STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055870	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunray Healthcare Center	3210 W Pico Blvd Los Angeles, CA 90019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a specific and individualized person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) for dysphagia (difficulty swallowing) for four of four sampled Residents (Resident 1, Resident 2, Resident 3, and Resident 4) reviewed for care plans. This failure placed Resident 1, Resident 2, Resident 3, and Resident 4 at an increased risk for aspiration (when something enters the airway or lungs by accident) and choking.Cross Reference F678 and F689.Findings:a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/10/2025 with diagnoses that included dysphagia, oropharyngeal phase, dementia (a progressive state of decline in mental abilities), encounter for attention to gastrostomy (care needed for gastrostomy tube [GT] a tube through the abdomen and into the stomach used for feeding, usually via a feeding tube), pneumonitis (inflammation of the lungs) due to inhalation of food and vomit, and chronic obstructive pulmonary disease (COPD, a disease that damages the lungs in ways that make it hard to breathe). During a review of Resident 1's History and Physical (H&P) dated 9/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 was hospitalized prior to the facility's admission due to Resident 1 ingested Lysol (cleaning solution product). During a review of Resident 1's Care Plan Report dated 9/15/2025, the Care Plan Report indicated Resident 1 was at risk aspiration related to dysphagia. The Care Plan Report indicated no nursing interventions. During a review of Resident 1's Order Summary Report dated 10/30/2025, the Order Summary Report indicated for Resident 1 to receive enteral feeding (getting liquid nutrition directly into stomach via a tube) Jevity (nutritional formula) 1.5 (1.5 calories per milliliter [ml, unit of measurement]) at 65 ml/hr (hour) for 20 hours. During a review of Resident 1's Order Summary Report dated 12/22/2025, the Order Summary Report indicated for Resident 1 to receive a pureed (a pudding-like texture that is smooth, blended) texture regular diet for oral gratification (providing pleasurable oral taste). During a concurrent interview and record review on 1/5/2026 at 2:08 PM, with the Director of Nursing (DON), Resident 1's admission Record and Resident 1's Care Plan Reports (in general) were reviewed. The DON stated Resident 1 had a diagnosis of dysphagia on admission and Resident 1 was at risk for aspiration. The DON stated staff (in general) were informed of the residents (unidentified) who were on aspiration precautions verbally at morning huddles (brief meetings). The DON stated each diagnosis needed a specific care plan (in general) to have interventions such as aspiration precautions, type of diet, monitor swallowing, and proper positioning. The DON stated Resident 1's care plan did not have nursing interventions to address dysphagia and the pureed diet. b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 7/22/2024 with diagnoses that included aphasia (a (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055870	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder that makes it difficult to speak), dysphagia following cerebral infarction (stroke, loss of blood flow to a part of the brain), dementia, and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 3/20/2025, the MDS indicated the resident had severe cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment. The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) for personal hygiene. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) for oral hygiene and upper body dressing. The MDS indicated Resident 2 was dependent on help for toileting hygiene, showering/bathing himself, lower body dressing, and putting on/taking off footwear. During a review of Resident 2's Order Summary Report, the Order Summary Report indicated Resident 2 had a physician order dated 9/16/2025 that indicated the resident was to have a controlled carbohydrate (a diet that focuses on eating consistent amounts of carbohydrates at meals to stabilize blood sugar), pureed texture, thin consistency diet. c. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 6/28/2025 with diagnoses that included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia, and dementia. During a review of Resident 3's MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment. The MDS indicated Resident 3 was dependent on help with eating, oral hygiene, toileting hygiene, showering/bathing himself, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 3 was on a mechanically altered diet (a diet in which the food texture is modified by chopping, griding, mashing, or pureeing to make the food soft, moist, and easy to chew and swallow). During a review of Resident 3's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 12/8/2025 for fortified (a diet with added vitamins, minerals, calories, and/or protein), pureed texture, thin consistency diet d. During a review of Resident 4's admission Record, the admission Record indicated the facility re-admitted the resident on 9/23/2025 with diagnoses that included aphasia and dysphagia following cerebral infarction. During a review of Resident 4's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 9/30/2025 for a fortified/high protein no added salt pureed texture thin consistency diet. During a review of Resident 4's MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment. The MDS indicated Resident 4 required substantial/maximal assistance for eating. The MDS indicated Resident 4 was dependent on help for oral hygiene, toileting hygiene, showering/bathing himself, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 4 had a mechanically altered and therapeutic diet (a medically prescribed meal plan that modifies a normal diet to treat a specific health condition). During an interview on 1/5/2026 at 2:08 PM with the Director of Nursing (DON), the DON stated a care plan was a plan of care that was written specifically for a resident (in general) so the nurses (in general) would be able to know how to take care of the resident. The DON stated each resident diagnosis and identified problem needed a care plan. The DON stated the care plan addressed each resident's specific needs. The DON stated the care plan was created upon admission, quarterly (every three months), and as needed when a situation would arise, such as when there was a change of condition and when new physician orders were received. The DON stated the diagnosis of dysphagia should have a specific care plan. The DON stated a care plan for dysphagia should include (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions for a speech therapist evaluation, diet orders, aspiration precautions (strategies to prevent food, liquids, or stomach contents from entering the lungs) such as raising the head of the bed 35-45 degrees, monitoring for coughing and shortness of breath, and monitoring the resident's swallowing. During a concurrent interview and record review on 1/6/2026 at 10 