STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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 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 and record review, the facility failed to ensure to 2 of 2 sampled residents (Residents 6 and 62) who required peritoneal dialysis (PD, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed]that uses the lining of the abdomen [peritoneum] as a natural filter to remove waste, toxins, and extra water from the body) receive such services, consistent with professional standards of practice and the Federal and State Department requirements prior to providing PD Services to the residents. The facility failed to: 1.For Resident 6 failed to receive ongoing assessment and oversight before, during, and after PD treatments. In addition, no documentation on the PD logs, MAR (Medication Administration Record, and TAR (Treatment Administration Record) to indicate Resident 6's vital signs, cardiac, respiratory, and skin assessments before, during, and after PD treatments were monitored. 2. For Resident 62's the resident was not assessed for competency for self-administration and self-disconnection of peritoneal dialysis. In addition, the physician order for PD solution was not specific when to administer Dextrose 1.5% (fluid with sugar) or Dextrose 2.5%. to the resident. These deficient practices had the potential for the residents to experience complications related to PD such as infections (peritonitis, catheter exit-site infections), mechanical issues (hernias, dialysate leaks, catheter blockage), and metabolic changes like weight gain or high blood sugar that can lead to hospitalization. Cross reference to F880 Findings: 1.During a review of Resident 6's admission Record (AR), the AR indicated that the facility admitted Resident 6 on 2/24/2026 with diagnoses that included End Stage Renal Disease (ESRD, irreversible kidney failure) and dependence on renal dialysis, During a review of Resident 6's history and physical (H&P), signed and dated on 2/27/2026, the H&P indicated that Resident 6 had the capacity to understand and make decisions. The H&P indicated that Resident 6 was diagnosed with ESRD on PD treatments. During a review of Resident 6's Minimal Data Set (MDS, a resident's assessment), dated 2/27/2026, the MDS indicated that Resident 6's cognitive (a person's thought process) was intact. The MDS indicated that Resident 6's active diagnoses included ESRD, and Resident 6 experienced shortness of breath when lying flat in bed. The MDS indicated that Resident 6 received PD treatments upon admission. During a review of Resident 6's Order Summary Report, an order, dated 2/24/2026, indicated that Resident 6 received PD treatments with Low Calcium 2.5% solution (type of dialysis solution used in PD) five times a day. The treatment started 2/25/2026 and ended 3/3/2026. During a review of Resident 6's care plan, revised 3/2/2026, the care plan indicated that Resident 6 (continued on next page)

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

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required PD related to ESRD. The care plan's interventions included identifying changes in Resident 6's behavior that may impact PD administration before and after treatment and assessing resident's condition before and after treatments for complications. The care plan's interventions included monitoring and documenting signs and symptoms of renal insufficiency (kidneys no longer filter waste products from blood) such as changes in level of consciousness, skin elasticity, and changes in heart and lung sounds, monitoring and documenting worsening peripheral edema (swelling of arms and legs), and monitoring for bleeding and signs of symptoms of bacteremia (bacteria in the blood) or septic shock (life-threatening infection). During a review of Resident 6's Order Summary Report, an order, dated 4/2/2026, indicated that Resident 6 received PD treatment with 2.5% Dextrose for 5 cycles with a fill volume of 2700 mL. The treatment was prescribed for 9.5 hours and started each evening at 7 PM. The treatment started 4/2/2026. During a review of Resident 6's care plans, revised 3/9/2026, the care plan indicated that Resident had chronic renal failure due to ESRD and dependence on PD. The care plan's interventions included to monitor for changes in mental status such as lethargy, fatigue, tremors, or seizures, to monitor for signs and symptoms of infection, urinary tract infections, and to monitor for neck vein distension (visible bulging of the large veins of the neck due to fluid overload), difficulty breathing, and lung sounds for crackles (abnormal lung sounds). Duringˆanˆobservationˆon 4/25/2026 at 11:19 AM in Residentˆ6's room,ˆResidentˆ6ˆwasˆobservedˆlying in bed and using his phone. There was aˆwhiteˆmachineˆwith the wordsˆHomechoiceˆClaria notedˆon the screen and Baxter noted on the bottom left of the machine with twoˆantenna-like objects was noted on the left side of Resident 6's bed on top of the bedside table.ˆThere was a urinal bottle (portable, handheld plastic container used to collect urine) hanging on the handle of the second drawerˆof the bedside table.ˆThere was a paper towel taped to the handle of the top drawerˆof the bedside tableˆwith theˆwrittenˆinstructionsˆas follows:ˆˆ ˆ At the end of therapy to:ˆ Push the down arrow to see I-Drain, total UFˆ[ultrafiltration], average dwell time.ˆ Push the down arrow until you see 'Manual Drain' and press the enter button. This will tell machine to drain patient. It will stop when itˆsensesˆno more fluid left. You might sit patient up toˆfacilitateˆfluid to drain easier.ˆˆ ˆ During the same observation on 4/25/2026 at 11:22 AM in Resident 6's room, on the left side of Resident 6'sˆbed with one opened packet of 4x4 gauze dressing, one opened packet of 2x2 gauze dressing, one open box of gloves, and 2 solutions noted onˆtop of the overbed table (an adjustable and mobile table with lockable wheels designed to slide over a bed or a chair to create a stable surface). One solution wasˆlabeled Alcavis, which was a high levelˆdisinfectantˆcompatibleˆwithˆcatheters,ˆcaps, and connections. The second solution was (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review 4/29/2026 at 11:02 AM with Certified Nurse Assistant (CNA) 6, Resident 6's CNA Nutrition – Amount Eaten record, dated for April 2026, was reviewed. CNA 6 stated that there was no separate documentation to monitor the specific amount of liquid intake Resident 6 had at mealtimes. CNA 6 stated, she was not aware that Resident 6 was on fluid restrictions. During a concurrent interview and record review on 4/29/2026 at 11:32 AM with LVN 5, Resident 6's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2026 was reviewed. LVN 5 stated that there was no monitoring documented on the MAR and TAR related to Resident 6's fluid restriction. LVN stated, she was not aware that Resident 6 had any fluid restriction orders. During an interview on 4/29/2026 at 3:15 PM with the Director of Nursing (DON), the DON stated, since Resident 6 was a PD patient, it was important to monitor his fluid intake and verify that he was compliant with the fluid restrictions because he was at risk for fluid overload. During an interview on 4/29/2026 at 3:25 PM with the Director of Nursing (DON), the DON stated, it was important to use hand sanitizer in-between changing gloves while performing PD because the PD exit catheter site was an opening into the body. The DON stated it was important to use hand sanitizer to prevent the spread of infection. During the same interview on 4/29/2026 at 3:28 PM with the DON, the DON stated, it was especially important to perform good hand hygiene when performing PD treatments because the PD catheter exit site was an open surgical site, and improper hand hygiene may lead to infection of the PD catheter exit site or peritonitis. During a concurrent interview and record review on 4/29/2026 at 3:30 PM with the DON, the facility's policy and procedure (P&P) titled Peritoneal Dialysis, dated 12/19/2022, was reviewed. The DON stated, the P&P indicated the facility will assure that each resident receives care and services for the provisions of peritoneal dialysis consistent with professional standards of practice. This will include: the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at the facility, and the 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 practices. During the same concurrent interview and record review on 4/19/2026 at 3:40 PM with the DON, Resident 6's MAR and TAR, dated for April 2026, was reviewed. The DON stated, there was no documented evidence of ongoing monitoring for Resident 6's mental status, cardiac status, respiratory status, or skin assessment before, during, or after PD treatments. The DON stated, PD residents required increased oversight and monitoring because they were already clinically unstable prior to PD, and these residents become even more clinically unstable during PD treatments. The DON stated that continuous monitoring was important to see the whole picture of the resident's condition and to identify whether the resident was improving or declining so the staff could intervene appropriately. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Peritoneal Dialysis, dated 12/19/2022, the P&P indicated that before, during, and after receiving the peritoneal dialysis, the facility must, based on the physician's orders and professional standards of care, do the following: 1.obtain vital signs, weights, assess the resident's stability, level of consciousness, and comfort or distress, 2.monitor for post-dialysis complications and symptoms such as, but not limited to dizziness, nausea, fatigue, or hypotension. . 2.During a review of Resident 62's admission Record (AR), the AR indicated the facility admitted Resident 62 on 2/8/2026 and readmitted on [DATE] with diagnoses that include end stage renal disease (ESRD, a condition that the kidneys [an organ that filters waste, excess fluids, and toxins from the blood to create urine] no longer function well enough to meet a body's needs) and infection (the invasion and multiplication of microorganisms in body, causing tissue damage and disease) and inflammatory reaction (body's defense mechanism against harmful stimuli) due to peritoneal dialysis catheter(a tube for PD access). During a review of Resident 62's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 4/22/2026, indicated Resident 62's had no cognitive impairment (ability to understand and make decisions). The MDS indicated Resident 62 was receiving PD. The MDS indicated Resident 62 required partial/moderate assistance with eating, oral hygiene, and substantial/maximal assistance with toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 62's Physician Order Summary dated 4/26/2026 indicated that starting 4/17/2026, the resident was to receive peritoneal dialysis (PD) using Extraneal (a dialysis solution used for PD). The physician ordered treatment consisted of five cycles totaling 10.5 hours, with fill volumes of 2000 mL for each cycle and a final fill of 1500 ml. The PD treatment was scheduled to begin at 7 PM and continue until completion During an observation on 4/26/2026 at 6:24 AM in Resident 62's room, Resident 62 disinfected and disconnect her PD catheter from the dialysis machine by herself in the presence of Licensed Vocational Nurse (LVN) 1. During an interview on 4/26/2026 at 6:45 AM with LVN 1, LVN 1 stated Resident 62 disconnected the PD catheter from the dialysis machine after her dialysis cycles completed most of the time and the nurse let the resident do it herself. LVN 1 stated she was endorsed by other nurses that Resident 62 could disconnect herself and the nurse just stayed at bedside to provide assistance as needed. During an interview on 4/26/2026 at 8:38 AM, the Director of Nursing (DON) stated indicated the resident was alert and oriented. The DON reported that Resident 62 informed the facility staff that she (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure that the accurate and current staffing data sheet (total number of actual hours worked by licensed [Registered Nurses (RNs), Licensed Vocational Nurses [LVNs], and unlicensed nurses [Certified Nurse Assistants (CNAs)]) was posted on 4/25/2026 for the 7 AM - 3 PM shift when the annual recertification survey team entered