STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055816	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Care Center	12232 Chapman Ave Garden Grove, CA 92840

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure one heavy-duty blender used for puree preparation was air dried and free of water residue prior to storing. * The facility failed to ensure the microwave utilized to warm up the food was in a sanitary condition. These failures had the potential for cross contamination and foodborne illnesses for the residents consuming the food prepared in the facility's kitchen.Findings: Review of the facility's Diet Type Report dated 1/14/26, showed 54 of 90 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Sanitation and Infection Control: Sanitizing Equipment, Food and Utility Carts (undated) showed all equipment will meet NSF (National Sanitation Foundation) guidelines. Food Equipment (NSF/ANSI 2): Ensures materials are non-toxic, corrosion-resistant, and that equipment is easy to clean and sanitize. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 1/14/26 at 0803 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS: - Three stainless steel slotted scoops with green handles discolored and partially melted. - One stainless steel scoop with green handle peeling, discolored and partially melted. - One stainless steel scoop with cream handle discolored and partially melted. - One stainless steel scoop with red handle partially melted. - Two rubber spatulas with red handles were chipped, cracked at the edges, discolored with one handle partially melted.- One white basting brush used to spread butter had worn out bristles. - One stainless steel spatula with black handle deformed and partially melted. - One wooden spoon partially burnt. - One white plastic spoon used to serve rice was discolored and peeling. - One stainless steel whisk with greenish-gray rubber handle was observed burnt and worn out.The DSS acknowledged the above findings and stated old and worn-out kitchen utensils should have been discarded and replaced for infection control purposes. 2. Review of the facility's P&P titled Cleaning Schedule undated showed good sanitation practices shall be established and enforced. All kitchen areas and equipment should be kept clean. In addition, further review of the facility's P&P titled Sanitation and Infection Control: Sanitizing Equipment, Food and Utility Carts (undated) showed all equipment should be sanitized to prevent the spread of disease and infection. All kitchenware equipment and surfaces which come in contact with food will be cleaned and sanitized before use. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 1/14/26 at 0803 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS:- One stainless steel scoop with cream handle had dry, sticky residue and watermarks.- One stainless steel scoop with yellow handle had dry, crusted residue. - One stainless steel dough cutter with black handle had dry residue and watermarks. - One white plastic grater had black residue in between the blade. - Three stainless steel tongs had dry, crusted residue and watermarks. The DSS acknowledged the above findings and stated all the dirty and crusted kitchenware should have been washed for infection control purposes. 3. Review of the facility's P&P titled Sanitation and Infection Control: Sanitizing Equipment, Food and Utility Carts (undated) showed all equipment will be air-dried. Use of towels to dry equipment is prohibited. In addition, further review of the facility's P&P titled Sanitation and Infection Control: Dishwashing Procedures (Dish machine) undated showed, allow racks of dishes/ trays/ utensils to air dry. If drying space is not ample for dishes to air dry, use utility carts. Do not use towels to dry dishes. Do not rack and stack wet dishes or trays. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 1/14/26 at 0803 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. One heavy-duty blender used for puree preparation stored on the countertop shelf was observed to be still moist and wet with visible water inside. The DSS verified the findings and stated all kitchen equipment should have been air dried to prevent bacteria growth. 4. Review of the facility's P&P titled Cleaning Schedule undated showed good sanitation practices shall be established and enforced. All kitchen areas and equipment should be kept clean. A cleaning schedule for all kitchen areas and equipment is established. Frequency and procedure for each item are identified. Review of the facility's P&P titled Sanitation and Infection Control: Sanitizing Equipment, Food and Utility Carts (undated) showed all equipment should be sanitized to prevent the spread of disease and infection. All kitchenware equipment and surfaces which come in contact with food will be cleaned and sanitized before use. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 1/14/26 at 0803 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The kitchen microwave on a countertop shelf was observed to be dirty with dry food residue inside the microwave. The DSS verified the findings and stated it should have been cleaned for infection control purposes.

