STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055918	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive, personˆcentered care plan for two of ten sampled residents (Resident 19 and Resident 23) by failing to:A. Ensure a comprehensive care plan was initiated for Resident 19 addressing hearing needs and physical therapy ([PT], a rehabilitation profession that restores, maintains, and promotes optimal physical function) services.B. Develop, and implement a comprehensive, personˆcentered care plan addressing Resident 23's toenail fungal infection as recommended by the podiatrist.These failures had the potential to result in unmet needs for Residents 19 and 23, negatively affecting their wellˆbeing and contributing to poor resident outcomes.Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including fracture of surgical neck of right humerus (a type fracture [broken bone] of the upper arm), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 19's history and physical (H&P), dated [DATE], the H&P indicated Resident 19 had the capacity to understand and make decisions. During a review of Resident 19's Minimum Data Set ([MDS], a resident assessment tool) dated [DATE], the MDS indicated Resident 19 was severely impaired in cognitive (thought process) functioning and required substantial support. The MDS indicated Resident 19 required supervision (helper provides verbal cues as resident completes activity) with eating but was dependent (helper does all the effort) with hygiene, bathing and dressing. The MDS indicated Resident 19 was dependent with mobility such as rolling, sitting and transfers. During a review of Resident 19's Order Summary Report, the Order Summary Report indicated that resident may have ear, nose and throat consultation as needed. The Order Summary Report indicated PT and or occupational therapy ([OT], a healthcare profession that helps people of all ages regain or improve the skills needed for daily living and working) evaluation and treatment. During a review of Resident 19's hearing consult note dated [DATE], the hearing consult notes indicated Resident 19 had moderately severe hearing loss to both left ear and right ear. The hearing consult note indicated the resident had hearing loss significant enough to qualify for hearing aids (a small, electronic, battery-operated medical device worn in or behind the ear that amplifies sound) and was eligible for them. The hearing consult note indicated Resident 19 had a greater hearing loss at higher frequencies (measure the number of sound wave vibrations per second) in the left ear, meaning the resident had greater difficulty discriminating between different sounds during conversations and (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hearing higher-pitched voices and sounds. During a review of Resident 19's physical therapy (PT) notes dated [DATE], the physical therapy notes indicated Resident 19 currently presented with generalized weakness and impaired bilateral (both) ankle range of motion ([ROM], full movement potential of a joint) resulting in increased immobility which limits Resident 19's independence with functional mobility (ability to move around to do activities of daily living). Resident 19 will benefit with PT services at this time to address these impairments with therapeutic exercises (planned performance of physical movements, postures, or activities designed to prevent impairments, restore physical function, reduce pain, and improve overall health and fitness) and activities (a structured physical activity prescribed to restore or maintain strength, flexibility, balance, and endurance), neuromuscular re-education (a PT/OT technique designed to retrain the nervous system to communicate properly with your muscles), wheelchair training to improve resident's muscle strength and endurance and improve her skills with functional activities (the physical and cognitive tasks performed in daily life, such as walking, eating, dressing, or working) to promote her return to prior level of function. During a review of Resident 19's occupational therapy (OT, rehabilitative profession that provides services to increase and/maintain a person's capability to participate in everyday life activities) notes dated [DATE], the occupational therapy notes indicated that Resident 19 presented with impairments in strength, gross motor coordination (involves using the large muscles in the arms, and legs to do movements like walking, running, and jumping), fine motor coordination (the ability to use small muscles in the hands, fingers, and wrists to perform small, and accurate movements), functional activity tolerance (a person's capacity to perform daily tasks like bathing, walking, or working without experiencing physical and/or emotional tiredness), active (engaging in action, producing motion) range of motion on right shoulder and postural stability (the ability to maintain the body's center of gravity within its base of support, allowing a person to stay upright) and balance resulting in limitations and/or restrictions in the areas of self-care and mobility which requires skilled OT services to increase independence with activities of daily living ([ADLs], basic, everyday self-care tasks required to manage one's health and maintain physical independence), maximize independence with ADLs, increase functional activity tolerance, strengthening, facilitate being able to sit, increase safety awareness and maximize rehabilitation (the process of helping individuals restore, maintain, or improve the physical, mental, or cognitive abilities they need for daily living) potential in order to live in environment with least amount of supervision. During a review of Resident 19's comprehensive care plan, undated, the comprehensive care plan did not indicate a focus or problem statement identifying the resident's hearing deficit or need for hearing aids, nor goals and interventions to ensure the resident could hear adequately and maintain functional hearing ability. The comprehensive care plan did not include focus or problem statement identifying that Resident 19 was receiving PT and OT services, nor goals and interventions to prevent decline in mobility or range of motion. During a concurrent interview and record review on [DATE] at 2:08 p.m., with the Social Services Director (SSD), Resident 19's undated comprehensive care plan was reviewed. The SSD stated there was no care plan implemented for Resident 19's hearing loss, and/or need for hearing aids. The SSD stated a care plan was a plan of care for residents with interventions and goals for addressing the specific needs of the residents. The SSD stated there should have been a care plan implemented for hearing loss with revisions as needed to make sure the goals and interventions are aligned with the resident's needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:25 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated there should be a care plan for residents receiving PT and/or OT services. RNS 1 stated there should be a care plan for residents receiving therapy, so the goals and interventions aligned with the resident's treatments. During a concurrent interview and record review on [DATE] at 4:32 p.m., with the Director of Rehabilitation (DOR), the physical therapy notes and occupational therapy notes dated [DATE] and comprehensive care plan, undated were reviewed. The DOR stated Resident 19 was receiving PT and OT services and started doing therapy with standing and splint placement. The DOR stated care plan for PT and OT should have been implemented for Resident 19 and that it was something the nursing staff should have started when Resident 19 was started on therapy services. The DOR stated a care plan was a plan of care for residents and how to care for the residents in the facility based on the services they receive. During an interview on [DATE] at 3:15 p.m. with the Director of Nursing (DON), the DON stated a care plan was important because it guides the facility staff for the care being provided to the residents. care plan should be implemented for each resident based on the care needed. The DON stated the care plan for hearing aid, HOH, and hearing loss should have been implemented because Resident 19 was hard of hearing, had a hearing test done that required hearing aids. The DON stated the care plan should be implemented to make sure the goals and interventions apply to the residents and if the interventions need to be revised, it can be revised as needed. The DON stated the care plan for PT/OT services should have been implemented. The DON stated a care plan for therapy was to see if the resident was getting better with the therapy services provided. The