

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055984	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 South Beach Blvd. Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, document review, and medical record review, the facility failed to ensure the residents or their representatives were informed in advance of the proposed treatment regarding the use of psychotropic for two of five residents (Residents 6 and 13) reviewed for unnecessary medications and three of 35 final sampled residents (Residents 10, 214, and 238). * The facility failed to ensure Resident 6's informed consents for the trazodone (antidepressant) medication included the indication for use and duration of use, and for the Buspar (antianxiety) medication included the duration of use. In addition, the facility failed to obtain informed consent for the use of the PRN lorazepam (antianxiety) medication for Resident 6. * The facility failed to ensure the informed consents for the paroxetine (antidepressant) medication included the behavior manifestation and for the trazadone (antidepressant) medication included the correct diagnosis and behavior manifestation for Resident 10. * The facility failed to ensure Resident 13's informed consent for Ativan (antianxiety) medication included the behavior manifestation. * The facility failed to ensure the informed consents for trazodone medication included the diagnosis for Resident 214. * The facility failed to ensure Resident 238's informed consent for the olanzapine (antipsychotic medication) was verified by two licensed nurses when the resident's representative gave consent via telephone. These failures had the potential for the residents' and residents' representative to not be aware of their rights and to be fully informed regarding the psychotropic medication in order to make an informed decision. Findings: Review of the facility's P&P titled Psychotropic Medication Use/Informed Consent dated 3/2024 showed the following: - Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtained informed written consent signed by the resident or resident's representative along with the signature of the healthcare professional declaring the required material information has been provided . The personal exam and signatures of the prescriber, resident or representative can be completed and signed using remote technology; and - Before initiating treatment with psychotherapeutic drugs, the facility staff must verify that the resident's health record contains written informed consent with the required signatures. Review of the facility's P&P titled Informed Consent revised date 3/25/24, showed the following: (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055984 If continuation sheet Page 1 of 87

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- For psychotherapeutic medications, prior to initiating the administration of a psychotherapeutic medication or physical restraint or a device, licensed nursing staff shall verify with the resident or surrogate decision maker that he/she has given informed consent for the proposed psychotherapeutic medication or physical restraint or device to the prescriber. Psychotherapeutic medications may not be administered until informed consent has been verified; and - Licensed nursing staff shall document either 1) in the order for the psychotherapeutic medication or physical restraint or device, when the order is given by the physician, that informed consent was obtained by the physician and the name/or relationship of the individual to the resident giving informed consent, or, 2) on a separate verification form; and - If a form is used to document that informed consent was verified, the licensed nursing staff will complete the Verification of Informed Consent Form and place it under the consent section in the clinical record. Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the facilities may use the CDPH (California Department of Public Health) Psychotherapeutic Drug Informed Consent Form or use their own in-house form as long as the in-house form contains all the data elements on the CDPH form. The form must be in use by January 1, 2026, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the CDPH 9168 document titled Psychotherapeutic Drug Informed Consent Form dated 12/2025 showed to include the following psychotherapeutic drug information: drug category, drug name, dosage prescribed, frequency, duration, administration method, caution and warning summary, reason for use of the psychotherapeutic drug and benefits, the probable side effects and significant risks associated with the use of the psychotherapeutic drug, and the reasonable alternative mode(s) of treatment or possible non-pharmacological approaches that could address the resident's needs. 1. Medical record review for Resident 6 was initiated on 6/1/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 4/11/26, showed Resident 6 had no capacity to understand or make decisions. Review of Resident 6's MAR for May 2026, showed the following: - Resident 6 was administered the buspirone 5 mg, one tablet via GT every eight hours for anxiety as manifested by physical restlessness from 5/1 to 5/21/26 at 0600, 1400, and 2100 hours; and - Resident 6 was administered trazodone 50 mg, one tablet via GT at bedtime for depression as manifested by inability to sleep. a. Review of Resident 6's Psychotherapeutic Drug Informed Consent Form dated 4/9/26, showed for the trazodone medication use, Resident 6 's responsible party was informed. However, further review (continued on next page)		

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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, medical record review, and P&P review, the facility failed to maintain a safe, clean, and homelike environment for three of 35 final sampled residents (Residents 5, 6, and 14) and two nonsampled residents (Resident 26 and 171). * The facility failed to ensure a homelike environment was provided for Residents 5 and 26 who were residing in Room A. Resident 5's closet door was observed in disrepair with peeled paint and the bottom left corner of the closet door was observed chipped and missing. Additionally, the wall behind Resident 26's bed was observed with chipped paint. * The facility failed to ensure a homelike environment was provided for Residents 6 and 171 who were residing in Room B. The wall between Resident 6's head of the bed and the bedside drawer was observed with multiple areas of chipped and peeled paint and the edges of Resident 6's bedside drawer were observed chipped. Additionally, the wall behind Resident 171's bed was observed with chipped and peeled paint. * The facility failed to protect and initiate an investigation for Resident 14, as per the facility's P&P. These failures had the potential to negatively impact the residents' quality of life. Findings: Review of the facility's P&P titled Safe, and Homelike Environment revised 12/19/22, showed in accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment allowing the resident to use his or her personal belongings to the extent possible. 1. On 6/1/26 at 0913 hours, an observation was conducted for Room A. Residents 5 and 26 were observed lying in bed and the following were observed: - Resident 5's closet door was observed in disrepair, with chipped/peeled paint, and the bottom left corner of the closet door was observed missing; and - The wall behind Resident 26's (Resident 6's roommate) bed was observed with multiple areas of chipped paint. a. Medical record review for Resident 5 was initiated on 6/1/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 was cognitively intact. b. Medical record review for Resident 26 was initiated on 6/1/26. Resident 26 was admitted to the facility on [DATE]. Review of Resident 26's H&P examination dated 5/22/26, showed Resident 26 had no capacity to understand and make medical decisions. 2. On 6/2/26 at 1010 hours, the following were observed inside Room B: (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 6 was observed lying in bed. The wall between Resident 6's bed and the bedside drawer was observed in disrepair with multiple areas of chipped and peeled paint. The edges of Resident 6's bedside drawer was also observed with chipped paint. - The wall behind Resident 171's (Resident 6's roommate) bed was observed with chipped and peeling paint. a. Medical record review for Resident 6 was initiated on 6/1/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 4/11/26, showed Resident 6 lacked the capacity for medical decision-making. b. Medical record review for Resident 171 was initiated on 6/2/26. Resident 171 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 171's H&P examination dated 12/30/25, showed Resident 171 could make his needs known but could not make medical decisions. On 6/4/26 at 1000 hours, an interview and concurrent observation inside Rooms A and B was conducted with ADON 2. ADON 2 stated the facility should ensure a homelike environment for the residents residing at the facility. ADON 2 verified the above findings in Rooms A and B. On 6/4/26 at 1122 hours, an interview was conducted with the DON. The DON stated the residents residing at the facility should be provided with a homelike environment. The DON further stated the walls with chipped paint or closets in disrepair should be addressed. 3. Review of the facility's P&P titled Theft and Loss Program revised date 12/19/22, showed the following; - The facility has a Theft and Loss Program to ensure that residents' property is safeguarded; - When a personal property is reported missing, the staff should immediately begin a search for the missing property. The facility staff should ask the resident when he/she last saw the property if he/she has any idea where it may be at this time; - If the property is not found, a Theft and Loss report is to be completed. Theft and Loss reports are available at the nurse's station in the Social Services Communication Book; - Social Services will continue the search and investigation of the loss to determine if the property can be found, or how the loss will be resolved; - The Individual Theft and Loss reports shall include, but not be limited to the following information: description of the missing item(s), an estimated value of the item, the date and time the theft or loss was discovered, the date and time of the theft or loss, if able to determine; and action taken; and (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the residents were free from unnecessary psychotropic drugs for two of five residents (Residents 3 and 152) reviewed for unnecessary medication and three of 35 final sampled residents (Residents 15, 212, and 214). * The facility failed to ensure the behaviors related to the use of quetiapine fumarate (antipsychotic), fluphenazine (antipsychotic), and sertraline (antidepressant) medications were monitored for Resident 3. In addition, the facility failed to ensure nonpharmacological interventions were provided prior to the use of sertraline medication for the resident. * The facility failed to ensure non-pharmacological interventions were provided prior to the use of olanzapine (antipsychotic) medication for Resident 15. * The facility failed to ensure Resident 152's orthostatic hypotensive blood pressure (blood pressure for the lying and sitting positions) were accurately monitored and the BP readings for lying and sitting were the same. Resident 152 was on Risperdal (antipsychotic) medication. * The facility failed to ensure Resident 212 was monitored for side effects such as dry mouth, constipation, blurred vision, disorientation, confusion, difficulty urinating, hypertension, dark urine, yellow skin, nausea and vomiting, lethargy, drooling was conducted for the use of escitalopram (antidepressant) medication. * The facility failed to ensure the behaviors related to the use of trazadone (antidepressant) medication were monitored for Resident 214. These failures had the potential for adverse effects from the psychotropic medications, not providing the correct data to the prescriber to adjust the dosage of the medications and to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Use of Psychotropic Medication(s) revised 3/17/25, the Policy Explanations and Compliance Guidelines sections showed:- Non-pharmacological interventions must be attempted unless clinically contraindicated to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medication;- The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication;- The effect of psychotropic medication on a resident's physical, mental, and psychosocial wellbeing will be evaluated on an ongoing basis, in accordance with the nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan; and- The resident's response to the medication(s), including progress towards the goal and presence/absence of adverse consequences, shall be documented in the resident's medical record. 1. Medical review for Resident 3 was initiated on 6/1/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 2/12/26, showed Resident 3 had the capacity to understand and make decisions. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 South Beach Blvd. Anaheim, CA 92804	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's Order Summary Report showed a physician's orders dated 2/11/26 for the following:- to administer quetiapine fumarate 50 mg one tablet by mouth in the evening for schizophrenia (mental health condition that affects how people think, feel and behave) as manifested by hallucinations;- to administer fluphenazine hydrochloride 5 mg one tablet by mouth at bedtime for schizophrenia delusions;- to administer sertraline hydrochloride 25 mg one tablet by mouth one time a day for depression as manifested by feeling sad;- to monitor behaviors of schizophrenia every shift and record the number of episodes: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and negative symptoms every shift;- to monitor depression as manifested by verbalization of feeling sad. Record number of times the behavior was exhibited every shift; and- nonpharmacological approach attempted prior to administration of psychotropic medication: 1. Encourage to verbalize feelings (needs/concern); 2. Encourage family to participate in care; 3. Encourage to attend daily activities; 4. Provide a calm and quiet environment with diversion (i.e. listening to music, watching TV); 5. Teach relaxation techniques or deep breathing exercises; 6. Redirect and provide gentle reality orientation; 7. Other every shift for Sertraline use. Review of Resident 3's MAR and Monitoring Record for April 2026 showed the following:a. Resident 3 received quetiapine fumarate 50 mg on 4/15, 4/16, and 4/21/26 at 1800 hours; however, review of Resident 3's Monitor Record failed to show the episodes of hallucinations were monitored and documented on 4/15, 4/16, and 4/21/26 during the AM shift.b. Resident 3 received fluphenazine 5 mg on 4/15, 4/16, and 4/21/26 at 2100 hours; however, review of Resident 3's Monitor Record failed to show the episodes of delusions were monitored and documented on 4/15, 4/16, and 4/21/26 during the AM shift.c. Resident 3 received sertraline 25 mg on 4/15, 4/16, and 4/21/26 at 0900 hours; however, review of Resident 3's Monitor Record failed to show the episodes verbalization of feeling sad were monitored and documented on 4/15, 4/16, and 4/21/26 during the AM shift. In addition, the nonpharmacological interventions were not provided to Resident 3 before the administration of sertraline medications on the above dates and times. On 6/3/26 at 1256 hours, an interview and concurrent medical record review for Resident 3 was conducted with ADON 1. ADON 1 verified the above findings. ADON 1 stated the manifested behaviors should be accurately documented to determine if the resident was getting better or worse and it would also assist in determining whether the medication should be continued or not. ADON 1 further stated the manifested behavior should be addressed by providing the nonpharmacological interventions first and if not effective, administer the prescribed medications. 2. Medical record review for Resident 15 was conducted on 6/1/26. Resident 15 was readmitted to the facility on [DATE]. Review of Resident 15's H&P examination dated 6/30/25, showed Resident 15 had decision making capacity. Review of Resident 15's Order Summary Report showed the following physician's orders:- dated 6/24/25, nonpharmacological approach attempted prior to administration of psychotropic medication: 1. Encourage to verbalize feelings (needs/concern); 2. Encourage family to participate in care; 3. Encourage to attend daily activities; 4. Provide a calm and quiet environment with diversion (i.e. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	listening to music, watching TV); 5. Teach relaxation techniques or deep breathing exercises; 6. Redirect and provide gentle reality orientation; 7. Other every shift for the olanzapine medication.- dated 2/3/26, to administer olanzapine 5 mg one tablet by mouth every 12 hours for schizophrenia bipolar type; and- dated 5/22/26, to administer olanzapine 5 mg one tablet by mouth at bedtime for schizophrenia bipolar type. Review of Resident 15's MAR for May and June 2026, showed Resident 3 received olanzapine 5 mg on the following dates and times:- dated 5/1 to 5/4/26 at 2100 hour;- dated 5/5/26 at 0900 hour;- dated 5/9/26 at 0900 and 2100 hours;- dated 5/11 and 5/13 to 5/16/26 at 2100 hour;- dated 5/18/26 at 0900 hour;- dated 5/26, 5/27, and 5/31/26 at 2100 hour; and- dated 6/2/26 at 2100 hour. Review of Resident 15's Monitor Record for May and June 2026 showed for the above dates and times, the nonpharmacological intervention for olanzapine medication section showed or marked with 0. On 6/4/26 at 0901 hours, an interview and concurrent medical record review for Resident 15 was conducted with ADON 1. ADON 1 verified the above findings. ADON 1 stated the nurses should be using the codes for which nonpharmacological interventions were provided as per physician's order. ADON 1 further stated the 0 could mean no nonpharmacological interventions were provided prior to the administration of the olanzapine medication to Resident 15. 3. Medical record review for Resident 214 was initiated on 6/1/26. Resident 214 was readmitted to the facility on [DATE]. Review of Resident 214's H&P examination dated 3/13/26, showed Resident 214 was alert, verbal, and oriented times three (to person/place/time). Review of Resident 214's Order Summary Report showed the following physician's orders:- dated 3/9/26, to administer trazadone hydrochloride 50 mg one tablet by mouth at bedtime for insomnia as manifested by inability to sleep, and monitor the hours of sleep every evening and night shift for the trazadone medication use; and- dated 3/10/26, to monitor for insomnia as manifested by inability to sleep every evening and night shift for the trazadone medication use. Review of Resident 214's MAR for May 2026 showed Resident 214 received trazadone 50 mg on 5/15/26 at 2100 hour. Review of Resident 214's Monitor Record for May 2026 failed to show the hours of sleep and inability to sleep were monitored and documented on 5/15/26, for the night shift. On 6/3/26 at 1615 hours, an interview and concurrent medical record review for Resident 214 was conducted with ADON 1. ADON 1 verified the above findings for Resident 214. On 6/4/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 3, 15, and 214. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Medical record review for Resident 212 was initiated on 6/3/26. Resident 212 was admitted to the facility on [DATE]. Review of Resident 212's Order Summary Report showed the following orders: - dated 4/28/26, to administered Escitalopram Oxalate 5 mg, give 1 tablet via PEG-tube one time a day for depression manifested by verbalizing sadness; and - dated 4/28/26, to monitor for dry mouth, constipation, blurred vision, disorientation, confusion, difficulty urinating, hypertension, dark urine, yellow skin, nausea and vomiting, lethargy and drooling. Enter Y (Yes) if side effect is observed, otherwise enter N (No), every shift for escitalopram use. Review of Resident 212's H&P examination dated 4/30/26, showed the resident had capacity to make decisions and had a diagnosis of depression. Review of Resident 212's Monitoring Record for May 2026 failed to show documented evidence the resident was monitored for the side effects of the escitalopram medication on the following dates and shifts: - on 5/2/26, during the 0700 to 1500 hours shift; - on 5/19/26, during the 0700 to 1500 hours shift; - on 5/21/26, during the 1500 to 2300 hours shift; and - on 5/22/26, during the 0700 to 1500 hours shift. On 6/3/26 at 1301 hours, an interview and concurrent medical record review for Resident 212 was conducted with ADON 2. ADON 2 verified the above findings and stated the facility should monitor the side-effects of the escitalopram medication and document on the monitoring record. On 6/4/26 at 1036 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. Medical record review for Resident 152 was initiated on 6/1/26. Resident 152 was admitted to the facility on [DATE]. Review of Resident 152's H&P examination dated 1/17/26, showed Resident 152 had no capacity to understand and make decisions. Review of Resident 152's Order Summary Report showed the following physician's orders: - dated 7/17/25, to monitor orthostatic BP while lying weekly every day shift on Fridays; and - dated 7/17/25, to monitor orthostatic BP while sitting weekly every day shift on Fridays. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 152's MAR for May 2026 showed the following: - on 5/1/26, the BP readings were 120/74 mmHg for the sitting and lying position; - on 5/8/26, the BP readings were 122/74 mmHg for the sitting and lying position; - on 5/15/26, the BP readings were 124/79 mmHg for the sitting and lying position; and - on 5/22/26, the BP readings were 126/70 mmHg for the sitting and lying position. On 6/3/26 at 1005 hours, an interview and concurrent medical record review for Resident 152 was conducted with ADON 1. ADON 1 stated the orthostatic hypotension BP was checked weekly in lying and sitting position every Friday. ADON 1 verified the orthostatic hypotension BP readings for lying and sitting were not accurate and should expect a difference in the BP readings. On 6/4/26 at 1350 hours, an interview and concurrent medical record review for Resident 152 was conducted with the DON. The DON verified the above findings. The DON acknowledged Resident 152's MAR showed the resident's orthostatic hypotension BP readings for both lying and sitting were the same values. The DON stated the BP readings were not accurate and stated the BP readings for lying and sitting would have some differences in the BP readings. On 6/4/26 at 1408 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and P&P review, the facility failed to revise the comprehensive care plan for four of 35 final sampled residents (Residents 10, 80, 174, and 238). * The facility failed to ensure Resident 10's care plan for pain and use of pain medication was revised to address the use of nonpharmacological interventions prior to the administration of the pain medications. * The facility failed to ensure Resident 80's care plan was revised to reflect the resident's use of oxygen. * The facility failed to ensure Resident 174's comprehensive care plan was revised to reflect Resident 174's current fluid restriction of 1200 ml per day. * The facility failed to ensure Resident 238's care plan intervention for the mirtazapine (antidepressant) medication was revised to show the correct behavior manifestation. These failures posed the risk of not providing appropriate, consistent and individualized care for Residents 10, 80, 174, and 238. Findings: Review of the facility's P&P titled Comprehensive Care Plans revised date 12/19/22, showed the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment, and the comprehensive care plan will describe, at a minimum, the following: resident specific interventions that reflect the resident's needs. 