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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, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure the infection control practices were maintained in the facility's laundry room when a facility staff's personal clothing was stored in the clean laundry storage area. * The facility failed to ensure the water management program was established and implemented to include the specific implementation of measures to prevent the growth of Legionella (type of bacteria that is naturally found in [NAME] environments) and other opportunistic pathogens; and a way to monitor the measures the facility had in place. * LVN 5 failed to perform hand hygiene after picking up Resident 64's bed remote from the floor. * LVN 4 failed to perform hand hygiene after touching a trash bag. * The facility failed to ensure the materials used to pad the bed side rails of Resident 80 were appropriately disinfected. * LVN 2 placed a bottle of hand sanitizer from the floor back onto a clean area during wound care observation. In addition, LVN 2 failed to perform hand hygiene during the wound care observation. * The facility failed to properly dispose of Resident 4's wound VAC canister. This failure had the potential to result in contamination, increased risk of infection, and compromised resident safety. These failures posed the risk for transmission of disease-causing microorganisms and infections.Findings: 1. Review of the facility's P&P titled Laundry dated 8/2016 showed the linens are handled, stored, processed and transported in such a manner as to prevent the spread of infection. Review of the facility's P&P titled Laundry Department (undated) showed careful precautionary procedures must be followed by laundry personnel to prevent the spread of the infectious disease to other staff members, residents and visitors. On 1/15/26 at 0832 hours, an observation of the laundry area and concurrent interview was conducted with the Maintenance Director. A laundry staff's personal clothing was observed stored in the rack of the clean linen area with clean linens. The Maintenance Director verified the findings and stated the laundry staff should not have stored their personal clothing in the rack of the clean linen area with clean linens. 2. According to the CDC's guidelines for Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings dated 9/30/25, control measures and limits should be established for each control point. You will need to monitor to ensure your control measures are performing as designed. Control limits, in which a chemical or physical parameter must be maintained, should include a minimum and a maximum value. Examples of chemical and physical control measures and limits to reduce the risk of Legionella growth: Water quality should be measured throughout the system to ensure that changes that may lead to Legionella growth (such as a drop in chlorine levels) are not occurring, water heaters should be maintained at appropriate temperatures, decorative fountains should be kept free of debris and visible biofilm, disinfectant and other chemical levels in cooling towers and hot tubs should be continuously maintained and regularly monitored. Surfaces with any visible biofilm (i.e., slime) should be cleaned. Under the section Your Program, the team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program is being implemented as designed. This step is called verification. Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program effectively controls the hazardous conditions throughout the building water systems. This (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	step is called validation. Review of the facility's P&P titled Legionnaire's Disease (Legionella Pneumophila) dated 6/2017 showed it was the policy of the facility to have plan for the prevention of the legionnaire's disease, recognize the signs and symptoms of the disease, test as appropriate with a physician's order and report confirmed cases to the local and state health department. Under the section Process to Develop, a water management program showed the facility will determine risk areas by completing the building water system process flowchart and implement controls and indicate where these controls are located by completing the control area monitoring flowchart. During routine inspections of control area, the facility will attempt to reduce areas of concern with the specific plan that has been developed. Preventative maintenance plans have been developed for each control area. Review of the facility's Building Water System Process Flowchart identified conditions that could allow bacteria to spread within the water system. Further review of the flowchart showed that the section on control area monitoring and potential monitoring recommends: Visual inspections Checking disinfectant levels Checking water temperature Monitoring representative fixtures located both near and far from the central distribution point However, the flowchart did not specify what should be inspected during visual inspections, the acceptable range for disinfectant levels, and the acceptable range for water temperature. On 1/15/26 at 1030 hours, an interview was conducted with the Maintenance Director. When asked what the facility was doing to prevent the growth of Legionella in the facility's water system, the Maintenance Director stated she checked the water temperature. The Maintenance Director was unable to verbalize what the acceptable range for the water temperature was to prevent growth of the Legionella. The Maintenance Director verified the facility did not test for Legionella on a regular basis. The Maintenance Director was unable to show the specific control measures that the facility was using to prevent the growth of Legionella bacteria in the facility. On 1/21/26 at 0856 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 1/16/26 at 0830 hours, a medication administration observation was conducted with LVN 5. LVN 5 was observed going to Resident 64's bed, then picking up Resident 64's bed remote from the floor. LVN 5 proceeded to administer Resident 64's medications without performing hand hygiene after picking up the bed remote from the floor. On 1/16/26 at 0940 hours, an interview was conducted with LVN 5. LVN 5 verified she did not perform hand hygiene after touching Resident 64's bed remote she picked up from the floor and prior to administering Resident 64's medications via GT. 4. a. On 1/20/26 at 0910 hours, a medication administration observation was conducted with LVN 4 for Resident 29. LVN 4 was observed touching the trash bag on the medication cart and then (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	proceeded to prepare the medications for Resident 29, without performing hand hygiene in between. b. On 01/20/26 at 1000 hours, a medication administration observation was conducted with LVN 4 for Resident 61. LVN 4 was observed touching the trash bag on the medication cart and then proceeded to prepare the medications for Resident 61, without performing hand hygiene in between. On 01/20/26 at 1021 hours, an interview was conducted with LVN 4. LVN 4 verified she did not perform hand hygiene after touching the trash bag on the medication cart and before preparing the medications for Residents 29 and 61. 5. On 1/15/26 at 1151 hours, an observation was conducted for Resident 80. Resident 80 was observed in bed sleeping. Resident 80 had bilateral lower side rails covered with a black foam padding, which was secured with black tape. The tape appeared to be worn and frayed at the edges. On 1/16/26 at 1023 hours, a follow up observation was conducted for Resident 80. Resident 80 was observed in bed with the bilateral lower side rails covered with a black foam padding, which was secured with black tape. The tape did not appear to have been changed since the previous observation. On 1/16/26 at 1025 hours, an interview was conducted with LVN 6. LVN 6 stated Resident 80 was very combative and frequently kicked and swung his legs out so the black foam on the lower side rails was used to protect the resident from injury. LVN 6 stated the maintenance department was responsible for placing the foam on the side rails. On 1/20/26 at 0922 hours, an interview was conducted with the DON. The DON stated the foam was in place for Resident 80 because he dangled and swung his legs over the side rails and was at a high risk for skin injuries. The DON stated the maintenance department was responsible for managing the foam on the side rails. Medical record review for Resident 80 was initiated on 1/20/26. Resident 80 was readmitted to the facility on [DATE]. Review of Resident 80's H&P examination dated 1/19/26, showed Resident 80 had the capacity to understand and make decisions. On 1/20/26 at 1012 hours, an interview was conducted with the Subacute Manager. The Subacute Manager stated the foam on the lower side rails for Resident 80 was used to prevent his skin from getting injured since he dangled his legs over the side rails. The Subacute Manager stated the maintenance department were responsible for the cleaning of the foam, according to the posted cleaning schedule on the board in Subacute Hallway 1. On 1/20/26 at 1028 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the housekeeping staff used a special wipe to clean the foam padding. The Maintenance Director stated the foam padding came from Home Depot and the tape was just a heavy-duty tape and not medical grade. The Medical Director retrieved a bottle of Oxivir cleaning wipes and stated those were the wipes used to clean the foam padding. Review of the Oxivir cleaning wipes label showed the wipes were appropriate for disinfecting hard, non-porous surfaces and were suitable for high-touch areas in healthcare. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/20/26 at 1034 hours, an interview was conducted with the IP. The IP stated she was aware of the use of the black foam padding for the side rails but did not have any further information regarding what type of foam was used or what cleaning requirements were needed for the foam. On 1/20/26 at 1109 hours, a follow-up interview was conducted with the IP. The IP stated she verified the foam was made by Everbilt and was purchased at Home Depot. The IP verified the foam was not medical grade foam and was not considered a hard surface. The IP stated she had not verified if the Oxivir wipes were appropriate for disinfecting the Everbilt foam. The IP stated the tape used to secure the foam was also not a hard surface and when tape was used, it could leave residue and trap bacteria. The IP verified the Everbilt foam and black tape were not hard surfaces and that the Oxivir wipes were not appropriate for disinfecting those surfaces. Review of the manufacturer's site of Everbilt Foam Pipe Insulation showed it is designed for insulating pipes and is fire-rated for safety. It is not specified for medical grade. It's primarily for protecting pipes from freezing or condensation and improving energy efficiency. On 1/21/26 at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 6. a. Review of the facility's P&P titled Hand Hygiene revised 7/2019 showed all staff members perform hand hygiene before and after direct resident care and after contact with potentially contaminated substances. On 01/16/26 at 0945 hours, a wound care treatment observation was conducted with LVN 2 for Resident 6. LVN 2 was observed wheeling a bedside table containing wound care treatment supplies (normal saline in a cup, paper tape, gloves, alcohol pads, gauze sponge) and a container of hand sanitizer on top of the bedside table. While LVN 2 was moving the bedside table, the bottle of hand sanitizer dropped on the floor. LVN 2 then proceeded to pick up the bottle of hand sanitizer and placed it back on the bedside table, where the wound care treatment supplies were set up. LVN 2 then stepped out of the room and verified he should not have placed the bottle of hand sanitizer back on the table with the wound care treatment supplies for infection control purposes. b. On 01/20/2026 from 0907 to 0945 hours, a wound care treatment observation was conducted with LVN 2 for Resident 4. The following was observed:- LVN 2 changed his gloves after performing the wound care treatment to Resident 4's sacrococcyx wound without performing hand hygiene between the glove changes.- LVN 2 donned on a pair of gloves prior to the wound care treatment, touched the wound VAC (medical device that applies gentle suction to chronic or severe wounds to speed up healing) bag, enteral feeding pump, and bed remote with the gloved hands, and then proceeded with the wound care treatment without performing hand hygiene and changing gloves.- After the wound care treatment, LVN 2 touched two scissors, including one used during the procedure, with his bare hands and placed them on top of the treatment cart.- LVN 2 failed to sanitize the bedside table used during the wound care treatment. On 01/20/26 at 1637 hours, an interview was conducted with the DON. The DON stated it was the policy of the facility that all the staff members performed hand hygiene before and after direct contact with potentially contaminated substances. c. On 1/20/25 at 0945 hours, an observation for Resident 4 was conducted with LVN 2. LVN 2 removed Resident 4's wound VAC canister containing approximately 25 ml of red to brown drainage, placed it inside a plastic bag on the bed, and disposed of the bag in regular trash. On 1/20/25 at 1000 hours, an interview was conducted with LVN 2. LVN 2 acknowledged they disposed of Resident 4's wound VAC canister in the regular trash. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/20/25 at 1345 hours, an interview was conducted with LVN 1. LVN 1 stated they felt confident in providing wound care, including the use of a wound VAC.

