STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055758	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Crest Post Acute	12350 Rosecrans Norwalk, CA 90650

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual 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 interview and record review, the facility failed to develop and implement a comprehensive care plan failed to address for three of 15 sample residents (Resident 64, 66, and 1) by failing to:a. Initiate a care plan for a Peripheral Intravenous line (PIV, short, flexible, small tube inserted into a vein to deliver medications or fluids directly into the bloodstream) monitoring for Resident 64.b. Initiate a fall care plan for Resident 66.c. Implement Resident 1's care interventions to monitor signs and symptoms of hyperglycemic (high blood sugar) and hypoglycemic (low blood sugar) episodes. These failures had the potential to negatively affect the delivery of necessary care and services.Findings: a. During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was initially admitted to the facility on [DATE] with diagnoses including fracture of left humerus (bone connecting the shoulder and elbow), pubis (front-lower portion of the hip bone), and left acetabulum (cup-shaped socket located on side of hip bone that holds the head of the thigh bone to form the hip joint), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and pulmonary fibrosis (chronic, progressive scarring and thickening of the lung tissue). During a review of Resident 64's History and Physical (H&P), dated 4/28/2026, the H&P indicated Resident 64 had the capacity to understand and make decisions. During a review of Resident 64's Minimum Data Set (MDS – a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 64 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision for personal hygiene, required moderate assistance (helper does less than half the effort) for eating and oral hygiene, required maximal assistance (helper does more than half the effort) for bathing and upper body dressing, and was dependent for toileting hygiene and lower body dressing. During a concurrent observation and interview on 5/2/2026 at 1:19 p.m. with Resident 64 in Resident 64's room, Resident 64 had a PIV in the right arm. Resident 64 stated the PIV was inserted at the general acute care hospital (GACH). Resident 64 stated the facility has not given any medication through the PIV for Resident 64 in the six days that they (Resident 64) have been in the facility. During a concurrent observation and interview on 5/3/2026 at 12:15 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 64's room, Resident 64 had a PIV in the right arm. LVN 2 stated the PIV was not dated and LVN 2 did not know when it was inserted. LVN 2 stated PIV accesses should be dated, required an order, and should be monitored. During a concurrent interview and record review on 5/3/2026 at 1:21 p.m. with the Minimum Data Set (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinator (MDSC), Resident 64's care plans were reviewed. The MDSC stated Resident 64 did not have a care plan addressing the PIV access. The MDSC stated the facility should have initiated a care plan to establish goals and monitoring interventions on admission. During an interview on 5/5/2026 at 11:55 a.m. with the Director of Nursing (DON), the DON stated it is important to initiate care plans so that the facility is aware of the plan of care and to evaluate if goals are being met. The DON stated the PIV access baseline care plan should have been initiated within 48 hours of admission. During a review of the facility's policy and procedures (P&P) titled, Baseline Care Plan, dated 12/19/2022, the P&P indicated the admitting, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including:.iii. Any special needs such as for IV therapy, dialysis, or wound car. c. Once established, goals and interventions shall be document4ed in the designated format. b. During a review of Resident 66's admission Record, the admission record indicated the facility admitted Resident 66 on 4/27/2026 with diagnoses including traumatic subarachnoid hemorrhage (bleeding in the brain after an injury happens), type 2 diabetes mellitus (a condition where the body does not use insulin properly, causing too much sugar to stay in the blood), muscle weakness, and hypertension (high blood pressure). During a review of Resident 66's H&P dated 4/28/2026, the H&P indicated had fluctuating capacity to understand and make decisions. During a review of Resident 66's MDS dated [DATE], the MDS indicated Resident 66 had severe cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 66 needed moderate assistance (helper does less than half the effort to complete activity) with upper body dressing, maximal assistance (helper does more than half the effort to complete activity) with showering, and was dependent on staff assistance with eating, oral and toileting hygiene, lower body dressing, and putting on or taking off footwear. During a review of Resident 66's dashboard (the front page of the residents' electronic medical record), the dashboard indicated Resident 66 was a fall risk. During a review of Resident 66's fall risk assessment dated [DATE], the fall risk assessment indicated Resident 66 was disoriented at all times, had one to two falls in the past 3 months. During a review of Resident 66's care plan report, the care plan report did not indicate a care plan for fall risk. During a concurrent interview and record review on 5/5/2026 8:28 a.m. with the Minimum Data Set Nurse (MDSC), Resident 66's care plan was reviewed. The MDSC stated the care plan for fall risk was not initiated. The MDSC stated the importance of initiating a care plan for fall risk was to ensure Resident 66 had a plan of care to follow and implement interventions necessary to prevent Resident 66 from falling. The MDSC stated if Resident 66's care plan for fall risk was not initiated, there would be potential for Resident 66 to fall multiple times and may cause more complicated injuries. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled Fall Prevention Program revised 4/20/2026, the P&P indicated, 7. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. interventions will be monitored for effectiveness b. the plan of care will be revised as needed. During a review of the facility's P&P titled Baseline Care Plan revised 12/19/2022, the P&P indicated, 1. The baseline care plan will: a. be developed within 48 hours of a resident's admission. During a review of the facility's P&P titled Comprehensive Care Plans revised 12/19/2022, the P&P indicated, 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. c. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Type II Diabetes Mellitus (DM, a chronic disease that affects how the body processes sugar) with hyperglycemia, and foot ulcer, hypertension (high blood pressure), and peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 1's H&P dated 3/30/2026, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 was mildly cognitively impaired. The MDS indicated Resident 1 is dependent on staff for lower body (below waist) dressing, toileting hygiene, roll left to right, sit to lying, lying to sitting on side of bed, required substantial assistance (Helper does more than half the effort) from staff for bathing, upper body (above waist) dressing, and required partial assistance (Helper does less than half the effort) from staff for eating, oral During a review of Resident 1's monitor record dated 3/1/2026 –3/31/2026 and 4/1/2026 –4/30/2026, there were no monitoring for hyperglycemia and hypoglycemia noted. During a review of Resident 1's care plan dated 4/3/2026, titled, the Resident has Diabetes Mellitus. The care plan goals were to have no complications related to diabetes. The care plan interventions were monitor/document/report as needed (PRN) any signs and symptoms (s/s) of hypoglycemia or hyperglycemia. During a review of Resident 1's change in condition (COC), dated 4/12/2026 at 8:22 p.m., the COC indicated Resident 1 had hyperglycemia. Resident 1 was ordered to repeat Lantus (long-acting insulin) 6 units (standardized measurement of the insulin's strength) subcutaneous (layer of fatty tissue acting as a cushion and fat storage for the body) in after 1 hour. During a review of Resident 1's Order Summary Report (physician order) dated 5/5/2026, the order summary report indicated monitor for s/s of hypoglycemia and hyperglycemia with a start date of 5/3/2026. During a concurrent interview and record review on 5/4/2026 at 4:28 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated residents that are diabetic and have insulin are on monitoring for hyper/hypoglycemia and would be in the physician orders. The MDSC stated the monitoring for s/s of hyper/hypoglycemia for the month of April in the monitor record wasot there. The MDSC stated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they would want to monitor residents that are diabetic to ensure they do not have any