1. Medical record review for Resident 174 was initiated on 6/1/26. Resident 174 was readmitted to the facility on [DATE]. Review of Resident 174's Order Summary Report showed a physician's order dated 4/8/25, for fluid restriction of 1200 ml per day. Review of Resident 174's Care Plan Report showed a care plan problem revised on 5/8/26, to address hemodialysis and fluid restriction of 1200 ml per day. However, the interventions included a fluid restriction of 1000 ml per day, which was initiated on 12/25/24. On 6/3/26 at 0936 hours, an interview and concurrent medical record review for Resident 174 was conducted with RN 4. RN 4 verified the intervention in Resident 174's plan of care was not revised to reflect the current fluid restriction of 1200 ml per day. On 6/3/26 at 1511 hours, an interview for Resident 174 was conducted with the DON. The DON was informed and acknowledged the above findings: 2. Medical record review for Resident 238 was initiated on 6/1/26. Resident 238 was readmitted to the facility on [DATE]. Review of Resident 238's Order Summary Report showed a physician's order dated 5/16/26, to administer mirtazapine 15 mg one tablet via PEG-tube at bedtime for depression as manifested by sad affect. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 238's Care Plan Report showed a care plan problem revised date 4/2/26, to address Resident 238's use of the mirtazapine medication as manifested by poor oral intake. The interventions included to monitor meal intake every breakfast, lunch, dinner, and record percentage. On 6/3/26 at 0845 hours, an interview and concurrent medical record review for Resident 238 was conducted with RN 4. RN 4 verified the care plan problem and intervention in Resident 238's plan of care was not revised to reflect the correct behavior manifestation related to the use of the mirtazapine medication. On 6/3/26 at 1453 hours, an interview for Resident 238 was conducted with the DON. The DON was informed and acknowledged the above findings: 3. Medical record review for Resident 80 was initiated on 6/1/26. Resident 80 was admitted to the facility on [DATE], and readmitted on [DATE] Review of Resident 80's H&P examination dated 1/21/25, showed Resident 80 was diagnosed with pneumonia, and had the capacity to understand and make medical decisions. On 6/1/26 at 0757 hours, an observation was conducted of Resident 80. Resident 80 was observed lying in bed. An oxygen concentrator was observed adjacent to Resident 80's bed. The oxygen concentrator was set to administer a continuous oxygen at a rate of 4 liters per minute. Review of Resident 80's Care Plan Report showed a care plan problem initiated on 1/29/26 and revised on 3/23/26, to address Resident 80's oxygen use. The interventions included oxygen; however, it was not updated specifically to the amount of oxygen the resident was currently on. On 6/1/26 at 1059 hours, an interview and concurrent medical record review for Resident 80 was conducted with RN 1. RN 1 verified the above findings and stated Resident 80's current plan of care for oxygen should be specific to the resident's current status. On 6/4/26 at 1040 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the care plan should be updated to reflect the resident's current status. 4. Medical record review for Resident 10 was initiated on 6/1/26. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's Order Summary Report showed a physician's order dated 4/20/26, to administer hydrocodone-acetaminophen (pain medication) 5-325 mg one tablet by mouth every six hours as needed for pain rate of 5-10 (scale of 0 to 10, 0 = no pain and 10 = severe pain). NPI (nonpharmacological interventions): 1-Relaxation; 2-Redirect/Reapproach; 3-Repositioning; 4-Heat/Cold Therapy; 5-Gentle Massage; 6-Distraction NPIO:1-Better; 2-Same; 3-Worsened. Review of Resident 10's Care plan Report revised 4/28/26, showed a care plan problem to address Resident 10's pain and use of pain medication. The interventions did not include the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nonpharmacological interventions for pain as ordered by the physician. On 6/3/26 at 1256 hours, an interview and concurrent medical record review for Resident 10 was conducted with ADON 1. ADON 1 stated Resident 10's current plan of care for pain and use of pain medication should reflect the nonpharmacological interventions as one of the interventions. ADON 1 verified the care plan for Resident 10 was not updated or revised to show or include the nonpharmacological interventions as one of the interventions for pain and to initiate prior to administering the pain medication. ADON 1 further stated the plan of care needed to be reviewed and updated to reflect current or ongoing problems with the interventions because it's the guide for the resident's treatment. On 6/4/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 10.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary quality of care and services were provided for three of 35 final sampled residents (Residents 6, 11, and 15). * The facility failed to ensure the injection sites for the insulin (medication to control blood glucose levels) administration were rotated for Residents 6 and 11. These failures had the risk for lipodystrophy (buildup of fatty lumps) and decreased insulin absorption. * The facility failed to ensure Resident 15 was continuously monitored when the resident had a change in condition related to weight loss. These failures had the potential for the residents to not receive the necessary care and services and negatively affect the residents' well-being. Findings: 1. Review of the facility's P&P titled Administration of Injections revised 12/19/22, showed injections are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Under the section: Procedure for subcutaneous injections, showed to identify the injection site (usually abdomen, upper hips, or lateral upper arms and thighs), and clean the injection site with an alcohol pad. For repeated injections, rotate the injection site. To document the procedure in the MAR, including the location of the injection site. a. Medical record review for Resident 6 was initiated on 6/1/26. Resident 6 was admitted to the facility on [DATE], with the diagnosis of type 2 diabetes mellitus (DM). Review of Resident 6's H&P examination dated 4/11/26, showed Resident 6 had no capacity to understand or make decisions. Review of Resident 6's MAR for May 2026 showed the following physician's order: * dated 4/9/26, to administer lispro insulin (rapid acting insulin, used to manage blood sugar) subcutaneously before meals and at bedtime for DM, as per the sliding scale, if the blood sugar was: - 0 to 150 mg/dl: administer zero (0) units; - 151 to 200 mg/dl: administer one unit; - 201 to 250 mg/dl: administer two units; - 251 to 300 mg/dl: administer three units; - 301 to 350 mg/dl: administer four units; - 351 to 400 mg/dl: administer five units; and - if BS >400 mg/dl: administer six units and call the physician; and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* dated 4/11/26, for the administration of the insulin glargine (long-acting insulin used to treat type 1 and 2 diabetes) pen-injector 100 units/ ml, to inject eight units subcutaneously at bedtime for diabetes mellitus, to rotate the injections sites. Further review of Resident 6's MAR for May 2026 showed the documentation when the injection sites were not rotated for the following insulin medications: * Resident 6 was administered the insulin glargine medication at the left lower quadrant of the abdomen on the following dates and times: - dated 5/23/26 at 2000 hours, - dated 5/24/26 at 2119 hours, - dated 5/25/26 at 2146 hours, - dated 5/26/26 at 2106 hours, - dated 5/27/26 at 2153 hours, - dated 5/30 at 2127 hours, and - dated 5/31/26 at 2151 hours. * Resident 6 was administered the lispro insulin medication at the left lower quadrant of the abdomen on the following dates and times: - dated 5/25/26 at 1646 hours, and - dated 5/26/26 at 1605 hours. On 6/2/26 at 1620 hours, an interview and concurrent medical record review for Resident 6 was conducted with LVN 1. LVN 1 stated for the administration of the insulin injections, prior to administering the insulin, the licensed nurse should review the MAR to determine the previous injection site. LVN 1 further stated the insulin injection site should be rotated. LVN 1 reviewed Resident 6's MAR for May 2026 and verified the above findings. 2. Medical record review for Resident 11 was initiated on 6/1/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's Order Summary Report dated 6/2/26, showed a physician's orders dated 2/20/26, to administer regular human insulin (short-acting insulin, used to manage blood sugar) 100 units/ml as per the sliding scale, subcutaneously every six hours for diabetes mellitus (DM), and administer insulin glargine 100 unit/ml, 10 units subcutaneously at bedtime for DM. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 11's MAR for May 2026 showed the documentation when the injection sites were not rotated for the following insulin medications: * Resident 11 was administered the insulin glargine medication at the left lower quadrant of the abdomen on the following dates and times: - dated 5/1/26 at 2136 hours - dated 5/2/26 at 2056 hours, - dated 5/3/26 at 2102 hours, - dated 5/12/26 at 2051 hours, - dated 5/13/26 at 2045 hours, - dated 5/14/26 at 2138 hours, - dated 5/15/26 at 2045 hours, - dated 5/24/26 at 2118 hours, and - dated 5/25/26 at 2113 hours. * Resident 11 was administered the regular huma insulin medication at the left lower quadrant of the abdomen on the following dates and times: - dated 5/1/26 at 0057 and 1836 hours, - dated 5/2/26 at 0047, 1233, and 1856 hours, - dated 5/3/26 at 1803 hours, - dated 5/12/26 at 1851 hours, - dated 5/13/26 at 1845 hours, - dated 5/14/26 at 1837 hours, and - dated 5/15/26 at 1844 hours. On 6/2/26 at 1634 hours, an interview and concurrent medical record review for Resident 11 was conducted with LVN 1. LVN 1 reviewed Resident 11's MAR for May 2026 and verified the above findings. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 South Beach Blvd. Anaheim, CA 92804	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/26 at 1122 hours, an interview was conducted with the DON. The DON stated for the administration of insulin injections, the injection sites should be rotated to prevent skin complication related to repeated injections at the same site. The DON further stated prior to the insulin injection, the licensed nurse should review the MAR for the previously injected site and administer the insulin injection at a different site. On 6/4/26 at 1150 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Review of the facility's P&P titled Weight Management Policy revised 11/1/24, showed significant changes in weight (loss or gain) or insidious weight changes (unintended loss or gain over a duration of time) may indicate a nutritional problem. Interventions will be identified, implemented, monitored, and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. Medical record review for Resident 15 was conducted on 6/1/26. Resident 15 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 15's H&P examination dated 6/30/25, showed Resident 15 had decision making capacity. Review of Resident 15's eInteract Change in Condition Evaluation dated 5/7/26 at 1719 hours, showed the physician was notified of Resident 15's weight loss of -7 lbs. in one month; the RD was aware and no new physician's order. Review of Resident 15's Care Plan Report showed a care plan problem revised on 5/7/26, to address Resident 15's unplanned/unexpected weight loss. The interventions included to monitor and evaluate any weight loss. Review of Resident 15's Progress Notes dated 5/7 to 5/10/26, failed to show documented evidence of the continued monitoring related to the resident's unplanned weight loss. On 6/4/26 at 0901 hours, an interview and concurrent medical record review was conducted with ADON 1. ADON 1 stated any weight loss whether it's significant or non-significant was considered a change in the resident's condition. ADON 1 stated for any change in condition, the resident would be assessed and monitored related to the change in condition every shift for 72 hours and may extend depending on the severity of the condition. ADON 1 verified Resident 15 was not monitored continuously related to Resident 15's unplanned/unexpected weight loss. On 6/4/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 15. Cross reference to F692, example #2.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and P&P review, the facility failed to ensure three of four final sampled residents (Residents 1, 4, and 15) received the appropriate services needed to maintain acceptable parameters of nutritional status. * The facility failed to implement a systematic approach to ensure effective monitoring of acceptable parameters of nutritional status when Resident 1 experienced severe weight loss. The severe weight loss of -24 lbs. was not assessed and monitored by the IDT. In addition, the facility failed to ensure the physician was notified and the resident's centered plan of care was revised related to Resident 1's severe weight loss. Resident 1 who had severe weight loss and poor PO intake ultimately received a GT placement. * The facility failed to ensure the RD's recommendations for Resident 15 were carried out when the resident had a weight loss of seven pounds in one month. * The facility failed to ensure the fluid restriction for 2000 ml per 24 hours was followed as per the physician's order for Resident 4. These failures had the potential for adverse nutritional outcomes and negatively affect the residents' well-being. Findings: A professional reference review of the National Library of Medicine titled, An approach to the management of unintentional weight loss in elderly people dated 3/15/05, showed in part, Unintentional weight loss, or the involuntary decline in total body weight over time, is common among elderly people who live at home. Weight loss in elderly people can have a deleterious effect on the ability to function and on quality of life and is associated with an increase in mortality over a 12-month period .Unintentional weight loss is the involuntary decline in total body weight over time. In clinical practice, it is encountered in up to 8% of all adult outpatients and 27% of frail people 65 years and older. Weight loss is an important risk factor in elderly patients. It is associated with increased mortality, which can range from 9% to as high as 38% within 1 to 2.5 years after weight loss has occurred .Weight loss of 4%-5% or more of body weight within 1 year, or 10% or more over 5-10 years or longer, is associated with increased mortality or morbidity or both. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC552892/ Review of the facility's P&P titled Weight Management Policy revised 11/1/24, showed based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. The facility will utilize a systematic approach to optimize a resident's nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors; b. Evaluating/analyzing the assessment information; c. Developing and consistently implementing pertinent approaches; (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Monitoring the effectiveness of interventions and revising them as necessary. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop and initiate an individualized care plan to address the resident's specific nutritional concerns and preferences. Weight analysis: the newly recorded resident weight should be compared to the previous recorded weight. Pursuant to the Resident Assessment Instrument (RAI) Manual, a significant change in weight is defined as 5% change in weight in one month (30 days) or 10% change in weight in 6 months (180 days). The RD will consult residents with significant weight changes as ordered by the attending physician. The documentation of significant weight changes shall be completed in accordance with the facility's documentation policies and procedures and acceptable standards of practice. 1. Review of the facility's P&P titled Notification of Changes revised 12/19/22, showed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representatives when there is a change requiring such notification. Circumstances requiring notification include: significant changes in the resident's physical, mental or psychosocial condition such as deterioration in health, mental, or psychosocial status. Medical record review for Resident 1 was conducted on 6/1/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE] with the diagnosis of unspecified severe protein-calorie malnutrition. Review of Resident 1's H&P (History and Physical) examination dated 5/25/26, showed Resident 1 had fluctuating capacity. a. Review of Resident 1's Weights and Vitals Summary from 11/1/25 through 6/30/26, showed the following weights and comparisons for Resident 1: - on 11/19/25, weight = 149 lb., - on 12/2/25, weight = 145 lbs., - on 4/1/26, weight = 121 lbs., a -10.0% change (compared to weight on 11/19/25 of 149 lbs., -18.0%, -28 lbs.) Review of Resident 1's Nutrition - Amount Eaten for March 2026 showed the following documentation: - dated 3/5/26, for the lunch meal: Resident 1 at 30% of the meal and resident refused the alternative meal, - dated 3/6/26, for the dinner meal: Resident 1 ate 20% of the meal and ate 26-50% of the alternative meal, - dated 3/9/26, for the breakfast meal: Resident 1 ate 40% of the meal, and response not required was documented for the alternative meal, (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 3/9/26, for the lunch meal: Resident 1 ate 30% of the meal, and response not required was documented for the alternative meal, - dated 3/13/26, for the dinner meal: Resident 1 ate 25% of the meal, and refused the alternative meal, - dated 3/14/26, for the breakfast meal: Resident 1 ate 30% of the meal and ate 26-50% of the alternative meal, - dated 3/15/26, for the lunch meal: Resident 1 ate 40% of the meal and ate 0-25% of the alternative meal, - dated 3/16/26, for the breakfast meal: Resident 1 ate 45% of the meal, and refused the alternative meal, - dated 3/16/26, for the lunch meal: Resident 1 ate 35% of the meal, and refused the alternative meal, - dated 3/17/26, for the breakfast meal: Resident 1 ate 45% of the meal, and refused the alternative meal, - dated 3/17/26, for the lunch meal: Resident 1 ate 45% of the meal, and refused the alternative meal, - dated 3/18/26, for the lunch meal: Resident 1 ate 30% of the meal, and refused the alternative meal, - dated 3/22/26, for the breakfast meal: Resident 1 ate 25% of the meal, and refused the alternative meal, - dated 3/22/26, for the lunch meal: Resident 1 ate 30% of the meal, and refused the alternative meal, - dated 3/24/26, for the dinner meal: Resident 1 ate 25% of the meal and refused the alternative meal, and - dated 3/27/26, for the dinner meal: Resident 1 ate 0% of the meal and ate 0-25% of the alternative meal. Review of Resident 1's Quarterly Nutritional Assessment by the RD dated 3/29/26 , showed the following documentation: - Resident 1 weighed 145 lbs., with the usual body weight (UBW) of 145 to 152 lbs. and the goal weight was the UBW range; - Recent weight change, indicated no; - Average percentage of meal eaten indicated 61% for two weeks. The nutritional assessment further showed Resident 1 had been refusing weights for three months. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1 was eating fairly, about 61% average intake of meals with snacks ordered daily. The RD recommended to increase snacks to three times daily. The RD visited the resident at bedside this afternoon, resident reported disliking some food items. The RD encouraged resident to provide food preferences, resident declined. The RD encouraged resident to provide additional snack ideas, resident requesting to add yogurt and cottage cheese, kitchen was notified. The RD encouraged the resident to agree to monthly weigh-in next week, resident agreeable. The RD will continue to monitor the PO intake, skin, weight, labs as available as needed per protocol. Further review of Resident 1's medical record failed to show any documentation to address Resident 1's poor PO intake in the month of March 2026. Resident 1's intake had less than or equal to 50%, including the two meals that were refused for 32 of the 90 meals recorded. Resident 1 was also not seen by the RD until 3/29/26. b. Review of Resident 1's Weights and Vitals Summary from 11/1/25 through 6/30/26, showed the following weights and comparisons for Resident 1: - on 11/19/25, weight = 149 lb., - dated 12/2/25, weight = 145 lbs.; and - dated 4/1/26, weight = 121 lbs., a -10.0% change (compared to weight on 11/19/25 of 149 lbs., -18.0%, -28 lbs.); and - dated 4/24/26, weight = 117 lbs. a -10.0% change (comparison weight 11/19/25 of 149 lbs., -21.5%, -32 lbs.) Review of Resident 1's eInteract Change in Condition Evaluation dated 4/1/26, showed the physician was notified of Resident 1's poor PO intake. The licensed nurse documented Resident 1 was noted with PO intake less than 50% with the last three meals. Under most recent weight the licensed nurse documented the weight of 145 lbs. obtained on 12/2/25. Further review of the Change in Condition Evaluation showed the physician was informed with recommendations to continue monitoring Resident 1 for 72 hours, encourage PO and fluid intake, offer substitutions, assist Resident 1 with meals, and offer Boost and high-calorie shakes. However, further review of the Change in Condition Evaluation failed to show the documentation if the physician was informed of Resident 1's current weight of 121 lbs. (a weight loss of 24 lbs. from 12/2/25 to 4/1/26, or a weight loss of 28 lbs. from 11/19/25). Resident 1 was also not seen by the RD until 4/28/26 when Resident 1 was readmitted to the facility on [DATE]. c. Review of Resident 1's Weights and Vitals Summary from 11/1/25 through 6/30/26, showed the following weights and comparisons for Resident 1:- dated 4/1/26, weight = 121 lbs., a -10.0% change (compared to weight on 11/19/25 of 149 lbs., -18.0%, -28 lbs.); and - dated 4/24/26, weight = 117 lbs. a -10.0% change (comparison weight 11/19/25 of 149 lbs., -21.5%, -32 lbs.) (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's Nutritional Assessment by the RD dated 4/28/26 for readmission, showed the following documentation: - Resident 1 weighed 117 lbs. on 4/27/26, usual body weight 120 lbs., - BMI (Body Mass Index) of 18.3, the goal weight range indicated gradual weight gain towards BMI 23.0 to 29.9, - Recent weight change indicated no - Average of meal percentage eaten indicated 64% for four days. The nutritional assessment further showed Resident 1's PO intake did not meet 100% of the estimated needs. Resident 1 was currently on a therapeutic diet and on 1:1 feeding assist. The resident may benefit from liberalization of diet to help promote PO intake/meet increased needs. The RD will continue to monitor the PO intake, skin, weight, labs as available as needed per protocol. Further review of the RD's nutritional assessment failed to show the documentation if the RD acknowledged Resident 1's weight loss of 24 lbs. from 12/2/25 to 4/1/26. In addition, Resident 1's Usual Body Weight was changed to 120 lbs. from 145 - 152 lbs. as documented in the nutritional assessment dated [DATE]. On 6/4/26 at 0919 hours, an interview and concurrent medical record review for Resident 1 was conducted with ADON 2. ADON 2 stated for any weight variances of 3% loss in one week, 5 % loss in one month, or 10% weight loss in three months, ADON 2 stated the physician would be notified, a change in condition evaluation would be completed to monitor the resident's weight loss and PO intake, the resident would be reevaluated by the RD, and an IDT meeting would be conducted to discuss the resident's weight variance. When asked about Resident 1's documented weight loss on 4/1/26, ADON 2 reviewed Resident 1's medical record and stated there was no documentation if the physician was informed of Resident 1's weight loss of 24 lbs (16.55%), a severe weight loss since 12/2/25, no IDT meeting was conducted to discuss Resident 1's weight variance, or an RD evaluation was conducted following the documented weight loss on 4/1/26. Additionally, ADON 2 verified Resident 1's care plan problem was not updated to address Resident 1's weight loss. On 6/4/26 at 1032 hours, an interview and concurrent medical record review for Resident 1 was conducted with the Lead Registered Dietician (LRD). The LRD reviewed Resident 1's medical record and verified Resident 1 had a