DON stated the care plan should have been implemented to follow the care of the resident receiving therapy services. During a review of the facility's policy and procedures (P&P) titled Comprehensive Care Plans, revised on [DATE], indicated, it is the policy to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. the comprehensive care plan will describe the following such as the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be furnished.the comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the residents' progress and alternative interventions will be documented, as needed. B. During a review of Resident 23's admission Record, the admission record indicated Resident 23 was initially admitted to the facility on [DATE] and was last readmitted on [DATE] with diagnoses including End Stage Renal Disease (ESRD – irreversible kidney failure), anemia (a condition in which the body does not have enough healthy red blood cells), heart failure (a condition in which the heart has difficulty pumping enough blood to meet the body's needs), and DM. During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23's cognition was moderately impaired. The MDS indicated Resident 23 required maximal assistance (helper performs more than half of the effort) from one staff member for toilet hygiene and showering, moderate assistance (helper performs less than half of the effort) from one staff member for bed mobility, transfers, and dressing, and supervision or touching assistance (helper provides verbal cues and/or touching, steadying, or contactˆguard assistance while the resident completes the activity) from one (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff member for oral hygiene and eating. During a concurrent observation and interview on [DATE], at 9:40 a.m., with Resident 23 in her room, Resident 23 was observed lying in bed watching television and asked to have her socks removed so her toenails could be observed. Resident 23's toenails were brittle, thick, long, and blackishˆyellow in color. Resident 23's feet appeared dry, and skin flakes were noted falling off when the socks were removed. Resident 23 stated she had been seen by the podiatrist few months ago but had not received any treatment for the fungal infection on her toenails. Resident 23 stated her toenails were long and painful when she stood up or when they were touched. Resident 23 stated the appearance of her infected toenails caused her embarrassment. Resident 23 stated if the facility podiatrist could not treat her toenails, she wanted to be seen by an outside specialist. During a review of Resident 23's Order Summary Report (OSR), dated [DATE], the OSR indicated an order for may see podiatrist was ordered on [DATE]. The OSR indicated an order dated [DATE] to apply A&D ointment (ointment that helps protect and heal skin) to the left and right foot and leave open to air for 60 days. The OSR also indicated that hydrocortisone 1% external cream (a medication used to treat itchiness and inflammation) was ordered on [DATE] to be applied topically to the affected area every six hours as needed for itchiness. The OSR indicated there was no order for clotrimazole (a medicated ointment to treat fungal infection) 1 percent (%) cream. The OSR indicated there were no orders to place a foot pillow or to avoid Resident 23 being barefoot during transportation as recommended. During a concurrent interview and record review on [DATE], at 11:38 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 23's Convalescent Podiatry Care Evaluation & Treatment, note dated [DATE], was reviewed. The Convalescent Podiatry Care Evaluation & Treatment note indicated Resident 23's toenails were thickened, discolored, brittle, and painful upon palpation (assessing a body with touch) . The Convalescent Podiatry Care Evaluation & Treatment note indicated Resident 23 had requested topical (applied to the skin) medication. The Convalescent Podiatry Care Evaluation & Treatment note indicated, the podiatrist recommended applying clotrimazole (a medicated ointment to treat fungal infection) 1 percent (%) cream daily, elevating the lower extremities with a foot pillow, applying lotion per facility protocol (A&D ointment or ammonium lactate 12%), providing footwear with a wide toe box, flexible upper, good arch support, and cushioned insoles, and avoiding going barefoot during transportation. RNS 1 stated that all recommendations should have been carried out as ordered and care -planned. RNS 1 stated she was unaware of the current condition of Resident 23's toenails. RNS 1 stated facility staff should have followed through with the podiatrist's recommendations to prevent further deformity (the state of being misshapen, distorted, or malformed) and pain in Resident 23's toenails. During a concurrent interview and record review on [DATE], at 4:07 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 23's Care Plan Report (CPR) titled Resident 23 has impairment to skin integrity related to fungal infection of bilateral toenails, revised [DATE], was reviewed. The CPR Goal indicated that the resident's condition would resolve without complication by the next review date of [DATE]. The CPR Interventions included monitoring for adverse effects of clotrimazole use, providing treatment as ordered, keeping the skin and toenails clean and dry, and obtaining a podiatry consultation as ordered. The MDSC stated that the podiatrist's recommended interventions should have been reflected in the care plan and implemented to prevent worsening of the infection and to appropriately treat the current condition. The MDSC stated the order for a foot pillow under the both feet was not implemented. The MDSC stated that the intervention treatment as ordered was not specific and should have listed the recommended treatments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 11:28 a.m., with the DON, the DON stated that the resident's care plan is the resident's specific plan of care and should be implemented as written. The DON stated that care plan interventions should be implemented and routinely reevaluated. The DON further stated that care plan interventions should reflect the recommendations from specialists and should be implemented to prevent recurrent events or complications. During a review of the facility's P&P titled Comprehensive Care Plan, revised [DATE], the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines: 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment . 7. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two out of four sampled residents (Resident 13 and 89) received Restorative Nursing Assistance services ([RNA] services focused on helping residents regain or maintain physical mobility) as indicated in the care plan. These failures had the potential to result in physical decline.Findings:During a review of Resident 13's admission Record, the admission Record indicated Resident13 was admitted to the facility on [DATE] with diagnoses including fracture (broken bone) of lower end of left femur (thigh bone), subsequent encounter for closed fracture (bone breaks but the skin remains intact) with routine healing, general weakness, lack of coordination, abnormal posture, and derangement of meniscus (damage in the knee) due to old tear, unspecified knee.During a review of Resident 13's Minimum Data Set ([MDS] a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 13's cognition was intact. The MDS indicated Resident 13 needed set-up assistance with oral hygiene and partial assistance (helper does less than half the effort to complete the task) with toileting hygiene, showering, and dressing. During a review of Resident 13's undated Care Plan titled, Restorative Nursing Program the intervention indicated, starting 4/9/2026, Active Range of Motion ([AROM] movement of a joint produced entirely by the resident's own voluntary muscle contractions, without any outside assistance) both upper extremities (arms), three times a week as tolerated.During a review of Resident 13's undated Care Plan titled, Potential for decline in range of motion (the measurement of the distance and direction a specific joint can move), bed mobility skills, self-feeding skills related to fracture indicated the intervention, starting 4/9/2026, AROM right lower extremities, gentle Active Assist of Range of Motion ([AAROM] a physical therapy and rehabilitation technique where the resident uses their own muscle power to move a joint, while an external force-such as a therapist assists with the movement) left lower extremity, or may use bilateral lower extremity (BLE) omni cycle (motorized equipment used for rehabilitation) for 15 minutes three times a week, as tolerated.During a review of