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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 interview, medical record review, and facility P&P review, the facility failed to appropriately obtain consent for the psychotherapeutic medication for one of five final sampled residents (Resident 12) reviewed for unnecessary medications. * Resident 12 was self-responsible, however, the facility obtained the informed consent for the use of the amitriptyline HCl (hydrochloride) (an antidepressant medication) from Family Member 1. This failure resulted in the resident not being provided the adequate information and the right to decline consent for a psychotherapeutic medication. Findings: Review of the facility's P&P titled Psychotropic Drug Treatment revised 9/2017 showed the resident or their representative will be given information regarding the need for, the desired effects, and the potential side effects of the medication to enable the resident/representative to make an informed consent. The resident or their representative should be involved in the medication management process and aware of the benefits and risks of medications and the treatment goals. Review of the facility's P&P titled Informed Consent revised 4/2024 showed the following:-The attending physician, PA, or NP, must obtain informed consent of the resident or their Responsible Party for the psychotherapeutic medications. -The facility shall verify the informed consent was obtained prior to the administration of the psychotherapeutic medications. - The rational, duration of therapy, side effects and significant risks, and the resident's right to refuse the treatment are material in making the decision Medical record review for resident 12 was initiated on 1/14/26. Resident 12 was readmitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 10/20/25, showed the resident had the capacity to understand and make decisions. Review of Resident 12's admission Record showed the resident was the responsible party. Review of Resident 12's Order Summary Report showed a physician's order dated 10/20/25, for amitriptyline HCl 10 mg by mouth at bedtime, Review of Resident 12's Informed Consent dated 10/20/26, for amitriptyline HCl capsule, 10 mg by mouth at bedtime showed the prescriber discussed the rationale, duration of therapy, side effects and significant risks, the resident's right to refuse the treatment, and consent was obtained over the telephone with Family Member 1. On 1/20/26 at 0853 hours, an interview and concurrent record review for Resident 12 was conducted with the DON. The the DON stated the process for psychotherapeutic medications' informed consent was the prescriber obtained consent form the resident if they had the capacity, and if the resident did not have capacity, then from their Responsible Party. The DON reviewed Resident 12's admission Record, H&P, and Informed Consent and verified the resident had the capacity to make their own decisions, and the informed consent should have been obtained from the resident, not Family Member 1.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure two of eight LVNs (LVNs 4 and 5) provided services meeting professional standards. * LVNs 4 and 5 placed their stethoscopes on the residents' abdominal area when auscultating for the residents' GT placement. This failure posed the risk of the residents not receiving appropriate care.Findings: According to Skills in Clinical Nursing 6th edition, when auscultating for enteral tube placement, the stethoscope is to be placed over the resident's epigastrium area. 1. On 1/20/26 at 0910 hours, a medication administration observation was conducted with LVN 4. LVN 4 was observed placing her stethoscope to Resident 29's right lower abdominal area. Per LVN 4, she was auscultating for the sounds to check Resident 29's GT placement. Medical record review for Resident 29 was initiated on 1/20/26. Resident 29 was readmitted to the facility on [DATE]. Review of Resident 29's H&P examination dated 5/23/25, showed Resident 29 had no capacity to understand or make decisions. Resident 29's diagnoses included diabetes and post status GT placement. On 1/20/26 at 1021 hours, an interview was conducted with LVN 4. LVN 4 verified and acknowledged the above findings. 2. On 1/16/26 at 0830 hours, a medication administration observation for Resident 64 was conducted with LVN 5. LVN 5 was observed placing her stethoscope approximately four inches to one side of Resident 64's belly button. Per LVN 5, she was auscultating for the sounds to check Resident 64's GT placement. On 1/16/26, at 0940 hours, an interview was conducted with LVN5. LVN 5 verified and acknowledged the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the proper pressure ulcer precautions and interventions were provided for four of four final sampled residents (Residents 4, 11, 37, and 94) reviewed for pressure ulcer. * The facility failed to ensure the LAL mattress settings were consistent with Resident 11, 37, and 94's weights. This failure had the potential for the residents to not benefit from the therapy provided by the LAL mattress.Findings: Review of the facility's P&P titled Low Air Loss Mattress date revised 3/2017 showed it is the policy of the facility to provide for the proper placement and management of a low air loss mattress when utilized by a resident. a. On 1/15/26 at 1608 hours, during an observation, Resident 11 was positioned on his back and lying on a LAL mattress with the normal pressure level set at 300 lbs. Medical record review for Resident 11 was initiated on 1/15/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's H&P examination dated 9/9/25, showed Resident 11 had no capacity to understand and make decisions. Review of Resident 11's Order Summary Report showed a physician's order dated 11/18/25, for LAL mattress for skin maintenance. May adjust to comfortable setting according to resident's body weight every shift. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 had memory problems and severely impaired cognitive skills for daily decision making. Further review of the MDS showed Resident 11 was dependent on staff for his activities of daily living. Review of Resident 11's Weights and Vitals Summary dated 1/6/26, showed Resident 11 had a weight of 118 lbs. On 1/20/26 at 1408 hours, an interview was conducted with CNA 3. CNA 3 stated the LAL mattress was checked by the licensed nurses and maintenance. Furthermore, CNA 3 added the LAL mattress setting was based on the resident's weight. On 1/15/26 at 1646 hours, an observation of Resident 11 and concurrent interview was conducted with LVN 7. LVN 7 verified the LAL mattress was set at 300 lbs. and should have been based on the resident's weight. LVN 7 stated the LAL mattress was monitored by the licensed nurses at the start and at the end of their shift. LVN 7 stated an incorrect setting could cause a potential risk for skin issue. On 1/21/26 at 0940 hours, an interview and concurrent medical record review for Resident 11 was conducted with the Subacute Manager. The Subacute Manager acknowledged the findings and stated the purpose of the LAL mattress was for pressure injury prevention and to help the resident with pressure injury. The Subacute Manager stated the LAL mattress setting was based on the resident's body weight and an incorrect setting could potentially create more problems than benefit for the resident. The Subacute Manager further stated it was the responsibility of the licensed nurses to check the LAL mattress setting every shift and as needed. On 1/21/26 at 1106 hours, an interview and concurrent medical record review for Resident 11 was conducted with the ADON. The ADON verified the findings and stated the purpose of the LAL mattress was to prevent pressure injury. The ADON stated the setting was based on the resident's body weight and doctor's orders. b. On 1/14/26 at 1104 hours, during the initial tour of the facility, Resident 37 was positioned on his back and lying on a LAL mattress with the normal pressure level set at 120 lbs. On 1/15/26 at 1555 hours, Resident 37 was positioned on his back and lying on a LAL mattress with the normal pressure level set at 120 lbs. Medical record review for Resident 37 was initiated on 1/15/26. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37's MDS assessment dated [DATE], showed Resident 37 had memory problems and had severely impaired cognitive skills for daily decision making. Further review of the MDS showed Resident 37 was dependent on the staff for his activities of daily living. Review of Resident 37's care plan for pressure injury dated 12/2/25, showed interventions including to utilize the LAL mattress. Review of Resident 37's H&P examination dated 12/3/25, showed Resident 37 had no capacity to understand and make decisions. Review of Resident 37's Weights and Vitals Summary dated 1/13/26, showed Resident 37 weighed 100 pounds. Review of Resident 37's Order Summary Report showed a (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order dated 1/16/26, for LAL mattress for skin and wound management. Comfortable bed setting based on resident's weight. Check for proper setting and function every shift. On 1/21/26 at 0814 hours, an interview and concurrent medical record review was conducted with the Subacute Manager. The Subacute Manager acknowledged the findings. c. On 1/14/26 at 1140 hours, during the initial tour of the facility, Resident 94 was positioned on her back and lying on a LAL mattress with the normal pressure level set at 350 lbs. On 1/15/26 at 1620 hours, Resident 94 was positioned on her back and lying on a LAL mattress with the normal pressure level set at 350 lbs. Medical record review for Resident 94 was initiated on 1/15/26. Resident 94 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 94's care plan for pressure injury dated 11/10/25, showed interventions including to utilize the LAL mattress. Review of Resident 94's H&P examination dated 11/11/25, showed Resident 94 had no capacity to understand and make decisions. Review of Resident 94's Order Summary Report showed a physician's order dated 11/18/25, for LAL mattress for wound management. Review of Resident 94's MDS assessment dated [DATE], showed Resident 94 had memory problems and had severely impaired cognitive skills for daily decision making. Further review of the MDS showed Resident 94 was dependent on staff for her activities of daily living. Review of Resident 94's Weights and Vitals Summary showed on 1/13/26, Resident 94 had the weight of 199 pounds. On 1/21/26 at 0915 hours, an interview and concurrent medical record review was conducted with the Subacute Manager. The Subacute Manager verified the findings.

