STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055954	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
National City Post Acute	220 East 24th Street National City, CA 91950

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure documentation of written information regarding formulating an advanced directive and the right to accept or refuse medical treatment was provided to 9 of 10 sampled residents (6, 9, 25, 33, 34, 60, 62, 78 and 89). This failure had the result for residents to not have the opportunity to express wishes for care if capacity for decision making was lost and the right to accept or refuse treatment.FindingsOn 12/18/25 a review of Resident 6's clinical record was conducted. Resident 6 was admitted to the facility on [DATE] per the facility's admission Record. The facility did not have documentation that information regarding an Advance Directive was provided to Resident 6 or Resident 6's representative. On 12/18/25 a review of Resident 9's clinical record was conducted. Resident 9 was admitted to the facility on [DATE], per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 12/20/22, indicated the line for Resident initials, .1. I have been given written materials . 2. I have been informed of my rights to formulate Advance Directives. was left blank. There was no documentation that the facility provided Resident 9 or Resident 9's representative with Advance Directive information. The witness signature was signed, SSA [first name only]. On 12/1825 a review of Resident 25's clinical record was conducted. Resident 25 was admitted to the facility on [DATE], per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 11/10/25, indicated the line for Resident initials, .1. I have been given written materials . 2. I have been informed of my rights to formulate Advance Directives. was left blank. There was no documentation that the facility provided Resident 25 or Resident 25's representative with Advance Directive information. The witness signature was signed SSA [first name only].On 12/18/25 a review of Resident 33's clinical record was conducted. Resident 33 was admitted to the facility on [DATE], per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 2/27/25, indicated the line for Resident initials .1. I have been given written materials . 2. I have been informed of my rights to formulate Advance Directives. was left blank. There was no documentation that the facility provided Resident 33 or Resident 33's representative with Advance Directive information. The witness signature was signed SSA [first name only].On 12/18/25 a review of Resident 34's clinical record was conducted. Resident 34 was admitted to the facility on [DATE], per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 4/1/25, indicated the line for Resident initials .1. I have been given written materials . 2. I have been informed of my rights to formulate Advance Directives. was left blank. There was no documentation that the facility provided Resident 34 or Resident 34's representative with Advance Directive information. The witness signature was signed SSA [first name only].On 12/18/25 a review of Resident 60's clinical record was conducted. Resident 60 was admitted to the facility on [DATE], per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 12/25/25, indicated the line for Resident initials .1. I have been given written materials . 2. I have been informed of my rights to formulate Advance Directives. was left blank. There was no documentation that the facility provided Resident 60 or Resident 60's (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative with Advance Directive information. The witness signature was signed SSA [first name only].On 12/18/25 a review of Resident 62's clinical record was conducted. Resident 62 was admitted to the facility on [DATE], per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 12/11/24, indicated the line for Resident initials .1. I have been given written materials . 2. I have been informed of my rights to formulate Advance Directives. was left blank. There was no documentation that the facility provided Resident 62 or Resident 62's representative with Advance Directive information. The witness signature was signed SSA first name only. On 12/18/25 a review of Resident 78's clinical record was conducted. Resident 78 was admitted to the facility on [DATE], per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 1/5/23, indicated the line for Resident initials .1. I have been given written materials . 2. I have been informed of my rights to formulate Advance Directives. was left blank. There was no documentation that the facility provided Resident 78 or Resident 78's representative with Advance Directive information. The witness signature was signed SSA [first name only].On 12/18/25 a review of Resident 89 's clinical record was conducted. Resident 89 was admitted to the facility on [DATE], per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 12/19/24, indicated the line for Resident initials .1. I have been given written materials . 2. I have been informed of my rights to formulate Advance Directives. was left blank. There was no documentation that the facility provided Resident 89 or Resident 89's representative with Advance Directive information. The witness signature was signed SSA [first name only].On 12/19/25 at 10:05 A.M., an interview and record review was conducted with the Social Services Director (SSD). The Social Services Assistant (SSA) was also present. The SSD reviewed the Advance Directive Acknowledgement forms for Residents 6, 9, 25, 33, 34, 60, 62, 78 and 89. The SSD stated that her expectation was that a Resident's initials were on the advanced directives acknowledgment form to document that they had been given written information regarding their rights to accept or refuse treatment and advised of their rights to formulate an Advance Directive. The SSD stated the advance directive acknowledgement forms should have been initialed by the residents when provided the written information. On 12/19/2025 at 4:20 P.M. an interview was conducted with the Director of Nursing (DON). The Administrator (ADM) was present. The DON stated that written documentation was not provided to Residents 6,9,25, 33, 34, 60, 62, 78 and 89 regarding Advance Directive information and the right to accept or refuse treatment. The DON stated her expectation was that there should have been documentation in the medical record that Advance Directive information was given or refused by the resident, the resident's family, and/or representative. The DON stated the witness signature should have had the first and last name of any witness. A review of the facility's policy titled Advance Directive dated 3/23/22 indicated, .Policy Statement. The facility. will provide the resident with information related to Advance Directives upon admission.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a clean and homelike environment was provided for eight residents (51, 53, 92, 45,100, 95, 34, 31).This deficient practice had the potential to reduce comfort, feelings of security, and well-being for the residents. Findings: A review of Resident 51's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 53's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 92's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 45's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 100's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 95's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 34's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 31's admission Record indicated the resident was admitted to the facility on [DATE]. 1. On 12/16/25 at 8:20 A.M., an observation and interview was conducted with Resident 92 while inside the resident's room. Resident 51, Resident 53 and Resident 92's shared bathroom was observed. The bathroom wall had a section of different paint colors approximately two feet by two feet in dimension. The shared bathroom had an uncovered ceiling fan with a loud motor sound. Resident 92 stated the bathroom fan had always been loud when turned on. On 12/18/25 at 7:43 A.M., a joint observation and interview was conducted with certified nursing assistant (CNA) 2. CNA 2 observed Resident 51, Resident 53, and Resident 92's shared bathroom that had an uncovered ceiling fan with a loud motor sound. CNA 2 stated the bathroom fan was, really loud and it doesn't look nice. CNA 2 stated the bathroom fan should have had a cover. CNA 2 observed the bathroom wall with different paint colors. CNA 2 stated if it was her bathroom at home, it would not look like that. CNA 2 stated it was not homelike. On 12/18/25 at 7:51 A.M., a joint observation and interview was conducted with CNA 4. CNA 4 observed Resident 45, Resident 100, and Resident 95's shared bathroom that had a ceiling fan with a (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	loud motor sound. CNA 4 observed the bathroom ceiling to have multiple splattered small brown spots. CNA 4 stated the bathroom was not homelike. CNA 4 stated, [I] wouldn't have a bathroom like this in my house. CNA 4 stated the loud ceiling fan hurt her ears. On 12/18/25 at 7:56 A.M., a joint observation and interview was conducted with the administrator (ADM) and the maintenance assistant (MA). The ADM and the MA observed the loud ceiling fan and the multiple brown spots on the ceiling in Resident 45, Resident 100 and Resident 95's shared bathroom. The ADM stated the ceiling fan was not what he would want if he had to use the bathroom. The ADM and the MA stated they did not know what the brown spots on the ceiling were and that the bathroom was not homelike. The ADM and the MA observed Resident 51, Resident 53 and Resident 92's shared bathroom that had an uncovered ceiling fan with a loud motor sound. The ADM stated the uncovered ceiling fan with a loud motor was not acceptable and was not homelike. 2. On 12/16/25 at 8:23 A.M., an observation and interview was conducted while inside Resident 34's room. Resident 34 stated he wanted to complain about the white patches on the walls and that the bathroom needed some repairs. Resident 34's room had several white painted patches on the wall, and the bathroom wall and had white spackle (putty used to fill holes, small cracks, and other minor surface defects in wood, drywall, and plaster) under the paper towel dispenser and a cemented square patch under the sink. Resident 34 stated the walls, and bathroom had been this way since he was admitted . Resident 34 stated it was ugly and wished the facility would paint the white patches on the wall in his room and fix the bathroom. On 12/16/25 at 3:55 P.M., an observation and interview was conducted with Resident 31's family member while in Resident 31's room. Resident 31's family member observed the bathroom. The family member observed white spackle on the wall under the paper towel dispenser. The family member stated they would not have the bathroom wall looking this way in their home and would have had it fixed. On 12/18/25 at 2:45 P.M., an observation and interview was conducted with Certified Nurse Assistant (CNA) 11. CNA 11 observed Resident 31's bathroom. CNA 11 observed the white spackle under the paper towel dispenser and stated, this was not a homelike environment, and it should be repaired. On 12/19/25 at 9:27 A.M., an observation and interview as conducted with the Administrator (ADM). The ADM observed Resident 31 and 34's room and bathroom and stated it was not a homelike environment. ADM stated it was important to have a homelike environment for residents to feel comfortable and be ascetically pleasing. A record review of the facility's policy titled, Homelike Environment, dated 2/21, indicated, Residents are provided with a safe, clean, comfortable and homelike environment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement resident-centered written care plans for 4 of 19 residents (92, 5, 95, and 60) when:1. Resident 92 kept perishable food routinely at her bedside and a care plan was not developed to address the behavior.2. Resident 95's severe weight loss was not care planned timely.3. Resident 5's care plan was not implemented when the resident's heel protector (device used to prevent pressure ulcer development) was not applied.4. Resident 60's left upper arm edema (fluid retention/swelling) was not care planned.As a result of these deficient practices, residents were at risk for not receiving care and treatment. Cross reference F686 and F580.Findings: 1. A review of Resident 92's admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses to include bipolar disorder (mood disorder characterized by mania and depression), major depressive disorder, and anxiety disorder. On 12/16/25 at 8 A.M., an observation and interview was conducted with Resident 92 while inside the resident's room. Resident 92's overbed table had perishable food items on it. The resident had a container of hummus, celery sticks and dip, opened salad dressing and sweet and sour sauce. Resident 92 stated she would like a place to store her perishable food but, They don't have a refrigerator for residents. On 12/18/25 at 10:20 A.M., an interview was conducted with certified nursing assistant (CNA) 6. CNA 6 stated Resident 92 was very particular and protective of her stuff. CNA 6 stated Resident 92 ordered food from outside vendors and would not let staff put her purchased food items in the resident refrigerator. On 12/18/25 at 11:50 A.