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 2, Resident 3, and Resident 4's Care Plan Reports were reviewed. LVN 2 stated the Care Plan Report listed all the care plans for a resident. LVN 2 stated a care plan was a guide for the resident's treatment of a problem. LVN 1 stated the care plan contained nursing interventions and physician orders that must be followed for a resident's treatment. LVN 2 stated each care plan was individualized and specific to the resident's clinical condition and disease process because each resident had different needs. LVN 2 stated each resident diagnosis should have a care plan. LVN 2 reviewed the Care Plan Report for Resident 2. LVN 2 stated Resident 2 had a diagnosis of dysphagia and a physician order for a pureed texture diet. LVN 2 stated Resident 2's Care Plan Report did not have a specific care plan for dysphagia. LVN 2 reviewed the Care Plan Report for Resident 3. LVN 2 stated Resident 3 had a diagnosis of dysphagia and a physician order for a pureed texture diet. LVN 3 stated Resident 3 did not have a specific care plan for dysphagia. LVN 2 reviewed Resident 4's Care Plan Report. LVN 2 stated Resident 4 had a diagnosis of dysphagia and a physician order for a pureed texture diet. LVN 2 stated Resident 4 did not have a specific care plan for dysphagia. LVN 2 stated Resident 2, Resident 3, and Resident 4 should each have a care plan for dysphagia with interventions that include upright positioning, a swallow evaluation (a medical assessment by a speech-language pathologist (SLP) (SLP) to diagnose difficulties with swallowing (dysphagia) by examining the muscles, coordination, and safety of the swallowing process), diet orders, and monitoring for signs and symptoms of aspiration such as coughing and shortness of breath. LVN 2 stated there was a potential for Resident 2, Resident 3, and Resident 4 to aspirate and develop pneumonia (infection/inflammation in the lungs) without a care plan for dysphagia because the nurses would not know the treatment and interventions the residents needed to treat their dysphagia. During a concurrent interview and record review on 1/6/2026 at 11:01 AM with the Quality Assurance Nurse (QAN), Resident 2, Resident 3, and Resident 4's Care Plan Reports were reviewed. The QAN stated the Care Plan Report described the plan of care for the residents. The QAN stated the care plans listed in the Care Plan Report had interventions the nurses (in general) needed to perform for resident care. The QAN stated the purpose of the care plan was to act as a guideline for the care of each residents' problems. The QAN stated every resident problem and diagnosis needed a care plan. The QAN stated each care plan was specific and individualized to each resident. The QAN stated licensed nurses had access to the care plans. The QAN stated the care plans should be updated by the licensed nurses on admission, quarterly, with a change of condition, and with any update in the resident's physician orders or plan of care. The QAN reviewed the Care Plan Report for Resident 2. The QAN stated Resident 2 had a diagnosis of dysphagia and a physician order for a pureed texture diet. The QAN stated Resident 2's Care Plan Report did not have a specific care plan for dysphagia. The QAN reviewed the Care Plan Report for Resident 3. The QAN stated Resident 3 had a diagnosis of dysphagia and a physician order for a pureed texture diet. The QAN stated Resident 3 did not have a specific care plan for dysphagia. The QAN reviewed Resident 4's Care Plan Report. The QAN stated Resident 4 had a diagnosis of dysphagia and a physician order for a pureed texture diet. The QAN stated Resident 4 did not have a specific care plan for dysphagia. The QAN stated Resident 2, Resident 3, and Resident 4 should each have a care plan that was initiated on admission for dysphagia. The QAN stated the dysphagia care plan should have interventions that include the resident's diet orders, monitoring for signs of aspiration like coughing, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	educating the resident and family on aspiration precautions, and a swallow evaluation by speech therapy. The QAN stated there was a potential for an increased risk for aspiration if Resident 2, Resident 3, and Resident 4 did not have a care plan for dysphagia. During a concurrent interview and record review on 1/7/2026 at 12:48 PM with the DON, Resident 2, Resident 3, and Resident 4's Care Plan Reports were reviewed. The DON stated Resident 2 had a diagnosis of dysphagia and a physician order for a pureed texture diet. The DON stated Resident 2 did not have a care plan initiated upon admission for dysphagia. The DON stated Resident 3 had a diagnosis of dysphagia and a physician order for a pureed texture diet. The DON stated Resident 3 did not have a specific care plan for dysphagia. The DON stated Resident 4 had a diagnosis of dysphagia and a physician order for a pureed texture diet. The DON stated Resident 4 did not have a care plan initiated upon admission for dysphagia. The DON stated Resident 2, Resident 3, and Resident 4 should have had a dysphagia care plan initiated on admission to address the residents' difficulty swallowing. The DON stated there was a potential for an increased risk for aspiration for Resident 2, Resident 3, and Resident 4 without a dysphagia care plan because nurses would not know the specific plan of care needed for the residents. During a review of the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 8/28/2025, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; any special services to be provided as a result of PASARR recommendations; and which professional services are responsible for each element of care; includes the residents stated goals upon admission and desired outcomes; building on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.When possible, interventions address the underlying source(s) of the problem area(s), and not just symptoms or triggers. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. Based on interview and record review the facility failed to ensure Licensed Vocational Nurse1 (LVN1), Certified Nursing Assistant 1 (CNA1), and Restorative Assistant 1 (RNA1) performed cardiopulmonary resuscitation (CPR, a life-saving procedure used when someone's heart or breathing has stopped) with no delays to one of four sampled residents (Resident 1), who was found with no mobility (movement), no reaction, not responding, and lifeless, on 12/31/2025 at approximately 1:10 PM to 1:15PM by failing to: -Ensure LVN1, CNA1, and RNA1 implemented the facility's Policy and Procedure (P&P) titled Emergency Procedure - Cardiopulmonary Resuscitation dated 8/28/2025 when LVN1, CNA1, and RNA1 failed to check Resident 1's pulse, checked for breathing, and failed to begin CPR when CNA1, LVN1, and RNA1 found Resident 1 who was a full code (resident who chooses to be resuscitated [saved] if he or she stops breathing of if the heart stops beating or wishes to have full treatment in life-threatening situations to do CPR) with no mobility, not responding, and with no reaction in bed inside Resident 1's room on 12/31/2025 at approximately 1:10 PM to 1:15PM. -Ensure