severe weight loss of 24 lbs. (16.55%) in four months from 12/2/25 to 4/1/26, and 28 lbs. (18.8%) in six months from 11/19/25 to 5/19/26. The LRD reviewed Resident 1's MDS assessment dated [DATE], and stated Resident 1 had a weight loss of more than 10% in six months and the coding for weight loss was inaccurate. The LRD verified there were no documented evidence Resident 1 was reevaluated by the RD following the weight loss on 4/1/26, until 4/28/26, when Resident 1's was readmitted to the facility. The LRD reviewed Resident 1's Nutritional Assessments dated 3/29/26 and 4/28/26, and verified the difference in the documentation of Resident 1's usual body weight from 145-152 lbs. to 120 lbs. When asked about the difference in the documentation of Resident 1's usual body weight, the LRD stated the RD who completed the (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment may have changed the weight based on the resident's current weight to provide a more accurate baseline. The LRD reviewed the nutritional assessment dated [DATE], and verified Resident 1's weight loss of 24 lbs. from 12/2/25 to 4/1/26 was not documented in the nutritional assessment. The LRD stated the weight loss should have been addressed as soon as possible. On 6/4/26 at 1122 hours, an interview was conducted with the DON. The DON stated, after inputting the weight, the unit manager/desk nurse was responsible for reviewing the resident's weights for any significant or severe weight changes. If a weight variance of 5% in one month, or 10% in six months was noted or identified, the unit manager/desk nurse was expected to initiate the Change in Condition evaluation, inform the physician/responsible party, and notify the RD for reassessment, and the IDT weight variance review should be conducted as soon possible for nutritional reassessment and interventions. On 6/4/26 at 1534 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 1. LVN 1 stated Resident 1's meal intake was dependent on his mood. LVN 1 stated Resident 1's average meal intake was 40-60% and Resident 1 needed encouragement and assistance with his meals. LVN 1 stated poor PO intake was when the resident would eat less than 50% of the meal for three meals. LVN 1 further stated if the resident's PO intake was less than 50% for three days, the desk nurse would be notified to inform the physician and initiate a change in condition evaluation. On 6/4/36 at 1556 hours, a follow-up interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON acknowledged the facility did not follow the facility's protocol for weight loss. When asked, the DON stated the CNAs were responsible for the documentation of the residents' meal intakes. The DON stated if the resident had less than 50% of the meal intake, the licensed nurse was responsible for communicating with the oncoming nurses the resident's poor PO intake. The DON stated if the resident had poor PO intake of less than 50% for three days or three consecutive meals, the licensed nurse should initiate a Change in Condition Evaluation and inform the physician to obtain orders. The DON reviewed Resident 1's meal intake records from 3/1 to 3/31/26, and verified Resident 1 had poor PO intake. The DON further reviewed Resident 1's medical record and verified a Change in Condition evaluation related to Resident 1's poor PO intake was not completed for Resident 1 during the month of March 2026, until 4/2/26. The DON verified a change of condition evaluation was not initiated, the physician and responsible party were not informed, an RD evaluation or IDT meeting was not conducted when Resident 1 had been refusing to be weighed for three months and had poor PO intake to evaluate Resident 1's nutritional status. The DON also verified the physician was not notified and there were no weight variance meeting conducted nor Resident 1 was seen by the RD when Resident 1 weighed only 121 lbs. on 4/1/26 (a weight loss of - 28 lbs. from 11/19/25). d. Review of the facility's P&P titled Comprehensive Care Plans revised 12/19/22, showed the comprehensive care plan will be reviewed and revised by the IDT team after each comprehensive and quarterly MDS assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident' needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monito the resident's progress. Alternative interventions will be documented as needed. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's Care Plan Report showed the following care plan problems: - dated 2/2/25, addressing Resident 1's resistive to care: refusal of meals and meal substitute. The interventions included allowing the resident to make decisions, educating the resident of the possible outcomes, encourage participation/interaction during care, praise the resident when behavior is appropriate. However, further review of the interventions failed to include specific interventions or monitoring related to Resident 1's refusal of meals and meal substitute; and - dated 5/7/26, addressing Resident 1's nutritional problem or potential nutritional problem showed on 3/29/26: quarterly review- resident refusing weights for three months, and on 5/27/26: - 5 lbs. weight loss in one month, and 33 lbs. weight loss in six months. The intervention included to monitor/record/report to the physician as needed for signs and symptoms of malnutrition: muscle wasting, significant weight loss: >5 % in one month, >7.5% in three months, >10% in six months). On 6/4/26 at 0919 hours, an interview and concurrent medical record review for Resident 1 was conducted with ADON 2. ADON 2 stated the resident weights were compared at one, three, and six-months intervals. When asked about Resident 1's documented weight loss on 4/1/26, ADON 2 reviewed Resident 1's medical record and verified the weight loss was not included in Resident 1's care plan. ADON 2 verified Resident 1's care plan problem was not revised to include Resident 1's weight loss of 24 lbs. (16.55%), a severe weight loss since 12/2/25. On 6/4/36 at 1556 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified Resident 1's care plan addressing Resident 1's refusal of meals or meal substitutes failed to include any specific monitoring/interventions related to Resident 1's weight loss. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 15 was conducted on 6/1/26. Resident 15 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 15's H&P examination dated 6/30/25, showed Resident 15 had decision making capacity. The H&P further showed the documentation Resident 15 was at high risk for life-threatening deterioration. Review of Resident 15's Weight Change Progress Note dated 5/5/26 at 1733 hours, showed Resident 15 was seen by the RD for weight change of (-) seven lbs./3.2% in one month; unplanned and non-significant. The resident was currently on therapeutic diet and modified diet texture, and the oral intake was desirable. The note further showed when the RD visited, the resident stated he was not aware of the weight loss and wanted to maintain current weight. The note also showed the cause of weight loss was unknown, and the resident stated he had been eating well. The RD recommended snacks in between meals and the resident was agreeable. RD recommended snacks BID and weekly weights for two weeks. The RD would continue to monitor po, skin, weight, labs as available as needed per protocol. Review of Resident 15's Weights and Vitals Summary from 4/1/26 through 5/31/26, showed the following weights recorded: (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 4/2/26, weight = 166 lbs.; and - dated 5/4/26, weight = 159 lbs. Further review of Resident 15's medical record did not show documented evidence Resident 15 was being monitored for weekly weights for two weeks and the RD's recommendation for snacks BID was not ordered until 5/30/26 as per the review of the resident's Order Summary Report. Review of Resident 15's 1's eInteract Change in Condition Evaluation dated 5/7/26 at 1719 hours, showed the physician was notified of Resident 15's weight loss of (-) seven pounds in one month, the RD was aware and no new physician's order. Review of Resident 15's IDT Care Conference for Weight Variance dated 5/7/26 at 1724 hours, showed the following documentation: Reason for review was for monthly weight. Resident 15's average percentage of meals eaten was 90-100%, the most recent weight was 159 lbs.; the significant weight loss/gain: +/- five lbs in one month; indicate how much weight loss: (-) seven lbs. The recommendations showed to continue to monitor the oral intake, continue with dietary regimen as ordered by the RD follow up, and notify the physician for any significant changes. On 6/1/26 at 1407 hours, an observation and interview was conducted with Resident 15. Resident 15 stated he just felt sleepy. Resident 15 stated he was eating ok but sometimes he just did not have an appetite. Resident 15 stated he was recently receiving snacks between meals, and it was ok. Resident 15 stated he remembered he was informed of his weight loss last month. Resident 15 further stated he did not know how much he weighs now because he was not weighed recently. On 6/4/26 at 0901 hours, an interview and concurrent medical record and facility document review for Resident 15 was conducted with ADON 1 and RN 5. ADON 1 verified Resident 15 had a weight loss of seven pounds in one month last May 2026. ADON 1 stated the RD was usually in the facility daily and following up with the residents. RN 5 stated the RD would fill up the Clinical Recommendation Form and would give to the nurse at the end of the day, the nurse would review and notify the physician of the RD's recommendations, and the nurse would carry out the order when the physician approved the recommendations within 72 hours. RN 5 further stated the nurse would document the communication with the physician. Review of the facility document titled Clinical Recommendation Form revised 11/27 for the month of May 2026 did not show documentation of the RD's noted weight loss for Resident 15 on 5/4/26. However, on 5/29/26, the following documentation showed: Resident 15's Problem/Concern: Resident's preference; Recommendations: add snacks BID (two times a day); and the Nursing & Dietary Sections were blank. ADON 1 verified the RD's recommendations on 5/7/26 were not communicated to the physician and carried out until 5/29/26. On 6/4/26 at 1200 hours, an interview was conducted with the LRD. The LRD stated the RD would communicate the recommendations to nursing by writing in the Clinical Recommendation Form and would also send email to the DON, medical record or Administrator as necessary. The LRD stated when the RD had recommendations, he/she needed to communicate it to the nursing preferably on that day or at least within 72 hours. The LRD was informed and acknowledged the above findings for Resident 15. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 15. Cross reference to F684, example #3. 3. Review of the facility's P&P titled Fluid Restriction revised 5/18/26, the Compliance Guidelines section showed the following: - The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes; - The food and nutrition department will be notified by facility communication methods of the fluid restriction; and - Water will not be provided at the bedside unless calculated into the daily total fluid restriction. On 6/1/26 at 1117 hours, during the initial tour of the facility, Resident 4 was observed awake and lying on the bed. Resident 4 stated he could drink water if the water container was on his table and if there was none, he would call and ask for it. Resident 4 stated he drank enough water, but he was swollen now. Resident 4's bilateral hands and arms were observed swollen with tightness of the skin. Medical record review for Resident 4 was initiated on 6/1/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's H&P examination dated 6/30/25, showed Resident 15 had the capacity to understand and make medical decisions. Review of Resident 4's Order Summary Report showed a physician's order dated 5/15/26, for fluid restriction of 2000 ml/24 hours as follows: * Total for Dietary: 960 ml - 360 ml at breakfast; - 360 ml at lunch; and - 240 ml at dinner. * Total for Nursing: 1040 ml - 240 ml for the 2300 to 0700 hours shift; - 400 ml for the 0700 to 1500 hours shift; and - 400 ml for the 1500 to 2300 hours shift. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/2/26 at 1136 hours, an interview for Resident 4 was conducted with CNA 2. CNA 2 stated Resident 4 could eat and drink by himself. CNA 2 stated he was familiar with Resident 4. CNA 2 stated during the morning huddle, the nurse would inform the CNAs if there were special orders for the resident like fluid restriction. CNA 2 stated he was not documenting the fluid intake of the residents but would report to the nurse after breakfast and lunch meal. CNA 2 stated he would report to the nurse the residents' food and fluid intake after he took out all the food trays. CNA 2 verified Resident 4 had a fluid restriction but did not know how much and there was no visible sign at Resident 4's room regarding the resident's fluid retraction for 24 hours. CNA 2 stated he would usually place a whole water pitcher at Resident 4's bedside which may be about 800-900 ml. CNA 2 further stated Resident 4 would tell him if the resident did not drink the water in the pitcher. CNA 2 stated he already reported to the nurse this morning the amount of fluid Resident 4 had for breakfast, but he could not recall it anymore when asked how much fluid the resident had for breakfast. On 6/2/26 at 1201 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 2. LVN 2 stated if the resident had a fluid restriction, a signage of how much fluid restriction in a day would be posted in the resident's room and the nurses would communicate to the CNAs not to place a water pitcher in the resident's room. LVN 2 stated she would inform the CNA how much fluid restriction in the dietary intake and nursing intake. LVN 2 stated the dietary intake would be from the kitchen like coffee, milk or juice which were in the food tray. LVN 2 stated the nursing intake would be the water or juice which were given during medication administration and the water from the bedside which was given by the nurse or CNA. LVN 2 stated the CNAs would report to the nurses the resident's fluid intake after each meal. LVN 2 stated the fluid restriction intake was recorded in the Monitor Record. Review of Resident 4's Monitor Record for May and June 2026 showed the fluid intake record for the following dates and shifts: - dated 5/15 and 5/16 for the 0700 to 1500 hours shift, the recorded fluid intake was 1120 ml; - dated 5/16 and 5/17 for the 1500 to 2300 hours shift, the recorded fluid intake was 1120 ml; - dated 5/22 for the 0700 to 1500 hours shift, the recorded fluid intake was 1120 ml; - dated 5/24 for the 0700 to 1500 hours shift, the recorded fluid intake was 720 ml; - dated 5/25 for the 1500 to 2300 hours shift, the recorded fluid intake was 600 ml; - dated 5/29 and 5/30/26 for the 0700 to 1500 hours shift, the recorded fluid intake was 720 ml; and - dated 6/2/26 for the 0700 to 1500 shift, the recorded fluid intake was 640 ml. LVN 2 stated there was no report received from CNA 2 regarding the resident 4's fluid intake for breakfast. LVN 2 stated the fluid intake recorded in the Monitor Record was only from the nursing department and not the dietary intake. LVN 2 was asked about the documentation of fluid intake coming from the dietary. Further review of Resident 4's medical record failed to show documented (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evidence of the fluid intake from the dietary to provide 960 ml of fluids in 24 hours. LVN 2 verified the findings. In addition, Resident 4 received more than the fluid restriction as per the physician's order for the above dates for May and June 2026. On 6/4/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 4. Cross Reference to F580.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and P&P review, the facility failed to provide the necessary care and services related to GT feeding for four of four final sampled residents (Residents 6, 11, 130, and 238) reviewed for tube feedings. * The facility failed to ensure Residents 6, 11, and 238 were administered the complete dose of the GT enteral feeding and water flushes as per the physician's order. * The facility failed to ensure Resident 130 was administered the complete dose of GT enteral feeding and water flushes as per the physician's order. In addition, the facility failed to follow the RD recommendations to increase the GT enteral feeding. These failures had the potential to not meeting the residents' nutritional needs and put the residents at risk for weight loss and/or dehydration. Findings: Review of the facility's P&P titled Appropriate Use of Feeding Tubes revised 12/19/22, showed it is a policy of the facility to ensure that a resident maintains acceptable parameters of nutritional and hydration status. A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal- pharyngeal ulcers. 1. On 6/1/26 at 0908 hours, Resident 6 was observed in bed. A feeding pump was observed hanging on the pole; however, there was no enteral feeding formula observed. Medical record review for Resident 6 was initiated on 6/1/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Order Summary Report showed the following physician's orders dated 4/18/26, to administer the following: - continuous enteral feeding Glucerna (enteral feeding formula) 1.5 at 55 ml per hour for 20 hours, to provide 1100 ml total, a total of 1650 kcal to start at 1100 hours until 1100 ml has infused; and - continuous water flushing via the GT at 50 ml per hour for 20 hours, to provide 1000 ml, to start the water flushing at 1100 hours until a total of 1000 ml has infused. On 6/4/26 at 0805 hours, a follow-up observation was conducted for Resident 6. Resident 6 was observed lying in bed without any GT feeding. On 6/4/26 at 0840 hours, an observation for Resident 6 and concurrent interview and medical record review was conducted with RN 7. RN 7 was asked to check Resident 6's GT feeding pump. The feeding pump showed feeding incomplete. RN 7 was then asked to check the GT feeding history. The feeding pump showed 1002 ml fed and 900 ml flushed. RN 7 reviewed Resident 6's medical records (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and verified Resident 6 was not administered the prescribed enteral feeding dose of 1100 ml, and was not administered the prescribed water flushes of 1000 ml. 2. On 6/1/26 at 0856 hours, Resident 11 was observed in bed. A feeding pump was observed hanging on the pole; however, there were no enteral feeding formula observed. Medical record review for Resident 11 was initiated on 6/1/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 had severely impaired cognitive skills for daily decision making. Review of Resident 11's Order Summary Report showed the following physician's orders: - dated 2/25/26, to administer continuous enteral feeding Glucerna 1.5 at 55 ml per hour for 20 hours, to start at 1100 hours until 1100 ml has infused, to provide 1100 ml total ; and - dated 4/28/26, to administer continuous water flushing via the GT at 25 ml per hour for 20 hours, to provide 500 ml. On 6/2/26 at 1023 hours and 6/4/26 at 0800 hours, a follow-up observation was conducted for Resident 11. Resident 11 was observed lying in bed, without any GT feeding being administered. On 6/4/26 at 0845 hours, an observation for Resident 11 and concurrent interview and medical record review was conducted with RN 7. RN 7 was asked to check Resident11's GT feeding pump. The feeding pump showed feeding incomplete. RN 7 was then asked to check the GT feeding history. The feeding pump showed 1024 ml fed and 450 ml flushed. RN 7 reviewed Resident 11's medical records and verified Resident 11 was not administered the prescribed enteral feeding dose of 1100 ml and was not administered the prescribed water flushes of 500 ml. RN 7 stated the residents should be fed the ordered volume of enteral feeding and water flushes to ensure the residents received the full nutrients. On 6/4/26 at 1122 hours, an interview was conducted with the DON. The DON stated all enteral feedings and water flushes should be administered as per the physician's order. The DON further stated if the enteral feedings and water flushes were not completely administered, there would be the potential risk of weight loss or dehydration. On 6/4/26 at 1150 hours, an follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 130 was initiated on 6/1/26. Resident 130 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 130's H&P examination dated 5/22/26, showed Resident 130 had no capacity to understand and make medical decisions. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 130's MDS assessment dated [DATE], showed Resident 130 had a feeding tube and medical diagnosis of dysphagia (difficulty swallowing). Review of Resident 130's Order Summary Report dated 6/4/25, showed the following orders dated 5/20/26, to administer Fibersource HN (enteral feeding formula) at 40 ml/hr for 20 hours to provide 800ml per day and administer water for 20 ml/hr for 20 hours to provide 400ml per day. Further review of Resident 130 Nutritional assessment dated [DATE], showed a recommendation to increase the enteral feeding of Fibersource HN (enteral feeding formula) to 50 ml/hr for 20 hours to provide 1000 ml/1200 kcal, for Resident 130 was noted with gradual weight loss for 90 days. On 6/4/26 at 0754 hours, an observation and concurrent interview for Resident 130 was conducted with LVN 4. Resident 130 was observed in bed with no GT enteral feeding hanging. LVN 4 verified Resident 130 was not connected with GT enteral feeding. When LVN was asked to check Resident 130's GT feeding pump, the feeding pump showed feeding incomplete. The pump feeding history showed 73 ml left, and 37 ml flushed. LVN 4 verified Resident 130 did not receive the prescribed dose of 800 ml of enteral feeding, and was not provided with the prescribed water flushes of 400 ml. On 6/4/26 at 1148 hours, an interview and concurrent medical record review was conducted for Resident 130 with ADON 1. ADON 1 verified the RD recommendation to increase the enteral feeding was not follow up with the physician. On 6/4/26 at 1408 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. On 6/1/26 at 0938 hours, Resident 238 was observed in bed. Resident 238's GT feeding of Fibersource was observed hanging and connected via a feeding pump. The feeding pump was observed beeping, and the screen showed feeding complete. Medical record review for Resident 238 was initiated on 6/1/26. Resident 238 was admitted to the facility on [DATE]. Review of Resident 238's Order Summary Report showed a physician's order dated 5/16/26, to administer the following: - continuous enteral feeding formula Fibersource at 80 ml per hour for 20 hours, to start at 1100 hours until 1000 ml has infused; and - continuous enteral flushing with water at 24 ml per hour for 20 hours until 480 ml has infused. On 6/2/26 at 1001 hours, a follow-up observation was conducted for Resident 238. Resident 238 was observed in bed without any GT feeding. On 6/2/26 at 1047 hours, an observation for Resident 238 and concurrent interview and medical record review was conducted with RN 6. RN 6 verified Resident 238 was not connected with GT (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feeding. When RN 6 was asked to check Resident 238's GT feeding pump, the feeding pump showed feeding incomplete. RN 6 was then asked to check the GT feeding history, and the feeding pump showed 967 ml fed, and 456 ml flushed. RN 6 verified Resident 238 did not receive the prescribed dose of 1000 ml of enteral feeding, and was not provided with the prescribed water flushes of 480 ml. On 6/3/26 at 1453 hours, an interview for Resident 238 was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the necessary pain management care and services for four of 35 final sampled residents (Residents 3, 22, 152, and 214) reviewed for pain management. * The facility failed to ensure the nonpharmacological interventions were provided and documented to Residents 3 and 214 prior to administering the pain medications. * The facility failed to accurately document the pain level as ordered by the physician when pain medication was administered to Resident 22. * The facility failed to ensure pain medication was administered as per physician's order for Resident 152's complaint of 9/10 pain. In addition, the facility failed to ensure the non-pharmacological pain interventions were implemented and documented before the resident was administered pain medication. These failures posed the risk for the residents not to receive the appropriate and necessary interventions to manage the residents' pain. Findings: Review of the facility's P&P titled Pain Management revised 3/17/25, showed the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The Pain Management and Treatment section showed: a. Non-pharmacological interventions will include but are not limited to: - Environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning); - Loosening any constrictive bandage, clothing or device; - Applying splinting (e.g., pillow or folded blanket); - Physical modalities (e.g., cold compress, warm shower/bath, massage, turning and repositioning); - Exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility; and - Cognitive/behavioral interventions (e.g., music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and education about pain). b. Pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain. 1. On 6/1/26 at 1011 hours, during the initial tour of the facility, Resident 3 was observed awake and sitting on the bed. Resident 3 was observed with right BKA (below the knee amputation). Resident 3 stated she had pain in her right leg all the time. Resident 3 stated she received pain medication when (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she needed it. Medical record review for Resident 3 was initiated on 6/1/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 2/12/26, showed Resident 3 had the capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed a physician's order dated 2/11/26, to administer hydrocodone-acetaminophen (pain medication) 5-325 mg one tablet by mouth every six hours as needed for 5-7 pain rate (in a scale of 0-10, 0 = no and 10 = severe pain). Review of Resident 3's Care Plan Report showed a care plan dated 6/13/25, addressing the resident's risk for pain related to diabetic neuropathy and status post right BKA. The interventions included to provide non-pharmacological intervention to alleviate pain (specify: provide warm blanket when cold, provide cool drink when hot, provide extra snack when hungry, provide quiet environment to sleep when tired). Review of Resident 3's MAR for May and June 2026 showed Resident 3 received hydrocodone-acetaminophen 5-325 mg medication on the following dates and times: - dated 5/11 at 1226 hour; - dated 5/13 at 1215 hour; - dated 5/14 at 1335 hour; and - dated 6/2/26 at 0720 hour. Further review of Resident 3's medical record failed to show any documented evidence of the nonpharmacological interventions provided to Resident 3 prior to the administration of the pain medication. On 6/3/26 at 1256 hours, an interview and concurrent medical record review for Residents 3 was conducted with ADON 1. ADON 1 stated the nonpharmacological interventions such as massage, providing quiet and calm environment, music, distraction, diversion or relaxation techniques should be used when the resident was experiencing pain. ADON 1 stated the nonpharmacological interventions should be provided prior to the administration of pain medications because this could minimize the use of medications and its side effects and prevent any episodes of over sedation or dependence due to the use of the medications. ADON 1 verified Resident 3 received pain medication on the days and times listed above and was not provided with any nonpharmacological interventions prior to the administration of the pain medication. 2. On 6/1/26 at 0815 hours, during the initial tour of the facility, Resident 214 was observed awake and sitting in the wheelchair inside the room. Resident 214 stated he had pain in his right shoulder (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	most of the time. Resident 214 stated the pain was like at number 5 or moderate pain. Resident 214 stated he received pain medication when he asked for it. Medical record review for Resident 214 was initiated on 6/1/26. Resident 214 was readmitted to the facility on [DATE]. Review of Resident 214's Order Summary Report showed a physician's order dated 3/9/26, to administer tramadol hydrochloride 50 mg one tablet by mouth every eight hours as needed for moderate (5-7) to severe (8-10) pain. Review of Resident 214's H&P examination dated 3/13/26, showed Resident 214 was alert, verbal, and oriented times three (to person/place/time). Review of Resident 214's MAR for May 2026 showed Resident 214 received tramadol 50 mg on 5/23 at 1735 hours, and 5/27/26 at 0953 hours. Further review of Resident 214's medical record failed to show any documented evidence of the nonpharmacological interventions provided to Resident 214 prior to the administration of the pain medication. On 6/2/26 at 1634 hours, an interview and concurrent medical record review for Residents 214 was conducted with ADON 1. ADON 1 verified Resident 214 received pain medication on the days and times listed above and was not provided with any nonpharmacological interventions prior to the administration of the pain medication. On 6/4/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 3 and 214. 4. Medical record review for Resident 22 was initiated on 6/2/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 5/8/26, showed Resident 22 has fluctuating capacity to understand and make decisions. Review of Resident 22's Order Summary Report showed a physician's order dated 5/8/26, to administer Hydrocodone-Acetaminophen (Norco) (pain medication) tablet 5-325 mg, give one tablet by mouth every four hours as needed for severe pain level of 8-10. Review of Resident 22's MAR for May 2026 showed the resident was administered the Norco medication on the following dates and times: - dated 5/24/26 at 0900 hours for a pain level of 6; and - dated 5/28/26 at 0800 hours, for a pain level of 6. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/2/26 at 0952 hours, an interview and concurrent medical record review for Resident 22 was conducted with ADON 2. ADON 2 stated for the residents who reported pain, the licensed nurse would assess the resident pain level prior to the administration of the pain medications. ADON 2 further stated the pain medication would be administered as per the physician's order and within the ordered parameters. ADON 2 stated for the pain level of 6, the licensed nurse should not give Norco because the order for Norco was for a pain level of 8-10. ADON 2 reviewed Resident 22's medical record and verified the above findings. On 6/4/26 at 1031 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to accurately document the resident's pain level and give the pain medication as the physician ordered. The DON was informed and acknowledged above findings. 3. Medical record review for Resident 152 was initiated on 6/1/26. Resident 152 was admitted to the facility on [DATE]. Review of Resident 152's H&P examination dated 1/17/26, showed Resident 152 had no capacity to understand and make decisions. Review of Resident 152's Order Summary Report showed a physician's order dated 7/17/25, to give for acetaminophen 325 mg (pain medication) give two tablets by mouth every four hours as needed for numerical pain scale 1-4. Review of Resident 152's MAR for May 2026 showed the resident received acetaminophen pain medication as needed on 5/18/26 at 1318 hours for a pain level of 9. On 6/3/26 at 1005 hours, an interview and concurrent medical record review for Resident 152 was conducted with ADON 1. ADON 1 verified the above findings and stated Resident 152's pain level of nine dated 5/18/26 was considered severe pain. ADON 1 verified Resident 152 did not have a pain medication ordered for severe pain, and the PRN acetaminophen order was for mild pain. ADON 1 further stated no non-pharmacological interventions were documented prior to administering the medication. ADON 1 stated the physician should have been contacted to obtain a different pain medication order to address Resident 152's severe pain. On 6/4/26 at 1408 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for three of three final sampled residents reviewed for hemodialysis (Residents 8, 158, and 174). * The facility failed to ensure Resident 8 and 158's fluid intake were monitored accurately. In addition, the facility failed to ensure Resident 8 and 158's hemodialysis access were monitored accurately * The facility failed to ensure Resident 174 was monitored for any extra fluids at bedside, and the appropriate emergency kit was provided for the resident who has a Permacath. These failures had the potential to result in accurate assessment of fluid status, complications associated with fluid overload, and delayed intervention in the event of a dialysis access emergency. Findings: Review of the facility's P&P titled Hemodialysis revised date 6/5/23, showed the following:- The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice. This includes the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility, and ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control;- The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as dialysis communication form or other form, that will include, but not limited to, nutritional/ fluid management including documentation of weights, resident compliance with food/ fluid restrictions or provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered, and dialysis adverse reactions/ complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site;- The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications; and- The nurse will ensure that the dialysis access site is checked before and after dialysis treatments and every shift for patency by auscultating for a bruit and palpating for a thrill. If absent, the nurse will immediately notify the attending physician, dialysis facility and/or nephrologist. Review of the facility's P&P titled Fluid Restriction revised date 5/18/26, showed the following:- The facility will ensure fluid restrictions will be followed in accordance with physician's orders;- The fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks and medication passes; and- Water will not be provided at the bedside unless calculated into the daily total fluid restriction. 1.a. On 6/3/26 at 0850 hours, Resident 8 was observed in bed, with a bottle of cranberry juice on the nightstand. Medical record review for Resident 8 was initiated on 6/1/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed the following physician's orders:- dated 8/11/25, for hemodialysis access site monitoring of AVF on the left forearm for bruit and thrill. Document P if present, and A if absent every shift;- dated 8/11/25, for hemodialysis access monitoring of AVF on the left forearm for R for redness, S for swelling, B for bleeding, and P for pain;- dated 8/12/25, for hemodialysis days on Monday, Wednesday, and Friday; and- dated 2/18/26, for fluid restriction of 1200 ml per day. The fluid intake limit for nursing was 600 ml, which was broken down to 240 ml for 0700 to 1500 hours shift, 240 ml for 1500 to 2300 hours shift, and 120 ml for 2300 to 0700 hours shift. The fluid intake limit for dietary was 600 ml, which was broken down to 240 ml for breakfast, 120 ml for lunch, and 240 ml for dinner. b. Review of Resident 8's fluid intake as per the CNA and licensed nurses' documentation (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed inconsistency. In addition, the CNA documentation of Resident 8's fluid intake have also exceeded the amount documented by the licensed nurses documentation in the Monitor Record. For example: Review of Resident 8's Follow Up Questions Report for May and June 2026 showed the following Resident 8's fluid intake from dietary/ meals as per the CNA documentation:- dated 5/2/26, there was no documentation of the resident's fluid intake during dinner;- dated 5/3/26 at 2252 hours, the fluid intake was 550 ml;- dated 5/8/26 at 0626 hours, the fluid intake was 120 ml;- dated 5/9/26 at 0545 hours, the fluid intake was 120 ml;- dated 5/11/26 at 1933 hours, the fluid intake was 200 ml;- dated 5/12/26 at 2037 hours, the fluid intake was 200 ml;- dated 5/13/26 at 0344 hours, the fluid intake was 120 ml;- dated 5/13/26, there was no documentation of the resident's fluid intake during dinner;- dated 5/22/26 at 0659 hours, the fluid intake was 4 ml;- dated 5/22/26 at 2118 hours, the fluid intake was 550 ml;- dated 5/24/26 at 1916 hours, the fluid intake was 200 ml;- dated 5/24/26, there was no documentation of the resident's fluid intake during breakfast and lunch;- dated 5/25/26 at 0505 hours, the fluid intake was 120 ml;- dated 5/26/26 at 1450 hours, the fluid intake was 360 ml;- dated 5/26/26 at 2222 hours, the fluid intake was 8 ml;- dated 5/27/26, there was no documentation of the resident's fluid intake during dinner;- dated 5/30/26 at 1212 hours, the fluid intake was 240 ml;- dated 5/30/26, there was no documentation of the resident's fluid intake during dinner;- dated 5/31/26 at 1444 hours, the fluid intake was 240 ml;- dated 6/1/26, there was no documentation of the resident's fluid intake during dinner; and- dated 6/2/26 at 2259 hours, the fluid intake was 600 ml. Review of Resident 8's Monitor Record for May and June 2026 showed the following Resident 8's fluid intake as per the licensed nurses' documentation:- dated 5/3/26 at 1500 to 2300 hours shift, the fluid intake was 480 ml;- dated 5/8/26 at 2300 to 0700 hours shift, the fluid intake was 100 ml;- dated 5/9/26 at 2300 to 0700 hours shift, the fluid intake was 100 ml;- dated 5/11/26 at 1500 to 2300 hours shift, the fluid intake was 200 ml;- dated 5/13/26 at 2300 to 0700 hours, the fluid intake was 100 ml;- dated 5/22/26 at 1500 to 2300 hours shift, the fluid intake was 240 ml;- dated 5/24/26 at 1500 to 2300 hours shift, the fluid intake was 100 ml;- dated 5/25/26 at 2300 to 0700 hours shift, the fluid intake was 100 ml;- dated 5/26/26 at 1500 to 2300 hours shift, the fluid intake was 220 ml;- dated 5/28/26 at 0700 to 1500 hours shift, there was no documentation of the resident's fluid intake;- dated 5/30/26 at 0700 to 1500 hours shift, the fluid intake was 220 ml;- dated 5/31/26 at 0700 to 1500 hours shift, the fluid intake was 220 ml; and- dated 6/2/26 at 2300 to 0700 hours shift, the fluid intake was 100 ml. c. Further review of Resident 8's Monitor Record for May and June 2026 showed Resident 8's hemodialysis access site was not monitored consistently and accurately. For example:- Under the monitoring for bruit and thrill of the AVF on the left forearm, and to document P if present, and A if absent every shift, the licensed nurses documented N on 5/22/26 at 1500 to 2300 shift, and on 5/9 and 5/22/26 at 2300 to 0700 shift. In addition, there was no documentation on 5/28/26 at 0700 to 1500 hours shift; and- Under the hemodialysis access, Resident 8 was documented to have pain (P) on 5/11 and 5/17/26 at 0700 to 1500 hours shift, on 5/11, 5/12, 5/14, 5/17, 5/18, 5/20, 5/22, 5/23, 5/24, and 5/26/26 at 1500 to 2300 hours shift, and on 5/2, 5/3, 5/4, 5/8, 5/10, 5/11, 5/12, 5/14, 5/15, 5/16, 5/17, 5/18, 5/20, 5/23, and 5/24/26 at 2300 to 0700 shift. In addition, there was no documentation on 5/28/26 at 0700 to 1500 hours shift. Further review of Resident 8's medical record did not show the licensed nurses notified the attending physician, dialysis facility and/or nephrologist of Resident 8's fluid intake, absence of bruit and thrill, and consistent complaint of pain. On 6/3/26 at 0900 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 4. RN 4 stated the resident's fluid intake from the dietary/ meals were documented by the CNAs on the Task (Follow-Up Questions Report). RN 4 stated the licensed nurses' documentation of the resident's fluid intake in the Monitor Record included the resident's fluid intake from the nursing and (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dietary/meals. RN 4 stated the licensed nurses would refer to the Task documentation to calculate the total amount of fluid intake by the resident. When asked about the monitoring of Resident 8's fluid intake, RN 4 stated the fluid intake for nursing and dietary was documented in the Monitor Record. RN 4 verified the resident's fluid intake from the dietary/meals under the Task (Follow-Up Question Report) was inconsistent and exceeded the fluid intake documented in the Monitor Record, which should have been the total fluid intake from the nursing and dietary. When asked about the hemodialysis access monitoring, RN 4 verified the licensed nurses documented N on the monitoring for bruit and thrill, and Resident 8 was documented to have pain on the hemodialysis access but there was no documentation if the physician or nephrologist nor the dialysis facility was notified. On 6/3/26 at 1010 hours, an observation of Resident 8 and concurrent interview was conducted with RN 4. RN 4 verified Resident 8 was lying in bed with a bottle of cranberry juice at bedside. RN 4 stated there should be no extra fluids at bedside. On 6/3/26 at 1433 hours, an interview for Resident 8 was conducted with the DON. When asked about residents on fluid restriction, the DON stated the facility has a protocol for the residents on fluid restriction to not have a water pitcher or extra fluids at bedside, and the resident's fluid intake from nursing and dietary will be documented by the licensed nurses in the Monitor Record. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 158 was initiated on 6/1/26. Resident 158 was admitted to the facility on [DATE]. Review of Resident 174's Order Summary Report showed the following physician's orders:- dated 5/16/24, for hemodialysis days on Tuesday, Thursday, and Saturday;- dated 2/18/26, for fluid restriction of 1000 ml per day. The fluid intake limit for nursing was 520 ml, which was broken down to 200 ml for 0700 to 1500 hours shift, 200 ml for 1500 to 2300 hours shift, and 120 ml for 2300 to 0700 hours shift. The fluid intake limit for dietary was 480 ml, which was broken down to 240 ml for breakfast, 120 ml for lunch, and 120 ml for dinner.- dated 4/15/26, for hemodialysis access site monitoring of AV shunt on the left forearm for bruit and thrill. Document P if present, and A if absent every shift; and- dated 4/15/26, for hemodialysis access monitoring of AV shunt on the left forearm for R for redness, S for swelling, B for bleeding, and P for pain. Review of Resident 158's Monitor Record for May and June 2026 showed the following:- Under the monitor for Resident 158's fluid restriction, Resident 158's total fluid intake on 5/15/26, was 1040 ml;- Under the monitoring for bruit and thrill of Resident 158's AV shunt on the left forearm, and to document P if present, and A if absent every shift, the licensed nurses documented N on 5/22/26 at 1500 to 2300 hours shift, and on 5/1, 5/6, 5/7, 5/9, and 5/22/26 at 2300 to 0700 hours shift. The licensed nurses also documented 0 on 5/2/26 at 1500 to 2300 hours shift. In addition, there was no documentation on 5/16 and 5/28/26 at 0700 to 1500 hours shift, 5/19/26 at 1500 to 2300 hours shift; and- Under the hemodialysis access, Resident 158 was documented to have pain (P) on 5/11 and 5/17/26 at 0700 to 1500 hours shift, on 5/11, 5/12, 5/14, 5/17, 5/18, 5/20, 5/23, 5/24, and 5/26/26 at 1500 to 2300 hours shift, and on 5/3, 5/4, 5/5, 5/8, 5/10, 5/11, 5/12, 5/14, 5/15, 5/16, 5/17, 5/18, 5/20, 5/23, 5/24, and 5/29/26 at 2300 to 0700 shift. In addition, there was no documentation on 5/16 and 5/28/26 at 0700 to 1500 hours shift, 5/19/26 at 1500 to 2300 hours shift. Further review of Resident 8's medical record did not show the licensed nurses notified the attending physician, dialysis facility and/or nephrologist of Resident 8's fluid intake, absence of bruit and thrill, and consistent complaint of pain. On 6/3/26 at 0916 hours, an interview and concurrent medical record review for Resident 158 was conducted with RN 4. RN 4 verified there was no CNA documentation of Resident 158's fluid intake under Task. RN 4 also verified Resident 158's fluid intake on 5/15/26, exceeded the allowed daily fluid limit. RN 4 further verified the licensed nurses documented N on the monitoring for bruit and thrill, and Resident 158 was documented to have pain on the hemodialysis access but there was no (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation if the physician or nephrologist nor the dialysis facility was notified. On 6/3/26 at 1506 hours, an interview for Resident 158 was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated she did not know why the licensed nurses documented 0 or N for the monitoring of bruit and thrill on Resident 158's AV shunt. The DON further stated the licensed nurses should have done nursing interventions when Resident 158 complained of pain on the hemodialysis access site. 3. On 6/1/26 at 0930 hours, during the initial tour of the facility, Resident 174 was observed awake in bed. A transparent bag marked with the resident's name and dialysis tourniquet kit was observed hanging on the wall. Resident 174 stated she goes to hemodialysis treatment, and her hemodialysis access was a permacath on the left shoulder. Resident 174 expressed concern that the emergency kit did not apply to her but applies to residents with an AV shunt hemodialysis access. On 6/3/26 at 0758 hours, Resident 174 was observed asleep in bed. A half-consumed bottle of soda, and a cup of water were observed at the bedside table. On 6/3/26 at 0759 hours, an observation of Resident 174 and concurrent interview was conducted with CNA 3. CNA 3 verified a half-consumed bottle of soda and a cup of water were observed at Resident 174's bedside table. CNA 3 stated Resident 174 was on fluid restriction, and the CNAs document the fluids consumed by the resident from the meal tray. When asked if the CNAs report to the licensed nurses about the resident's fluid intake from the meal tray, CNA 3 answered no. CNA 3 further stated the nurses knew the resident takes 240 ml for breakfast, and for lunch, it depends, sometimes 120 ml in the morning, or 120 ml in the afternoon. Medical record review for Resident 174 was initiated on 6/1/26. Resident 174 was readmitted to the facility on [DATE]. Review of Resident 174's Order Summary Report showed the following physician's orders:- dated 9/25/24, for hemodialysis days on Tuesday, Thursday, and Saturday;- dated 9/25/24, for hemodialysis access monitoring of central catheter on the left chest. Permacath site dressing changes at dialysis and as needed. To monitor access site for signs and symptoms of infection every shift; and- dated 4/8/26, for fluid restriction of 1200 ml per day. The fluid intake limit for nursing was 600 ml, which was broken down to 240 ml for 0700 to 1500 hours shift, 240 ml for 1500 to 2300 hours shift, and 120 ml for 2300 to 0700 hours shift. The fluid intake limit for dietary was 600 ml, which was broken down to 240 ml for breakfast, 120 ml for lunch, and 240 ml for dinner. Further review of Resident 174's medical record did not show CNA documentation of Resident 174's fluid intake under Task. On 6/3/26 at 0814 hours, an observation for Resident 174 and concurrent interview was conducted with LVN 2. LVN 2 verified a half bottle of soda, and a cup of water were observed at Resident 174's bedside table. LVN 2 further verified a transparent bag marked with the resident's name and dialysis tourniquet kit was observed hanging on the wall inside Resident 174's room. LVN 2 verified the transparent bag contained a roll of stretch bandage, bordered gauze, T-drain sponges, rolls of paper tape, and a roll of a blue tourniquet. LVN 2 stated in case of emergency involving Resident 174's hemodialysis access, they would use the emergency supplies inside the transparent bag. LVN 2 verified the transparent bag did not contain plastic clamps, and the tourniquet would not be appropriate for the residents with Permacath hemodialysis access. When asked about Resident 174's fluid intake, LVN 2 stated Resident 174 was on fluid restriction, and the licensed nurses document the fluid intake from the nursing and dietary in the Monitor Record. LVN 2 further stated the fluid intake from the medication administration would be under the nursing department, and the fluid intake from the meal trays would be under the dietary department. LVN 2 stated they would have to add the extra amount of fluid from the half bottle of soda found on Resident 174's bedside. On 6/3/26 at 0936 hours, an interview and concurrent medical record review for Resident 174 was conducted with RN 4. RN 4 verified there was no CNA documentation of Resident 174's fluid intake under Task. On 6/3/26 at 1511 hours, an interview for (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 174 was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the kitchen employees had the appropriate competencies and skill sets to carry out the functions of the food and nutrition services department. 