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated Resident 92 would not allow staff to put her perishable food in the facility resident refrigerator. The ADON stated the resident had been educated on the risks and consequences of not putting perishable food in the refrigerator. The ADON stated Resident 92's behavior regarding perishable food items should be care planned. A review of Resident 92's Social Service Progress Note dated 5/21/25, indicated, .[Resident 92] bought & had delivered Monster energy drinks & outside food. Items included hot food, salad, monster energy drinks, ice-cream, Danishes & cakes. A review of Resident 92's Social Services Progress Note dated 6/9/25, indicated, .spoke with [Resident 92] in regard to grocery not being outside if needed to be refrigerated. On 12/18/25 at 2:37 P.M., another interview was conducted with the ADON. The ADON stated Resident 92's behavior related to food storage of perishable items was not developed as a care plan until this afternoon. The ADON stated the written care plan should have been developed when the issue was first identified. The ADON stated it was important to have a care plan for this. 2. A review of Resident 95's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include chronic kidney disease and stroke. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 95's Monthly Weight Report dated 12/19/25, indicated the following weights: October 2025, the resident weighed 154 lbs. (pounds). November 2025, the resident weighed 153.6 lbs. December 2025, the resident weighed 140.6 lbs. (the weight was taken/recorded on 12/6/25). A review of Resident 95's Nutritional assessment dated [DATE], indicated, .-13 lbs (8%) x 30d [in a month]. According to the State Operations Manual (SOM) revised 7/23/25, a resident's weight loss of more than 5% body weight in one month was considered a severe weight loss. On 12/19/25 at 9:45 A.M., an interview and record review was conducted with the minimum data set coordinator (MDSC). The MDSC stated the restorative nursing assistant who took a resident's weight had to report any weight loss or gain of more than three lbs. to the licensed nurse (LN) the same day the weight was obtained. The MDSC stated the LN would then have to assess the resident, complete the change of condition (COC) form, notify the physician and the resident's responsible party, and develop a written care plan that addressed the COC. The MDSC reviewed Resident 95's clinical record and stated there was no written care plan developed to address resident's severe weight loss until 12/17/25. The MDSC stated the written care plan was not timely. On 12/19/25 at 10:53 A.M., an interview and record review was conducted with the assistant director of nursing (ADON). The ADON reviewed Resident 95's clinical record and stated the resident's 13 lbs. weight loss identified on 12/6/25, should have been developed as a written care plan when the weight loss was identified. The ADON reviewed Resident 95's care plan for The resident has unplanned /unexpected weight loss r/t [related to] poor food intake. dated 12/17/25, and stated it was not developed in a timely manner. 3. A review of Resident 5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and weakness) affecting the left side, contracture (shortening of the muscle) of left ankle, and muscle wasting and atrophy. A review of Resident 5's written care plan for higher risk/ potential for pressure ulcer development related to impaired mobility and fragile skin condition dated 3/14/22, indicated an intervention, .Apply heel protector to left foot when in bed for off loading. A review of Resident 5's physician's order dated 9/22/25, indicated, Apply heel protector on left foot when in bed for offloading. On 12/17/25 at 8:50 A.M., Resident 5 was observed sitting up in bed. Resident 5 did not have the heel protector on. The heel protector was observed on top of the resident's nightstand. On 12/17/25 at 9:40 A.M., 11:15 A.M., and 4 P.M., Resident 5 was observed lying in bed. Resident 5 did not have the heel protector on. The heel protector was observed on top of the resident's nightstand. On 12/18/25 at 7:40 A.M., 8:20 A.M., 10:02 A.M., 11:42 A.M., 2:23 P.M., and 4:35 P.M., Resident 5 was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed lying in bed. Resident 5 did not have the heel protector on. The heel protector was observed on top of the resident's nightstand. On 12/19/25 at 7:45 A.M., Resident 5 was observed in bed. Resident 5 did not have the heel protector on. The heel protector was observed on top of the resident's nightstand. On 12/19/25 at 7:50 A.M., a joint observation and interview was conducted with restorative nursing assistant (RNA) 1. RNA 1 observed Resident 5 in bed and her heel protector was on the nightstand. RNA 1 stated the heel protector should have been on while the resident was in bed. RNA 1 stated Resident 5 was cognitively impaired and never gets up. On 12/19/25 at 9:11 A.M., an interview was conducted with the director of staff development (DSD). The DSD stated Resident 5 had a heel protector as an intervention to prevent pressure ulcers. The DSD stated Resident 5's heel protector should have been applied as it was ordered by the physician and was on the resident's care plan. On 12/19/25 at 10:30 A.M., an interview was conducted with licensed nurse (LN) 8. LN 8 stated developing resident-specific care plans was important for creating treatment goals, to catch things before it's too late, to communicate the resident's condition and to plan for care. On 12/19/25 at 3:50 P.M., an interview was conducted with the director of nursing (DON). The administrator was also present. The DON stated the facility should have developed a care plan that addressed Resident 92's behavior of keeping perishable food at her bedside. The DON stated Resident 95's written care plan for his recent severe weight loss was not developed timely and it should have been. The DON further stated Resident 5's heel protector should have been on as ordered. The DON stated Resident 5's written pressure ulcer care plan was not implemented and it should have been. 4. A review of Resident 60's admission record indicated Resident 60 was admitted on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a stroke affecting left non-dominant side) and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in the swelling of extremities). On 12/16/25 at 4:10 P.M., an observation and interview was conducted with Resident 60 in Resident 60's room. Resident 60 was lying in bed watching tv and eating a snack. Resident 60's left forearm and hand were swollen and were resting on a pillow. Resident 60 stated she put her arm on the pillow because her left arm is swollen due to her stroke. Resident 60 stated the nurses don't do anything special for the swelling of her left arm. A review of Physician's Orders dated 12/3/25 indicated monitor swelling to left upper extremity (LUE). There were no parameters or guidelines. On 12/18/25 at 12:10 P.M., an interview and record review were conducted with the Director of Staff Development (DSD). The DSD reviewed the physician's order for monitoring LUE for swelling. The DSD stated there was no documentation of monitoring for swelling of the LUE and there should have been. The DSD stated there was no care plan for swelling of Resident 60's LUE and there should have been so care could be consistently provided. On 12/19/2025 at 8:27 A.M., an interview and record review were conducted with Licensed Nurse (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(LN) 13. LN 13 stated Resident 60 has LUE swelling related to her recent stroke and congestive heart failure. LN 13 reviewed the physician's orders for monitoring Resident 60's swelling and stated there was no documentation of the swelling of Resident 60's LUE. The LN 13 stated documentation of the swelling was important so the nursing staff could see if it was getting better or worse. LN 13 stated there was no care plan for LUE swelling for Resident 60 and there should have been so everyone would have known how to care for the Resident's arm. On 12/19/25 at 4:20 P.M., an interview with the Director of Nursing (DON) was conducted. The Administrator (ADM) was also present. The DON stated her expectation was that a care plan should have been developed and implemented for a resident with LUE swelling and followed so the staff would have known how to care for this resident. A review of the facility's policy titled Care Plan Comprehensive dated 8/25/21, indicated, .The facility's Interdisciplinary team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident. a. Incorporate identified problem areas. B. Incorporate risk and contributing factors associated with identified problems. C. Build on the resident's individualized needs, strengths, preferences.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services when:1. Licensed Nurse (LN) 1 administered Geri Tussin DM (cough syrup containing dextromethorphan, a cough suppressant, and guaifenesin, an expectorant - loosens mucus) to Resident 52 instead of Geri Tussin (cough syrup containing guaifenesin), which was ordered. This failure had the potential to expose Resident 52 to additional side effects and slow her recovery. 2. Controlled medications (medications with a high abuse potential) for pain were not administered as ordered for one of five sampled residents (Resident 6). This failure had the potential for Resident 6 to experience harmful effects and negative health outcomes from the controlled medication. 