CNA1, LVN1, and RNA1 had the competencies necessary to perform Basic Life Support (BLS, is the foundational level of emergency medical care focused on maintaining a resident's airway, breathing, and circulation until advanced care arrives, primarily through high-quality CPR, and clearing airway obstructions [like choking] for victims of cardiac arrest [loss of heart function] or respiratory distress [trouble breathing] measures). As a result, the paramedics pronounced Resident 1 dead on 12/31/2025 at 1:34 PM. This failure had the potential for other unidentified full code residents (68 residents) not to receive life-saving measures during an emergency that could lead to harm and death. On 1/7/2026 at 5 pm, the Department called an Immediate Jeopardy (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM), Director of Nursing (DON), and Administrative Consultant due to the facility's failure to ensure LVN1, CNA1, and RNA1 performed CPR without delays after finding Resident 1 unresponsive, with no mobility and no reaction. Resident 1 died and placed other unidentified full code residents at risk not to receive life-saving measures during an emergency that could lead to harm and death. On 1/8/2025 at 8:54 PM, the Department removed the IJ situation while onsite in the presence of the ADM and the Director of Nursing (DON) after the surveyor verified the facility's implementation of the IJ removal plan (includes all actions the agency has taken or will take to immediately address the noncompliance that resulted in or made serious injury, serious harm, serious impairment, or death likely) through observation, interview, and record review, wherein all nurses would receive CPR training to ensure 68 residents who were full code would receive BLS in case of an emergency The scope and severity was lowered to a G. The IJ removal plan included: -On 1/7/2026, the facility implemented a Quality Assurance (is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards) Performance Improvement (QAPI) Performance Improvement Project (PIP is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes) regarding CPR with return demonstrations. -On 1/8/2026, a third-party vendor educated all nurses on the procedure for initiating CPR and received certifications. CPR drills were conducted. -On 1/8/2026, nurses would not be permitted to work without a CPR card until a certification was completed. -On 1/8/2026, the Medical Records Director audited 80 residents' medical charts and identified two residents (unidentified) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	who did not have a Physician Orders for Life-Sustaining Treatment (POLST is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency). Cross reference F656 and F689Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/10/2025 with diagnoses that included dysphagia, oropharyngeal phase, dementia (a progressive state of decline in mental abilities), encounter for attention to gastrostomy (care needed for gastrostomy tube [GT] a tube through the abdomen and into the stomach used for feeding, usually via a feeding tube), pneumonitis (inflammation of the lungs) due to inhalation of food and vomit, and chronic obstructive pulmonary disease (COPD, a disease that damages the lungs in ways that make it hard to breathe). During a review of Resident 1's History and Physical (H&P) dated 9/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 was hospitalized prior to the facility's admission due to Resident 1 ingested Lysol (cleaning solution product). During a review of Resident 1's POLST dated 9/11/2025, the POLST indicated to attempt CPR. The POLST indicated to provide full treatment to Resident 1 with the primary goal to prolong life by all medically effective means. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 9/15/2025, the MDS indicated the resident had severe cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) for eating, oral hygiene, lower body dressing, personal hygiene, putting on footwear, and taking off footwear. The MDS indicated Resident 1 was dependent on help for toileting hygiene, showering, and bathing himself. The MDS indicated Resident 1 had a feeding tube. During a review of Resident 1's Care Plan Report dated 9/19/2025, the Care Plan Report indicated the resident's POLST specified to attempt resuscitation. The Care Plan Report indicated to provide full treatment to Resident 1 with the primary goal of prolonging life by all medically effective means. The Care Plan Report indicated an intervention to respect Resident 1 and Resident 1's family's wishes. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 9/23/2025 to provide CPR and attempt resuscitation (is an emergency, life-saving procedure designed to restore spontaneous breathing and heartbeat) according to the resident's POLST. During a review of Resident 1's Progress Notes dated 12/31/2025 at 2:45 PM, the Progress Notes indicated that on 12/31/2025 at around 1:15 PM there was a page for a code blue (alert for a life-threatening medical emergency). The Progress Notes indicated Resident 1 was seated on a chair across Resident 1's bed and an RNA (RNA1) was performing a Heimlich maneuver while licensed staff (LVN1) and Respiratory Therapist 1 (RT1) suctioned (draw out) Resident 1's secretions (mucus/fluids) from Resident 1's mouth. The Progress Notes indicated FAM 3 gave a chocolate chip cookie to Resident 1 and to Resident 4. The Progress Notes indicated Resident 1 was pale and Resident 1 did not have a pulse. The Progress Notes indicated Resident 1 was transferred back to bed and staff-initiated CPR and called 911 at around 1:20 PM. The Progress Notes indicated the paramedics declared the time of Resident 1's death at 1:34 PM. During a review of Resident 1's Progress Notes dated 12/31/2025 at 8:30 PM, the Progress Notes indicated FAM3 told the Social Services Designee (SSD) that she (FAM3) gave a chocolate cookie (unidentified size) to Resident 1 because Resident 1 asked for the cookie. The Progress Notes indicated the local police officers (unidentified) arrived at the facility before 2 PM and the coroner (investigates sudden, unexpected, violent, or suspicious deaths to determine the cause and manner of death) picked up Resident 1's body at around 5:30 PM. During an interview on 1/5/2026 at 12:54 PM with CNA 1, CNA 1 stated that on 12/31/2025 at around (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1:10 PM to 1:15 PM she (CNA1) was in the hallway when FAM3 called for her attention saying come in, come in to Resident 1's room. CNA 1 stated when she (CNA1) entered Resident 1's room, Resident 1 was looking in front, was sitting straight up in bed, not moving, and with his mouth a little open. CNA 1 stated she (CNA1) saw food running down from Resident 1's mouth. CNA 1 stated she told Resident 1 to spit out, spit out. CNA 1 stated Resident 1 looked very scary; the resident's eyes were open and big. CNA1 stated Resident 1 did not move, was not gasping, and was not trying to spit out. CNA 1 stated Resident 1 was pale and had no reaction when CNA 1 touched him. CNA 1 stated she (CNA1) tried to bring out the food in Resident 1's mouth by using her