STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055960	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Crescenta Healthcare Center	3050 Montrose Ave LA Crescenta, CA 91214

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on observation, interview and record review, the facility failed to ensure prompt attempts were made to resolve grievances brought by resident representative (Family [FM] 1) for one of three sampled residents (Resident 1) to the facility, and reports/resolution was signed and made available to the resident or FM 1, in accordance to the facility policy and procedure (P&P) titled Grievances and Complaints. This deficient practice violated the resident ' s right to have their grievance properly addressed and resulted in care that did not align with the resident ' s wishes/preferences. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated Resident 1 was admitted on [DATE], with diagnoses that included cerebral infarction (when blood flow to the brain is blocked) , cardiac pacemaker(a small medical device implanted in the chest to regulate abnormal heart rhythms) and Atrial fibrillation (irregular heartbeat). The AR indicated FM 1 is Resident 1 ' s responsible party. During a review of Resident 1 ' s History and Physical dated, 4/18/2024, indicated Resident 1 had a diagnosis of dementia (a condition that affects the brain, making it harder for a person to remember things, think clearly, make decisions, or take care of themselves). The H&P indicated Resident 1 had fair rehabilitation potential and confused. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/15/2024, the MDS indicated the resident had severely impaired cognition (ability to reason and thought process). The MDS also indicated the resident required setup or clean - up assistance (helper sets up or cleans up) with eating. (continued on next page)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Grievance Complaint Report dated 8/5/2024, indicated FM 1 stated concerns about inconsistency in care and stated that FM 1 did not wish for Resident 1 to be assigned to a registry staff. Further documentation of the facility ' s follow- up indicated that a group meeting was held with FM 1, the social Services Director (SSD), the Administrator, and the Director of Nursing (DON). During the meeting, it was stated that while Resident 1 ' s preference was to avoid using registry staff, Resident 1 could be assigned registry staff if no other option were available. However, the grievance form did not indicate that FM 1 agreed with this resolution, nor was their evidence that Resident 1 ' s care plan was updated to reflect these concerns. During a review of Resident 1 ' s Grievance Complaint Report dated 2/22/25, the Grievance Report indicated FM 1 reported multiple bruises on Resident1 ' s arms after discovering that she had once again been placed in the care of registry staff. The Grievance Report stated FM 1 complained this was despite a prior grievance report stating that FM 1 did not want registry staff to provide care for Resident 1. The Grievance Report indicated multiple grievances had been filed by FM 1 without resolution. Documentation of the facility ' s follow- up indicated that the grievance had been reported to the police, the California Department of Public health (CDPH), and Ombudsman services, and that an in-service training had been provided to staff. The Grievance Report indicated the resident ' s care plan had not been updated for the above grievance, and the resolution of grievance remained blank. During a review of Resident 1 ' s care plan developed on 2/23/2025, after FM 1 filed a grievance report for Resident 1 ' s bruising to both arms observed on 2/22/2025, the care plan titled Alteration in Psychosocial due to Alleged Physical Abuse, indicated a goal to prevent any further changes in behavior towards incident of alleged abuse. The goals further indicated the care plan was developed for Resident 1 to feel safe after the incident to prevent any further incidents of alleged abuse. The care plan interventions included to Remind the resident to report any abuse that she feels happened to her or any other resident . Reassure resident that any type of abuse is not tolerated, and she will be protected . There was no documented evidence that Resident 1 ' s newly developed care plans and interventions after the alleged abuse allegation and/or grievance brought up by FM 1 and reported by Resident 1 on 2/22/2025 included accommodating FM 1 ' s request not to assign Resident 1 to registry staff and/or staff with certain ethnicity as requested by the resident. During a review of a facility document titled Nursing Assignment Direct Care log dated 2/21/2025, during the 11 PM to 7AM shift, the document indicated that there was a total of seven CNAs during that shift on 2/21/2024- (four registry staff and three permanent facility staff). Additionally, the Nursing Assignment indicated two Licensed Nurses on the schedule were available as alternatives to assist Resident 1 for any activities of daily living needs. The Nursing Assignment Direct Care log indicated CNA 2 and CNA 5 were from a nursing registry). During an interview on 2/24/2025 at 3 PM, Family Member (FM) 1 stated that she has requested the facility for Resident 1 not to be assigned with a registry staff because Resident 1 ' s non-compliant with mostly registry staff. FM 1 stated she had repeatedly informed the facility of this and stated, I do not wish for registry CNA to provide care for (Resident 1). The facility responded that they would try, meaning that if no permanent CNA was available, they would still have to use a registry CNA. FM 1 stated completing a grievance on 2/22/2025 but has not received a response or update. FM 1 stated not receiving any signed/written grievance resolution after filing multiple grievances to the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 2/25/2025 at 9:14 AM, FM 1 stated Resident 1 fears registry staff. FM 1 stated that Resident 1 has had bad experiences in the past with registry staff of a certain ethnicity and this had been repeatedly