3. Random controlled medication use audit for two of four sampled residents (Residents 93 and 60) indicated medications were signed out of the controlled drug record (CDR, count sheet used to track controlled medications), but were not documented on the Medication Administration Record (MAR, section of the medical record where all medications given to the resident are recorded to ensure patient safety) to indicate they were administered to the residents. For Resident 60, three administrations were documented on the MAR, but not signed out on the CDR. These failures had the potential for diversion (unlawful distribution or use), mismanagement of controlled medications and inadequate narcotic accountability, healthcare professional clinical decision-making based on an incomplete medical record which could result in adverse resident outcomes, and the potential to not meet the needs of the residents in the facility.4. E-kits (emergency medication kits) were not re-sealed and replaced timely after use. This failure had the potential to delay treatment for residents in need of emergency medications.5. LN 13 did not administer medications to Resident 62 and left them unattended at the resident's bedside. This failure had the potential for Resident 62 not to receive her medication as prescribed.5. A review of Resident 62's admission Record indicated that Resident 62 was admitted to the facility on [DATE]. On 12/16/25 at 9:35 A.M., an observation and interview was conducted with Resident 62 in Resident 62's room. Resident 62 was sitting in a wheelchair at the bedside. Resident 62's area was cluttered with folded clothes and pillows on her bed and nightstand. A pile of magazines and food were on the overbed table. The bedside drawers were open and full of paper and books. A dresser at the end of the bed had a pile of towels and plastic bags on it. A plastic pill cup that had 1 white pill and 1 yellow pill in it and a cup that had clear liquid in it, was on the overbed table. Resident 62 stated the pills were her medication and was left there by the nurse. The resident stated the pills are her tramadol and her Vitamin B complex. Resident 62 stated the liquid was Miralax for constipation. Resident 62 stated that the nurse knows I keep these at the bedside. On 12/16/25 at 10:48 A.M., an interview and record review was conducted with Licensed Nurse (LN)13. LN 13 stated she had medicated Resident 62 earlier in the morning. LN 13 stated she had left some of Resident 62's medications at the beside because the resident liked to take them when she wanted to. LN 13 reviewed Resident 62's physician's orders and stated the resident did not have an order for self-administration of medication. LN 13 stated there was no care plan for self-administration of medication for Resident 62. LN 13 stated she should not have left the medications at Resident 62's bedside. LN 13 stated if Resident 62 did not want to take her medications, she should have taken the medication with her and returned to the room to administer the medication at a later time. On 12/17/25 at 10:59 A.M., an observation and interview was conducted with Resident 62 in (continued on next page)

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National City Post Acute	220 East 24th Street National City, CA 91950

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident's 62's room. Resident 62 was sitting on the bed. On the bedside table, was a clear plastic cup with clear liquid in it. Resident 62 stated it was her Miralax and the nurse had left it there for her to take. On 12/18/25 at 9:52 A.M., an interview was conducted with LN 9. LN 9 stated medication was to be taken by the resident when the LN was watching. LN 9 stated medications were not to be left at the bedside for any resident at any time. LN 9 stated this was for resident safety; so no one else took the medication and to make sure the resident took the medication as prescribed. On 12/19/25 at 8:11 A.M., an interview was conducted with the Director of Staff Development (DSD). The DSD stated the LN was to watch the resident take each medication. The DSD stated a LN never, never, never should have left a medicine at the bedside. The DSD stated if a resident had refused to take the medication in front of the LN, the LN must take the medication out and go back at a later time to administer it. On 12/19/25 at 4:20 P.M., an interview was conducted with the Director of Nursing (DON). The Administrator (ADM) was also present. The DON stated during medication administration, the LN should have stayed with the resident and observed the resident taking her medications. The DON stated the LN never, ever should have left medications at the bedside for resident to self-administer. The DON stated when the resident refused to take her medication in front of the LN, the LN should have removed the medications from the resident and came back to administer them later. The DON stated a LN should not leave medication at the resident's bedside because the resident could have been hoarding medicine or someone else could have taken it. The facility's policy title Administering Medications undated indicates that .Policy Interpretation and Implementation . 4. Medications are administered in accordance with prescriber orders, including any required time frame.23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered. 27. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Findings: 1. During a medication administration observation on 12/16/25 at 9:36 A.M. outside of Resident 52's room, LN 1 was observed preparing and administering five medications for Resident 52. One of the medications LN 1 prepared was Geri Tussin DM. A review of Resident 52's clinical record indicated she had an active order for Geri Tussin – give 15 mL (milliliters, a unit of measure) by mouth three times a day for cough for 14 days, started 12/13/25. During a concurrent interview and record review with LN 1 on 12/17/25 at 7:57 A.M., LN 1 confirmed the Geri Tussin DM bottle in the Back East Medication Cart that was administered to Resident 52 was different from the Geri Tussin order in Resident 52's clinical record. During a telephone interview with the Consultant Pharmacist (CP) on 12/19/25 at 12:54 P.M., the CP stated Geri Tussin DM was not the same as Geri Tussin. The CP stated the two cough syrups are not doing the same thing. The CP stated dextromethorphan was for dry cough, while guaifenesin was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	used to loosen and break up the mucus. 2. A review of Resident 6's medical record indicated she had an active order for oxycodone (a medication used to control pain) 5 mg (milligrams, a unit of measure) - give one tablet by mouth every 4 hours as needed for severe pain (8-10 level pain out of 10, with 0 being no pain and 10 being the worst pain imaginable), originally dated 9/19/25 and re-ordered 9/26/25. Resident 6 received doses, as documented on her September 2025 through December 2025 MAR, despite having a pain level less than 8 on the following dates: 9/26/25 at 6:30 A.M. pain level 7 9/27/25 at 11 A.M. pain level 6 10/7/25 at 7:16 A.M. pain level 7 10/19/25 at 2:30 A.M. pain level 7 10/20/25 at 6 A.M. pain level 7 10/30/25 at 6 A.M. pain level 7 11/7/25 at 6 A.M. pain level 7 11/29/25 at 11:10 A.M. pain level 5 12/14/25 at 11 A.M. pain level 0 During a telephone interview with the CP on 12/19/25 at 12:48 P.M., the CP stated Resident 6's oxycodone should only be administered for pain levels of 8, 9 or 10. During a concurrent interview and record review with the Director of Nursing (DON) on 12/19/25 at 2:08 P.M., the DON reviewed Resident 6's September, October, November and December 2025 MARs and acknowledged the physician's order was not followed. A drug review of oxycodone on Daily Med, a drug resource site, updated 2/3/25, indicated side effects, such as dizziness, headache, nausea, vomiting and constipation. Signs and symptoms of overdose listed included respiratory depression (slow, shallow breathing), somnolence (excessive sleepiness), cold and clammy skin, low blood pressure, low blood sugar and coma. Retrieved 12/22/25 from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=20bb6bb4-230a-c9c2-01d8-a6e9341e96ba. A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, indicated, .Medications are administered in accordance with prescriber orders. 3. During an inspection of the Back [NAME] Medication Cart conducted with LN 8 on 12/17/25 at 10:27 A.M., the CDRs for three random residents receiving PRN (as needed) controlled medications were requested for review. Additionally, one other CDR from the Front [NAME] Medication Cart was requested for review on 12/17/25 at 10:59 A.M. from LN 9. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) A review of Resident 93's medical record indicated an order for oxycodone 5 mg tablet – give one tablet by mouth every 4 hours as needed for moderate pain, dated 11/30/25. During a concurrent interview and record review with the DON on 12/17/25 at 3:24 P.M., a review of Resident 93's CDR for oxycodone 5 mg and November 2025 MAR indicated the nursing staff signed out of the CDR, but did not document the medication administration on one occasion: 11/30/25 at 7:36 P.M. The DON confirmed there was no documentation on the MAR on 11/30/25 at 7:36 P.M. The DON stated her expectation was for the CDR and MAR documentation to match and be correct to prevent diversion and ensure the medication was given at the right time. b) A review of Resident 60's medical record indicated an order for oxycodone-acetaminophen (a controlled medication used to manage pain) 10/325 mg tablet – give one tablet by mouth every 6 hours as needed for severe pain, dated 11/24/25. During a concurrent interview and record review with the DON on 12/18/25 at 8:14 A.M., Resident 60's CDR for oxycodone-acetaminophen 10/325 mg and December 2025 MAR were reviewed. The CDR indicated the nursing staff signed out one tablet of oxycodone-acetaminophen 10/325 mg, but did not document the medication administration on the following days: 12/7/25 at 6:30 A.M. 12/9/25 at 5:05 A.M. 12/9/25 at 12 P.M. 12/12/25 at 6 A.M. 12/12/25 at 12 P.M. 12/12/25 at 6 P.M. 12/13/25 at 6 P.M. 12/13/25 at 9 P.M. The DON confirmed the lack of documentation in the medical record for the above dates and times. The December 2025 MAR indicated the medication was administered on 12/4/25 at 4:42 A.M., 10:58 A.M., and 8:17 P.M. The CDR was not signed out on 12/4/25 at the above times. The DON confirmed there were no entries on 12/4/25 at 4:42 A.M., 10:58 A.M., and 8:17 P.M. A review of the facility's P&P titled, Administering Medications, revised 4/2019, indicated, .As required.for a medication, the individual administering the medication records in a resident's medical record: a. The date and time the medication was administered. A review of the facility's P&P titled, Controlled Substances, revised 11/2022, indicated, .The system of reconciling the.dispensing.of controlled substances includes the following.b. Medication administration records. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent observation and interview on 12/16/25 at 10:53 A.M., an inspection of the Back Medication Room was conducted with the Assistant Director of Nursing (ADON). A refrigerated e-kit was observed unsealed in the refrigerator. The ADON confirmed the e-kit was opened and unsealed. The ADON stated the e-kit came from the pharmacy sealed with a red tag. The ADON stated nursing staff were expected to call pharmacy for authorization to remove a medication from the e-kit, document what was removed, fax the information to the pharmacy and file the documentation in a binder. The ADON stated nursing staff were to seal the e-kit with a yellow lock and the e-kit was to be replaced the following day. An inspection of the e-kit indicated a Humalog (a medication for high blood sugar) vial had been removed. The ADON confirmed one Humalog vial was missing from the e-kit. A review of the e-kit binder confirmed a nurse removed insulin lispro (generic for Humalog) on 12/10/25, six days prior to the inspection. A second, larger e-kit was observed unsealed in the same Medication Room during the inspection. The ADON confirmed the second e-kit was also unsealed. The ADON stated the second e-kit was an IV (intravenous, medications administered through a vein) e-kit. The contents of the unsealed e-kit were inspected with the ADON and LN 2. IV bags of clindamycin (an antibiotic) and a supply called, Control-A-Flo Regulator (an IV flow regulator) were not observed in the e-kit, although they were typed on the content list. During a concurrent observation and interview on 12/19/25 at 8:12 A.M., a follow up inspection of the Back Medication Room and the Front Station Medication Room was conducted with the ADON. One large IV e-kit was observed to be unsealed in both medication rooms. The ADON was asked when the IV e-kits were opened based on documentation in the e-kit binders. The ADON stated there was no documentation in either binder. A review of the facility's P&P titled, Emergency Medications, revised 4/2021, indicated, .Required documentation after dispensing an emergency medication is the same as for any other medication. Any medication that is removed from the emergency kit must be documented on the emergency medication administration log. Medications and supplies used from the emergency medication kit must be replaced upon the next routine drug order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure refrigerated medications were stored under proper temperature controls in two of two Medication Rooms. This failure had the potential to negatively alter the drugs' stability, physical properties (such as consistency) and effectiveness, which could result in adverse resident outcomes.Findings:During a concurrent observation and interview on 12/16/25, 10:53 A.M., an inspection of the Back Medication Room was conducted with the Assistant Director of Nursing (ADON). A medication refrigerator was inspected. A thermometer inside read 40 F (degrees Fahrenheit, a measurement of temperature). Two boxes of acetaminophen (medications used to treat pain and/or fever) suppositories (medications designed to be inserted into a body cavity, such as the rectum) were found to be wet. The ADON confirmed that the boxes were wet and stated she would discard the suppositories. The inside of the refrigerator was observed to be wet to sight and touch. The ADON grabbed paper towels and wiped down the inside of the refrigerator. Another basket full of medications in the refrigerator was visibly wet and icicles were observed under a mini-freezer area. During a concurrent observation and interview on 12/16/25 at 11:54 A.M., an inspection of the Front Station Medication Room was conducted with the ADON. A medication refrigerator was opened for inspection and observed to be wet. A temperature log from that morning indicated the medication refrigerator was 40 F. Medications were observed inside plastic bags. The exterior bags and labeling were observed to be wet. After closing the refrigerator and later reopening it, the inside thermometer read 48 F on 12/16/25 at 12:09 P.M. The ADON confirmed the reading.During a concurrent observation and interview on 12/17/25 at 8:30 A.M., an inspection of the Front Station Medication Room refrigerator was conducted with the ADON. The thermometer read 36 F. The ADON confirmed the reading. The ADON was asked to call the Maintenance Director (MAIN) to come and independently take the refrigerator temperature. While waiting, a puddle of water was found on the countertop leaking from the refrigerator. The ADON dried it with sheets of paper towel. The MAIN arrived and took the refrigerator temperature with his thermometer gun (thermogun) at 8:43 A.M. It read 44.2 F, which was 8.2 degrees higher than the refrigerator thermometer reading. Water was observed and felt on the bottom shelf of the refrigerator. The ADON and MAIN were asked to touch the shelf. The MAIN confirmed it was wet and stated it should not be wet. The MAIN stated it was not normal for a refrigerator to be wet.A review of the pharmacy delivery log indicated medications stored in the Front Station Medication Room refrigerator included, but were not limited to the following: an emergency medication kit, insulin lispro (a medication for high blood sugar) for Resident 79, Epogen (a medication for anemia) for Resident 48, Lantus (a medication for high blood sugar) for Resident 34, Lantus for Resident 48, Lantus for Resident 81, Humalog (a medication for high blood sugar) for Resident 34, Humalog for Resident 64, and Veltassa (a medication for high potassium) for Resident 42 Dupixent (a medication used to treat various conditions, including asthma, a lung condition that affects breathing)During a concurrent observation and interview on 12/17/25 at 8:47 A.M., an inspection of the Back Medication Room refrigerator was conducted with the ADON and MAIN. The MAIN's thermogun read the refrigerator temperature as 51.4 F, while the internal thermometer simultaneously read 40 F, a difference of 11.4 degrees. A second thermogun reading indicated the refrigerator temperature was 46.8 F. The top shelf immediately underneath the mini freezer area was observed to be wet. The ADON and MAIN were both asked to touch the shelf. The ADON stated the refrigerator temperature should be 36-46 F, but the refrigerator exceeded the limit at 46.8 F. The ADON stated it was important to maintain proper temperatures because temperature excursions could decrease the potency of drugs. The ADON stated the integrity of medications stored in either medication refrigerator could not be guaranteed.A review of the pharmacy delivery log indicated medications stored in the Back Medication Room refrigerator (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included, but were not limited to the following: an emergency medication kit, Trulicity (a medication for high blood sugar) for Resident 67, Epogen for Resident 32, Basaglar (a medication for high blood sugar) for Resident 5, Humalog for Resident 5, and Novolog (a medication for high blood sugar) for Resident 17 Acetaminophen suppositories On 12/19/25 at 8:12 A.M., the ADON stated the facility obtained two new medication refrigerators and thermometers the previous day.A review of the facility's policy and procedure (P&P) titled, Storage of Medication, revised 11/2020, indicated, Drugs.used in the facility are stored.under proper temperature. A review of the facility's P&P titled, Medication Storage in the Facility, revised 1/2025, indicated medications in containers that are cracked, soiled.are immediately removed from stock.Medication storage areas are kept clean.and free of.extreme temperatures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow appropriate infection prevention and control practices when:1. Tuberculin test (TB) was not done annually for Resident 5.2. The Licensed Nurse did not perform hand hygiene when dispensing medications.3. The back shower room and a shower chair was not clean and disinfected according to facility's cleaning schedule. In addition, the shower stall was not disinfected between residents' use.As a result of these deficient practices, residents, staff, and visitors were placed at risk for contracting infections.3. On 12/16/25 at 10:55 A.M., a joint observation and interview was conducted with certified nursing assistant (CNA) 6 in the back shower room. The back shower room was observed with two shower stalls with a wet musty smell. Two shower stalls had dark, scattered black residue in some of the grout and tiles on the wall and on the floor. A shower chair was observed in the right shower stall with torn tape and scattered black spots on the shower chair handle. CNA 6 stated, it looks like mold. CNA 6 stated she rinsed the shower stall after each resident use with water and no disinfectant. CNA 6 stated she wiped down the used shower stall with bleach wipes at the end of the shift. CNA 6 stated she would not want her own mother to use areas that had mold on them. CNA 6 stated it was the housekeeper's duty to maintain the shower rooms. On 12/18/25 at 8:27 A.M., an interview and record review was conducted with the housekeeping director (HD) in the laundry room. The HD stated the back shower room should not have been in the condition observed on 12/16/25. The HD stated, I believe it was dirt. The HD stated that friction and brushing was required to remove, the dirt. The HD stated the housekeeping department was responsible for deep cleaning the shower rooms on Sundays and Wednesdays. The HD further stated the shower chairs were deep cleaned by the housekeeping department at the end of each month. The HD stated the expectation was for the janitor to clean the shower chairs and document completion by signing off on the Cleaning Log. The HD stated the Janitor was to deep clean the shower rooms using a side by side machine to scrub the tile and grout. The HD stated the janitor was required to sign off on Sundays and Wednesdays by initialing the calendar to indicate the task was complete. The HD stated it was her responsibility to oversee the shower cleaning log. The HD reviewed the facility's Wheelchairs and Shower Chairs Cleaning Log dated November 2025 that had blank entries for the back and front station shower chairs. The HD stated the shower chairs were not deep cleaned in November and they should have been. The HD stated the shower chairs were supposed to be cleaned monthly to remove build up and to disinfect the chairs. The HD reviewed the facility's Janitor Calendar dated December 2025 with the janitor's initials on 12/7/25 for shower room floors with side by side. The HD stated the shower rooms had not been documented as cleaned on 12/3/25, 12/10/25, and 12/14/25. The HD stated based on what she saw of the back shower room on 12/16/25 and the Janitor Calendar not consistently signed, the deep cleaning of the shower room did not appear to have been done. The HD stated it should have been done. On 12/18/25 at 9:55 A.M., an interview was conducted with the director of staff development (DSD). The DSD stated CNAs were expected to use bleach wipes after each resident showered. The DSD stated the CNA was to wipe the shower stall floor, walls, and handrails. The DSD stated this was for infection control. On 12/18/25 at 10:08 A.M., an interview was conducted with CNA 3. CNA 3 stated she wiped down (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shower stall with bleach wipes only if the resident had a bowel movement in the shower. CNA 3 stated otherwise she would rinse the shower stall with water after the residents showered. On 12/18/25 at 11:50 A.