STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055764	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Pacific Care Center	7716 S Pickering Avenue Whittier, CA 90602

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 observation, interview, and record review, the facilityˆfailed toˆdevelop and implement a comprehensive, person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for three of 25 sampled residents (Resident 90, 91, and 100) by failing to: a. Develop and implement a care plan for Resident 90's Gastro-jejunal (GJ tube, two main ports labeled G leading to the stomach for draining air or fluid and J bypassed the stomach to deliver nutrition directly into the small intestine, used for feeding and medicine) tube and implement a care plan for Resident 90's GJ tube formula feeding. b. Develop and implement a care plan for Resident 100's gastrostomy (G-tube, a small flexible feeding tube inserted through the skin directly into the stomach to provide nutrition, fluids, and medication) tube formula feeding. c. Develop interventions for Resident 92's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) services and accurately revise the care plan to remove the provision of Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) services. These deficient practicesˆhad the potential toˆaffect Resident 90 and Resident 100's nutritional status, safety, and overall well-being, and the potential to result in the provision of inaccurate care to increase Resident 92's mobility. Findings: a. During a review of Resident 90's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included G-tube, chronic respiratory failure (a long-term condition where the lungs could not properly move oxygen into the blood or remove carbon dioxide), and tracheostomy (a surgical procedure that created a small, permanent or temporary hole [stoma] in the neck and into the windpipe [trachea] to help a person breathe). During a review of Resident 90's History and Physical (H&P) dated 3/9/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 90'sˆMinimum Data Set (MDS,ˆa federally mandated resident assessment tool)ˆdated 12/26/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident had a feeding tube. During a review of Resident 90's Physician's Order dated 3/9/2026 at 5:01 PM, the Physician's Order indicated for the resident to have an enteral feed: Vital 1.5 at 32 cubic centimeters (cc, measurement of volume) per hour for 20 hours via pump (small, portable medical device that delivered liquid nutrition directly into a resident's feeding tube at a steady, controlled rate) to provide 640 cc/960 (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	kilocalorie (kcal, unit of energy to equal up to 1,000 small calories) per day. During a review of Resident 90's Comprehensive (complete) Care Plan, the Care Plan did not include a resident specific care plan that included goals and interventions for the resident's GJ tube. During an interview on 3/12/2026 at 8:50 AM, Licensed Vocational Nurse (LVN) 5 stated there should have been a care plan for Resident 90's GJ tube to know what would be used for the J-tube, G-tube, and to know the plan, goals, and interventions. LVN 5 stated if there was not a care plan for the resident's GJ tube, the facility staff would not know which port to use and what to give through each port. During a concurrent interview and record review of Resident 90's Care Plan on 3/12/2026 at 10:09 AM, Registered Nurse (RN) 2 stated there should have been a care plan for the resident GJ tube. RN 2 stated if there was not a care plan for the resident's GJ tube, Resident 90 could have complications, and she could continue having the same issues of vomiting and go back to the hospital. During a concurrent interview and Record Review of Resident 90's Care Plan on 3/13/20269 at 11:28 AM, the Director of Nursing (DON) stated there should have been a care plan for the resident's GJ tube otherwise the facility staff could miss that the resident had one. The DON stated the resident's GJ tube formula should have also been in the care plan so all facility staff would be on the same page when taking care of the resident. The DON stated if the care plan did not have the formula, Resident 90 may not be receiving the correct formula ordered. b. During a review of Resident 100's AR, the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included respiratory failure, tracheostomy, and gastrostomy. During a review of Resident 100's H&P dated 1/5/2026, the H&P indicated the resident was able to make decisions for activities of daily living. During a review of Resident 100'sˆMDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated the resident had a feeding tube. During a review of Resident 100's Physician's Order dated 12/14/2024 at 9:31 PM, the Physician's Order indicated for the resident to have an enteral feed: Glucerna 1.2 at 55 cc per hour for 20 hours via pump to provide 1,100 cc/1320 kcal per day. During a review of Resident 100's G-tube Feeding Care Plan, the Care Plan indicated goals to minimize the risk of weight loss daily and minimize the risk of aspiration and feeding tolerance daily. The Care Plan indicated interventions to administer enteral feedings as ordered, assess the tolerance of feedings, and to check feeding bag prior to the end of shift to ensure adequacy and accuracy of volume. The Care Plan did not include what type of formula was ordered for Resident 100. During an interview on 3/12/2026 at 9:35 AM, LVN 4 stated a resident's care plan was the plan of care for the resident and should have entailed everything the resident required, including the G-tube, the G-tube care, the size, the medications that go through the G-tube, and the type of formula. LVN 4 stated the G-tube formula Resident 100 was receiving should have been on the care plan so the facility staff would know what type of formula Resident 100 was ordered, otherwise the resident could receive the wrong formula. (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 concurrent interview and record review of Resident 100's Care Plan on 3/12/2026 at 9:39 AM, LVN 4 stated the resident's G-tube formula was not on the care plan but should have been to monitor the residents nutrition, otherwise the resident could have a change in condition that could affect the resident's blood sugar or blood pressure. During a concurrent interview and record review on 3/12/2026 at 10:02 AM, RN 2 stated the care plan was the plan of care for the resident with goals and interventions to improve the resident's quality of life. RN 2 stated Resident 100's care plan did not include the G-tube formula the resident was receiving but should have been to show the calories needed, goals, and any specific dietary needs. RN 2 stated if the formula was not in the care plan someone could put up the wrong formula and the resident could lose/gain weight which could affect their health. During an interview on 3/13/2026 at 10:55 AM, the DON stated a care plan was a process used to identify a resident's goals, outline the interventions needed to achieve those goals, and establish how those interventions were to be implemented. The DON stated a care plan was individualized and needed to be updated every time there was a change, including Resident 100's G-tube formula to monitor the progress and if the resident was meeting the calories set for them by the dietician otherwise that could affect the resident's weight. During a concurrent interview and record review of Resident 100's care plan on 3/13/2026 at 11:01 AM, the DON stated the resident's G-tube formula was not on the care plan but should have been so the facility staff would all be on the same page when taking care of the resident. The DON stated if the G-tube formula was not on the care plan the facility staff could miss something which could affect the resident's weight and the resident might not get what they're supposed to. c. During a review of Resident 92's admission Record, the admission Record indicated the facility initially admitted Resident 92 on 1/13/2023 and readmitted on [DATE] with diagnoses that included difficulty walking, muscle weakness, and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the right dominant side. During a review of Resident 92's care plan titled, [At] risk for further decline in contractures (stiffening/shortening at any joint that reduces the joint's range of motion) and tightness in both legs, initiated 3/4/2025, the care plan indicated interventions to continue with RNA for ambulation (the act of walking) with the front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking), three times per week or as tolerated, and to apply a right ankle foot orthosis ([AFO] brace to hold the foot and ankle in the correct position) when Resident 92 was in bed for four hours or as tolerated. During a review of Resident 92's PT Evaluation and Plan of Treatment, dated 2/16/2026, the PT Evaluation indicated Resident 92's goal included improving strength to tolerate gait (manner of walking) training tasks and improve time out of bed. The PT Evaluation indicated Resident 92 required maximum assistance (required between 51-75 percent [%] physical assistance to perform the task) for bed mobility and did not test transfers and gait due to Resident 92's refusal. During a review of Resident 92's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 2/19/2026, the MDS indicated Resident 92 had clear speech, expressed ideas and wants, understood verbal content, and had intact cognition (clear ability to think, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understand, learn, and remember). The MDS also indicated Resident 92 required substantial/maximal assistance (helper does more than half the effort) for rolling to either side while lying in bed and transferring from lying on the back to sitting at the side of the bed. The MDS also indicated Resident 92 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for toileting, bathing, and lower body dressing. During a review of Resident 92's physician's Order Summary Report, dated 3/11/2026, Resident 92's active physician's orders did not include RNA services. During a concurrent observation and interview on 3/11/2026 at 10:26 a.m. with Resident 92 in the resident's room, Resident 92 was observed awake and lying in bed. Resident 92 was observed to move both arms. Resident 92 stated the stroke (loss of blood flow to a part of the brain) mainly affected the right leg. During an interview on 3/11/2026 at 2:11 p.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 92 walked with the RNA prior to Resident 92's most recent hospitalization (on 2/11/2026). The DOR stated the Resident 92's PT Evaluation was completed on 2/16/2026 after Resident 92's readmission to the facility and was receiving PT treatment. The DOR stated PT recommended a knee-ankle-foot orthosis ([KAFO] custom made, long-leg brace designed to stabilize, align, or support the knee, ankle and foot) to improve Resident 92's ability to walk. During an interview on 3/12/2026 at 4:17 p.m. with the MDS Coordinator (MDSC), the MDSC stated the care plans (in general) were revised to individualize the care provided to the residents. During a concurrent interview and record review on 3/12/2026 at 4:23 p.m. with the MDSC, Resident 92's care plans were reviewed. The MDSC stated Resident 92's care plans were revised on 3/10/2026. The MDSC stated Resident 92's care plan did not include but should have included a care plan for the provision of PT services. The MDSC stated Resident 92's care for RNA should have been discontinued because Resident 92 was not receiving any RNA services. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2023, the P&P indicated the comprehensive person-centered care plan described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated care plans are revised as information about the residents and the residents' conditions change. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated March 2023, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The P&P indicated The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being. The P&P indicated Assessments of residents are ongoing and care plan are revised as information about the resident's and the resident's condition change. The interdisciplinary team reviews and updates the care plan: when the resident has been readmitted to the facility from a hospital stay.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and implement range of motion ([ROM] full movement potential of a joint) interventions for one of five sampled residents (Resident 6) reviewed for ROM limitations by failing to: 1. Complete Resident 6's Joint Mobility Screen ([JMS] brief assessment of a resident's range of motion in each joint of both arms and legs) (Occupational Therapy [(OT) profession aimed to increase or maintain a person's capability of participating in everyday life activities]) - Upper Extremities (arms) to assess ROM in both arms after readmission on [DATE] and 3/7/2026 in accordance with the facility's policy and procedure (P&P) titled, Screening, dated 8/10/2023. 