1. Two of 32 kitchen employees (DAs 1 and 2) failed to follow proper manual ware washing procedures. 2. One of 32 kitchen employees (Cook 2) failed to show competency in checking the sanitizing solution concentration. 3. Two of 32 kitchen employees (DA 1 and [NAME] 1) failed to perform proper hand hygiene. These failures had the potential for cross contamination and food preparation equipment, dishware, and utensils not to be cleaned and sanitized correctly. Findings: 1. According to the USDA Food Code 2022, 4-301.12 Manual Ware washing, Sink Compartment Requirements. The 3-compartment requirement allows for proper execution of the 3-step manual ware washing procedure. If properly used, the 3 compartments reduce the chance of contaminating the sanitizing water and therefore diluting the strength and efficacy of the chemical sanitizer that may be used. Alternative manual ware washing equipment, allowed under certain circumstances and conditions, must provide for accomplishment of the same 3 steps: 1. Application of cleaners and the removal of soil; 2. Removal of any abrasive and removal or dilution of cleaning chemicals; and 3. Sanitization. According to the USDA Food Code 2022 4-603.16 Rinsing Procedures. Washed utensils and equipment shall be rinsed so that abrasives are removed and cleaning chemicals are removed or diluted through the use of water or a detergent-sanitizer solution by using one of the following procedures: Use of a distinct, separate water rinse after washing and before sanitizing if using: (3) A 3-step washing, rinsing, and sanitizing procedure in a ware washing system. It is important to rinse off detergents, abrasive, and food debris after the wash step to avoid diluting or inactivating the sanitizer. Review of the facility's P&P titled Manual Warewashing-2 or 3 Compartment Sink revised 12/19/22, showed to prevent the spread of bacteria that may cause food borne illness, this facility washes, rinses, and sanitizes pots, pans, and other utensils using a 2 or 3 compartment sink in accordance with current standards for food safety. a. Review of the facility's document titled Dietary Aide- Job Descriptions signed and dated 8/1/22 by DA 1, showed the Dietary Aide position was responsible to perform dishwashing/cleaning procedures. Assume that utensils, etc., are readily available for next meal. Review of the facility's document titled Employee Performance Evaluation signed by DA 1 on 3/21/25, showed DA 1 was above average on job performance - a. knowledge of job. On 6/1/26 at 0854 hours, an observation of the manual ware washing process using a two-compartment sink was observed with DA 1. DA 1 was observed scrubbing soiled pans in compartment one of the manual ware washing sink with hot soapy water. Then, using the sink faucet, DA 1 rinsed the pan allowing the water to run into compartment one of the manual ware washing sink diluting the cleaning solution. Next, DA 1 was observed submerging the dish pan in compartment two of the ware washing sink with a sanitizing solution. b. Review of the facility's document titled Dietary Aide- Job Descriptions signed by DA 2 on 10/25/23, showed the Dietary Aide position was responsible to perform dishwashing/cleaning procedures. Assume that utensils, etc., are readily available for next meal. Review of the facility's document titled Employee Performance Review (Dietary Aide) signed by DA 2 on 2/1/25, showed DA 2 was average on wash and clean utensils as directed. On 6/2/26 at 0930 hours, an observation and interview was conducted with DA 2. DA 2 was observed cutting cantaloupes on a food preparation table using a knife and a cutting board. After DA 2 finished, DA 2 gathered the knives and the cutting board and walked to the two-compartment manual ware washing station. Without washing the knives in the first compartment (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the manual ware washing sink, DA 2 rinsed the two knives using the faucet, then placed the two knives into the clean knife holder inside the dry storage room. DA 2 acknowledged she did not follow the manual ware washing procedure to clean the two knives. On 6/3/26 at 1008 hours, an interview was conducted with the LRD. The LRD stated the facility's policy did not specify how to use a two-compartment manual ware washing sink. The LRD further stated compartment one of a manual ware washing sink was used for both washing and rinsing. The LRD stated the water in compartment one of a manual ware washing sink should be emptied after washing the pots and pans then filled with fresh water to rinse the pots and pans. The washed and rinsed pots and pans are then submerged in a sanitizing solution in compartment two of the manual ware washing sink. The LRD acknowledged DAs 1 and 2 did not follow the proper manual ware washing procedure. On 6/4/26 at 1653 hours, a follow-up interview was conducted with the LRD. The LRD stated there was no evidence the facility provided in-service training on manual ware washing for food service staff in the past year. 2. According to the USDA Food Code 2022 4-501.116 Ware washing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. Review of Manufacturer's guidelines on Micro Essential Lab QT- 10 Hydrion QT Test Quaternary Ammonia Check Test Paper Dispenser showed test paper should be held motionless in solution for ten seconds and results should be read immediately. Review of the facility's document titled Employee Performance Evaluation signed by [NAME] 2 on 8/26/25, showed superior on Job Performance - a. knowledge of job. On 6/2/26 at 1003 hours, an observation and interview was conducted with [NAME] 2. [NAME] 2 was observed testing the sanitizer concentration used for sanitizing food preparation surfaces. [NAME] 2 was observed dipping the test strip into the sanitizing solution for six seconds. [NAME] 2 removed the sanitizing test strip, looked at the sanitizing test strip then put the sanitizing test strip back in the sanitizing solution. [NAME] 2 stirred the sanitizing test strip in the sanitizing solution then without comparing the sanitizing test strip with the color chart located on the sanitizing test strip container, [NAME] 2 stated the sanitizing solution was less than 200 ppm. [NAME] 2 stated the sanitizing solution was changed every two hours or when it was visually dirty it should be changed. On 6/4/26 at 1653 hours, an interview was conducted with the LRD. The LRD stated there was no evidence the facility provided in-service training on properly testing the sanitizing solution for food service staff in the past year. On 6/4/26 at 1450 hours, an interview was conducted with the LRD and the Administrator. The LRD and Administrator were informed and acknowledged [NAME] 2 did not check sanitizing solution correctly. 3. Review of the facility's P&P titled Hand Hygiene revised dated 12/19/22, showed the staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. a. Review of the facility's document titled Dietary Aide- Job Descriptions signed by DA 1 on 8/1/22, showed to follow established Infection Control Precautions policies and procedures when performing daily tasks. Review of the facility's document titled Employee Performance Evaluation signed by DA 1 on 3/21/25, showed DA 1 was above average on job performance- a. knowledge of job. On 6/1/26 at 0830 hours, an observation of the manual ware washing process was conducted with DA 1. DA 1 wore gloves as she manually washed the soiled pans. DA 1 used the two compartment manual ware washing sink to wash the pans. DA 1 was observed scrubbing soiled pans in the first sink compartment. DA 1 then rinsed the pans using the faucet, then placed the pans in the sanitizing solution in sink two. Next, DA 1 was observed removing her gloves then rinsed her hands using the faucet over the first sink compartment. Finally, DA 1 was observed picking up the clean pans without performing hand hygiene and storing the clean pans in the dry storage room. b. Review of the facility's document titled Cook- Job Descriptions signed and dated 10/15/25 by [NAME] 1, showed h. Follow (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	defined safety codes while performing all duties. Follow defined Infection Control procedures Review of the facility's document titled Employee Performance Review (Cook) signed and dated 2/27/26 by [NAME] 1, showed Strongly agree on follow established Infection Control Precautions policies and procedures when performing daily tasks. On 6/2/26 at 1031 hours, an observation was conducted with [NAME] 1. [NAME] 1 wore a black hat and gloves while he was thawing raw chicken in a sink. Using his gloved hands, [NAME] 1 touched the raw chicken then touched his hat. Next, [NAME] 1 removed his gloves and donned a new pair of gloves without performing hand hygiene. On 6/1/26 at 0854 hours, an interview was conducted with the LRD. The LRD was informed and acknowledged the above findings and stated the kitchen staff should wash their hands using the hand washing station. On 6/4/26 at 1653 hours, an interview was conducted with the LRD. The LRD stated there was no evidence the facility provided in-service training on hand washing for food service staff in the past year. On 6/4/26 at 1450 hours, an interview was conducted with the LRD and Administrator. The LRD and Administrator were informed and acknowledged the above findings.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed when: 1. The cool down process for time, temperature control for safety (TCS) food, food that needs to be kept at specific temperatures to prevent bacteria growth and foodborne illnesses, was not monitored.2. Two of 32 kitchen employees failed to perform proper hand hygiene.3. The thawing process for fish and meat was not followed.4. The manual ware washing process was not followed.5. The kitchen utensils and equipment were not clean and were not stored in a sanitary manner.6. One of 32 kitchen employees failed to don an appropriate hair restraint.7. Food service equipment was not air-dried.8. Five cutting boards were heavily marred, and one was not clean.9. Two can opener blades were heavily worn and were not clean. These failures posed the risk for food borne illnesses in highly susceptible resident population of 187 facility residents who received food prepared in the kitchen.Findings: Review of the facility's Matrix dated 6/1/26, showed 187 of 217 residents consumed food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from135 Fahrenheit (F) to 70 F and (2) Within a total of 6 hours from 135 F to 41 F or less. (B) Time/Temperature Control for Safety Food shall be cooled within 4 (four) hours to 41 degrees Fahrenheit (F) or less if prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna. On 6/1/26 at 0756 hours, an observation and interview was conducted with the Assistant Dietary Manager (ADM). The following were observed inside the walk-in refrigerator:- Egg salad, dated 6/1/26, with a temperature of 70.5 F- Tuna salad, dated 6/1/26, with a temperature of 65.5 F- Ham salad, dated 6/1/26, with a temperature of 54.4 FThe ADM stated the eggs used for the egg salad were cooked in the facility kitchen and the salads were made in the facility kitchen. On 6/1/26 at 0920 hours, an observation and temperature checked of the salads was conducted. The salads were observed stored in the walk-in refrigerator and the temperature of the salads was the following:- Egg salad, dated 6/1/26, with a temperature of 62.1 F- Tuna salad, dated 6/1/26, with a temperature of 59.0 F- Ham salad, dated 6/1/26, with a temperature of 52.7 F On 6/1/26 at 1206 hours, another observation and temperature check of the salads was conducted. The salads were observed stored in the walk-in refrigerator and the temperature of the salads was the following:- Egg salad, dated 6/1/26, with a temperature of 52.7 F-Tuna salad, dated 6/1/26, with a temperature of 53.4 F- Ham salad, dated 6/1/26, with a temperature of 48.0 F On 6/1/26 at 1410 hours, an interview was conducted with the Dietary Manager (DM), ADM, and Lead Registered Dietitian (LRD). The ADM stated egg salad, tuna salad, and ham salad were made in the kitchen in the morning around 0700 to 0730 hours. When asked to show the cool down monitoring for the salads, the Dietary Manager stated they did not have a cool down log since he had been working in the facility. The Dietary Manager added there should be a cool down log. The ADM discarded egg salad, tuna salad, and ham salad. The LRD confirmed the facility did not monitor the cool down process for TCS foods. 2. Review of the facility's P&P titled Hand Hygiene revised dated 12/19/22, showed the staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. a. On 6/1/26 at 0830 hours, using a two-compartment manual ware washing sink, the manual ware washing was observed with Dietary Aide 1. DA 1 was observed scrubbing soiled pans using a two-compartment sink. DA 1 washed the pans in the first sink compartment, rinsed the pans using the faucet and sanitized the pans in the second sink compartment. Next, DA 1 was observed removing her gloves and rinsing her hands using (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the faucet over the first sink compartment. Finally, DA 1 was observed picking up the clean dish pans without performing hand hygiene and storing the clean dish pans in the dry storage room. b. On 6/2/26 at 1031 hours, an observation was conducted with [NAME] 1. [NAME] 1 wore a black hat and gloves while he was thawing raw chicken in a sink. Using his gloved hands, [NAME] 1 touched the raw chicken then touched his hat. Next, [NAME] 1 removed his gloves and donned a new pair of gloves without performing hand hygiene. On 6/2/26 at 1040 hours, an interview with LRD was conducted. The LRD was informed and acknowledged the above findings and stated kitchen staff should wash their hands using the hand washing station. 3. Review of the facility's P&P titled Thawing Food revised date 4/10/23, showed to label food that is to be thawed with the pull date and the date to be cooked. On 6/1/26 at 0748 hours, an observation and interview were conducted with the ADM. 30 pounds of tilapia, and five pounds of diced beef were observed thawing in the walk-in refrigerator. The tilapia and diced beef did not have a label indicating the date they were pulled from the freezer nor a date they were to be cooked. The ADM stated the thawing process was usually 72 hours and confirmed the tilapia and diced beef should be dated with a pull date and use by date. 4. According to the USDA Food Code 2022, 4-301.12 Manual Ware washing, Sink Compartment Requirements. The 3-compartment requirement allows for proper execution of the 3-step manual ware washing procedure. If properly used, the 3 (three) compartments reduce the chance of contaminating the sanitizing water and therefore diluting the strength and efficacy of the chemical sanitizer that may be used. Alternative manual ware washing equipment, allowed under certain circumstances and conditions, must provide for accomplishment of the same 3 steps: 1. Application of cleaners and the removal of soil; 2. Removal of any abrasive and removal or dilution of cleaning chemicals; and 3. Sanitization. According to the USDA Food Code 2022 4-603.16 Rinsing Procedures. Washed utensils and equipment shall be rinsed so that abrasives are removed and cleaning chemicals are removed or diluted through the use of water or a detergent-sanitizer solution by using one of the following procedures: Use of a distinct, separate water rinse after washing and before sanitizing if using: (3) A 3-step washing, rinsing, and sanitizing procedure in a ware washing system. It is important to rinse off detergents, abrasive, and food debris after the wash step to avoid diluting or inactivating the sanitizer. On 6/1/26 at 0854 hours, an observation of the manual ware washing process using a two-compartment sink was observed with DA 1. DA 1 was observed scrubbing soiled pans in compartment one of the manual ware washing sink with hot soapy water. Then, using the sink faucet, DA 1 rinsed the pan allowing the water to run into compartment one of the manual ware washing sink diluting the cleaning solution. Next, DA 1 was observed submerging the dish pan in compartment two of the ware washing sink with a sanitizing solution. On 6/3/26 at 1008 hours, an interview was conducted with the LRD. The LRD stated the facility's policy did not specify how to use a two compartment manual ware washing sink. The LRD further stated compartment one of a manual ware washing sink was used for both washing and rinsing. The LRD stated the water in compartment one of a manual ware washing sink should be emptied after washing the pots and pans then filled with fresh water to rinse the pots and pans. The washed and rinsed pots and pans are then submerged in a sanitizing solution in compartment two of the manual ware washing sink. 5. Review of the facility's P&P titled Dish and Utensil Procedure revised date 9/22/25, showed any dish, tray, or utensil with debris should not be used. Send back to the dish room to be properly washed and sanitized. On 6/1/26 at 0843 hours, an observation and interview were conducted with the Dietary Manager. Two dirty knives were stored in a knife holder. The Dietary Manager verified the two dirty knives and took the knives to be washed. a. On 6/1/26 at 0910 hours, an observation of the storage of clean kitchen utensils was conducted with the Dietary Manager. Multiple kitchen utensils were observed stored in (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uncovered plastic bins. The four plastic bins had dried food debris and three food service scoops stored inside the plastic bins were soiled. The Dietary Manager verified the findings and stated they should be cleaned. 6. Review of the facility's P&P titled Dietary Employee Personal Hygiene revised 6/23/25, showed hair restraints a. All dietary staff must wear hair restraints (e.g. hairnet, hat and/or beard restraint) to prevent hair from contacting food. On 6/1/26 at 0748 hours, during the initial tour of the kitchen, the Dietary Manager was observed with facial hair not covered with a beard restraint. On 6/1/26 at 0823 hours, an interview was conducted with the Dietary Manager. The Dietary Manager verified he was not wearing a beard restraint then donned a beard restraint. 7. Review of the facility's P&P titled Air Drying - Dishes and Utensils revised 3/2/26, showed dishes must be stored to promote air drying i.e. use dish racks or trays with plastic mesh that allow air to circulate and air dry the dishes. On 6/1/26 at 0748 hours, during the initial kitchen tour, an observation and interview were conducted with the Dietary Manager. In a room used for clean dishware and utensil storage, the following was observed:- more than five plastic storage bins were wet and stacked together on a drying rack.- multiple steam table pans were stacked wet on a metal rack.- two blenders were store wet.The Dietary Manager verified the food service equipment was not air dried. 8. Review of the facility's P&P titled Dish and Utensil Procedure revised date 9/22/25, showed cutting boards need to be washed and sanitized between each use. Replace cutting boards once lined with knife marks and they are un-sanitizable. On 6/1/26 at 0910 hours, an observation and interview was conducted with the ADM. Five green cutting boards were observed to be heavily marred and one cutting board was soiled. The ADM verified the five green cutting boards were heavily marred and one cutting board was soiled. The ADM removed the five marred cutting boards. 9. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment, food contact surfaces and utensils shall be clean to sight and touch, (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, residue and other debris. On 6/1/26 at 0905 hours, an observation and interview were conducted with the Dietary Manager. Two can openers were not clean, and the blades had excessive wear. The Dietary Manager stated the can opener blades should be replaced and the can openers washed. On 6/4/26 at 1450 hours, an interview was conducted with the LRD and the Administrator. The LRD and Administrator were informed and acknowledged the above findings.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure safe food handling of the food brought for the residents from outside sources. * The facility failed to ensure the visitors and family members were educated on safe food handling practices when bringing food from outside sources. This failure had the potential to cause foodborne illness to the medically vulnerable resident population who consumed food [NAME] from outside resources. Findings: Review of CMS S&C-09-39 dated 5/29/09, showed the residents had the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices. The CMS guideline further showed the facility has the responsibility under the food safety regulation to help the visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. Review of the facility's P&P titled Outside Food Brought in by Family or Visitor revised 8/18/25, showed It is the right of the residents of this facility to have food brought in by family or other visitors; however, the food must be handled in a way to ensure the safety of the resident. On 6/1/26 at 1236 hours, an observation and interview was conducted with RN 2 in Dining room [ROOM NUMBER]. A designated resident's food refrigerator was observed in Dining room [ROOM NUMBER]. RN 2 stated the residents and family were allowed to bring outside food, which was stored inside the resident's refrigerator. When asked about education provided to residents and families regarding safe food handling practices, RN 2 stated the facility instructed the residents and family that food brought from home could be stored in the refrigerator for 72 hours before being discarded. RN 2 did not describe education on food temperature control, transport, or other safe handling practices. On 6/3/26 at 1042 hours, an interview was conducted with the DON. The DON stated the residents and families were allowed to bring in outside food and uneaten food would be discarded after two hours if not consumed. When asked about education on safe food handling practices, the DON stated the residents and families were educated that manufactured food brought from home would be discarded after 72 hours from open date and unopened manufactured food was kept until its expiration date. The DON verified the residents, and families did not receive education on safe food handling practices as temperature control, transport, and prevention of foodborne illness.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following:1. Active involvement of required individuals in developing the Facility Assessment;2. A plan to maximize recruitment and retention of direct care staff; and3. A contingency plan for staffing needs. These failures had the potential not to meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed.Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's Assessment review dated 10/21/25, did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; a plan to maximize recruitment and retention of the direct care staff; and a contingency plan for staffing needs. On 6/3/26 at 1622 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility Assessment review dated 10/21/25, and verified there were no direct care staff, direct care representatives, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there was no documentation of a plan to maximize recruitment and retention of direct care staff and a contingency plan for staffing needs in the Facility Assessment. The Administrator stated she was not aware of the current guidance. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.		