finger to clean his mouth, but Resident did not blink, did not move, did not react, and did not push her (CNA1's) hand. CNA 1 stated Resident 1 did not push back or cough when she (CNA1) put her finger in Resident 1's mouth. CNA 1 stated Resident 1's lips were pale to bluish in color. CNA 1 stated FAM 3 stated she (FAM3) gave Resident 1 a cookie. CNA 1 stated she (CNA1) told FAM 3 to call for help. CNA 1 stated she (CNA1) started to do the Heimlich maneuver because she (CNA1) saw food in Resident's mouth. CNA 1 stated Resident 1 did not react or show any movement during or after the Heimlich maneuver. CNA 1 stated Resident 1 did not have any rise and fall of his chest. CNA 1 stated she (CNA1) did the Heimlich two to three times on Resident 1.CNA 1 stated RNA 1 and LVN 1 came to Resident 1's room. CNA 1 stated RNA 1 helped her (CNA1) transfer Resident 1 from the bed to a chair to perform the Heimlich maneuver. CNA 1 stated RNA 1 told her (CNA1) to call a code blue. CNA 1 stated when she (CNA1) left Resident 1's room Resident 1 was still not moving and not reacting to touch. During a telephone interview on 1/5/2026 at 1:10 PM, with FAM 1, FAM1 stated on 12/31/2025 the facility called to inform FAM1 that a visitor took cookies to Resident 1's roommate (Resident 4) and fed a cookie to Resident 1. FAM1 stated Resident 1 could not safely swallow solid foods. FAM1 stated Resident 1 was supposed to be on a pureed diet so when Resident 1 ate the cookie he (Resident 1) choked and passed away. During a telephone interview on 1/5/2026 at 3:30 PM, with FAM3, FAM3 stated that on 12/31/2025 she (FAM3) visited Resident 4 who was Resident 1's roommate. FAM3 stated she (FAM3) would often visit Resident 4 and would take food to Resident 4 weekly. FAM3 stated Resident 4 had requested cookies and FAM3 purchased chocolate chip and oatmeal cookies and took the cookies inside the facility. FAM3 stated when she (FAM3) saw Resident 4, she (FAM3) told Resident 4 I got your cookies, Resident 1 overheard and Resident 1 stated, I want a cookie too. FAM3 stated she (FAM3) was feeding Resident 4 a cookie inside the room, Resident 1 kept repeating can I get a cookie, I want a cookie. FAM3 stated after she (FAM3) fed Resident 4 a cookie, she (FAM3) asked Resident 1 if he (Resident 1) wanted a cookie and Resident 1 said yes. FAM3 stated she (FAM3) gave Resident 1 a cookie at around 1PM. FAM3 stated she (FAM3) then sat down and started talking with Resident 4 for approximately five to ten minutes, then looked over at Resident 1 and saw Resident 1 shaking, pale, and choking. FAM3 stated she (FAM3) then went to call the nurse (unidentified). FAM3 stated a nurse (unidentified) went into the room and told FAM3 to call for help. FAM3 stated she (FAM3) then went to the hallway and called for help and multiple staff (unidentified) entered the room. FAM3 stated facility staff (unidentified) were trying to revive Resident 1 and called the paramedics, but Resident 1 passed away. FAM3 stated she (FAM3) did not ask a staff (in general) if it was ok to give Resident 1 a cookie. FAM3 stated she (FAM3) gave the cookie to Resident1 because Resident 1 kept asking for a cookie. FAM3 stated she (FAM3) made a mistake and should not have given Resident 1 a cookie. During an interview on 1/6/2026 at 2 PM with RNA 1, RNA 1 stated that on 12/31/2025 at 1 PM he was in the hallway by the nurse's station when he (RNA1) heard there was a resident (unidentified) who was choking. RNA 1 stated he (RNA1) ran towards a voice stating, Patient is choking, patient is choking and was able to identify the voice was coming from Resident 1's room. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sunray Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3210 W Pico Blvd Los Angeles, CA 90019	

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RNA 1 stated when he (RNA1) entered Resident 1's room and saw Resident 1 sitting at a 45-degree angle (head of the bed elevated) with Resident 1's head tilted towards the front. RNA 1 stated CNA 1 was with Resident 1. RNA 1 stated he (RNA1) did not have time to check if Resident 1 had a pulse. RNA 1 stated he (RNA1) did not check if Resident 1 was responsive. RNA 1 stated he (RNA1) positioned Resident 1 in bed to lean on him (RNA 1) to perform the Heimlich maneuver. RNA 1 stated he (RNA1) performed a couple of blows of the Heimlich maneuver while Resident 1 was in bed then LVN 1 came to Resident 1's room. RNA 1 stated that both he and LVN 1 agreed to transfer Resident 1 to a chair to better position Resident 1 to perform the Heimlich maneuver. RNA 1 stated that he (RNA1) and LVN 1 did not check if Resident 1 had a pulse or if Resident 1 was responsive. RNA 1 stated that it was RT 1 who said that Resident 1 did not have a pulse. RNA 1 stated that RT 1 stated to put Resident 1 back in bed and initiate CPR. During a concurrent interview and record review on 1/6/2026 at 2:37 PM, with CNA 1, CNA 1's BLS certificate dated 3/10/2023 and 1/2/2026 were reviewed. CNA 1 stated she (CNA1) was certified to perform BLS and CPR. CNA 1 stated she (CNA1) last took the BLS Certification class in 2023 as indicated on CNA 1's BLS Certificate dated 3/10/2023. Upon review, CNA 1's BLS certificate dated 3/10/2023 indicated the BLS certificate needed to be renewed by 3/2025. CNA 1 stated she (CNA1) had a BLS Certificate dated 1/2/2026, however, CNA 1 stated she (CNA1) did not take the BLS Certification class as indicated on her BLS Certificate dated 1/2/2026. CNA 1 stated she (CNA1) called the instructor (unidentified) listed on the BLS Certificate dated 1/2/2026 and the instructor gave her (CNA1) the BLS Certification without taking the BLS class. CNA 1 stated the first step for CPR was to check for responsiveness by asking the resident (in general) if the resident (in general) was ok. CNA 1 stated the next step for CPR was to check the resident's (in general) pulse. CNA 1 stated if the resident (in general) had no pulse, she (CNA1) would give the resident (in general) breaths, and then do chest compressions (giving strong, rapid pushes to the chest to keep blood moving through the body). CNA1 stated she (CNA1) did not check for a pulse and did not perform CPR. CNA 1 stated for CPR she (CNA1) would do 20 compressions and then she (CNA1) would give one breath. CNA 1 stated it was important to take the BLS classes because there could be updates and changes in the steps to provide CPR. CNA 1 stated if classes were not taken to get the certification for BLS, she (CNA1) would not know how to do the updated CPR steps to revive a resident, which could lead to the resident's death (in general). During an interview on 1/6/2026 at 3:28 PM, with LVN 1, LVN1 stated that on 12/31/2025 at around 1 PM FAM3 was in the hallway saying help, help and called LVN 1 to Resident 1's room. LVN 1 stated when she (LVN1) entered Resident 1's room, she (LVN1) saw Resident 1 sitting on a chair. LVN 1 stated Resident 1's lips were slightly blue. LVN 1 stated Resident 1's eyes were open. LVN 1 stated Resident 1 did not appear to be choking. LVN 1 stated she (LVN1) did not check if Resident 1 was responsive, did not check if Resident 1 was breathing