2. Provide Resident 6 with ROM exercises to both arms from 11/24/2025 to 2/15/2026. 3. Provide Resident 6 with ROM exercises to both legs from 11/24/2025 to 3/3/2026. These failures had the potential for Resident 6 to experience a decline in ROM in both arms and legs and the development of contractures (stiffening/shortening at any joint that reduces the joint's range of motion) which could lead to positioning issues, discomfort, and skin breakdown (tissue damage caused by surfaces rubbing against each other, moisture, or pressure), potentially affecting Resident 6's quality of life. Findings: During a review of Resident 6's admission Record, the admission Record indicated the facility initially admitted Resident 6 on 1/27/2021 and readmitted on [DATE]. The admission Record indicated Resident 6's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the right dominant side, end stage renal (kidney) disease, dependence on renal dialysis (treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and aphasia (disorder that makes it difficult to speak) following cerebral infarction. During a review of Resident 6's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge summary, dated [DATE], the PT Discharge Summary indicated recommendations for the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to provide ROM (unspecified). During a review of Resident 6's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated recommendations for RNA to provide active range of motion ([AROM] performance of an exercise to move a joint without any assistance or effort of another person) (to unspecified joints), passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) (to unspecified joints), and apply a resting hand splint (material secured with straps that extends from the fingers to the forearm to properly position the fingers and wrist) on the right hand. During a review of Resident 6's JMS (OT) - Upper Extremities, dated 8/5/2025, the JMS (OT) indicated Resident 6's left shoulder, elbow, wrist, and hand joints had full ROM. The JMS (OT) indicated Resident 6 had minimal ROM loss (less than 25 percent [%] loss of motion in the joint) in the right wrist and hand and moderate ROM loss (26-50% loss of motion in the joint) in the right elbow and shoulder. The JMS (OT) indicated recommendations for the RNA to provide Resident 6 with PROM to both arms. During a review of Resident 6's care plan titled, Patient at risk for decline in both arms, initiated 8/20/2025, the care plan interventions included RNA to provide active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to the left arm and PROM to the right arm, three times per week as tolerated. During a review of Resident 6's care plan titled, Risk for unavoidable decline related to reduced mobility, initiated 10/25/2025, the care plan interventions included RNA for PROM exercises to both legs, five times per week as tolerated. During a review of Resident 6's JMS (PT) - Lower Extremities (legs), dated 10/27/2025, the JMS (PT) indicated Resident 6 had full ROM in both hips and knees. The JMS (PT) indicated Resident 6 had severe ROM (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	loss (more than 50% loss of motion in the joint) in both ankles with plantarflexion (ankle bent with toes pointing away from the body) contractures of 26 degrees (unit of measure for joints, normal is 0 degrees) in the right ankle and 33 degrees in the left ankle. The JMS (PT) indicated recommendations for RNA (unspecified). During review of Resident 6's Census List (record of hospitalizations, room changes, and payer source changes), the Census List indicated the facility discharged Resident 6 to the hospital on [DATE] and readmitted Resident 6 to the facility on [DATE]. During a review of Resident 6's JMS (PT) - Lower Extremities, dated 11/24/2025, the JMS (PT) indicated Resident 6 had full ROM in both hips and knees and severe ROM loss in both ankles. The JMS (PT) indicated Resident 6 had decline in ROM to both ankles with 45 degrees of plantarflexion contracture in the right ankle and 35 degrees of plantarflexion contracture in the left ankle. The JMS (PT) indicated recommendations for RNA (unspecified). During a review of Resident 6's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 11/30/2025, the MDS indicated Resident 6 had no speech, sometimes expressed ideas and wants, responded adequately to simple and direct communication, and was moderately impaired for daily decision making. The MDS indicated Resident 6 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning or places a resident at risk for injury) on one arm and both legs. During a review of Resident 6's JMS (OT) - Upper Extremities, dated 2/15/2026, the JMS (OT) indicated Resident 6 had full range in the left shoulder, elbow, wrist, and hand. The JMS (OT) indicated Resident 6 had minimal ROM loss in the right elbow, wrist, and hand and moderate ROM loss in the right shoulder. The JMS (OT) indicated to continue the RNA program (unspecified). During a review of Resident 6's physician's orders, dated 2/15/2026, the physician's orders indicated for RNA to perform AAROM to the left arm and PROM to the right arm, three times per week as tolerated. During a review of Resident 6's RNA Documentation (documentation for the provision of RNA services), dated 2/2026, the RNA Documentation indicated Resident 6 started receiving AAROM to the left arm and PROM to the right arm, three times per week, on 2/16/2026. During a review of Resident 6's RNA Documentation, dated 3/2026, the RNA Documentation indicated Resident 6 received AAROM to the left arm and PROM to the right arm on 3/2/2026. During review of Resident 6's Census List, the Census List indicated the facility discharged Resident 6 to the hospital on 3/3/2026 and readmitted to the facility on [DATE]. During a review of Resident 6's JMS (PT) - Lower Extremities, dated 3/9/2026, the JMS (PT) indicated Resident 6 refused to participate in the assessment. During an interview on 3/10/2026 at 9:24 a.m. with the Director of Rehabilitation (DOR), the DOR stated PT and OT completed the JMS (in general) upon a resident's admission and after readmission to the facility. The DOR stated the RNA program (in general) maintained a resident's functional level after the resident's discharge from therapy services. The DOR stated the RNA program included the provision of ROM, application of splints, sit-to-stand transfers, and walking with an assistive device. During a dining observation on 3/10/2026 at 12:17 p.m. in the resident's room, Resident 6 was lying in bed with the head-of-bed elevated and the lunch tray positioned directly in front of Resident 6. Certified Nursing Assistant 1 (CNA 1) was observed setting up Resident 6's silverware, uncovering Resident 6's lunch plates and cups, repositioning Resident 6, and leaving the room. Resident 6 was observed using utensils with the left arm to eat lunch, which consisted of orzo pasta (small rice-shaped pasta), puree meat (food altered into a smooth and creamy texture for people with difficulty chewing or swallowing), and green peas. Resident 6 was observed eating all the orzo pasta then used the left hand to turn the plate counterclockwise to begin eating the puree meat. Resident 6 was observed without any movement or attempt to move the right arm throughout the meal. Resident 6 was transported to dialysis immediately after finishing lunch. During an interview on 3/11/2026 at 1:23 p.m. with Restorative Nursing Aide 2 (RNA 2), RNA 2 stated Resident 6 was recently readmitted to the facility from the hospital and has not received RNA since readmission. RNA 2 stated Resident 6's right side was paralyzed but could move the left arm. RNA 2 stated Resident 6 used to receive RNA for ROM exercises to both arms prior to Resident 6's recent hospitalization. RNA 2 stated Resident 6 did not (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Pacific Care Center	7716 S Pickering Avenue Whittier, CA 90602

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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 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, and record review the facility failed to procure, store, prepare, and serve food under sanitary conditions in accordance with the facility's policy and procedures titled Sanitation and Infection Control and Refrigerator/Freezer Storage by failing to: a. Discard six bags of turkey slices, three bags of ham slices, and one bag of pork patties that were expired from the walk-in freezer. Properly label the used by date for six bags of turkey slices, three bags of ham slices, and label the open and used by date for one bag of pork patties. b. Perform proper hand hygiene or changing gloves between handling soiled and clean items when the Dietary Aid (DA) was taking dirty equipment to the sink and picking up clean metal containers without changing gloves or washing hands. c. Wear a hair net properly to cover all hair when the Dietary Supervisor's (DS) hair net was observed half off her head during lunch preparation. These deficient practices had the potential to affect all residents receiving food services in the facility to be at risk for foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: a. During a review of the Facility's Refrigerator & Freezer Storage Chart dated March 2018, the Chart indicated Since product dates aren't a guide for safe use of a product, consult this chart and follow these tips. The Chart indicated for ham slices, should be kept in the freezer for one to two months only lunch meats, they should have been kept in the freezer for one to two months only. During an observation in the Facility's Walk-In Freezer on 3/9/2026 at 8:24 AM, the Walk-In Freezer had bags of turkey slices dated 9/2/2025, two bags dated 9/26/2025, 10/28/2025, 12/9/2025, and 12/16/2025. The bags of turkey slices did not indicate a used by date. The Walk-In Freezer had bags of ham slices dated 8/28/2025, 9/26/2025, and 1/1/2026. The bags of ham slices did not have a used by date. The Walk-In Freezer had a bag of 11 pork patties with no open or used by date. During a concurrent interview and record review on 3/9/2026 at 8:55 AM, the [NAME] stated the facility could keep frozen meat for a few months and followed the Refrigerator & Freezer Storage Chart guidelines. The [NAME] stated the turkey slices, ham slices, and the pork patties should not have been in the freezer because the facility kitchen staff must know how long the meat has been in the freezer and when to use the meat by. The [NAME] stated that without a used by date the meat could have had freezer burn or go bad and that could have caused stomach aches or diarrhea in the residents. During an interview on 3/12/2026 at 1:15 PM, the Dietary Supervisor (DS) stated there should not have been expired meat in the freezer because the facility kitchen staff were allowed to keep meat for a certain amount of time per the facility's policy and could not keep the meat any longer. The DS stated if the facility kitchen staff kept the frozen meat longer than they should have, that could have made the resident's sick. b. During an observation during lunch preparation in the Facility's Kitchen on 3/11/2026 at 12 PM, the Dietary Aid (DA) was observed taking dirty equipment to the sink and picking up clean metal containers without changing gloves or washing hands. During an interview on 3/11/2026 at 12:15 PM, the Registered Dietitian Nutritionist (RDN) stated the DA should have changed gloves after taking dirty dishes to the sink and bringing clean metal containers for hygiene and infection prevention. The RDN stated if the DA did not change his gloves, that could have caused risk for cross contamination and could have affected the resident's getting sick. During an interview on 3/12/2026 at 1:37 PM, the DA stated if kitchen staff touched dirty dishes, they would have to change their gloves, wash their hands in the sink, and then put on new gloves. The DA stated the reason kitchen staff needed to change gloves and wash hands before touching clean items was to ensure the dirty did not touch the clean, otherwise there could have been germs or bacteria on the items, and everybody could have been sick. During an interview on 3/12/2026 at 1:39 PM, the DS stated the DA should have changed gloves and washed hands before touching clean items to prevent cross contamination. The DS stated if the DA used dirty gloves, they could have contaminated what they touched and the patients could get sick. c. During an observation on 3/9/2026 at 8:13 AM, the DS was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed with her bangs hanging out of the hair net walking from the back office to the kitchen entrance. During an observation on 3/10/2026 at 10:26 AM, the DS hair with bangs