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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. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the facility's infection prevention and control program in accordance with the facility's P&P. * The facility failed to maintain an accurate infection control surveillance program for January 2026 through May 2026. * The facility conducted surveillance based solely on whether the residents' were prescribed antimicrobial medications. * The facility failed to include the residents who exhibited signs and/or symptoms of infection but were not prescribed antimicrobials on the surveillance report. * The facility failed to determine whether the residents who exhibited signs and/or symptoms of infections, and were not prescribed antimicrobial medications, met the facility's criteria for infection (McGeer's criteria) and thus, failed to include these residents in the facility's infection control surveillance program. * The facility failed to ensure the Surveillance Data was accurate to determine whether the residents' infection met McGeer's (a standardized surveillance definitions used to detect infections in long-term care facilities, ensuring consistent reporting and monitoring) criteria for true infection for Residents 21, 37, 55, 104, 243, 244, 245, 246, and 247. These failures posed the risk of not identifying the residents' infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility. Findings: Review of the facility's P&P titled Infection Prevention and Control Program revised 12/19/22, showed the IP was responsible for oversight of the program and serves as a consultant to the staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for residents' staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. Review of the facility's P&P titled Infection Surveillance revised 12/19/22, showed all resident infections will be tracked. The CDC's National Healthcare Safety Network (NHSN) Long Term Care Criteria, updated McGeer criteria or other nationally recognized surveillance criteria will be used to define infections. The facility will collect data to properly identify possible communicable diseases or infections before they spread by identifying: Data to be collected, including how often and the type of data to be documented, including: The infection site, pathogen (if available), signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections: Observations of staff including the identification of ineffective practices, if any; and The identification of unusual or unexpected outcomes, infection trends and patterns. How the data will be used and shared and with appropriate individuals when applicable, to ensure that staff minimize spread of the infection or disease. Review of the facility's monthly Infection Surveillance Report from January 2026 through May 2026 showed the following infection surveillance data for HAIs (Healthcare Acquired Infections) and CAIs (Community Acquired Infections): - For January 2026: a total of 45 infections, including 22 HAIs; however, review of the log showed 20 CAIs, 13 HAIs, 12 infections not identified. - For February 2026: a total of 55 infections, including 27 CAIs and 27 HAIs; however, review of the log showed 24 CAIs, 19 HAIs, 12 infections not identified. - For March 2026: a total of 68 infections, including 22 CAIs and 45 HAIs; however, review of the log showed 17 HAIs, 40 HAIs, and 11 infections not identified. - For April 2026: a total of 67 infections, including 34 CAIs and 32 HAIs; however, review of the log showed 27 CAIs, 28 HAIs, and 12 infections not identified. - For May 2026: a total of 78 infections, including 36 CAIs and 41 HAIs; However, review of the log showed 25 CAIs, 28 HAIs, and 25 infections not (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified. Further review of the facility's Infection Surveillance Report from January 2026 through May 2026 showed documentation all the residents categorized as having HAI, CAI, or not identified were prescribed antimicrobial medications. There was no documentation showing whether the residents who exhibited signs and/or symptoms of infection and were not prescribed an antimicrobial medication had met McGeer's criteria. On 6/3/26 at 1340 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated he was responsible for conducting surveillance and tracking infections in the facility. The IP stated when the residents had signs and/or symptoms of an infection, the licensed nurses were responsible for initiating the Infection Screening Evaluation. Once the Infection Screening Evaluation was complete, the licensed nurse would notify the physician for orders. The IP stated if the antimicrobial therapy was prescribed (and also for the residents admitted to the facility with antimicrobial therapy), the IP would be responsible for initiating the Antibiotic Time Out to determine if the resident had met the McGeer's criteria for a true infection. The IP stated the tracking of this information was documented in the monthly Infection Surveillance Report. The IP was asked when a resident at the facility exhibited signs and/or symptoms of infection and was not prescribed antimicrobial medications, whether the facility initiated the McGeer's criteria form for these residents and included these residents in the facility's infection surveillance program (from January 2026 through May 2026). The IP stated McGeer's criteria was only used for the residents who were prescribed antimicrobial therapy to determine whether the infection was a true infection and those residents were included in the monthly Infection Surveillance Report. The IP reviewed the facility's monthly Infection Surveillance Reports from January through May 2026 and verified all the residents in the report were prescribed antimicrobial medications. The IP also verified the reported numbers of HAIs and CAIs did not match the numbers in the logs from January 2026 to May 2026. Review of the Antibiotic Time Out for Residents 21, 37, 55, 104, 243, 244, 245, 246, and 247 was conducted with the IP. The residents' Antibiotic Time Out showed the following documentation: a. For Resident 37, the report dated 1/5/26, showed the following:- the antibiotic treatment prescribed for Resident 37 was meropenem (antimicrobial) 1 gm every 12 hours for 10 days for urinary tract infection.- under the presenting clinical symptoms showed pulse oximetry less than or equal to 94 % on room air and asymptomatic. - further review of the form showed the IP documented criteria met; Resident 37 was diagnosed with ESBL (extended-spectrum beta-lactamase, a group of enzymes produced by certain bacteria that make them resistant to many standard antibiotics) in the urine. Per the physician, to complete the antibiotic regimen. - Review of the Infection Surveillance Report for January 2026 showed Resident 37's infection was categorized as an MDRO (multidrug-resistant organism) Infection (not urinary tract infection) and the infection was documented as an HAI. - Review of the Surveillance Data Collection Form for UTIs for residents without an indwelling catheter showed both criteria 1 and 2 must be present. For criteria 1- at least one of the following:- acute dysuria or acute pain,- fever or leukocytosis (high white blood cell count signaling the immune system is responding to an infection) and at least one of the following localizing urinary tract infections: acute costovertebral (connects the ribs and the spine) angle pain or tenderness, suprapubic pain, gross hematuria (blood in the urine), new or marked increase in incontinence, urgency, or frequency,- in the absence off fever or leukocytosis, then two or more of the following localized criteria: suprapubic pain, gross hematuria, or new or marked increased incontinence, urgency, or frequency.However, the Antibiotic Time Out showed Resident 37 was afebrile and asymptomatic. b. For Resident 104, the report dated 1/6/26, showed the following:- the antibiotic treatment prescribed for Resident 104 was ceftriaxone (antimicrobial) 1 gm every 24 hours for five days, for urinary tract infection.- under the presenting clinical symptoms showed the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation Resident 104 was asymptomatic. - further review of the form showed the IP documented criteria met; Resident 104 was diagnosed with ESBL in the urine. The physician was aware of the lab results, per the physician, to complete the antibiotic regimen. - Review of the Infection Surveillance Report for January 2026 showed Resident 104's infection was documented as HAI. - Review of the Surveillance Data Collection Form for UTIs for residents with an indwelling catheter showed both criteria 1 and 2 must be present. For criteria 1- at least one of the following:a. fever, rigors, or new-onset hypotension, with no alternate site of infection,b. either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis,c. new-onset suprapubic pain or costovertebral angle pain or tenderness,d. purulent discharge from around the catheter or acute pain, swelling, or tenderness Review of Resident 104's Infection Screening Evaluation dated 1/3/26, showed Resident 104 had no malaise or loss of appetite, afebrile, no new onset on hypotension, and no complaints of pain. Further review of Resident 104's Antibiotic Time Out showed Resident 78 was afebrile and asymptomatic. c. For Resident 243, the report dated 2/5/26, showed the following:- the antibiotic treatment prescribed for Resident 243 was levofloxacin (antimicrobial) 750 mg one tablet daily for seven days for sepsis (a serious condition in which the body responds improperly to an infection).- the clinical symptoms included erythema and asymptomatic.- further review of the form showed the documentation no diagnostic tests were ordered and the IP documented: criteria met; Resident 243 was diagnosed with sepsis; the physician was aware of the skin erythema and to complete the antibiotic regimen. - Review of the Infection Surveillance Report for February 2026 showed Resident 243's infection was categorized as blood/systemic infection, and the infection was documented as CAI. - Review of the Surveillance Data Collection Form for other infections, showed the Loeb's Minimum Criteria for Initiating Antibiotic Therapy required both of the following criteria's to be met: a temperature greater than 100 degrees F or 2.4 degrees F above baseline, and at least rigors or delirium; however, none of the symptoms were documented for Resident 243. d. For Resident 244, the report dated 2/27/26, showed the following:- the antibiotic treatment prescribed for Resident 244 was ceftriaxone (antimicrobial) 1 gm daily in the evening, for urinary tract infection.- under clinical symptoms showed the documentation Resident 244 was asymptomatic. - further review of the form showed the IP documented: criteria met, the physician was aware and per the physician, to complete the antibiotic regimen. - Review of the Infection Surveillance Report for February 2026 showed Resident 244's infection was CAI. - Review of the Surveillance Data Collection Form for UTIs for residents without an indwelling catheter showed both criteria 1 and 2 must be present. For criteria 2: a. at least 100,000 cfu/ml of no more than two species of microorganism in a voided urine sample, or b. at least 100 cfu/ml of any number of organisms in a specimen collected by in and out catheter. However, review of Resident 244's medical record failed to show any documentation of the urine culture results. e. For Resident 245, the report dated 3/7/26, showed the following:- the antibiotic treatment prescribed for Resident 245 was Zosyn (antimicrobial) 3.375 gm every six hours for pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus).- under presenting clinical symptoms showed Resident 245 had cough and shortness of breath. - further review of the form showed Resident 245 was afebrile, had no change in activity level and was tolerating meals. The IP documented: criteria met, Resident 245 was diagnosed with pneumonia, the physician was aware of Resident 245's shortness of breath and cough. Per the physician to complete the antibiotic regimen. - Review of the Infection Surveillance Report for March 2026 showed Resident 245's infection was documented as HAI. - Review of Surveillance Data Collection Form for Respiratory Infections, under the criteria for pneumonia, showed all three criteria must be present. For criteria 1- (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interpretation of chest radiograph as demonstrating pneumonia or the presence of new infiltrates. For criteria 3- at least one of the constitutional criteria: fever, leukocytosis, acute mental status change or acute functional decline. However, review of Resident 245's chest radiograph results dated 3/5/26, showed prominent interstitial markings in both lungs concerning for mild congestion, blunted right costophrenic angle, concerning for pleural thickening. No focal infiltrates are seen and there is no pleural effusion on the left side. f. For Resident 21, the report dated 4/10/26 showed the following:- the antibiotic treatment prescribed for Resident 21 was piperacillin-tazobactam (antimicrobial) 3.375 gm three times a day for sepsis.- under clinical symptoms showed the documentation Resident 21 was afebrile and had confusion.- further review of the form showed no diagnostic tests were ordered and the IP documented: criteria met, Resident 21 was diagnosed with sepsis. The physician was aware of Resident 21's confusion, per the physician to complete the antibiotic regimen. - Review of the Infection Surveillance Report for April 2026 showed Resident 21's infection was categorized as blood/systemic infection, and the infection was documented as HAI. - Review of the Surveillance Data Collection Form for other infections, showed the Loeb's Minimum Criteria for initiating antibiotic therapy required both of the following criteria's to be met: a temperature greater than 100 degrees F or 2.4 degrees F above baseline, and at least rigors or delirium; however, the documentation showed Resident 1 was afebrile. g. For Resident 247, the report dated 4/11/26, showed the following:- the antibiotic treatment prescribed for Resident 247 was levofloxacin 500 mg for pneumonia/leukocytosis.- under presenting clinical symptoms showed Resident 247 had low-grade fever and pulse oximetry reading of less than or equal to 94% on room air. - further review of the form showed Resident 247 was afebrile, had no change in activity level and tolerating meals. The IP documented: criteria met, per the physician to complete the antibiotic regimen. - Review of the Infection Surveillance Report for April 2026 showed Resident 247's infection was categorized as a respiratory infection, and the infection was documented as HAI. - Review of Surveillance Data Collection Form for Respiratory Infections, under the criteria for pneumonia, showed all three criteria must be present. For criteria 1- interpretation of chest radiograph as demonstrating pneumonia or the presence of new infiltrates. However, review of Resident 247's medical records showed the following chest radiograph results:- dated 4/8/26: normal chest x-ray, both lung fields are clear with no consolidation, collapse, nodule, or interstitial changes; and- dated 4/9/26: right lower lung lobe with linear opacities likely inflammatory; prominence of both pulmonary hila and attenuation of bronchovascular markings in bilateral lung represents congestion. h. For Resident 246, the report dated 4/17/26, showed the following:- the antibiotic treatment prescribed for Resident 246 was vancomycin (antimicrobial) 10 ml every six hours for C. difficile (bacterial infection of the intestines that causes diarrhea and inflammation of the colon).- the presenting clinical symptoms showed the documentation: abnormal bowel movements/bowel habits.- further review of the form showed no diagnostic tests were ordered and the IP documented: criteria met, the physician was aware of the abnormal bowel habits, per the physician to complete the antibiotic regimen. - Review of the Infection Surveillance Report for April 2026 showed Resident 246's infection was categorized as HAI. - Review of the Surveillance Data Collection Form for gastrointestinal infections, for C. difficile, showed both criteria 1 and 2 must be met: 1. a. Diarrhea of three or more liquid or watery stools within a 24-hour period or b. the presence of toxic megacolon (abnormal dilation of the large bowel) and 2 a. a stool sample yields a positive laboratory result for C. Difficile toxin A or B, or a toxin- producing C. difficile organism is identified from a stool sample culture or b. Pseudomembranous colitis is identified during endoscopic examination or surgery or in histopathologic examination of a biopsy specimen. However, review of Resident 246's medical record failed to show documented evidence a toxicology of Resident (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	246's stool was completed. i. For Resident 55, the report dated 4/22/26, showed the following:- the antibiotic treatment prescribed for Resident 55 was ceftriaxone 1 gm daily for urinary tract infection.- under presenting clinical symptoms showed Resident 55 had urinary frequency/urgency. - further review of the form showed the IP documented criteria met, the physician was aware of increased frequency/urgency, per the physician, to complete the antibiotic regimen. - Review of the Infection Surveillance Report for April 2026 showed Resident 55's infection was HAI. - Review of the Surveillance Data Collection Form for UTIs for residents without an indwelling catheter showed both criteria 1 and 2 must be present. For criteria 2: a. at least 100,000 cfu/ml of no more than two species of microorganism in a voided urine sample, or b. at least 100 cfu/ml of any number of organisms in a specimen collected by in and out catheter. However, review of Resident 55's medical record failed to show any documentation the urine cultures were obtained. On 6/3/26 at 1340 hours, an interview and concurrent facility document review was conducted with the IP. The IP reviewed the medical records for Residents 21, 37, 55, 104, 243, 244, 245, 246, and 247 and verified the classification of the residents' infections as true infections were incorrect. The IP stated the determination of a true infection should be accurate to effectively conduct surveillance and track the prevalence of infections in the facility. On 6/4/16 at 1122 hours, an interview was conducted with the DON. The DON stated the IP was responsible for the surveillance of infections in the facility. The DON stated for the residents with signs and/or symptoms of infection, the McGeer's tool should be conducted to determine if the infection was a true infection. The DON stated the determination of true infections and whether it was HAI or CAI should be accurate. The DON further stated the residents with signs and/or symptoms of infection but were not prescribed any antimicrobial medications should be included in the monthly infection surveillance report. On 6/4/26 at 1150 hours, a follow up interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to accurately monitor and address the use of the antibiotics for one final sampled resident (Resident 1) and nine nonsampled residents (Residents 21, 37, 55, 104, 243, 244, 245, 246 and 247) reviewed for antibiotic stewardship. * The facility failed to ensure the Infection Screening Evaluation and Antibiotic Time Out were conducted when Resident 1 was prescribed an antibiotic therapy. * Residents 21, 37, 55, 104, 243, 244, 245, 246, and 247 who did not meet the McGeer's criteria (a set of specific definitions to identify true infections in long term nursing facilities) were prescribed antimicrobial therapy. These failures resulted in continued use of unnecessary antibiotic therapy, increasing the risk of adverse drug reactions, Clostridioides difficile infection, and the development of antibiotic resistant organisms. Findings: According to the Centers for Disease Control and Prevention (CDC), antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile (a type of bacteria that can cause diarrhea and inflammation of the colon), increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Review of the facility's P&P titled Infection Prevention and Control Program revised 12/19/22, showed an antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. The IP, with oversight from the DON, serves as the leader of the antibiotic stewardship program. Review of the facility's P&P titled Antibiotic Stewardship Program revised 12/19/22, showed the Infection Preventionist coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff. The program includes antibiotic use protocols and a system to monitor antibiotic use. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR prior to notifying the physician. Laboratory testing shall be in accordance with current standards of practice. The facility uses CDC's NHSN Surveillance Definitions, updated McGeer's criteria, or other surveillance tool to define infections. Monitoring antibiotic use: i. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g. antibiotic time out). ii. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. Review of the facility's monthly Infection Surveillance Report from January 2026 through May 2026 showed the following infection surveillance data for HAIs (Healthcare Acquired Infections) and CAIs (Community Acquired Infections):- for January 2026: a total of 45 infections, including 22 HAIs;- for February 2026: a total of 55 infections, including 27 CAIs and 27 HAIs;- for March 2026: a total of 68 infections, including 22 CAIs and 45 HAIs;- for April 2026: a total of 67 infections, including 34 CAIs and 32 HAIs; and - for May 2026: a total of 78 infections, including 36 CAIs and 41 HAIs. On 6/3/26 at 1340 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated he was responsible for conducting surveillance and tracking infections in the facility. The IP stated when the residents had signs and symptoms of an infection, the licensed nurses were responsible for initiating the infection screening evaluation. Once the infection screening evaluation was complete, (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the licensed nurse would notify the physician for orders. The IP stated if the antimicrobial therapy was prescribed (and also for the residents admitted to the facility with antimicrobial therapy), the IP would be responsible for initiating the Antibiotic Time Out to determine if the resident had met the McGeer's criteria for a true infection. The IP further stated if the infection did not meet the criteria for a true infection, the physician would be notified that the antimicrobial therapy may not be appropriate, to prevent the unnecessary use of the antimicrobial therapy and thus leading to antimicrobial resistance. The IP stated in the monthly QA meetings he reported the trends in the different types of infections in the facility, the HAI infection rates, and the number of HAIs, CAIs, and the infections that were prescribed antimicrobial therapy and did not meet McGeer's criteria. a. Medical record review for Resident 1 was conducted on 6/1/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 5/25/26, showed Resident 1 had fluctuating capacity. Review of Resident 1's Order Summary Report showed a physician's order dated 5/28/26, to administer azithromycin (antibiotic) 500 mg intravenously daily for five days. However, further review of Resident 1's medical record failed to show documented evidence the Infection Screening Evaluation or the Antibiotic Time Out was completed to determine if Resident 1's infection met the criteria for a true infection. On 6/3/26 at 1340 hours, an interview and concurrent facility document review was conducted with the IP. The IP reviewed Resident 1's medical record and verified the above findings. The IP stated the Antibiotic Time Out should be completed within 72 hours of the antimicrobial therapy being prescribed for the resident to determine if the antimicrobial therapy was appropriate. b. Review of the facility's Antibiotic Time Out for Residents 21, 37, 55, 104, 243, 244, 245, 246 and 247 was conducted with the IP. After reviewing Resident 21, 37, 55, 104, 243, 244, 245, 246 and 247's Antibiotic Time Out forms, the IP verified the residents' infections did not meet the McGeer's criteria for a true infection, yet each residents were prescribed antimicrobial therapy, and the forms did not indicate as DNMC. On 6/4/26 at 1150 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to offer and provide education for the pneumococcal immunizations for three of five final sampled residents (Residents 5, 11, and 69) reviewed for immunizations. * The facility failed to ensure Residents 11 and 69's consent for the pneumococcal vaccination specified the type of pneumococcal vaccine to be administered. * Resident 5's consented for the pneumococcal 21 (type of pneumococcal vaccine) vaccine; however Resident 5 was administered the Prevnar 20 (type of pneumococcal vaccine) vaccination. These failures had the potential for the residents and/or their representatives not being fully informed of the pneumococcal vaccines and to not be aware of the exact type of pneumococcal vaccine being offered by the facility. Findings: Review of the facility's P&P titled Pneumococcal Vaccine (Series) revised 12/19/22, showed each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident had already been immunized. Further review of the P&P showed prior to offering the pneumococcal immunization, each resident or the resident representative will receive education regarding benefits and potential side effects of the immunization. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record. The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with CDC guidelines and recommendations. 1. Medical record review for Resident 5 was initiated on 6/1/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 was cognitively intact. Review of Resident 5's Pneumococcal Vaccine Consent Form dated 5/4/26, showed Resident 5's signature and consented to receive the pneumococcal 21 vaccine. However, review of Resident 5's MAR for May 2026 showed Resident 5 was administered the Pneumococcal 20-Valent Conjugate Vaccine (type of pneumococcal vaccine) on 5/10/26. 2. Medical record review for Resident 11 was initiated on 6/1/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 had severely impaired cognitive skills for daily decision making. Review of Resident 11's Pneumococcal Vaccine Consent Form dated 5/5/26, showed Resident 11's resident representative's electronic signature and consented to receive the pneumococcal vaccine. Further review of the consent form showed I have read or had explained to me the vaccine information statement for the pneumococcal vaccine. I have been educated on and understand risk, benefits and potential side effects of the pneumococcal vaccine. Under the section to indicate kind of pneumococcal vaccine to be given did not show any entry (blank). Review of Resident 11's MAR for May 2026 showed Resident 11 was administered the Pneumococcal 20-Valent Conjugate Vaccine (type of pneumococcal vaccine) on 5/10/26. 