the facility on 4/25/2025 at 8:30 AM. This deficient practice had the potential to delay recognition of inadequate staffing levels, which may lead to delayed response times, unmet resident needs, and decreased supervision, particularly for residents who require assistance with activities of daily living (ADLs), such as bathing, dressing, and toileting, or who require ongoing safety monitoring. This deficient practice also had the potential to prevent residents, families, and visitors from accurately assessing staff availability, which may affect their ability to raise concerns, request assistance, or make informed decisions regarding the resident's care environment. Findings: During an observation on 4/25/2026 at 8:35 AM, a Census and Direct Care Services Hours per Patient Day (DHPPD, a CMS issued document used to record direct care service hours over a 24-hour period), dated 4/25/2026 was observed posted by the Nurse's Station. The document indicated that the facility's patient census was 91. During the same observation on 4/25/2026 at 8:38 AM, a Nursing Staff Projection document, dated 4/24/2026 was observed posted by the Nurse's Station. The document indicated that the facility's patient census for each shift (11 PM - 7 AM, 7 AM - 3 PM, and 3 PM to 11 PM) was 89. During a concurrent interview and record review on 4/28/2026 at 3 PM with the Director of Staff Development (DSD), a photo of the facility's Nursing Staff Projection sheet, dated 4/26/2026 timed at 8:45 AM, was reviewed. The DSD stated, the Nursing Staff Projection was not updated by the 11 PM - 7 AM RN supervisor for the 7 AM - 3 PM shift on 4/25/2026. The DSD stated that during the weekends and holidays, the RN supervisor of the 11 PM - 7 AM shift was responsible for completing the CHHPD and the Nursing Staff Projection sheet. During the same interview on 4/28/2026 at 3:05 PM, the DSD stated it was important to accurately update and post the Nursing Staff Projection sheet each day to inform residents, families, and visitors of how many CNAs, LVNs, and RNs were projected to work on the current day. The DSD stated that when the Nursing Staff Projection sheet was not accurate, residents, families, and visitors may not be aware of the actual staffing availability. This lack of information could affect their ability to request assistance with residents' ADLs, make informed decisions regarding a resident's plan of care, or address concerns about the resident's physical environment, which may result in delays in care. During a review of the facility's policies and procedures (P&P) titled Nurse Staffing Posting Information, dated 9/16/2024, the P&P indicated that the Nurse Staffing Sheet will be posted on a daily basis and will contain the following information but not limited to the current date and the facility's current resident census. The P&P indicated that the facility will post the Nurse Staffing Sheet at the beginning of each shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receiving anticoagulant or antiplatelet medications (blood thinner) were monitored for medication side effects, in accordance to the resident's care plan and failed to obtain the correct safe dose for a prescribed antiˆnausea medication, in accordance to professional standard of practice and pharmaceutical recommendation for four of six sampled residents (Residents 3, 40, 75, and 65) by failing to: 1. The facility did not monitor Resident 3 for signs and symptoms of bleeding while receiving Eliquis (a bloodˆthinner medication).2. The facility did not monitor Resident 40 for signs and symptoms of bleeding while receiving Eliquis. 3. The facility did not monitor Resident 75 for signs and symptoms of bleeding while receiving Brillinta (a medication that prevents blood from sticking together) and Aspirin (medication that prevent blood clot to form). 4. For Resident 65, the facility failed to include a maximum daily dose for ondansetron (Zofran-medication to relieve nausea and vomiting) in the physician's order for 8ˆmg every 8 hours as needed, which could allow administration of up to 32ˆmg in 24 hours and place Resident 65 at risk for adverse reactions. These deficient practices placed Residents 3, 40, and 75 at increased risk for preventable complications associated with anticoagulant or antiplatelet use, including internal bleeding or bruising, which could result in serious injury or death. The failure to ensure the correct Ondansetron dose also placed Resident 65 at risk for medicationˆrelated harm. Findings: 1. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with included diagnoses of acute respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide) with hypoxia (low levels of oxygen), cachexia (loss of muscle and fat), Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated on 3/27/2026, the MDS indicated Resident 3's cognition (the ability to process thoughts) was severely impaired. During a review of Resident 3's Order Summary Report dated 4/28/2026, indicated Resident 3 had a physician order of Aspirin (medication that prevents the blood from sticking together) 81 milligrams (mg - unit of measurement), once a day for prophylaxis (preventative) for cerebrovascular accident (CVA - a stroke, loss of blood flow to a part of the brain) stop if bleeding. Eliquis 2.5 mg one tablet two times a day for CVA prophylaxis. During a record review of Resident 3's care plan titled The Resident is on Anticoagulant dated on 3/26/2026, the care plan indicated to monitor for any of the following: blood in the urine, blood in the stool, unusual bleeding from shaving, bleeding from the gums, nose, excessive bleeding from the wounds, large hemorrhagic area, petechiae, if I've observed signs and symptoms, hold anticoagulant/antiplatelet dose and notify MD if my initial is N it signifies the absence of listed signs and symptoms. During an interview on 4/26/2026 at 1:53 PM with the Registered Nurse 3 (RN 3), RN 3 stated no monitoring is being done because it is in the care plan, RN 3 stated that she was told not to add a physician order for monitoring because it is in the care plan. During an interview on 4/6/2026 at 1:57 PM with the Director of Nurses (DON), the DON stated that there were no physician orders for monitoring for adverse reactions to anticoagulant/antiplatelet medication stated that the facility removed it from the physician orders because she was told by the facility's nurse consultant that monitoring was not needed as long as they had it in the care plan. During a concurrent record review, the resident's records did not indicate documented evidence that the facility staff had monitored Resident 3 for adverse reactions brought about by the use of anticoagulants such as blood in the urine, blood in the stool, unusual bleeding from shaving, bleeding from the gums, nose, excessive bleeding from the wounds, large hemorrhagic area, petechiae, if I've observed signs and symptoms, hold anticoagulant/antiplatelet dose and notify MD if my initial is N it signifies the absence of listed signs and symptoms. 2. During a review of Resident 40's admission Record (AR), the AR indicated Resident 40 was admitted to the facility on [DATE] with diagnoses (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which included dementia (a progressive state or decline in mental abilities), Diabetes Mellitus (DM a disorder characterized by difficulty in blood sugar control and poor wound healing), Atrial Fibrillation (heart rhythm disorder where the heart beats irregularly and rapidly). During a review of Resident 40's MDS dated [DATE], the MDS indicated Resident 40's cognition was severely impaired. During a review of Resident 40's Order Summary Report dated 4/28/2026 indicated that on 3/21/2026 the physician order Eliquis 2.5 mg two times a day to prevent deep vein thrombosis (blood clot forms in a vein). During a review of Resident 40's Medication Administration Record dated 3/21/2026 - 4/28//2026 Resident 40 received daily dose of Eliquis. During a review of Resident 40's care plan titled The Resident is on Anticoagulant dated 3/23/2026 indicated to monitor/document/report as necessary adverse reactions of anticoagulant therapy such as blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs, bleeding gums, nosebleed, unusual bruising, fall levels in lab results, fall in blood pressure, and blood clot. During a record review, the resident's records did not indicate documented evidence that the facility staff had monitored Resident 40 with adverse reactions of anticoagulant therapy such as blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs, bleeding gums, nosebleed, unusual bruising, fall levels in lab results, fall in blood pressure, and blood clot, in accordance to the written care plan. 3. During a review of Resident 75's AR, the AR indicated Resident 75 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses which included Diabetes Mellitus, kidney failure (kidneys fail to filter waste, regulate blood pressure, and maintain proper red blood cell levels). During a review of Resident 75's MDS dated [DATE] indicated Resident 75's cognition was moderately impaired. During a review of Resident 75's Order Summary Report dated 4/29/2026, the AR indicated Resident 75 on 10/6/2025 had a physician order for Brillinta 60 mg two times a day for Myocardial Infarction (MI - heart attack). On 2/2/2025 Resident 75 had a physician order for Aspirin Delayed Release 81 mg for CVA prophylaxis. During a review of Resident 75's Medication Administration Record dated 2/1/2026 - 4/29/2026 Resident 75 received daily dose of Brillinta. Resident 75 received daily dose of Aspirin 3/7/2026 - 4/30/2026. During a review of Resident 75's care plan titled The Resident is on Antiplatelet Agent dated 11/12/2021 with a revision date on 4/26/2026 indicated to monitor for any of the following: blood in the urine, blood in the stool, unusual bleeding after shaving, bleeding from the gums, bleeding from the nose, excessive bleeding from wounds, large hemorrhagic area, petechiae. Monitor/document/report as necessary adverse reactions of antiplatelet agent such as blood tinged, red blood in the urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in the vital signs. During an observation on 4/26/2026 at 1:04 PM, a large bruise was observed covering the left anterior hand area dark purple in color, Resident 75 stated he probably bumped his hand on the doorway. During an interview on 4/26/2026 at 2:32 PM with RN 3 stated that the bruise on Resident 75's left hand has not been reported to the physician because nursing was not aware of the condition and the need to monitor the resident for bruising or bleeding due to use of antiplatelets. RN 3 stated that the attending Certified Nurse Assistant 5 (CNA 5) assigned to Resident 75 had not reported to the licensed nurses that Resident 75 had a bruise. During a concurrent record review of Resident 75's records, the bruising was not documented anywhere in the resident's records. During an interview on 4/26/2026 at 2:41 PM with CNA 5, CNA 5 stated that she did not report the bruise today because she noticed the bruise three days ago. CNA 5 stated that she reported it to a nurse on Thursday but could not remember who she told to. During an interview on 4/26/2026 at 2:57 PM with the DON and CNA 5. The DON brought in CNA 5 to interview in (continued on next page)