requested with the facility staff. FM 1 stated she had called the facility on 2/22/2025 at 7:15 AM and spoke with the night shift supervisor to notify them of the bruising on Resident 1 ' s arms. FM 1 stated the night shift supervisor stated she had no information and was not notified by any staff including the registry staff assigned to Resident 1. FM 1 stated she had placed several grievances to ask that the facility to no longer assign Resident1 to registry staff and yet the resident is still being assigned to registry staff. During an interview on 2/25/25 at 12 PM, the DON stated there had been multiple grievances filed by FM 1 requesting that registry staff not be assigned to Resident 1. The DON further stated that he had informed FM 1 that the facility would try not to assign registry staff to Resident 1 but that sometimes it was not possible. During a concurrent interview and record review on 2/25/2025 at 12 PM, with DON, Resdient1 ' s Grievance complaint report dated 8/5/2024, was reviewed. The Grievance complaint report stated that R1did not want her to be assigned a registry CNA due to concerns about inconsistency in care. The DON stated that a care plan meeting was held on 8/5/2024, indicating the family agreed that the resident could be assigned a CNA From the registry if no other option was available. Further review of the Grievance report dated 8/5/2024 with the DON, the DON stated the report indicated no documented evidence that FM 1 signed the specific grievance report, nor were any specific interventions/resolution documented as resolution to the grievance presented by FM 1 on behalf of Resident 1. During another interview on 2/25/2025 at 3:35 PM, with the DON, the DON stated he did not provide FM 1 with a written grievance resolution for the grievance filed to the facility on [DATE], nor did he provide FM 1 any written copy of any of the grievances in the past. A review of the facility ' s policy and procedure (P&P) titled Grievances and Complaints undated, indicated the purpose of policy is to support each resident ' s right to voice grievances and to ensure that after a grievance has been received, the Company will actively resolve the issue and communicate the resolution ' s progress to the resident and / or resident ' s family in a timely manner. Further stating the Administrator (Grievance Official) is responsible for the resolution of all grievances and / or complaints. All grievances and complaints are investigated, resolved, and documented. The resident, or person filing the grievance and /or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. All reports must be signed and will be made available to the resident or person acting on behalf of the resident. The original reports are filed in a binder labeled Grievance and maintained in the office of the Grievance Official.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48219 Based on observation, interview, and record review the facility failed to implement the resident ' s care plan to wear protective clothing and/or Geri sleeves to protect skin due to pinching/scratching self and/or when agitated for one of three sampled residents (Resident 1). This deficient practice may have the potential to compromise quality of life, unmet care needs, increased risk of health decline and emotional and psychological distress. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated Resident 1 was admitted on [DATE], with diagnoses that included cerebral infarction (when blood flow to the brain is blocked) , cardiac pacemaker(a small medical device implanted in the chest to regulate abnormal heart rhythms) and Atrial fibrillation (irregular heartbeat). During a review of Resident 1 ' s History and Physical dated, 4/18/2024, indicated Resident 1 had a diagnosis of dementia. The H&P indicated Resident 1 had fair rehabilitation potential and confused. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/15/2024, indicated the resident had severely impaired cognition (ability to reason and thought process). The MDS indicated the resident has the ability to express ideas and wants, both verbally and nonverbally. The MDS also indicated the resident requires setup or clean - up assistance (helper sets up or cleans up) with eating. During a review of resident 1 ' s care plans, the care plans indicated the following: During a review of Resident 1 ' s Care plan titled Pressure ulcer Risk dated 11/6/2024, indicated resident at risk for development of pressure ulcer/ skin breakdown with intervention to include Geri-sleeves (are protective sleeves often used to prevent skin breakdown and provide protection for the arms especially for residents at high risk of injury) to left and right arms for skin management every shift During a review of Resident 1 ' s Care plan titled Ecchymosis on left Forearm dated 2/11/2025, indicated a goal of further skin damage and to ensure protective clothing be used as well as to handle resident gently while giving care During a review of Resident 1 ' s care plan titled discoloration on left Forearm near wrist, and slight redness on left wrist dated 11/6/204, with a goal to prevent further skin damage indicated to handle resident gently while giving care and use protective clothing. During a review of Resident 1 ' s care plan titled skin integrity impaired related to skin bruising and discoloration dated 11/6/2024, with a goal to prevent further skin damage and indicated to handle resident gently while giving care and use of protective clothing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s care plan titled multiple discoloration on right upper extremity dated 11/6/2024, with a goal to prevent further skin damage and indicated to handle resident gently while giving care while using protective clothing. During a review of Resident 1 ' s care plan titled Other, resident picking on skin and pinching skin unconsciously dated 11/6/2024, with a goal that resident will understand the risk associated with being non - compliant. Intervention includes to monitor for manifestations. No interventions indicated to provide safety and prevent further injury. During