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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, medical record review, and facility P&P review, the facility failed to provide the necessary GT (delivery of nutrients through a feeding tube directly into the stomach, duodenum (first part of small intestine), or jejunum (middle part of the small intestine) care and services for two of two final sampled resident (Residents 29 and 83) reviewed for enteral feeding care. * The facility failed to ensure Resident 83 was administered the total amount of enteral feeding as ordered by the physician. In addition, the facility failed to ensure physician order for enteral feeding was complete. * The facility failed to ensure the tubing for Resident 29's GT feeding and water flush was not expired. These failures posed the risk for the resident to develop complications related to GT.Findings: 1. Review of the facility's P&P titled Enteral Tube Medication Administration dated [DATE] showed the facility assures the safe and effective administration of enteral formulas and medication via enteral tubes. Selection of enteral formulas, routes and methods of administration, and the decision to administer medication via enteral tubes are based on nursing assessment of the resident's condition, in consultation with the physician and dietitian. Further review of the P&P dated enteral formulas , equipment, route of administration, and flow rate are selected based on an assessment of the resident condition and need Review of the facility P&P titled Physician Services and Orders dated 1/2017 showed the orders for the medication must include: * Name and strength of the drug; * quantity or specific duration of therapy; * dosage and frequency of administration; * route of administration if other than oral; and, * reason or problem for which it is given. Medical record review for Resident 83 was initiated on [DATE]. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's H&P examination dated [DATE], showed Resident 83 had no capacity to understand and make decisions. Review of Resident 83's MDS dated [DATE], showed Resident 83 had moderate cognitive impairment. Review of Resident 83's Order Summary Report showed following enteral feed orders: * dated [DATE], for enteral feed to provide 660 ml per 990 kcal of Isosource (a brand of calorically dense, nutritionally complete tube feeding formulas) 1.5 formula via GT. Further review of the above order did not show specific amount of formula to be administrated per hour. * dated [DATE], for enteral feed to administer via kangaroo pump and to infuse 50 ml per hour over (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12 hours or until volume limit is completed. To start at 1900 hours until dose is complete. * dated [DATE], for water flush to administer via kangaroo pump at 50 ml per hour over 12 hours or until volume limit is completed. To start at 1900 hours until dose is complete. Review of Resident 83's Care Plan dated [DATE], showed Resident 83 required GT feeding secondary to failure to thrive. The intervention included to administer GT feeding Isosource 1.5 formula at 55 ml per hour for 12 hours. Review of Resident 83's Nutritional assessment dated [DATE], showed the RD monthly notes to continue on Isosource 1.5 at 55 ml for 12 hours, which is 990 kcal in 660 ml. Review of Resident 83's Weekly Summary dated 1/7, [DATE], 12/31, 12/24, [DATE], 11/12, and [DATE], showed the GT feeding Isosource 1.5 for Resident 83 was being administered at 50 ml per hour. On [DATE] at 0940 hours, on [DATE] at 1100 hours, [DATE] at 0853 hours, Resident 83 was observed lying in her bed. Resident 83's lips was observed to be dry. On [DATE] at 1515 hours, an observation and concurrent interview was conducted with Resident 83. Resident 83 was observed lying on her bed. Resident 83's lips was not observed to be dry. Feeding tube Isosource 1.5 kcal and water flush bag with kangaroo pump was observed to be hanging on the left side of Resident 83's bed. Feeding tube was not observed to be connected to Resident 83. Label on the feeding tube showed the feeding was started on [DATE] at 0300 hours, at 50 ml per hour rate. An interview was conducted with Resident 83, translated (Korean to English) by the facility's Hospitality Staff. When asked Resident 83, if she felt thirsty, she stated no and stated she was ok. Resident 83 stated her lips usually gets dry and she had to put Chapstick on it. Resident 83 stated sometimes she forgets to put Chapstick on her lips. On [DATE] at 1525 hours, an observation and concurrent interview and medical record review for Resident 83 was conducted with the ADON. The ADON stated physician order for enteral feeding should specify hourly rate for the enteral feeding and enteral feeding should be administered as per the physician order. The ADON stated if the enteral feeding order was not specific then physician should be called for clarification of the order. The ADON verified enteral feeding hanging on the side of Resident 83 showed label on the feeding was 50 ml per hour. The ADON reviewed the records and stated physician order for enteral feeding Isosource 1.5 kcal 660 ml/990 cal did not specify hourly rate for the feeding. The ADON was observed calculating the rate from the enteral feed order and stated the feeding should be administered 55 cc per hour not 50 cc per hour. The ADON stated staff should have clarified the physician order for enteral feeding with the physician. On [DATE] at 0856 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 29 was initiated on [DATE]. Resident 29 was readmitted to the facility on [DATE]. Review of Resident 29's H&P examination dated [DATE], showed Resident 29 had no capacity to understand and make decisions. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1041 hours, during the initial tour of the facility, Resident 29 was observed in bed with a GT feeding connected but not turned on. The GT feeding formula and water flush bags were dated for [DATE] at 2330 hours. On [DATE] at 1025 hours, during a second tour of the facility, Resident 29 was observed in bed with a GT feeding connected but not turned on. The GT feeding formula and water flush bags were dated for [DATE] at 2330 hours. On [DATE] at 1030 hours, an interview and concurrent observation of Resident 29 was conducted with the ADON. The ADON stated the GT feeding formula and water flush bags should be changed every 24 hours. The ADON stated the GT feeding formula and water flush bags were expired and should have been thrown away when the feeding was complete. On [DATE] at 1058 hours, an interview was conducted with the DON. The DON stated the formula bags were left up until the GT feeding formula was fully consumed then the nurse should throw everything away and replace the bags and tubing when the next feeding was due. On [DATE] at 1109 hours, an interview was conducted with the ADON. The ADON stated the facility policy states the tubing and GT feeding formula was good for 48 hours as long as it was closed system. The ADON stated the tubing the facility was using was not really a closed system because the water flush bag was an open-system. The ADON stated they should be changing everything every 24 hours, but they were treating it like a closed system. On [DATE] at 1145 hours, an observation was conducted of the GT feeding tubing manufacturer's packaging. The Cardinal Health, Kangaroo Omni Feeding Set with Flush Bag and Enplus Spike, showed Not made with natural rubber latex. Not made with DEHP. Do not use for greater than 24 hours. On [DATE] at 1229 hours, an interview was conducted with LVN 3. LVN 3 verified the GT feeding tubing manufacturer's packaging showed to not use for greater than 24 hours. On [DATE] at 1445 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of five final sampled residents (Resident 73) reviewed for respiratory care. * The facility failed to ensure Resident 73's nebulizer mask was stored properly. This failure had the potential to affect the respiratory health and well-being of the resident in the facility.Findings: Review of the facility's P&P titled Administering Medication through a Nebulizer or Mask dated 8/2025 showed the following:- The purpose of this procedure is to safely, and with good infection control practice, administer aerosolized particles of medication to the resident's airway,- When treatment is complete, rinse and disinfect the nebulizer equipment, cleanse with soap and water, allow equipment to airdry or utilize a paper towel, and- Once equipment is dry, store it in a plastic bag with the resident's name and the date on it. Medical record review for Resident 73 was initiated on 1/16/26. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's H&P examination dated 12/15/25, showed Resident 73 had the capacity to make decisions. Review of Resident 73's Order Summary Report dated 1/16/26, showed a physician's order dated 12/19/25, for albuterol sulfate (bronchodilator medication) 2.5 mg/3 ml solution, give one unit orally every four hours as needed for SOB, administer orally via hand held nebulizer. On 1/14/26 at 1034 hours, during the initial tour of the facility, Resident 73 was not in her room. The nebulizer mask connected to a tubing was observed lying in Resident 73's basin with other items on the nightstand. The tubing was dated 1/9/26. On 1/15/26 at 0856 hours, another observation was conducted for Resident 73. Resident 73 was observed asleep in her bed. The nebulizer mask connected to a tubing was observed lying in Resident 73's basin with other items on the nightstand. On 1/15/26 at 0901 hours, a follow-up observation for Resident 73 and concurrent interview was conducted with the ADON. The ADON verified the nebulizer mask should not be lying in the Resident 73's basin at bedside and should be in a dedicated bag so it can be closed up and stored. The ADON stated leaving the mask out can cause contamination and harbor bacteria. On 1/16/26 at 1032 hours, an interview was conducted with RT 1. RT 1 stated once the respiratory treatment was completed, the nebulizer mask should be stored in a bag with the resident's name and date. RT 1 stated it is not appropriate to store a nebulizer mask in the resident's basin at bedside and it should be in a bag. RT 1 stated the mask was exposed to germs and would replace the mask, tubing, and bag if she found a resident's nebulizer mask stored in the basin at the bedside. On 1/16/26 at 1047 hours, an interview was conducted with the IP and DON. The IP stated once the nebulizer treatment was complete, the nurse was required to wash the equipment with soap and water and allow to airdry with a barrier in place like a paper towel. Once the equipment is dry the nurse has to place the nebulizer in the dedicated bag for the resident. The IP stated it is not appropriate to store the nebulizer mask in the basin at the bedside, especially without a barrier in place. The IP stated if she found a nebulizer mask stored in the resident's basin at the bedside without a barrier in place, she would replace everything because there is a risk of contamination. The DON acknowledged the above findings.