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	055989	A. Building B. Wing	04/30/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	front of surveyor. CNA 5 stated that she did not report the bruise today because she did not see it today and it must have just happened. The DON stated that she talked to Resident 75 and Resident 75 told the DON that he did not report the hand bruise to anyone. CNA 5 stated that Resident 75 had bruises three days ago. The DON stated that there was no change of condition and physician notification for the bruises observed three days ago. The DON stated that the physician was going to be made aware and that the facility was going to initiate a care plan for the bruising. During a concurrent record review, the resident's records did not indicate documented evidence that the facility staff had monitored Resident 75 with adverse reactions of antiplatelet agent such as blood tinged, red blood in the urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in the vital signs, in accordance to the written care plan. 4. During a review of Resident 65's admission Record (AR), the AR indicated that Resident 65 was admitted on [DATE], with diagnoses that included muscle wasting and atrophy (the wasting or loss of muscle tissue caused by reduced protein and increased degradation), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 65's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/7/2026, the MDS indicated that Resident 65 has severely impaired cognition (the ability to process thoughts). During a review of Resident 65's Order Summary Report dated 4/22/2026, the Report indicated a physician order to administer Ondansetron 8 mg every 6 hours as needed for nausea/vomiting for 14 days. The physician order did not indicate the adult maximum dose for Ondasetron by mouth, according to manufacturer's guidelines. During an interview on 4/28/2026 at 11:45 AM with RN 1, RN 1 stated that Resident 65 had vomiting and was administered Ondansetron 8 mg on 4/27/2026 at 9:25 PM and 4/28/2026 at 7:55 AM. RN1 stated that a change of condition was done on Resident 65. Medication dosing review with RN 1 per dosing guidelines for Ondansetron the maximum daily allowance is 24 mg per day. RN 1 stated that she was going to call and verify the dosage with pharmacy. Exceeding 24 mg of Ondansetron per day can lead to severe side effects including cardiac issues. During a concurrent interview and record review of Resident 65's MAR on 4/28/2026 at 12:24 PM with RN 1, RN 1 stated that the physician order for Ondansetron was clarified on 4/28/26 timed at 12:15 PM, with the pharmacist and the physician to administer Ondasetron 8 mg and added the parameter according to guidelines not to exceed dosing 24 mg in 24 hours. During an interview on 4/29/2026 at 9:25 AM with the DON, the DON stated that the dosage for Ondansetron exceeded the recommended dosage and this was a potential for overdosing. During a review of facility's policy and procedure (P&P) titled, High Risk Medications - Anticoagulants revised date 12/19/2022, indicated that anticoagulant medications are associated with greater risks of adverse consequences than other medication. The policy indicates that the residents plan of care shall alert staff to monitor for adverse consequences. During a review of the facility's P&P titled Provider Pharmacy Requirements revised date 1/2025, indicated that the pharmacy will provide medication information and consultation to the facility's nursing staff. During a review of the Mayo Clinic Side effects and dosage of Ondansetron is used to prevent nausea and vomiting that is caused by cancer medicines (chemotherapy) or radiation therapy. It is also used to prevent nausea and vomiting that may occur after surgery. Ondansetron works in the stomach to block the signals to the brain that cause nausea and vomiting. For oral dosage forms (oral disintegrating tablets, solution, or tablets): For prevention of moderate nausea and vomiting after treatment with cancer medicines: Adults and children [AGE] years of age and older-At first, 8 milligrams (mg) taken 30 minutes before starting cancer treatment. The 8-mg dose is taken again 8 hours after the first dose. Then, the dose is 8 mg every 12 hours for 1 to 2 days. Ondansetron (oral route,oromucosal route) - Side effects & dosage - Mayo Clinic.com Document last updated: April 30, 2026

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	055989	A. Building B. Wing	04/30/2026

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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 and record review, the facility failed to ensure to store and serve food for 69 residents receiving food from the kitchen in accordance with professional standards for food service safety, and the facility's policy and procedure titled, Food Safety and Food Storage, revised 12/19/2022. This deficient practice had the potential for the residents to acquire food-borne illness (a life-threatening infection due to consuming contaminated food) from ingesting expired food. Findings: During an observation on 4/25/2026 at 8:45 AM in the kitchen with the dietary staff there were open and expired food items in the freezer as listed: One open bag full of mixed vegetables store in the freezer Ten (10) cups of expired ice cream store in the freezer Ice scoop stored inside the ice container machine During a concurrent observation and interview on 4/25/2026 at 8:45 AM with the Kitchen staff (KS 1) stated that the vegetable bag that was slightly opened was overlooked by staff and should have been disposed. KS 1 stated the ice cream cups expired on 4/24/2026 and should have been discarded and not store in the freezer. During a concurrent observation and interview on 4/25/2026 at 9:00 AM, the Dietary Supervisor (DS 1) acknowledged that the ice scoop should not have been left inside the ice machine. DS 1 explained that there were plans to install a hook outside the ice machine to properly store the ice scoop, but this task had not yet been completed. During an interview on 4/28/2026 at 2:42 PM with the Registered Dietitian (RD 1), RD 1 stated that the ice scoop should never be stored inside the ice machine, additionally RD 1 stated that expired food should never be stored in the freezer and open bags in the freezer can be exposed to the elements of the freezer and can affect the taste of the food. During a review of the facility's policy and procedure (P&P) titled, Food Safety and Food Storage date revised 12/19/2022, indicated that food safety practices shall be followed throughout the facility's entire food handling process. Food should be stored in a manner that helps prevent deterioration or contamination of the food. Equipment used in the handling of the food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food.

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	055989	A. Building B. Wing	04/30/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement the facility's policy and procedure for infection control for 5 of 5 sampled residents Residents 43, 46, 62, 67 and 106. The facility failed to: 1.Resident 106's nasal canula (NC-a lightweight, flexible tube used to deliver supplemental oxygen) was properly stored when not in use to prevent contamination in accordance with Oxygen Administration facility policy. 2.Appropriately cohort Resident 62 who was on peritoneal dialysis (PD, a home-based treatment for kidney failure) with Resident 46 who had active infection with Escherichia coli Extended-Spectrum beta-lactamase (ESBL E. coli, bacteria resistant to many common antibiotics, making infection harder to treat) in urine in the same room. 3. Ensure Resident 43's intravenous site (IV- catheter inserted into the vein) was labeled with a date and initialed by the registered nurse (RN) who last changed the IV site dressing. 4. Ensure Resident 67's personal items located in a three-drawer plastic bin at Resident 67's bedside was not expired. These deficient practices had the potential to spread infection to Residents 43, 46, 62, 67 and 106, other residents in the facility. Findings 1.During a review of Resident 106's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including essential hypertension (high blood pressure), acute congestive heart failure (the heart can't pump enough blood). During a review of Resident 106's History and Physical (H&P), dated [DATE], the H&P indicated Resident 106 did not have the capacity to understand and make decisions. During a review of Resident 106's Order Summary Report dated [DATE] indicated a Physicians order for: Oxygen via NC at 2 liters (a unit of measurement) per minute as needed, may titrate Oxygen up to 5 liters per minute to maintain Oxygen saturation greater or equal to 93% with a start date of [DATE]. During an observation on [DATE] at 9:39 AM, Resident 106's NC was observed laying on the floor next to Resident 106's head of bed. During a concurrent interview and observation on [DATE] at 9:41 AM of Resident 106's room with Registered Nurse 2 (RN 2), RN 2 stated she did not know why resident 106's NC was laying on the room floor. RN 2 stated Resident 106's NC should be stored in a plastic clear bag when not in use to prevent it from being contaminated. During an interview on [DATE] at 1:41 PM with Director of Nursing (DON), the DON stated all resident Oxygen NC should be stored properly inside clear plastic bag that is labeled when not in use. The DON stated it can make a resident sick if it falls on the floor and then is used by the resident as the NC can become contaminated. (continued on next page)

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	055989	A. Building B. Wing	04/30/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure (P&P) titled Oxygen Administration, revised [DATE], indicated 4. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include keep delivery devices covered in plastic bag when not in use. 2.During a review of Resident 62's admission Record (AR), the AR indicated the facility admitted Resident 62 on [DATE] and readmitted on [DATE] with diagnoses that include end stage renal disease (ESRD, a condition that the kidneys [an organ that filters waste, excess fluids, and toxins from the blood to create urine] no longer function well enough to meet a body's needs) and infection (the invasion and multiplication of microorganisms in body, causing tissue damage and disease) and inflammatory reaction (body's defense mechanism against harmful stimuli) due to peritoneal dialysis catheter(a tube for PD access). During a review of Resident 62's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated [DATE], indicated Resident 62's had no cognitive impairment (ability to understand and make decisions). The MDS indicated Resident 62 was receiving PD. The MDS indicated Resident 62 required partial/moderate assistance with eating, oral hygiene, and substantial/maximal assistance with toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 62's Physician Order Summary dated [DATE] indicated that starting [DATE], the resident was to receive peritoneal dialysis (PD) using Extraneal (a dialysis solution used for PD). The physician ordered treatment consisted of five cycles totaling 10.5 hours, with fill volumes of 2000 mL for each cycle and a final fill of 1500 ml. The PD treatment was scheduled to begin at 7 PM and continue until completion each evening. b. During a review of Resident 46's AR, the AR indicated the facility admitted Resident 46 on [DATE] with diagnoses that include urinary tract infection (UTI, an infection in any part of the urinary system (organs that produce and release urine, caused by bacteria). During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46's had moderately impaired cognition and memory. The MDS indicated Resident 46 required partial/moderate assistance with eating, oral hygiene and personal hygiene, and was dependent on toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 46's Order Summary Report, dated [DATE], the report indicated the physician ordered Resident 46 to be placed on contact isolation precautions (precautions to prevent the spread of infections transmitted by direct or indirect contact with a patient or their environment) starting on [DATE] due to presence of ESBL E. coli. During an observation on [DATE] at 1:18 PM, Residents 62 and 46 reside in the same room and were roommates. During an observation and concurrent interview on [DATE] at 4:13 PM with the Infection Preventionist (IP), the IP stated Resident 46 was placed on contact isolation due to presence of ESBL and E. coli in the urine on [DATE]. The IP stated the facility staff should not have cohort Resident 62 with Resident 46 together because Resident 62 was at high risk for contracting infection due to having kidney failure and receiving peritoneal dialysis. The IP stated she did not notice Resident 62 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had been in the cohort with Resident 46 who had active infection since [DATE]. During an interview on [DATE] at 2:01 PM with the Director of Nursing (DON), the DON stated Resident 62 was at high risk for contracting infection because she was receiving PD. The DON stated Resident 46 had an active infection with ESBL E.coli. The DON stated the facility should not place these two residents in the same room to prevent potential infection for Resident 62. The DON stated the facility staff did not check the residents' status and did not ensure these two residents were not cohort in the same room. During a review of the facility's policy and procedure (P&P) titled, Peritoneal Dialysis, dated [DATE], the P&P indicated the facility will establish policies/procedures based upon current standard of practice to include transmission-based precautions including placement/location (Cohorting). During a review of the facility's P&P titled, Transmission-Based (Isolation) Precautions, dated [DATE], the P&P indicated when implementing transmission-based precautions, the facility will consider sharing a room with a roommate with limited risk factors (without indwelling or invasive devices, without open wounds, and not immunocompromised) as appropriate based on the pathogen and method of transmission. 