s/s of hyper/hypoglycemia as it can lead to death if the resident was not being monitored. The MDSC stated the purpose of care plans was to show care for the residents during their length of stay and indicated care plans are important. During an interview on 5/5/2026 at 11:52 a.m. with the Director of Nursing (DON), the DON stated when there is a COC, they monitor the residents to ensure they are following up with the residents to see if they are getting better or worse. The DON stated a care plan is a plan of care, to have a goal and identify if the goal has been met or not. The DON stated care plans are initiated upon admission and as needed. The DON stated monitoring for hyperglycemia/hypoglycemia is done every shift. The DON stated if a resident is diabetic, they would have a monitoring for hyper/hypoglycemia and is the standard protocol for all diabetic residents. The DON stated monitoring is documented in the monitoring record. The DON stated residents are monitored to ensure there are no complications and indicated care plans should be implemented as it is the residents' plan of care and if it is not implemented, there is no plan of care. During a review of the facility's policy and procedures (P&P) titled, Comprehensive Care Plans, dated 12/19/2022, the P&P indicated it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. During a review of the facility's P&P titled, Nursing Care of the Resident with Diabetes Mellitus, dated 12/19/2022, the P&P indicated the management of individuals with diabetes mellitus should follow relevant protocols and guidelines. Residents whose blood sugar is poorly controlled of those taking insulin may require more frequent monitoring, depending on the situation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure:1. The door was closed for Resident 66 who was on Novel Respiratory Precautions (isolation)2. Facility staff did not wear the same gown from room to room.3. Staff performed hand hygiene prior to giving medications to Resident 47 and Resident 11. 4a./4b. A Peripheral Intravenous line (PIV, short, flexible, small tube inserted into a vein to deliver medications or fluids directly into the bloodstream) for Resident 64 and Resident 67 was discontinued and removed when no longer indicated. These failures had the potential to increase the risk of infection and cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) among residents.Findings: 1. During a review of Resident 66's admission Record, the admission record indicated the facility admitted Resident 66 on 4/27/2026 with diagnoses including traumatic subarachnoid hemorrhage (bleeding in the brain after an injury happens), type 2 diabetes mellitus (a condition where the body does not use insulin properly, causing too much sugar to stay in the blood), muscle weakness, and hypertension (high blood pressure). During a review of Resident 66's history and physical (H&P) dated 4/28/2026, the H&P indicated Resident 66 had diagnosis of positive Covid (a respiratory illness caused by a virus called coronavirus) and had fluctuating capacity to understand and make decisions. During a review of Resident 66's Minimum Data Set (MDS – a resident assessment tool) dated 5/2/2026, the MDS indicated Resident 66 had severe cognitive (ability to think or make decisions) impairment. The MDS indicated Resident 66 needed moderate assistance (helper does less than half the effort to complete activity) with upper body dressing, maximal assistance (helper does more than half the effort to complete activity) with showering, and was dependent on staff assistance with eating, oral and toileting hygiene, lower body dressing, and putting on or taking off footwear. During a review of Resident 66's Care Plan Report, the Care Plan Report dated 4/28/2026 indicated Resident 66 tested positive for Covid-19 with interventions including maintain novel respiratory precautions guideline per Los Angeles County Department of Public Health (DPH) which included keeping the door closed as much as possible. During a concurrent observation and interview on 5/2/2026 at 7:38 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 66's door was observed slightly open. LVN 1 stated novel respiratory precaution indicated isolation room should be closed. LVN 1 stated it was important for Resident 66's door to be completely closed because there would be potential for spreading the infection to other residents and staff. During a concurrent interview and record review on 5/5/2026 at 7:56 a.m. with the Infection Prevention Nurse (IPN), the County of Los Angeles Public Health's Novel Respiratory Precautions was reviewed. The IPN stated the facility does not have a policy specific to covid, but the facility follows the County of Los Angeles Public Health's Novel Respiratory Precautions. The IPN stated the Novel Respiratory Precautions indicated, keep door closed as much as possible, including when the residents are out of room. The IPN stated the importance of keeping the door closed was to prevent the spread of Covid throughout the facility. The IPN stated if the door was not closed there would be potential for spread of Covid throughout the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/5/2026 at 12:17 p.m. with the Director of Nursing (DON), the DON stated the importance of making sure the doors were closed for rooms with residents that were on novel respiratory precautions was to prevent the spread of the infection to other residents. During a review of the facility policy and procedure (P&P) titled Transmission-based precautions (a.k.a. Isolation Precautions) revised 7/18/2023, the P&P did not indicate procedures for Covid isolations. 2. During an observation on 5/2/2026 at 10:00 a.m. Treatment Nurse (TXN) 1 was observed wearing gown (personal protective equipment) obtained from room [ROOM NUMBER] then walked across the hallway to perform tasks in room [ROOM NUMBER]. During an interview on 5/2/2026 at 10:10 a.m. with TXN 1, TXN 1 stated he obtained the gown from room [ROOM NUMBER] because there was no gown available in room [ROOM NUMBER]. TXN 1 stated he should not have worn the gown and walked through the hallway with the gown on. TXN 1 stated the importance of not wearing a gown in the hallway was to prevent cross contamination. TXN 1 stated there would be potential for the spread of infection between residents. During an interview on 5/5/2026 at 12:13 p.m. with the Director of Nursing (DON), the DON stated it was important that staff did not wear the gown in the hallway to prevent cross contamination. The DON stated other residents would be exposed to different pathogens. During a review of the facility policy and procedure (P&P) titled Personal Protective Equipment revised 12/19/2022, the P&P indicated, 6. PPE supply management: .c. The charge nurse shall check isolation supply carts twice per shift (such as beginning and halfway point) and replenish as needed. The P&P did not indicate specific procedures for use or wearing of gown in the hallway. 3a. During an observation on 5/2/2026 at 8:47 a.m., Licensed Vocational Nurse (LVN) 1 was observed not performing hand hygiene coming out of Resident 47's room after taking Resident 47's blood pressure, observed going into Resident 47's room after preparing Resident 47's medication with no hand hygiene, observed coming out of Resident 47's room post medication administration without hand hygiene and proceeded to chart in the computer of the medications Resident 47 refused, took the medications that was refused to the medication disposal area, came back, proceeded to wear gloves with no hand hygiene, cleaned the blood pressure cuff, and observed hand washing in Resident 47's bathroom at the end of all tasks completed. During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was admitted to the facility on [DATE] with diagnoses including dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), hypertension (high blood pressure), and abnormalities of gait (walk) and mobility. During a review of Resident 47's H&P dated 9/5/2025, the H&P indicated Resident 47 has the capacity to understand and make decisions. During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47 was cognitively intact. The MDS indicated Resident 47 was dependent for sit to lying, chair/bed-to-chair transfer, lying to sitting on side of bed, shower transfer, lower body dressing, toileting hygiene, required substantial assistance (Helper does more than half the effort) from staff for bathing, roll left to right, required partial assistance (Helper does less than half the effort) from staff for upper body dressing, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and required supervision from staff for eating, oral hygiene, and personal hygiene. During an interview on 5/2/2026 at 9:02 a.m. with LVN 1, LVN 1 stated hand hygiene is performed before and after giving medications and indicated she does not do hand hygiene when she does not touch the resident or goes in and out of the residents' room. LVN 1 stated, since she had medications, she needed to dispose of she could not do hand hygiene. LVN 1 stated she would do hand hygiene after coming out of the residents' room; however she continued to indicate since she did not touch anything and had to dispose of medications she did not find the need to perform hand hygiene. LVN 1 stated hand hygiene is performed for infection control, and not doing hand hygiene could cause residents to get an infection. 