Resident 13's Documentation Survey Report v2, 4/2026 and 5/2026, the report indicated the facility staff did not administer RNA services three times a week during the weeks of 4/19/2026, 4/26/2026, and 5/3/2026. During a concurrent interview and record review on 5/19/2026 at 3:06 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 13's RNA services provided from 4/2024 to 5/2026 were reviewed. RNS 1 stated Resident 13 did not receive RNA services from 4/2024 to 5/2026 three times a week as care planned. During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis (muscle break down), contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) in multiple sites, and reduced mobility. During a review of Resident 89's MDS, dated [DATE], the MDS indicated Resident 89's cognition was moderately impaired. The MDS indicated Resident 89 needed supervision when eating, partial assistance with oral hygiene, toileting hygiene, maximal assistance (helper does more than half the effort to complete the task) with personal hygiene, and showering. During a review of Resident 89's undated care plan titled, Restorative Nursing Program indicated the following interventions, starting 6/26/2025:1. AAROM both upper extremities, five times a week.2. Apply knee splints (medical device used to immobilize, protect, and support an injured body part) to left and right knees, to be worn by the resident for up to 3 hours five times a week, as tolerated.3. Passive Range of Motion ([PROM] movement applied to a joint entirely by an external force-such as a caregiver) both lower extremities five times a week as tolerated.During a review of Resident 89's Documentation Survey Report v2, 11/2025, 12/2025, and 1/2026, the reports indicated RNA services were not administered five times a week: on the weeks of 11/9/2025, 11/23/2025, 11/30/2025, 12/21/2025, and 1/4/2026. During a concurrent interview and record review on 5/21/2026 at 10:33 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 89's (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RNA services provided from 11/2025 to 1/2026 were reviewed and RNS 1 stated Resident 89 did not receive RNA services from 11/2025 to 1/2026 five times a week as care planned. During an interview on 5/21/2026 at 12:24 p.m. with the Director of Nursing (DON), the DON stated RNA services were important to maintain and improve the residents' range of motion. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Programs, revised 4/20/2026, the P&P indicated it was the policy of the facility to provide maintenance and restorative services to maintain or improve resident's abilities to the highest practicable level.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure bowel and bladder frequency was documented according to facility documentation practices for one of one sample resident (Resident 14).This failure had the potential to result in delay of diagnosis and treatment of bowel or bladder issues.Findings:During a concurrent interview and record review on 5/20/26 at 10:27 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 14's B&B- Bowel elimination documentation and medication administration record (MAR) dated 5/4/2026 through 5/10/2026 were reviewed. LVN 3 stated the documentation indicated Resident 14 did not have a bowel movement from 5/4/2026 through 5/10/2026. LVN 3 stated if a resident has no bowel movement in three days that facility will implement interventions and give administer stool softeners indicated.During an interview on 5/20/2026 at 10:27 a.m. with LVN 4, LVN 4 stated she remembered Resident 14 having a bowel movement within the timeframe of 5/4/2026 through 5/10/2026 because she translates for the CNAs to communicate to with residents. During an interview on 5/20/2026 at 10:48 a.m. with Resident 14 and LVN 4, LVN 4 translated and inquired whether the resident had experienced any difficulties with bowel movements and the frequency of his restroom use. Resident 14 stated that he had no issues and reported having a bowel movement every day or every two days.During an interview on 5/21/2026 at 4:08 p.m., with Director of Staff Development (DSD) 2, DSD 2 stated correct documentation was important in providing a clear indicator of the resident's daily status, functional abilities, overall health for the day, and any change in condition. DSD 2 stated CNAs failing to chart accurately could lead to safety issues. The DSD 2 stated that errors in CNA documentation could be problematic, as charge nurses depend on this information to provide hands on care to residents.During a review of the facility's policy and procedure (P&P) titled Documentation in Medical Record, dated 12/19/2022 indicated documentation shall be accurate, relevant and complete, containing sufficient details about the resident's care and/or response to care.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, and address the resident's preferences by making reasonable efforts to accommodate her needs, and document regarding a preferred seating location in the activity room for one of two sampled residents (Resident 43):These failures have the potential to cause emotional distress, decreased satisfaction with care, and a diminished quality of life.Findings:During a review of Resident 43's admission Record, the admission Record indicated the facility admitted Resident 43 on 8/5/2009 and readmitted on [DATE] with diagnoses including hemiplegia (weakness to one side of the body), hemiparesis (inability to move one side of the body) following cerebral infraction (stroke-blockage of the flow of blood brain, causing or resulting in brain tissue death), contracture (loss of motion of a joint) of left ankle and left elbow.During a review of Resident 43's History and Physical (H&P), dated 8/11/2025, the H&P indicated Resident 43 had the ability to understand and make decisions.During a review of Resident 43's Minimum Data Set (MDS- a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 43 was cognitively (functions your brain uses to think, pay attention, process information, and remember things) intact. The MDS indicated Resident 43 required set up assistance with eating, supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with oral hygiene, moderate assistance (helper does less than half the effort to complete the task) with personal hygiene, was dependent(helper does all of the effort) with toileting hygiene, showering. The MDS also indicated Resident 43 used a manual wheelchair for mobility.During a review of Resident 34's admission Record, the admission record indicated the facility admitted Resident 34 on 10/5/2024 with diagnoses including hemiplegia, hemiparesis affecting right dominant side.During a review of Resident 34's H&P, dated 3/25/2026, the H&P indicated, Resident 58 had ability to make health care decisions.During a review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 was cognitively intact. The MDS indicated Resident 34 required supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with eating, moderate assistance (helper does less than half the effort to complete the task) with oral hygiene, maximal assistance (helper does more than half the effort to complete task) with toileting hygiene, showering, and personal hygiene.During a concurrent observation and interview on 5/18/2026 at 10:23 a.m., in Resident 43's room, Resident 43 was observed in seated in an oversized wheelchair and wearing pressure relieving ankle foot orthosis (PRAFO, plastic boot-shaped brace to support your foot and ankle in the right position) on the left leg, doing crossword puzzles. Resident 43 stated there was limited appropriate seating available to meet her needs in the activity room. Resident 43 stated there was only one table in the activity room, which was wider, better suited to her size, and did not interfere with her wheelchair footrests. Resident 43 stated she was not always able to secure the preferred seat due to her condition and scheduled treatments in the morning.During an interview on 5/20/2026 at 2:17 p.m., with Resident 43, Resident 43 stated, on the previous Friday (5/15/2026), Resident 34 was seated at the table she (Resident 43) could comfortably sit at. Resident 43 stated when she brought this to the Activity Directors (AD)'s attention, the AD did not address her concern or attempt to accommodate her seating preference, and informed her, in front of the rest of the residents in the activity room, that seating was first come first served. Resident 43 stated she felt embarrassed and uncomfortable.During an interview on 5/20/2026 at 2:55 p.m., with the AD, the AD stated, on the previous Friday, Resident 34 was already sitting at Resident 43's preferred seat when Resident 43 arrived and expressed her