3.During a review of Resident 43's admission Record (AR), the AR indicated the facility originally admitted Resident 43 on [DATE] and readmitted her on [DATE] with diagnoses that include pneumonia (infection of lungs) and hypertension (high blood pressure). During a review of Resident 43's Minimum Data Set (MDS, a resident tool), dated [DATE], the MDS indicated Resident 43 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 43 was dependent on oral hygiene and personal hygiene, toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a concurrent observation and interview on [DATE] at 12:53 PM with Registered Nurse (RN) 2, Resident 43 was lying on the bed, and she had an intravenous catheter (IV catheter, a flexible plastic tube inserted into a vein to deliver fluids, medications, or blood products directly into the bloodstream) inserted in her right foot. The IV site was covered with a transparent dressing that was unlabeled. There was not date or initial of who last changed Resident 43's IV site dressing. RN 2 stated she inserted the IV catheter two days ago and she put a label sticker with the date and initial on the IV site transparent dressing, but she could not find the label sticker at this time. RN 2 stated the reason the IV was labeled and initialed with the nurse who changed the IV site dressing was so other nurses would know when the IV was inserted and when the dressing required changing. RN 2 stated the date and the initial on the IV site should be visible at all times and changed every 72 hours in accordance with the facility's policy to prevent infection. During an interview on [DATE] at 1:53 PM with the Director of Nursing (DON), the DON stated the as the standard of practice, the RNs should label the date and initial when they insert a new IV catheter (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	into the resident and monitor the IV site. The DON stated the date and initial must be visible at all times, so they would know when to change the IV catheter to prevent infection for the resident. During a review of the facility's policy and procedure (P&P) titled, Intravenous Therapy, dated [DATE], the P&P indicated IV sites are changed every 72 hours unless otherwise by the physician. 4.During a review of Resident 67's AR, the AR indicated the facility originally admitted Resident 67 on [DATE] and readmitted her on [DATE] with diagnoses that include dementia (a progressive, irreversible syndrome characterized by a decline in memory, thinking, behavior, and daily function, commonly affecting older adults) and hyperlipidemia (a common condition characterized by high levels of fats). During a review of Resident 67's MDS, dated [DATE], the MDS indicated Resident 67's had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 67 was dependent on oral hygiene and personal hygiene, toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a concurrent observation and interview on [DATE] at 10:07 AM, the Infection Preventionist (IP) was observed was moving a three-drawer plastic storage bin that was in Resident 67's room out of the room. The storage cart drawers have the following: a. four (4) opened bottles of normal saline (a mixture of water and salt) and one (1) of the bottles was labeled with an open date of[DATE] b. 4 opened, used tubes of Medihoney (a medical-grade honey used to treat wound and burns) in a gloves box c. 1 opened, used tube of Bacitracin Zinc Ointment (a topical ointment used to treat and prevent infection in a wound). d. three (3) opened, used Medihoney, 1 opened, used tube of Silverhoney (a medical-grade honey used to treat wound and burns) and 1 opened and used Bacitracin Zinc ointment were inside a Ziploc bag e. 3 opened, half-full bottles of ultrasound gel (a gel used during a ultrasound test [a test used a sound wave to capture the image inside the body]) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. 1 opened bottle of Artificial Teas lubricant eye drops (eye drops used to treat dry, scratchy, or burning eyes) g. multiple linen sheets, diapers and towels The IP stated the plastic storage bin was at Resident 67's bedside and she was removing it from the room because the items should not be stored at the bedside because of infection control concerns. The IP stated she was not sure for how long the resident had these items kept in the plastic storage cart. During an interview on [DATE] at 4:05 PM with the Treatment Nurse (TXN), the TXN stated Resident 67 did not have any skin issues except requiring g-tube site care. The TXN stated she saw the plastic storage bin at Resident 67's bedside but she did not know what was stored inside the cart. The TXN stated the facility had never provided the NS, Bacitracin Zinc ointment, Medi Honey and ultrasound gem to Resident 67. The TXN stated the family members were the ones who brought those items from outside into the facility. The TXN stated she saw the family members use NS to clean Resident 67's hands before. During an interview on [DATE] at 10:55 AM, the IP stated the items in Resident 67's plastic storage bin at bedside were contaminated and expired. The IP stated when the FM continued to use these items on Resident 67, the resident was at risk for infection. The IP stated the facility staff did not check the items that were stored inside Resident 67's plastic storage bin and did not address the potential infection issue with FM and other staff. During an interview on [DATE] at 2:33 PM with Certified Nursing Assistant (CNA) 3, CNA 3 stated she took care Resident 67 before and she noticed that there was a plastic storage bin was at Resident 67's bedside, but she did not know what was inside the cart. During an interview on [DATE] at 1:55 PM with the Director of Nursing (DON), the DON stated the facility staff did not check what was stored inside Resident 67's plastic storage cart and did not talk to the family members to address proper storage of residents' personal items. The DON stated properly storing resident's items was important so the resident would not receive contaminated and expired solution, gel, ointment and eye drops. The DON stated the nurse should report any improper storage issue at residents' bedside and prevent infection to the residents. During a review of the facility's P&P titled, Infection Prevention and Control Program, dated [DATE], the P&P indicated the facility to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infections.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain or enhanced a resident's dignity, in accordance with the facility's policy and procedure titled Promoting/Maintaining Resident Dignity, for two of six sampled residents (Residents 1 and 49) by failing to: 1.Cover Resident 1's urinary collection bag (a bag where urine drains from the bladder) with a privacy bag. 2.Provide privacy to Resident 49 while being assisted after a shower. Resident 49 was left in a shower chair with no clothes or covering from the waist down in the middle of her room while the door was open exposed to the facility hallway. These deficient practices had the potential for lowering the resident's self-esteem and self-worth. Findings: 1.During a review of Resident 1's admission Record (AR), the AR indicated that Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with included diagnoses of Dementia (a progressive stated of decline in mental abilities), lack of coordination, anxiety disorder. During a review of Resident 1's Medical Summary dated 1/28/2026, the Summary indicated that Resident 1 has atonic bladder status post suprapubic catheter. During a review of Resident 1's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated on 2/9/2026, the MDS indicated that Resident 1 has moderately impaired cognition (the ability to process thoughts). During a review of Resident 1's Order Summary Report dated 4/28/2026. The Report indicated Resident 1 had a physician order dated 3/6/2026 to maintain suprapubic catheter size 16, change for blockage, leaking, pulled out, excessive sedimentation, and change catheter drainage bag as needed. During a concurrent observation and interview on 4/25/2026 at10:21 AM, Resident 1 was observed sitting on the side of his bed with an indwelling catheter with the drainage bag hanging on the side of his right-side bed rail without a privacy bag. Resident 1 did not answer when asked if he was comfortable exposing his urinary drainage bag. Resident answered with other past life stories when asked questions. During an interview on 4/28/2026 at 11:24 AM with Treatment Nurse (TXN), TXN stated that all staff are responsible to ensure that a dignity bag is covering the urinary bag unless the resident refuses the dignity bag. TXN unsure why Resident 1 did not have a dignity bag present. During an interview on 4/29/2026 at 9:00 AM with Director of Nurses (DON) stated that residents with a foley bag should have a dignity bag unless they refused as well as a basin underneath it to protect the bag from touching the floor. 2. During a review of Resident 49's admission Record (AR), the AR indicated the resident was (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE] with diagnoses including cirrhosis of liver (a condition in which a liver stops functioning normally), fronto-temporal neurocognitive disorder (a mental health condition characterized by abnormal shrinkage in two parts of the brain). During a review of Resident 49's History and Physical (H&P), dated 1/27/2025, the H&P indicated Resident 49 does not have the capacity to understand and make decisions. During a review of Resident 49's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 1/29/2026, the MDS indicated Resident 49 requires maximal assistance (helper does more than half the effort, helper lifts, holds, or support). During an observation on 4/25/2026 at 8:30 AM in Resident 49's room, Resident 49 was observed sitting in the shower in the middle of the room chair wearing no clothes or cover from the waist down. Resident 49's bedroom door was open. During an interview and concurrent observation on 4/25/2026 at 8:32 AM with Certified Nursing Assistant (CNA8), CNA 8 stated she was Resident 49's CNA that morning and was in the middle of dressing Resident 49 when the RN supervisor told her to go assist another resident in the restroom. CNA 8 stated she left and forgot to cover Resident 49 before leaving. During an interview on 4/28/2026 at 2:35 PM with the Director of Nursing (DON), the DON stated facility nurses should never [NAME] a resident undressed and exposed in the middle of the room. The DON stated doing this violates a resident's dignity and right to privacy. During a review of the facility's policy and procedure (P&P) titled, Promoting/Maintaining Resident Dignity , with a revision date of 12/19/2022, the P&P indicated It is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances residents quality of life by recognizing each resident's individuality.