was hanging out of the hair net walking from the back office to the kitchen entrance. During an observation on 3/11/2026 at 12:21 PM, the DS's was observed with the hair net was placed halfway off her head and using her hands to move her hair away from her face. The DS was observed walking around the kitchen during lunch preparation going into the refrigerator to bring out food/drinks and use the mixer to mince and puree food items. During a concurrent observation and interview on 3/11/2026 at 12:38 PM, the RDN stated the hair net should have been covering all of the kitchen staff's hair to prevent any hair falling into the food and risking cross contamination. The RDN stated if the kitchen staff's hair net was not properly placed on their head, they should not have been preparing any food. The RDN stated if the hair net was not properly placed on the head and hair fell into the food, the residents could have gotten sick and if the RDN ever found a hair in her food, she would not want to eat the food anymore. During a concurrent observation and interview on 3/12/2026 at 1:33 PM, the DS was observed with the hair net covering all of her hair. The DS stated the hair net should have been covering all the kitchen staff's hair to prevent hair from falling on the floor or contaminating the food. The DS stated there was risk of contaminating the food and that could have made anybody who ate the food sick. During a review of the facility's undated policy and procedure (P&P) titled Sanitation and Infection Control, the P&P indicated Food service employees will follow infection control policies to ensure the department operates under sanitary conditions at all times. The P&P indicated A hair net or head covering which completely covers all hair should be worn at all times. The P&P indicated, Employees must wash hands frequently. After handling carts, soiled dishes and utensils. Before and after handling foods. During food preparation, as often as necessary when it gets soiled and when changing task to prevent cross contamination. During a review of the facility's undated P&P titled, Refrigerator/Freezer Storage the P&P indicated All items should be properly covered, dated, and labeled. Food items should have the following appropriate dates: delivery date - upon receipt, open date - opened containers of PHF, and thaw date - any frozen items. The P&P indicated, Frozen food taken from the original packaging should be labeled and dated. Food that has freezer burn should be discarded. The P&P indicated No food item that is expired or beyond the best buy date are in stock. Refrigerator and freezer storage chart to be followed unless manufacture recommendation showing it can be kept longer. During a review of the facility's P&P titled, Policies and Practices - Infection Control dated October 2018, the P&P indicated This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections. The P&P indicated The objectives of our infection control policies and practices are to prevent, detect, investigate, and control infections in the facility and maintain a safe, sanitary, and comfortable environment for personnel, resident's, visitors, and the general publics. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain the complete and accurate medical records in accordance with the facility's policy and procedure (P&P) titled, Charting and Documentation, for four of four sampled residents (Resident 2 and Resident 7, 112, and 114) as evidenced by: 1. For Resident 112, Licensed Vocational Nurse 1 (LVN 1) documented the administration two of Resident 112's prescribed supplements that were omitted during medication pass. 2. For Resident 114, the facility failed to document Resident 114's vomiting on 3/11/2026, including the interventions taken after vomiting. These failures had the potential to prevent Resident 112 from receiving the intended therapeutic benefit of her supplements and had the potential to worsen her health status and condition. This failure had the potential to result in the nursing staff being unaware that Resident 114 vomited and the need to monitor Resident 114 for additional vomiting. 3. For Resident 2, the dosage and frequency of paroxetine (a prescribed medication to treat mental disorders) was not documented in the informed consent (a process in which a healthcare professional educates a patient about the risks, benefits, and alternatives of a given procedure or intervention). 4. For Resident 7's Licensed Vocational Nurse (LVN) 4 did not document in the Medication Administration Record (MAR) the medication that were administered at 9 AM on 2/18/2026. These deficient practices had the potential to result in the residents or responsible party not being fully informed of the correct treatments being administered, increased miscommunication between the resident/or responsible party and the medical provider. These deficient practices also had the potential to result in medication Findings: 1.During a review of Resident 112's admission Record, the record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including HTN, osteoarthritis (a progressive disorder of the joints caused by a gradual loss of cartilage) of the left hip, and aftercare following joint replacement surgery. During a review of Resident 112's Minimum Data Set (MDS- a resident assessment tool) dated 3/1/26, the MDS indicated Resident 112 was cognitively intact. During a review of Resident 112's Medication Administration Record (MAR) for the month of 3/2026, the MAR indicated the following: Oyster Shell Oral Tablet (a calcium supplement used to maintain bone health and treat calcium deficiencies) 500 mg (milligrams- a unit of measurement) Give one tablet by mouth two times a day for supplement, scheduled at 9 AM and 5 PM. Glucosamine-Chondroitin (a supplement used to reduce joint pain, stiffness, and improve function in individuals with osteoarthritis) Oral Tablet 750-600 mg. Give one tablet by mouth one time a day for supplement, scheduled at 9 AM. During a medication pass observation and interview with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed preparing Resident 112's medications scheduled for 9 AM. LVN 1 did not administer Oyster Shell or Glucosamine-Chondroitin. During an interview with LVN 1 on 3/11/26 at 1:50 PM and concurrent record review of Resident 112's MAR for 3/2026, LVN 1 stated she documented that she administered Resident 112's Oyster Shell and Glucosamine-Chondroitin by mistake. LVN 1 stated she was nervous during the medication (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pass observation and should have verified the medications with the MAR prior to documenting that the supplements were administered. During an interview with the Director of Nursing on 3/12/26 at 4:18 PM, the DON stated LVN 1 made an error by incorrectly documenting she administered Resident 112's Oyster Shell and Glucosamine-Chondroitin. The DON further explained that incorrect documentation can prolong the next dose of the medication or supplement given and lose their therapeutic effectiveness for the resident. 2. During a review of Resident 114's admission Record, the admission Record indicated the facility admitted Resident 14 on 3/3/2026 with diagnoses including chronic obstructive pulmonary disease ([COPD] long-term lung disease causing difficulty in breathing), difficulty walking, muscle weakness, subarachnoid hemorrhage (excessive bleeding into the space surrounding the brain between two layers of the brain), subdural hemorrhage (excessive bleeding into the space between the brain's surface and the outer layer of the brain), and skull fracture. During a review of Resident 114's History and Physical (H&P), the H&P indicated Resident 114 had an unwitnessed fall and had the capacity to understand and make decisions. During an observation on 3/11/2026 at 11:03 a.m. in the resident's room, Resident 114's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) treatment session was observed. Resident 114 was observed lying in bed with the head-of-bed slightly elevated. Certified Occupational Therapy Assistant 1 (COTA) 1 physically cued Resident 114 to bring both legs over the left side of the bed. Resident 114 was observed sitting at the edge of the bed without any assistance. COTA 1 stated Resident 114 felt dizzy. COTA 1 encouraged Resident 114 to move both ankles while sitting at the edge of the bed to assist with decreasing the dizziness. COTA 1 stated Resident 114 started sweating and the dizziness continued. During an observation on 3/11/2026 at 11:09 a.m., COTA 1 assisted Resident 114 back into bed. Resident 114 stated feeling the need to vomit. COTA 1 provided a basin to Resident 114, who vomited while side-lying in bed. COTA 1 left the room to call Resident 114's nurse. During a concurrent observation and interview on 3/11/2026 at 11:16 a.m. in the resident's room, Registered Nurse 1 (RN 1) came to Resident 114's bedside and was observed taking Resident 114 blood pressure, oxygen saturation (measurement of how much oxygen the blood is carrying as percentage), and temperature. RN 1 stated Resident 114's blood pressure was 124/62 millimeters of mercury ([mmHg] unit of measurement for blood pressure, normal 120/80 mmHg), 95% oxygen saturation (normal 95-100%), and temperature 98.8 degrees Fahrenheit (unit of measurement for temperature, normal 98.6). During an interview on 3/11/2026 at 11:23 a.m. with the Director of Rehabilitation (DOR), the DOR stated Resident 114 walked 20 feet (unit of measurement) yesterday (3/10/2026) during the PT session. The DOR stated Resident 114 did not have any dizziness and did not vomit during the PT session. During an interview on 3/11/2026 at 11:27 a.m. with COTA 1, COTA 1 stated Resident 114 had dizziness during the OT session yesterday (3/10/2026) which resolved with ankle movements. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/12/2026 at 12:01 p.m. with RN 1, Resident 114's medical record for 3/11/2026 was reviewed. RN 1 stated Resident 114 had one instance of vomiting on 3/11/2026. RN 1 stated that Resident 114's vomiting was verbally communicated to the nursing staff on the next shift but was not documented Resident 114's medical record. RN 1 stated the purpose of documentation (in general) was to document what occurred and the response. RN 1 stated the medical record did not have evidence Resident 114's vomiting occurred. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 7/2017, the P&P indicated 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. The P&P also indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 3. During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 1/13/2026 with diagnoses that include depression (a common, serious mental health disorder characterized by persistent low mood, loss of interest, and4 reduced energy) and hypertension (high blood pressure). During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 1/19/2026, the MDS indicated Resident 2 had intact cognition (ability to understand and make decisions) and memory. During a review of Resident 2's Order Summary Report, dated 3/12/2026, the report indicated the physician ordered to administer paroxetine 30 milligram (MG, a measurement unit) by mouth one time a day for depression, starting on 2/5/2026. During a review of Resident 2's MAR, dated 2/2026 and 3/2026, the MAR indicated Resident 2 received paroxetine 30 MG one time a day. During a concurrent interview and record review on 3/12/2026 at 10:22 AM with Licensed Vocational Nurse (LVN) 3, Resident 2's Psychotherapeutic Drug (medications that alter brain chemistry to treat mental health conditions by improving mood, cognition, and behavio) Informed Consent Form for Paroxetine, dated 1/13/2026, was reviewed. LVN 3 stated she did not document the dosage and frequency of paroxetine on the informed consent form when obtaining the consent. LVN 3 stated it was important to document the dosage and frequency of the medication on the consent form to ensure that the resident and the responsible party (RP) were fully informed and agreed on the treatment. During an interview on 3/12/2026 at 4:24 PM with the Director of Nursing (DON), the DON stated the nurse should document the dosage and frequency of a psychotropic medication on the informed consent to ensure that the residents and the RP were informed about the medication, so they could agree or disagree on the treatment. The DON stated it was also important to keep accurate and complete information on the residents' medical records. 