preference regarding the seat in the activity room. The AD stated she asked Resident 43 to sit at a different table. The AD did not assess Resident 43's seating needs, explore alternatives, options or document regarding Resident 43's preferences.During an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 5/21/2026 at 10:12 a.m. with Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility 1, RNA 1 stated there was one out of six tables in the activity room where Resident 43 appeared comfortable, that table near the door was lower and wider, did not interfere with Resident 43's wheelchair leg rests, and allowed Resident 43 to comfortably rest her arms during activities. RNA 1 stated Resident 43 could not comfortably sit at the other tables. RNA 1 stated facility staff should have assessed and discussed Resident 43's seating preference and explored possible alternatives, to ensure Resident 43 could comfortably participate in activities.During an interview on 5/21/2026 at 3:24 p.m., with the Director of Nursing (DON), the DON stated Activity Staff should assess residents' needs when residents express their preferences to ensure their rights are respected and try to provide alternatives or communication to find a way to meet their needs.During a review of the facility's policy and procedure (P&P) titled, Promoting/ Maintaining Resident Dignity, dated 12/19/2022, the P&P indicated during interactions with residents, staff must report, document and act upon information regarding resident preferences.During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, dated 12/19/2022, the P&P indicated the facility staff shall make efforts to reasonably accommodate the needs and preferences of the resident as they make use of their physical environment.During a review of the facility's policy and procedure (P&P) titled, Activities, dated 12/19/2023, the P&P indicated the facility will consider accommodations in schedules, supplies and timing to optimize a resident's ability to participate in an activity of choice. The P&P also indicated the facility will provide one or more rooms designated for resident dining and activities. These rooms will be adequately furnished.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide accurate information in the Minimum Data Set ([MDS], a resident assessment tool) for one of five sampled residents (Resident 19) who had aggressive physical (any intentional action that causes or is intended to cause bodily harm, pain, or injury to another person, or oneself) and verbal behavior (communication intended to harm, control, or intimidate another person) symptoms receiving medication.This deficient practice had the potential to result in inaccurate assessments and services for the resident due to inaccurate MDS assessment and care screening.Findings:During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive state of decline in mental abilities). During a review of Resident 19's history and physical (H&P), dated 1/9/2026, the H&P indicated Resident 19 had the capacity to understand and make decisions.During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 was severely impaired in cognitive (thought process) functioning. The MDS indicated Resident 19 required supervision (helper provides verbal cues as resident completes activity) with eating but was dependent (helper does all the effort) with hygiene, bathing and dressing. The MDS indicated Resident 19 was dependent with mobility such as rolling, sitting and transfers. The MDS indicated Resident 19 did not have physical behavioral symptoms (hitting, kicking, pushing others), verbal behavioral symptoms (screaming or cursing at others), or other behavioral symptoms (hitting or scratching self, or throwing items). During a review of Resident 19's Order Summary Report, the Order Summary Report indicated monitoring episodes of ((a mental condition where a person has trouble telling what is real from what is not) manifested by physical aggression as evidence by grabbing, scratching towards others and recording the number of times the behavior was observed every shift. The Order Summary Report indicated to monitor episodes of psychosis manifested by verbal aggression as evidence by screaming and cursing at others and recording the number of times the behavior was observed every shift.During a review of Resident 19's Monitoring Record (the systematic process of observing, defining, and logging specific actions over time) dated March 2026, indicated, Resident 19 had 16 days of physical aggression as evidence by grabbing, scratching towards others was observed, and had 18 days of verbal aggression as evidence by screaming, and cursing at others was observed. During a review of Resident 19's Monitor Record, dated April 2026, indicated, Resident 19 had 19 days of physical aggression as evidence by grabbing, scratching towards others was observed, and had 20 days of verbal aggression as evidence by screaming, and cursing at others was observed.During a review of Resident 19's Monitor Record, dated May 2026, indicated, Resident 19 had 15 days of physical aggression as evidence by grabbing, scratching towards others was observed so far, and had 15 days of verbal aggression as evidence by screaming, and cursing at others was observed so far.During a concurrent interview and record review on 5/21/2026 at 10:20 a.m., with the Social Service Assistant (SSA), the MDS dated [DATE] and the Monitor Record for March, April and May 2026 were reviewed. The SSA stated the Monitor Record indicated Resident 19 had episodes of physical aggression and verbal aggression for the month of March, April, and May 2026 and the MDS assessment indicated Resident 19 had no behaviors, but should have indicated 4 to 6 days per week. The SSA stated when she was doing the MDS assessment, she went based off what she observed from the resident but that it was not accurate as the SSA only saw Resident 19 for short periods at a time and not every second of the day. The SSA stated she should have double checked with other facility staff such as the nursing staff who observe and care for this resident all day every day. The SSA stated Resident 19 did have a care plan for physical and verbal aggression and that should have been an indicator Resident 19 had (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	some behavioral symptoms. During a concurrent interview and record review on 5/21/2026 at 10:42 a.m. with MDS Nurse (MDSN), the MDS dated [DATE] and Monitor Record for March, April and May 2026 were reviewed. MDSN stated that the role of the MDSN was to ensure the accuracy of the MDS assessment before submission to the Centers for Medicare & Medicaid Services ([CMS, a federal agency within the U.S. Department of Health and Human Services responsible for operating and administering the federal Medicare program, as well as partnering with state governments to run Medicaid). The MDSN stated that she was expected to communicate with other facility staff who contribute to the MDS assessment to confirm its accuracy. The MDSN stated Resident 19 did have behavioral symptoms according to the Monitor Record and the MDS assessment should have indicated so. During an interview on 5/21/2026 at 3:25 p.m., with the Director of Nursing (DON), the DON stated that the MDS assessment must provide an accurate evaluation of all residents in the facility. The DON stated that the comprehensive MDS assessment outlines resident care needs including behaviors, psychosocial status, dietary needs, and more that get submitted to CMS. The DON stated that the assessment reflects the care and treatment provided to the residents and therefore must be accurate.During a review of the facility's policy and procedure (P&P) titled MDS 3.0 Completion, revised 12/19/2022, indicated, residents are assessed, using a comprehensive assessment process, to identify care needs. the responsibility of all sections of the MDS will be clearly assigned. People completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections. The R.N. Coordinator signs, dates, and attests to timely completion of the MDS, once all other disciplines have completed their sections.During a review of the facility's P&P titled MDS Coordinator (Nurse), dated 2024, indicated the MDS Coordinator does the coordination of the facility's Resident Assessment Instrument (RAI) process in accordance with state and federal regulations and ensure accurate completion of all MDS assessments and any supporting assessments or clinical documentation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive, personˆcentered care plan was revised and updated after an unwitnessed second fall on 3/17/2026 that resulted in a cut to the left temple (the area