or if Resident 1 had a pulse. LVN 1 stated she (LVN1) performed the Heimlich maneuver on Resident 1 because she (LVN1) was told Resident 1 was choking. During a concurrent interview and record review on 1/7/2026 at 8:42 AM with the DON, CNA 1's BLS certificate dated 3/10/2023 and 1/2/2026 were reviewed. The DON stated on 12/31/2025 at around 1:10 PM to 1:15 PM she (DON) heard a code blue (an alert for a life-threatening medical emergency) paged and was informed there was a choking incident in Resident 1's room. The DON stated she (DON) went to Resident 1's room and when she (DON) got there, Resident 1 was in a chair and RNA 1 was doing the Heimlich maneuver on Resident 1. The DON stated LVN 1 was suctioning Resident 1. The DON stated RT 1 was also in Resident 1's room assisting with suctioning. The DON stated RT 1 checked Resident 1's pulse because Resident 1 was pale. The DON stated RT 1 said Resident 1 did not have a pulse and put Resident1 back in bed. The DON stated CPR was started. The DON stated whoever was the first (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to come into a resident's room (in general) needed to initiate the CPR steps when the resident (in general) was unresponsive and had no pulse. The DON stated it was strongly recommended that CNAs were certified (in general) for BLS. The DON stated CNAs with a BLS certificate (in general) were expected to know and perform the CPR steps until a licensed nurse went in. The DON stated a BLS/CPR certificate was good for two years. The DON stated to become BLS/CPR certified the individual must be trained to do CPR through a class. The DON stated it was important to take a BLS class to ensure the staff (in general) had an understanding of how to do CPR. The DON stated the CPR steps were to first check the resident (in general) for responsiveness, check the resident's pulse (in general), and if the resident had no pulse and was not responsive, to start CPR (in general). The DON stated if someone was given a BLS certificate without having to take the BLS class they would not know what to do when a resident had an emergency (in general), and that resident (in general) was at risk for not getting the proper emergency care that could lead to death. During an interview on 1/7/2026 at 10:38 AM with RNA 1, RNA 1 stated that on 12/31/2025 at around 1PM to 1:15 PM, he (RNA1) suddenly heard someone say, a patient is choking. RNA 1 stated LVN 1 was on her way to Resident 1's room but he passed her because he (RNA1) was moving fast. RNA 1 stated when he (RNA1) got to Resident 1's room, he (RNA1) saw people in the room and one nurse (unidentified) was with Resident 1. RNA 1 stated he (RNA1) saw Resident 1 sitting up in bed at 45 degrees. RNA 1 stated Resident 1 was leaning forward and slumped forward not moving not responding. RNA 1 stated he (RNA1) saw a staff member (CNA1) performing the Heimlich maneuver and took over the task. RNA 1 stated he (RNA1) took a bed sheet which was covering Resident 1's legs and used it to place Resident 1's legs on the side of the bed and down onto the floor. RNA 1 stated he (RNA1) was behind Resident 1 and then leaned Resident 1's body on to himself to start the Heimlich maneuver because he (RNA1) was told Resident 1 was choking. RNA 1 stated Resident 1's lips were pale to bluish in color. RNA 1 stated Resident 1 did not react or did not show any movement when he (RNA1) was doing the Heimlich maneuver. RNA 1 stated he (RNA1) did a couple of Heimlich maneuvers. RNA 1 stated LVN 1 pulled a chair next to Resident 1's bed and he (RNA1) and LVN 1 put Resident1 onto the chair and started the Heimlich maneuver on Resident 1. RNA 1 stated RT 1 came and suctioned Resident1, checked Resident1 and said, No Pulse, put him back in bed. RNA 1 stated he (RNA1) lifted Resident1's shoulder and RT 1 lifted Resident 1's legs. RNA 1 stated RT 1 then started CPR. During an interview on 1/7/2026 at 11:04 AM with LVN 1, LVN 1 stated when she (LVN1) entered Resident 1's room on 12/31/2025 Resident 1 was unresponsive (not moving, not responding). LVN 1 stated she (LVN1) was told Resident 1 was choking and her immediate action was to perform the Heimlich maneuver on Resident 1. LVN 1 stated she (LVN1) did not check Resident 1's pulse. LVN 1 stated CPR might have been delayed on Resident 1 because Resident 1's pulse was not checked. LVN 1 stated if Resident 1's pulse was checked and no pulse was felt, the immediate step would be to initiate CPR on Resident 1. During an interview on 1/7/2026 at 11:44 AM, RT 1 stated that on 12/31/2025 at around 1 PM, he (RT1) heard a CNA (unidentified) call out for help. RT 1 stated when he (RT1) went to Resident 1's room, Resident 1 was sitting in a foldable metal chair. RT 1 stated RNA 1 was doing the Heimlich maneuver. RT 1 stated a CNA (unidentified) was next to Resident 1 and told him (RT 1) that Resident 1 was choking. RT 1 stated Resident 1 was not alert and did not have the universal sign of choking (clutching the throat with one or both hands). RT 1 stated it did not look like Resident 1 was breathing. RT 1 stated Resident 1 looked lifeless. RT 1 stated he (RT1) checked Resident 1's pulse. RT 1 stated Resident 1 did not have a pulse. RT 1 stated he (RT1) told the CNA (unidentified), RNA 1, and LVN (unidentified) who were in Resident 1's room to put Resident 1 back to bed to start CPR. RT 1 stated that if a resident was found unresponsive (in general) the staff (in general) needed to (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	immediately (no delay) check the resident's pulse first (in general) and immediately start CPR if the resident had no pulse (in general). RT 1 stated that there could have been a delay in initiating CPR for Resident 1. RT 1 stated Resident 1's pulse should have been checked sooner when Resident 1 was initially found unresponsive (not moving and not responding). During an interview on 1/7/2026 at 12:18 PM with CNA 2, CNA 2 stated on 12/31/2025 at around 1 PM, she (CNA2) heard there was a code blue in Resident 1's room. CNA 2 stated she (CNA2) went to Resident 1's room and saw RNA 1 already in Resident 1's room. CNA 2 stated RNA 1 was doing the Heimlich maneuver on Resident 1. CNA 2 stated Resident 1's whole face looked purple. CNA 2 stated she (CNA2) offered to help with Heimlich maneuver. CNA 2 stated she (CNA2) performed the Heimlich maneuver for 1 minute and then LVN 1 took over. During an interview on 1/7/2026 at 1:33 PM with the DON, the DON stated when she (DON) went into Resident 1's Room on 12/31/2026 at around 1:10 PM to 1:15 PM Resident 1 was sitting on a chair and RNA 1 was doing the Heimlich maneuver on Resident 1. The DON stated Resident 1 was not moving. The DON stated Resident 1 was pale. The DON stated she (DON) did not assess Resident 1 for responsiveness. The DON stated RT 1 came and assisted with suctioning and setting up oxygen from the crash cart (a cart stocked with emergency medical equipment, supplies, and drugs for use by medical personnel especially during efforts to resuscitate a resident). The DON stated RT 1 said Resident 1 did not have a pulse and to put Resident 1 back in bed. The DON stated CPR was then