3b. During an observation on 5/4/2026 at 8:17 a.m., Registered Nurse (RN) 1 was observed not performing hand hygiene prior to putting on personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) and gloves on prior to entering Resident 11's room to administer medications. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Parkinson's Disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), dementia (group of thinking and social symptoms that interfere with daily functioning), and a gastrostomy tube (G-tube- a tube placed directly into the stomach for long-term feeding) During a review of Resident 11's H&P dated 10/6/2025, the H&P indicated Resident 11 is unable to make healthcare decisions due to dementia. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 was severely cognitively impaired. The MDS indicated Resident 11 was dependent on all aspects of activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview on 5/4/2026 at 8:45 a.m. with RN 1, RN 1 stated hand hygiene is performed before entering and leaving the room, before you touch the resident, or when changing gloves. RN 1 stated he did not perform hand hygiene prior to entering Resident 11's room and indicated hand hygiene is performed to prevent infection. 4a. During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was initially admitted to the facility on [DATE] with diagnoses including fracture of left humerus (bone connecting the shoulder and elbow), pubis (front-lower portion of the hip bone), and left acetabulum (cup-shaped socket located on side of hip bone that holds the head of the thigh bone to form the hip joint), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and pulmonary fibrosis (chronic, progressive scarring and thickening of the lung tissue). During a review of Resident 64's H&P, dated 4/28/2026, the H&P indicated Resident 64 had the capacity to understand and make decisions. During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supervision for personal hygiene, required moderate assistance (helper does less than half the effort) for eating and oral hygiene, required maximal assistance (helper does more than half the effort) for bathing and upper body dressing, and was dependent for toileting hygiene and lower body dressing. During a concurrent observation and interview on 5/2/2026 at 1:19 p.m. with Resident 64 in Resident 64's room, Resident 64 had a PIV in the right arm. Resident 64 stated the PIV was inserted at the general acute care hospital (GACH). Resident 64 stated the facility had not given any medication through the PIV in the six days that they (Resident 64) have been in the facility. During a concurrent observation and interview on 5/3/2026 at 12:15 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 64's room, Resident 64 was observed with a PIV in the right arm. LVN 2 stated the PIV was not dated and LVN 2 did not know when it was inserted. LVN 2 stated PIVs should be dated, required an order, and should be monitored. During a concurrent interview and record review on 5/3/2026 at 1:21 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 64's orders, Monitoring Records April – May 2026, Medication Administration Record (MAR) April – May 2026, and Treatment Administration Record (TAR) April – May 2026 were reviewed. The MDSC stated Resident 64 did not receive any intravenous (IV – given through the PIV into the bloodstream) medication. The MDSC stated the facility should have clarified with the physician to determine if Resident 64 requires the PIV. The MDSC stated if Resident 64 did not require the PIV, the PIV should be discontinued to prevent infection. 4b. During a concurrent observation and interview on 5/2/2026 at 7:25 a.m. with Resident 67, Resident 67 stated he was getting antibiotics and had a PIV on the right forearm. During a concurrent observation and interview on 5/3/2026 at 12:20 p.m. with Resident 67, Resident 67 was observed with the PIV dated 4/30/2026 and Resident 67 stated the PIV was placed at the hospital prior to getting admitted to the facility and the facility has not used it since the admission. During a review of Resident 67's admission Record, the admission Record indicated Resident 67 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), hypertension (high blood pressure), and hypothyroidism (thyroid gland does not produce enough thyroid hormones to meet the body's needs). During a review of Resident 67's H&P dated 5/1/2026, the H&P indicated Resident 67 has the capacity to understand and make decisions. During a review of Resident 67's MDS, dated [DATE], the MDS indicated Resident 67 was mildly cognitively impaired. The MDS indicated Resident 67 was dependent on staff for bathing, required substantial assistance from staff for eating, oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene. During an interview on 5/3/2026 at 12:52 p.m. with Registered Nurse (RN 2), RN 2 stated PIVs are there upon admission from the hospital as the residents sometimes continue antibiotics. RN 2 stated if a resident has a PIV, they would monitor the dressing and assess every shift for any signs and symptoms (s/s) for infection. During a concurrent observation and interview on 5/3/2026 at 12:55 p.m. with RN 2, Resident 67's was observed with a PIV in his arm. RN 2 stated when they do the admission, they must put the order (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the PIV and is always monitor and check the PIV. RN 2 stated it was not shown in their computer system Resident 67 had a PIV and indicated if the resident does not need the PIV, they will ask the doctor to remove it. RN 2 stated leaving in an PIV when not indicated could cause an infection. RN 2 stated Registered Nurses (RNs) are the only ones that monitor and put the orders for PIV and indicated Resident 67 did not need a PIV. During an interview on 5/5/2026 at 11:55 a.m. with the Director of Nursing (DON), the DON stated the licensed nurse should clarify with the physician on admission when the resident arrives at the facility with a PIV. The DON stated if PIVs are not required for antibiotics or hydration, the nurse should get an order to discontinue the PIV. During an interview on 5/5/2026 at 11:58 a.m. with the Director of Nursing (DON), the DON stated upon admission, the RN will document the indication for a PIV and would monitor the PIV. The DON stated the decision made by the doctor on whether the PIV is necessary or not will be documented in the progress notes. The DON stated if there is no indication for antibiotics or hydration the PIV should not be in place. During an interview on 5/5/2026 at 12:28 p.m. with the DON, the DON stated hand hygiene should be performed as much as possible and is done before and after resident care or certain tasks, when exiting the residents' room, or when changing gloves. The DON stated hand hygiene is performed even if you do not touch the resident to prevent cross contamination. During a review of the facility's P&P titled, Hand Hygiene, revised 12/19/2022, the P&P indicated all staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. The use of gloves do not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand hygiene Table: Either Soap and Water or Alcohol Based Hand Rub (ABHR is preferred) before applying and after removing personal protective equipment (PPE), including gloves, before preparing or handling medications. During a review of the facility's P&P titled, Intravenous Therapy, revised 12/19/2022, the P&P indicated IV sites are changed every seventy-two (72) hours unless otherwise ordered by the physician, if the site becomes infiltrated, or if the resident exhibits signs and symptoms of phlebitis (inflammation of a vein). In the event an IV is left in place longer than seventy-two (72) hours, IV site care will be done every twenty-four (24) hours. IV sites are checked every four (4) hours or as per facility protocol and as needed (PRN) for signs and symptoms of infection or inflammation. Factors that may affect frequency or assessment include: ability of resident to report symptoms of pain, redness, etc., type of infusion –is it an irritant or vesicant (an agent that induces blistering)? location of IV catheter – is it inserted in an area of flexion; facility policy based on long-term care IV policies and procedures. IV documentation is recorded in the nurses' notes and/or Medication Administration Record. The nurse will notify the practitioner to assess the need for continuation of the catheter if not being used for IV fluids or medications and will discontinue as per the practitioner's order. (continued on next page)