on either side of the head behind the eyes) for one of five sampled residents (Resident 7). This failure had the potential to result in repeated falls and injuries for Resident 7. During a review of Resident 7's admission Record, the admission record indicated that Resident 7 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses included Parkinson's disease (a progressive disorder of the nervous system characterized by tremors, muscle rigidity, and slow, imprecise movements), dementia (a progressive decline in cognitive functioning), syncope (a temporary loss of consciousness), and a history of falls.During a review of Resident 7's History and Physical (H&P), dated 1/29/2026, the H&P indicated that Resident 7 did not have the capacity (ability) to understand information and make decisions.During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 5/5/2026, the MDS indicated that Resident 7 required maximal assistance (helper performs more than half of the effort) from one staff member for transfers, showering, toileting hygiene, and lowerˆbody dressing. The resident required moderate assistance (helper performs less than half of the effort) from one staff member for oral hygiene, upperˆbody dressing, personal hygiene, and bed mobility. The resident required supervision or touching assistance (helper provides verbal cues and/or touching, steadying, or contactˆguard assistance while the resident completes the activity) from one staff member for eating.During a review of Resident 7's Nursing Progress Note, dated 3/17/2026, the Nursing Progress Note indicated that Resident 7 was found sitting on the floor mat facing the cabinet, with a skin cut noted on the left temple. The Nursing Progress Note further indicated that Resident 7 was transferred to a General Acute Care Hospital (GACH) via 911, as directed by the primary care physician. The Nursing Progress Note indicated, upon return from GACH, Resident 7 was noted to have Steri-Strips (thin, sterile, adhesive skin closures used to secure small cuts, lacerations, and surgical incisions) applied to the left eyebrow, near the left templeDuring a phone interview on 5/18/2026, at 12:26 p.m., with Resident 7's Family Member (FM) 1, FM 1 stated that Resident 7 had two fall incidents on 1/20/2026 and 3/17/2026. FM 1 stated that both falls were unwitnessed, and Resident 7 was found on the floor. FM 1 stated that Resident 7 sustained a fracture (broken bone) during the first fall incident and suffered a deep cut above the eyebrow during the second fall incident. FM 1 stated she was not notified of Resident 7's falls right away and was very concerned about Resident 7's safety.During a concurrent interview and record review on 5/20/2026, at 11:58 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 7's Situation, Background, Assessment, Recommendation (SBAR; a technique that can be used to facilitate prompt and appropriate communication between healthcare staff) Summary for Providers, dated 3/17/2026, was reviewed. The SBAR Summary for Providers indicated Resident 7 was found sitting on the floor mat near the foot of the bed, facing the bedside nightstand drawer, with a skin cut noted on the left temple area and slight bleeding. RNS 1 stated that Resident 7 had a first fall incident on 1/20/2026 which resulted in an acute mildly displaced right femoral neck fracture (a type of hip fracture occurring just below the ballˆandˆsocket joint), and the 3/17/2026 incident was the second fall. RNS 1 stated that both fall incidents represented a change in condition, and Resident 7's care plan should have been updated and revised to reflect both incidents and update, change or improve interventions to prevent falls.During a concurrent interview and record review on 5/20/2026, at 4:17 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 7's Care Plan (CP) titled Resident 7 is at risk for repeat falls/injury. readmitted on [DATE] after right hip total arthroplasty (surgical reconstruction or replacement of a joint), revised 4/17/2026, was reviewed. The CP Goal indicated that Resident 7 would not sustain a major injury from a fall through the review date of (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/2/2026. The CP Interventions indicated, instructing 1:1 staff to stay with the resident at all times and placing the call light within reach. The CP did not include any documentation regarding the second unwitnessed fall that occurred on 3/17/2026, which resulted in a deep cut to the left temple area. The MDSC stated that staff should have updated and revised the care plan whenever there was a change in condition, and that the second unwitnessed fall on 3/17/2026 was considered a change in condition. The MDSC stated that the care plan should have been updated to reflect the second fall and should have included interventions specific to this incident, as different causes of unwitnessed falls may require different interventions. The MDSC stated that the purpose of care planning is to prevent repeated incidents and injuries.During an interview on 5/21/2026, at 3: 26 p.m., with the Director of Nursing (DON), the DON stated, stated that residents' care plans are required to be updated and revised whenever there is a change in condition and at least quarterly to ensure they reflect the residents' current health status. The DON further stated that the Resident 7's second fall incident constituted a change in condition, and the care plan should have been updated and revised to address the fall, implement additional interventions, and prevent further injuries or repeated falls. The DON stated, she acknowledged that this revision did not occur.During a review of the facility's Policy and Procedure (P&P) titled, Care Plan Revisions Upon Status Change, revised 12/19/2022, the P&P indicated, Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident conditions and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the residents will report resident responses to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff members will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide nail care to one of four sampled residents (Resident 89).This failure resulted in Resident 89 having long, unclean fingernails and had the potential to result in infections.Findings:During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis (rare muscle injury where your muscles break down), contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) in multiple sites, and reduced mobility.During a review of Resident 89's Minimum Data Set ([MDS] a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 89's cognition was moderately impaired. The MDS indicated Resident 89 needed maximal assistance (helper does more than half the effort to complete the task) with personal hygiene.During a review of Resident 89's Care Plan initiated 8/21/2023, the care plan focus indicated, Resident 89 had Self-Care Deficit require assistance with most activities of daily living ([ADL] activities such as bathing, dressing and toileting a person performs daily). The care plan indicated to provide Resident 89 assistance with ADLs as needed.During a concurrent observation and interview on 5/18/2026 at 11:27 a.m., in Resident 89 room with Resident 89, Resident 89 had long dirty fingernails and Resident 89 stated she preferred to have clean fingernails.During a concurrent observation and interview on 5/18/2026 at 11:30 a.m., in Resident 89 room with Certified Nurse Assistant (CNA) 2, CNA 2 observed Resident 89's long dirty fingernails and stated the nails looked dirty and needed to be cleaned or trimmed.During an interview on 5/21/2026 at 12:24 p.m. with the Director of Nursing (DON), the DON stated Resident 89's nails should be kept clean and trimmed for a dignified experience and for hygienic reasons.During a review of the facility's policy and procedure (P&P) titled, Nail Care revised 12/19/2022, the P&P indicated routine cleaning, inspection, and trimming of nails will be provided as the need arises.