3. Medical record review for Resident 69 was initiated on 6/1/26. Resident 69 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 69's H&P examination dated 5/22/26, showed Resident 69 had no capacity to understand and make decisions. Review of Resident 69's Pneumococcal Vaccine Consent Form dated 5/8/26, showed Resident 69's Representative electronic signature and consented to receive the pneumococcal vaccine. Further review of the consent form showed I have read or had explained to me the vaccine information statement for the pneumococcal vaccine. I have been educated on and understand risk, benefits and potential side effects of the pneumococcal vaccine. Under the section to indicate kind of pneumococcal vaccine to be given did not show any entry (blank). Review of Resident 69's MAR for May 2026 showed Resident 69 was (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered the Pneumococcal 20-Valent Conjugate Vaccine (type of pneumococcal vaccine) on 5/10/26. On 6/3/26 at 1340 hours, an interview and concurrent medical record review for Residents 5, 11, and 69 was conducted with the IP. The IP verified the informed consents for Residents 11 and 69 did not indicate the type of pneumococcal vaccine the resident received. The IP stated the informed consents for the vaccinations should have indicated the type of vaccine the resident received to ensure the resident and resident representatives were fully informed. Additionally, the IP reviewed Resident 5's informed consent and verified Resident 5 did not receive the vaccination her resident representative had consented to. On 6/4/26 at 1150 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to maintain the essential equipment in safe operating condition when the ice machine manufacturer guidelines for sanitizing the ice machine and ice storage bin were not followed. This failure created the potential for the residents to receive ice from the kitchen that was not adequately clean for safe consumption. Findings: Review of Scotsman Ice Systems model number C1030 manufacture guidelines showed: 14. Create a solution of sanitizer by mixing a 1 gallon or 4-liter solution of locally approved sanitizer and clean, warm water. Use an EPA approved food equipment sanitizer at the solution mix recommended by the sanitizer manufacturer. Scotsman offers Stera Sheen [NAME] Label sanitizer, part number 14-0382-01. And 20. Pour the sanitizing solution into the reservoir until it is full. The unit will circulate the sanitizer, then drain and flush it. This will take 35 minutes, then the machine will stop and the display will show 0. Further reviews of the manufacture guidelines showed: Ice storage Bin 3. Mix a solution of sanitizer and thoroughly wash all interior surfaces of the ice storage bin. Pour excess sanitizer solution into the bin's drain. On 6/1/26 at 0939 hours, an interview and product manufacture guideline review was conducted with the Maintenance Director. The Maintenance Director stated the ice machine was cleaned monthly. When the Maintenance Director was asked how the ice machine was cleaned, the Maintenance Director stated he used Scotsman Clear 1 Scale Remover to clean the ice machine by mixing one ounce of Scotsman Clear 1 and 32 ounces of water then pressed the clean cycle on the ice machine. When asked how the ice machine was sanitized, the Maintenance Director stated he used Scotsman Clear 1 scale remover for the ice machine by mixing one ounce of Scotsman Clear 1 and 32 ounces of water and poured the mixed solution into the ice machine's reservoir and the ice machine would go through the sanitizing cycle. When asked how the ice storage bin was sanitized, the Maintenance Director stated he used Scotsman Clear 1 scale remover to sanitize the ice machine storage bin by mixing one ounce of Scotsman Clear 1 and 32 ounces of water. The manufacturer guidelines were reviewed with the Maintenance Director. The Maintenance Director stated he thought the Scotsman Clear 1 was to be used for both cleaning and sanitizing the ice machine. The Maintenance Director verified the ice machine, and the ice storage bin were not being sanitized per the manufacture's guidelines. On 6/4/26 at 1450 hours, an interview was conducted with the LRD and Administrator. The LRD and Administrator were informed and acknowledged the above findings.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to determine if the residents were safe to self-administer the medications left at the bedside for two of 35 final sampled residents (Residents 49 and 113). * The facility failed to ensure it was safe for Resident 49 to self-administer the vitamin C (supplement) medication observed at bedside. Additionally, there was no physician's order or care plan problem developed to address the resident's self-administration of this medication. * The facility failed to ensure it was safe for Resident 113 to self-administer refresh eye drop (used to lubricate and instantly soothe dry, burning and irritated eyes) medication observed at the bedside. In addition, there was no physician's order, assessment or care plan for the self-administration of the medications. These failures had the potential for Resident 49 and 113 to administer the medications inaccurately and could affect the residents' well-being. Findings: Review of the facility's P&P titled Self-Administration of Medications revised date 12/19/22, showed the following: - Resident's preference so self-administer medications will be documented on the appropriate form and placed in the medical record; - Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective, and the medications provided to the residents for bedside storage are kept in containers dispensed by the provider pharmacy; - All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary; and - The care plan must reflect resident self-administration and storage arrangements for such medications. 1. On 6/1/26 at 0918 and 1040 hours, Resident 49 was observed sitting in bed. A bottle of vitamin C was observed on the shelf in the corner of Resident 49's room. Resident 49 did not respond when asked if he would self-administer the vitamin C medication. Medical record review for Resident 49 was initiated on 6/1/26. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's Self-Administration of Medication dated 4/2/24, showed Resident 49 was not capable of self-administering medications safely. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 49's Order Summary Report showed a physician's order dated 12/25/20, to administer ascorbic acid (Vitamin C) 500 mg one tablet two times a day. Review of Resident 49's medical record failed to show a physician's order to self-administer the vitamin C medication. Review of Resident 49's plan of care failed to show that a care plan problem was developed to address the resident's self-administration of medications, nor the storage of the medication at bedside. On 6/1/26 at 1052 hours, an observation for Resident 49 and concurrent interview was conducted with LVN 2. LVN 2 verified a bottle of the vitamin C medication was observed on the shelf in the corner of Resident 49's room. Resident 49 stated his family brought the bottle of the vitamin C medication to the facility. On 6/3/26 at 0833 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 4. RN 4 verified Resident 49 was assessed to be incapable of self-administering medications safely. RN 4 further verified there were no physician's order to self-administer the medication for Resident 49, and there were no care plan problem developed to address the self-administration of medications for the resident. On 6/3/26 at 1522 hours, an interview for Resident 49 was conducted with the DON. The DON was informed and acknowledged the above findings. 2. On 6/1/26 at 0804 hours, during the initial tour of the facility, an observation was conducted for Resident 113. Resident 113 was observed lying in bed with five vials of refresh eyedrop on the overbed table. Medical record review for Resident 113 was initiated on 6/1/26. Resident 113 was admitted to the facility on [DATE]. Review of Resident 113's MDS quarterly assessment dated [DATE], showed Resident 113 had a BIMS summary score of 12 (meaning moderately cognitive impairment). Review of Resident 113's Order Summary Report did not show a physician's order for Resident 113 to self-administer the medications. Review of Resident 113's plan of care did not show a care plan problem to address Resident 113's self-administration of the medications. Further review of Resident 113's medical record failed to show a physician's order to self-administer medications, nor was an assessment completed for Resident 113 to safely self-administer a medication. On 6/1/26 at 0903 hours, an observation, interview with Resident 113, and concurrent interview and (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record review for Resident 113 was conducted with ADON 1. Resident 113 stated she was putting the eyedrop on her eye and she could not remember how often in a day she would put the eyedrops her eyes. The ADON verified there were five vials of refresh eyedrop on Resident 113's overbed table. ADON 1 verified Resident 113 had no physician's order, assessment, or care plan for the self-administration of any medications. ADON 1 further stated that it was not safe to leave a medication at bedside due to other resident's potential access and administer the medication to themselves. On 6/4/26 at 1408 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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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, medical record review, and facility P&P review, the facility failed to ensure the physician was informed of a change of condition for one or three final sampled residents (Resident 1) reviewed for nutrition. * The facility failed to notify Resident 1's physician and the resident's responsible party of the 24 lbs. (16.56%) weight loss from 12/2/25 to 4/1/26. This failure had the potential for Resident 1 to not received the necessary care and treatment to manage the resident's weight loss. Findings: Review of the facility's P&P titled Notification of Changes revised 12/19/22, showed the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representatives when there is a change requiring such notification. Circumstances requiring notification include significant changes in the resident's physical, mental or psychosocial condition such as deterioration in health, mental, or psychosocial status. Medical record review for Resident 1 was conducted on 6/1/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE] with the diagnosis of unspecified severe protein-calorie malnutrition. Review of Resident 1's H&P examination dated 5/25/26, showed Resident 1 had fluctuating capacity. Review of Resident 1's Weights and Vitals Summary from 11/1/25 through 6/30/26, showed the following weights and comparisons for Resident 1:- dated 11/19/25, weight = 149 lb.;- dated 12/2/25, weight = 145 lbs.; and- dated 4/1/26, weight = 121 lbs., -28 lbs., a 18.8% severe weight loss since 11/19/25. Review of Resident 1's E-interact Change in Condition Evaluation dated 4/1/26, showed the physician was notified of Resident 1's poor PO (oral) intake. The licensed nurse documented Resident 1 was noted with PO intake less than 50% with the last three meals. Under most recent weight the licensed nurse documented the weight of 145 lbs. obtained on 12/2/25. Further review of the Change in Condition Evaluation showed the physician was informed with recommendations to continue monitoring Resident 1 for 72 hours, encourage PO and fluid intake, offer substitutions, assist Resident 1 with meals, and offer Boost and high-calorie shakes. However, further review of the Change in Condition Evaluation failed to show the documentation if the physician was informed of Resident 1's current weight of 121 lbs., a weight loss of 24 lbs. from 12/2/25 to 4/1/26. On 6/4/26 at 0919 hours, an interview and concurrent medical record review for Resident 1 was conducted with ADON 2. ADON 2 stated for any weight variances of 3% loss in one week, 5 % loss in one month, or 10% weight loss in three months. ADON 2 further stated the physician would be notified, a change in condition evaluation would be completed to monitor the resident's weight loss and PO intake. When asked about Resident 1's documented weight loss on 4/1/26, ADON 2 reviewed Resident 1's medical record and stated there was no documentation the physician was informed of Resident 1's weight loss of 24 lbs. (16.55%) severe weight loss since 12/2/25. On 6/4/26 at 1122 hours, an interview was conducted with the DON. The DON stated after input of the weight, the unit manager/desk nurse was responsible for reviewing the resident's weights for any significant or severe weight changes. If a weight variance of 5% in one month, or 10% in six months was noted or identified, the unit manager/desk nurse was expected to initiate the Change in Condition evaluation, inform the physician/responsible party, and notify the RD for reassessment. On 6/4/26 at 1556 hours, a follow-up interview was conducted with the DON. The DON verified following the documentation of Resident 1's weight loss on 4/1/26; however, there was no documentation if the physician or the resident's responsible party were informed of Resident 1's 24 lbs. weight loss from 12/2/25 to 4/1/26. The DON was informed and acknowledged the above findings. Cross Reference to F692, #1.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and P&P review, the facility failed to ensure the MDS assessment was accurate for three of 35 final sampled residents (Residents 1, 11, and 183) reviewed for MDS. * The facility failed to ensure the MDS assessment was accurately coded related to Resident 1's weight loss of 5% in one month or 10% in six months. * The facility failed to ensure the MDS assessment was accurately coded related to Resident 11's use of the hypoglycemic (including insulin) medication. Additionally, the facility coded Resident 11's MDS for the use of the anticonvulsant medication; however, Resident 11 was not prescribed any anticonvulsant medication. * The facility failed to ensure the MDS assessment was accurately coded related to Resident 183's use of enoxaparin (blood thinner medication) subcutaneously. These failures posed the residents at risk of not receiving an individualized plan of care based on their specific needs. Findings: Review of the facility's P&P titled MDS 3.0 Completion dated 12/19/22, showed the residents are assessed, using a comprehensive process, in order to identify care needs and to develop an interdisciplinary care plan. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. 1. Medical record review for Resident 11 was initiated on 6/1/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's Order Summary Report dated 6/2/26, showed a physician's order dated 2/20/26, to administer regular human insulin (short acting insulin to treat high blood sugar) 100 units/ml as per the sliding scale, subcutaneously every six hours for diabetes mellitus (DM, group of diseases that resulted in too much sugar in the blood) and administer insulin glargine (long acting insulin) 100 unit/ml, 10 units subcutaneously at bedtime for DM. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 was not coded for taking the hypoglycemic medications (including insulin). Further review of the MDS assessment showed Resident 1 was coded for taking the anticonvulsant medication; however, Resident 11 was not taking any anticonvulsant medication. On 6/2/26 at 1214 hours, an interview and concurrent medical record review for Resident 11 was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 11's medical records and verified the above findings 2. Medical record review for Resident 1 was conducted on 6/1/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of unspecified severe protein-calorie malnutrition. Review of the Resident 1's Weights and Vitals Summary from 11/1/25 through June 2026, showed the (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following weights and comparisons for Resident 1: - on 11/19/25, weight = 149 lb., - on 12/2/25, weight = 145 lbs., - on 4/1/26, weight = 121 lbs., -28 lbs., 18.8% weight loss since 11/19/25 [comparison weight 149 lbs.] - on 5/11/26, weight = 121 lbs., -28 lbs., 18.8% weight loss in six months [comparison weight on 11/19/25, 149 lbs.] - on 5/19/26, weight = 116 lbs., -29 lbs., 20% weight loss in five months [comparison weight 12/2/25, 145 lbs.] Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was coded for the weight of 116 lbs., and had no weight loss of 5% or more in the last month, or loss of 10% or more in the last six months. However, Resident 1 had a weight loss of 22.15% (33 lbs.) from 11/19/25 to 5/19/26. On 6/4/26 at 1032 hours, an interview and concurrent medical record review for Resident 1 was conducted with the Lead Registered Dietician (LRD). The LRD reviewed Resident 1's weight trends and verified the above findings. The LRD verified Resident 1 had a weight loss greater than 10% in six months. The LRD reviewed section K of the MDS assessment and verified the coding was inaccurate. On 6/4/26 at 1122 hours, an interview was conducted with the DON. The DON stated the MDS assessments were used to identify the care needs of the residents and assist with creating/developing the care plan specific to each resident needs. The DON further stated the MDS assessments should be accurate. On 6/4/26 at 1150 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 183 was initiated on 6/1/26. Resident 183 was admitted to the facility on [DATE]. Review of Resident 183's H&P examination dated 2/27/26 showed Resident 183 can make her needs known but cannot make medical decisions. Review of Resident 183's Order Summary Report dated 6/3/26, showed a physician's order dated 2/26/26, for enoxaparin (blood thinner medication) 40 mg subcutaneously every day for DVT (deep vein thrombosis is a serious medical condition that occurs when a blood clot forms in the deep veins) prophylaxis. Review of Resident 183's MAR for April and May 2026 showed Resident 183 received the enoxaparin medication from 4/29/26 to 5/5/26. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 183's MDS quarterly assessment dated [DATE], under Section N for Medication showed Resident 183 was not coded for to have received injections. On 6/2/26 at 1615 hours, an interview and concurrent medical record review for Resident 183 was conducted with the MDS Assistant Coordinator. The MDS Assistant Coordinator verified the above findings and stated the MDS assessment related to Resident 183's use of the enoxaparin medication subcutaneously was coded incorrectly. On 6/4/26 at 1408 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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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** Based on interview, medical record review, and facility P&P review, the facility failed to develop a comprehensive person-centered care plan for one of 35 final sampled residents (Resident 4). * The facility failed to ensure a care plan was developed to address Resident 4's impaired communication related to bilateral hard of hearing and use of the bilateral hearing aids. This failure had the potential for the resident to receive inconsistent, inappropriate, and inadequate care. Findings: Review of the facility's P&P titled Comprehensive Care Plans revised 12/19/22 showed the following:- It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment;- The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record; and- The comprehensive care plan will describe, at a minimum, the following: a) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; b) Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment; and c) Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate. On 6/1/26 at 1117 hours, during the initial tour of the facility, Resident 4 was observed awake and lying on the bed. Resident 4 instructed the state surveyor to speak louder close to his left ear as he could not hear clearly. Resident 4 further stated he had hearing aids but those were broken and not being fixed. Medical record review for Resident 4 was initiated on 6/1/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's H&P examination dated 6/30/25, showed Resident 4 had the capacity to understand and make medical decisions. Review of Resident 4's MDS assessment dated [DATE], Section B - Hearing, Speech, and Vision showed the Hearing section (ability to hear with hearing aid or hearing appliances if normally used, and the minimal difficulty (difficulty in some environments; e.g., when person speaks softly or setting is noisy) was selected. The Hearing Aid section showed the yes was selected. Further review of Resident 4's medical record failed to show a plan of care was developed to address the resident's hard of hearing and use of the bilateral hearing aids. On 6/2/26 at 1201 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 2. LVN 2 verified Resident 4 was hard to hear and used bilateral hearing aids. LVN 2 stated Resident 4's hearing aid was broken. LVN 2 could not remember if it was the right or left hearing aid which was broken. LVN 2 stated she reported it to the social worker a week ago. LVN 2 stated the hard of hearing problem and use of the hearing aids should be addressed in the resident's plan of care. LVN 2 further stated all care plan problems assessed for the resident should be addressed in the plan of care in order to provide the appropriate care or interventions to the resident. LVN 2 verified there was no plan of care developed for Resident 4 to address the resident's impaired communication (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to hard of hearing and use of hearing aids. On 6/4/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of four final sampled residents (Resident 10) reviewed for pressure injury were provided with the necessary care and services. * The facility failed to ensure Resident 10's LAL mattress setting was accurate to the resident's weight and was not in static mode while the resident was in bed. These failures had the potential for the resident not to receive the appropriate care and services to promote the skin healing. Findings: According to National Pressure Injury Advisory Panel (NPIAP) 2019 Clinical Practice Guideline, a support surface is a specialized device designed for pressure redistribution, microclimate management, and other therapeutic functions. These devices include mattresses, bed systems, overlays, and seat cushions. In low air loss mattresses, alternating air pressure mode provides pressure relief and redistribution by cyclically inflating and deflating air cells, promoting circulation and preventing pressure ulcers. Static mode, on the other hand, keeps the cells inflated at a constant pressure, offering a stable surface for patient care activities and transfers. Review of the facility's P&P titled Use of Support Surfaces revised 9/12/23, showed support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. The Policy Explanation and Compliance Guidelines showed:- support surfaces will be chosen by matching the potential therapeutic benefit with the resident's specific situation. Considerations for utilizing specialized support surfaces: medical condition, Size and weight, mobility and activity levels, need for microclimate (i.e. moisture) control or shear reduction, presence of pressure injuries, including severity and location, cannot be positioned off the existing pressure injury, has pressure injuries on two or more turning surfaces, pressure injury fails to heal or deteriorates, risk for developing a pressure injury or at high risk for additional pressure injuries, pain or discomfort, bottoms out on the current surface (i.e. excessive penetration of the surface such that less than one inch of material is noted between the bottom of the support surface and the skin surface); and- support surfaces will be utilized in accordance with manufacturer recommendations (including considerations for contraindications). Review of the Invacare Microair MA800 User Manual (undated) showed the mattress is indicated for patients who are at risk of developing pressure ulcers according to your sound clinical judgement. The Instructions for Proper Use section showed:- pulsate Function: Push the Mode button to select pulsate mode and activate the pulsate function for additional pressure relief. Once activated, the mattress will automatically inflate for about one minute and after that, it will deflate to original setting for one minute and go on for the next cycle;- dynamic Function: Push the Mode button to select Alternate mode and enable the 3-1 alternate function;- alternation time can be adjusted by the Cycle button. The time could be varied from three minutes to 95 minutes. If Static Function is selected, the time window would not show any figures; and- comfort Level Setting (pressure level setting on the weight chart guideline):Level 1 - 80 lbs.;Level 2 - 100 lbs.;Level 3 - 125 lbs.;Level 4 - 150 lbs.;Level 5 - 175 lbs.;Level 6 - 200 lbs.;Level 7 - 225 lbs.;Level 8 - 250 lbs.;Level 9 - 275 lbs.; andLevel 10 - 300 lbs. On 6/1/26 at 0930 hours, during the initial tour of the facility, Resident 10 was observed awake and lying in bed. The LAL mattress was observed set in static mode and there was no light for the numbers in comfort setting. A label of #4 was taped in the LAL mattress machine apparatus was observed. Resident 10 stated she had wounds in her buttocks. Resident 10 stated the nurses managed the bed and she did not know how to operate machine attached to the bed. Medical record review for Resident 10 was initiated on 6/1/26. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 4/24/26, (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Quarterly MDS assessment dated [DATE], showed Resident 10 had no pressure injury and the resident was at risk for developing pressure ulcers/injuries. Review of Resident 10's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 5/18/26, showed the score of 15 (at risk). Review of Resident 10's Order Summary Report showed a physician's order dated 5/18/26, for LAL mattress for skin management and comfort care every shift. Review of Resident 10's Weights and Vitals Summary for May 2026, showed the resident weighed 142 lbs. on 5/26/26. On 6/1/26 at 1033 hours, an observation was conducted for Resident 10. Resident 10 was observed sleeping in the bed. The LAL mattress was observed set in static mode and there was no light for the numbers in comfort setting. On 6/1/26 at 1125 hours, a follow up observation of Resident 10 and concurrent interview was conducted with LVN 3. LVN 3 was observed coming out from the resident room. LVN 3 stated she just did the skin care for the resident. Resident 10 stated the nurse checked her skin. The LAL mattress was observed set in the static mode and there was no light for the numbers in comfort setting. On 6/1/26 at 1147 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 3. LVN 3 stated Resident 10 had a healed stage 3 pressure injury in her sacrum. LVN 3 stated the LAL mattress was being used for preventative purposes since Resident 10 was at risk for developing pressure injury. LVN 3 stated the LAL mattress is being set according to the resident's weight and it could be on static or alternating mode. LVN 3 stated when the LAL mattress was on static mode, the mattress was firmed and it was being used when the resident was being repositioned or cleaned. LVN 3 stated the alternating mode was when the air was continuously cycling in the mattress and it helped to further prevent any skin breakdown. LVN 3 stated the comfort setting would be based on the resident's weight. LVN 3 stated the treatment and charge nurses managed the LAL mattress. LVN 3 stated the CNAs could set the LAL mattress to static mode if they needed to clean or turn the resident and if they did not know how to operate it, the CNAs could always call the nurse to do it. LVN 3 verified Resident 10's LAL mattress was set in static mode and there was no light in the comfort setting. LVN 3 stated the comfort setting should have a light into which they set based on the resident's weight even if the LAL mattress was in static mode. On 6/4/26 at 1433 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 10.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the respiratory services in a safe and sanitary manner in accordance with the facility's P&P for one of three final sampled residents (Resident 80) reviewed for the respiratory care.* The facility failed to ensure Resident 80 had a physician's order for the use of oxygen. In addition, the facility failed to ensure the oxygen tubing was labeled and the signage Oxygen In Use was posted on Resident 80's door. These failures had the potential to result in negative health outcomes for a highly vulnerable resident population due to poor infection control practices and the administration of oxygen therapy without a physician's order. Findings: Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed oxygen is administered under orders of a physician; change oxygen tubing and mask/canula weekly and as needed if it becomes soiled or contaminated; and oxygen warning signs must be placed on the door of the resident's room where oxygen is in use. Medical record review for Resident 80 was initiated on 6/1 and 6/2/26. Resident 80 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 80's H&P examination dated 1/21/25, showed Resident 80 was diagnosed with pneumonia, and had the capacity to understand and make medical decisions. On 6/1/26 at 0757 hours, an observation was conducted of Resident 80. Resident 80 was observed lying in bed. An oxygen concentrator was observed adjacent to Resident 80's bed. The oxygen concentrator was set to administer a continuous oxygen at a rate of 4 liters per minute. The oxygen tubing and nasal cannula were observed attached to the oxygen concentrator without a labeled date when it was changed. In addition, the resident's room was observed with no signage of Oxygen in Use. On 6/1/26 at 1042 hours, an observation, and concurrent interview for Resident 80 was conducted with RN 1 in the resident's room. RN 1 stated Resident 80 had received an oxygen therapy from the time the resident was readmitted to the facility. RN 1 verified Resident 80 currently receiving continuous oxygen at a rate of 4 liters per minute. RN 1 also verified Resident 80's oxygen tubing and nasal cannula was not labeled with date changed and there was no signage of Oxygen in Use posted outside of the resident's room. On 6/1/26 at 1059 hours an interview and concurrent medical review for Resident 80 was conducted with RN 1 at the nurses' station. RN 1 was asked to review Resident 80's current physician orders specific to the oxygen therapy. RN 1 then reviewed Resident 80's physician's orders and verified Resident 80 did not have a physician's order for the oxygen therapy. RN 1 further stated, the resident should have an order for the oxygen therapy, and the oxygen tubing should be labeled with dated changed, and the Oxygen in Use signage should be posted outside of the resident's door while the oxygen was in use. On 6/4/26 at 1040 hours, an interview was conducted with the DON. The DON was informed of and verified the above findings. The DON stated it was important to place the date on the nasal cannula so staff would know when to change it to prevent infection. The DON further stated a physician's order was always required to administer oxygen, and an Oxygen In Use sign should be posted outside the resident's room to prevent accidents.