an interview on 2/26/2025 at 10:05AM, with LVN1, LVN 1 stated she had seen Resident 1 pinching her arms. LVN 1 stated Resident 1 sees worms, or some type of creatures crawling on her. During an interview on 2/26/2025 at 10:15 AM, with CNA 4, CNA 4 stated Resident 1 at times talks about seeing animals or bugs on her skin and on her food and cereals. CNA 4 stated she see creatures. Further stating she has witnessed the resident touching and picking up her skin at times. During an interview on 2/26/2025 at 10:31, with CNA 1, CNA 1 stated she had seen Resident1 scratching her arms. During a concurrent interview and record review on 2/26/2025 at 1:20PM with MDS, Resident 1 ' s care plan titled Pressure ulcer Risk dated 11/6/2024, indicated resident at risk for development of pressure ulcer/ skin breakdown with intervention to include Geri-sleeves (are protective sleeves often used to prevent skin breakdown and provide protection for the arms especially for residents at high risk of injury) to left and right arms for skin management every shift. MDS stated the resident should be wearing the geri-sleeves and/or protective clothing as indicated in the care plan. During an observation on 2/26/2025 at 2:02PM, in Activity Room, observed Resident 1 without Geri sleeves present. Resident 1 stated she does not wear anything on her arms. During a current observation and interview on 2/26/2024 at 2:04PM, with LVN2 in Residents 1 room, LVN2 stated she does not wear [NAME] Sleeves and stated there are no [NAME] sleeves in either the resident ' s drawer or the residents ' closet. Maybe it ' s a new order. During an interview on 2/26/2024 at 2:13 PM with CNA 4, stated she has not seen Resident 1 wearing Geri sleeves. During an interview on 2/26/2024 at 2:15 PM with the DON, the DON stated he is aware Resident 1 is care planned for Geri sleeves and should have geri-sleeves available for staff to put on the resident at all times to protect from skin breakdown and bruising. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) Titled Comprehensive Plan of Care (undated, the P&P indicated the purpose of policy states each resident will have a comprehensive care plan developed that includes goals, measurable objectives, and timetables, to meet their medical , nursing , mental, and psychosocial needs identified during the comprehensive assessment. The comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial wellbeing. The comprehensive care plan must address the resident ' s individual needs, strengths, and preferences, reflect current standards of professional practice, include treatment goals with measurable objectives, reflect interventions to meet both short- and long-term resident goals, include intervention to prevent avoidable decline in function or functional level.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on interview, and record review, the facility failed to meet professional standards of quality for one of three sampled residents (Resident 3) by failing to ensure medications were administered by licensed personnel only, in accordance the facility policy and procedure (P&P) titled Medication Pass Guidelines. This deficient practice had the potential to result in serious harm, including the risk of injury to the resident due to medication errors that could have occurred. Findings: During a review of Resident 3 ' s Admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE], with a diagnoses that included Peripheral vascular disease(a condition where the blood vessels outside the heart and brain become narrowed or blocked), paraplegia (paralysis affecting one half of the body) and cardiomegaly(an abnormal enlargement of the heart, leading to high blood pressure). During a review of Resident 3 ' s History and Physical (H&P) dated 11/3/2024, the H&P indicated resident had the capacity to make health care decisions. During a review of Resident 3 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/25/2024, indicated the resident is cognitively intact (having the ability to think, learn, remember, and use language without significant impairment). During a review of Resident 3 ' s Medication Administration (MAR) history record dated 2/1/2025 to 2/26/2025, the MAR indicated LVN 2 ' s documented initials that indicated LVN 2 administered the Amlodipine (blood pressure medication) 10 mg tablet orally scheduled at 9 AM on February 4, 5, 6,8, 13,14, 18,19, 22, and 26, 2025 to Resident 3. During a review of Resident 3 ' s MAR history record dated 2/1/2025 to 2/26/2025, the MAR indicated LVN 2 ' s documented initials that indicated LVN 2 administered the Hydralazine (blood pressure medication) tablet 100 mg orally scheduled at 9 AM on [DATE], 5, 6, 8,13,14,18,19, 20, 21, 22, 25 and 26, 2025 to Resident 3. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/2025 at 2:21 PM, with Resident 3, Resident 3 stated that his assigned nurse (LVN 2) does not administer his blood pressure medications directly to him in the morning, instead LVN 2 gives the medications to a CNA or another nurse to administer to him. Resident 3 stated that his blood pressure was not checked before receiving his blood pressure medications in the morning. Resident 3 expressed concern about the competence of his assigned nurse (LVN 2), stating She (LVN 2) is very incompetent. I am very aware and alert. Resident 3 stated that on multiple occasions, CNAs have given him his medications instead of a licensed nurse and that this had been going on for months, that his assigned LVN (LVN 2) does not personally administer his morning medications to him. Resident 3 also stated that he would prefer a different medication nurse to provide his care, stating he has high blood pressure, and he felt neglected. Resident 3 stated that during the day shift, he did not feel like he had a licensed nurse to provide care for him. Resident 3 further stated that in the event of a medical issue or emergency, Resident 3 would have to wait until the evening shift to receive proper care because of LVN 2. Resident 3 stated he feels bad. Resident 3 stated This where I live ever day, and I ' m assigned to