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement the podiatrist (a medical specialist dedicated to the prevention, diagnosis, and treatment of disorders of the foot, ankle, and lower leg) recommended treatment for a toenail fungal infection for one of three sampled residents (Resident 23).This failure resulted in a delay in necessary foot care services and had the potential to negatively affect Resident 23's physical health and psychosocial wellˆbeing.Findings:During a review of Resident 23's admission Record, the admission record indicated Resident 23 was initially admitted to the facility on [DATE] and was last readmitted on [DATE]. Resident 23's documented diagnoses included End Stage Renal Disease (ESRD - irreversible kidney failure), anemia (a condition in which the body does not have enough healthy red blood cells), heart failure (a condition in which the heart has difficulty pumping enough blood to meet the body's needs), and Diabetes Mellitus (DM - a disorder characterized by impaired blood sugar control and poor wound healing).During a review of Resident 23's Minimum Data Set (MDS - resident assessment tool), dated 5/5/2026, the MDS indicated Resident 23's cognition was moderately impaired (a decline in mental functioning-memory, language, or reasoning). The MDS indicated that Resident 23 required maximal assistance (helper performs more than half of the effort) from one staff member for toilet hygiene and showering, moderate assistance (helper performs less than half of the effort) from one staff member for bed mobility, transfers, and dressing, and supervision or touching assistance (helper provides verbal cues and/or touching, steadying, or contactˆguard assistance while the resident completes the activity) from one staff member for oral hygiene and eating.During a review of Resident 23's Order Summary Report (OSR), dated 5/19/2026, the OSR indicated that an order for may see podiatrist was ordered on 2/6/2026. The OSR indicated an order dated 3/25/2026 to apply A&D ointment to the left and right feet and leave open to air for 60 days. The OSR also indicated that hydrocortisone 1% external cream (a medication used to treat itchiness and inflammation) was ordered on 2/6/2026 to be applied topically to the affected area every six hours as needed for itchiness. The OSR indicated there was no order for clotrimazole. The OSR indicated there were no orders to place a foot pillow or to avoid Resident 23 being barefoot during transportation as recommended. During a concurrent observation and interview on 5/18/2026, at 9:40 a.m., with Resident 23 in her room, Resident 23 was observed lying in bed watching television and asked to have her socks removed so her toenails could be observed. Resident 23's toenails were brittle, thick, long, and blackishˆyellow in color. Resident 23's feet appeared dry, and skin flakes were noted falling off when the socks were removed. Resident 23 stated she had been seen by the podiatrist few months ago but had not received any treatment for the fungal infection on her toenails. Resident 23 stated her toenails were long and painful when she stood up or when they were touched. Resident 23 stated the appearance of her infected toenails caused her embarrassment. Resident 23 stated if the facility podiatrist could not treat her toenails, she wanted to be seen by an outside specialist.During a concurrent interview and record review on 5/20/2026, at 11:38 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 23's Convalescent Podiatry Care Evaluation & Treatment, dated 3/25/2026, was reviewed. The Convalescent Podiatry Care Evaluation & Treatment indicated that Resident 23's toenails were thickened, discolored, brittle, and painful upon palpation. The Convalescent Podiatry Care Evaluation & Treatment indicated that Resident 23 had requested topical medication. The Convalescent Podiatry Care Evaluation & Treatment indicated, the podiatrist recommended applying clotrimazole (an medicated ointment to treat fungal infection) 1 percent (%) cream daily, elevating the lower extremities with a foot pillow, applying lotion per facility protocol (A&D ointment or ammonium lactate 12%), providing footwear with a wide toe box, flexible upper, good arch support, and cushioned insoles, and avoiding going barefoot during transportation. RNS 1 stated that all recommendations should have been carried out as ordered and care -planned. RNS 1 stated she was unaware of the current condition of Resident 23's toenails. RNS 1 stated the (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff should have followed through with the podiatrist's recommendations to prevent further deformity (the state of being misshapen, distorted, or malformed) and pain in Resident 23's toenails.During an interview on 5/20/2026, at 1:55 p.m., with the Social Service Director (SSD), the SSD stated she was not aware of Resident 23's current condition of her toenails. The SSD stated she should have contacted the podiatrist's office to schedule visits more frequently. The SSD stated the podiatrist visits were routinely scheduled every 60 days when there were no significant concerns; however, based on Resident 23's current condition, she might have needed more frequent visits. The SSD stated that Resident 23 was diagnosed with Diabetes Mellitus (DM) and emphasized that foot care is critical in preventing complications such as diabetic foot ulcers (open sores or wounds on the foot commonly associated with diabetes due to poor circulation and nerve damage). The SSD stated that she would have referred Resident 23 to an outside specialist if she had known Resident 23 was dissatisfied with her current treatment.During an interview on 5/21/2026, at 11:28 a.m., with the Director of Nursing (DON), the DON stated that staff should have followed through with the podiatrist's recommendations and implemented them. The DON stated that staff should have placed a pillow under the resident's legs and feet to prevent pressure injury (localized, pressureˆrelated damage to the skin and/or underlying tissue, usually over a bony prominence), applied clotrimazole to treat the fungal infection, applied lotion to restore moisture, and ensured the resident had wellˆfitted shoes to prevent diabetic ulcers and deformities. The DON stated that the fungal toenail infection was a serious concern for individuals with diabetes because the nails can become thick and brittle, creating pressure points inside shoes that may lead to skin tears, ulcers, and severe secondary bacterial infections that are difficult to heal due to poor circulation. The DON further stated that the condition could also affect Resident 23's psychosocial wellˆbeing and contribute to social isolation.During a review of the facility's Policy and Procedure(P&P) titled, Skin Integrity- Foot Care, revised 9/12/2023, the P&P indicated, Policy: It is the policy of this facility to ensure residents receive proper treatment and care within professional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health. This policy pertains to maintaining the skin integrity of the foot. Policy Explanation and Compliance Guidelines: 1. The facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the residents' medical conditions. a. The facility will utilize a systematic approach for the prevention and management of foot ulcers, including efforts to identify risk; stabilize, reduce, or remove underlying risk factors; monitor the impact of the interventions; and modify the interventions as appropriate . 2. Assessment of Risk. b. The comprehensive assessment process will be utilized for identifying additional risk factors or conditions that increase risk for impaired skin integrity of the foot. Examples include, but are not limited to: diabetes, peripheral vascular disease, peripheral arterial disease, venous insufficiency, peripheral neuropathy, and lack of sensation in feet. 3. Interventions for Prevention and to Promote Healing . ii. Appropriate offloading or orthopedic devices, diabetic shoes, or pressure-relieving. Iii. Referrals to podiatrists, vascular or orthopedic surgeons, or wound care physicians will be made when appropriate.During a review of the facility's Policy and Procedure(P&P) titled, Podiatry Services, revised 12/2/2024, the P&P indicated, Policy Explanation and Compliance Guidelines: 2.Foot disorders which may require treatment include, but are not limited to: corns, neuromas, calluses, hallux valgus (bunions), digiti flexus (hammertoe), heel spurs, and nail disorders.3.Employees should refer any identified need for foot care to the social