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated she was also the infection prevention nurse. The ADON stated the shower stall should be rinsed with water and then wiped down with a bleach wipe after each resident use. The ADON stated the shower room should not have visible dirt or mold on the tiles. The ADON stated this was an infection control concern as infections could be transmitted to others if the shower room was not appropriately cleaned. On 12/19/25 at 3:50 P.M., an interview was conducted with the director or nursing (DON) and the administrator (ADM). The DON stated the shower stall should be wiped down with bleach wipes after each resident's shower for infection control purposes. Both the ADM and DON stated shower stalls should be maintained in a cleanly manner at all times. A review of the facility's Environmental Services Policy Manual dated 2025 stated .Restrooms will be regularly cleaned and disinfected, with a particular focus on disinfecting high-touch surfaces. A review of the facility's policy titled Wheelchair & Geri Chair Cleaning revised 2/1/25 did not provide guidance related to cleaning of shower chairs. Findings: 1. A review of Resident 5's admission Record indicated Resident 5 was admitted to the facility on [DATE] with a diagnosis of Vascular Dementia (a cognitive decline caused by damaged blood vessels in the brain, which reduces blood flow, oxygen, and nutrients, impacting thinking, memory, and behavior) and Type II Diabetes Mellitus with Hyperglycemia (high blood sugar). On 12/19/25 at 2:15 P.M., an interview and record review was conducted with the Infection Preventionist (IP). The IP reviewed Resident 5's immunization record. The IP stated the last date Resident 5 had a TB test was on 1/29/24. The IP stated there was no documentation that Resident 5 had a TB test after 1/29/24 and no documentation of a chest x-ray. The IP stated Resident 5 should have had an annual TB test on 1/29/25. The IP stated it was important for all residents to have an annual TB test to be able to identify if any residents tested positive for TB and should be treated. The IP stated TB was contagious and if left unidentified could put Resident 5 untreated and other resident at risk to contract TB. On 12/19/25 at 4:20 P.M., an interview was conducted with the Director of Nursing (DON). The Administrator was also present. The DON stated Resident 5 was due for a TB test on 1/29/25. The DON stated Resident 5 should have had an annual TB test done. According to the CDC recommendations: Titled Clinical Testing and Diagnosis for Tuberculosis, dated April 17,2025, indicated .higher risk of being infected with TB germs, you should get tested. You have a higher risk of being exposed to TB germs if you. People who currently live or used to live in large group settings where TB is more common. or nursing homes. People with diabetes mellitus. A review of the facility's policy titled Tuberculosis Infection Control Program, revised August 2019, indicated .b. An annual TB risk assessment (TBRA) and TB risk classification based on the information obtained from the TBRA.d. Screening and surveillance of residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 28's admission record indicated Resident 28 was admitted on [DATE]. On 12/18/25 at 9:52 A.M., an observation and interview was conducted in the hallway outside Resident 28's room. Licensed Nurse (LN) 9 came out of Resident 28's room with gloves on. LN 9 did not remove his gloves and perform hand hygiene. LN 9 touched the garbage can of the medication cart with his gloved hand. LN 9 opened the drawer of the medication cart and removed a pill pack for Resident 28. LN 9 removed a pill from the pill pack and put it into a pill cup. LN 9 removed his gloves. LN 9 did not perform hand hygiene. LN 9 opened a drawer of the medication cart and pulled out one bottle of medication. LN 9 opened the bottle of medication and put a pill into a pill container. LN 9 closed the bottle of medication. LN 9 touched the mouse to the computer. LN 9 opened the medication cart drawer and put the medication bottle back in the drawer. LN 9 did not perform hand hygiene. LN 9 put on gloves and went into Resident 28's room with the pill cups. LN 9 came out of Resident 28's room and stated he did not remove his gloves and did not perform hand hygiene when he came out of and went into Resident 28's room and he should have. LN 9 stated hand hygiene was important to stop the spread of infection, and it was best practice. On 12/19/25 at 10:29 A.M., an interview with the Infection Preventionist (IP) was conducted. The IP stated her expectation was that hand hygiene was done before going in and coming out of residents' rooms. The IP stated hand hygiene was best practice and prevented the spread of infection. On 12/19/25 at 4:20 P.M., an interview was conducted with the Director of Nursing (DON). The Administrator (ADM) was also present. The DON stated that her expectation was that LN 9 would have performed hand hygiene whenever entering or exiting a resident's room to prevent the spread of infection. The facility's policy and procedure titled Administering Medications undated indicated .25. Staff follows established facility infection control procedures (eg., handwashing, antiseptic technique, gloves .) for the administration of medications. The facility's policy and procedure titled Handwashing/Hand Hygiene dated 9/18/23 indicated, .2. All personnel shall follow the handwashing/hand hygiene procedures .7. a Before and after contact with the resident .7. d. After removing personal protective equipment. 8. The use of gloves does not replace hand washing/hand hygiene.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 19 residents (Resident 5), who was cognitively impaired, had a representative (responsible party, RP) designated.This failure had the potential for Resident 5 not to have the opportunity to have a representative make decisions on their behalf.Findings:A review of Resident 5's admission Record indicated the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses to include vascular dementia (a decline in thinking, memory, and reasoning caused by damaged blood vessels) and bipolar disorder (a mood disorder characterized by mania and depression).A review of Resident 5's admission Minimum Data Set Assessment (MDS, an assessment tool), acceptance date 1/29/21, indicated the Brief Interview for Mental Status (BIMS) was scored five out of 15 (which meant the resident was cognitively impaired).A review of Resident 5's History and Physical dated 9/23/25, indicated, .This resident: Has NO capacity to understand and make decisions.A review of Resident 5's quarterly MDS assessment, acceptance date 11/4/25, indicated the BIMS was coded, Should the Brief interview for Mental Status (C0200-C0500) be conducted? The answer selected was, 0-No (resident is rarely/never understood).On 12/16/25 at 8:45 A.M., an observation was conducted with Resident 5 while inside the resident's room. Resident 5 was observed in bed looking across the room and mumbling to herself. An interview was attempted; however, Resident 5's attempts at speech were not understood.On 12/17/25, Resident 5's admission Record was reviewed. The section for resident contacts was blank.On 12/17/25 at 9 A.M., an interview and record review was conducted with the assistant director of nursing (ADON). The ADON stated Resident 5 was very confused. The ADON acknowledged Resident 5's admission Record did not list a representative or RP as a contact and was blank. The ADON reviewed Resident 5's Physician Orders for Life-Sustaining Treatment (POLST) form, dated 1/20/21 and signed by cousin-next of kin. The ADON stated it would be Resident 5's cousin who was her RP and listed as the contact. The ADON stated in the event of emergencies or decisions regarding treatment, the licensed nurse would need to notify Resident 5's RP. The ADON stated she had not seen Resident 5's cousin/RP, nor was she aware if the cousin/RP participated in decision making for the resident.On 12/17/25 at 3:20 P.M., an interview and record review was conducted with the facility's case manager (CM). The CM stated the resident or resident's RP should be invited to participate in care conferences to make determinations related to care and treatment plans. A review of Resident 5's Interdisciplinary Care Conference -V5 dated 10/24/25 and electronically signed on 10/31/25, indicated only facility staff attended the resident's care conference. The document further indicated that Resident 5 and the resident's RP were not invited to the conference.On 12/17/25 at 3:33 P.M., an interview and record review was conducted with the social services director (SSD). The SSD stated the facility did not know what became of Resident 5's cousin/RP, or if the person wanted to be involved in decision making for the resident. The SSD stated Resident 5 was, very impaired and could not make her own decisions. The SSD stated even upon admission Resident 5 was too far gone [mentally]. The SSD stated it was very important for Resident 5 to have a designated decision maker. The SSD stated she was working on it now and had reached out to the Department of Aging for assistance. The SSD stated Resident 5 had resided in the facility for almost five years. The SSD stated the facility should have already discussed this issue and had it figured out in a timely manner.On 12/19/25 at 3:50 P.M., an interview was conducted with the director of nursing (DON) and administrator (ADM). The DON stated representation for Resident 5 should have been looked into a long time ago. The ADM stated the facility should have reached out in a timely manner to the Department of Aging who could have assisted the facility with arranging representation for Resident 5.A review of the facility's policy titled Resident Representative revised February 2021, indicated, .3. The term ?resident representative' is defined as: a. an individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making.6. Documentation (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	designating that the representative has been delegated the necessary authority to exercise the resident's rights for decision-making issues is obtained by the director of nursing or a designee.8. The director of nursing (or designee) is responsible for making reasonable efforts to obtain updates or changes.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light for one of 19 residents (Resident 8) was within reach.This deficient practice had the potential for Resident 8 to not have his needs met. Findings:A review of Resident 8's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include hemiplegia, hemiparesis (paralysis and weakness) following a stroke affecting the left side of the body.A review of Resident 8's Minimum Data Set Assessment (a comprehensive assessment tool) Section GG-Function Abilities, dated 9/16/25, indicated Resident 8 was coded, .01 Dependent (Helper does ALL the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required or the resident to complete the activity. for toileting and was coded, .02. Substantial/maximal assistance-Helper does, MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. with the upper body tasks. The resident was coded 02 for sit to stand activities. On 12/16/25 at 10:09 A.M., an observation and interview was conducted with Resident 8 while inside the resident's room. Resident 8 was observed laying in bed. Resident 8 stated, I need a diaper change. Resident 8 appeared upset. Resident 8 stated he could not find his call light to ask for help. Resident 8 stated he had been waiting for a long time. Resident 8's call light was observed behind Resident 8's head of the bed and tucked behind the nightstand. Resident 8 asked for help with calling a certified nursing assistant (CNA).On 12/16/25 at 10:10 A.M., a joint observation and interview was conducted with CNA 5 while inside Resident 8's room. CNA 5 was observed looking for call light. CNA 5 stated, I can't find it, while searching Resident 8's side of the room. Then CNA 5 located the resident's call light on the resident's nightstand, tucked behind belongings, and stated, I found it. CNA 5 acknowledged Resident 8's call light was not within the residents reach. CNA 5 stated Resident 8's call light should be attached to Resident 8's bed where Resident 8 can use the call light to call for help. On 12/19/25 at 9:45 A.M., an interview was conducted with the Minimum Data Set Coordinator (MDSC). The MDSC stated the call light should have been at the bedside and within the residents' reach. The MDSC stated, [Resident 8] can't get it on the nightstand.On 12/19/25 at 10:53 A.M., and interview was conducted with the assistant director of nursing (ADON). The ADON stated Resident 8 was capable of using the call light to ask for help if it were within his reach. The ADON stated Resident 8 could not get out of bed and go around the bed to get the call light when it was placed behind objects on the nightstand. The ADON stated Resident 8's call light should have been within reach at all times so resident could use it. On 12/19/25 at 3:50 P.M., a joint interview was conducted with the director of nursing (DON) and the administrator (ADM). The DON and the ADM both stated the call light should be within the residents' reach at all times. The DON and the ADM stated the call light should have been on Resident 8's bed. A review of the facility's policy titled, Answering the Call Light dated 10/24/24, indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs.5. Ensure that the call light is accessible to the resident when in bed.A review of the facility's policy titled Accommodation of needs revised January 2020, indicated, .Per facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well being.b. Staff will arrange toiletries and personal items so that they are in easy reach of the resident