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Cottage Crest Post Acute	12350 Rosecrans Norwalk, CA 90650

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P), titled Intravenous Therapy, dated 12/19/2022, the P&P indicated IV documentation is recorded in the nurses' notes and/or Medication Administration Record. The nurse will notify the practitioner to assess the need for continuation of the catheter if not being used for IV fluids or medications and will discontinue as per the practitioner's order.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' medical records were updated to show documentation an advance directive ([AD] written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) was discussed and written information provided to the resident and/or responsible party ([RP] the person handling a resident's finances and care decisions) in their primary language for one of 15 sampled residents (Resident 4).This deficient practice violated the Resident 4 and the RP right to be fully informed of the option to formulate their AD and had the potential to cause conflict with the residents' wishes regarding health care.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including dementia (group of thinking and social symptoms that interfere with daily functioning), Type II Diabetes Mellitus (DM, (a chronic disease that affects how the body processes sugar) with hyperglycemia (high blood sugar), and a gastrostomy tube (G-tube- a tube placed directly into the stomach for long-term feeding)During a review of Resident 4's history and physical (H&P) dated 6/16/2025, the H&P indicated Resident 4 cannot make his own medical decisions.During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 4 was moderately cognitively impaired. The MDS indicated Resident 4 required substantial assistance (Helper does more than half the effort) from staff for chair/bed-to-chair, sit to lying, rolling left and right, required partial assistance (Helper does less than half the effort) from staff for toileting hygiene, bathing, lower body (below waist) dressing, and required supervision from staff for eating, oral hygiene, upper body (above waist) dressing, and personal hygiene.During a record review of Resident 4's Social Service Assessment indicated the following:-6/25/2025 at 11:53 a.m.: Resident 4's primary language is Vietnamese and was unable to formulate an advance Directive due to Resident 4's dementia. Resident 4's family member (FM) 1 is the RP and helps with Resident 4's healthcare decision making.-10/2/2025 at 4:38 p.m.: Unable to formulate an Advance Healthcare Directive. Will continue with current plan of care.-12/19/2025 at 5:39 p.m.: Resident 4 is unable to formulate an Advance Healthcare Directive due to his cognitive impairment. FM 1 helps with healthcare decision making.During a record review of Resident 4's Social Service assessment dated [DATE] at 1:00 p.m., the Social Service Assessment indicated the following: No Advance Healthcare Directive, unable to formulate.During a concurrent interview and record review on 5/3/2026 at 2:19 p.m. with the Social Service Director (SSD), the SSD stated advance directives are offered upon admission, and if the resident does not have the capacity or have dementia, she will ask the RP if the resident has an advance directive or formulate one. The SSD stated an AD is explained when the resident's baseline and assessment is performed. The SSD stated Resident 4's representative was FM 1 and was Vietnamese. The SSD stated FM 1 brings FM 2 when she visits Resident 4 so FM 2 could translate for FM 1. The SSD stated on the Social Service assessment dated [DATE], the Social Service Assessment indicated: No Advance Healthcare Directive, unable to formulate due to his Dementia and FM 1 helps with healthcare decision making. The SSD stated when they had an Interdisciplinary Team (IDT: Resident's healthcare team consisting of various specialties that share and combine their knowledge and information to create the best possible care plan for the resident) over the phone with FM 1, she had explained what an AD was to FM 1 and indicated since FM 1 did not know what an AD was, she provided a website. The SSD stated FM 1 could barely speak English and had a family friend that translates. During an interview on 5/5/2026 at 12:44 p.m. with the Director of Nursing (DON), the DON stated advance directives are offered upon admission and needs to be explained what it is to ensure the resident/RP knows the risk and benefits of having an AD. The DON stated if an AD was not explained, the resident/RP would not (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know what it was and indicated it was important to explain the advance directive in the resident's preferred language.During a review of the facility's policy and procedures (P&P) titled, Resident Rights, revised 4/6/2026, the P&P indicated the facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Information about resident rights will be given to the resident in a language that the resident understands to the extent possible. If a resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident will be made available and implemented. The resident has the right to be informed of, and participate in, his or her treatment, including: the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, hir or her medical condition.During a review of the facility's P&P titled, Residents' Rights Regarding Treatment and Advance Directive, revised 12/19/2022, the P&P indicated the facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician that a resident was experiencing new abdominal pain for one of three sampled residents (Resident 64).This deficient practice had the potential to result in Resident 64 delay of treatment and further harm. Findings:During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was initially admitted to the facility on [DATE] with diagnoses including fracture of left humerus (bone connecting the shoulder and elbow), pubis (front-lower portion of the hip bone), and left acetabulum (cup-shaped socket located on side of hip bone that holds the head of the thigh bone to form the hip joint), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and pulmonary fibrosis (chronic, progressive scarring and thickening of the lung tissue).During a review of Resident 64's History and Physical (H&P), dated 4/28/2026, the H&P indicated Resident 64 had the capacity to understand and make decisions.[NAME] a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 64 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision for personal hygiene, required moderate assistance (helper does less than half the effort) for eating and oral hygiene, required maximal assistance (helper does more than half the effort) for bathing and upper body dressing, and was dependent for toileting hygiene and lower body dressing. During an interview on 5/2/2026 at 1:19 p.m. with Resident 64 in Resident 64's room, Resident 64 complained of having abdominal pain due needing to have a bowel movement. Resident 64 stated the current medication has not been working to relieve the pressure in the abdomen. Resident 64 stated the pain in the abdomen is so bad that they (Resident 64) requested a pain pill to be able to sleep.During an interview on 5/3/2026 at 1:19 p.m. with Resident 64 in Resident 64's room, Resident 64 stated having abdominal pain and pressure and reported to Licensed Vocational Nurse (LVN) 2.During a concurrent interview and record review on 5/4/2026 at 4:50 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 64's change of condition documentation and nursing notes were reviewed. The MDSC stated there is no documentation that the physician was notified that Resident 64 was experiencing new abdominal pain or pressure. The MDSC stated the facility should have documented a change of condition and communicated the abdominal pain to the physician to ensure Resident 64's implemented treatment and condition is being monitored and to prevent further harm.During an interview on 5/5/2026 at 11:50 a.m. with the Director of Nursing (DON), the DON stated it was important a change of condition was initiated and physician was notified to ensure Resident 64 was monitored and to see if the intervention was effective.During a review of the facility's policy and procedure (P&P), titled Notification of Changes, dated 12/19/2022, the P&P indicated the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include:.2, Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications; 3. Circumstances that require a need to alter treatment. This may include: a. New treatment.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a communication system was in place to translate for one of 15 sample residents (Resident 4) in their primary language.This deficient practice had the potential for Resident 4 not being provided with the appropriate care and treatment needed.