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	055918	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure a performance review for one of two Certified Nurse Assistants (CNA 9) was completed at least once every 12 months.This failure had the potential to result in poor resident health outcomes.Findings:During a concurrent interview and record review on 5/20/2026, at 2:19 p.m., with the Director of Staff Development (DSD), CNA 9's Employee File, dated from 8/2022 to 5/2026 was reviewed. The Employee File indicated, no performance evaluation was completed or documented for the year 2025, nor was an annual evaluation completed as required. The DSD stated, the employee performance evaluations are required to be completed and documented upon hire, 90 days after hire, and annually thereafter. The DSD stated, CNA 9's performance evaluation had not been conducted or documented.During an interview on 5/21/2026, at 11:48 a.m., with the Director of Nursing (DON), the DON stated that employee performance evaluations should be conducted at least annually to identify strengths and weaknesses in an employee's skills. The DON stated, annual performance evaluations are essential to reinforce strengths and address weaknesses to ensure staff are competent to provide appropriate care to residents.During a review of the facility's Policy and Procedure (P&P) titled, Evaluation Process, revised 12/19/2022, the P&P indicated, Policy: It is the policy of our facility to review the work performance of employees with a formal written evaluation annually. Policy Explanation and Compliance Guidelines: c. The manager/Supervisor is to complete the Employee Evaluation Form .f. Once the evaluation review is complete, the employee and manager should sign the evaluation form. g. Original evaluation tools are to be forwarded to the Human resources within the facility to be processed and placed in the appropriate personnel file.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to:a. Ensure one of five residents (Resident 91) received ondansetron (medication to treat nausea and vomiting) in a timely manner. As a result, Resident 91was not treated for nausea and vomiting for seventeen hours, which had the potential to cause discomfort. b. Maintain accurate documentation of hydrocodone acetaminophen (a controlled medication [medications with a high potential for abuse] used to manage moderate to severe acute and chronic pain) tablet on the controlled drug record ([CDR], a document indicating the inventory and administration of controlled substances) sheet, affecting one resident (Resident 5) in one of two inspected medication carts (Station 2 Medication Cart).This deficient practice of failure to maintain accurate documentation of controlled medications poses a significant risk for misuse, drug diversion, and inaccurate medication count. Findings: a.During a review of Resident 91's admission Record, the admission Record indicated Resident 91 was admitted to the facility on [DATE] with diagnoses including fracture (broken bone) of neck, and protein-calorie malnutrition (nutritional deficiency that occurs when the body lacks both adequate calories and protein). During a review of Resident 91's Minimum Data Set ([MDS] a resident assessment tool), dated 4/6/2026, the MDS indicated Resident 91's cognition (thought process)was intact. The MDS indicated Resident 91 required partial assistance (helper does less than half the effort) with eating, oral hygiene, was dependent (helper does all the effort to complete the task) with toileting hygiene, and showering. During a review of Resident 91's Nurses Progress Notes, 4/12/2026 at 9:26 a.m., the note indicated the resident was nauseated and does not have the medication. During a review of Resident 91's Change in Condition Evaluation – V 5.1 C, 4/12/2026 at 9:27 a.m., the form indicated Resident 91 complained of nausea and had vomited in the trash can. During a review of Resident 91's order, dated 4/12/2026 9:39 a.m., the order indicated Ondansetron tablet 4 milligrams, give one tablet by mouth every 6 hours as needed for nausea and vomiting. During a review of Resident 91's Nurses Progress Notes 4/12/2026 5:13 p.m. Resident 91 reported vomiting and having abdominal discomfort. During a review of Resident 91's Medication administration Record (MAR), 4/2026, the MAR indicated Resident 91 did not receive Ondansetron on 4/12/2026 at 9:39 a.m. and at 5:12 p.m. Resident 91 received Ondansetron on 4/13/2026 at 1:55 a. and it was effective. During a concurrent interview and record review on 5/19/2026 at 2:06 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 91's medical records were reviewed. RN1 stated on 4/12/2026 at approximately 9:30 a.m., Resident 91 had nausea and vomiting and the medication the physician ordered was unavailable. RNS 1 stated on 4/12/2026 at 5:13 p.m., Resident 91 complained of nausea and vomiting and did not receive the Ondansetron. RNS 1 stated Resident 91 received his medication the next day on 4/13/2026 at approximately 1:55 a.m., 16 hours after it was ordered. RN 1 stated Resident 19 should have received his medication right away. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 5/21/2026 at 12:24 p.m. the DON stated if a resident complained of nausea and was vomiting the ordered medication should be administered as soon as possible. During a review of the facility's Policy and Procedure (P/P) titled, Medication Administration, revised 12/19/2022, the P/P indicated medication will be administered as ordered by the physician in accordance with professional standards in a timely manner. During a review of the facility's P/P titled, Medication Reordering, revised 12/19/2022, the P/P indicated acquisition of medication should be completed in a ensure medications are administered in a timely manner to meet the residents needs. b. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to facility on 11/10/2023 and readmitted on [DATE]. Resident 5's diagnoses included End Stage Renal Disease ([ESRD], irreversible kidney failure), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and congestive heart failure ([CHF], a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 5's History and Physical (H&P), dated 3/13/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set ([MDS], a resident assessment tool), dated 5/12/2026, the MDS indicated Resident 5 had intact cognitive (thought process) function. The MDS indicated Resident 5 required supervision (helper provides verbal cues and/or touch assistance) to moderate assistance (helper does less than half the effort) with self-care abilities such as eating, hygiene, bathing and dressing. The MDS indicated Resident 5 required supervision with mobility such as rolling, sitting, standing and transfers. During a review of Resident 5's Order Summary Report, dated 5/18/2026, the Order Summary Report indicated hydrocodone-acetaminophen tablet 7.5-325 milligram ([mg], a unit of measurement for medication) give one tablet by mouth every four hours as needed for severe pain seven to ten out of ten pain (pain scale rating pain from 0 no pain to 10 excruciating pain) During a review of Resident 5's Medication Administration Record (MAR) for May 2026, the MAR indicated on 5/21/2026, hydrocodone-acetaminophen tablet 7.5-325 mg medication was last given at 2:17 a.m. During a concurrent observation, interview and record review on 5/21/2026 at 2:20 p.m., with Licensed Vocational Nurse (LVN) 4 at the Station 2 Medication Cart, Resident 5's hydrocodone-acetaminophen medication bubble pack, and the facility's CDR sheet for hydrocodone-acetaminophen tablet were reviewed. Resident 5's hydrocodone-acetaminophen medication bubble packs had 32 tablets. The facility's CDR sheet indicated a quantity of 33 tablets remaining with the last dose administered on 5/20/2026 at 8:04 p.m. LVN 4 opened up the MAR on the computer on the Station 2 Medication Cart for Resident 5 and the MAR indicated Resident 5 received the hydrocodone-acetaminophen tablet 7.5-325 mg pain medication around 2:00 a.m. LVN 4 stated the licensed nurse that administered the medication at that time forgot to write on the CDR sheet that the pain medication was given so that was why there was a discrepancy with the medication count on the CDR sheet. LVN 4 stated the importance of making sure the CDR sheet count matches the number of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablets in the bubble pack because the medication was a narcotic medication and both the CDR sheet and the bubble pack had to match to ensure there was no diversion. LVN 4 stated the CDR was a legal document and facility staff had to make sure the medication was given to the correct resident and that no error was made. During an interview on 5/28/2026 at 3:35 p.m. with the Director of Nursing (DON), the DON stated the CDR sheet needed to be accurate. The DON stated if it was not accurate, there could be possible diversion, so the facility staff must make sure the medication was given to the correct resident. The DON stated the MAR, CDR sheet and bubble pack should all match to make sure medication was given to the correct resident, not to the wrong resident or even facility staff. The DON stated there should be no discrepancy as this medication was a narcotic (a potent, medically defined class of psychoactive drugs that dull the senses, relieve moderate to severe pain, and often induce stupor or sleep) medication. During the facility's policy and procedure (P&P) titled Medication Administration, revised 12/19/2022, indicated, medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.sign MAR after administered.if medication is a controlled substance, sign narcotic book.correct any discrepancies and report to nurse manager.