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the physician was notified of a resident's change of condition (COC) in a timely manner for one of two residents (Resident 95) reviewed for nutrition.As a result, Resident 95's severe weight loss was not reported to the physician in a timely manner which had the potential to delay the resident's care and treatment.Findings:A review of Resident 95's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include chronic kidney disease and stroke.A review of Resident 95's Monthly Weight Report dated 12/19/25, indicated the following weights:October 2025, the resident weighed 154 lbs. (pounds).November 2025, the resident weighed 153.6 lbs.December 2025, the resident weighed 140.6 lbs. (the weight was taken/recorded on 12/6/25).A review of Resident 95's Nutritional assessment dated [DATE], indicated, .-13 lbs (8%) x 30d [in a month].According to the State Operations Manual (SOM) revised 7/23/25, a resident's weight loss of more than 5% body weight in one month was considered a severe weight loss.On 12/19/25 at 9:45 A.M., an interview and record review was conducted with the minimum data set coordinator (MDSC). The MDSC stated the restorative nursing assistant who took a resident's weight had to report any weight loss or gain of more than three lbs. to the licensed nurse (LN) the same day the weight was obtained. The MDSC stated the LN would then have to assess the resident, complete the COC form, notify the physician and the resident's responsible party, and develop a written care plan that addressed the COC. The MDSC stated a resident's COC must be reported to the physician the same day it was identified. The MDSC reviewed Resident 95's clinical record and stated the resident lost 13 lbs. in one month which was identified on 12/6/25. The MDSC stated a 13 lbs. weight loss in one month was considered severe and it was definitely a COC. The MDSC stated the resident's weight loss was unplanned. The MDSC stated the importance of notifying the physician timely, was so they could evaluate the resident's condition and determine what care or treatment was required. The MDSC reviewed Resident 95's clinical record and stated there was no documentation that the resident's physician was notified of the resident's severe weight loss until 12/17/25. The MDSC stated physician notification was not timely.On 12/19/25 at 10:53 A.M., an interview and record review was conducted with the assistant director of nursing (ADON). The ADON reviewed Resident 95's clinical record and stated the resident's 13 lbs. weight loss identified on 12/6/25, should have been reported to the resident's physician right away. The ADON stated a 13 lbs. weight loss in one month was a COC. The ADON reviewed Resident 95's COC documentation dated 12/17/25, and stated the COC was not reported to the physician in a timely manner.On 12/19/25 at 3:50 P.M., an interview was conducted with the director of nursing (DON). The administrator was also present. Resident 95's 13 lbs. weight loss was discussed with the DON. The DON acknowledged a 13 lbs. weight loss was considered severe and a COC. The DON was asked what her expectation for reporting a resident's severe weight loss/COC to the provider was. The DON stated, He's [Resident 95] a difficult patient. The DON was again asked the question related to COC and notifying the physician. The DON then stated the physician notification was not timely, and it should have been.A review of the facility's policy titled Change in Condition: Notification of, dated 8/25/21, indicated, .A facility must immediately inform the resident, consult with the resident's physician and/or NP [nurse practitioner], and notify.where there is.A significant change in the resident's physical, mental, or psychosocial status. A need to alter treatment significantly (that is, a need to discontinue treatment or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment).A review of the facility's undated policy titled Weight Management, indicated, .5. In the event of a patterned or significant, unplanned weight loss/gain of at least 2% in a week, 5% in 30 days. the following interventions will be carried out: a. Notification of attending physician.by nursing staff.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure that one out of five sampled residents (Resident 6) was free from unnecessary psychotropic (affecting brain activities associated with mental processes and behavior) medication when Resident 6 was prescribed a psychotropic medication as needed for more than 14 days. This failure had the potential for Resident 6 to receive an unnecessary psychotropic medication which can lead to side effects, such as sedation and falls, and a decline in psychosocial (how a person feels about themselves and their environment) well-being.Findings: A review of Resident 6's medical records indicated she had an active order for lorazepam (a medication for anxiety, a condition characterized by excessive worrying) 0.5 milligrams (mg, unit of measure) by mouth every six hours prn (as needed) anxiety aeb (as evidenced by) restlessness for 30 days, dated 12/2/25.During an interview with the Director of Nursing (DON) on 12/19/25 at 2:08 P.M., the DON confirmed she was aware that orders for prn psychotropics exceeding a 14-day treatment duration required a specified duration and a rationale for exceeding 14 days. The DON was asked to provide documentation with the prescriber's rationale for using lorazepam prn for 30 days. During a concurrent record review and interview with the DON on 12/19/25 at 3:50 P.M., of Resident 6's prescriber's documentation for lorazepam indicated, Treatment Justification: Ongoing follow-up is medically necessary to monitor efficacy, tolerability, and adherence of current psychopharmacological interventions. The prescriber electronically signed the document on 12/4/25, two days after the prescriber ordered lorazepam. The DON was asked if that treatment justification was appropriate. The DON stated it was not justified.A review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, revised 2/2025, indicated, .3. PRN orders for psychotropic medications are limited to 14 days. a.if the prescriber.believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of transfer to a resident's responsible party (RP) and the Long-Term Care Ombudsman for one of three residents (Resident 97) reviewed for closed records.This deficient practice had the potential for the Resident 97's RP to not be aware of the resident's rights pertaining to transfers. FindingsOn 12/18/25 a review of Resident 97's clinical record was conducted. Resident 97 was admitted to the facility on [DATE] per the facility's admission Record. A review of Resident 97 Alert Charting dated 9/17/25 indicated the resident was assessed to have an acute change in level of consciousness (a crucial neurological indicator of a patient's arousal and awareness) and was transferred to the hospital for evaluation. On 12/19/25 at 2:12 P.M., a record review and interview was conducted with the Social Services Director (SSD). SSD stated Resident 97 was discharged from the facility to the hospital on 9/17/25. SSD stated the written notice of transfer to the RP or Ombudsman was not done and should have been. On 12/19/25 at 4:20 P.M., an interview was conducted with the Director of Nursing (DON). The Administrator (ADM) was also present. The DON stated Resident 97 was discharged from the facility to the hospital on 9/17/25. The DON stated the written notice of transfer to the RP and Ombudsman was not done and should have been. A review of the facility's policy titled Transfer or Discharge Documentation dated [DATE] does not indicate the facility must send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure it completed a pre-admission screening and resident review (PASARR) and appropriately referred one of two residents (Resident 8), reviewed for PASARR, after the resident was newly diagnosed with schizophrenia (a mental disorder characterized by paranoia and psychosis) while residing in the facility.As a result of this deficient practice, there was the potential Resident 8 required specialized services that he did not have access to.Findings: A review of Resident 8's admission Record indicated the resident was admitted to the facility on [DATE]. The admission Record did not indicate Resident 8 had been admitted with schizophrenia.A review of Resident 8's PASARR I level screening, completed while at the hospital prior to admission to the facility on [DATE], indicated, .9. Diagnosed Serious Mental Illness. Does the individual have a serious mental disorder such as.Schizophrenia.? The question was marked, No.A review of Resident 8's Psychiatry Referral dated 1/7/25, indicated the resident was newly diagnosed with schizophrenia and was to receive Seroquel (a medication to treat/manage schizophrenia) at bedtime.On 12/19/25 at 9:45 A.M., an interview and record review was conducted with the minimum data set coordinator (MDSC). The MDSC reviewed Resident 8's clinical record and the resident's Psychiatry Referral dated 1/7/25, and stated the resident was newly diagnosed with schizophrenia while at the facility. The MDSC stated Resident 8 did not have a mental disorder diagnosis prior to admission. The MDSC stated schizophrenia was a mental disorder that would prompt a PASARR evaluation/screening. The MDSC stated the facility should have completed a PASARR I for Resident 8 upon receipt of the new diagnosis so that it would prompt the facility to then do a PASARR II evaluation.On 12/19/25 at 3:50 P.M., an interview was conducted with the director of nursing (DON) and administrator (ADM). The ADM stated the facility should have started a PASARR for Resident 8 when he was newly diagnosed with schizophrenia. The DON stated she agreed with what the administrator said.A review of the facility's policy titled PASRR Completion Policy revised 9/30/24, indicated, .5. The facility will wollow [sic] state-specific guidelines for completion.