4. During a review of Resident 7's AR, the AR indicated the facility originally admitted Resident 7 on 10/11/2023 and readmitted on [DATE] with diagnoses that include amyotrophic lateral sclerosis (ALS, a progressive disease in which a person's brain loses connection with the muscles, slowly taking away their ability to walk, talk, eat and eventually breathe) and major depressive disorder (a common, serious mental health disorder characterized by persistent low mood, loss of interest, and4 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reduced energy). During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 had intact cognition and memory. During a review of Resident 7's Order Summary Report, dated 3/12/2026, the report indicated the physician ordered to administrator: Apixaban (a medication used to prevent and treat blood clots) 5 MG via G-tube every 12 hours, starting on 12/4/2025. Asperflex lidocaine (a medication is used on the skin to stop itching and pain from certain skin conditions) 4% patch apply to right hip topically one time a day, starting on 12/5/2025. Buspirone (used to treat certain anxiety disorders [a feeling of fear, dread, or uneasiness]or to relieve the symptoms of anxiety) HCL 7.5 MG via G-tube two times a day, starting on 12/4/2026. Docusate sodium (a medication is used to treat constipation which allowed easy passage of stool) 100 MG via G-tube every 12 hours, starting on 12/4/2025. Escitalopram oxalate (a medication is used to treat major depressive disorder and generalized anxiety disorder) solution 5 MG/milliliter (ML, a measurement unit) 5 ML via G-tube one time a day, starting on 12/5/2025. Ferrous sulfate (iron supplement which help making healthy blood cells) solution 220 MG/5 ML give 7.5 ML via J-tube two times a day, starting on 12/4/2025 Folic Acid (a medication is used to help body to make body cells) 1 MG via G-tube one time a day, starting on 12/5/2025 LiquaCel Liquid (a protein supplement is used to promote wound healing) 30 ML via G-tube one time a day for wound healing, starting on 2/13/2026 Metoprolol tartrate (a medication is used to treat high blood pressure) tablet 25 MG give 0.5 tablet via G-tube two times a day, starting on 12/19/2025 Multivitamin (a dietary supplement) with mineral 1 tablet via G-tube one time a day, starting on 12/5/2025 Omeprazole (a medication is used to reduces stomach acid) 20 MG via G-tube one time a day, starting on 12/5/2025 Rilutek (a medication is used to treat patients with ALS) 50 MG via J-tube every 12 hours, starting on 12/4/2025 Vitamin C (a dietary supplement) 500 MG via G-tube one time a day, starting on 12/5/2025 During a concurrent interview and record review on 3/12/2026 at 2:30 PM with Licensed Vocational Nurse (LVN) 4, Resident 4's MAR, dated 2/2026, was reviewed. LVN 4 stated she did not document (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the medications that were scheduled at 9 AM in Resident 7's MAR after administering the medications to the resident on 2/18/2026, including: Apixaban 5 MG Asperflex lidocaine 4% patch Buspirone HCL 7.5 MG Docusate sodium 100 MG Escitalopram oxalate solution 5 MG/ML 5 ML Ferrous sulfate solution 220 MG/5 ML give 7.5 ML Folic Acid 1 MG LiquaCel Liquid 30 ML Metoprolol tartrate tablet 25 MG give 0.5 tablet Multivitamin with mineral 1 tablet Omeprazole 20 MG Rilutek 50 MG Vitamin C 500 MG LVN 4 stated it was important to document the medications in the resident's MAR after administering the medication to ensure that the resident receives the medication according to the physician's order and prevent medication error. During an interview on 3/12/2026 at 4:27 PM with the Director of Nursing (DON), the DON stated the nurse should document the medications that were administered to the resident in the resident's MAR to prevent medication error. The DON stated if the nurse did not document the medication administration, then, the medication was not done; in addition, another nurse would think the resident did not receive the medication and administer it again, which would lead to double dosing. During a review of the facility's P&P titled, Charting and Documentation, dated 7/2017, the P&P indicated that 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. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. During a review of the facility's P&P titled, Administering Medications, dated 3/2023, the P&P indicated The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. The P&P indicated the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	individual administering the medication records in the resident's medical record includes the date and time the medication was administered, the dosage, the route of administration, .the signature and title of the person administering the drug. During a review of the facility's P&P titled, Psychotherapeutic Drug Informed Consent, dated 1/2026, the P&P indicated To ensure that residents and/or their representatives are fully informed of the benefit, risk, frequency/duration, possible side effects and alterative approaches before initiating the administration of psychotherapeutic drugs. The P&P indicated the residents or their representatives must be provided the topic including the probable degree, frequency and duration of the medication and A licensed nurse will verify the informed consent information and sign it to confirm its accuracy and completeness. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation dated 7/2017, the P&P indicated documentation in the medical record will be objective, complete, and accurate.

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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 implement infection control practices for three of five residents (Resident 71, 79 and 88) reviewed for infection control by failing to: 1. Ensure Certified Nursing Assistant (CNA) 2 and CNA 3 wore an isolation gown when assisting with feeding for two of two sampled residents (Residents 79 and 71) who was placed on Enhanced Barrier Precautions (EBP-an infection prevention and control intervention to reduce the spread multidrug resistant organisms [MDRO- disease causing organism resistant to medication used to treat infection]). 2. Clean Resident 88's hearing aid after falling on the floor and prior to placing it into Resident 88's right ear. These deficient practices had the potential to introduce bacteria (organisms that can cause disease) into Resident 88's ear, which could result in infection. In addition, Residents 79 and 71 could result in acquiring MDROs and/or spreading MDROs to other residents in the facility which could result in the spread of infection. Findings: 1.During a review of Resident 79's admission Record (AR) indicated Resident 79 was originally admitted on [DATE] and readmitted on [DATE], with diagnoses that included history of sepsis (a life-threatening medical emergency where the body has an extreme, harmful response to an infection), urinary tract infection (UTI) (an infection in any part of the urinary system), and muscle weakness. During a review of Resident 79's Minimum Data Set (MDS) -a resident assessment tool dated 2/18/2026, indicated Resident 79's cognitive status (ability to process and comprehend information) was severely impaired. The MDS indicated Resident 79 was dependent with staff with eating, bathing, toileting and personal hygiene. During a review of Resident 79's Order Summary Report (OSR) dated 3/18/2026, the OSR indicated Resident 79 was placed on Enhanced Barrier Precautions due having a Sacro coccyx (tail bone) wound and a foley catheter. During a review of Resident 79's care plan (CP) for Enhanced Barrier Precaution due to high risk for infection dated 2/6/2026, intervention included post signage for EBP and provide EBP gloves, gowns and mask. During a review of Resident 71's admission Record (AR), dated 3/11/2026, indicated Resident 71 was originally admitted on [DATE] and readmitted on [DATE], with diagnoses that included quadriplegia, attention to tracheostomy, and history of diseases of the respiratory system During a review of Resident 's Minimum Data Set (MDS) -a resident assessment tool dated 12/2/2025, indicated Resident 71's cognitive level had no impairment and intact. The MDS indicated Resident 71 was dependent with eating, bathing, toileting and personal hygiene. During a review of Resident 71's Order Summary Report (OSR) dated 3/18/2025, the OSR indicated Resident 71 was placed on Enhanced Barrier Precautions due having a tracheostomy site. During a review of Resident 71's care plan (CP) for Enhanced Barrier Precaution due to tracheostomy and risk 2for infection dated 5/9/2024, intervention included post signage for EBP and provide EBP gloves, gowns and mask. (continued on next page)

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Whittier Pacific Care Center	7716 S Pickering Avenue Whittier, CA 90602

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/11/2026 at 8:10 AM with Certified Nurse Assistant (CNA) 2 in Resident 79's room , observed by the door an EBP signage that indicated to use gloves and gown for high contact care that includes feeding, also observed CNA 2 feeding Resident 79 not wearing an isolation gown. CNA 2 stated, she was aware that she was supposed to wear an isolation gown when feeding Resident 79 because feeding was a high contact care, she just forgot. During a concurrent observation and interview on 3/11/2026 at 8:15 AM with CNA 3 in Resident 71's room. the EBP signage on the doorway indicated to use gloves and gown for high contact care that includes feeding, also observed CNA 3 feeding Resident 71 not wearing an isolation gown. CNA 3 stated, she forgot to wear an isolation gown, she also added, the gown was to protect Resident 71 and other residents in the facility from infection. During an interview on 3/11/2026 at 10:30 AM with the Infection Preventionist Nurse (IPN), IPN stated, CNA 's should have worn a gown during feeding as per our signage for resident's on EBP, because feeding is considered a high contact care. Resident 79 and Resident 71 are both on EBP to protect both Residents from acquiring MDRO, as well as protecting other Residents in the facility in acquiring MDRO's. During an interview on 3/12/2026 at 8:55 AM with the Director of Nurses (DON), DON stated, Resident 79 and Resident 71 are both on EBP and feeding was considered as high contact care, so CNA who are feeding these Residents should have worn an isolation gown. DON stated, not wearing an isolation gown during the feeding of these Residents had the potential to result in Resident 79 and Resident 71 to acquire MDRO as well as the other residents in the facility which could negatively affect their health and quality of life. A review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 6/2024, the P&P indicated, a) Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents, b) gloves and gown are applied prior to performing the high contact care activity, and c) EBPs are indicated for residents with wounds and/or indwelling medical devices. 2. During a review of Resident 88's admission Record, the admission Record indicated the facility initially admitted Resident 88 on 8/3/2021 and readmitted on [DATE]. The admission Record indicated Resident 88's diagnoses included cerebral infarction (brain damage due to a loss of oxygen to the area), muscle weakness, dysphagia (difficulty swallowing), and dementia (progressive state of decline in mental abilities). During a review of Resident 88's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 2/6/2026, the MDS indicated Resident 88 had clear speech, expressed ideas and wants, understood verbal content, and had severely impaired cognition (clear ability to think, understand, learn, and remember). During an interview on 3/10/2026 at 2:04 p.m. with Resident 88, Resident 88 stated both of Resident 88's hearing aids were not working. During a concurrent observation and interview on 3/10/2026 at 3:28 p.m. with Licensed Vocational Nurse 1 in the activity room, LVN 1 placed Resident 88's hearing aid into the right ear. Resident 88's right hearing aid spontaneously fell out of the resident's right ear and landed on the floor while LVN 1 was attempting to place the left hearing aid. LVN 1 picked up Resident 88's right hearing aid from the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor and immediately placed it back into Resident 88's right ear. LVN 1 stated Resident 88's hearing aid should have been cleaned after falling on the floor. During an interview on 3/10/2026 at 3:39 p.m. with LVN 1, LVN 1 stated Resident 88's hearing aid should have been cleaned after falling on the floor for infection control purposes. LVN 1 stated the hearing aid could have bacteria from the floor which could be introduced into Resident 88's right ear. LVN 1 stated the hearing aid was not cleaned because LVN 1 felt nervous. During an interview on 3/12/2026 at 12:55 p.m. with the Infection Prevention Nurse (IPN), the IPN stated a resident item (in general) that falls on the floor should be cleaned with disinfectant wipes to remove bacteria that can potentially be on the item from the floor. The IPN stated a hearing aid that fell on the floor should not be placed back into a resident's ear due to the risk of infection. The IPN stated the hearing aid should be cleaned for the recommended period of wet time and then placed back into the resident's ear. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 9/2022, the P&P indicated resident-care equipment, including reusable items, will be cleaned and disinfected.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain sanitary, environment when the exterior trash storage area in a clean and sanitary manner when the trash bin was overflowing with garbage, with the lid unable to fully close, and two empty boxes were left on the ground near the bin. This deficient practice had the potential to attract pests for the environment for residents, staff and the public that could result in widespread infection in the facility. Findings: During an observation on 3/9/2026 at 9:35 AM, an outside trash bin was observed with trash bags over filling the open bin and the lid was unable to fully close. Two empty boxes were also observed on the ground near the bin. During an interview on 3/13/2026 at 12 PM, the Maintenance Supervisor (MS) stated the outside trash bin lid should have been completely closed and boxes should not have been lying around. The MS stated the surrounding area had a lot of wildlife and had lots of greenery so if the trash bins were overfilled or empty boxes were left out, rodents could come and potentially scare the residents/family or carry disease that could transfer to the residents. During a review of the facility's policy and procedure (P&P) titled, Waste Disposal dated January 2012, the P&P indicated, All infectious and regulated waste shall be handled and disposed of in a safe and appropriate manner. The P&P indicated, The infection preventionist and environmental services director will ensure that waste is properly disposed of and the following rules are observed: disposal of all infectious and regulated waste shall be in accordance with applicable federal, state, and local regulations. During a review of the facility's P&P titled, Policies and Practices - Infection Control dated October 2018, the P&P indicated This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of disease and infections. The P&P indicated, The objectives of our infection control policies and practices are to maintain a safe, sanitary, and comfortable environment for personal, residents, visitors, and the general public. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the primary physician and responsible party regarding a significant change of condition for one of five sampled residents (Resident 40) reviewed for limited range of motion ([ROM] full movement potential of a joint) when Resident 140's left knee ROM declined from normal joint movement on 6/30/2025 to moderate ROM limitations (25-50 percent [%] loss of motion in the joint) on 3/3/2026. This failure prevented Resident 40's physician from being informed for additional interventions to prevent further ROM decline in Resident 40's left knee. This failure also prevented Resident 40's responsible party from being informed of Resident 40's change of condition in the left knee. Findings: During a review of Resident 40's admission Record, the admission Record indicated the facility originally admitted Resident 40 on 5/1/2025 and readmitted on [DATE] with diagnoses that included encephalopathy (disease that affects the brain, causing changes in its function), dysphagia (difficulty swallowing), reduced mobility, muscle weakness, dementia (progressive state of decline in mental abilities), and personal history of cerebral infarction (brain damage due to a loss of oxygen to the area) without residual deficits. During a review of Resident 40's Joint Mobility Screen ([JMS] brief assessment of a resident's range of motion in each joint of both arms and legs) [Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function)] - Lower Extremities (legs), dated 6/30/2025, the JMS (PT) indicated Resident 40 had full ROM in both hips, both knees, and both ankles. During a review of Resident 40's PT Evaluation and Plan of Treatment, dated 6/30/2025, the PT Evaluation indicated Resident 40 had within normal limits ([WNL] normal joint movement) ROM in both legs. The PT Evaluation indicated Resident 40 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for bed mobility and transferring from lying in bed to sitting at the side of the bed. During a review of Resident 40's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated Resident 40 was dependent for bed mobility and recommended to receive a Restorative Nursing Program ([RNP] nursing aide program that helps residents to maintain their function and joint mobility) that included passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) exercises to both legs. During a review of Resident 40's physician's orders, dated 7/20/2025, the physician's orders indicated for Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to perform PROM to both legs, five times per week or as tolerated. During a review of Resident 40's physician's orders, dated 8/6/2025, the physician's order indicated Resident 40 was admitted to hospice (interdisciplinary care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual in the last phases of life due to a terminal disease) with diagnosis of cerebral vascular accident ([CVA] stroke, loss of blood flow to a part of the brain). During a review of Resident 40's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 8/6/2025, the MDS indicated Resident 40 had clear speech, sometimes expressed ideas and wants, responded adequately to simple and direct communication only, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 40 required substantial/maximal assistance (helper does more than half the effort) for eating, hygiene, toileting, bathing, dressing, rolling to either side while lying in bed, transferring from lying in bed to sitting at the side of the bed, and chair/bed-to-chair transfers. During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40 had clear speech, expressed ideas and wants, understood verbal content, and had severely impaired cognition. The MDS indicated Resident 40 was dependent for chair/bed-to-chair transfers and required substantial/maximal assistance for eating, substantial/maximal assistance (helper does (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	more than half the effort) for eating, hygiene, toileting, bathing, dressing, rolling to either side while lying in bed, transferring from lying in bed to sitting at the side of the bed. During a review of Resident 40's JMS (PT) lower-extremity assessment, dated 3/3/2026, the JMS (PT) indicated Resident 40 had moderate ROM loss in the left knee, resisted stretching, and maintained only 90 degrees (unit of measurement for joints) of flexion (bend). The JMS (PT) indicated Resident 40 had a ROM decline. During observation on 3/10/2026 at 2:48 p.m. in the resident's room, Restorative Nursing Aide (RNA) 1 was observed providing ROM exercises to Resident 40's legs. Resident 40 was observed lying in bed with both knees bent and legs rotated to the right. Resident 40's right leg was externally rotated (hip joint rotated away from the body), the left leg was internally rotated (hip rotated toward the body), and the left knee rested on top of the right knee without a positioning or cushioning device in place. RNA 1 performed PROM to both of Resident 40's ankles, knees, and hips. RNA 1 was observed to extend (straighten) Resident 40's left knee, which continued to have a 90-degree bend. RNA 1 placed a pillow in between Resident 40's knees at the end of the session. During an interview on 3/10/2026 at 3:06 p.m. with RNA 1, RNA 1 stated Resident 30 received PROM to both legs. RNA 1 stated Resident 40 resisted PROM into left knee extension and could not extend the left knee past 90 degrees. During a concurrent observation and interview on 3/11/2026 at 1:29 p.m. with Certified Nursing Assistant 1 (CNA 1) in the resident's room, Resident 40 was observed lying in bed with both knees bent and rotated to the right side. Resident 40's right leg was observed in an externally rotated position while the left leg was an internally rotated position. A pillow was observed under Resident 40's right leg, and another pillow was observed in between both knees. CNA 1 stated Resident 40's legs were in the observed position due to having leg contractures (stiffening/shortening at any joint that reduces the joint's range of motion). CNA 1 attempted to extend Resident 40's left knee, which was observed to have a 90-degree bend. CNA 1 stated Resident 40 would still end up positioned with both legs turned to the right side despite the CNAs attempts to turn Resident 40's body toward the left side. During an interview on 3/11/2026 at 4:29 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 40's legs were usually in a slightly bent position. CNA 2 stated Resident 40's legs were straight about one month ago (unspecified date) when CNA 2 last worked with Resident 40. During an interview on 3/12/2026 at 11:24 p.m. with CNA 1, CNA 1 stated it was difficult to turn and reposition Resident 40 due to the positioning of both legs. During an interview on 3/12/2026 at 12:38 p.m. with RNA 1, RNA 1 stated Resident 40's legs have been in a bent position for approximately one to two months. RNA 1 stated the DOR was informed that Resident 40 resisted motion to both legs and checked on Resident 40. RNA 1 stated the DOR educated RNA 1 on using communication techniques while stretching Resident 40's legs into extension. During a concurrent interview and record review on 3/12/2026 at 1:34 p.m. with the Director of Rehabilitation (DOR), Resident 40's PT Evaluation, dated 6/30/2025, and JMS (PT), dated 3/3/2026, were reviewed. The DOR stated Resident 40 had normal range of motion during a PT evaluation on 6/30/2025. The DOR stated Resident 40 was assessed after an RNA (unknown) reported Resident 40 had ROM limitations in both legs. The DOR stated Resident 40 was assessed twice but did not document the first assessment and could not recall when Resident 40's ROM limitations were first reported. The DOR stated Resident 40 was assessed a second time during the JMS (PT) on 3/3/2026. The DOR stated Resident 40 pulled the left leg back during stretching and could not extend the left knee past 90 degrees. The DOR stated Resident 40 experienced a significant decline from normal ROM on 6/30/2025 to moderate ROM loss on 3/3/2026. The DOR stated she could not remember whether nursing was notified of this decline. During a concurrent interview and record review on 3/12/2026 at 3:25 p.m. with the Assistant Director of Nursing (ADON), Resident 40's JMS (PT), dated 6/30/2025 and 3/3/2026, were reviewed. The ADON stated the JMS (PT), dated 6/30/2025, indicated Resident 40 had full ROM in both knees. The ADON stated the JMS (PT), dated 3/3/2026, indicated Resident 40 had moderate ROM loss in the left knee. The ADON stated Resident 40's moderate decline in left knee ROM was not normal. The ADON stated Resident 40's decline in left knee ROM should have been reported to the physician and the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interdisciplinary team since it was a change in Resident 40's mobility. The ADON stated nursing should have been notified about Resident 40's ROM decline of the left knee to contact the physician for another intervention. The ADON reviewed Resident 40's medical record for changes of condition and nursing progress notes. The ADON stated Resident 40's medical record did not include any documentation of Resident 40's decline in left knee ROM. During an interview on 3/12/2026 at 4:46 p.m. with the Director of Nursing (DON), the DON stated a change of condition assessment should be completed upon identification of a resident's decline in mobility (in general) to determine the reason for the resident's change, to notify the resident's physician and responsible party, to determine additional interventions, and to discuss the change of condition with the interdisciplinary team. The DON stated a decline in a resident's ROM could lead to contractures and loss of mobility, which could affect the resident's quality of life. During a telephone interview on 3/12/2026 at 5:08 p.m. with Resident 40's Responsible Party (RP 1), RP 1 stated Resident 40's legs were bent, which was new occurrence, during RP 1's visit to the facility approximately two weeks ago. RP 1 stated that RP 1 thought both of Resident 40's legs were bent in response to feeling cold and shivering since Resident 40 did not have a blanket. RP 1 stated the facility did not notify RP 1 about Resident 40's ROM limitation in the left knee. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised 3/2023, the P&P indicated the facility would promptly notify the, the attending physician, and the resident representative of changes in the resident's condition. The P&P also indicated the nurse would notify the resident physician and resident's representative when there has been a significant change in the resident's physical condition.