started. The DON stated CPR continued until the paramedics came to the facility at around 1:20 PM. The DON stated the first staff to respond to the incident with Resident 1 was CNA 1. The DON stated CNA 1 did not perform the step of checking Resident 1's pulse. The DON stated checking Resident 1's pulse should have been done first if Resident 1 was found unresponsive. The DON stated the steps for CPR were to check Resident 1's vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions), assess Resident 1 for responsiveness, if Resident 1 was not responsive, then CNA1 needed to check Resident 1's pulse and breathing, and then start CPR if there was no pulse. The DON stated if CNA 1 checked Resident 1's pulse first when she (CNA1) found Resident unresponsive, CNA 1 would have known which step to take next. The DON stated if Resident 1 had no pulse the immediate intervention would be to initiate CPR. The DON stated there was a delay in CPR for Resident 1 because Resident's pulse was not checked when Resident was initially found unresponsive (not responding and not moving). During an interview on 1/8/2026 at 12:51 PM with Medical Director 1 (MD 1), MD 1 stated the facility informed him of the incident that happened with Resident 1 on 12/31/2025. MD 1 stated he (MD1) was informed that FAM3 gave a cookie to Resident 1 without consulting a nurse. MD 1 stated Resident 1 choked and passed away. MD 1 stated he (MD1) was also informed that CPR protocol was not followed for Resident 1 when a CNA (unidentified) did not check Resident 1's pulse. MD 1 stated the steps for CPR (in general) were to first check the resident (in general) for responsiveness, check the resident's pulse and airways, and if the resident did not have a pulse initiate chest compressions. MD 1 stated if Resident 1 was unresponsive (not moving and not reacting) then Resident 1's pulse should have been checked first and if Resident 1 did not have a pulse, CPR should have been initiated immediately. MD 1 stated because Resident 1's pulse was not checked there was a delay in initiating CPR. During a review of the facility's undated job description titled Certified Nurse Assistant, the job description indicated it was a requirement for the Certified Nurse Assistants (in general) to have a CPR certificate. During a review of the facility's Policy and Procedure (P&P) titled CPR Certification dated 8/28/2025, the P&P indicated It is the policy of the facility that all licensed nurses maintain current CPR Certification through nationally recognized certify organizations (i.e., American Red Cross, American Heart (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Association), and strongly recommended that C.N.A.'s maintain certification. During a review of the facility's P&P titled Emergency Procedure - Cardiopulmonary Resuscitation dated 8/28/2025 the P&P indicated It is the policy of the facility that residents will receive cardio pulmonary resuscitation to maintain cardiac and/or respiratory function, in the absence of a physician's order to withhold CPR .Upon finding an unconscious resident, attempt to arouse resident. If unable to arouse, assess presence of respirations and heartbeat. Absence of breath sounds or air movement through the mouth, establish airways. Perform chest thrust maneuver if airway obstructed or suction resident as appropriate. Activate emergency medical services - call 911. Absence of palpable carotid or femoral pulse, call for help, active overhead paging Code Blue to room #. Initiate CPR (Cardio Pulmonary Resuscitation) based on the identified clinical needs of the patient. During a review of the American Heart Association guidelines titled 2025 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care dated 2025, the guidelines indicated Verify scene safety. Check for responsiveness, shout for nearby help, activate the emergency response system, send someone to get AED/defibrillator, look for breathing or only gasping and check pulse (simultaneously). No breathing or only gasping, pulse not felt, start CPR. Perform cycles of 30 compressions and 2 breaths.If an adult is unconscious/unresponsive, with absent or abnormal breathing (ie, only gasping), the lay rescuer should assume the person is in cardiac arrest. If an adult is unconscious/unresponsive, with absent or abnormal breathing (ie, only gasping), the health care professional should check for a pulse for no more than 10s and, if no definite pulse is felt, should assume the person is in cardiac arrest. Reference: https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) reviewed for pureed diet (a pudding-like texture that is smooth, blended) diet received food consistent with the ordered diet by failing to: -Ensure staff (in general) implemented accident-prevention measures by requiring visitors to notify nursing staff when food was brought into resident care area on 12/31/2025, so staff could supervise and prevent unsafe food from creating an accident hazard.-Ensure staff provided adequate supervision and environmental safeguards to prevent visitors (Family Member 3, FAM3) from providing unsafe food (non-pureed chocolate chip cookie/unidentified size) on 12/31/2025 at approximately 1 PM to Resident 1 who had a diagnosis of dysphagia oropharyngeal phase (inability/difficulty swallowing food or drink, can also cause breathing difficulties, choking, and drooling), and was on a pureed (a pudding-like texture that is smooth, blended) gratification (providing pleasurable oral taste) diet, severe cognitive impairment, and high aspiration risk (when something enters the airway or lungs by accident). -Ensure licensed nurses (in general) implemented supervision and environmental controls to prevent unsafe food from entering the resident environment and creating an accident hazard for Resident 1's who had a diagnosis of dysphagia oropharyngeal phase, including supervision, positioning, monitoring, and restriction of access to unsafe food. -Ensure licensed nurses (in general) implement accident-prevention measures by informing and directing visitors, including FAM3, residents, residents' representatives (in general) to notify staff when food was brought into the facility, so staff could supervise and prevent unsafe food from creating an accident hazard. On 12/31/2025 at approximately 1 PM, FAM3 gave a chocolate chip cookie (unidentified size) to Resident 1 while Resident 1 was in bed. At approximately 1:05 PM to 1:10PM, FAM3 saw Resident 1 shaking, choking, pale, and FAM3 called for help. Certified Nursing Assistant 1 (CNA1) went inside Resident 1's room and saw Resident 1 in bed with no mobility, with no reaction, with his mouth a little open, and saw food running down from Resident 1's mouth. Restorative Nursing Assistant 1 (RNA1) then went inside Resident 1's room and performed a Heimlich maneuver (a lifesaving first-aid technique used to remove an object [like food] stuck in a person's throat or windpipe) while Resident 1 was on his bed. Licensed Vocational Nurse 1 (LVN1) went inside Resident 1's room and asked CNA1 and RNA 1 to place Resident 1 on a foldable metal chair. Respiratory therapist 1 (RT1) identified Resident 1 did not have a