a nurse who does not wish to provide me care or even check on me. During an interview on 2/26/2025 at 2:30 PM, with the Director of Nursing (DON), the DON was asked if he was aware that LVN 2 had not been providing direct care to Resident 3 and had been asking other staff members especially CNAs, to administer medications to Resident 3. The DON stated that he was aware that LVN 2 had been delegating medication administration to others because Resident 3 and LVN 2 do not get along. The DON stated that this practice does not meet professional standard of practice and the facility ' s policy. The DON stated LVN 2 should first Resident 3 prior to administering medications. The DON stated he would change the assignment immediately. During an interview on 2/26/2025 at 2:57PM, with LVN 2, LVN 2 stated she had never given a medication to an unlicensed CNA to administer to a resident and further stated I give the licensed nurse at Station 2 or to whoever is licensed to administer medications to Resident 3. LVN 2 stated she pop out (prepare) the medication and hand it to another nurse and asked them to give to Resident 3 inside his room. During another interview on 2/26/2025 at 3:30 PM, with Resident 3, Resident 3 stated CNA 3 had administered his medications 3 or 4 times already. Resident 3 stated when the CNAs administered the medications, he had never seen LVN 2 standing by even outside his door. Resident 3 further stated, his assigned LVN (LVN 2) never check on him or properly assesses him prior to receiving his morning medications. During an interview on 2/26/2025 at 3:39 PM, with CNA 3, CNA 3 stated he had been asked by LVN 2 to administer Resident 3 ' s morning medications. CNA 3 stated LVN 2 hands over the medication cup and says to give Resident 3 his medications. During a review of the facility ' s policy and procedure titled, Medication Pass Guidelines undated, indicated the purpose of the P&P is to assure the most complete and accurate implementation of physicians ' medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate , safe, timely, and sanitary manner. To systematically distribute medication to resident in accordance with state and federal guidelines. Further indicating only authorized personnel (licensed) may prepare, administer, and record the administering of medication.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan with individualized interventions that included the dementia (a disorder of mental processes caused by brain disease or injury and marked by memory disorder, Personality changes, and impaired reasoning) care needs with behavioral issues for one of three sampled residents (Resident 1), in accordance with the resident ' s care plans written for dementia and ADL functional /Rehabilitation and the facility ' s policy & procedures (P&P) titled Behavioral Symptoms Associated with Dementia Management. Resident 1 manifested increased in behavior/agitation when care was rendered by registry staff of certain ethnicity as requested and repeatedly filed through the facility ' s grievance process. The facility failed to assess and implement resident centered interventions to address the root cause of Resident 1 ' s increased in behavior symptoms when care was provided by registry staff of certain ethnicity. The facility continued to assign Resident 1 to be cared for by registry staff. These failures resulted in Resident 1 to have increased in agitation, refused care, and manifest combative behavior and results in bruising and discoloration in Resident 1 ' s bilateral arms. Furthermore, the facility did not ensure that Resident 1, who was assessed as having severely impaired cognition (ability to reason and thought process) wears the correct identification bracelet at all times for proper identification during provision of medical and nursing care, in accordance with the facility ' s policy and procedure (P&P) on Resident Identification System. This deficient practice has the potential to result in adverse effects, such as pain, injury, and harm and negatively affect the delivery of services. Cross referenced to F585 Findings: 1. During a review of Resident 1 ' s Admission Record (AR), the AR indicated Resident 1 was admitted on [DATE], with diagnoses that included cerebral infarction (when blood flow to the brain is blocked) , cardiac pacemaker(a small medical device implanted in the chest to regulate abnormal heart rhythms) and Atrial fibrillation (irregular heartbeat). During a review of Resident 1 ' s History and Physical dated, 4/18/2024, indicated Resident 1 had a diagnosis of dementia. The H&P indicated Resident 1 had fair rehabilitation potential and confused. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/15/2024, indicated the resident had severely impaired cognition (ability to reason and thought process). The MDS indicated the resident has the ability to express ideas and wants, both verbally and nonverbally. The MDS also indicated the resident requires setup or clean - up assistance (helper sets up or cleans up) with eating. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Grievance Complaint Report dated 8/5/2024, indicated Family Member (FM) 1 stated concerns about inconsistency in care and stated that FM 1 did not wish for Resident 1 to be assigned to a registry staff. Further documentation of the facility ' s follow- up indicated that a group meeting was held with FM 1, the social Services Director (SSD), the Administrator, and the Director of Nursing (DON). During the meeting, it was stated that while Resident 1 ' s preference was to avoid using registry staff, Resident 1 could be assigned registry staff if no other option were available. However, the grievance form did not indicate that FM 1 agreed with this resolution, nor was their evidence that Resident 1 ' s care plan was updated to reflect these concerns. During a review of Resident 1 ' s care plan titled Cognitive loss/ Dementia dated 11/06/2024, the care plan indicated a long-term goal of resident's ability to make activities of daily living decisions and recall information at highest practicable level would be promoted. The