - On 3/23/26 at 1630 hours. On 4/10/26 at 0926 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated the licensed nurse should have followed the insulin sliding scale dosing. On 4/10/26 at 1012 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 verified the above findings. LVN 8 stated the licensed nurse should have reviewed and double checked the insulin sliding scale before giving the medication. On 4/10/26 at 1317 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of four final sampled residents reviewed for nutrition (Resident 8) received the appropriate services needed to maintain acceptable parameters of nutritional status. * The facility failed to follow up when Resident 8 refused CNA Helping Hands assistance, as recommended by the dietician and as ordered by the physician, after the resident experienced a weight loss of more than 5 (five) pounds in one month. This failure had the potential to result in inadequate monitoring and evaluation of the effectiveness of nutritional interventions and increase the risk for further weight loss and nutritional decline.Findings: Review of the facility P&P titled Nutrition (impaired)/ Unplanned Weight Loss Clinical Protocol (undated) showed the staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes. The physician will authorize appropriate interventions, as indicated. The physician will document if cause specific interventions could not be identified or are not feasible. The physician and staff will monitor nutritional status, an individual's response to intervention, and possible complication of such interventions (for example, additional weight gain or loss, nausea, or vomiting). Medical record review for Resident 8 was initiated on 4/7/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 3/4/25, showed Resident 8 was competent and able to make decisions. Review of Resident 8's Weights and Vitals Summary showed the following:On 3/2/26, 106 lbs.On 4/1/26, 101 lbs. and,On 4/6/26, 100 lbs. (6 lbs. weight loss since 3/2/26; 5.7% in one month) Review of Resident 8's Dietary Note dated 4/1/26 at 1345 hours, showed Resident 8 weighed 101 lbs., had a 5-lb weight loss since 3/2/26, and was consuming 0-50-100% of meals. Resident 8 received a controlledˆcarbohydrate, soft and biteˆsized diet with thin liquids and fortified foods. The dietitian recommended CNA Helping Hands. Review of Resident 8's IDT Weight Management Update dated 4/2/26, showed the physician agreed to implement the dietitian's recommendations including CNA Helping Hands. Review of the Resident 8's Order Summary Report showed a physician's order dated 4/2/26, for CNA Helping Hands with meals. On 4/8/26 at 1255 hours, Resident 8 was observed sitting on a wheelchair beside her bed. CNA 2 was observed setting up the meal tray and then left the room. The resident's meal tray was observed to include pureed sweet potato, bite sized baked ham, pureed corn bread, bite sized cooked cabbage. Resident 8 was observed eating less than 50 % of her meal with no facility staff providing assistance or encouragement, despite the CNA Helping Hands order. On 4/9/26 at 0751 hours, Resident 8 was observed eating her breakfast independently with no facility staff assisting. Resident 8 was not observed eating the main entree of her meal and was observed eating less than 25% of her meal tray. CNA 2 was then observed removing the meal tray out without offering alternatives to Resident 8. Review of Resident 8's document titled Amount Eaten showed on 4/8/26, the resident consumed 26-50% of the lunch meal, and on 4/9/26, the resident consumed 0-25% of the breakfast meal.Review of Resident 8's document titled Meal Substitute Provided showed that on 4/8/26 for lunch meal substitute was not offered and on 4/9/26 for breakfast, Resident 8 refused the offered meal substitutes. On 4/9/26 at 0755 hours, an observation and concurrent interview was conducted with the CNA 2. CNA 2 verified the observations and stated Resident 8 only ate cereal and milk at breakfast. CNA 2 verified she did not offer meal alternatives to the resident and stated even if she offered the meal alternative to the resident, she knew the resident would refuse. CNA 2 stated she was supposed to assist the resident during the feeding; however, Resident 8 refuses to be assisted. CNA 2 stated she notified the assigned LVN of Resident 8's refusal to be assisted during the meal and that the resident ate less than 50% of her meal. When asked CNA 2 if she documented the notification to LVN, CNA 2 stated she notified LVN verbally and did not document it. On 4/10/26, at 0836 hours, (continued on next page)