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including dementia (group of thinking and social symptoms that interfere with daily functioning), Type II Diabetes Mellitus (DM, (a chronic disease that affects how the body processes sugar) with hyperglycemia (high blood sugar), and a gastrostomy tube (G-tube- a tube placed directly into the stomach for long-term feeding).During a review of Resident 4's history and physical (H&P) dated 6/16/2025, the H&P indicated Resident 4 could not make his own medical decisions.During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 4 was moderately cognitively impaired. The MDS indicated Resident 4 required substantial assistance (Helper does more than half the effort) from staff for chair/bed-to-chair, sit to lying, rolling left and right, required partial assistance (Helper does less than half the effort) from staff for toileting hygiene, bathing, lower body (below waist) dressing, and required supervision from staff for eating, oral hygiene, upper body (above waist) dressing, and personal hygiene.During an interview on 5/2/2026 at 3:09 p.m. with Family Member (FM) 1, FM 1 stated she did not speak English only Vietnamese.During a concurrent interview and record review on 5/3/2026 at 2:33 p.m. with the Social Service Director (SSD), the SSD stated Resident 4's representative is FM 1 and is Vietnamese. The SSD stated FM 1 brings Family Member (FM) 2 when she visits Resident 4 so FM 2 can translate for Resident 4. The SSD stated FM 1 could barely speak English and would have a family friend or family translate on behalf of FM 1. The SSD stated the facility would try to utilize the resident's family member to translate before contacting the translation line.During a concurrent interview and record review on 5/3/2026 at 2:48 p.m. with the SSD, the SSD stated there is a language barrier and sometimes uses a free online translation service that instantly converts text, speech, and images from one language to another, but most of the time, the family will translate. The SSD stated if the family is not available, they will use a picture board or communication board. The SSD stated the family is the one that translates when they sign in the informed consent.During a concurrent interview and record review on 5/3/2026 at 2:56 p.m. with the SSD, the SSD stated communication is important to keep the family informed of the residents' status, and if there is no communication in the residents preferred language, the resident may feel confused and worried.During an interview on 5/5/2026 at 12:38 p.m. with the Director of Nursing (DON), the DON stated the facility does not have a language line and indicated family members will be used when translation is needed. The DON stated they utilize a free online translation service but could not say it was a reliable source for translation. The DON stated they do not want to use the free online translation service and indicated a family member was needed, however they are not sure if the information being provided is being translated accurately and appropriately to Resident 4 through the family member. The DON stated it was important for the facility to be able to communicate with the residents in their preferred language and would document the family members that were present when translation services were required.During a review of the facility's policy and procedures (P&P) titled, Resident Rights, revised 4/6/2026, the P&P indicated the facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Information about resident rights will be given to the resident in a language that the resident understands to the extent possible. If a resident's knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibilities in a language familiar to the resident will be made available and implemented. The resident has the right to be informed of, and participate in, his or her treatment, including: the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, hir or her medical condition.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to objectively measure the range of motion (ROM, full movement potential of a joint) for one of five sampled residents (Resident 23) in the left hand in the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation, dated 2/17/2026. This deficient practice had the potential for Residents 23 to experience further decline in ROM resulting in contracture (loss of motion of a joint associated with stiffness and joint deformity) development and have a decline in physical functioning, mobility (ability to move), and activities of daily living (ADL, basic activities such as eating, dressing, toileting).Findings:During an observation on 5/2/2026 at 7:52 a.m., Resident 23 was lying in bed there was a slight flexion contraction (stiff or bending of joint) noted in the left hand involving the thumb, index, middle, and ring fingers, while the left little finger presented with hyperextension (joint forced to move beyond its normal anatomical range of motion) at the metacarpophalangeal (MCP, knuckles or area where your fingers and thumb connects to your palm) joint.During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) affecting right dominant side, rheumatoid arthritis (a chronic autoimmune inflammatory disease that affects the joints), and osteoarthritis (loss of protective cartilage that cushions the ends of your bones).During a review of Resident 23's history and physical (H&P) dated 3/14/2026, the H&P indicated Resident 23 has the capacity to understand and make decisions.During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 23 was cognitively intact. The MDS indicated Resident 23 was dependent for toileting hygiene, bathing, lower body (below waist) dressing, sit to lying, lying to sitting on side of bed, shower transfer, required substantial assistance (Helper does more than half the effort) from staff for upper body (above waist) dressing, roll left and right, sit to stand, chair/bed-to-chair transfer, toilet transfer, required supervision from staff for personal hygiene, and required set up for eating and oral hygiene. The MDS indicated Resident 23 had impairments on one side of the upper (arms/shoulders) and lower (hips/legs) extremities and utilized a wheelchair.During a record review of Resident 23's OT evaluation, dated 2/17/2026, the OT Evaluation indicated Resident 23's ROM of the left hand, left thumb, left index finger, left middle finger, left ring finger, and left little finger were impaired.During an interview on 5/4/2026 at 9:53 a.m. with Resident 23, Resident 23 stated her left pinky being hyperextended occurred in the facility and indicated she has been at the facility for two years and it occurred a year and a half ago.During a concurrent interview and record review on 5/4/2026 at 3:58 p.m. with the Director of Rehabilitation (DOR), the DOR stated the OT evaluation dated 2/16/2026 indicates Resident 23's left fingers are impaired. The DOR stated she did not know how Resident 23's fingers have been before, and it was difficult to tell the degree of the impairment. The DOR stated during the evaluation, if there was an impairment, they would measure it and put it on the evaluation. The DOR stated doing measurements would be good to show if there was more limitation or impairment and can check if it is getting worse or better. The DOR stated if there were no measurements, they would not know whether Resident 23 was improving or declining.During an interview on 5/5/2026 at 12:51 p.m. with the Director of Nursing (DON), the DON stated it was important to provide rehabilitation services to prevent decline. The DON stated if the decline was not measured, they do not have a baseline and could not monitor the extent of the status of the resident. The DON stated they would need to know Resident 23's baseline to know if they are getting better or not and indicated it is important for residents to wear splits to prevent them from further complications and decline as they may become contracted.During a review of the facility's (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedures (P&P) titled, Purpose and Objectives of Inpatient Rehabilitation Services, revised 12/19/2022, the P&P indicated Inpatient Rehabilitation Services Department consists of physical therapist & physical therapist assistant, occupational therapist, and occupational therapist assistant and speech therapist. It is the objective of the rehabilitation department to provide comprehensive and integrated therapy services to restore patients to their highest level of function. Therapists will develop an individualized plan of care upon evaluation and continuous assessment during treatment plan.During a review of the facility's P&P titled, Occupational Therapist Job Description, revised 3/23/2016, the P&P indicated provides, directs and supervises all aspects of quality patient care, including, but not limited to; screening, evaluation and treatment, treatment planning, goal setting, family education and documentation, in order to assure the best outcome possible for the patient. Essential Functions: Appropriately and effectively completes documentation including evaluations daily notes, progress notes, discharge summaries, or monthly reports as required.