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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 medical record review, the facility failed to ensure medication error rate was below 5%. * LVN 5 used dissolved Miralax to dissolve and flush Resident 64's medications. * LVN 4 did not administer ascorbic acid to Resident 29 as ordered. * LVN administered multiple drops to Resident 76, however, the physician's order was to instill one drop to each eye. These failures posed the risk of the residents not receiving their medications as prescribed. Also, these failures resulted in medication error rate of 7.41%.Findings: 1. a. On 1/16/26 at 0830 hours, a medication administration observation was conducted with LVN 5. LVN 5 was observed preparing and administering medications, including the following, for Resident 64: one tablet acidophilus (probiotic)one tablet of calcium carbonate (antacid) 500 mg10 ml lacosamide (anticonvulsant)30 ml lactulose (laxative)one tablet lisinopril (antihypertensive) 5 mgone capful of Miralax (laxative) powder dissolved in eight ounces of waterone tablet of multivitamin with minerals (supplement) LVN 5 was observed using dissolved Miralax powder to dissolve and to flush Resident 64's medications into the GT. During this medication observation, LVN 5 was observed pouring Resident 64's lacosamide into Resident 64's syringe. LVN 5 was then observed pouring dissolved Miralax powder into Resident 64's GT. The two medications formed two separate layers, not blending, in Resident 64's syringe. On 1/16/26 at 0940 hours, an interview was conducted with LVN 5. LVN 5 verified the above findings. Medical record review for Resident 64 was initiated on 1/16/26. Resident 64 was readmitted to the facility on [DATE]. Review of Resident 64's H&P dated 11/3/25, showed Resident 64's diagnoses included history of GT dislodgement, post status GT replacement, seizure, history of coffee ground vomit, and stroke. Resident 64 had no capacity to understand and make decisions. Review of Resident 64's January 2026 Order Summary Report showed an order dated 11/1/25, to flush Resident 64's GT with 30 ml of water before administering medications and 10 ml of water in between each medication. On 1/16/26 at 940 hours, LVN 5 verified the above findings. When asked why LVN 5 used dissolved Miralax powder to flush medications into Resident 64's GT, LVN 5 was unable to explain. b. On 1/20/26, at 0910 hours, a medication administration observation for Resident 29 was conducted with LVN 4. LVN 4 was observed preparing and administering the following medications for Resident #29: 30 ml Prostat one tablet of chewable 81 mg aspirin (medication used for analgesics (pain relievers), antipyretics (fever reducers), anti-inflammatories (inflammation reducers), and platelet aggregation inhibitors (anticlotting agents),15 units of Basaglar injection (antidiabetic medication)one capsule of cefdnir (antibiotic) 300 mg one tablet of cranberry (supplement) 450 mgone tablet of docusate sodium (stool softener) 100 mgone tablet Eliquis (anticoagulant) 2.5 mgone tablet of lactobacillus (probiotic)one tablet metoprolol (antihypertensive) 25 mgone tablet midodrine (used to treat orthostatic hypotension) 10 mgone tablet of Geri-kot (laxative) 8.6 mg LVN 4 was observed crushing all medications to administer to Resident 29. The above medications were verified with LVN 4. Medical record review for Resident 29 was initiated on 1/20/26. Resident 29 was readmitted to the facility on [DATE]. Review of Resident 29's H&P exam dated 5/23/25, showed Resident 29 had no capacity to understand and make decisions. Review of Resident 29's January 2026 Order Summary Report showed an order dated 4/20/24, for ascorbic acid (supplement) 500 mg/5 ml, to give 5 ml twice daily for wound management. Review of Resident 29's January 2026 MAR showed Resident 29 was administered ascorbic acid at 0900 hours on 1/20/26 On 1/20/26, at 1354 hours, an interview was conducted with LVN 4. LVN 4 was informed she did not include ascorbic acid during the medication administration observation. c. On 1/14/26, at 1630 hours, a medication administration observation for Resident 76 was conducted with LVN 7. LVN 7 was observed administering multiple eye drops into both of Resident 76 eyes. On 1/14/26 at 1650 hours, an interview was conducted with Resident 76. Resident 76 stated she wanted and needed multiple eye drops in both her eyes because the eye drops helped her see. When asked how often multiple eye drops were instilled into her eyes, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 76 verbalized she was scheduled to get eye drops every hour, daily but staff could not always administer the drops on the hour. Medical record review for Resident 76 was initiated on 1/20/26. Resident 76 was readmitted to the facility on [DATE]. Review of Resident 76's H&P exam dated 12/21/25, showed Resident 76's diagnoses included diabetes, anxiety disorder, and bipolar disorder. Resident 76 had a left eye prosthesis. Resident 76 had the capacity to understand and make decisions. Review of Resident 76's January 2026 Order Summary Report showed an order dated 12/19/25, for Refresh eye drops, instill one eye drop into each eye every hour for severe dry eyes. On 1/14/26 at 1700 hours, concurrent interview and medical record review was conducted with LVN 7. LVN 7 verified he administered multiple eye drops into Resident 76's eyes and that Resident 76 had an order for one drop of the medication to be administered into each eye. LVN 7 verbalized Resident 76 requested the multiple eye drops. When asked if Resident 76's physician had been notified of this change in administration of the medication, LVN 7 stated he verbally discussed this with Resident 76's physician. LVN 7 acknowledged there was no order to administer multiple eye drops to the resident. The LVN verified the findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medications were stored securely and maintained in a cleanable condition for three of six medication carts. * Medication Cart 1 contained a UTI stat liquid medication without an expiration date. * The Subacute Treatment cart was observed left unlocked and unattended. * Medication Cart 1 had two areas of layered paper tape on a cracked drawer front, creating a non-cleanable surface. These failures had the potential to result in contamination of medications and unauthorized access, which could lead to the medication errors or harm to the residents.Findings: 1. On 1/16/26 at 0830 hours, a medication preparation observation for Resident 64 was conducted with LVN 5. LVN 5 retrieved a bottle of UTI-Stat Oral liquid from Medication Cart 1. LVN 5 verified the medication did not have an expiration date written. LVN 5 stated she would hold the medication because the medication did not have an expiration date on it. 2. On 1/16/26 at 0945 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 left the treatment cart outside Resident 6's room, facing the door. The treatment cart was unlocked. The treatment cart was left in the hallway, which was a high-traffic area where other staff and residents were observed walking and passing through. The treatment cart contained medications, including Santyl ointment and normal saline. LVN 2 verified the treatment cart was unlocked and unattended when they went inside Resident 6's room to provide treatment. LVN 2 further stated it should have been locked. 3. On 1/20/26 at 1012 hours, an inspection of Medication Cart 1 was conducted with LVN 1. The cart had eight drawers with drawer pulls. One drawer pull for a drawer filled with medication had two areas with layered paper tape. LVN 1 stated the drawer pull was cracked underneath the taped areas. On 1/20/26 at 1105 hours, a follow up observation and concurrent interview was conducted with LVN 1. LVN 1 stated she was unaware of when the drawer pull broke, and pointed to a container of Clorox Healthcare Germicidal Wipes and stated they were used to disinfect the medication carts. The container of Clorox Healthcare Germicidal Wipes showed it was for use on hard, nonporous surfaces. LVN 1 verified the paper tape was not a hard, nonporous surface.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary hospice care and services for one of two final sampled residents (Resident 30) reviewed for hospice services. * The facility failed to ensure Hospice A was notified when the medications listed in Hospice A medication list were discontinued for Resident 30. * The facility failed to ensure the complete documentation of the hospice staff visits were available for Resident 30, and if Hospice A staff visited Resident 30 as scheduled in the Hospice A calendar. These failures posed the risk for the delay in communication and provision of the hospice care between the hospice provider and facility.Findings: Review of the facility's P&P titled Hospice Services dated 1/2017 showed when a resident participates in the hospice program, a coordinated plan of care between the facility , the hospice agency and resident/responsible party should be developed and should include directive for managing pain and other uncomfortable symptoms. The care plan should be revised and updated as necessary to reflect the residents' status. Further review of the P&P showed the hospice and the facility should communicate with each other when any changes are indicated or made to the plan of care. 1. Medical record review for Resident 30 was initiated on 1/15/26. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's H&P examination dated 12/28/26, showed Resident 30 had no capacity to understand and make decisions. Review of Resident 30's Hospice A Current Treatment/Medication/DME (Durable Medical Equipment) list showed the following:- dated 12/26/25, for gabapentin (medication used to treat nerve pain) 100 mg tablet, one tablet by mouth two times a day for nerve pain.- dated 12/26/25, hydromorphone hydrochloride (medication to treat severe pain) 1 mg per ml solution to give 2 mg per 2 ml by mouth sublingual (under the tongue) every four hours as needed for pain management.- dated 12/26/25, for lorazepam (medication to treat anxiety) 2 mg per ml to give 0.5 mg per 0.25 ml by sublingual. Review of Resident 30's Order Summary Report showed the following orders:- dated 1/14/26, for Resident 30 to be admitted to Hospice A on 12/26/25, under the routine level of care.- dated 1/9/26, to transfer service from Physician 1 to Hospice A physician. Further review of the Order Summary Report failed to show physician's orders for the above medications listed in the Current Treatment/Medication/DME list. Review of Resident 30's Discontinued Physician Orders showed the following:- hydromorphone HCL 1 mg per ml was discontinued on 1/2/26 at 1138 hours, reason for discontinued showed Physician 1 spoke with resident representative for Resident 30 and ordered to discontinue the above medication.- gabapentin was discontinued by Physician 1 as per resident representative for Resident 30's request. - Ativan 0.5 mg per 0.25 ml was discontinued on 12/31/25 at 1600 hours, the reason for discontinuation showed the order was clarified from Hospice A nurse. Review of Resident 30's medical record showed the above discontinued medications were electronically signed by Physician 1. Further review of the medical record failed to show if Hospice A physician was notified when the facility discontinued the above medications. On 1/21/26 at 0833 hours, an interview and concurrent medical record review for Resident 30 was conducted with the ADON. The ADON verified the above findings. The ADON reviewed the medical record and verified there was no documented evidence if Hospice A physician was notified when the above listed medication was discontinued by the facility physician. The ADON stated Hospice A physician should have been notified when the medication for the resident who was on hospice was discontinued. 2. Review of Resident 30's Order Summary Report dated 1/14/26, showed the frequency for visits for RN/LVN to visit Resident 30 two times a week, CHHA to visit two times a week, and MSW to visit every two months. Review of Resident 30's Hospice A Calendar showed the following:- For December 2025, Hospice RN to visit Resident 30 on 12/26, 12/27, 12/28, and 12/30/25; and- For January 2026, Hospice RN to visit Resident 30 on 1/3/26, Hospice LVN and CHHA to visit Resident 30 on 1/7, 1/10, 1/14, and 1/17/26. Review of (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 30's Hospice A flowsheet showed entries on 12/26 and12/30/25; and 1/2 and 1/14/26; however, the entries did not have the designation of the staff making the entries. Further review of the flowsheet did not show if Hospice A RN visited Resident 30 on 12/27 and 12/28/25, and 1/2/26; and if Hospice A LVN visited Resident 30 on 1/10 and 1/14/26; and if Hospice A CHHA visited the resident on 1/17/26. On 1/20/26 at 0927 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 30 was receiving hospice services. When CNA 2 was asked how often the hospice CHHA visited Resident 30, CNA 2 stated she has not seen the hospice CHHA visiting Resident 30, and she did not know how often the hospice CHHA visited Resident 30. On 1/20/26 at 1013 hours, an interview was conducted with LVN 5. LVN 5 stated Resident 30 was receiving hospice services. When LVN 5 was asked when Hospice A RN/LVN visited Resident 30, LVN 5 stated Hospice LVN/RN visited Resident 30 twice a week; however, she stated she was not sure about which day of the week they visited Resident 30. On 1/20/26 at 1013 hours, an interview and concurrent medical record review for Resident 30 was conducted with the ADON. The ADON verified the entries on Resident 30's Hospice A flowsheet did not show designation of the staff making the entries on 12/26 and 12/30/25; 1/2 and 1/14/26. The ADON verified the hospice flowsheet did not show if Hospice A RN visited Resident 30 on 12/27 and 12/28/25; and on1/2/26, if Hospice A LVN visited Resident 30 on 1/10 and 1/14/26; and if Hospice A CCHA visited the resident on 1/17/26. The ADON stated the hospice staff should make progress notes every time they visited the resident and clearly documented their designation. On 1/21/26 at 0856 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide the required Medicare beneficiary notices to one of three final sampled residents (Resident 12) reviewed for beneficiaries. * Resident 12 did not receive the Medicare beneficiary notice. This failure resulted in the resident not receiving the notice and right to appeal.Findings: Medical record review for Resident 12 was initiated on 1/14/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's admission Record dated 10/27/25, showed the resident was their own responsible party. Review of Resident 12's H&P examination dated 10/20/25, showed the resident had the capacity to understand and make decisions. Review of Resident 12's Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) form dated and signed on 12/22/25, showed the resident's level of care did not meet the Medicare's coverage requirements and beginning on 12/24/25, the resident may have to start paying out of pocket. Review of Resident 12's Notice of Medicare Non-Coverage form dated and signed on 12/22/25, showed the Medicare will likely not pay for the resident current services at the facility after 12/23/25. The form showed the resident's right to appeal and how to appeal the decision. On 1/20/26 at 1340 hours, an interview and concurrent medical record review was conducted with the Business Office Manager. The Business Office Manager reviewed Resident 12's SNF ABN and the Notice of Medicare Non-Coverage signed and dated 12/22/25, and stated the resident's Family Member 1 signed the form because he was the resident's responsible party. The Business Office Manager reviewed Resident 12's medical records and verified the resident was self-responsible and the resident should have been provided and signed the forms.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to provide privacy during personal care for one of three final sampled residents (Resident 4) reviewed for privacy. * LVN 2 failed to fully close the privacy curtain while providing care to Resident 4. Resident 4's back was exposed from the waist down during the treatment and the resident's door was wide open. This failure exposed Resident 4's body to public view and had the potential to negatively impact the resident's dignity, self-esteem, and sense of self-worth.Findings: On 1/20/26 at 0904 to 0945 hours, an observation of Resident 4 was conducted with LVN 2 in Resident 4's room. LVN 2 provided care to Resident 4 in the coccyx area. The privacy curtain was partially open, and the resident's door remained wide open. During the treatment, Resident 4's buttocks and lower back were exposed from the waist down. On 1/20/26 at 1052 hours, an interview was conducted with LVN 2. LVN 2 acknowledged Resident 4's privacy curtain was partially open and the door was open. LVN 2 verified the above findings.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure an accurate MDS assessment was completed for one of two final sampled residents (Resident 67) reviewed for falls. * The facility failed to code in the MDS assessment Resident 67 had a fall. This failure posed the risk for the resident to not have an individualized plan of care based on the resident's specific needs. Findings: Review of the facility's P&P titled Resident Assessment Instrument (RAI) Process revised April 2017 showed the facility will use the RAI process for the accurate assessment of each resident's functional capacity and health status. Medical record review for Resident 67 was initiated on 1/14/26. Resident 67 was readmitted to the facility on [DATE]. Review of Resident 67's SBAR (Situation, Background, Assessment, Recommendation) Communication Form dated 11/14/25, showed the resident had an unwitnessed fall. Review of Resident 67's Fall Risk Assessment showed the following:- An admission assessment dated [DATE], showed no falls in the past three months. - An assessment dated [DATE], showed the resident had one to two falls in the past three months. Review of Resident 67's MDS assessment dated [DATE], showed the resident had no falls since their readmission or the prior MDS assessment. On 1/20/26 at 1611 hours, an interview and concurrent medical record review for Resident 67 was conducted with the MDS Coordinator. The MDS Coordinator stated he tracked the resident's falls from the daily stand-up meetings, as well as the resident's Fall Risk Assessment and SBAR Communication Forms. The MDS Coordinator reviewed Resident 67's medical record and verified the resident had a fall on 11/14/25, and the MDS dated [DATE], should have been coded to show the resident had a fall.