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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, and record review, the facility failed to ensure one of five sampled residents (Resident 4) was free of unnecessary medications when: 1. Registered Nurse (RN) 4 renewed Resident 4's discontinued order for Lorazepam (Ativan- a medication that reduces anxiety) without authorization from Medical Doctor (MD) 1 or Nurse Practitioner (NP) 1. 2. Licensed Nurses (LNs) did not document nonpharmacological interventions (NPI- non-medication approaches to address behavioral symptoms such as anxiety, insomnia, or agitation) prior to administering Resident 4's PRN Lorazepam. This failure to notify MD 1 or NP 1 to evaluate Resident 4's condition and to evaluate the effectiveness and necessity of the psychotropic medication (a drug that affects brain chemistry to treat mental health conditions by influencing mood, thoughts, or behavior) prior to the medication being renewed and failure to provide NPI prior to administering Lorazepam increased Resident 4's risk of experiencing adverse effects of Lorazepam such as oversedation, weakness, confusion, and muscle tremors. Findings: During a review of Resident 4's admission Record, the record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including anxiety, dementia (a progressive state of decline in mental abilities), and tracheostomy (a surgically created opening in the windpipe to provide a direct airway) with ventilator (a medical device to help support or replace breathing) dependence. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 1/26/26, the MDS indicated Resident 4 was rarely/never understood and had severely impaired cognition (ability to reason) and make decisions regarding tasks of daily life. During a review of Resident 4's Order Summary Report (OSR) dated 2/26/26, the OSR indicated the following orders: Lorazepam Oral Tablet one (1) mg (milligram- a unit of measurement). Give one (1) tablet via g-tube (gastrostomy tube- a surgical opening fitted with a device to allow feedings and medication to be administered) every eight (8) hours as needed for 14 days for anxiety manifested by physical movement leading to exhaustion. The order indicated to provide 1. Rest and reposition. 2. Cues, prompt, reassurance. 3. Redirection/Diversion/Reorientation. 4. Document result effectiveness of NPI: E- Effective, N- Noneffective. Ordered on 2/23/26 and end date on 3/9/26. During a review of Resident 4's Telephone Order dated 3/10/26 at 6:42 AM, the document indicated the following order: Lorazepam oral tablet one (1) mg. Give one (1) tablet via g-tube every eight (8) hours as needed for anxiety manifested by restless by pulling life sustaining tubing for 14 days. Informed Consent obtained by responsible party from MD. The document also indicated the order was communicated via phone and was confirmed by RN 4. The telephone order did not indicate to provide or document nonpharmacological interventions prior to administration of Ativan. During a review of Resident 4's Medication Administration Report (MAR) for the month of 3/2026, the MAR indicated Resident 4 was administered Lorazepam on the following days without providing NPI prior to administration: 3/10/26 at 9 AM, administered by RN 2 3/11/26 at 12:26 AM administered by Licensed Vocational Nurse (LVN) 7 3/11/26 at 9:01 AM, administered by LVN 8 3/12/26 at 5:29 AM, administered by LVN 7 3/12/26 at 2:16 PM, administered by LVN 8 During an interview with LVN 8 on 3/12/26 at 1:57 PM, LVN 8 stated that nonpharmacological interventions should be done prior to administering psychotropic medications like Lorazepam PRN in order to determine if the resident's needs could be met without having to give medication. LVN 8 stated NPI documentation was only documented in the resident's MAR when a PRN medication indicated for NPIs to be documented in the order. LVN 8 further stated he did not think he needed to document NPIs for Resident 4 when administering her PRN Lorazepam because the order did not indicate for him to document NPI. During an interview with RN 2 on 3/12/26 at 2:44 PM and concurrent record review of Resident 4's MAR, RN 2 stated that if the NPIs were not documented in the MAR then that could indicate that nonpharmacological interventions were not done prior to administering Resident 4's PRN Lorazepam. RN 2 stated it was important to provide NPI prior to (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering Lorazepam to ensure Resident 4 actually needed the medication and not anything else. RN 2 stated that administering Lorazepam when it was not needed placed Resident 4 at a higher risk of experiencing adverse effects of Lorazepam such as drowsiness and oversedation. During another interview with RN 2 on 3/12/26 at 2:50 PM and concurrent record review of Resident 4's Progress Notes dated 3/12/26, RN 2 stated that there was no documentation of nonpharmacological interventions in the resident's clinical records including the progress notes and MAR. During a phone interview with RN 4 on 3/12/26 at 5PM, RN 4 stated that when she renewed Resident 4's Lorazepam order, she forgot to include for LNs to document nonpharmacological interventions prior to administering the medication. RN 4 stated that it was important to implement NPI prior to administering PRN Lorazepam because overuse can cause Resident 4 to become so sedated to the point of being unresponsive and her vital signs can decompensate. RN 4 stated that providing NPI can prevent overmedicating Resident 4. During another phone interview with RN 4 on 3/13/26 at 8:45 AM, RN 4 stated that on 3/10/26, when she attempted to administer Resident 4's Lorazepam, she noticed the order was discontinued. RN 4 stated she called the pharmacy for a refill of Resident 4's Lorazepam and the pharmacy staff stated they would send the medication. Because there was a refill available in the pharmacy, she believed that it was implied MD 1 or NP 1 wanted to renew Resident 4's Lorazepam. RN 4 stated she put in a new order for Lorazepam in Resident 4's chart without speaking to MD 1 or NP 1. During an interview on 3/13/26 at 9:25 AM with the Director of Nursing (DON), the DON stated that PRN Psychotropic medications were ordered for 14 days by the MD and, if the order needed to be renewed, licensed nurses were expected to call the MD to renew the order. The DON stated RN 4 should have called MD 1 or NP 1 to renew Resident 4's Lorazepam order. The DON explained that RN 4 acted outside of her scope of practice when she renewed Resident 4's Lorazepam order without the practitioner's authorization. The DON further explained RN 4 should have called NP 1 or MD 1 to renew Resident 4's Lorazepam order so the providers could have reevaluated Resident 4's condition and the effectiveness of Lorazepam. During a phone interview with NP 1 on 3/13/26 at 9:26 AM, NP 1 stated that Resident 4's PRN Lorazepam was ordered for 14 days and when the medication needed to be renewed, RN 4 should have called him for a new order. NP 1 stated that he was not contacted by the facility to renew Resident 4's Lorazepam. NP 1 further explained that if the facility did not contact him to renew a PRN psychotropic medication, then he would not have the opportunity to evaluate the medication's effectiveness or potential adverse effects. During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use and dated 3/2023, the P&P indicated: Nonpharmacological approaches were used to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation when possible. PRN orders for psychotropic medications were limited to 14 days. For psychotropic medications that were not antipsychotics: If the prescriber or attending physician believed it was appropriate to extend the PRN order beyond 14 days, he or she would document the rationale for extending the use and include the duration for the PRN order.

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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. Based on interview and record review, the facility failed to ensure weekly wound assessments were completed and documented for one of three sampled residents (Resident 112) who had a postˆsurgical wound. This failure resulted in the facility's inability to monitor the wound's healing progress, identify changes in condition, and ensure timely intervention. Findings: During a review of Resident 112's admission Record (AR), the AR indicated the facility admitted Resident 112 on 2/23/2026 with diagnoses that include left hip replacement (a surgical procedureˆto remove damaged sections of the hip joint and replace them) and hypertension (high blood pressure). During a review of Resident 112's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 3/1/2026, the MDS indicated Resident 112 intact cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 112 required surgical wound care. The MDS indicated Resident 112 required partial/moderate assistance with toileting hygiene and shower/bathe self. During a review Resident 112's Physician Summary Report, dated 3/12/2026, the report indicated the physician ordered to provide wound care to left lateral thigh post-surgical incision site with 20 staples (surgical staples are commonly used in place of sutures for closing wounds after surgery): cleanse with normal saline (a mixture of salt and water), pat dry, paint with betadine solution (a first aid solution used to treat or prevent infections in minor cuts, scrapes, and burns) air dry, then cover with dry dressing every day shift for 30 days. During a review of Resident 112's Skin Assessment, dated 2/24/2026, the Assessment indicated Resident 112 had a surgical incision at left lateral leg, measuring nine centimeters (CM, a measurement unit) in length and one CM in width. During an interview on 3/9/2026 at 11:16 AM with Resident 112, Resident 112 stated she had a surgical wound at left hip, and she was concerned if the wound was healing properly.ˆ On 3/11/2026 at 12:13 PM during a concurrent interview and record review, the Treatment Nurse (TXN) stated he did not assess or document the weekly wound assessment for the resident's left lateral thigh surgical incision on 3/3/2026. The TXN stated he was responsible for completing and documenting weekly wound assessments, including wound location, type, size, drainage, tissue type, and surrounding skin, to ensure proper healing and evaluate treatment effectiveness. During an interview and record review on 3/11/2026 at 12:13 PM, the TXN stated that he failed to assess and document Resident 112's left lateral thigh surgical wound on 3/3/2026. TXN stated that he was responsible for completing and documenting weekly wound assessments, including wound bed (the base or open area of a wound), location, type, size, drainage, tissue type, and surrounding skin, to ensure proper healing and effective treatment. During an interview on 3/12/2026 at 4:20 PM with the Director of Nursing (DON), the DON stated to perform and document weekly skin/wound assessment was important because the facility staff wound see if the wound was getting better and worse, and intervene timely to ensure proper wound healing. During an interview and record review on 3/12/2026 at 5 PM with the DON, Resident 112's medical record was reviewed, the DON stated there was no weekly wound assessment that showed the size, color and drainage of Resident 112's surgical wound after 2/24/2026. During an interview and record review on 3/12/2026 at 5:03 PM with the DON, the facility's policy and procedures (P&P), titled Pressure ulcers/Skin Breakdown-Clinical Protocol, dated 4/2018, and Resident Examination and Assessment, dated 3/2023, were reviewed. The DON stated the facility policies did not specify the frequency of wound assessment for non-pressure ulcer wounds, so the nurses did not conduct and document weekly and routine wound assessments for non-pressure ulcer wounds. The DON stated the nurses only conduct and document wound assessments for non-pressure ulcer wounds upon admission and when there was a change of condition of the wound. During a review of the facility's P&P titled, Resident Examination and Assessment, dated 3/2023, the P&P indicated to examine and assess the resident for any abnormalities in health status and document All assessment data obtained during the procedure. During a review of the facility's P&P titled, Wound Care, dated 3/2023, the P&P indicated All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound should be recorded in the resident's medical records.