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure safe and effective pharmaceutical services for one of 35 final sampled residents (Resident 152) and one nonsampled resident (Resident 110). * A delayed-release medication was crushed and administered to Resident 152. This failure had the potential to release all the medication into the body at once, causing toxicity and preventable resident harm. * A nebulizer treatment was not administered at the right time to Resident 110 in accordance with the manufacturer's specifications (requirements). This failure had the potential for the ineffective use of the drug which could result in fluctuations (uneven) drug levels in the body leading to increased risk of side effects or subtherapeutic treatment with the resident experiencing breathing problems. Findings: 1. Review of the facility's P&P titled Medication Administration dated 12/19/22, showed to administer medications as ordered in accordance with manufacturer specifications. Review of the facility's medication leaflet for Depakote (anticonvulsant medication and can be use for bipolar disorder) dated 5/6/26, showed do not chew, break, or crush the medication. Review of Resident 152's Order Summary Report showed a physician's order dated 7/17/25, for Depakote oral Delayed Release (DR) tablet 125 mg two times a day. On 6/3/26 at 1255 hours, a medication pass observation for Resident 152 was conducted with RN 8 in Room D. RN 8 was observed crushing the Depakote 125 mg DR tablet and administering it to Resident 152. Resident 152 was observed taking the crushed medication. On 6/3/26 at 1304 hours, an interview was conducted with RN 8. RN 8 verified Resident 152 was administered the crushed medication. On 6/3/26 at 1305 hours, an observation and concurrent interview was conducted with RN 8 near Room D. The Depakote DR 125 mg bubble pack was observed to show the instructions, Do not crush or chew. RN 8 verified the Depakote DR 125 mg bubble pack was labeled to not crush the medication. RN 8 stated she was not trained that on what DR meant for the Depakote medication. On 6/4/26 at 1103 hours, an interview was conducted with the DON. The DON stated the medication bubble pack label showed whether the medication was crushable or not crushable. The DON stated the licensed nurses could not just assume that all medications were crushable. On 6/4/26 at 1400 hours, a telephone interview was conducted with the Consultant Pharmacist. The Consultant Pharmacist stated the medication Depakote should not be crushed. 2. Review of the facility's Prescribing Information for arformoterol nebulization solution dated 8/2025 showed arformoterol tartrate inhalation solution is indicated for the long-term, twice daily (morning and evening) maintenance treatment of bronchoconstriction [airways tighten making it hard to breathe] in patients with chronic obstructive pulmonary disease (COPD). Review of Resident 110's Order Summary Report showed a physician's order dated 7/13/25, for arformoterol nebulization solution inhale via nebulizer two times a day for COPD. Review of Resident 110's H&P examination dated 7/15/25, showed the patient was readmitted to the facility on [DATE] after being sent out to another facility for evaluation for symptoms of shortness of breath. Review of Resident 110's MAR from 5/1/26 to 6/1/26, showed the arformoterol treatment was scheduled to be administered to Resident 110 at 1200 hours and 2100 hours. Further review of the MAR showed the medication was administered on 6/1/26 at 1200 hours. On 6/1/26 at 1401 hours, an interview was conducted with LVN 4. LVN 4 stated the arformoterol treatment was showing on MAR as scheduled at 1200 hours and 2100 hours. LVN 4 stated they gave the arformoterol nebulizer at 1200 hours to Resident 110 on 6/1/26 but verified the medication was supposed to be given in the morning. On 6/2/26 at 1255 hours, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview was conducted with Resident 110 in Room C. Resident 110 stated they had trouble breathing and the only thing that helps are the nebulizer breathing treatments. On 6/4/26 at 1107 hours, an interview was conducted with the DON. The DON stated the arformoterol medication must be administered in the morning and evening according to the package insert.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the Pharmacist Consultant identified and reported all irregularities during the monthly medication regimen for one of 35 final sampled residents (Resident 8) and one nonsampled resident (Resident 110). * The facility failed to ensure the consultant pharmacist identified and reported a medication irregularity for Resident 110's roflumilast medication (used in adults to decrease the number of flare-ups (exacerbations) in severe (COPD) chronic obstructive pulmonary disease) dose. * The facility failed to ensure the Pharmacy Consultant's recommendation to inform physician about Resident 8's elevated systolic blood pressure readings was acted upon. These failures had the potential for the residents to experience adverse outcomes. Findings: Review of the facility's P&P titled Medication Regimen Review (MRR) dated 12/19/22, showed Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes a review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. Review of the facility's P&P, titled Medication Administration dated 12/19/22, showed administer the medication as ordered in accordance with manufacturer specifications [requirements]. Review of the facility's Prescribing Information for roflumilast tablet dated 8/2024 showed the maintenance dose of roflumilast is one 500 mcg tablet per day.starting treatment with a dose of roflumilast 250 mcg once daily for four weeks and increasing to roflumilast 500 mcg once daily.however, 250 mcg per day is not the effective (therapeutic) dose. Review of Resident 110's Order Summary Report showed an order dated 7/13/25, for roflumilast oral tablet 250 mcg by mouth one time a day for COPD. Review of Resident 110's H&P examination dated 7/15/25, showed the resident was readmitted to the facility on [DATE], after being sent out to another facility for evaluation for symptoms of shortness of breath. On 6/2/26 at 1255 hours, an interview was conducted with Resident 110 in Room C. Resident 110 stated they had trouble breathing and the only thing that helps were the nebulizer breathing treatments. On 6/4/26 at 1112 hours, an interview and concurrent medical record review for Resident 110 was conducted with the DON. The Consultant Pharmacist's MRR reports were reviewed for Resident 110. The DON stated there were no recommendations from the Consultant Pharmacist. On 6/4/26 at 1400 hours, a telephone interview was conducted with the Consultant Pharmacist. The (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Consultant Pharmacist verified the dosage instructions of the drug roflumilast in the drug manufacturer's package insert. The Consultant Pharmacist verified there were no recommendations in the MRR reports about the roflumilast dose. 2. Medical record review for Resident 8 was initiated on 6/1/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Order Listing Report showed the following physician's orders: - dated 8/11/25, to administer furosemide (diuretic) 40 mg one tablet one time a day for hypertension. Hold if SBP is less than 110 mmHg; and - dated 4/15/26, to administer clonidine (antihypertensive) 0.1 mg by mouth every six hours as needed for hypertension. Give if SBP is greater than 160 mmHg. Review of Resident 8's Consultant Pharmacist's Medication Regimen Review dated 5/21/26, showed to make sure the physician is aware the systolic blood pressure readings have been consistently high with values regularly above 140 mmHg, and if any changes in the antihypertensive therapy warranted. Under the Follow-through column, a handwritten note showed, nurses in-serviced. On 6/3/26 at 1433 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON verified the above findings. When the DON was asked how the facility informed the prescribing physician about the pharmacy consultant's recommendations, the DON stated they called the prescribing physician to inform of the pharmacy consultant's recommendation. When asked how soon the facility should follow up on the pharmacy consultant's recommendations, the DON stated as soon as they received the consultation reports, the designated RN had to follow-up or complete in two to three days. When asked about the pharmacy consultation's recommendation for Resident 8, the DON could not show documented evidence the physician was made aware about Resident 8's systolic blood pressure readings have been consistently high with values regularly above 140 mmHg, and the physician verified if any changes in the antihypertensive therapy was warranted. The DON verified the pharmacy consultant's recommendation for Resident 8 was not acted upon.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of 35 final sampled residents (Resident 113) and one nonsampled resident (Resident 110) were free from the unnecessary medications. * The facility failed to follow the physician's order to hold the atenolol (antihypertensive) and benazepril (antihypertensive) medications when Residents 113's pulse rate was below 70 beats per minute. * The facility failed to ensure the potassium levels were closely monitored for Resident 110 who was receiving at the same time the medications potassium chloride oral solution and an ACE inhibitor (antihypertensive). These failures had the potential for the residents to receive unnecessary medications and develop significant side effects. Findings: Review of the facility's P&P titled Medication Administration dated 12/19/22, showed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Obtain and record vital signs, when applicable or per physicians' orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 1. Medical record review for Resident 113 was initiated on 6/1/26. Resident 113 was admitted to the facility on [DATE]. Review of Resident 113's quarterly MDS assessment dated [DATE], showed Resident 113 had a BIMS summary score of 12 (meaning moderately cognitive impairment). Review of Resident 113's MAR for May 2026 showed the following physician's orders: - dated 8/20/24, to administer atenolol 25 mg one tablet by mouth everyday hold if systolic blood pressure below 110 or pulse rate below 70 for hypertension; and - dated 5/7/26, to administer benazepril 40 mg, one tablet by mouth everyday hold if systolic blood pressure below 110 or pulse rate below 70 for hypertension. Review of Resident 113's MARs for May and June 2026 showed Resident 113 was administered atenolol 25 mg on the following dates when Resident 113's pulse rate was below 70 beats per minute: - On 5/3/26, when Resident 113's pulse rate was 60 beats per minute; - On 5/7/26, when Resident 113's pulse rate was 68 beats per minute; - On 5/8/26, when Resident 113's pulse rate was 66 beats per minute; - On 5/9/26, when Resident 113's pulse rate was 60 beats per minute; - On 5/14/26, when Resident 113's pulse rate was 60 beats per minute ; (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/15/26, when Resident 113's pulse rate was 60 beats per minute; - On 5/16/26, when Resident 113's pulse rate was 64 beats per minute; - On 5/20/26, when Resident 113's pulse rate was 68 beats per minute; - On 5/21/26, when Resident 113's pulse rate was 62 beats per minute; - On 5/25/26, when Resident 113's pulse rate was 68 beats per minute; - On 5/28/26, when Resident 113's pulse rate was 68 beats per minute; and - On 6/1/26, when Resident 113's pulse rate was 61 beats per minute. Further review of Resident 113's MARs for May and June 2026 showed Resident 113 was administered benazepril 40 mg on the following dates when Resident 113's pulse rate below 70 beats per minute: - On 5/7/26, when Resident 113's pulse rate was 68 beats per minute; - On 5/8/26, when Resident 113's pulse rate was 68 beats per minute; - On 5/9/26, when Resident 113's pulse rate was 60 beats per minute; - On 5/12/26, when Resident 113's pulse rate was 55 beats per minute; - On 5/14/26, when Resident 113's pulse rate was 60 beats per minute; - On 5/15/26, when Resident 113's pulse rate was 60 beats per minute; - On 5/16/26, when Resident 113's pulse rate was 64 beats per minute; - On 5/20/26, when Resident 113's pulse rate was 68 beats per minute; - On 5/21/26, when Resident 113's pulse rate was 62 beats per minute; - On 5/22/26, when Resident 113's pulse rate was 68 beats per minute; - On 5/25/26, when Resident 113's pulse rate was 68 beats per minute; - On 5/28/26, when Resident 113's pulse rate was 68 beats per minute; and - On 6/1/26, when Resident 113's pulse rate was 61 beats per minute. On 6/2/26 at 1359 hours, an interview and concurrent medical record review for Resident 113 was (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with RN 8. RN 8 stated for the administration of the BP medications to the residents, the licensed nurse would check the resident's BP and pulse rate prior to administering the BP medication. RN 8 stated if the BP reading was within the parameters as ordered by the physician, RN 8 would then administer the medication. RN 8 stated if the BP reading was outside of the ordered parameters, the medication would be held. RN 8 further stated after the administration of the medication, she would document in the MAR. RN 8 stated a check mark in the MAR indicated the medication was administered to the resident on the indicated date. On 6/4/26 at 1408 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's Prescribing Information for potassium chloride oral solution dated 1/2026 showed drugs that inhibit the renin-angiotensin-aldosterone system (RAAS) including angiotensin converting enzyme (ACE) inhibitors.closely monitor potassium in patients receiving concomitant (at the same time) RAAS therapy. Review of Resident 110's Order Summary Report the following physician's orders: - dated 7/13/25, for potassium chloride oral packet 20 mEq one time a day; and - dated 7/13/25, for lisinopril (ACE inhibitor medication) oral tablet 5 mg one time a day. Review of Resident 110's laboratory results showed the potassium levels were most recently measured during July 2025. On 6/4/26 at 1109 hours, an interview was conducted with the DON. The DON stated they were unable to locate any additional potassium laboratory results in Resident 110's medical record between 7/16/25 and 6/3/26. On 6/4/26 at 1400 hours, a telephone interview was conducted with the Consultant Pharmacist. The Consultant Pharmacist stated the administration potassium chloride oral solution and lisinopril ace inhibitor medications at the same time could potentially increase the resident's potassium levels.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure safe medication labeling practices in accordance with accepted professional standards. * Three opened eye drop bottles and an opened nasal spray bottle were not properly labeled with sufficient information to clearly identify the specific resident for Residents 108, 109, 195, and 212 in Medication Carts A and B. This failure had to potential to cause medication errors and preventable infections from cross-contamination from other residents if accidentally mixed up with other residents similar or same drugs. Findings: Review of the facility's P&P titled Labeling of Medications and Biologicals dated 12/19/22, showed all medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications. a. On 6/3/26 at 0752 hours, an observation of Medication Cart A and interview was conducted with LVN 5. There was an opened carton of fluticasone nasal spray observed inside the opened medication carton. There was no label indicating resident-specific information. LVN 5 verified the unlabeled fluticasone nasal spray was for Resident 212. LVN 5 stated the nasal spray needed to be labeled with the resident's name to make sure the right medication was given to the right resident. b. On 6/3/26 at 0825 hours, an observation of Medication Cart B and interview was conducted with LVN 6. There were three unlabeled bottles of artificial tears observed inside the opened medication cartons. LVN 6 verified the unlabeled artificial tears bottles were for Residents 108, 109, and 195. LVN 6 stated they understood the resident safety concern of the resident-specific information not being labeled on the three bottles of artificial tears for the different residents. On 6/3/26 at 1035 hours, an interview was conducted with the IP. The IP stated it was important to label the medication bottles inside the medication cartons with resident specific information to prevent swapping of the medications being accidentally exchanged with another resident. The IP stated the infection control outcome was the spreading of infection to another resident. On 6/3/26 at 1514 hours, an interview was conducted with RN 9. RN 9 stated the nasal spray bottles inside the medication carton were supposed to be labeled with resident-specific information to prevent medication errors and prevent infection. On 6/4/26 at 0956 hours, an interview and concurrent medical record review for Residents 108, 109, and 195 was conducted with LVN 6. LVN 6 stated there were physician's orders for the artificial tear eye drops for Residents 108 and 195. LVN 6 verified there was no medication order for artificial tears for Resident 109. On 6/4/26 at 1001 hours, an interview was conducted with RN 7. RN 7 stated both the box and the bottle of artificial tears needed to be label to prevent mix-up of residents' drugs and for infection control. On 6/4/26 at 1059 hours, an interview was conducted with the DON. The DON stated once the medication carton was opened, the expectation was to label the multidose unit inside the medication carton with the date and the name.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055984	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 South Beach Blvd. Anaheim, CA 92804	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and facility document review, the facility failed to ensure:* Federal regulations related to the education qualification requirements of the dietary manager were followed as outlined in the California Code, Health and Safety Code (HSC 1265.4), * The Dietary Manager was competent in managing the day-to-day functions of the food and nutrition department and,* The Registered Dietitian provided an adequate oversight of the day-to-day functions of the food and nutrition department. These failures to employ staff with the federal and state mandated qualifications to manage the food and nutrition department, the competencies to effectively and competently run the day to day operations of the food and nutrition department and adequate Dietitian oversight of the food and nutrition department to effectively implement departmental processes in accordance with standards of practice had the potential to jeopardize the health and well-being of the 187 residents who received food prepared in the kitchen. Findings: Review of the facility's Matrix dated 6/1/26, showed 187 residents consumed food prepared in the kitchen. According to the Health and Safety Code 1265.4, (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. Review of the facility's document titled Director of Food Nutrition Services/Dietary Services- Job Description signed on 2/12/26, showed the Dietary Supervisor must meet a minimum one of the following qualifications: a. A Certified Dietary Manager. 9. The Director of Food and Nutrition Services should provide the community with their current licenses and record of continuing education. On 6/1/26 at 0748 hours, the initial tour observation of the kitchen and interview was conducted with the Dietary Manager. The Dietary Manager stated he had been working in the facility for one to two months. The Dietary Manager further stated he completed an online course from North Dakota, and he was a Certified Dietary Manager (CDM). On 6/3/26 at 1330 hours, an interview and facility document review was conducted with the Dietary Manager. The Dietary Manager showed his CDM certificate with an issuance date of 7/2020 and stated he renewed his certification a year ago and had not received a new certificate. Furthermore, the Dietary Manager stated he was not aware he was required to complete continuing education credits in order to keep his credentials current. Upon review of the Association of Nutrition and Food Service Professionals (ANFP) website (https://www.anfponline.org), the Dietary Manager was not registered with the ANFP as a Certified Dietary Manager. On 6/3/26 at 1357 hours, an interview was conducted with the LRD. The LRD stated it was questionable that the Dietary Manager's name did not appear on the ANFP website to verify credentials. On 6/3/26 at 1443 hours, a follow up interview was conducted with the LRD. The LRD stated there was a lapse in the Dietary Manager's credential because he did not complete his required continuing education and was currently not a Certified Dietary Manager. The LRD further stated she will be the interim Dietary Manager. 2. Review of the facility's document titled Director of Food Nutrition Services/Dietary Services- Job Description signed on 2/12/26, showed the Dietary Supervisor's primary responsibility was to organize, coordinate, and supervise the Food and Nutrition Services Department personnel, work, food production, and food service. The Director of Food and Nutrition Services must understand and comply with all the policies contained in the issued standard manuals that apply to the functioning of the department. During the annual recertification (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 South Beach Blvd. Anaheim, CA 92804	
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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey from 6/1/26 to 6/4/26, multiple issues were found in the kitchen, including lack of the cool down process for time, temperature control for safety food, improper hand hygiene, the thawing process for meats was not followed, appropriate manual ware washing was not followed, kitchen utensils and equipment were not clean or stored in a sanitary manner, hair restraints were not worn, food service equipment was not air dried, and multiple cutting boards were heavily marred and not clean. On 6/4/26 at 1450 hours, an interview was conducted with the LRD and Administrator. The LRD and Administrator were informed and acknowledged the above findings. Cross reference to F812 examples #1, #2, #3, #4, #5, #6, #7, #8, and #9. 3. Review of facility's document titled Healthcare Services Group, INC. Job Description for the Registered Dietitian, for Administrative duties showed Provides oversight and guidance to the Dining Services Director regarding dining services operations. During the annual recertification survey from 6/1/26 to 6/4/26, multiple issues were found in the kitchen, including: including lack of cool down process for time, temperature control for safety food, improper hand hygiene, the thawing process for meats was not followed, appropriate manual ware washing was not followed, kitchen utensils and equipment were not clean or stored in a sanitary manner, hair restraints were not worn, food service equipment was not air dried, and multiple cutting board were heavily marred and not clean. Review of the facility's document titled Quality Assurance Evaluation- Dining for 3/17, 4/15, and 5/13/26, completed by the Registered Dietitian (RD) showed the following were satisfactory:- Hair and/or beard completely covered.- Thawing foods labeled and dated when pulled from the freezer.- Minor equipment clean (example: can opener, cutting boards are free from gouges, robot coupe and blender and not stored wet or with debris, knife rack, plate, and tray lowerators are free from crumbs or spills).- Proper cooling procedures were observed.- Dish machine and 3 (three) compartment sink tested and ran at appropriate temperature and chemical ppm.- Dishware and utensils cleaned, sanitized, and stored separately without wet nesting or food debris.- Staff is able to articulate and follow proper handwashing procedures.- Manager is Qualified per state and federal regulation & food handler permits where applicable are up to date. On 6/4/26 at 1120 hours, an interview and concurrent document review of the Quality Assurance Evaluations dated 3/17, 4/15, and 5/13/26, facility document review was conducted with the LRD. The LRD stated the facility's RD was on vacation and she was covering the position temporarily. The LRD stated the Quality Assurance Evaluation was completed by the RD every month to identify areas of concern in the food and nutrition services department. The LRD acknowledged the multiple issues identified during the annual recertification survey were scored as satisfactory on the Quality Assurance Evaluation completed by the RD for the past consecutive three months. Cross reference to F802 and F812 examples #1, #2, #3, #4, #5, #6, #7, #8, and #9.		

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NAME OF PROVIDER OR SUPPLIER Anaheim Healthcare Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 South Beach Blvd. Anaheim, CA 92804	
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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to offer and provide education for the COVID-19 vaccine for one of five final sampled residents (Resident 11) reviewed for immunizations. * The facility failed to ensure Residents 11's informed consent for the COVID-19 vaccination specified the type of COVID-19 vaccine to be administered. This failure had the potential for the resident and/or the resident's representatives not being fully informed of the COVID-19 vaccines and to not be aware of the exact type of COVID-19 vaccine being offered by the facility. Findings: Review of the facility's P&P titled COVID-19 Vaccine revised 6/9/23, showed COVID-19 vaccine recipients should be informed that Moderna, Novavax, and Pfizer-BioNTech (types of COVID-19 vaccines) COVID-19 vaccines are recommended. Prior to offering the COVID-19 vaccine, staff, residents, or the resident's representative, will be educated regarding the risks, benefits and potential side effects associated with the vaccine in a form and manner that can be assessed and understood. Residents or their representatives and staff will sign the consent form prior to the administration of the COVID-19 vaccine. Medical record review for Resident 11 was initiated on 6/1/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 had severely impaired cognitive skills for daily decision-making. Review of Resident 11's COVID-19 Vaccine Consent Form dated 5/5/26, showed Resident 11's resident representative's electronic signature and consented to receive the COVID-19 vaccine. Further review of the consent form showed I have been educated on and understand the risks, benefits, and potential side effects of the COVID-10 vaccine. Under the section to indicate the brand of COVID-19 vaccine to be given did not show any entry (blank). Review of Resident 11's MAR for May 2026 showed Resident 11 was administered the Spikevax Vaccine (Moderna COVID-19 vaccine) on 5/10/26 at 1215 hours. On 6/3/26 at 1340 hours, an interview and concurrent medical record review for Resident 11 was conducted with the IP. The IP verified the COVID-19 vaccine informed consent for Resident 11 did not indicate the type of COVID-19 vaccine the resident received. The IP stated the informed consents for the vaccinations should have indicated the type of vaccine the resident received to ensure the resident and resident representatives were fully informed. On 6/4/26 at 1150 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		