care plan interventions indicated to allow time to make simple decision and provide encouragement, approach resident in a calm, gentle, matter of fact approach, assess level of cognition and formulate a plan of care, call resident by preferred name if applicable, encourage family/friends pictures in resident ' s room, encourage social interaction, identify yourself to the resident, provide environmental cues such as clock, provide verbal cues to the resident. The care plan did not indicate the reason why Resident 1 was not to be assigned to a registry staff and behaviors manifested when assigned to a registry staff. The care plan did not indicate that this intervention to be communicated and endorsed to facility staff. During a review of Resident 1 ' s care plan titled ADL functional /Rehabilitation with a goal that the resident will be provided with need assistance with ADLs to maintain comfort and dignity with interventions to provide a 2 person assist or Hoyer with transfers, FM1 requested not to assign Resident 1 to a registry CNA. The care plan did not indicate the reason why Resident 1 was not to be assigned to a registry staff and behaviors manifested when assigned to a registry staff. The care plan did not indicate that this intervention to be communicated and endorsed to facility staff. During a review of Resident 1 ' s care plan with problem start dated 12/9/2024, titled Aggressive behavior: Resisting Care/Striking Out, the care plan indicated interventions that included providing support by allowing resident to express self without confrontation, remove from triggering environment to a calm and quiet place with supervision, and identifying the cause that might have caused behavioral problem and assist resident resident in resolving identified issues. The interventions further indicated for staff to observe for pain or discomfort that that might trigger negative behavior. The care plan did not indicate the reason why Resident 1 was not to be assigned to a registry staff and behaviors manifested when assigned to a registry staff. The care plan did not indicate that this intervention to be communicated and endorsed to facility staff. During a review of Resident 1 ' s care plan with problem start dated 11/6/2024, titled Resident with emotional and psychological deficit due to anxiety disorder manifested by physically aggressive towards others. The care plan goals included how the resident ' s emotional and psychological condition would be stabilized by interventions and to improve the resident ' s quality of life as evidenced by being calm. The care plan interventions included monitoring the resident ' s behaviors and identifying issues that may trigger behavioral manifestations. The care plan interventions further indicated how the staff would provide support and understanding and plan for consistent routine activities for the resident. The care plan did not indicate the reason why Resident 1 was not to be assigned to a registry staff and behaviors manifested when assigned to a registry staff. The care plan did not indicate that this intervention to be communicated and endorsed to facility staff. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another review of Resident 1 ' s care plan with problem start dated 11/6/2024, titled Rejection of care: Behavior that interrupts or interferes with the delivery or receipt of care, picking on skin, and pinching skin unconsciously. The care plan goal indicated Resident 1 to understand the risks associated with being non-compliant. The care plan goals included staff to be empathetic, and recognize the challenges the resident may experience, educate the consequences of rejecting care . and avoiding ultimatum, and to offer available and reasonable alternate if possible. The interventions included if alternative was offered, and not work, FM 1 would be called to speak with the resident regarding the importance of care. The care plan did not indicate the reason why Resident 1 was not to be assigned to a registry staff and behaviors manifested when assigned to a registry staff. The care plan did not indicate that this intervention to be communicated and endorsed to facility staff. During a review of Resident 1 ' s Medication Administration Record (MAR) for February 2025, the MAR indicated the resident was on the following medications: Clopidogrel 75 mg oral once a day(a blood thinner) and Atorvastatin 10 mg oral at bedtime (lipid lowering medication that may cause bruising more easily than normal due to low level of blood Platelets). During a review of facility ' s typewritten Interview statements on 2/22/2025, with permanent facility staff CNA 1, the statement indicated that CNA 1 was assigned to Resident 1 on Friday, 2/21/2025 during the 11-7 shift. The statement indicated in the early morning of Saturday around 5:30 AM (within the same 11-7 shift), the night shift RN2 supervisor told CNA 1 that Resident 1 had an early morning appointment at the clinic and will be picked - up by transport around 6:50 AM. CNA 1 stated at about 5:45 AM, CNA 1 went to Resident 1 ' s room together with CNA 2 (registry staff), being that CNA 1 may need assistance with Resident 1. CNA 1 indicated in the interview that Resident 1 was happy at first but midway of the care, after removing her brief and cleaning her, Resident 1 began to ask where she was going? CNA 1 stated telling Resident 1 she is going to the doctor's clinic for appointment. CNA1 stated it was at this point when Resident 1 ' s behavior became erratic, agitated and started to kick and swing her hand and trying to scratch at both CNA 1 and CNA 2. During a review of facility ' s typewritten Interview statements on 2/22/2025, with Registry CNA 2 indicated that CNA 2 was asked by CNA1 to assist with cleaning Resident 1. CNA 2 stated it was CNA1 who mainly attended to the resident, and she only helped support the resident's shoulder to keep her on side lying position while CNA1 was cleaning. CNA 2 stated she had never grabbed the Resident 2's arms. CNA 2 stated Resident 1 started to struggle when she asked where she was going and CNA1 told her that