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure staff provided feeding assistance for one of seven residents (Resident 10) who required one to one (1:1) feeding assistance during meals and was at risk for aspiration as recommended by the speech therapist.This failure had the potential to result in Resident 10's inadequate nutritional intake, weight loss, dehydration, choking and aspiration.Findings:During an observation on 5/4/2026 at 12:45 p.m., in Resident 10's room a lunch tray was delivered by staff and Resident 10 was observed attempting to feed himself by dipping his hand in his food.During a review of Resident 10's admission Record, the admission indicated the facility admitted Resident 10 on 12/18/2025 with diagnosis including spina bifida (a birth defect that affects the spine and spinal cord causing limitation of movement of limbs), dysphagia (difficulty swallowing), and muscle weakness.During a review of Resident 10's History and Physical (H&P) dated 4/1/2026, the H&P indicated Resident 10 was able to make medical decisions.During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool) dated 3/23/2026, the MDS indicated Resident 10 had the ability to think and make decisions. The MDS indicated Resident 10 needed supervision with eating and oral hygiene, partial assistance (helper does less than half the effort to complete activity) with toileting hygiene, showering, upper body dressing, and personal hygiene, and maximum assistance (helper does more than half the effort to complete activity) with lower body dressing and putting on or talking off footwear.During a review of Resident 10's lunch meal ticket dated 5/4/2026, the meal ticket indicated Resident 10 was 1:1 feeding assist.During a concurrent observation and interview on 5/4/2026 at 12:55 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 10 was observed sitting up in bed with the lunch tray in front of him. LVN 3 stated Resident 10 feeds himself.During a concurrent interview and record review on 5/4/2026 at 12:57 p.m. with LVN 3, Resident 10's physician order was reviewed. LVN 3 stated Resident 10 was a 1:1 feeder and he would assist Resident 10 to eat. LVN 3 stated the importance of making sure Resident 10 was assisted during meals was to ensure Resident 10 did not choke. LVN 3 stated if Resident 10 was not assisted during meals, there would be potential for Resident 10 to choke, aspirate, lose weight, and affect wound healing.During a concurrent interview and record review on 5/5/2026 at 7:39 a.m. with the Director of Rehabilitation (DOR), Resident 10's speech therapy evaluation notes, communication banner and feeder list were reviewed. The DOR stated the speech therapist evaluation notes dated 5/1/2026 indicated Resident 10 was evaluated by the speech therapist recommended to be placed on 1:1 feeding assistance. The DOR stated the communication banner dated 5/1/2026 indicated Resident 10's diet change, 1:1 feeding assistance, and swallow precautions was communicated to nursing. The DOR stated the feeder list, undated, indicated residents who needed 1:1 feeding assistance and the list would be given to nursing.During a concurrent interview and record review on 5/4/2026 at 1:37 p.m. with the Director of Staff Development (DSD) the facility policy and procedure (P&P) titled Restorative Nursing Programs revised 4/20/2026 was reviewed. The DSD stated the P&P did not indicate specific procedures for 1:1 resident feeding.During an interview on 5/5/2026 at 12:24 p.m. with the Director of Nursing (DON), the DON stated residents who were identified as 1:1 feeders, the communication between rehabilitation department to nursing department would be documented under the special instructions, mentioned during huddles, documented in the communication banner, and assigned to a specific Certified Nursing Assistant (CNA). The DON stated the importance of making sure Resident 10 was assisted by staff during meals was to ensure Resident 10 would meet his caloric needs and ensure Resident 10 was safe during meals. The DON stated if Resident 10 was not assisted by staff during meals there would be potential for Resident 10 to choke or aspirate and Resident 10 would not meet his nutritional needs.During a review of the facility's policy and procedure (P&P) titled Restorative Nursing Program revised 4/20/2026, the P&P did not indicate a specific procedure for communicating residents identified by the rehabilitation department requiring 1:1 (continued on next page)

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	055758	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Crest Post Acute	12350 Rosecrans Norwalk, CA 90650

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feeding assistance to the nursing department to ensure residents were assisted during meals to prevent weight loss, choking and aspiration.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: a. Assess and monitor the urinary catheter (tube inserted into the bladder to drain urine) for one of seven sampled residents (Resident 64). b. Ensure one of seven sampled residents (Resident 7) had a physician order with indication for the urinary catheter. These deficient practices had the potential to result in a urinary tract infection (UTI, an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney). Findings: a. During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was initially admitted to the facility on [DATE] with diagnoses including fracture of left humerus (bone connecting the shoulder and elbow), pubis (front-lower portion of the hip bone), and left acetabulum (cup-shaped socket located on side of hip bone that holds the head of the thigh bone to form the hip joint), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and pulmonary fibrosis (chronic, progressive scarring and thickening of the lung tissue). During a review of Resident 64's History and Physical (H&P), dated 4/28/2026, the H&P indicated Resident 64 had the capacity to understand and make decisions. During a review of Resident 64's Minimum Data Set (MDS – a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 64 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision for personal hygiene, required moderate assistance (helper does less than half the effort) for eating and oral hygiene, required maximal assistance (helper does more than half the effort) for bathing and upper body dressing, and was dependent for toileting hygiene and lower body dressing. During a concurrent observation and interview on 5/2/2026 at 1:19 p.m. in Resident 64's room, Resident 64 had a urinary catheter. Resident 64 stated the urine catheter was inserted at the general acute care hospital (GACH). During a concurrent observation and interview on 5/3/2026 at 12:15 p.m. with Resident 64 and Licensed Vocational Nurse (LVN) 2 in Resident 64's room, Resident 64 had the urinary catheter. Resident 64 asked LVN 2 if the urinary catheter was going to be removed today. During a concurrent interview and record review on 5/5/2026 at 8:19 a.m. with Treatment Nurse (TXN) 2, Resident 64's orders, Monitoring Records April – May 2026, Medication Administration Record (MAR) April – May 2026, and Treatment Administration Record (TAR) April – May 2026 were reviewed. TXN 2 stated Resident 64's urinary catheter was not being monitored from 4/27/2026 to 5/1/2026. TXN 2 stated the facility should have monitored and assessed Resident 64's urinary catheter starting on admission on [DATE]. TXN 2 stated it is important to monitor resident's output, pain levels, urine characteristics, signs and symptoms of infection, and ensure it did not become dislodged. During an interview on 5/5/2026 at 11:55 a.m. with the Director of Nursing (DON), the DON stated urinary catheter's need to be monitored starting on admission. The DON stated if the urinary catheter is not being monitored, there is a risk of infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Indwelling Catheter Use and Removal, dated 12/19/2022, the P&P indicated if an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to:.ongoing monitoring for changes in condition related to potential catheter-associated urinary tract infections, recognizing, reporting, and addressing such changes.residents that admit with an indwelling catheter or subsequently receives one will be assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that the catheter is necessary.Additional care practices include: recognition and assessment for complications and their causes, and maintaining a record of any catheter-related problems. b. During a review of Resident 7's admission Record, the admission Record indicated the facility admitted Resident 7 on 3/1/2025 and was readmitted [DATE] with diagnosis including obstructive and reflux uropathy (a medical condition when urine flow is blocked). During a review of Resident 7's H&P dated 4/6/2026, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set, dated [DATE], the