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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, medical record review, and facility P&P review, the facility failed to ensure the PICC line assessments were performed and documented for one of one final sampled resident (Resident 58) reviewed for the IV management. * The facility failed to obtain and document the external catheter length measurement upon admission for Resident 58's PICC line. This failure posed the risk for the resident developing complications related to PICC line displacement, malfunction, or infection.Findings: Review of the facility's P&P titled PICC Dressing Change dated 3/2023 showed the length of external catheter is obtained upon admission. Medical record review for Resident 58 was initiated on 4/7/26. Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's H&P examination dated 3/23/26, showed the resident had the capacity to make medical decisions. Review of Resident 58's PICC line insertion documentation (undated) showed the PICC was inserted on 3/22/26, at the acute care hospital. Review of Resident 58's Order Summary Report showed the following physician's orders: - dated 3/23/26, to change the PICC line dressing, Stat-lock (medical device used to securely anchor catheters to the resident's skin) every day shift every Saturday if gauze dressing is used change every 48 hours. - dated 3/31/26, for vancomycin (antibiotic medication) gram intravenously once a day in the evening until 3/31/26. - dated 4/4/26, for vancomycin 1.25 grams intravenously in the afternoon for MRSA (Methicillin-resistant Staphylococcus aureus; type of bacteria) in blood until 4/10/26 at 2359 hours. On 4/7/26 at 0815 hours, an observation and concurrent interview was conducted with Resident 58. Resident 58 was observed with a PICC line in the right arm. Resident 58 stated he was receiving IV antibiotics for an infection. On 4/8/26 at 1027 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 was asked to describe the facility's practice for the resident's PICC line management and assessment. LVN 2 stated upon admission to the facility and every 7 (seven) days thereafter, during the PICC line dressing changes, the RN would obtain measurements specific to the PICC line. LVN 2 stated the purpose of documenting the external length is to ensure the catheter remains in place. LVN 2 stated the measurements were recorded on the IV MAR or in progress notes. However, review of Resident 58's medical record failed to show documentation for the measurements of the PICC line external catheter length or Resident 58's arm circumference upon admission. LVN 2 verified the findings. On 4/10/26 at 1336 hours, an interview and concurrent medical record review was conducted with the Administrator and DON. The DON verified the above findings and stated the facility would ensure the licensed nurses measure and document the PICC line external catheter lengths and arm circumference upon admission. The Administrator and DON were informed and acknowledge the above findings.

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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, medical record review, and facility P&P review, the facility failed to ensure necessary respiratory care and services were provided for one of three sampled resident (Resident 44) reviewed for respiratory care. * The facility failed to ensure Resident 44 received the correct amount of oxygen via nasal canula per the physician's order. This failure had the potential to negatively affect Resident 44's medical conditions. Findings: Review of the facility's P&P titled Oxygen Administrator (undated) showed to verify that there is a physician's order; review the physician's order or facility protocol for oxygen administration. On 4/7/26 at 0744 hours, an observation of Resident 44 was conducted in the resident's room. Resident 44 was observed with a nasal canula tubing in her nose connected to the oxygen concentrator, which was on and set at 2.5 liters per minute. On 4/7/26 at 1009 hours, an observation of Resident 44 and concurrent interview was conducted with the DON inside the resident's room. The DON verified the oxygen concentrator was set at 2.5 liters per minute. The DON stated the physician's order was for 2 liters per minute, and licensed nurses are required to follow the ordered amount. Medical record review for Resident 44 was initiated on 4/7/26. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 44's H&P examination dated 3/30/26, showed Resident 44 had the capacity to understand and make decisions. Review of Resident 44's Order Summary Reported dated 4/8/26, show a physician's order dated 3/30/26, to administer oxygen at 2 liters per minutes via nasal cannula as needed for shortness of breath. On 4/9/26 at 1139 hours, a follow-up interview and concurrent medical record review was conducted with the DON. The DON verified Resident 44's physician's order for oxygen was at 2 liters per minute via nasal cannula. On 4/10/26 at 1335 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the needs of the residents. * One of four LVNs (LVN 4) observed for medication administration discarded the liquid medication in the medication cart's trash bin. This failure had the potential for the medications to be administered in error and opportunities for drug misuse.Findings: Review of the facility's P&P titled Discarding and Destroying Medications (undated) showed non-controlled and Schedule V (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications. Review of the facility's document titled Lesson Plan- Course Subject: Medication Admin/Blood Pressure Medication Parameters dated 1/8/26, showed the medications would be disposed in the red container located inside each nurse cart, not in the trash can or resident personal trash. Review of the facility's document titled Inservice Lesson Plan and Attendance Record dated 1/8/26, showed the in-service title: Proper Medication Disposal and Destruction with the objective to not throw medications in the trash can. The in-service attendance record showed LVN 4 was in attendance of the in-service. On 4/8/26 at 0835 hours, a medication administration observation and concurrent interview for Resident 106 was conducted with LVN 4. LVN 4 was observed pouring 15 ml of liquid iron sulfate (supplement) into the medication cup. LVN 4 stated he needed to discard the liquid iron sulfate and re-pour the medication because the resident's physician's order was for 7.5 ml. LVN 4 was observed discarding 15 ml of liquid iron sulfate into the medication cart trash bin and repouring 7.5 ml of the iron medication into another medication cup. When asked about his process when discarding medication, LVN 4 stated since the medication was liquid, it would be discarded in the trash bin. LVN 4 stated this was his normal process when he needed to discard liquid medications. On 4/8/26 at 1108 hours, a follow-up interview was conducted with LVN 4. LVN 4 verified he discarded the first liquid iron sulfate (15 ml) he prepared into the medication cart trash bin because he initially overpoured the medication and wanted to re-pour the right amount (7.5 ml) as ordered by the physician. LVN 4 stated there was a small red sharps container located in the medication cart where he would discard tablets, but he stated he did not use the sharps container to waste liquid medications. When asked about the facility's policy where to properly discard liquid medications, LVN 4 stated he would find out. On 4/8/26 at 1113 hours, a follow-up interview and concurrent observation was conducted with LVN 4. LVN 4 stated there was a container located inside the facility's biohazard room where the liquid medications were discarded. LVN 4 showed a white waste container with a blue lid inside the facility's biohazard room but stated he has never used the waste container to discard medications. On 4/8/26 at 1240 hours, an interview was conducted with the DON. The DON was informed of the above findings. The DON stated the licensed nurses were supposed to use the waste container inside the facility's biohazard room to discard non-controlled medication, including liquid medications. The DON stated the licensed nurses were provided with education on how to properly discard medications. On 4/9/26 at 1446 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the drugs, biologicals, or medical supplies were stored in a safely for one of 19 final sampled residents (Resident 6) and one nonsampled resident (Resident 91). * The facility failed to ensure Resident 6's Inhaler medication (ciclesonide) was not left at unattended at the resident's bedside. * The facility failed to ensure a packet of Vitamins A&D (skin protectant) ointment was properly stored for Resident 91. These failures had the potential to result in medications being contaminated, misused, or accidentally administered to the wrong resident.Findings: Review of the facility's P&P titled Medication Labeling, and Storage (undated) showed the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. 1. Medical record review for Resident 6 was initiated on 4/7/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 2/1/26, showed Resident 6 had capacity to understand and make decisions. Review of Resident 6's Order Summary Report showed the following physician's orders: - dated 1/26/26, to administer ciclesonide (used to treat and prevent difficulty breathing, chest tightness, wheezing and coughing) inhalation 80mcg/act 1 puff inhale orally two times a day for Asthma, rinse mouth well after use. - dated 4/5/26, for Ciclesonide Inhalation Aerosol Solution 80mcg; one puff inhale orally two times a day for asthma. On 4/7/26 at 0852 hours, during the initial tour of the facility, an observation of Resident 6's room was conducted. An inhaler (handheld devices that deliver medication directly to the lungs to treat conditions like asthma) medication (ciclesonide) was observed unattended on top of the night stand on the left side of Resident 6's bed. On 4/7/26 at 0910 hours, an observation of Resident 6's room was conducted. The inhaler remained at the resident's bedside, unattended was still observed at the bedside left unattended. The facility staff, residents, and visitors were observed passing by the room, and a CNA entered to reposition the resident while the inhaler remained accessible. On 4/7/26 at 0930 hours, an observation and concurrent interview was conducted with LVN 1 inside Resident 6's room. LVN 1 verified the inhaler was left unattended and stated it should have been stored in the medication cart. LVN 1 stated leaving an inhaler at the bedside posed a risk for contamination or inappropriate use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/26 at 1333 hours, an interview was conducted with the Administrator and DON. The DON stated inhalers and all the medications must be stored securely until needed. The Administrator and DON were informed and acknowledged the above findings. 