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F 0644 Level of Harm - Potential for minimal harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to comply with the Level II categorical determination requirements of DHCS as part of the PASRR process for one final sampled resident (Resident 6) reviewed for PASRR. * The facility did not accurately complete the Level I screening following a change in status for Resident 6 who was receiving psychotropic medications. This failure had the potential for the resident to not receive appropriate care and services due to their mental disorder or intellectual disability not being properly identified and evaluated. Findings: Review of the facility's P&P titled PASRR revised 3/2019 showed the facility was to complete a periodic review of PASRR status until the case was closed. Review of Resident 6's PASRR Level I screening dated 2/25/25, showed the resident was receiving Buspar (psychotropic medication) and Doxepin (psychotropic medication). Review of the facility's letter from DHCS dated 2/28/25, showed Resident 6's Level II evaluation could not be completed because facility staff were unresponsive to two or more communication attempts within 48 hours of the Level I screening. On 1/15/26 at 1456 hours, an interview was conducted with the Subacute Manager. The Subacute Manager verified the above findings and stated the failure to complete the Level II evaluation could result in an inability to provide proper care. On 1/16/26 at 1134 hours, an interview was conducted with the DON and ADON. The DON and ADON confirmed Resident 6's PASRR Level I screening should have triggered a Level II evaluation due to the use of psychotropic medications and the diagnosis of serious mental illness. The DON and ADON acknowledged the facility should have followed up accordingly.

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure accurate PASARR Level I screening for one of one final sampled resident (Resident 6) reviewed for PASARR.* Resident 6's PASARR Level 1 screening showed the resident had no serious mental illness, however, Resident 6 was prescribed psychotropic medications. This failure had the potential to prevent appropriate evaluation and services rendered for the residents who had serious mental illness. Findings: Review of the facility's P&P titled PASRR (Preadmission Screening Resident Review) revised in March 2019 showed it is the policy of the facility to screen each resident, regardless of payment source, when applying for admission to, or residing in the facility, which is a Medicaid-certified facility, for mental illness and intellectual disability. The P&P also showed the Level 1 Case List should be reviewed periodically online until the case is resolved. Medical record review for Resident 6 was initiated on 1/14/26. Resident 6 was readmitted to the facility on [DATE]. Review of Resident 6's PASARR Level 1 screening dated 1/16/25, showed the resident was negative for SMI. However, review of Resident 6's H&P examination dated 1/14/25, showed the resident had diagnoses of anxiety and depression. Review of Resident 6's Order Summary Report showed the following physician's orders:- dated 11/14/25, to administer buspirone (antianxiety) HCl 20 mg via GT every eight hours for anxiety manifested by inability to relax.- dated 11/14/25, to administer doxepin (antidepressant) HCl 75 mg via GT every bedtime for depression manifested by excessive scratching of self. On 1/15/26 at 1456 hours, an interview and concurrent medical record review was conducted with the Subacute Manager. The Subacute Manager verified the above findings and stated the resident exhibited combative behaviors, received psychotropic medications and the PASARR Level 1 screening should have been coded as having serious mental illness. On 1/16/26 at 1134 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified the above findings.

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F 0689 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to address the falls for two of two final sampled residents (Residents 30 and 67) reviewed for falls. * The facility failed to ensure the post fall neurological checks were completed for the full 72 hours, as ordered by the physician for Residents 30 and 67. This failure had the potential for the delay in identifying and intervening post-fall neurological changes.Findings: 1. Medical record review for Resident 67 was initiated on 1/14/26. Resident 67 was readmitted to the facility on [DATE]. a. Review of Resident 67's SBAR (Situation, Background, Assessment, Recommendation) Communication Form dated 11/14/25, showed the resident had an unwitnessed fall. Review of Resident 67's physician's order dated 11/14/25, showed to complete the neurological checks per facility protocol due to an unwitnessed fall. Review of Resident 67's Resident Care Plan showed a care plan problem dated 11/14/25, for an actual fall. The interventions included neurological checks per facility protocol. Review of Resident 67's 72 Hours Neuro-Check List initiated on 11/14/25 at 0115 hours, showed for the first 24 hours neurological checks will be done every: 30 minutes for two checks; every hour for three checks; every two hours for two checks; and then every four hours for two checks. However, the above time schedule only went up to 16 hours. The log then showed for the next 48 hours, the neurological checks will be conducted every eight hours for six checks. The template was completed with the first post-fall neurological check on 11/14/25 at 0115 hours, and the last check being completed on 11/16/25 at 1645 hours, for a total of 63.5 hours of neurological checks, and not 72 hours. b. Review of Resident 67's SBAR Communication Form dated 1/1/26, showed the resident had an unwitnessed fall. Review of Resident 67's physician's order dated 1/1/26, showed to complete 72 hours neurological checks. Review of Resident 67's Resident Care Plan showed a care plan problem dated 11/14/25, for an actual fall. The interventions included 72 hour neurological checks. Review of Resident 67's 72 Hours Neuro-Check List initiated 1/1/26 at 1330 hours, showed for the first 24 hours neurological checks will be done every: 30 minutes for two checks; every hour for three checks; every two hours for two checks; and then every four hours for two checks. However, the above time schedule only goes up to 16 hours. The log then showed for the next 48 hours, the neurological checks will be conducted every eight hours for six checks. The template was completed with the first post-fall neurological check on 1/1/26 at 1330 hours, and the last check being completed on 1/4/26 at 0500 hours, for a total of 63.5 hours of neurological checks, and not 72 hours. On 1/20/26 at 1508 hours, an interview and concurrent medical record review for Resident 67 was conducted with the ADON. The ADON stated the neurological checks were conducted for 72 hours for residents who had unwitnessed falls, to identify and act upon potential neurological injury sustained during the fall. The ADON reviewed the above Neuro-Check List and verified the neurological checks were not completed for the full 72 hours, as ordered. On 1/20/26 at 1533 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed a blank Neuro-Check List and verified the neurological checks' scheduled frequency listed on the log was incorrect, and did not result in a full 72 hours. 2. Medical record review for Resident 30 was initiated on 1/14/26. Resident 30 was readmitted to the facility on [DATE]. Review of Resident 30's SBAR Communication Form dated 12/30/25, showed the resident had an unwitnessed fall at 0019 hours. Review of Resident 30's physician's order dated 12/30/25, showed to complete 72 hour neurological checks due to an unwitnessed fall. Review of Resident 30's Resident Care Plan showed a care plan problem dated 12/30/25, for an actual fall. The interventions included 72 hour neurological checks. Review of Resident 30's 72 Hours Neuro-Check List initiated on 12/30/25 at 0019 hours, showed for the first 24 hours neurological checks will be done every: 30 minutes for two checks; every hour for three checks; every two hours for two checks; and then every four hours for two (continued on next page)