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the use of a heel protector (pressure ulcer prevention device) as ordered by the physician and identified on the care plan for one of two residents (Resident 5).This deficient practice had the potential for the resident to be at risk for pressure injury and skin breakdown.Findings:A review of Resident 5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and weakness) affecting the left side, contracture (shortening of the muscle) of left ankle, and muscle wasting and atrophy.A review of Resident 5's written care plan for higher risk/ potential for pressure ulcer development related to impaired mobility and fragile skin condition dated 3/14/22, indicated an intervention, .Apply heel protector to left foot when in bed for off loading.A review of Resident 5's physician's order dated 9/22/25, indicated, Apply heel protector on left foot when in bed for offloading.On 12/17/25 at 8:50 A.M., Resident 5 was observed sitting up in bed. Resident 5 did not have the heel protector on. The heel protector was observed on top of the resident's nightstand.On 12/17/25 at 9:40 A.M., 11:15 A.M., and 4 P.M., Resident 5 was observed lying in bed. Resident 5 did not have the heel protector on. The heel protector was observed on top of the resident's nightstand.On 12/18/25 at 7:40 A.M., 8:20 A.M., 10:02 A.M., 11:42 A.M., 2:23 P.M., and 4:35 P.M., Resident 5 was observed lying in bed. Resident 5 did not have the heel protector on. The heel protector was observed on top of the resident's nightstand.On 12/19/25 at 7:45 A.M., Resident 5 was observed in bed. Resident 5 did not have the heel protector on. The heel protector was observed on top of the resident's nightstand.On 12/19/25 at 7:50 A.M., a joint observation and interview was conducted with restorative nursing assistant (RNA) 1. RNA 1 observed Resident 5 in bed and her heel protector was on the nightstand. RNA 1 stated the heel protector should have been on while the resident was in bed. RNA 1 stated Resident 5 was cognitively impaired and never gets up.A review of Documentation Survey Report v2 (CNA documentation) for 12/17/25 and 12/18/25, indicated Resident 5 had the heel protector on her left foot during the day shifts (7 A.M to 3 P.M.).On 12/19/25 at 8:40 A.M., a joint observation, interview, and record review, was conducted with certified nursing assistant (CNA) 2. Resident 5 was observed in bed with the left heel protector on. CNA 2 stated that RNA 1 told her to put Resident 5's heel protector on. CNA 2 reviewed her documentation on the Documentation Survey Report v2 for 12/18/25 and stated that she documented incorrectly. CNA 2 stated she did not apply Resident 5's heel protector on 12/18/25. CNA 2 stated she did not know Resident 5 required a heel protector and she was not sure why the resident needed one. CNA 2 further stated she did not get a report from the licensed nurse before her shift on resident needs.On 12/19/25 at 8:50 A.M., an interview and record review was conducted with CNA 3. CNA 3 reviewed her documentation on the Documentation Survey Report v2 for 12/17/25 and stated she did not put Resident 5's heel protector on the entire shift. CNA 3 stated she did not know Resident 5 required a heel protector. CNA 3 stated she would sometimes get information on the residents from the licensed nurse if there was time for report.On 12/19/25 at 9:11 A.M., an interview was conducted with the director of staff development (DSD). The DSD stated Resident 5 had a heel protector as an intervention to prevent pressure ulcers. The DSD stated Resident 5's heel protector should have been applied as it was ordered by the physician and was on the resident's care plan. The DSD stated CNAs were expected to look on the computer at the start of their shift to get information related to the care their assigned residents needed.On 12/19/25 at 3:50 P.M., an interview was conducted with the director of nursing (DON). The administrator was also present. The DON stated Resident 5's heel protector should have been applied while the resident was in bed. The DON stated it was a physician's order and it was in the resident's care plan. The DON stated CNAs should have received information about Resident 5's heel protector from the licensed nurses as part of the daily report. The DON acknowledged the conflicting expectations of how CNAs should obtain information related to (continued on next page)

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	055954	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
National City Post Acute	220 East 24th Street National City, CA 91950

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their residents' care needs.A review of the facility's policy titled Pressure Ulcers/Injuries Overview revised March 2020, did not provide guidance related to preventing pressure injuries.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory services were provided according to acceptable standards of practice for two of two residents (55, 60) when:1. Resident 55's nasal cannula (device delivering oxygen into the nostrils) and oxygen tubing were not changed per facility's protocol.2. The director of business development (DBD) picked Resident 60's nasal cannula off the floor and placed it into the resident's nostrils.These deficient practices had the potential to place the residents at risk for respiratory infection and compromised oxygen therapy effectiveness.Findings: 1. A review of Resident 55's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include pneumonia (a respiratory illness). A review of Resident 55's physician orders dated 12/16/25, indicated, Oxygen at 2 L/Min [liters per minute] via nasal cannula for SOB [shortness of breath] every shift. On 12/16/25 at 10:11 A.M., an observation was conducted with Resident 55 while inside his room. Resident 55's oxygen tubing was hanging over the siderail of his bed with the oxygen still running. The nasal cannula had crusted brown build up on it. The oxygen tubing had a handwritten label on it dated 11/24/25. On 12/16/25 at 10:20 A.M., a joint observation and interview was conducted with the Minimum Data Set Coordinator (MDSC). Resident 55 was observed in his room while in bed. The MDSC observed Resident 55's oxygen tubing hanging over the siderail of his bed with brown build up on the nasal cannula. The MDSC asked Resident 55 if he recently had a nosebleed. Resident 55 stated he hit his nose on the siderail about a week ago and had a small nosebleed. The MDSC acknowledged the build up on Resident 55's nasal cannula and oxygen tubing dated 11/24/25. The MDSC stated residents receiving oxygen therapy should have their oxygen tubing and humidifier changed out once a week and as needed if soiled. The MDSC stated Resident 55's oxygen tubing had not been changed since 11/24/25 and it should have been changed weekly. On 12/18/25 at 11:50 A.M., an interview was conducted with the assistant director of nursing (ADON). The ADON stated she was also currently the infection prevention nurse. The ADON stated residents receiving oxygen therapy had to have their oxygen tubing changed out once a week. The ADON stated this was to be done by the licensed nurse on the night shift every Sunday. The ADON stated this facility protocol had to be followed as a measure to prevent infections like pneumonia, and to avoid irritation to the residents' nasal pathways. On 12/19/25 at 3:50 P.M., an interview was conducted with the director of nursing (DON). The administrator was also present. The DON stated Resident 55's oxygen tubing should not have had build up on it. The DON stated the resident's oxygen tubing should have been changed by the night shift every Sunday as per facility protocol. 2. A review of Resident 60's admission record indicated Resident 60 was admitted on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a stroke affecting left non-dominant side and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/25 at 4:10 P.M., an observation and interview was conducted with Resident 60 in Resident 60's room. Resident 60 was lying in bed and watching tv. Resident 60's call light was activated and ringing. Resident 60 stated she needed her oxygen because she had COPD and she could not reach her oxygen cannula because it was on the floor. Resident 60's nasal cannula was laying on the floor next to the oxygen concentrator machine on the left side of the bed. On 12/16/25 at 4:33 P.M., an observation was conducted in Resident 60's room. The DBD came into Resident 60's room and asked Resident 60 if she needed assistance. Resident 60 told the DBD that she needed her nasal cannula because she was having trouble breathing. The DBD picked up the nasal cannula tubing from the floor and placed the nasal cannula into Resident 60's nostrils. The DBD stated she should not have picked up the nasal cannula from the floor and put it in the Resident's nostrils because the nasal cannula was dirty and could cause infection. On 12/19/25 at 10:29 A.M., an interview was conducted with the Infection Preventionist (IP). The IP stated the nasal cannula should have been stored in a plastic storage bag on the concentrator when not in use. The IP stated nasal cannula that had been lying on the floor should not have been used because it was dirty and could have caused an infection. The IP stated only clinical personnel should have given the resident clean nasal cannula for use because the DBD is not qualified to administer oxygen. On 12/19/25 at 4:20 P.M., An interview was conducted with the Director of Nursing (DON). The Administrator (ADM) was also present. The DON stated her expectation was that only clean and sanitary nasal cannula was to be used by a resident. The DON stated that only clinical personnel should have placed the nasal cannula on the Resident. The DON stated that clean nasal cannula was to be used to prevent infection. A review of the facility's policy titled Oxygen Administration dated 1/31/23, did not provide guidance related to changing the oxygen tubing and/or qualified staff to perform oxygen therapy/services.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure the cook was competent to carry out dietary functions according to standards of practice when the cook did not prepare pureed foods according to the recipe.This failure had the potential to create a choking hazard, lessen nutritional value, and contribute to weight loss for the 12 residents on a pureed diet.Findings:A review of the facility's therapeutic diet menu dated 12/16/25 indicated there were 12 residents on a pureed diet.On 12/18/25 at 11 A.M., an observation during prepping of pureed foods was conducted with the Cook, (CK) 1. CK 1 stated the pureed menu for the day was mixed vegetables, chicken stroganoff, and bread. CK 1 put mixed vegetables in the blender and then put the blended vegetables in a metal container. CK 1 looked at the recipe, then proceeded to put water in a pitcher, held it up, and put thickener in it. CK 1 turned to the Kitchen Manager (KM) to ask if it was correct. The KM stated it was not and took the pitcher away from CK 1 and dumped the water with thickener into the sink. The KM rinsed out the pitcher. The KM took the pitcher and measured hot water and put it on the counter. The KM then measured the thickener and put it in the water, stirred it and put it in the metal with the blended mixed vegetables. CK 1 mixed the chicken stroganoff in the blender and put the blended chicken stroganoff in a metal container. CK 1 asked the KM for assistance on how to mix the thickener to make sure he was doing it right. The KM instructed CK 1 on how to thicken the chicken stroganoff. CK 1 put slices of bread in the blender and put the blended bread in a metal container. CK 1 then again, asked for assistance from the KM to make sure he was mixing the thickener correctly. The KM assisted CK 1 again.On 12/19/25 at 8 A.M., an interview was conducted with the KM. The KM stated CK 1 should have known how to use the thickener for pureed foods. The KM stated it was important to have the right consistency to prevent choking.On 12/19/25 at 4:20 P.M., an interview was conducted with the Administrator (ADM). The Director of Nursing was also present. The ADM stated his expectation was for the cooks to be competent when making pureed foods for the residents who are on a pureed diet. A review of the facility's undated policy titled Diet and Nutrition Care Manual indicated, This diet is used only for people who have severe chewing and/or swallowing problems. All foods are pureed to simulate a soft food bolus, eliminating the chewing phase. Provide adequate nutrients as recommended by the Dietary Guidelines.