2. On 4/7/26 at 0816 hours, during the initial tour of the facility, Resident 91 was observed sitting in bed with a packet of Vitamins A&D ointment on top of the bedside table. Medical record review for Resident 91 was initiated on 4/7/26. Resident 91 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 91's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 91's Order Summary Report for April 2026 failed to show a physician's order for Vitamins A&D ointment. On 4/7/26 at 0843 hours, an observation and concurrent interview was conducted with Resident 91. Resident 91 stated the treatment nurse applied the ointment on her skin. On 4/7/26 at 0849 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified the ointment packet was on Resident 91's bedside table and stated the resident was not permitted to keep medications at the bedside. On 4/7/26 at 0853 hours, an observation and concurrent interview was conducted with RN 3. RN 3 verified the above findings. RN 3 stated the Vitamins A&D ointment should not have been left out at bedside because it was considered medication. On 4/7/26 at 0910 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated the Vitamin A&D ointment packet should have been returned to the treatment nurse and that a licensed nurse should obtain a physician's order before applying or storing the ointment for the resident. On 4/10/26 at 1317 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menu and recipes were followed for one of 81 residents (Resident 14) who consumed food prepared in the kitchen. * The facility failed to ensure Resident 14 was served the braised cabbage as per the menu. This failure posed the risk of negatively impacting Resident 14's satisfaction and dietary compliance.Findings: Review of the facility's Diet Type Report dated 4/7/26, showed 81 of 87 residents consumed the food prepared in the kitchen. Review of the facility's P&P titled Menus (undated) showed menus are developed and prepared to meet resident choices including religious, cultural and ethnic needs while following established national guidelines for nutritional adequacy. Menus for regular and therapeutic diets are written at least two (2) weeks in advance and are dated and posted in the kitchen at least one (1) week in advance. The dietitian reviews and approves all menus. Review of the facility's document titled Week at a Glance (undated) showed the lunch menu for Wednesday, 4/8/26, was baked ham, whipped sweet potatoes, braised cabbage, cornbread, and banana gelatin. Medical record review for Resident 14 was initiated on 4/8/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's Order Summary Report showed a physician's order dated 5/14/25, for Resident 14 to have a carbohydrate controlled, no added salt, regular texture, thin consistency, no caffeine, no decaf, fortified diet for liberalized diet. On 4/8/26 at 1240 hours, an observation of the tray line was conducted in the kitchen, Resident 14's noon meal ticket dated 4/8/26, showed baked ham, whipped sweet potatoes, braised cabbage, cornbread, and banana gelatin, water, melted margarine. Resident 14's lunch plate was observed with baked ham, whipped sweet potatoes, carrots, and cornbread. On 4/8/26 at 1240 hours, an interview and concurrent observation of Resident 14's meal tray was conducted with the DSS. The DSS verified Resident 14's tray had diced carrots instead of the braised cabbage. The DSS stated they ran out of the braised cabbage. On 4/8/26 at 1255 hours, an observation and concurrent interview was conducted with Resident 14. Resident was observed eating in her room. Resident 14 stated she was not informed by the staff she would receive carrots instead of the braised cabbage. Resident 14 further stated she liked cabbage. On 4/10/26 at 1302 hours, the DSS and Administrator were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were followed. * The facility failed to conduct a facility-wide risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in facility water system. This failure posed a risk of exposure and potential illness to the residents, staff, and visitors by allowing unidentified and uncontrolled areas within the water system where Legionella and other opportunistic waterborne pathogens could grow. Findings: Review of the facility's P&P titled Legionella Water Management Program (undated) showed the facility was committed to the prevention, detection and control of water-borne contaminants, including legionella. The purpose of the water management program are to identify areas in the water system where legionella bacteria can grow and spread, and to reduce the risk of legionnaires disease. Further review of the P&P showed the identification of the situation that can lead to Legionella growth, such as :Construction;Water main breaks;Changes in municipal water quality;The presence of biofilm, scale or sediment;Water temperature fluctuations;Water pressure changes; and,Water stagnation; and inadequate disinfection. Review of CMS Quality, Safety and Oversight Group guidance titled Requirement to Reduce Legionella Risk in Healthcare Facility Water System to Prevent Cases and Outbreaks of Legionnaires' Disease revised 7/6/18, showed facilities must, at a minimum:- Conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread.- Develop and implement a water management program that considers ASHRAE standards and the CDC toolkit.- Specify testing protocols, acceptable control measure ranges, and document testing results and corrective actions. Review of the facility's document titled Water System Flow Diagram showed the following:- The receiving water and the fireˆsuppression sprinkler system in the kitchen were coded blue.- The coldˆwater distribution system supplying the kitchen ice machine, and sinks and showers in residentˆcare areas, was coded green.- The heating components, including the kitchen and laundry water heaters and the water heaters serving sinks and showers in residentˆcare areas, were coded yellow.- The hotˆwater distribution system supplying kitchen appliances, sinks, the dishwasher, residentˆcare area sinks and showers, and laundry washing machines, was coded brown.- The sanitary sewer system was coded red. Review of the facility's document titled Areas Where Legionella Could Grow and Spread (undated) showed the same colorˆcoded descriptions as above but did not identify:- areas of potential water stagnation,- areas prone to temperature fluctuations,- areas where pressure changes could occur,- highˆrisk locations for bacterial growth, or- the direction of water flow or sections of piping where hazardous conditions could develop. Review of the facility's documents related to Legionella and other opportunistic waterborne pathogens did not show evidence that the facility completed a comprehensive risk assessment identifying where pathogens could grow and spread within the water system. On 4/9/26 at 0941 hours, an interview and concurrent facility document review was conducted with the IP. The IP verified he document titled Areas Where Legionella Could Grow and Spread only identified water entry points, cold water distribution, and areas where water was heated and distributed. The IP confirmed the document did not include:- water flow direction,- identification of areas where stagnation, pressure changes, or temperature fluctuations could occur, or- identification of water system locations at highest risk for pathogen growth.When asked whether a facilityˆwide risk assessment had been completed to identify where Legionella or other opportunistic waterborne pathogens could grow and spread, the IP was unable to provide documentation showing such an assessment had been done.The IP stated the facility had a water management program, monitored the water system, and conducted testing as needed; however, the IP could not provide documentation showing how the facility identified hazardous areas within the water system where opportunistic pathogens could grow. On 4/10/26 at 1020 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to offer and provide required education on the benefits and potential side effects for the seasonal influenza and pneumococcal immunizations for two of five residents (Residents 8 and 14) reviewed for the immunizations. * The facility failed to ensure Resident 8 was offered pneumococcal and seasonal influenza vaccinations and provided with education regarding their benefits and potential side effects. * The facility failed to ensure Resident 14 was offered seasonal influenza vaccination and provided with education regarding its benefits and potential side effects. These failures had the potential for the residents and/or their representatives not being informed of the benefits and risks of the seasonal influenza and pneumococcal vaccines to make an informed decisions and put the residents at increased risk of infection and transmission of influenza and pneumococcal vaccination.Findings: Review of the facility's P&P titled Influenza Vaccine dated 3/2022 showed all the residents and employees who have no medical contraindications to the vaccine will be offered influenza vaccine annually to encourage and promote benefits associated with vaccination against influenza. Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized. Prior to vaccination, the resident or their legal representative or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. A resident refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. Review of the facility's P&P titled Pneumococcal Vaccine dated October 2023 showed all the residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infection. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Before receiving a pneumococcal vaccine, the resident or their legal representative receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Resident/representatives have the right t refuse vaccination. If refused, appropriate information is documented in the resident medical records. 1. Medical record review for Resident 8 was initiated on 4/7/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 3/4/25, showed Resident 8 was competent and able to make decisions. Review of Resident 8's CAIR 2 report (undated) showed Resident 8 had not received pneumococcal and seasonal influenza vaccinations. Review of Resident 8's Immunization Report showed Resident 8 had refused both pneumococcal and influenza vaccines. Further review of Resident 8's medical record did not show if the Resident 8 was provided education regarding the benefits and potential side effects of the seasonal influenza and/or pneumococcal vaccines before refusing. 2. Medical record review for Resident 14 was initiated on 4/9/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's MDS assessment dated [DATE], showed Resident 8 was cognitively intact. Review of Resident 14's CAIR2 report (undated) showed Resident 14 had received influenza seasonal vaccine on 2/15/24, and was past due for the annual influenza vaccine as of 2/15/25. Review of Resident 14's Immunization Report showed Resident 14 refused the seasonal influenza vaccine. Further review of Resident 14's medical record did not show if Resident 14 was offered and provided education regarding the benefits and potential side effects of the season influenza vaccine. On 4/9/26 at 1015 hours, an interview and concurrent medical record review for Residents 8 and 14 was conducted with the IP. The IP stated the seasonal influenza vaccination should be offered every year. The IP verified the above findings. The IP stated he was not able to find the documented evidence to show if Resident 8 was offered or educated about the 2025 seasonal influenza and/or pneumococcal vaccine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055742	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Villa Care Center	861 S. Harbor Blvd Anaheim, CA 92805

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP verified he could not find the documented evidence to show if Resident 14 was offered or educated regarding the benefits and potential side effects of the seasonal influenza vaccine. On 4/10/26 at 1020 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the residents were offered and provided education regarding the benefits and potential side effects of seasonal COVID-19 vaccine for two of five residents (Residents 8 and 14) reviewed for the COVID-19 immunization. * The facility failed to offer and provide education regarding the benefits and potential side effects of seasonal COVID-19 vaccine for Residents 8 and 14. This failure placed the residents at risk for increased risk of infection and transmission of COVID-19 and had the potential for the residents and/or their representatives not being informed of the seasonal COVID-19 vaccines.Findings: Review of facility P&P titled Coronavirus Disease (COVID-19) - Vaccination of Residents dated May 2023 showed each resident is offered COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. The resident (or resident representative) has the opportunity to accept or refuse a COVID-19 vaccine, and to change his/her decision. Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. 1. Medical record review for Resident 8 was initiated on 4/7/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 3/4/25, showed Resident 8 was competent and able to make decisions. Review of Resident 8's CAIR2 report (undated) showed Resident 8 had not received seasonal COVID-19 vaccine and was past due as of 8/22/25. Review of Resident 8's Immunization Report showed Resident 8 refused the COVID-19 vaccine. Further review of Resident 8's medical record did not show documentation if Resident 8 was offered and provided education regarding the benefits and potential side effects of season COVID-19 vaccine prior to refusal. 2. Medical record review for Resident 14 was initiated on 4/9/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's MDS assessment dated [DATE], showed Resident 8 was cognitively intact. Review of Resident 14's CAIR2 report (undated) showed Resident 14 had received the seasonal COVID-19 vaccine on 5/7/24, and was past due for the next seasonal COVIDˆ19 dose on 8/27/24. Review of Resident 14's Immunization Report showed Resident 14 refused the seasonal COVID-19 vaccine. Further review of Resident 14's medical record did not show documentation if Resident 14 was offered and provided education regarding the benefits and potential side effects of the seasonal COVID-19 vaccine prior to refusal. On 4/9/26 at 1015 hours, an interview and concurrent medical record review for Residents 8 and 14 was conducted with the IP. The IP stated the seasonal COVID-19 vaccone should be offered annually. The IP verified the above findings and stated he was not able to find the documented