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure titled, Call Lights: Accessibility and Timely Response for three out of six sampled residents (Resident 1) to ensure that the residents had the call system within reach and were able to use it if desired. This deficient practice placed the residents at risk of not having their needs met timely, especially during an emergency or accident. Findings: 1. During a review of Resident 65's admission Record (AR), the AR indicated that Resident 65 was admitted on [DATE], with diagnoses that included muscle wasting and atrophy (the wasting or loss of muscle tissue caused by reduced protein and increased degradation), and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 65's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/7/2026, the MDS indicated that Resident 65 has severely impaired cognition (the ability to process thoughts). The MDS also indicated that Resident 65 was dependent (helper does all the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and needed substantial/maximal assistance in personal hygiene, upper body dressing, oral hygiene, and eating. During a review of Resident 65's care plan (CP) with the focus on ADL (Activities of Daily Living, the basic tasks that people do every day to take care of themselves) Function, dated 4/20/2026, the care plan included the intervention for staff to keep call light within easy reach of Resident 65. During an observation on 4/25/2026 at 9:27 AM, a call light was hanging on the side of Resident 65's roommate's bed, which was not reachable to Resident 65 the call light was hanging on the wall behind the roommate's bed. During an interview on 4/26/2026 at 12:53 PM with Certified Nurse Assistant (CNA 2), CNA 2 stated Resident 65 is able to use his call light. CNA 2 stated CNA 2 has been busy and did not realize that the call light was out of Resident 65's reach. b. During a review of Resident 3's AR, the AR indicated that Resident 3 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide) with hypoxia (low levels of oxygen), cachexia (loss of muscle and fat), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's MDS dated on 3/27/2026, the MDS indicated that Resident 3 has severely impaired cognition (the ability to process thoughts). The MDS also indicated that Resident 3 was dependent (helper does all the effort) in personal hygiene, putting on and off footwear, lower body dressing, upper body dressing, shower/bathe self, toileting hygiene, oral hygiene. During a review of Resident 3's CP with the focus on ADL Function, dated 4/9/2026, the CP included the intervention for staff to keep the call light within easy reach of the resident. During an observation on 4/25/2026 at 10:17 AM, Resident 3's call light was on the floor near the resident's oxygen concentrator. During an interview on 4/26/2026 at 11:25 AM with CNA 3, CNA 3 stated that it is important to have the call light within the reach of the resident to be able to assist the resident with their needs. c. During a review of Resident 1's AR, the AR indicated that Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included dementia (a progressive stated of decline in mental abilities), lack of coordination, anxiety disorder (mental health conditions involving excessive, uncontrollable, and persistent fear or worry that interferes with daily life). During a review of Resident 1's MDS dated [DATE], the MDS indicated that Resident 1 has moderately impaired cognition (the ability to process thoughts), the MDS also indicated that Resident 1 was dependent (helper does all the effort) in putting on/taking off footwear, lower and upper body dressing, shower/bathe self, toileting hygiene, oral hygiene, eating. During an observation on 4/25/2026 at 10:21 AM, Resident 1's call light was covered under the resident's blanket and was hanging off the side of the bed nearly touching the floor unreachable to Resident 1. During an interview on 4/29/2026 at 9:03 AM with CNA 8, CNA 8 stated that the call light must always be within reach with the purpose to assist resident. CNA 8 stated that (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not having the call light within reach can potentially cause an injury such as a fall. During an interview on 4/29/2026 at 1:52 PM with the Director of Nurses (DON) stated that the call light must be within residents reach and answered timely to prevent potential falls or injury. During a review of facility's policy and procedures (P&P) titled Promoting/Maintaining Resident Dignity indicated that it is the practice of the facility to protect and promote residents' rights and treat each resident with respect. Staff are required to respond to residents' request for assistance in a timely manner. During a review of facility's policy and procedure (P&P) titled Call lights: Accessibility and Timely Response dated 12/29/2022, indicated that staff will be educated on the proper use of the resident call light system, ensuring resident access to the call light. Staff will ensure that the call light is within reach of resident and securely position.

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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 observation, interview, and record review, the facility failed to inform Physician 1 of the significant change in condition of one of three sample residents (Resident 38) on the morning of 4/25/2025 when Registered Nurse (RN) 3 assessed Resident 38, diagnosed with Diabetes Mellitus [DM, a disorder characterized by difficulty in blood sugar control and poor wound healing], with a blood pressure (the force blood pushes against the arteries; normal reading is 120/80 milliliters of mercury [mmHg, unit of measure]) of 85/50 mmHg and was drowsier than usual and RN 3 administered IV (Intravenous or administered into the vein) 5% Dextrose Normal Saline (solution with salt and glucose) without the physician's order. This deficient practice resulted in Resident 38 receiving 5% Dextrose Normal Saline for 1 hour at a rate of 200 milliliters per hour (mL/hr, unit of rate) without a physician's order. This deficient practice had the potential to result in Resident 38 experiencing worsening hyperglycemia (high blood sugar levels), edema (swelling), and electrolyte imbalance, and fluid overload that could lead to hospitalization. Cross Reference with F757 Findings: During a review of Resident 38's admission Record (AR), the AR indicated that the facility admitted on [DATE] and readmitted Resident 38 on 10/9/2025 with diagnoses included Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), lumbar spinal stenosis (narrowing of the space within the spine causing pressure on the nerves), and chronic viral Hepatitis B (chronic liver infection caused by the hepatitis B virus). During a review of Resident 38's history and physical (H&P), signed and dated 2/23/2026, the H&P indicated that Resident 38 did not have the capacity to understand and make decisions. During a review of Resident 38's Minimal Data Set (MDS, a resident assessment tool), dated 2/26/2026, the MDS indicated that Resident 38's cognitive (a resident's thought process) skills were severely impaired. The MDS indicated that Resident 38 required maximal assistance (helper does more than half the effort) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) such as eating and oral hygiene, and required maximal assistance for mobility such as transfers from lying to sitting at the edge of the bed and transferring from sitting to standing position. The MDS indicated that Resident 38's active diagnoses included DM. During a review of Resident 38's Weight and Vitals Summary report, dated from 4/1/2026 to 4/30/2026, the report indicated on 4/25/2026 timed at 7:35 AM, Resident 38's blood pressure was 86/50 mmHg. During a review of Resident 38's telephone order (TO, a verbal order prescribed by a physician or other authorized prescribing provider and transcribed by nurse or other authorized personnel), dated 4/25/2026 timed at 8 AM, the TO indicated that Physician 1 ordered IV 5% Dextrose Normal Saline (solution with salt and glucose) at 50 milliliters per hour (mL/hr, rate of infusion) for three days for low blood pressure. During an observation on 4/25/2026 at 9:29 AM in Resident 38's room, Resident 38 was observed sleeping in bed with the 5% Dextrose 0.9% Normal Saline was hanging from an IV pole (a metal stand used to hold IV solutions and IV medications) with an unlabeled IV solution bag of 5% Dextrose Normal Saline at a rate of 200 mL/hr infusing into Resident 38's IV catheter site (the specific spot where a small, flexible tube is inserted into the vein to deliver fluids or medication) in her right hand. During a concurrent interview and record review on 4/26/2026 at 3:24 PM with RN 3 , RN 3 reported that on 4/25/2026 at 8 AM, she observed Resident 38 drowsier than usual and decided to proactively start IV fluids without notifying Physician 1 before initiating the IV therapy. RN 3 wrote the telephone order herself and timed it at 8 AM to reflect when she began the IV. RN 3 stated she selected 5% Dextrose in Normal Saline because Resident 38 was diabetic, and she believed dextrose-containing fluids typically raise blood pressure more quickly. During an interview on 4/28/2026 at 9:30 AM with Physician 1, Physician 1 stated he did not prescribe IV solutions of 5% Dextrose Normal Saline at a rate of 200 mL/hr to be administered to Resident 38. Physician 1 stated, if the nurses see a change of (continued on next page)

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	055989	A. Building B. Wing	04/30/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition [in a resident], he expected the nurses to call me and notify me first. During an interview on 4/28/2026 at 1:55 PM with the Director of Nursing (DON), the DON stated, RN 3 did not notify Physician 1of Resident 38's change of condition before starting the IV solutions. The DON stated that Physician 1 needed to be aware of Resident 38's change of condition in order to prescribe the most appropriate intervention for Resident 38. During a review of the facility's policies and procedures (P&P) titled Notification of Changes, dated 12/19/2022, the P&P indicated that the facility must inform the resident, consult the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. During a review of the same facility's P&P titled Notification of Changes, dated 12/19/2022, the P&P indicated that circumstances that require notification include significant changes in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status. During a review of the facility's job description titled Registered Nurse, date unknown, the job description indicated that the Registered Nurse's major duties and responsibilities included observing for changes in residents' status, notifying the physician and resident's family or representative and documenting accordingly.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and closed record review, the facility failed to ensure the required Notice of Proposed Transfer/Discharge (a written notification to the resident or responsible party (RP) was fully completed and sent to the Long^Term Care Ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities) for two of two sampled residents (Resident 7 and Resident 101). The required notice, which provides written information to the resident or responsible party regarding the reason for the transfer or discharge, was not completed in full before being sent to the Ombudsman. This deficient practice failed to ensure the residents' rights to have the Long^Term Care Ombudsman notified and able to advocate on behalf of Resident 7 and Resident 101 regarding their proposed transfer/discharge. Findings: 1 During a review of Resident 7's admission Record (AR), the AR indicated that the facility admitted Resident 7 on 9/5/2022 and readmitted Resident 7 on 4/5/2026 with diagnoses that included sepsis (a life threatening blood infection), acute respiratory failure (condition where the lungs cannot supply oxygen-rich blood to the body) with hypoxia (condition where the body tissues do not have enough oxygen rich-blood, and Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar). During a review of Resident 7's history and physical (HP), signed and dated 4/7/2026, the HP indicated that Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS), dated [DATE], the MDS indicated that Resident 7's cognitive skills (a resident's thought process) were severely impaired. The MDS also indicated that Resident 7 was dependent (the helper performs all of the effort) for activities of daily living (ADLs) and functional mobility, including repositioning in bed and transferring from bed/chair to chair. During a concurrent interview and record review on 4/28/2026 at 9:30 AM with the Medical Records Director (MRD), Resident 7's Notice of Transfer/Discharge, dated 3/9/2026, was reviewed. The MRD stated the record indicated Resident 7 was transferred/discharged because Resident 7's health had improved sufficiently such that he no longer required the services provided by the facility. The MRD stated the record showed that Resident 7 was transferred on 3/6/2026 to a General Acute Care Hospital (GACH). During the same concurrent interview and record review on 4/28/2026 at 9:32 AM with the MRD, Resident 7's SBAR (Situation, Background, Assessment, Recommendation, a communication tool used by healthcare workers when there is a change of condition among the residents) record, dated 3/9/2026, was reviewed. The MRD stated that the SBAR record indicated that Resident 7 had a change of condition that required him to be transferred to the GACH via 911. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same concurrent interview and record review on 4/28/2026 at 9:34 AM with the MRD, Resident 7's Notice of Transfer/Discharge, dated 3/9/2026, was reviewed. The MRD stated the record did not indicate the appropriate reason for Resident 7's transfer to the GACH. The MRD stated it was important to document the most appropriate reason for transfer/discharge so that the Ombudsman would be accurately informed of Resident 7's location. The MRD stated Resident 7 experienced a change of condition that could not be managed by the facility and therefore required transfer to a higher level of care. During a concurrent interview and record review on 4/28/2026 at 9:40 AM with Registered Nurse (RN) 2, Resident 7's Notice of Transfer/Discharge, dated 3/9/2026, was reviewed. RN 2 stated she was the licensed nurse who completed the document. RN 2 stated she did not select the correct reason for Resident 7's transfer to the GACH. RN 2 acknowledged that the Ombudsman was not accurately informed of Resident 7's reason for transfer. During a review of the facility's policies and procedures (P&P) titled Transfer and Discharge (including AMA), dated 12/19/2022, the P&P indicated that the facility's transfer/discharge notice will be provided to the resident and the RP and will provide the specific reason and basis for transfer or discharge. 2.During a review of Resident 101's admission Record (AC), the AC indicated the resident was originally admitted to the facility on [DATE], with diagnoses that included pancytopenia (abnormally low amounts of all three types of blood cells), heart failure (a condition in which the heart muscle can't pump enough blood). During a review of Resident 101's Order Summary Report dated 3/12/2026, the Order Summary Report indicated an order for: May discharge on [DATE]. Request ultra-light wheelchair, 3 in 1 commode with home health with an order date of 2/13/2026 timed at 12:11 PM. During a review of Resident 101's facility provided document Transmission of verification report of Resident 101's Notice of Transfer/Discharge, the document indicated it was faxed to the Ombudsman on 2/13/2026. The document did not indicate the reason for Resident 101's transfer/discharge. During an interview and record review on 4/26/2026 at 1:10 PM with Medical Record Director (MRD) of Resident 101's Notice of Transfer/discharge date d 2/13/2026, the MRD stated when a resident was transferred or discharged the facility must send a completed copy of the Transfer/ Discharge form to the ombudsman with the reason for Resident 101's discharge/transfer and keep a copy of the fax confirmation as part of their medical records. The MRD stated she had not noticed the copy the facility had sent to the ombudsman was not filled out and did not include a reason why Resident 101 was discharged from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Transfer and Discharge (Including AMA), dated with a revision 12/19/ 2022, the P&P indicated The facility's transfer/discharge notice will be provided to the resident and the resident representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided A. The specific reason and basis for transfer or discharge. The P&P further stated, The notice must be provided to the resident, resident representative and Long-Term Care Ombudsman as soon as practicable before the transfer or discharge.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services based on Professional Standard of Practice for two of two sampled residents (Residents 38 and 43). The facility failed to: 1.For Resident 38 with diabetes (a condition of having high blood sugar) Registered Nurse (RN) 3 transcribed in a physician order to administered IV (intravenous or administered into the vein) 5% Dextrose Normal Saline (solution with salt and glucose) to the resident without a physician order. This deficient practice had the potential to result in inaccurate treatment and inappropriate IV fluid administration and result in serious complications that included hyperglycemia (high blood glucose levels) fluid overload (the body retaining and unable to remove excess fluids) or need of hospitalization. 2. For Resident 46, who had a foley catheter (a flexible tube used to drain urine from the bladder continuously into a bag) the Treatment Nurse (TXN) reinserted the foley catheter without a physician order after the physician ordered to removed the foley catheter on 4/10/2026. The deficient practice had potential to received unnecessary use of foley catheter. Findings: 1.During an observation on 4/25/2026 at 9:29 AM in Resident 38's room, Resident 38 wasˆobservedˆalone, sleeping in bedˆwith theˆ5% Dextrose 0.9% Normal Saline was hanging from an IV pole (a metal stand used to hold IV solutions and IV medications) with an unlabeled IV solution bag of 5% Dextrose Normal Saline at a rate of 200 mL/hrˆinfusing into Resident 38's IV catheter site (the specific spot where a small, flexible tube is inserted into the vein to deliver fluids or medication) in her right hand.ˆˆ During a review of Resident 38's admission Record (AR), the AR indicated that the facility admitted on [DATE] and readmitted Resident 38 on 10/9/2025 with diagnoses included Type 2 Diabetes Mellitus (DM,ˆa disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), lumbar spinal stenosis (narrowing of the space within the spine causing pressure on the nerves), and chronic viral Hepatitis B (chronic liver infection caused by the hepatitis B virus).ˆˆ ˆ During a review of Resident 38's history and physical (H&P), signed and dated 2/23/2026, the H&PˆindicatedˆthatResident 38 did not have the capacity to understand and make decisions.ˆˆ During a review of Resident 38's Minimal Data Set (MDS, a resident assessment tool), dated 2/26/2026, the MDS indicated that Resident 38's cognitive (a resident's thought process) skills were severely impaired. The MDS indicated that Resident 38's active diagnoses included DM.ˆˆ During a review of Resident 38's Weight and Vitals Summary report, dated from 4/1/2026 to 4/30/2026, the reportˆindicatedˆon 4/25/2026 timed at 7:35 AM, Resident 38's blood pressure was 86/50 mmHg.ˆˆ During a review of Resident 38's telephone order (TO, a verbal order prescribed by a physician or other authorized prescribing provider and transcribed by a nurse or other authorized personnel), dated (continued on next page)

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	055989	A. Building B. Wing	04/30/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/25/2026 timed at 8 AM, the TO indicated that Physician 1 ordered IV ˆ5% Dextrose in Normal Salineˆ(solution with salt and glucose)ˆat 50 milliliters per hour (mL/hr, rate of infusion) for three days for low blood pressure.ˆˆ During a review of Resident 38's electronic physician orders, dated 4/25/2026 timed at 9:45 AM, the physician's order indicated that Physician 1 ordered IV 5% Dextrose in Normal Saline at 50 mL/hr for low blood pressure and poor intake for 3 days. During a review of Resident 38's electronic physician orders, another order was entered dated 4/25/2026 timed at 10:45 AM, the physician's order indicated Physician 1 ordered to administer IV 45% Sodium Chloride Solution (solution with salt) at 50 mL/hr for low blood pressure and poor oral intake. During a concurrent interview and record review conducted on 4/26/2026 at 3:10 PM with Registered Nurse (RN) 1, Resident 38's electronic Active Orders were reviewed. RN 1 stated that the telephone (TO) order had been written by RN 3. RN 1 further stated that she electronically transcribed the TO order, dated 4/25/2026, and backdated the time to 8:00 AM for the 5% Dextrose Normal Saline at 50 mL/hr as indicated in the TO order written by RN 3. RN 1 stated she entered this order into Resident 38's electronic medical record on 4/25/2026 at 9:45 AM. During the same concurrent interview and record review on 4/26/2026 at 3:15 PM with RN 1, Resident 38's electronic Active Orders, was reviewed. RN 1 stated, she received the phone call from Physician 1 for the order of 45% Normal Saline solution at 50 mL/hr. RN 1 stated, she disconnected the 5% Dextrose Normal Saline solution and administered the IV 45% Normal Saline solution ordered by Physician 1 to Resident 38. During a concurrent interview and record reviewˆonˆ4/26/2026 at 3:24 PMˆwithˆRNˆ3,ˆRN 3 reported that on 4/25/2026 at 8 AM, sheˆobservedˆResident 38ˆwas more drowsy than usual and decided to proactively start IV fluidsˆwithoutˆnotifyingˆPhysician 1 first beforeˆinitiatingˆthe IV therapy. RN 3 stated she wrote the telephone order herself and timed it at 8 AM to reflect when she began the IV.ˆˆRN 3ˆstatedˆsheˆselected the IV 5% Dextrose in Normal Saline becauseˆResident 38ˆwas diabetic, and she believed dextrose-containing fluids typically raise blood pressure more quickly.ˆ RN 3 stated that after initiating the IV therapy, she called Physician 1's office and left a voicemail to notify Physician 1 of Resident 38's change of condition. RN 3 stated she did not document Resident 38's change in condition of low blood pressure and poor intake in the resident's records on 4/25/2026. During an interview on 4/28/2026 at 9:30 AM with Physician 1, Physician 1 stated he did not prescribe IV solutions of 5% Dextrose Normal Saline at a rate of 200 mL/hr to be administered to Resident 38. Physician 1 stated, if the [licensed] nurses see a change of condition [in a resident], he expected the nurses to call me and notify me first. Physician 1 stated, he did not know why the 5% Dextrose Normal Saline Solution was administered to Resident 38 because Resident 38 was a known diabetic resident. Physician 1 stated, the 5% Dextrose Normal Saline Solution would increase her (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood glucose levels but he did not know by how much Resident 38's blood glucose levels would had increased because her blood glucose levels were not checked before or after the 5% Dextrose Normal Saline Solution was infused. During an interview on 4/28/2026 at 1:55 PM with the Director of Nursing (DON), the DON stated, RN 3 should not have administered the IV fluids without physician orders. The DON stated, it was nursing standards for RN 3 to notify Physician 1 of Resident 38's change in condition and to follow the physician's recommendation prior to initiating treatment. During a review of the facility's policies and procedures (P&P) titled Intravenous Therapy, dated 12/19/2022, the P&P^indicated^that^a physician's order is obtained before starting IV therapy.^^ During a review of the facility's P&P titled Medication Administration, dated 12/19/2022, the P&P^indicated^that medications are administered by licensed nurses,^or other staff who are legally authorized to do so in this state, as ordered by the physician.^ During a review of the same facility's P&P titled Notification of Changes, dated 12/19/2022, the P&P indicated that circumstances that require notification include^significant^changes in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status.^^ During a review of the facility's P&P titled Documentation in Medical Record, dated 12/19/2022, the P&P indicated that the principles of documentation included that false information shall not be documented and to record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. During a review the same facility's P&P titled Documentation in Medical Record, dated 12/19/2022, the P&P indicated that the documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. The P&P indicated that documentation shall be timely and in chronological order, and record date and time of entry. During a review of the California Nursing Practice Act, as codified in the Business and Professions Code and [NAME] Regulations, Registered Nurses (RNs) do not have authority to prescribe medications—their role is limited to administering medications and therapeutic agents only under the order of an authorized prescriber. During a review of the facility's job description titled Registered Nurse, date unknown, the job description^indicated^that the Registered Nurse's major duties and responsibilities included^observing^for changes in residents' status, notifying the physician and resident's family or representative and documenting accordingly.^ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the same facility's job description titled Registered Nurse, date unknown, the job description indicated that the Registered Nurse's major duties and administrations included transcribing physician orders to medical record and carries out orders as written, and preparing and administering medication as per physicians' orders and observes for adverse effects. 2. During a review of Resident 46's admission Record (AR), the AR indicated the facility admitted Resident 46 on 3/22/2026 with diagnoses that include urinary tract infection (UTI, an infection in any part of the urinary system (organs that produce and release urine, caused by bacteria) and Parkinson's disease (a progressive condition that affects movement). During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46's had moderately impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 46 required partial/moderate assistance with eating, oral hygiene and personal hygiene, and was dependent on toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 46's Order Summary Report, dated 4/26/2026, the report indicated the physician ordered to insert a Foley catheter on 4/1/2026. During a review of Resident 46's Physician's Order (PO), dated 4/7/2026, the PO indicated the physician ordered to discontinue Foley catheter on 4/10/2026 at 7 AM, then, obtain a bladder scan (a quick, painless, and non-invasive procedure used to measure the volume of urine in the bladder [an organ that hold urine], assessing how well it empties) every eight hours, if residual was greater than 250 milliliter (ML, a measurement unit), then, do in and out catheterization (a single-use, flexible tube inserted into the urethra to empty the bladder and then removed immediately). During a review of Resident 46's Change in Condition Evaluation (COC), dated 4/10/2026 timed at 9:30 AM, the COC indicated Resident 46's Foley catheter was discontinued per physician's order. The COC indicated the physician's recommendation was to monitor for urine output. Bladder scan, if residual is >250 ml do in and out catheter. During a concurrent observation and interview on 4/25/2026 at 1:23 PM, Resident 46 was lying on the bed with a Foley drainage bag hanging on the bed frame. Resident 46 stated she had a Foley catheter inserted for urination. During a concurrent interview and record review on 4/26/2026 at 11:33 AM with Licensed Vocational Nurse (LVN) 3, Resident 46's medical record was reviewed. LVN 3 stated there was an order to discontinue Resident 46's Foley catheter on 4/10/2026 and her Foley catheter was discontinued on 4/10/20206, but she currently has Foley catheter again. LVN 3 stated there was no documentation recording that physician ordered the re-insertion of foley catheter. LVN 3 stated it was confusing to the nurses what order to follow. During a concurrent interview and record review on 4/26/2026 at 12:04 PM with the Treatment Nurse (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(TXN), Resident 46's Physician Orders, dated 4/1/2026 to 4/26/2026, were reviewed. The TXN stated there was no documentation of a physician order to reˆinsert a Foley catheter after Resident 46's Foley catheter was removed on 4/10/2026. The TXN stated the Foley catheter was removed on the morning of 4/10/2026, but three hours later the resident reported she was unable to void and requested that the Foley catheter be reˆinserted, so the TXN reˆinserted a Foley catheter. The TXN stated Resident 46 had a Foley catheter in place prior to the removal on 4/10/2026, and the facility staff were aware of Resident 46's condition; therefore, she felt they did not need a new physician order for reˆinsertion of the Foley catheter on 4/10/2026. During an interview on 4/29/2026 at 1:43 PM with the Director of Nursing (DON), the DON stated that if a resident's Foley catheter was discontinued, the nurse should obtain a new physician order prior to reˆinsertion. The DON stated the nurse who obtained the physician order for the reˆinsertion of Resident 46's Foley catheter on 4/10/2026 did not transcribe the order into Resident 46's medical record. The DON stated it was a nursing standard of practice to transcribe all physician orders into the resident's medical record to ensure accurate documentation and to ensure the resident received consistent care while in the facility. During a review of the facility's policy and procedure (P&P) titled, Appropriate Use of Indwelling Catheters, dated 12/19/2022, the P&P indicated The use of an indwelling urinary catheter will be in accordance with physician orders. During a review of the facility's policy and procedure (P&P) titled, Registered Nurse Job Description, dated 2023, the P&P indicated registered nurse's major duties and responsibilities including transcribing physician orders to medical record. During a review of the facility's P&P titled, Licensed Vocational Nurse Job Description, dated 2023, the P&P indicated licensed vocational nurse's major duties and responsibilities including transcribing physician orders to medical record.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based onˆobservation,ˆinterview, and record review, the facility failed toˆensure to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, sufficient fluid intake to maintain proper hydration and health to two of two sampled residents (Residents 6 and 65) by failing to: 1.For Resident 65, who has had weight loss, the staff failed to monitor and document the percentage of intake of nourishments/snacks to indicate if the snacks were consumed or not as ordered by the physician and recommended by the Registered Dietician. 2.For Resident 6, who required peritoneal dialysis (PD, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) was not monitored to restrict fluid intake to 1500 milliliters (mL, unit of measure) as indicated in the Nutritional Assessment on 3/3/2026. These failures had the potential to place Resident 6 and Resident 65 to be at risk for altered nutritional or hydration status which may lead to severe dehydration or fluid overload which may result in a hypotensive (low blood pressure) or hypertensive (high blood pressure) blood pressure emergency, edema (swelling), shortness of breath, heart failure (heart cannot effectively pump blood to the rest of the body), unplanned weight loss or gain and may lead to hospitalization. ˆ Cross Reference with F698 ˆ Findings: 1.During a review of Resident 65's admission Record (AR), the AR indicated that Resident 65 was admitted on [DATE], with diagnoses that included muscle wasting and atrophy (the wasting or loss of muscle tissue caused by reduced protein and increased degradation), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and protein-calorie malnutrition (a condition caused by not eating enough food [calories] and protein to meet the body's needs). During a review of Resident 65's care plan (CP) titled The Resident Has Nutritional Problem dated 4/5/2026, the CP indicated the CP interventions for staff to provide, serve Resident 65 diet as ordered, monitor and record the resident's intake after every meal, and for the Registered Dietitian (RD) to evaluate and make diet change recommendations as necessary. During a review of Resident 65's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 4/7/2026, the MDS indicated that Resident 65 has severely impaired cognition (the ability to process thoughts). The MDS indicated that Resident 65 was dependent (helper does all the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and needed substantial/maximal assistance in personal hygiene, upper body dressing, oral hygiene, and eating. During a review of Resident 65's weight record for April 2026, the record indicated Resident 65 weighed 125 pounds (lbs., unit of weight) on 4/3/2026, and 122 lbs. on 4/24/2026, indicating that Resident 65 lost 3 lbs. in weight (2.4 % weigh loss) in 22 calendar days. During a record review of Resident 65's Order Summary Report (OSR), indicated a physician order on (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/15/2026 for Resident 65 to have dietary supplement snack two times a day between meals. During a review of Resident 65's Nutrition Nourishment intake documentation regarding the intake of snacks two separate occasions were documented given by Certified Nurse Assistants on 4/10/2026 and 4/21/2026. (documented by CNAs/RNAs) During an interview on 4/27/2026 at 9:32 AM with Registered Nurse 1 (RN 1), RN 1 stated that the weight loss of 3 lbs. was not reported to the physician because they still have another week to monitor weight loss and that it was also not reported to the Registered Dietitian. RN 1 stated that she does not know why the Certified Nurse Assistants (CNA's), Restorative Nurse Assistants (RNA's) are not recording the percentage intake of the snacks. During an interview on 4/27/2026 at 10:32 AM with CNA 6 stated that they do not document the percentage of intake of nourishments/snacks. During record review, there was no documented evidence that Resident 65's percentage intake for nourishments/snacks was monitored and documented. During an interview on 4/27/2026 at 10:34 AM with CNA 7 stated that CNAs do not document the percentage of intake or snacks stated that the CNA's do not give them to the residents stated the RNAs are the ones that give them to the residents. During an interview on 4/27/2026 at 10:36 AM RNA 1 stated that the RNAs are the ones responsible to pass out the snacks to the residents but do no document the intake. RNA 1 stated that most residents don't even like the snacks. RNA 1 stated that they do not report to the License Nurses when residents don't like or refuse snacks. During a record review of Resident 65's Dietary Preference, dated 4/27/2026 timed at 10:52 AM, the RD wrote that she interviewed Resident 65 and Resident 65 stated that he would like to have health shakes with his meals and fortified foods to help him not to lose weight. During an interview on 4/28/2026 at 2:42 PM with RD 1, RD 1 stated that her expectation is to be made aware when a resident is refusing or does not like snack. RD 1 stated that she expects nursing to be aware of the amount of intake of the snack. RD 1 stated that she needs to be made aware of issues with the snacks for early intervention. During an interview on 4/29/2026 at 9:18 AM with Director of Nurses (DON), DON stated that the expectation that staff assist residents with snacks and if not consuming to let nursing know with the purpose to prevent weight loss. DON stated that the CNA should document the amount of intake of the snack. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Weight Management Policy revised date 11/1/2024 indicated that the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as body weight. Interventions will be monitored and modified as appropriate consistent with choices, preferences, goals to maintain acceptable parameters of nutritional status. 2.During a review of Resident 6's admission Record (AR), the AR indicated that the facility admitted Resident 6 on 2/24/2026 with diagnoses that included End Stage Renal Disease (ESRD, irreversible kidney failure) and dependence on renal dialysis. During a review of Resident 6's history and physical (H&P), signed and dated on 2/27/2026, the H&P indicated that Resident 6 had the capacity to understand and make decisions. The H&P indicated that Resident 6 was diagnosed with ESRD on PD treatments. During a review of Resident 6's Minimal Data Set (MDS, a resident's assessment), dated 2/27/2026, the MDS indicated that Resident 6's cognitive (a person's thought process) was intact. The MDS indicated that Resident 6's active diagnoses included ESRD, and Resident 6 experienced shortness of breath when lying flat in bed. The MDS indicated that Resident 6 received PD treatments upon admission. During a review of Resident 6's care plan, revised 3/2/2026, the care plan indicated that Resident 6 needed PD related to ESRD. The care plan's interventions included a fluid restriction of 1500mL, with nursing providing 780 mL of fluids and dietary providing 720 mL and monitoring his intake and output. During a review of Resident 6's Nutritional Assessment record, dated 3/3/2026, the record indicated that Registered Dietitian (RD) indicated Resident 6's fluid restriction of 1500 mL each day. During a review of Resident 6's Order Summary Report, an order, dated 3/5/2026, indicated that Resident 6 had a fluid restriction of 1500 mL. The order indicated that Resident 6's total nursing fluid amount was 780 mL and total dietary fluid amount was 720 mL with meals. During a review of Resident 6's Order Summary Report, an order, dated 4/2/2026, indicated that Resident 6 received PD treatment with 2.5% Dextrose for 5 cycles with a fill volume of 2700 mL. The treatment was prescribed for 9.5 hours and started each evening at 7 PM. The treatment started 4/2/2026. During a concurrent observation and interview on 4/25/2026 at 11:19 AM in Resident 6's room, Resident 6 was observed lying in bed and his water pitcher and cup on top of his overbed table (portable table with lockable wheels designed to slide over the bed or chair) on the right side of his bed. Resident 6 stated that he receives PD 10 hours a day, 7 days a week in the facility. Resident 6 stated that he was able to drink 1000 mL to 2000 mL of fluids a day. Resident 6 stated, he does not know how much liquids he drinks and only takes sips here and there really. (continued on next page)