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F 0689 Level of Harm - Potential for minimal harm Residents Affected - Some	checks. However, the above time schedule only went up to 16 hours. The log then showed for the next 48 hours, the neurological checks will be conducted every eight hours for six checks. The template was completed with the first post-fall neurological check on 12/30/25 at 0019 hours, and the last check being completed on 1/1/26 at 1549 hours, for a total of 63.5 hours of neurological checks, and not 72 hours. On 1/20/26 at 1050 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 30's post-fall neurological checks were not conducted for the full 72 hours as ordered by the physician.

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F 0726 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one of four licensed nurses observed possessed the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs. * LVN 5 documented administering the insulin medication to six residents at the same time LVN 5 obtained the residents' blood sugar levels. However, LVN 5 administered the insulin medications at different times from what LVN 5 had documented. This failure posed the risk of the residents not getting appropriate care. Findings: On 1/15/26 at 1140 hours, LVN 5 was asked which residents required blood sugar monitoring with possible insulin medication administration. LVN 5 stated she had already checked the blood sugars for the residents in Station A. LVN 5 stated she started obtaining the blood sugar levels for the residents around 1130 hours and then would wait for the residents' lunch to arrive so she could then administer insulin to the residents. LVN 5 stated she administered the insulin medications to the residents when residents' food arrived because the insulin medications administered were short acting insulins. When asked about the blood sugar results obtained for the residents in Station A, LVN 5 showed a paper note with a list of resident room numbers and the results of blood sugar check. The paper note showed Room A listed twice with two different results. LVN 5 stated Room A with results the 128 mg/dL belong to the resident in Room B. LVN 5 acknowledged she wrote down the wrong room number. When asked about the exact time each of the blood sugar results listed on the paper note were obtained, LVN 5 stated she started at 1130 hours. LVN 5 verified there was no exact time documented for the blood sugar results obtained. The glucometer machine used to obtain the blood sugar results only listed the results but not the exact time or date the results were obtained. On 1/15/2, at 1220 hours, the meal cart for Station A had not yet arrived. LVN 5 was observed not administering any insulin medications to the residents in Station A. Review of the facility's census showed Resident 89 was in Room B. a. Medical record review for Resident 15 was initiated on 1/15/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's H&P examination dated 5/20/25, showed Resident 15 had no capacity to understand and make decisions. Further review of the H&P showed Resident 15's diagnoses included diabetes. Review of Resident 15's MAR for January 2025 showed Resident 15 was to be administered Humulin R insulin (antidiabetic) injections as per sliding scale. Further review of the MAR showed Resident 15 was administered two units of insulin at 1138 hours. b. Medical record review for Resident A was initiated on 1/15/26. Resident A was admitted to the facility on [DATE]. Further review of Resident A's medical record showed Resident A's diagnoses included diabetes. Review of Resident A's MAR January 2025 showed Resident A was to be administered insulin as per sliding scale. Further review of the MAR showed Resident A received two units of insulin at 1156 hours. c. Medical record review for Resident 40 was initiated on 1/15/26. Resident 40 was readmitted to the facility on [DATE]. Review of Resident 40's H&P examination dated 10/7/25, showed Resident 40 had the capacity to understand and make decisions. Further review of this H&P showed Resident 40's diagnoses included diabetes. Review of Resident 40's MAR for January 2025 showed Resident 40 was to be administered Humalog insulin (antidiabetic) injections seven units three times daily, give same time as corrective insulin, do not give until resident's meal arrives and Humalog injections as per sliding scale. Further review of the MAR showed Resident 40 was administered 10 units of insulin as per sliding scale at 1131 hours. d. Medical record review for Resident 69 was initiated on 1/15/26. Resident 69 was admitted to the facility on [DATE]. Review Resident 40's medical record showed the resident had diagnoses including diabetes and Resident 40 was administered insulin. e. Medical record review for Resident 95 was initiated on 1/15/26. Resident 95 was readmitted to the facility on [DATE]. Review of Resident 95's H&P examination dated 9/24/25, showed Resident 95 had no capacity to understand and make decisions. Further review of the H&P showed Resident 95's diagnoses included diabetes. (continued on next page)

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F 0726 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 95's MAR for January 2025 showed Resident 95 was to be administered lispro insulin (antidiabetic) injections as per sliding scale. Further review of the MAR showed Resident 95 was administered four units of insulin at 1154 hours. On 1/16/26 at 1300 hours, an interview was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 acknowledged the Station A meal cart did not arrive until after 1220 hours on 1/15/26. LVN 5 verified she documented the residents' insulin administration at the same time she obtained the blood sugar results, which was inaccurate since LVN 5 had verified on 1/15/26, she started obtaining the residents' blood sugar results at 1130 hours and did not administer the insulin to the residents until after 1220 hours.

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	055816	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Care Center	12232 Chapman Ave Garden Grove, CA 92840

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	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, medical record review, and review of the facility's P&P, the facility failed to ensure the pharmaceutical services were followed. * The insulin for six of six residents was documented as administered at the same time the blood sugar checks were obtained. This failure posed the risk of not knowing exactly when the insulin was administered. * LVN 5 used dissolved Miralax (laxative) powder to flush the medications * Resident 64's lacosomide (anticonvulsant medication) and dissolved Miralax powder were administered together into Resident 64's GT and did not mix the two medications These failures posed the risk of causing discomfort to Resident 64.Findings: 1. a. On 1/15/26 at 1140 hours, LVN 5 was asked if she would be doing any blood sugar checks on the residents for possible insulin administration. Per LVN 5, LVN 5 had already checked Station A residents' blood sugars. Per LVN 5 she started obtaining the blood sugar checks for the residents starting at 1130 hours. Per LVN 5 she would then wait for residents' lunches to arrive so she could then administer insulin to the residents. LVN 5 stated the residents' insulins were being administered short acting insulin. LVN 5 said she administered the residents their insulins when residents' food arrived. When asked about the obtained blood sugar results, LVN 5 showed a post-it showing a list of room numbers and results of blood sugar checks. The post-it showed Room A listed twice with two different results. Per LVN 5, Room A with results 128 mg/dl belonged to the resident in Room B. LVN acknowledged she wrote down the wrong room number. When asked exactly what time were each of the blood sugar results listed on the post-it obtained, LVN 5 stated she started at 1130 hours. LVN 5 verified there was no exact time documented for the blood sugar results. The glucometer machine used to obtain the blood sugar results only listed the results but not the exact time or date the results were obtained. On 1/15/26, at 1220 hours, the meal cart for Station A had not yet arrived. LVN 5 was observed not administering any insulin to the residents. Review of the facility's census showed Nonsampled Resident 89 was in Room B. Medical record review for the residents who received insulin was initiated on 1/15/26. * Nonsampled Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's H&P dated 5/20/25 showed Resident 15 had no capacity to understand and make decisions. Further review of this H&P showed Resident 15's diagnoses included diabetes. Review of Resident 15's January 2025 MAR showed Resident 15 was to be administered Humulin R insulin (antidiabetic) injections as per sliding scale. Further review of the MAR showed Resident 15 was administered two units of insulin at 1138 hours. * Nonsampled Resident A was admitted to the facility on [DATE]. Review of Resident A's medical record showed Resident A's diagnoses included diabetes. Review of Resident A's January 2025 MAR showed Resident A was to be administered insulin as per sliding scale. Further review of this MAR showed Resident A received two units of insulin at 1156 hours. * Nonsampled Resident 40 was readmitted to the facility on [DATE]. Review of Resident 40's H&P dated 10/7/25, showed Resident 40 had the capacity to understand and make decisions. Further review of this H&P showed Resident 40's diagnoses included diabetes. Review of Resident 40's January 2025 MAR showed Resident 40 was to be administered Humalog insulin (antidiabetic) injections seven units three times daily, give same time as corrective insulin, do not give until resident's meal arrives and Humalog injections as per sliding scale. Further review of this MAR showed Resident 40 was administered 10 units of insulin as per sliding scale at 1131 hours. * Final sampled Resident 69 was admitted to the facility on [DATE]. Further review of this H&P showed Resident 40's diagnoses included diabetes. Resident 40 was administered insulin. * Nonsampled Resident 95 was readmitted to the facility on [DATE]. Review of Resident 95's H&P dated 9/24/25 showed Resident 95 had no capacity to understand and make decisions. Further review of this H&P showed Resident 95's diagnoses included diabetes. Review of Resident 95's January 2025 MAR showed Resident 95 was to be administered lispro insulin (continued on next page)