MDS indicated Resident 7 had severely impaired ability to think and make decisions. The MDS indicated Resident 7 was dependent on staff with showering and needed moderate assistance (helper does less than half the effort to complete the activity) with eating, oral and toileting hygiene, upper and lower body dressing, putting on or taking off footwear, and personal hygiene. The MDS indicated Resident 7 had a urinary catheter. The MDS indicated Resident 7 had an active diagnosis of obstructive uropathy. During a concurrent interview and record review on 5/4/2026 at 10:56 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 7's physicians order was reviewed. The MDSC stated Resident 7 did not have an order with the indication for his urinary catheter. The MDSC stated the importance of having an order with an indication was to ensure the urinary catheter was medically necessary for Resident 7. The MDSC stated if the urinary catheter was not medically necessary, there would be potential for Resident 7 to have the urinary catheter in place for an extended period which could lead to urinary infections. During an interview on 5/5/2026 at 5/5/2026 at 12:03 p.m. with the DON, the DON stated the importance of making sure there was a urinary catheter order with a diagnosis was to ensure the urinary catheter was medically necessary and indicated with a diagnosis. The DON stated there would be potential for the urinary catheter not being monitored which could lead to urinary complications or infection. During a review of the facility's policy and procedures (P&P) titled Indwelling Catheter Use and Removal revised 12/19/2022, the P&P indicated It is the policy of this facility to ensure that indwelling urinary catheters that are inserted or remain in place are justified. 5. Appropriate indications for indwelling catheter use include: a. acute urinary retention or bladder outlet obstruction; b. need for accurate measurement of urinary output; c. assistance in healing of open sacral or perineal wounds in incontinent residents (typically stage 3 or 4); d. residents that require prolonged immobilization (e.g. potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic factures); and e. to improve comfort for end of life care, if needed.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 11) received the correct amount of gastrostomy tube (GT - an opening to the stomach from the abdominal wall made surgically for the introduction of food) feeding formula.This deficient practice had the potential to result in weight loss or gain, dehydration and fluid overload.Findings:During an observation on 5/2/2026 at 7:15 a.m., Resident 11 was observed receiving the GT feeding formula Jevity (calorie dense, fiber fortified, and nutrient dese liquid feeding formula) 1.5 infusing at 47 milliliters (mL - unit of measurement)/hour (hr) and the water flush infusing at 30 mL/hr. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), protein-calorie malnutrition (condition when body does not get the right balance of protein and calories), and dysphagia (difficulty swallowing), and gastrostomy (GT) present.During a review of Resident 11's History and Physical (H&P), dated 10/6/2025, the H&P indicated Resident 11 did not have the capacity to understand and make decisions.During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 11 had severed cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, dependent for eating, oral and toileting hygiene, bathing, and dressing. During a concurrent observation and interview on 5/4/2026 at 12:55 p.m. with Licensed Vocational Nurse (LVN) 2 in Resident 11's room, LVN 2 stated Resident 11's GT feeding formula Jevity 1.5 was infusing at 47 mL/hr and water flush was infusing at 30 mL/hr.During a concurrent observation and interview on 5/4/2026 at 12:59 p.m. with LVN 2, Resident 11's orders were reviewed. LVN 2 stated the GT feeding formula rate was incorrect. LVN 2 stated Resident 11's orders indicated the physician ordered Jevity 1.5 infused at 44 mL/hr and water flush infused at 25 mL/hr starting on 5/1/2026.During an interview 5/5/2026 at 12:06 p.m. with the Director of Nursing (DON), the DON stated the enteral feeding requires a physician order because a specific quantity needs to be given to the resident. The DON stated the enteral feeding and water flush administered should match the order. The DON stated if the enteral feeding and/or water flush administered does not match the order, the resident w/ at risk of losing weight or gaining weight.During a review of the facility's policy and procedure (P&P), titled Provision of Physician Ordered Services, revised 5/15/2023, the P&P indicated medication and therapeutic treatments qualified nursing personnel will administer medications as ordered by the physician, physician assistant, nurse practitioner, or clinical nurse specialist. Medications will be administered following the facility protocols dosage guidelines. And documentation procedures. Dietary Modifications Dietary staff will implement and monitor dietary modifications as prescribed by the physician, physician assistant, nurse practitioner, or clinical nurse specialist. Nutritional needs and restrictions will be communicated to the dietary department and documented for proper meal planning.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three out of 10 sampled residents (Resident 64, 1, and 3)'s medication regimens were monitored for side effects and signs/symptoms as ordered by failing to:a. Monitor for side effects of opioid medication for Resident 64.b. Monitor signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar) for Resident 1.c. Monitor signs and symptoms of anticoagulant therapy for Resident 3.These deficient practices had the potential to result in adverse drug reactions, unrecognized complications, and ineffective medication management for the affected residents.Findings: a. During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was initially admitted to the facility on [DATE] with diagnoses including fracture of left humerus (bone connecting the shoulder and elbow), pubis (front-lower portion of the hip bone), and left acetabulum (cup-shaped socket located on side of hip bone that holds the head of the thigh bone to form the hip joint), rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and pulmonary fibrosis (chronic, progressive scarring and thickening of the lung tissue). During a review of Resident 64's History and Physical (H&P), dated 4/28/2026, the H&P indicated Resident 64 had the capacity to understand and make decisions. During a review of Resident 64's Minimum Data Set (MDS – a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 64 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision for personal hygiene, required moderate assistance (helper does less than half the effort) for eating and oral hygiene, required maximal assistance (helper does more than half the effort) for bathing and upper body dressing, and was dependent for toileting hygiene and lower body dressing. During an interview on 5/2/2026 at 1:19 p.m. with Resident 64 in Resident 64's room, Resident 64 stated they had abdominal pain due needing to have a bowel movement. Resident 64 stated the current medication had not been working to relieve the pressure in the abdomen. Resident 64 stated sometimes the pain in the abdomen is so bad that they (Resident 64) requested a pain pill to be able to sleep. During an interview on 5/3/2026 at 1:19 p.m. with Resident 64 in Resident 64's room, Resident 64 stated having abdominal pain and pressure and reported it to Licensed Vocational Nurse (LVN) 2. During a concurrent interview and record review on 5/3/2026 at 1:21 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 64's orders, Monitoring Records April – May 2026, and Medication Administration Record (MAR) April – May 2026 were reviewed. The MDSC stated Resident 64 had an order for Oxycodone with (w/) acetaminophen (narcotic pain reliever given for moderate to severe pain) Oral Tablet 5-325 milligrams (MG – unit of measurement) every five hours as needed for moderate to severe pain. The MDSC stated there was no documentation Resident 64 was being monitored for adverse effects or side effects of oxycodone w/ acetaminophen. The MDSC stated the facility should have monitored Resident 64 for adverse or side effects such as constipation or respiratory depression. During an interview on 5/5/2026 at 12:08 p.m. with the Director of Nursing (DON), the DON stated it (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was important to monitor side effects and adverse effects such as constipation of opioid medication to evaluate if the medication is therapeutic for the resident or if it needs to be discontinued. The DON stated if it was not documented, the monitoring did not happen. During a review of the facility's P&P titled, Pain, dated 12/19/2022, the P&P indicated Facility staff will reassess resident's pain management regularly for effectiveness and/or adverse consequences such as: i. Tolerance, ii. Physical dependence, iii. Increased sensitivity to pain, iv. Constipation, v. Nausea, vomiting, and dry mouth, vi. Sleepiness, dizziness, and/or confusion, vii. Depression, viii. Itching and sweating. During a review of the facility's P&P titled, Medication Monitoring, dated 12/19/2022, the P&P indicated This policy addressed the facility's collaborative, systemic approach to medication management, including the monitoring of medications for efficacy and safety. Licensed nurses, with periodic oversite by nurse managers, shall adhere to facility policies and current standards of practice for administration and monitoring of medications. b. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Type II Diabetes Mellitus (DM, a chronic disease that affects how the body processes sugar) with hyperglycemia (high blood pressure) and foot ulcer, hypertension (high blood pressure), and peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 1's H&P dated 3/30/2026, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 was mildly cognitively impaired. The MDS indicated Resident 1 is dependent on staff for lower body (below waist) dressing, toileting hygiene, roll left to right, sit to lying, lying to sitting on side of bed, required substantial assistance (Helper does more than half the effort) from staff for bathing, upper body (above waist) dressing, and required partial assistance (Helper does less than half the effort) from staff for eating, oral hygiene, and personal hygiene. During a review of Resident 1's monitor record dated 3/1/2026 –3/31/2026 and 4/1/2026 –4/30/2026, there were no monitoring for hyperglycemia and hypoglycemia noted. During a review of Resident 1's change in condition (COC), dated 4/12/2026 at 8:22 p.m., the COC indicated Resident 1 had hyperglycemia. Resident 1 was noted with hyperglycemia and was ordered to repeat Lantus (long acting insulin) 6 units (standardized measurement of the insulin's strength) subcutaneous (layer of fatty tissue acting as a cushion and fat storage for the body) in after 1 hour. During a review of Resident 1's Order Summary Report (physician order) dated 5/5/2026, the order summary report indicated the following to monitor for s/s of hypoglycemia and hyperglycemia with a start date of 5/3/2026. During an interview on 5/5/2026 at 11:52 a.m. with the Director of Nursing (DON), the DON stated monitoring for s/s of hyper/hypoglycemia is done every shift. The DON stated if a resident is diabetic, they would have a monitoring for hyper/hypoglycemia and is the standard protocol for all diabetic residents. The DON stated monitoring is documented in the monitoring record. The DON stated they would want to monitor the s/s hyper/hypoglycemia every shift as well as for the use of (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anticoagulants to ensure they will be able to identify any issues if any changes occur. The DON stated if it is not signed and documented, it did not happen. c. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including atrial fibrillation (irregular heart rate that can cause poor blood flow), hypertension (high blood pressure), and anxiety disorder. During a review of Resident 3's H&P dated 3/10/2026, the H&P indicated Resident 3 has fluctuating capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was mildly cognitively impaired. The MDS indicated Resident required partial assistance from staff for lower body dressing, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer, required supervision for bathing, upper body dressing, personal hygiene, roll left and right, sit to lying, and required setup for eating, oral hygiene, and toileting hygiene During a record review of Resident 3's Order Summary Report (physician order) dated 5/5/2026, the order summary report indicated the following to monitor for any of the following: blood in the urine, blood in the stool, unusual bleeding after shaving, bleeding from the gums, bleeding from the nose, excessive bleeding from wounds, large hemorrhagic area, petechiae (tiny spots of bleeding under the skin) with an order date of 4/10/2026. During a record review of Resident 3's monitor record dated 4/1/2026 –4/30/2026, the monitor record indicated on the days of 4/12/2026, 4/18/2026, 4/24/2026, and 4/29/2026 during the 7:00 a.m. to 3:00 p.m. shift (day shift), the following documentation was left blank to monitor for any of the following: blood in the urine, blood in the stool, unusual bleeding after shaving, bleeding from the gums, bleeding from the nose, excessive bleeding from wounds, large hemorrhagic area, petechiae every shift for use of Apixaban (anticoagulant medication). During a concurrent interview and record review on 5/4/2026 at 4:44 p.m. with MDSC, the MDSC stated anticoagulants were monitored every day due to the risk of bleeding. The MDSC stated the monitor record dated 4/1/2026 –4/30/2026 for Resident 3 has days (4/12/2026, 4/18/2026, 4/24/2026, and 4/29/2026) with no documentation during the day shift and indicated the document should be audited and corrected as soon as possible. The MDSC stated if there was no monitoring for the medication, Resident 3 may have unusual signs of blood in their stool and could be harmed. During a review of the facility's policy and procedures (P&P) titled, Nursing Care of the Resident with Diabetes Mellitus, dated 12/19/2022, the P&P indicated the management of individuals with diabetes mellitus should follow relevant protocols and guidelines. Residents whose blood sugar is poorly controlled of those taking insulin may require more frequent monitoring, depending on the situation. During a review of the facility's P&P titled, High Risk Medications-Anticoagulants, dated 12/19/2022, the P&P indicated This facility recognizes that some medications, including anticoagulants, are associated with greater risks, of adverse consequences than other medications. This policy addressed the facility's collaborative, systemic approach to managing anticoagulant therapy for efficacy and safety. Anticoagulant refers to a class of medications that are used to prevent clot extension and formation. They do not dissolve clots. Examples include Eliquis. Adverse consequence is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. During a review of the facility's P&P titled, Medication Monitoring, dated 12/19/2022, the P&P indicated This policy addressed the facility's collaborative, systemic approach to medication management, including the monitoring of medications for efficacy and safety. Licensed nurses, with periodic oversite by nurse managers, shall adhere to facility policies and current standards of practice for administration and monitoring of medications.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, interview, and record review, the facility failed to ensure fortified diets (diet to increase calories) were identified and communicated during lunch tray line meal service for ten residents who were on fortified diet as recommended by the dietitian and ordered by the physician.This failure had the potential to result in residents not receiving required nutritional fortification (adding extra vitamins and minerals to food), leading to inadequate nutritional intake, and unintended weight loss.Findings:During an observation on 5/3/2026 at 12:05 p.m. during lunch tray line, [NAME] (CK) 1 did not communicate the fortified diet orders written on the meal tickets to CK 2 who was serving the food.During an interview on 5/3/2026 at 12:58 p.m. with CK 1, CK 1 one stated she had forgotten to communicate the fortified diets to CK 2. CK 1 stated the importance of communicating the fortified diet orders was to ensure the residents receive the calories needed. CK 1 stated if the fortified diet orders were not communicated during tray line, there would be potential for residents to lose weight.During an interview on 5/3/2026 at 1:41 p.m. with the Dietary Supervisor (DS), the DS stated CK 1 did not communicate the fortified diets to CK 2 during tray line. The DS stated the importance of communicating fortified diets during tray line was to ensure residents receive the calories needed for the day. The DS stated there would be potential for residents to lose weight.During an interview on 5/5/2026 at 11:05 p.m. with the Registered Dietician (RD), the RD stated the importance of making sure fortified diets were communicated during tray line was to ensure residents with fortified diet orders were receiving meals with fortified items such as cereal, health shake, vegetables, and pudding. The RD stated if fortified diet orders were not communicated during tray line, the facility was not verifying that residents were receiving fortified food items which could potentially lead to residents losing weight.During a review of the facility's policy and procedure (P&P) titled Standardized Recipes revised 8/31/2018, the P&P indicated 3. Standardized recipes will be adjusted for therapeutic and consistency modifications. The P&P did not indicate specific procedures for diet fortification.