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	055989	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/28/2026 at 2:55 PM with RD 1, RD 1 stated that residents with fluid restrictions were expected to be monitored by nursing. RD 1 stated that nursing was aware of the total fluid intake per day calculation done by the RD. RD 1 stated, it was important for nursing to know the fluid intake of the resident and to verify that the resident was compliant with the fluid restrictions. RD 1 stated that if a resident was not compliant with the fluid restrictions, the resident was at risk for complications such as fluid retention and fluid overload. During a concurrent interview and record review 4/29/2026 at 11:02 AM with Certified Nurse Assistant (CNA) 6, Resident 6's CNA Nutrition – Amount Eaten record, dated for April 2026, was reviewed. CNA 6 stated, the only documentation to monitor for Resident 6's food and liquid intake collectively was in the CNA Nutrition – Amount Eaten record. CNA 6 stated that there was no separate documentation to monitor the specific amount of liquid intake Resident 6 had at mealtimes. CNA 6 stated, she was not aware that Resident 6 was on fluid restrictions. During a concurrent interview and record review on 4/29/2026 at 11:32 AM with Licensed Vocational Nurse (LVN) 5, Resident 6's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2026 was reviewed. LVN 5 stated that there was no monitoring on the MAR and TAR related to Resident 6's fluid restriction. LVN 5 stated, Resident 6 was able to drink as much fluid as he wanted. LVN 5 stated, she was not aware that Resident 6 had any fluid restriction orders. During an interview on 4/29/2026 at 3:15 PM with the Director of Nursing (DON), the DON stated, since Resident 6 was a PD patient, it was important to monitor his fluid intake and verify that he was compliant with the fluid restrictions. The DON stated, if a resident was not compliant with the fluid intake, the resident was at risk for fluid overload. During the same concurrent interview and record review on 4/29/2026 at 3:20 PM with the DON, Resident 6's MAR and TAR, dated for April 2026, was reviewed. The DON stated that there was no monitoring of Resident 6's fluid intake by nursing. During a review of the facility's policies and procedures (P&P) titled Fluid Restrictions, dated 12/19/2022, the P&P indicated that it is the policy of this facility to ensure that fluid restrictions will be followed in accordance with physician's orders. The P&P indicated that the restriction of fluids may be due to underlying medical conditions that may cause fluid build-up such as ESRD and electrolyte imbalance disorders. During a review of the same facility's P&P titled Fluid Restrictions, dated 12/19/2022, the P&P indicated that the fluid restriction distribution will take into consideration the amount of fluid to be given at mealtimes, snacks, and medication passes. The P&P indicated that water will not be provided at bedside unless calculated into the daily total fluid

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store drugs and destruct biologicals in accordance with the facility's policy and procedure titled Medication Storage and Destruction of Unused Drugs when unknown white medication tablet was found on the floor in one of the two medication rooms. This deficient practice resulted in unsafe storage of the medication and had the potential to result in medication errors and misuse. During an observation Medication Room (MR) and concurrent interview with Licensed Vocational Nurse (LVN) 2 on [DATE] at 5:22 AM, a white round unknown medication tablet was found on the floor. LVN 2 stated she did not know what medication it was and why the tablet was on the floor. LVN 2 stated nurses should check the MRs for any loose tablets and discard medication tablet into the Medication Disposable bin to prevent medication errors.^ During an interview on [DATE] at 1:46 PM with the Director of Nursing (DON), the DON stated that nurses are required to check the medication rooms each shift to ensure no loose medications are present. The DON explained that any loose or unknown tablets found on the floor should be discarded in the Medication Disposal bin for distraction according to facility's policy to prevent contamination and medication errors. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated [DATE], the P&P indicated the facility to ensure all medications housed on the premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. During a review of the facility's P&P titled, Destruction of Unused Drugs, dated [DATE], the P&P indicated All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations. The P&P also indicated Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the arbitration agreement (AA, a written contract where parties agree to settle disputes privately through a neutral third party [an arbitrator] rather than in a public courtroom) was adequately explained so the resident or their responsible party (RP) could understand its terms for one of three sampled residents (Resident 65) by failing to inform Resident 65's RP that he had 30 days after signing to fully review the agreement and rescind any agreement if it was not understood at the time of admission. This deficient practice has the potential to affect Resident 65's and the resident's RP's right to make informed decisions and choices about important aspects of the resident's health, safety and welfare. Findings: During a review of Resident 65's admission Record (AR), the AR indicated that Resident 65 was admitted on [DATE], and Resident 65's RP was Family Member (FM 1). The AR indicated that Resident 65 was admitted with diagnoses that included encephalopathy (a temporary brain dysfunction caused by a chemical imbalance in the body). During a review of Resident's 65 History and Physical Examination (H&P), dated 4/4/2026, the H&P indicated that Resident 65 does not have the capacity to understand and make decisions. During a review of Resident 65's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/7/2026, the MDS indicated that Resident 65 has severely impaired cognition (the ability to process thoughts). The MDS indicated that Resident 65 was dependent (helper does all the effort) in toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, and needed substantial/maximal assistance in personal hygiene, upper body dressing, oral hygiene, and eating. During a review of Resident 65's Arbitration Agreement (AA), dated 4/9/2026, the AA indicated that FM 1 signed the agreement. During an interview on 4/29/2026 at 10:50 AM with FM 1, FM 1 stated that he signed the AA but did not receive a copy of the AA. FM 1 stated that the facility did not inform him that the AA was not required for admission and that he could rescind within 30 days after signing it. FM 1 stated that he thought that it was part of the admission agreement. During an interview on 4/29/2025 at 12:35 PM with Business Office Assistant (BOA 1), BOA 1 stated that he explains to the residents and their RPs that the AA is a [NAME] who decides the outcome instead of a jury (a group of ordinary people chosen from the community to hear evidence during a trial and decide the truth). BOA 1 stated that they (the resident and RP) normally understand and BOA 1 did not have to explain further. BOA 1 stated he did not know and did not inform the residents and their RPs that the AA can be rescinded within 30 days. During an interview on 4/29/2026 at 12:39 PM with the Business Office Manager (BOM), the BOM stated that BOA 1 is expected to explain the purpose of the AA, inform residents and their RPs that signing the AA is optional and not required for admission, and clarify that they have 30 days to change their mind and cancel the agreement. The BOM stated that she was not aware that BOA 1 did not know that the AA could be rescinded within 30 days. The BOM added that it is important for BOA 1 to be knowledgeable when explaining the AA to the residents or their RPs, so they fully understand what they are signing. During a review of the facility's policy and procedure (P&P) titled Binding Arbitration Agreement revised 12/19/2022, the P&P indicated that when explaining arbitration agreement, the facility shall explicitly inform the resident of his or her representative of his or her right not to sign the agreement as a condition of admission or that is a requirement to receive care at the facility.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and record review, the facility failed to ensure call light was within reach for five of five sampled residents (Resident 46, . The deficient practices had potential for Resident 46 not being able to call the facility staff to ask for help or assistance, especially during emergencies. During a review of Resident 46's admission Record (AR), the AR indicated the facility admitted Resident 46 on 3/22/2026 with diagnoses that included displaced fracture of base of neck of right femur (right hip fracture) and Parkinson's disease (a progressive condition that affects movement). During a review of Resident 46's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 3/26/2026, indicated Resident 46's had moderately impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 46 required partial/moderate assistance with eating, oral hygiene and personal hygiene, and was dependent on toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a concurrent observation and interview on 4/25/2026 at 1:20 PM, Resident 46 was in her room with the door closed, making her not visible from the hallway. Resident 46 was sitting in bed with the head of the bed elevated more than 60 degrees. Resident 46 stated she needed a tissue but could not reach it, and she was unable to call staff because she did not know where her call light was. The call light cord was observed hanging over the headboard, out of her reach. During a concurrent observation and interview on 4/25/2026 at 1:21 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she forgot to put Resident 46's call light within the resident's reach after she showered her in the morning. CNA 1 stated it was important to keep the call light within residents' reach to ensure they get the help they needed. During an interview on 4/292026 at 1:49 PM with the Director of Nursing (DON), the DON stated the call light should be within residents' reach at all times to ensure their needs were met and their safety. During a review of the facility's Policy and Procedure (P&P) titled, Call lights: Accessibility and Timely Response, dated 12/19/2022, the P&P indicated The call system will be accessible to residents while in their bed .within the resident's room.