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	(antidiabetic) injections as per sliding scale. Further review of this MAR showed Resident 95 was administered four units of insulin at 1154 hours. On 1/16/26, at 1300 hours, an interview was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 acknowledged the Station A meal cart did not arrive until after 1220 hours on 1/15/26. LVN 5 verified she documented she administered the residents' insulin at the same time she obtained the results which was inaccurate since LVN 5 had verified on 1/15/26 she started obtaining the residents' blood sugar results at 1130 hours and did not administer the insulin to the residents until after 1220 hours. b. Review of the facility's P&P titled Specific Medication Administration, Enteral Tube Medication Administration effective 10/2017 showed to administer each medication separately. On 1/16/26, at 0830 hours, a medication administration observation for Resident 64 was conducted with LVN 5. Per LVN 5, Resident 64 was to be administered his medications via his GT. During the medication preparation observation for Resident 64, LVN 5 was observed mixing Resident 64's Miralax powder in a plastic see through cup of water. LVN 5 was observed bringing into Resident 64's room, medications including a total of six crushed medications, one white plastic spoon, 10 ml of lacosomide (medication used for seizures), and the cup of water with the dissolved Miralax powder. LVN 5 was observed using the dissolved Miralax powder to stir and dissolve Resident 64's crushed medications with the same spoon, and flushing Resident 64's GT before and after administering the crushed medications with the Miralax powder to Resident 64's GT. LVN 5 was observed pouring Resident 64's lacosomide into Resident 64's GT. The medication was observed not going down into Resident 64's GT. When LVN 5 tried to flush Resident 64's lacosomide with dissolved Miralax, the two medications were observed forming two layers; with the lacosomide on the bottom and the Miralax solution on top. LVN 5 was then observed inserting the plunger into Resident 64's syringe, apply pressure into the syringe with the plunger to push the two medications into Resident 64's GT. Resident 64 was then observed coughing and saliva coming out of his mouth. Medical record review for Resident 64 was initiated on 1/16/26. Resident 64 was readmitted to the facility on [DATE]. Review of Resident 64's H&P dated 11/3/25, showed Resident 64's diagnoses included history of GT dislodgement, post status GT replacement, seizure, history of coffee ground vomit, and stroke. Resident 64 had no capacity to understand and make decisions. Review of Resident 64's January 2026 Order Summary Report showed an order dated 11/1/25, to flush Resident 64's GT with 30 ml of water before administering medications and 10 ml of water in between each medication. On 1/16/26 at 940 hours, LVN 5 verified the above findings. When asked why LVN 5 used dissolved Miralax powder to flush medications into Resident 64's GT, LVN 5 was unable to explain.

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F 0842 Level of Harm - Potential for minimal 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, medical record review, and facility P&P review, the facility failed to ensure the medical records were accurate for one of 18 final sampled resident (Resident 35). * The facility failed to maintain accurate clinical records and monitor significant weight changes for Resident 35. This failure resulted in inaccurate clinical records and lack of timely interventions for significant weight changes, placing the resident at risk for malnutrition and dehydration.Findings: Review of the facility's P&P titled Weight Variance Committee dated 4/2017 showed any weight gain greater than 3% per week should be reviewed by the IDT for cause and further recommendation. The resident's weekly weights will be re-evaluated regularly and if their weight had stabilized, they will be discharged from the program. Review of the facility's P&P titled Documentation Principles dated 2/2018 showed it was the policy of the facility that resident's clinical records shall be current and kept in detail consistent with good medical and professional practice based on the care provided to each resident. Entries must be accurate, timely objective, specific, concise, legible, clear and descriptive. Medical record review for Resident 35 was initiated on 1/15/26. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's Weight Records (undated) via the electronic health record showed the following weights: - dated 10/28/25, a weight of 165 lbs.; - dated 11/04/25, a weight of 143 lbs., a 13.33% weight loss in less than one week; and - dated 1/13/26, a weight of 147 lbs., a 10.91% weight loss from 10/28/2025. Review of Resident 35's Weekly Weight Record (undated) via a physical document showed Resident 35's weight was 146 lbs. on 10/28/25 Review of Resident 35's MDS assessment dated [DATE], showed the resident did not have weight loss or gain in the last month or six months. Review of Resident 35's Care Plans did not address the significant weight loss of 13.33% on 11/4/25. Review of Resident 35's Nutrition Risk assessment dated [DATE], showed the resident was at high risk for malnutrition and dehydration. On 1/16/26 at 1157 hours, an interview and concurrent medical record for Resident 35 was conducted with the ADON. The ADON stated the weights should be monitored weekly for four weeks after admission and monthly thereafter, and significant weight changes required physician notification, registered dietician consultation, and care plan updates. The ADON verified Resident 35 had a 22 lbs. weight loss from 10/28/25 to 11/4/25, and acknowledged these steps were not completed. The ADON further stated Resident 35 should have been re-weighed to confirm the above weight change. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	The ADON stated he was not sure which weight on 10/28/25, was accurate. On 1/16/26 at 1207 hours, an interview and concurrent medical record review for Resident 35 was conducted with the Subacute Manager. The Subacute Manager admitted she made a documentation error and documented Resident 35's weight to be 165 lbs. instead of 146 lbs. in the electronic health record, and failed to accurately track weight changes. On 1/21/26 at 0856 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the facility's Arbitration Agreement was presented to the resident in their preferred language for one of three sampled residents (Resident 12) reviewed for Arbitration. * Resident 12 was presented with an Arbitration agreement in English which was not the resident's primary or preferred language. This failure had the potential for the resident to not understand the Arbitration Agreement thoroughly before they signed the agreement.Findings: Medical record review for resident 12 was initiated on 1/14/26. Resident 12 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's MDS assessment dated [DATE], showed Foreign Language 1 as the resident's preferred language, and needed or wanted an interpreter to communicate with health care staff. Review of Resident 12's Arbitration Agreement dated 6/6/25, showed the agreement was signed by Resident 12 and the Admissions Coordinator. The form was in English, which was not the resident's primary or preferred language. The record failed to show if an interpreter was used to assist the resident. On 1/15/26 at 0954 hours, an interview was conducted with Resident 12 using a translator service in Foreign Language 1. Resident 12 stated she can speak some English, but not very well, and she preferred important documents to be explained in or written in Foreign Language 1. Resident 12 did not recall signing an Arbitration Agreement. On 1/15/26 at 1021 hours, an interview and concurrent record review for Resident 12 was conducted with the Admissions Coordinator. The Admissions Coordinator verified the Arbitration Agreement was in English and signed by herself and Resident 12. The Admissions Coordinator stated if using a staff to translate a form in Foreign Language 1, the staff who translated would sign the agreement instead of the Admissions Coordinator. The Admissions Coordinator stated she did not speak Foreign Language 1. The Admissions Coordinator verified Resident 12's MDS assessment dated [DATE], showed the resident wanted or needed a translator.

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and facility document review, the facility failed to implement their QAPI plan and their past Recertification Survey POC for F759. * The facility failed to ensure the Pharmacy Nurse Consultant conducted medication pass observations for licensed nurses as per facility's QAPI plan. This failure had the potential for ongoing non-compliance and incomplete data being reviewed by the QAPI committee. Findings: Review of the facility's 2024 Recertification Survey POC accepted by the Department on 1/17/25, included the following for F769:- The Pharmacy Nurse Consultant will conduct medication pass observations for all newly hired licensed nurses;- The Pharmacy Nurse Consultant will conduct medication pass observations with three licensed nurses per month; and- The DON will report the findings monthly to the QAPI committee for evaluation and further recommendation. Review of the facility's QAPI binders for February through December 2025 showed 10 of 11 months, the Pharmacy Nurse Consultant conducted two or less medication pass observations per month. The Administrator stated there must have been a miscommunication and the Pharmacy Nurse Consultant only did medication pass observations for new hires only.