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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 facilityˆfailed toˆensure services were provided in accordance with professional standards of practice for enteral nutrition for one of four sampled residents (Resident 90) by failing to: 1.Complete a comprehensive assessment upon readmission to the facility and identify Resident 90's new Gastro-jejunal (GJ tube, two main ports labeled G leading to the stomach for draining air or fluid and J bypassed the stomach to deliver nutrition directly into the small intestine, used for feeding and medicine) tube. 2. Follow Physician's Orders to administer medications via gastrostomy tube (G-tube, a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medication) instead of through the jejunostomy tube (J-tube, a thin, flexible feeding tube surgically inserted directly into the small intestine [jejunum] through the abdomen). These deficient practicesˆhad the potential toˆplace Resident 90 at risk for complications such as tube occlusion, improper medication absorption, and gastrointestinal intolerance. Findings: During a review of Resident 90's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included gastrostomy (G-tube, a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medication). chronic respiratory failure (a long-term condition where the lungs could not properly move oxygen into the blood or remove carbon dioxide), and tracheostomy (a surgical procedure that created a small, permanent or temporary hole [stoma] in the neck and into the windpipe [trachea] to help a person breathe. During a review of Resident 90'sˆMinimum Data Set (MDS,ˆa federally mandated resident assessment tool)ˆdated 12/26/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident had a feeding tube. During a review of Resident 90's History and Physical (H&P) dated 3/9/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 90's Progress Note dated 3/6/2026 at 8:15 PM, the Progress Note indicated the resident was readmitted to the facility from the General Acute Care Hospital (GACH) and the physician and family were notified. The Progress Note did not include assessment of the resident's GJ tube. During a review of Resident 90's Clinical admission dated 3/6/2026 at 8:15 PM, the Clinical admission indicated skin issue number eight included a g-tube site wound that was present on admission. The Clinical admission indicated skin issue number 35 included a g-tube site that was present on admission. The Clinical admission did not indicate the resident had a GJ tube in the gastrointestinal (GI, a continuous long tube-like pathway in the body - running from the mouth to the anus - that broke down food, absorbed essential nutrients, and eliminated waste) assessment. During a review of Resident 90's General Acute Care Hospital Discharge Order dated 3/6/2026 at 12:10 PM, the Discharge Order indicated the resident was evaluated for nausea and vomiting and secondary to high Percutaneous Endoscopic Gastrostomy (PEG, a medical feeding tube inserted directly into the stomach through the abdominal wall, usually via a quick endoscopic procedure) residual (gastric residual volume), the resident's PEG was converted to a GJ tube. During an interview on 3/12/2026 at 8:40 AM, Licensed Vocational Nurse (LVN) 5 stated Resident 90 had a PEG and was unsure if the resident had a GJ tube. During a concurrent observation and interview in Resident 90's room on 3/12/2026 at 8:46 AM, the resident was observed to have a GJ tube and a Lopez valve (a three-way stopcock device used with feeding tubes that allowed caregivers to give medication, flush the ling, or suction the stomach without disconnecting the feeding pump) connected to the J Port. LVN 5 stated for GJ tubes, the J port was for feeding and the G port was for medications but the facility was only using Resident 90's port for both feedings and medications. LVN 5 stated the facility staff were not accessing the G port of Resident 90's GJ tube. During a concurrent interview and record review on (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/12/2026 at 9:59 AM, the Registered Nurse (RN) 2 stated she did not know Resident 90 had a GJ-tube. RN 2 stated a G-tube, J-tube, and GJ tube were all different and each port would be used differently, pending orders. RN 2 stated there was no documented evidence of Resident 90's GJ tube but there should have been to avoid the risk of the resident vomiting again and having the same issue. During an interview on 3/12/2026 at 11:17 AM, RN 2 stated when residents were admitted to the facility, the facility staff go through the referral paperwork from the GACH, an assessment of the resident was completed, and the facility staff would let the Physician know of any changes or the facility staff's findings. RN 2 stated there must have been miscommunication since the feeding and the medication were going in the J-tube. RN 2 stated if the medication was going through the J-tube there could have been decreased absorption because the gastric was where the body absorbed nutrients and the medication could be less effective. During a concurrent interview and record review of Resident 90's Physician's Orders on 3/12/2026 at 11:20 AM, RN 2 stated the facility staff were not following the Physician's Orders but should have been to ensure the resident gets the full benefit of the medication otherwise, that could be a medication error. During an interview on 3/12/2026 at 12:40 PM, the Primary Physician (PP) stated she was aware of Resident 90's GJ tube and followed the GACH orders to run the feeding through the J-tube for the resident to hopefully get enough nutrition and stop the resident's emesis. The PP stated the GACH orders indicated to give medication through the G-tube and she was unaware the facility staff were using the J-port to give medication. The PP stated if she changed the medication to go through the J-tube there was a risk of the medication not being metabolized properly and that could be problematic. During an interview on 3/13/2026 at 10:40 AM, RN 3 stated the facility staff were not following the Physician's Order to use the G-tube for medications but should have been because the Physicians were the prescribers and the facility staff must follow the orders. RN 3 stated if the facility staff did not follow the Physician's Orders, the resident's condition could worsen if the facility staff did something they were not supposed to do because that was not within their scope of practice. During an interview on 3/13/2026 at 10:43 AM, RN 3 stated assessing a resident upon admission was important to know the resident's current condition, otherwise a lot of things could be missed. RN 3 stated she received report this morning that Resident 90 had a GJ tube but RN 3 was unaware prior to today. RN 3 stated that because a proper assessment was not done, the facility staff missed an important observation of Resident 90's GJ tube and the facility staff did not know which port was used for feeding and medication which could affect the absorption because some medications need stomach acid to process the medication. During an interview on 3/13/2026 at 10:50 AM, the Director of Nursing (DON) stated when residents were admitted to the facility, the facility staff reviewed the discharge paperwork from the GACH and the RN would do a full body assessment of the resident. The DON stated when Resident 90 was re-admitted , the hospital records all said G-tube and she did not know the resident had a GJ when the discharge report was given to the RN. During a concurrent interview and record review of Resident 90's Clinical admission on [DATE] at 11:12 AM, the DON stated there was no documented evidence showing the resident had a GJ tube but there should have been to alert the facility staff. The DON stated if there was no documentation of the resident's GJ tube, the facility staff might use the wrong port and the medication or formula could go to the wrong place. During an interview on 3/13/2026 at 11:39 AM, the DON stated the facility staff were not following the Physician's Orders but should have been because the facility staff were using Resident 90's J-tube to administer medications and not the G-tube. The DON stated the facility staff's job was to oblige what the Physician ordered otherwise there could be adverse effects for the resident. During a review of Resident 90's Order Summary Report as of 3/13/2026, the Order Summary Report indicated all medications that needed to be given via feeding tube, must be given through the G-tube. The Order Summary Report did not indicate to give medication through the J-tube. During a review of the facility's policy and procedure (P&P) titled, admission Assessment and Follow Up: Role of the Nurse dated September 2012, the P&P indicated, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. The P&P indicated Conduct a physical assessment, including the following systems: Gastrointestinal. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The P&P indicated The following information should be record in the resident's medical record: All relevant assessment data obtained during the procedure. Report other information in accordance with the facility policy and professional standards of practice. During a review of the facility's P&P titled, Charting and Documentation dated July 2017, the P&P indicated 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. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. During a review of the facility's P&P titled, Enteral Feedings - Safety Precautions dated March 2023, the P&P indicated Preventing aspiration: Check enteral tube placement every 4 hours q shift and prior to feeding or administration of medication. The P&P indicated Document all assessments, findings and interventions in the medical record.