pulse, Resident 1 looked lifeless, and instructed CNA1, RNA1, and LVN1 to place Resident 1 back to bed to perform cardiopulmonary resuscitation (CPR, an emergency treatment that is done when someone's breathing or heartbeat has stopped). The facility called 911 (phone number for emergency services) at 1:20PM, and the paramedics (a person trained to give emergency medical care) to people who are seriously ill declared Resident 1 dead on 12/31/20/2025 at 1:34 PM. As a result, Resident 1 received food inconsistent with the ordered diet, choked, and died on12/31/2025 at 1:34 PM. On 1/5/2026 at 5:22 PM, the Department called an Immediate Jeopardy (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) in the presence of the facility's Administrator (ADM) related to the failure to implement the Foods Brought by Family/Visitors policy and procedure to ensure the facility staff (in general) asked visitors (in general, including FAM3) to inform the nursing staff (in general) when visitors (in general, including FAM3) would bring outside food to the facility to ensure compliance with an ordered diet, and had the potential to place other residents (Resident 2, Resident 3, Resident 4, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, and Resident 15) with pureed diets at risk for choking and death. On 1/8/2025 at 5:25 pm, the Department removed the IJ situation (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	while onsite after the surveyor verified the facility's implementation of the IJ removal plan (includes all actions the agency has taken or will take to immediately address the noncompliance that resulted in or made serious injury, serious harm, serious impairment, or death likely) through observation, interview,On 1/8/2025 at 5:25 pm, the Department removed the IJ situation while onsite after the surveyor verified the facility's implementation of the IJ removal plan (includes all actions the agency has taken or will take to immediately address the noncompliance that resulted in or made serious injury, serious harm, serious impairment, or death likely) through observation, interview, and record review, wherein the nursing staff updated the care plans of eleven residents who had mechanically altered diets (changes food consistency to be soft, moist, and easy to chew and swallow, used for issues like poor teeth or dysphagia), all staff received training on the policy regarding Food Brought by Family/Visitors and residents, and families were informed of the policy. The scope and severity was lowered to a G. The IJ removal plan included: -On 12/31/2025, the Administrative Consultant educated the ADM and the Director of Nursing (DON) on the policy regarding Food Brought by Family/Visitors. -On 1/5/2026 and on 1/6/2026, the DON conducted in-services for all staff on the policy regarding Food Brought by Family/Visitors. -On 1/5/2026, a third-party software sent messages via text and email to all the facility's residents and their responsible parties (someone legally designated or acting as the person accountable for an entity) educating them to inform the facility's nursing staff when foods are brought to the facility for a resident, as well as instructing them not to share with or distribute to other residents.-On 1/5/2026, the facility posted a signage throughout the facility regarding the policy for the Food Brought by Family/Visitor. -On 1/5/2026, the facility's receptionist or designee encouraged visitors to sign in on the facility's Visitor Log and to indicate whether they (visitors) brought food/drinks. If the visitors brought food/drinks, the Licensed Vocational Nurses (LVNs, in general) ensured the food/drinks were appropriate with the residents' (in general) prescribed diet. The LVNs educated the visitors to not to share food/drinks with other residents. -On 1/5/2026, the facility's Registered Dietitian posted a Dietary Log outside the kitchen allowing the staff to cross-check special requests from residents/staff/family to ensure all special requests are following doctor's dietary orders which were posted in the kitchen. -On 1/5/2026 the facility's Interdisciplinary Team (IDT, group of diverse health care professionals from different fields) identified eleven residents (unidentified) with mechanically altered diets (changes food consistency to be soft, moist, and easy to chew and swallow, used for issues like poor teeth or dysphagia) and the care plans were updated, and no negative outcomes were noted.Cross Reference F656 and F678Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/10/2025 with diagnoses that included dysphagia, oropharyngeal phase, dementia (a progressive state of decline in mental abilities), encounter for attention to gastrostomy (care needed for gastrostomy tube [GT] a tube through the abdomen and into the stomach used for feeding, usually via a feeding tube), pneumonitis (inflammation of the lungs) due to inhalation (breathing in) of food and vomit, and chronic obstructive pulmonary disease (COPD, a disease that damages the lungs in ways that make it hard to breathe). During a review of Resident 1's History and Physical (H&P) dated 9/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 was hospitalized prior to the facility's admission due to Resident 1 ingested Lysol (cleaning solution product). During a review of Resident 1's Care Plan Report dated 9/15/2025, the Care Plan Report indicated Resident 1 was at risk aspiration related to dysphagia. The Care Plan Report indicated no nursing interventions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 9/15/2025, the MDS indicated Resident had severe (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) with eating. During a review of Resident 1's Order Summary Report dated 10/30/2025, the Order Summary Report indicated for Resident 1 to receive enteral feeding (getting liquid nutrition directly into stomach via a tube) Jevity (nutritional formula) 1.5 (1.5 calories per milliliter [ml, unit of measurement]) at 65 ml/hr (hour) for 20 hours. During a review of Resident 1's Order Summary Report dated 12/22/2025, the Order Summary Report indicated Resident 1 to receive a pureed texture regular diet for oral gratification (providing pleasurable oral taste) . During a review of Resident 1's Progress Notes dated 12/31/2025 at 2:45 PM, the Progress Notes indicated that on 12/31/2025 at 1:15 PM, a code blue (alert for a life-threatening medical emergency) was called. The Progress Notes indicated Resident 1 was seated on a chair across Resident 1's bed and RNA1 was performing a Heimlich maneuver while licensed staff (LVN1) and Respiratory Therapist 1 (RT1) suctioned Resident 1's secretions (mucus/fluids) from Resident 1's mouth. The Progress Notes indicated FAM 3 gave a chocolate chip cookie to Resident 1 and to Resident 4. The Progress Notes indicated Resident 1 was pale and Resident 1 did not have a pulse. The Progress Notes indicated Resident 1 was transferred back to bed and staff-initiated CPR and called 911 at around 1:20 PM. The Progress Notes indicated the paramedics declared the time of Resident 1's death at 1:34 PM. During a review of Reside's Progress Notes dated 12/31/2025 at 8:30 