she was going to a clinic appointment, and at that time Resident 1 began to kick and swing her arms. CNA 2 stated we moved back away from the resident, CNA1 calmed Resident 1 which allowed CNA 1 and 2 to finish cleaning her. During a review of another facility ' s typewritten Interview statements on 2/22/2025, with RN 2 supervisor indicated RN2 supervisor had told CNA1 about the need to prepare Resident 1 early because the resident had and early appointment for a procedure and will be picked up between 6:30 AM - 6:45 AM. The statement indicated RN 2 instructed CNA 1 to clean, have the resident ' s briefs changed and place the resident in a hospital gown, with jacket and blanket to go with her. RN 2 stated transportation picked up Resident 1 at 6:50 AM via gurney accompanied by CNA 3 to the appointment. CNA 1 and 2 did not report any incident or issue during the time the resident was prepared and incontinence care done to RN 2. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Grievance Complaint Report dated 2/22/25, the Grievance Report indicated FM 1 reported multiple bruises on Resident1 ' s arms after discovering that she had once again been placed in the care of registry staff. The Grievance Report stated FM 1 complained this was despite a prior grievance report stating that FM 1 did not want registry staff to provide care for Resident 1. The Grievance Report indicated multiple grievances had been filed by FM 1 without resolution. Documentation of the facility ' s follow- up indicated that the grievance had been reported to the police, the California Department of Public health (CDPH), and Ombudsman services, and that an in-service training had been provided to staff During an interview on 2/24/2025 at 3 PM, Family Member (FM) 1 stated that she has requested the facility not to be assigned with a registry staff because Resident 1 ' s non-compliant with mostly registry staff. FM 1 stated she had repeatedly informed the facility of this and stated, I do not wish for registry CNA to provide care for (Resident 1). The facility responded that they would try, meaning that if no permanent CNA was available, they would still have to use a registry CNA. During the same interview on 2/24/2025 at 3 PM, with Family Member (FM) 1 stated during the month of January 2025 while visiting Resident 1, FM 1 had witnessed Resident 1 wearing an incorrect identification (ID) bracelet. FM 1 stated Resident 1 was wearing an ID bracelet with a different resident name written on it. FM 1 stated she reported the incident to Registered Nurse (RN) 1. FM 1 stated the facility did not seem alarmed by this incident and at sometime, the staff later replaced Resident 1 ' s ID bracelet with correct name. During an observation on 2/25/2025 at 9:14 AM in Resident 1 ' s room, Resident 1 was observed sleeping in bed, with bilateral padded side rails up. During a concurrent observation, in the presence of FM 1, Resident 1 ' s bilateral lower arms were noted to have visible dark purple/blackish bruises, no open tears visible with medium Tegaderm covering larger bruises. During a subsequent interview with FM 1, FM 1 stated Resident 1 would easily bruise when staff would not handle the resident carefully and if resident is grabbed during care. FM 1 stated that on the day of Resident 1 ' s doctor ' s appointment on 2/22/2025, FM 1 stated she had specifically informed the night shift RN2 supervisor to just change Resident 1 ' s briefs but let the resident stay in her pajamas. FM 1 stated it would be less stress and agitation for Resident 1. FM 1 stated when she saw Resident 1 in the Doctor ' s office on 2/20/2025, Resident 1 had bruising on both arms and staff had removed her pajamas and changed the resident ' s clothing to a hospital gown. FM 1 stated that it is difficult for a staff to assist Resident 1 during dressing and changing briefs especially when a registry staff was assigned to care for her. During the same interview, on 2/25/2025 at 9:14 AM, FM 1 stated Resident 1 fears registry staff. FM 1 stated that Resident 1 has had bad experiences in the past with registry staff of a certain ethnicity and this had been repeatedly requested with the facility staff. FM 1 stated she had called the facility on 2/22/2025 at 7:15 AM and spoke with the night shift supervisor to notify them of the bruising on Resident 1 ' s arms. FM 1 stated the night shift supervisor stated she had no information and was not notified by any staff including the registry staff assigned to Resident 1. FM 1 stated she had placed several grievances to ask that the facility to no longer assign Resident1 to registry staff and yet the resident is still being assigned to registry staff. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/25/2025 at 10 AM, CNA 4 (regular facility staff assigned to Resident 1 on 2/25/2025) stated she had been taking care of Resident 1 for a year now. CNA 4 was observed assisting Resident 1 during incontinence brief change. Resident 1 appeared calm and corporative during changing. No behaviors such as hitting or kicking observed. CNA 4 stated it depends on Resident 1 ' s mood if she wants to be changed. CNA 4 stated Resident 1 needs to be asked everything prior to giving care. CNA 4 stated if Resident 1 refuses, CNA 4 would inform the charge nurse and wait and come back later when Resident 1 says it ' s okay to be assisted again. During an interview with the LVN Treatment Nurse on 2/25/2025 at 10:20AM, LVN Treatment Nurse she was not present on 2/22/2025 when Resident 1 went to the doctor ' s appointment. However, LVN Treatment Nurse stated that according to her nursing experience, she believed that bruises like the ones Resident 1 had at present can develop within a shift, especially if residents are at risk for bruising. During an interview on 2/25/25 at 12 PM, the DON stated there had been multiple grievances filed by FM 1 requesting that registry staff not be assigned to Resident 1. The DON further stated that he had informed FM 1 that the facility would try not to assign registry staff to Resident 1 but that sometimes it was not possible. During a review of a facility