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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 food that accommodated a resident's preference for one of 19 sampled residents (Resident 34).This failure had the potential to affect Resident 34 appetite and meal intake and lead to frustration.Findings:According to the admission Record, Resident 34 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus with hyperglycemia (high blood sugar).On 12/16/25 at 8:32 A.M., an observation and interview was conducted with Resident 34 while in Resident 34's room. Resident 34 was sitting in his wheelchair with a meal tray on top of the side table. The meal tray consisted of milk, juice, fruit cup, dry cereal, toast and two sausage patties. Resident 34's tray card (a paper indicating diet orders and any preferences or allergies) indicated dislikes of egg, sausage patties, pancakes and sweet bread. Resident 34 stated often the tray does not match his tray card. Resident 34 stated you see, says right here on ticket, I don't like sausage patties and they [the facility] gave me two pieces. Resident stated, I get frustrated and feel they [the facility] don't care what they [the facility] put on my tray.On 12/16/25 at 8:40 A.M., an observation and interview was conducted with Certified Nurse Assistant (CNA) 12 while inside Resident 34's room. CNA 12 reviewed the tray card with the meal tray and stated the sausage patties should not have been put on the plate.On 12/19/25 at 8 A.M., an interview was conducted with the Kitchen Manager (KM). The KM stated the sausage patties should not have been plated for Resident 34. The KM stated her expectation for kitchen staff to read meal tickets and honor residents dislikes.On 12/19/25 at 4:20 P.M., an interview was conducted with the Administrator (ADM). The Director of Nursing was also present. The ADM stated his expectation was for the kitchen staff to read the meal tickets and follow the choices and preferences of the residents. The ADM stated it was important to give resident choices and to honor their preferences.A review of the facility's policy titled Resident Food Preferences revised July 2017, indicated, .The Dietary Department will provide residents with meals consistent with their preferences, as indicated on their tray card.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow appropriate infection prevention and control practices when:1. There was an expired box of tomatoes stored in the refrigerator.2. [NAME] (CK) 1 did not perform hand hygiene between gloves changes.These failures had the potential to result in foodborne illness to an already vulnerable population.Findings:1. On 12/16/25 at 7:36 A.M., an initial facility kitchen tour, observation and interview was conducted with Kitchen Manager (KM). In refrigerator number two, there was a small box of tomatoes with a used by date of 12/14/25 written on the box. The KM stated the box of tomatoes should have been thrown away. The KM stated expired food could cause residents to become ill. The KM stated her expectation was for the staff to have discarded the box of tomatoes.On 12/19/25 at 4:20 P.M., an interview was conducted with Administrator (ADM). The ADM stated there should never be expired food in the kitchen and staff should have thrown the expired box of tomatoes away. The ADM stated his expectation was for the kitchen staff to discard any expired foods.A review of the facility's policy titled Refrigerator and Freezers, revised November 2022, indicated, .9. Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates.2. On 12/18/25 at 11:15 A.M. an observation was conducted of the kitchen tray line. Ck 1 was observed changing his gloves several times while prepping and plating the food and did not wash hands before putting on a new pair of gloves.On 12/19/25 at 7:50 A.M., an interview was conducted with CK 2. CK 2 stated hands must be washed every time you put on a new pair of gloves.On 12/19/25 at 8 A.M., an interview and record review was conducted with the Kitchen Manager (KM). The KM stated CK 1 should have washed his hands every time gloves were changed. The KM stated it was important to perform proper hand hygiene to prevent the spread of germs.On 12/19/25 at 4:20 P.M., an interview was conducted with the Administrator (ADM). The Director of Nursing was also present. The ADM stated his expectations was for all staff including the kitchen staff to follow the proper hand hygiene protocols.A review of the facility's policy titled Proper Wearing of Gloves in Healthcare revised 12/15/2022, indicated .When gloves are used, handwashing must occur per the following procedure prior to putting on gloves and whenever gloves are changed.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure documentation in the medical record was complete and accurate for 2 of 19 residents (95, 17) when:1. There was no documentation the nurse communicated Resident 95's condition and obtained a new order for megace (appetite stimulant) from the provider.2. Non-applicable and irrelevant additional medication directions were attached to Resident 17's levothyroxine (medication for underactive thyroid).As a result, the rationale could not readily be determined for the treatment that was provided to Resident 95. In addition, there was the potential to cause confusion during medication administration for Resident 17.Findings: 1. A review of Resident 95's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include chronic kidney disease and stroke. A review of Resident 95's physician order dated 12/12/25, indicated the resident was to take megace 40 milligrams/milliliter, 5 milliliters once a day. A review of Resident 95's Nutritional assessment dated [DATE], indicated, .-13 lbs (8%) x 30d [in a month]. Recommendations: Nutritional recommendations: add megace daily. On 12/19/25 at 9:45 A.M., an interview and record review was conducted with the minimum data set coordinator (MDSC). The MDSC reviewed Resident 95's Nutritional assessment dated [DATE] and the physician order for megace dated 12/12/25. The MDSC stated recommendations from the dietitian had to be discussed with the provider as the dietitian could not prescribe medication. The MDSC stated the discussion of the resident's condition, any new orders or recommendations that were discussed with the provider would have to be documented in the resident's clinical record. The MDSC stated there was no documentation the licensed nurse discussed Resident 95's weight loss and the new order for megace with the provider prior to entering the order in the resident's clinical record. On 12/19/25 at 10:30 A.M., an interview was conducted with licensed nurse (LN) 8. LN 8 stated when a LN communicated the resident's condition to the physician, or took an order from the physician, this had to be documented in the resident's clinical record as a progress note so the rationale for the new treatment could be understood. LN 8 stated the LN communicating with the physician had to document it the same day. On 12/19/25 at 10:53 A.M., an interview and record review was conducted with the assistant director of nursing (ADON). The ADON reviewed Resident 95's megace order dated 12/12/25 and stated she was the LN who took the order. The ADON stated she discussed the dietitian's recommendation with the nurse practitioner and got the order for megace. The ADON stated she should have documented the discussion with the provider and receipt of the new order. The ADON stated she could not recall if the conversation with the nurse practitioner took place in person or via phone. The ADON could not explain how the megace order predated the nutritional assessment. On 12/19/25 at 3:50 P.M., an interview was conducted with the director of nursing (DON). The administrator was also present. The DON stated LNs should document as a nursing note, the communication of a resident's condition with the provider. The DON stated this included a progress note for receipt of new orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Nursing Documentation dated 6/27/22, indicated, To communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. 2. During a concurrent interview and record review with the MDSC on 12/19/25 at 8:57 A.M., a review of Resident 17's clinical record was conducted. Resident 17's clinical record indicated she had active orders for medications, including the following: levothyroxine 100 micrograms (mcg, unit of measurement for dose) – give one tablet by mouth in the morning for hypothyroidism (underactive thyroid). Warning! Confirm patient. Insulin (a medication used to lower blood sugar) pens (a device to inject medications) are for use in one patient only, started 8/29/25. The MDSC was asked if the levothyroxine order made sense. The MDSC stated, no, while shaking her head. On 12/19/25 at 11:18 A.M., a concurrent interview and record review was conducted with LN 8 outside of Resident 17's room. LN 8 was asked to read Resident 17's levothyroxine order. LN 8 stated the additional direction was odd. During an interview with the DON on 12/19/25 at 1:58 P.M., the DON stated additional directions serve as reminders to the nurses administering the medications. The DON stated the additional directions should be applicable to the order. The DON stated the levothyroxine order needed to be corrected to avoid confusing nursing staff. A review of the facility's P&P titled, Physician Orders, effective 3/22/2022, indicated, .all physician orders are complete and accurate.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review the facility failed to ensure one of five residents sampled (Resident 5) received the influenza vaccine in accordance with the Center for Disease Control (CDC) recommendations and facility policy.This failure had the potential to place Resident 5 at risk for acquiring, transmitting, or experiencing complications from influenza (a contagious respiratory illness caused by influenza viruses that infects the nose, throat, and sometimes lungs).Findings:A review of Resident 5's admission Record indicated Resident 5 was admitted to the facility on admission date on 11/27/21 with a diagnosis of Vascular Dementia (a cognitive decline caused by damaged blood vessels in the brain, which reduces blood flow, oxygen, and nutrients, impacting thinking, memory, and behavior), Type II Diabetes Mellitus with Hyperglycemia (high blood sugar)On 12/19/25 at 2:15 P.M., an interview and record review was conducted with the Infection Preventionist Nurse (IP). The IP reviewed Resident 5's immunization record. The IP stated the last date Resident 5 received an influenza vaccine was on 11/21/23. The IP stated there was no documentation of influenza vaccine being offered or declined for the years 2024 or 2025. The IP stated it was important to offer the vaccine to all residents during the flu season to lessen the risk of contracting the flu or lessen the complications of the flu. The IP stated Resident 5 should have been offered the flu vaccine annually.On 12/19/25 at 4:20 P.M., an interview was conducted with the Director of Nursing (DON). The Administrator was also present. The DON stated Resident 5 should have been offered the influenza vaccine.According to the CDC recommendations: Influenza Vaccine Information Sheet dated 1/31/25 indicated .CDC recommends everyone 6 months and older get vaccinated every flu season.A review of the facility's policy titled Influenza Prevention and Control of Seasonal revised March 2022, indicated, .1. The infection preventionist organizes and oversees an annual influenza vaccine campaign. 2. All residents and staff are offered the vaccine prior to the onset of the influenza season.