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the fruit cup and health shake (nutrient dense beverage) as indicated on one of five residents breakfast menu (Resident 12).This failure had the potential to result in loss of appetite and cause unplanned weight loss.Findings:During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), gastroesophageal reflux disease (digestive disorder most often causes a burning and sometimes squeezing sensation in the mid-chest), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 12's Minimum Data Set ([MDS] a resident assessment tool), dated 4/16/2026, the MDS indicated Resident 12 had severely impaired cognition. The MDS indicated Resident 12 was dependent (helper does all the effort to complete the task) on staff with activities of daily living (activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 12's Order Summary report, dated 5/19/2026, the orders indicated Regular Diet, with minced and moist texture (features finely mashed or ground foods that are soft, cohesive, and easy to swallow), fortified (adding nutrient dense to meal) and a health shake 4 ounces with meals.During a concurrent observation and interview on 5/19/2026 at 7:48 a.m., in Resident 12's room, with Certified Nurse Assistant (CNA) 1, there was no fruit cup and health shake on Resident 12's tray and bedside table. CNA 1 stated there was no fruit cup or health shake on Resident 12's tray for breakfast while CNA 1 was helping Resident 12 to eat.During a concurrent interview and record review on 5/19/2026 at 8:05 a.m. with the Dietary Supervisor (DS), the facility's Diet Spreadsheet: Menu Copy for Spring 2026 was reviewed. The DS confirmed and stated for breakfast today a minced and moist fruit cup or apple sauce should have been included in Resident 12's breakfast.During a concurrent interview and record review on 5/19/2026 at 8:10 a.m., with CNA 1, Resident 12's diet ticket (paper indicating what the resident diet should have in their meal) was reviewed and the ticket indicated food items that included a fruit cup and health shake. CNA 1 stated for breakfast this morning, Resident 12 did not consume a fruit cup or health shake because the items were missing.During an interview on 5/21/2026 at 12:24 p.m. with the Director of Nursing (DON), the DON stated the diet ticket and menu should be followed for nutrition and health reasons.During a review of the facility's policy titled, Menus and Adequate Nutrition, revised 12/19/2022, the policy indicated residents will be offered that meet their choices and needs. The policy indicated menus will be posted and followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff followed infection control practices for three of 30 sampled residents (Resident 8, 32 and 37) when:a. The facility failed to ensure padded side rails that were wrapped with porous foams were disinfected properly for two of six sampled residents (Resident 8 and 37).b. The facility failed to ensure the laundry hamper for Resident 32 was free from bowel residue. These failures had the potential to increase the risk of cross-contamination (the transfer of bacteria, viruses, microorganisms or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and spread infection among the residents, staff and visitors. Findings: During an observation on 5/18/2026 at 10:22 a.m. in Resident 8's room, the resident's upper side rails were observed padded with black foam. a. During a review of Resident 8's admission Record, the admission Record indicated the facility admitted the resident on 6/24/2019 and readmitted on [DATE] with diagnoses including Dysphagia (difficulty swallowing), Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement) and atherosclerotic heart disease (buildup of plaque in the coronary arteries). During a review of Resident 8's Minimum Data Set (MDS-a resident assessment tool), dated 3/26/2026, the MDS stated the resident's cognitive skills for daily decision making were severely impaired. The MDS stated Resident 8 was dependent (helper does all the effort) for oral hygiene, toileting hygiene, showering, and personal hygiene. During a review of Resident 8's Order Summary Report, dated 5/19/2026, the Order Summary Report indicated starting 3/17/2026, Resident 8 may have padded bilateral 1/2 side rails as seizure precaution. During an observation on 5/18/2026 at 10:01 a.m. in Resident 37's room, the resident's upper side rails were observed padded with black foam. During a review of Resident 37's admission Record, the admission Record indicated the facility admitted Resident 8 on 2/16/2024 with diagnoses including multiple sites contracture (loss of motion of a joint) of muscle, multiple sclerosis (a disease in which the immune system attacks the protective covering of the nerves causing nerve damage) and seizures (abnormal electrical activity in the brain). During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 8's cognition (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired. The MDS indicated Resident 8 was dependent (helper does all effort) on eating, oral hygiene, toileting hygiene, showering and personal hygiene. During a review of Resident 37's Order Summary Report, dated 5/19/2026, the Order Summary Report indicated starting 3/17/2026, Resident 37 may have padded bilateral 1/2 side rails as seizure precaution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/2026 at 2:13 p.m. with housekeeper (HK) 1, HK 1 stated she performed deep cleaning in residents' rooms including the side rails wrapped with porous foams using disinfectants identified as Sani-Klean weekly. HK 1 stated she cleaned all equipment, including the foam-wrapped side rails, using a disinfectant. During a concurrent interview and record review on 5/19/2026 at 3:04 p.m. with the Infection Preventionist (IP), manufacturer's guidelines for Sani-Klean, undated, was reviewed. The IP stated the porous foams on Resident 8 and 37's side rails were used for seizure precautions. The IP stated the product was designed for nonporous surfaces. The IP stated using the disinfectants on the porous foam was not appropriate because they were porous and could cause the surface not to be cleaned properly and break down the foam. The IP stated, this practice would place vulnerable residents including Resident 8 and 37 at risk for infection. During an interview on 5/21/2026 at 3:24 p.m. with the Director of Nursing (DON), the DON stated the facility should disinfect padded side rails that were wrapped with porous foam properly for the residents to prevent the spread of infection. During a review of the faculty 's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Equipment, dated 12/19/2022, the P&P indicated, staff should verify the disinfectant is compatible with the equipment and follow manufacturer recommendations for cleaning equipment. During a review of the manufacturer's guideline titled, Sani-Klean, undated, the guideline indicated the disinfectant is designed for hard and non-porous surfaces. b. During a concurrent observation and interview on 5/19/2026 at 4:01 p.m., in Resident 32's room, Resident 32's personal laundry hamper was located in the corner of the room with a sign posted on the lid of the hamper indicating if clothes have poop on them, please place them separately in a plastic bag and put them in the facility laundry, thank you. The handle of the hamper was noted to have a thin layer of a brown-colored, caked-on substance. Certified Nurse Assistant (CNA) 7 stated the brown substance on the hamper handle was feces. During a concurrent interview and record review on 5/21/2026 at 10:09 a.m. with Housekeeping Supervisor (HS), a photograph was shown to the HS. The HS stated that the photograph of the hamper handle showed visible feces was Resident 32's personal hamper. HS stated it was important for a resident's room to be clean and free from feces on objects to prevent passing disease to other residents, prevent contamination, and keep residents clean. During a concurrent interview and record review on 5/21/2026 at 3:45 p.m. with the Director of Nursing (DON), the DON stated the presence of feces on objects in a resident's room was unsanitary and poses an infection control risk. The DON stated that maintaining cleanliness helps ensure a homelike environment, prevents unsanitary conditions, and supports infection control practices. During a review of the facility's policy and procedure (P&P) titled Routine Cleaning and Disinfection dated 12/29/2022, indicated it is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.