document titled Nursing Assignment Direct Care log dated 2/21/2025, during the 11 PM to 7AM shift, the document indicated that there was a total of seven CNAs during that shift on 2/21/2024- (four registry staff and three permanent facility staff). Additionally, the Nursing Assignment indicated two Licensed Nurses on the schedule were available as alternatives to assist Resident 1 for any activities of daily living needs. The Nursing Assignment Direct Care log indicated CNA 2 and CNA 5 were from a nursing registry). During an interview on 2/25/2025 at 12:49 PM, with CNA 2 (registry staff on 2/21/2025 during 11 PM to 7 AM shift), CNA 2 stated while she was providing care to another resident, CNA1, who was assigned to care for Resident 1 on 2/21/2025 during 11 PM to 7 AM shift), called for assistance in changing Resident 1 ' s incontinent brief. Initially, Resident 1 agreed to the change, but suddenly, Resident 1 began to yell, Don't change me! Stop! CNA 2 stated that CNA1 and CNA 2 both attempted to reassure Resident 1 and asked her to calm down, but Resident 1 suddenly extended her arms and continued to say, don ' t change me. CNA 2 stated eventually, CNAs 1 and 2 were able to complete the change after telling Resident 1 that CNA 1 and 2 were taking her to the casino. During an interview on 2/25/2025 at 12:56 PM, with CNA 5, CNA 5 stated he was also from a nursing registry. CNA 5 stated he was not asked to assist in changing Resident1 ' s briefs during that night shift (early morning of 2/22/2025) and denied grabbing or touching Resident 1 ' s ankles. CNA 5 also stated that he heard CNA 1 asked Resident 1 to calm down. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 9:14 AM, with Resident 1, Resident 1 stated three CNAs were trying to change her pajamas that day (2/21/2025). Two registry staff and one from the facility staff (CNA1). Resident 1 stated that the staff in her room that day appeared angry. Resident 1 stated there were two female staff (CNA 1 and CNA 2) and one male staff (CNA 5), who were trying to change her pajamas. Resident 1 stated the two female CNA ' s (CNA 1 and 2) were grabbing her arms while the male CNA (CNA 5) was holding her by the ankles. Resident 1 stated two of the CNAs were from a (certain ethnicity that resident did not prefer). Resident 1 stated she was not asked if she wanted to be changed, she was forced and said she screamed help, help, help. Resident 1 stated her room ' s door was closed and no one came to stop this. Resident 1 stated that time I was very scared and further stated the same incident has happened to her in the past. Resident 1 stated she was in pain, and it felt like chili had been poured on her arms. Resident stated she did not tell any staff but only FM 1. During an interview on 2/26/2025 at 10:31AM, with CNA 1, CNA 1 stated that RN 2 had instructed her to prepare Resident 1 for an early morning appointment on 2/21/2025 (night shift) for 2/22/205. Before entering the resident ' s room, CNA 1 stated she requested assistance from CNA 2 which was a registry staff, despite having prior knowledge of Resident 1 ' s care preferences. CNA 1 stated that she asked CNA 2 from registry for assistance because CNA 2 had an assignment close to hers (CNA 1). A review of the schedule indicated that sufficient permanent staff were available as a substitute option for assistance. During a review of Resident 1 ' s care plan developed on 2/23/2025, after FM 1 filed a grievance report for Resident 1 ' s bruising to both arms observed on 2/22/2025, the care plan titled Alteration in Psychosocial due to Alleged Physical Abuse, indicated a goal to prevent any further changes in behavior towards incident of alleged abuse. The goals further indicated the care plan was developed for Resident 1 to feel safe after the incident to prevent any further incidents of alleged abuse. The care plan interventions included to Remind the resident to report any abuse that she feels happened to her or any other resident . Reassure resident that any type of abuse is not tolerated, and she will be protected . There was no documented evidence that Resident 1 ' s newly developed care plans and interventions after the alleged abuse allegation and/or grievance brought up by FM 1 and reported by Resident 1 on 2/22/2025 included accommodating FM 1 ' s request not to assign Resident 1 to registry staff and/or staff with certain ethnicity as requested by the resident. 2. During an interview on 2/26/2025 at 12:57 PM, with LVN 3, LVN 3 stated that she noticed the incorrect wristband on Resident 1 and reported it to her supervisor but could not recall the exact date. LVN 3 stated that the RN1 supervisor informed the next shift about the issue. LVN3 stated she remembered the first name on the ID bracelet was incorrect. LVN 3 stated FM 1 removed the incorrect ID band and showed it to her. During an interview on 2/26/2025 at 12:57 PM, with RN1, RN 1 stated she recalled Resident 1 that had the wrong ID bracelet on. RN 1 stated that the error was corrected by replacing the ID bracelet with one containing the correct name of Resident 1. During a review of the facility ' s policy and procedure (P&P) titled, Comprehensive plan of Care undated, indicated each resident will have a comprehensive care plan developed that includes goals , measurable objectives, and timetables to meet their medical, nursing, mental, and psychosocial needs identified during the comprehensive assessment that will include interventions to attempt to manage risk factors and be periodically reviewed and revised by the interdisciplinary team as changes in the resident ' scare and treatment occur and to reflect participation of resident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled Behavioral Symptoms Associated with Dementia Management dated 8/2/2024, indicated the licensed Nurse, Social Services Director/ Designee, and other members of the Company ' s interdisciplinary Team (IDT) will describe the resident's behaviors(s). Perform assessment and evaluate the environment, and to implement non pharmacologic interventions. Non pharmacologic treatment of underlying medical conditions as a first treatment strategy will be implemented to all resident with agitation or distress. Further indicating treatment to include individualized caregiver ' s approach that recognized the needs of the resident. During a review of the facility ' s P&P titled, Resident Identification System indicated a resident identification system is used to assist company personnel in providing medical and nursing care. Identification bracelet is required and not an option.