PM indicated FAM3 told the Social Services Designee (SSD) that she (FAM3) gave a chocolate cookie (unidentified size) around 1PM to Resident 1 because Resident 1 asked for the cookie. During an interview on 1/5/2026 at 12:54 PM with CNA 1, CNA 1 stated that on 12/31/2025 at around 1:10 PM to 1:15 PM she (CNA1) was in the hallway when FAM3 called for her attention saying come in, come in to Resident 1's room. CNA 1 stated when she (CNA1) entered Resident 1's room she (CNA1) saw Resident 1 sitting upright in bed with no mobility, with no reaction, with his mouth a little open, and saw food running down from Resident 1's mouth. CNA 1 stated Resident 1 was not moving. CNA 1 stated Resident 1's face was pale. CNA 1 stated she (CNA1) asked Resident 1 are you okay? twice but Resident 1 did not respond. CNA 1 stated that she (CNA1) performed a sweep in Resident 1's mouth with her finger and removed pieces of cookie from Resident 1's mouth. CNA 1 stated FAM 3 stated she (FAM3) gave Resident 1 a cookie. CNA1 stated she (CNA1) told FAM 3 to call for help. CNA 1 stated RNA 1 and LVN 1 came to Resident 1's room. CNA 1 stated RNA 1 helped her (CNA1) transfer Resident 1 from the bed to a chair to perform the Heimlich maneuver. During a telephone interview on 1/5/2026 at 1:10 PM, FAM1 stated Resident 1 had dementia and was forgetful and had poor safety awareness and required constant supervision. FAM1 stated Resident 1 was admitted to the facility after being hospitalized for swallowing laundry detergent thinking it was milk. FAM1 stated the facility did not hold any meeting with FAM1 to discuss Resident 1's plan of care. FAM1 stated she (FAM1) would frequently express concerns to facility staff (unidentified) about Resident 1 eating or being fed when Resident 1 was not supposed to because Resident 1 had such poor memory and would put things in his mouth. FAM1 stated there were no signs or anything in place to help Resident 1 remember not to eat or tell people not to feed him. FAM1 stated she (FAM1) had asked the staff (unidentified) for signs to be put up (unidentified date). FAM1 stated on 12/31/2025 (unidentified time) the facility called to inform FAM1 that a visitor (FAM3) took cookies for Resident 4 and fed a cookie to Resident 1. FAM1 stated Resident 1 was very forgetful and would not remember that he (Resident 1) was not allowed to eat food. FAM1 stated Resident 1 could not safely swallow solid foods and was supposed to be on a pureed diet. FAM1 stated she (FAM1) was not informed of the policy for outside food or what steps would be taken to prevent Resident 1 from being fed food from outside. FAM1 stated outside food was not communicated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in any plan of care. FAM1 stated there were no meetings held to discuss the plan of care. FAM1 stated she (FAM1) would worry very much that Resident 1 would accidentally eat something or drink something that he (Resident 1) was not supposed to. During a concurrent interview and record review on 1/5/2026 at 2:08 PM, with the Director of Nursing (DON), Resident 1's admission Record and Resident 1's Care Plan Reports (in general) were reviewed. The DON stated Resident 1 had a diagnosis of dysphagia on admission and Resident 1 was at risk for aspiration. The DON stated staff (in general) were informed of the residents (unidentified) who were on aspiration precautions (specialized safety measures, often termed dysphagia precautions or feeding precautions, designed to prevent food, fluids, saliva, or vomit from entering the airway and lungs, reducing the risk of choking) verbally at morning huddles (brief meetings). The DON stated each diagnosis needed a specific care plan (in general) to have interventions such as aspiration precautions, type of diet, monitor swallowing, and proper positioning. The DON stated Resident 1's care plan did not have nursing interventions to address dysphagia and the pureed diet. During a concurrent interview and record review on 1/5/2026 at 2:15 PM with DON, the facility's Foods Brought by Family /Visitors policy and procedure dated 8/29/2025 was reviewed. The DON stated the policy indicated food brought by family/visitors were not to be shared with or distributed to other residents. The DON stated the staff (in general) needed to tell the family/visitors to check with the nurses (in general) when bringing food to the residents. The DON stated that visitors were told to check with the nurses when bringing food to the residents. The DON stated there was no documentation of licensed nurses checking visitor's food brought from outside (in general). The DON stated there was no education given to visitors regarding food from outside. The DON stated there were no signs posted for visitors regarding food brought by family and not to share and distributed to other residents. The DON stated there was potential for harm to the residents if the visitors were not aware of the policy. During a telephone interview on 1/5/2026 at 3:30 PM, with FAM3, FAM3 stated that on 12/31/2025 she (FAM3) visited Resident 4 who was Resident 1's roommate. FAM3 stated she (FAM3) would often visit Resident 4 and would take food to Resident 4 weekly. FAM3 stated Resident 4 had requested cookies and FAM3 purchased chocolate chip and oatmeal cookies and took the cookies inside the facility. FAM3 stated when she (FAM3) saw Resident 4, she (FAM3) told Resident 4 I got your cookies, Resident 1 overheard and Resident 1 stated, I want a cookie too. FAM3 stated she (FAM3) was feeding Resident 4 a cookie inside the room, Resident 1 kept repeating can I get a cookie, I want a cookie. FAM3 stated after she (FAM3) fed Resident 4 a cookie, she (FAM3) asked Resident 1 if he (Resident 1) wanted a cookie and Resident 1 said yes. FAM3 stated she (FM3) gave Resident 1 a cookie at around 1PM. FAM3 stated she (FAM3) then sat down and started talking with Resident 4 for approximately five to ten minutes, then looked over at Resident 1 and saw Resident 1 shaking, pale, and choking. FAM3 stated she (FAM3) then went to call the nurse (unidentified). FAM3 stated a nurse (unidentified) went into the room and told FAM3 to call for help. FAM3 stated she (FAM3) then went to the hallway and called for help and multiple staff (unidentified) entered the room. FAM3 stated facility staff (unidentified) were trying to revive Resident 1 and called the paramedics, but Resident 1 passed away. FAM3 stated she (FAM3) did not ask a staff (in general) if it was ok to give Resident 1 a cookie. FAM3 stated she (FAM3) gave the cookie to Resident1 because Resident 1 kept asking for a cookie. FAM3 stated she (FM3) made a mistake and should not have given Resident 1 a cookie. FAM3 stated there were no signs above Resident 4 or Resident 1's bed or by the door indicating not to give the residents food or to ask staff prior to giving residents food. FAM3 stated the facility staff (unidentified) saw FAM3 take food into the facility almost weekly and never said anything to FAM3. FAM3 stated the facility would let FAM3 take whatever food she (FAM3) wanted to Resident 4. FAM3 (continued on next page)

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