evidence to show if Residents 8 and 14 were offered and/or educated regarding the benefits and potential side effects of the seasonal COVID-19 vaccine for 2025. On 4/10/26 at 1020 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure the residents' care equipment was maintained in a safe operating condition. * One of four LVNs (LVN 1) observed for medication administration used a non-facility issued BP automatic machine to obtain Resident 6's BP prior to medication administration. The facility failed to ensure the calibration for the personal BP machine was conducted. This failure had the potential for the essential equipment not to function in the way it was intended and the risk of resulting in inaccurate resident BP measurements.Findings: Review of the Omron BP5100 (automated BP machine) Instruction Manual (undated) showed Home as the environment of use. On 4/8/26 at 0938 hours, a medication administration observation for Resident 6 was conducted with LVN 1. Prior to administering the medications for Resident 6, LVN 1 obtained the resident's BP reading using a non-facility issued automatic BP machine (Omron BP5100) and the resident's BP reading was 103/68 mmHg and heart rate was 68 beats per minute. On 4/8/26 at 1138 hours, an observation and concurrent interview was conducted with LVN 1 and LVN 3. The automated BP machine was observed labeled with [NAME]. LVN 3 stated the BP machine was his personal equipment and not facility issued. LVN 1 stated during the medication administration observation, his medication cart had no BP machine, or manual BP cuff but only a stethoscope, so he borrowed the Omron BP machine from LVN 3 and used it to obtain Resident 6's BP and heart rate measurements. On 4/8/26 at 1234 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of the above findings. The DON was shown the Omron BP machine and was asked if the BP machine was facility issued. The DON was unsure, but the Administrator verified the BP machine was not facility issued. The Administrator stated the facility had facility issued vital signs machine towers for the staff to use. The DON stated the licensed nurses were not supposed to use their personal BP machines (brought from home). The DON was asked to provide the Omron BP machine's manufacturer's guidelines and documentation to show the calibration for the BP machine. On 4/8/26 at 1240 hours, a follow-up interview was conducted with the DON. The DON stated the facility did not have the manual/ manufacturer's guideline for the Omron BP machine and that the facility did not calibrate the Omron BP machine to ensure the BP machine was working properly and/or had accurate measurements. On 4/9/26 at 1426 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	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, medical record review, and facility P&P review, the facility failed to develop the comprehensive personˆcentered care plan to reflect the individualized care needs of one of 19 final sampled residents (Resident 3). * The facility failed to develop a care plan to address the skin discoloration on Resident 3's bilateral hand. This failure had the potential to result in Resident 3 not receiving appropriate, consistent, and individualized care and monitoring.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered (undated) showed comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. On 4/7/26 at 0954 hours, during the initial tour of the facility, Resident 3 was observed sitting in her wheelchair with visible skin discoloration on both hands. Medical record review for Resident 3 was initiated on 4/7/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 3's Order Summary Report dated 4/9/26, showed a physician's order dated 11/15/25, to administer apixaban (anticoagulant medication) oral tablet 5 mg, give one tablet by mouth two times a day for atrial fibrillation. However, further review of Resident 3's medical record review failed to show documented evidence a care plan was developed to address Resident 3's skin discoloration on both hands. On 4/8/26 at 0901 hours, an observation and concurrent interview was conducted with CNA 4. CNA 4 verified Resident 3 had bilateral hand skin discoloration. CNA 4 stated the licensed nurses were aware of Resident 3's bruise and he did not know how it occurred. On 4/9/26 at 0928 hours, an observation and concurrent interview was conducted with LVN 8. LVN 8 verified Resident 3 had bilateral had skin discoloration. On 4/9/26 at 0932 hours, a follow-up interview and concurrent medical record review for Resident 8 was conducted with LVN 8. LVN 8 stated Resident 3 was admitted to the facility with bruising on both hands. LVN 8 stated Resident 3 was on apixaban medication that could contribute to the bruising. LVN 8 verified there was no care plan addressing Resident 3 's bilateral hand skin discoloration. LVN 8 stated a care plan should have been developed so the facility staff could monitor the condition and prevent complications. On 4/10/26 at 1317 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.