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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** 48219 Based on observation, interview, and record review the facility failed to follow the prescribed diet order for one of three sampled residents (Resident 1). Resident 1, who is on a very low- carbohydrate, double protein, 1200- calorie diet, did not receive meals in accordance with correct order and prescribed portion sizes. This deficient practice resulted in an unintentional weight gain (not on purpose) , potentially delaying recovery from illness or injury. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated Resident 1 was admitted on [DATE], with diagnoses that included cerebral infarction (when blood flow to the brain is blocked) , cardiac pacemaker(a small medical device implanted in the chest to regulate abnormal heart rhythms) and Atrial fibrillation (irregular heartbeat). During a review of Resident 1 ' s History and Physical dated, 4/18/2024, indicated Resident 1 had a diagnosis of dementia. The H&P indicated Resident 1 had fair rehabilitation potential and confused. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/15/2024, indicated the resident had severely impaired cognition (ability to reason and thought process). The MDS indicated the resident has the ability to express ideas and wants, both verbally and nonverbally. The MDS also indicated the resident requires setup or clean - up assistance (helper sets up or cleans up) with eating. During a review of Resident 1 ' s Physician Order Report with start date of 1/29/2025, the Order indicated a diet order of very low carbohydrates with double portions of protein 1200 calorie diet. The texture is regular with no juice with meals. During a review of Resident 1 ' s care plans titled Nutritional status, dated 11/6/2024, the care plan indicated on 1/8/25 Resident 1 had a 5-pound weight gain in one month, on 2/15/25 Resident 1 had a 16 -pound weight gain in 6 months. The care plan goals are to maintain weight acceptable to resident/responsible party and clinically appropriate. The care plan interventions included a diet consisting of very low carbohydrates, double portions of protein, 1200 calories, with no juice. The care plan indicated to honor resident ' s reasonable food preference and offer substitutes if needed. The care plan further indicated to monitor food and fluid intake. During a review of Resident 1 ' s Vital Report dated from 2/20/2025 indicated a weight loss of 14 pounds in 6 months. During a review of Resident 1 ' s Dietary Progress notes dated 2/10/2025, written by the Registered Dietitian indicated a significant weight gain in 6 months, Resident 1 ' s weight for February 2025 was 152 pounds, a 11.8 % weight gain in 6 months which is not beneficial or planned. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/25/2025 at 9:14 AM, with Family Member (FM) 1 in Resident 1 ' s room, Resident 1 was served a breakfast tray which contained 2 pieces of toast bread, 1 whole large banana, oatmeal/ Cream of wheat, one 8oz glass of milk, jelly and butter. Further observation of Tray label /card indicated Resident 1 is to have double portion protein and half a banana. During an observation on 2/26/2025 at 11:10 AM in Activities Room, observed Resident 1 sitting with red colored liquid in plastic glass. When asked Resident 1 what she was drinking, she replied juice. During a concurrent interview and observation on 2/26/2025 at 11:27 AM with Dietary Supervisor (DS), after showing Resident 1 ' s breakfast tray and menu card for 2/25/2025 served breakfast, the dietary supervisor stated, the meal served to Resident 1 did not match what was indicated in the ordered menu card. Specifically, the protein portion was missing as well. The dietary supervisor stated that it was the facility ' s responsibility to ensure the proper nutrition is provided on Resident 1 ' s meal trays. If a resident does not like a certain protein, alternatives such as cottage cheese, yogurt, or a peanut butter and jelly sandwich may be provided as replacements. During a concurrent interview and observation on 2/26/2025 at 11:27 AM with the Dietary Supervisor (DS) in Activity Room, Resident 1 was observed drinking a glass of juice served by Activity staff. The DS stated yes that it was juice that Resident 1 was drinking, that was contrary to the resident ' s diet orders. During an interview on 2/26/2025 at 11:58 AM with the Registered Dietician (RD), the RD stated that Resident 1 is on a consistent carbohydrate diet. The RD stated that the breakfast served to Resident 1 on 2/25/2025 did not match the prescribed diet ordered by the physician. The RD further stated that the meal served to Resident 1 also did not align with the meal ticket/card. Additionally, the RD noted that FM 1 had requested double portions of protein, and the resident should have received a protein source on the tray. While milk contains protein, the RD clarified that it is not an adequate amount according to the diet order of double portion of protein. During a review of the facility ' s policy and procedure (P&P) titled Diet Tray Card, undated, the P&P indicated the diet card ' s primary purpose is to inform the dietary staff how to assemble the resident ' s meal tray and to provide caregivers with mealtime information. Further to indicate the ordered diet, portion sizes, food dislikes, and special requests. Further procedure is to ensure that the tray card information is current and that it matches the diet as prescribed by the physician. To ensure that food items served are consistent with tray card information and the planned menu.