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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. Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 46) received oxygen therapy at two liter per minute (L/mi) continuously according to the physician's order. This deficient practice had resulted in Resident 46 receiving less oxygen than prescribed and had the potential to cause respiratory distress. Findings: During a review of Resident 46's admission Record (AR), the AR indicated the facility originally admitted Resident 46 on 9/10/2012 and readmitted her on 4/3/2025 with diagnoses that include respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood or remove waste gas from the body) with hypoxia (a condition not enough oxygen to the body) and dementia (a progressive, irreversible decline in cognitive function, including memory, thinking, and reasoning, and can become severe enough to interfere with daily life). During a review of Resident 46's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 1/15/2026, the MDS indicated Resident 46 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 46 was dependent on oral hygiene, toileting hygiene, shower/bathe self and personal hygiene. During a review of Resident 46's Weight and Vitals Summary, dated from 3/2/2026 to 3/9/2026, indicated Resident 46's oxygen level ranged from 97-98 percent with oxygen administration via nasal cannula (NC, a flexible tube with two prongs used to deliver supplemental oxygen directly into the nostrils). During a review Resident 46's Physician Summary Report, dated 3/12/2026, the report indicated the physician ordered to administered oxygen at two liter per minute (L/min-a measurement unit) via NC that started on 4/3/2025. During an observation on 3/9/2026 at 9:52 AM, Resident 46 was lying on the bed with limitation of her hands. Resident 46's oxygen NC was on the right side of her pillow, not applied to her nostrils. The oxygen concentrator at Resident 46's bedside was off. During a concurrent observation and interview on 3/9/2026 at 10:05 AM with the Assistant Director of Nursing (ADON), the ADON stated Resident 46 was not getting oxygen as the physician's order. The ADON inserted oxygen NC into Resident 46's nostrils and turned on the oxygen concentrator and set at 2 L/min. The ADON checked Resident 46's oxygen level with an oxygen pulse oximeter (a device to measure the oxygen level in the blood) and the result was 94 percent. The ADON stated it was important to administer oxygen to Resident 46 as the physician's order to ensure the resident receives enough oxygen to prevent respiratory distress. During an interview on 3/9/2026 at 10:12 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she did not notice if Resident 46's oxygen NC was inserted into her nostrils, and the oxygen concentrator was on when she changed the resident this morning. During an interview on 3/9/2026 at 11:14 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she saw Resident 46's oxygen NC was in place and oxygen concentrator was on when she did her morning rounding around 7:30 AM, but she did not know why, when and who removed Resident 46's oxygen NC and turned off the oxygen concentrator. During an interview on 3/12/2026 at 4:18 PM with the Director of Nursing (DON), the DON stated the nurses should follow the physician's order for oxygen therapy to ensure adequate oxygenation and the resident safety. During a review of the facility's policy and procedures (P&P) titled, Oxygen Administration, dated 10/2010, the P&P indicated to Turn on the oxygen, Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter), Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened, Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services for one of three residents sampled for medication administration (Resident 112) by failing to reorder Resident 112's routine Olmesartan Medoxomil (a blood pressure medication), Isosorbide Dinitrate (another blood pressure medication), and Raloxifene Hydrocholoride (a medication used to treat osteoporosis- weak and brittle bones due to lack of calcium and Vitamin D) three (3) days prior to the last dosage being administered per the facility's policy and procedure (P&P). This deficient practice resulted in Resident 112 missing her medications as scheduled and placed Resident 112 at risk of complications related to hypertension (HTN- high blood pressure) and osteoporosis. Findings: During a review of Resident 112's admission Record, the record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including HTN (hypertension-high blood pressure), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left hip, and aftercare following joint replacement surgery. During a review of Resident 112's Minimum Data Set (MDS- a resident assessment tool) dated 3/1/26, the MDS indicated Resident 112 was cognitively intact. During a review of Resident 112's Order Summary Report (OSR) dated 3/12/26, the OSR indicated the following physician's orders: Olmesartan Medoxomil Oral Tablet 20 mg (milligrams- a unit of measurement). Give one (1) tablet by mouth one time a day for HTN. Hold if SBP (systolic blood pressure- the pressure of blood against the arteries when the heart is contracted) less than 110 or pulse less than 60. Isosorbide Dinitrate Oral Tablet 10 mg. Give 5 (five) mg by mouth one time a day for HTN. Take half a tablet daily, hold is SBP less than 110 or pulse less than 60. Raloxifene HCl Oral Tablet 60 mg. Give one (1) tablet by mouth one time a day for osteoporosis. During a medication pass observation and interview with Licensed Vocational Nurse (LVN) 1 on 3/11/26 at 8:22 AM, LVN 1 was observed preparing Resident 112's medications. LVN 1 set aside three empty medication bubble packs (a form of pharmaceutical packaging where individual doses of medication are sealed in separate pockets) for Olmesartan Medoxomil, Isosorbide Dinitrate, and Raloxifene HCl and stated that she could not administer the medications because the medications were not available and needed to be refilled by pharmacy. During an interview with the Assistant Director of Nursing (ADON) on 3/11/26 at 2:02 PM, the ADON stated the facility's protocol in refilling medications was to request a refill from pharmacy at least one week prior to the medication running out. The ADON explained that by the time there was only three-day supply of a medication left, licensed nurses were expected to call the pharmacy for a refill because it takes a few days for medications to be delivered to the facility. The ADON stated that a resident's medications should never run out, and he did not know why three of Resident 112's medications (Olmesartan Medoxomil, Isosorbide Dinitrate, and Raloxifene HCl) were not refilled on time. The ADON also stated Resident 112 was planned for discharge from the facility at 4 PM. During an interview with the Director of Nursing (DON) on 3/12/26 at 4:18 PM, the DON stated that the pharmacy had no record of the facility requesting a refill for Resident 112's Olmesartan Medoxomil, Isosorbide Dinitrate, and Raloxifene HCl prior to 3/11/26. The DON stated it was important to refill medications before they ran out to ensure residents do not miss a dose. The DON stated it was especially important for Resident 112 to have at least seven days' worth of each prescribed medication available when she discharged from the facility because it could take a week before Resident 112 could get a refill from her local pharmacy. The DON explained that Resident 112 could have missed several days' worth of her blood pressure and osteoporosis medications and it would not be safe. During a review of the facility's P&P titled, Medication and Treatment Orders dated 7/2016, the P&P indicated drugs and biologicals that were required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills were readily available.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the medication error rate was less than five percent (%). During medication pass four (4) medication errors out of a total of 30 opportunities contributed to 13.33% medication error rate affecting one of three residents observed for medication administration (Resident 112). 1.Failure to check Resident 112's pulse rate prior to administering Metoprolol Succinate (a blood pressure medication that lowers both blood pressure and pulse rate) with parameters to hold the medication for a pulse rate less than 60 beats per minute (bpm). 2.Failure to administer Olmesartan Medoxomil (another blood pressure medication) due to failing to refill Resident 112's medication after it ran out. 3.Failure to administer Isosorbide Dinitrate (another blood pressure medication) due to failing to refill Resident 112's medication after it ran out. 4.Failure to administer Raloxifene Hydrocholoride (a medication used to treat osteoporosis- weak and brittle bones due to lack of calcium and Vitamin D) due to failing to refill Resident 112's medication after it ran out. These failures to check vital signs in accordance with medication parameters placed Resident 112 at risk of complications related to slow or decreased heart that can lead to dizziness, fainting, and fatigue. And failing to reorder Resident 112's medications three days prior to the last dosage being administered per the facility's policy and procedure placed Resident 112 at risk of complications related to hypertension (HTN- high blood pressure) and osteoporosis from missing medications. Cross-referenced to F755Findings: During a review of Resident 112's admission Record, the record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including HTN, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left hip and aftercare following joint replacement surgery. During a review of Resident 112's Minimum Data Set (MDS- a resident assessment tool) dated 3/1/26, the MDS indicated Resident 112 was cognitively intact. During a review of Resident 112's Order Summary Report (OSR) dated 3/12/26, the OSR indicated the following physician's orders: Metoprolol Succinate Oral Capsule ER 24 Hour Sprinkle 25 mg (milligrams- a unit of measurement). Give one capsule by mouth one time a day for HTN. Hold if SBP (systolic blood pressure- the pressure of blood against the arteries when the heart is contracted) is less than 110 or pulse is less than 60. Olmesartan Medoxomil Oral Tablet 20 mg. Give one (1) tablet by mouth one time a day for HTN. Hold if SBP less than 110 or pulse less than 60. Isosorbide Dinitrate Oral Tablet 10 mg. Give 5 (five) mg by mouth one time a day for HTN. Take half a tablet daily, hold is SBP less than 110 or pulse less than 60. Raloxifene HCl Oral Tablet 60 mg. Give one (1) tablet by mouth one time a day for osteoporosis. During a medication pass observation and interview with Licensed Vocational Nurse (LVN) 1 on 3/11/26 at 8:22 AM, LVN 1 was observed checking Resident 112's blood pressure but did not check Resident 112's pulse rate. While preparing Resident 112's medications, LVN 1 was observed setting aside three empty medication bubble packs (a form of pharmaceutical packaging where individual doses of medication are sealed in separate pockets) for Olmesartan Medoxomil, Isosorbide Dinitrate, and Raloxifene HCl and stated that she could not administer the medications because they were not available and needed to be refilled by pharmacy. LVN 1 was observed preparing one capsule of Metoprolol Succinate. LVN 1 stated she intended to administer Resident 112's Metoprolol Succinate before she was stopped by the surveyor. During an interview with LVN 1 on 3/11/26 at 8:43 AM, LVN 1 stated she forgot to check Resident 112's pulse rate prior to administering Metoprolol Succinate because she was focused on checking Resident 112's blood pressure. LVN 1 stated it was important to assess the resident's pulse rate when indicated by a medication's parameters because the medication can decrease the resident's pulse rate. During an interview with the Assistant Director of Nursing (ADON) on 3/11/26 at 2:02 PM, the ADON stated the facility's protocol in refilling medications was to request a refill from pharmacy at least one week prior to the medication running out. The ADON explained that by the time there was only a three-day supply of a medication left, licensed nurses were expected to call the pharmacy for a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055764	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Pacific Care Center	7716 S Pickering Avenue Whittier, CA 90602

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refill because it takes a few days for medications to be delivered to the facility. The ADON stated that a resident's medications should never run out, and he did not know why three of Resident 112's medications (Olmesartan Medoxomil, Isosorbide Dinitrate, and Raloxifene HCl) were not refilled on time. The ADON also stated Resident 112 was planned for discharge from the facility at 4 PM. During an interview with the Director of Nursing (DON) on 3/12/26 at 4:18 PM, the DON stated LVN 1 should have checked Resident 112's pulse rate prior to administering Metoprolol Succinate, because Metoprolol can lower a resident's heart rate to the point of a medical emergency if pulseˆrate parameters are not followed. The DON also stated the pharmacy had no record of the facility requesting refills for Resident 112's Olmesartan Medoxomil, Isosorbide Dinitrate, or Raloxifene HCl prior to 3/11/26. The DON stated it was important to refill medications before they ran out to ensure residents did not miss a dose. The DON added that it was especially important for Resident 112 to have at least seven days' worth of each prescribed medication available upon discharge because it could take up to a week for her to obtain refills from her local pharmacy. The DON explained that Resident 112 could have missed several days of her blood pressure and osteoporosis medications, which would not be safe. During a review of the facility's Policy and Procedure (P&P) titled Medication Administration - General Guidelines dated 10/2017, the P&P indicated medications are administered as prescribed in accordance with good nursing principles and practices. Medications are administered in accordance with written orders of the attending physician. During a review of the facility's P&P titled, Administering Medications dated 3/2023, the P&P indicated medications were to be administered in a safe and timely manner, and as prescribed. Vital signs were to be checked/verified for each resident prior to administering medications if necessary. During a review of the facility's P&P titled, Medication and Treatment Orders dated 7/2016, the P&P indicated drugs and biologicals that were required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills were readily available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055764	A. Building B. Wing	03/13/2026

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services for one of two medication storage areas (MSA 1) by failing to discard an opened vial of Aplisol (Tuberculin Purified Protein Derivative, PPD) within 30 days as required by the manufacturer's instructions. The Aplisol vial, opened on [DATE], remained stored in the facility's medication refrigerator until [DATE], exceeding the 30ˆday discard date by 11 days. This failure had the potential to result in inaccurate test results, misuse of expired medication, and compromised resident safety. Findings: During an observation of the facility's Medication Storage Area 1 on [DATE] at 2:30 PM, and a concurrent interview with the Assistant Director of Nursing (ADON), an opened Aplisol vial dated [DATE] was observed inside of the refrigerator in the medication room. The manufacturer's label on the Aplisol bottle indicated, Once entered, vial should be discarded after 30 days. The ADON stated the vial was opened and used on [DATE] and should have been discarded 30 days after being opened (on [DATE]). During another interview with the ADON on [DATE] at 3:46 PM, the ADON stated that the Aplisol would not have been effective if used after 30 days of being opened. The ADON further explained that a TB test with expired Aplisol could produce a false negative test result and residents could unknowingly have TB without being treated. During an interview with the Director of Nursing on [DATE] at 4:18 PM, the DON stated it was important to store and discard medications and biologicals according to the manufacturer's guidelines so that they can be used safely and effectively for the residents. The DON stated that using the Aplisol after its expiration date can cause a false negative TB screening test and can spread TB in the facility. During a review of the facility's Policy and Procedure (P&P) titled Vials and Ampules of Injectable Medications dated 4/2008, the P&P indicated medication in multi-dose vials may be used until the manufacturer's expiration date or six months after opening unless otherwise specified.