STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain an informed consent from a resident's responsible party for one of five sampled residents (Resident 79). This failure had the potential to result in violating the resident's right to be informed and refuse treatment. Findings: During a review of Resident 79's admission record, the admission record indicated Resident 79 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (damage or disease that affects brain function) and dementia (a progressive state of decline in mental abilities). During a review of Resident 79's History and Physical (H&P), dated 1/20/2025, the H&P indicated Resident 79 did not have the capacity to understand and make own medical decisions. During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool), dated 5/7/2025, the MDS indicated had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision assistance when eating, required moderate assistance (helper does less than half the effort) when bathing and dressing, and was dependent (helper does all the effort) when toileting. During a concurrent interview and record review on 6/25/2025 at 9:17 a.m. with the Infection Prevention Nurse (IPN), Resident 79's Vaccine Consent form dated 1/30/2025, and admission Interdisciplinary Team (IDT - a group of medical professionals from different disciplines who work together to help a resident achieve their goals) Meeting documents were reviewed. The IPN stated Resident 79 was admitted on [DATE] and the Vaccine Consent form indicated the IDT gave consent for the pneumococcal (bacteria causing pneumonia and other respiratory infections) vaccine and Respiratory Syncytial Virus (RSV- a common respiratory virus) vaccine on 1/30/2025. The admission IDT Meeting dated 1/31/2025 indicated Resident 79's responsible party was involved in the meeting. The IPN stated when the consent was obtained on 1/29/2025, the facility did not know Resident 79 had a responsible party. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/2025 at 12:10 p.m. with Social Services (SS), Resident 79's medical record was reviewed. SS stated Resident 79's hospital referral packet (documentation received from the hospital prior to admission to the facility) indicated the name and contact information for Resident 79's responsible party listed under patient information. SS stated the facility only uses an IDT Consent if a resident does not have capacity and there is no responsible party or conservator for the resident. SS stated the responsible party should have given the consent for Resident 79's vaccine consent. During an interview on 6/26/2025 at 4:25 p.m. with the Director of Nursing (DON), the DON stated IDT consents are when the IDT team is temporarily assigned to a resident who does not have the capacity make decisions until a designated person can act on their behalf. The DON stated that if there is a responsible party, the responsible party should give the consent for care. The DON stated it is the resident and their responsible party's right to be informed and make decisions about the resident's care. During a review of the facility's policy and procedure (P&P), titled Health, Medical Condition and Treatment Options, Informing Residents of, dated February 2021, the P&P indicated Each resident is informed of his/her total health status and medical condition, including diagnosis, treatment recommendations and prognosis, in advance of treatment and on an on-going basis. If a resident has an appointed representative, the representative is also informed. The Resident's attending physician, the facility's medical director, or the director of nursing services is responsible for informing the resident of his or her medical condition. Such information includes providing the resident/representative with information about the residents: i. type of care or treatment recommended, k. risk and benefits of proposed care or treatment, l. treatment alternatives or options, n. right to discontinue or refuse care of treatment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure that the call light device was within reach for one of six sampled residents (Resident 41). This deficient practice had the potential to prevent Resident 41 from receiving necessary care and services. Findings: During a review of Resident 41's admission Record, the admission Record indicated the facility admitted Resident 41 on 5/10/2025 with diagnoses including Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), diaphragmatic hernia (birth defect where there is an abnormal opening in the diaphragm [muscle separating the chest and abdomen]), and lack of coordination (ability to use different parts of the body together smoothly and efficiently). During a review of Resident 41's Minimum Data Set (MDS, a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 41 had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 41 required supervision or touching assistance for eating, substantial/maximal assistance for oral hygiene, personal hygiene, and rolling to both sides and was dependent for bathing, dressing, and toilet hygiene. The MDS indicated Resident 41 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand). During an observation and interview on 6/24/2025 at 12:40 pm, in the resident's room, Resident 41 was lying in bed eating from a plate placed on the bedside table to the right of Resident 41's bed. Resident 41 spilled food onto the right side of her upper gown while trying to eat. Resident 41 stated she needed help cleaning the food off the gown and changing clothing since her gown was dirty. Resident 41 looked around the bed and was unable to find the call light to ask for assistance. Resident 41's call light cord and device were laying on the oxygen concentrator machine (machine that supplies oxygen) on the right side of Resident 41's bed which was located over one foot away from Resident 41's bed. Resident 41 stated she could not reach the call light and did not know how to call staff for assistance. During an observation and interview on 6/24/2025 at 12:48 pm, in the resident's room, Certified Nursing Assistant 6 (CNA 6) confirmed Resident 41's call light was out of reach and Resident 41 would be unable to call for nursing assistance if needed. CNA 6 stated she placed Resident 41's call light on the oxygen concentrator machine in the morning while providing nursing care and forgot to place it within Resident 41's reach when she finished. CNA 6 stated Resident 41's call light should have been clipped to the bed and resting over Resident 41's right shoulder to ensure the call light was accessible. CNA 6 stated it was important call lights were always within a resident's reach to ensure the resident would be able to call for assistance if needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2025 at 4:14 pm, the Director of Nursing (DON) stated call lights should always be accessible and within the resident's reach. The DON stated that if the call light was not within the resident's reach, the resident would be unable to call for assistance to get his or her needs met. During a review of the facility's Policy and Procedure (P/P) titled, Answering the Call Light, revised 10/24/2024, the P/P indicated the call light was to be accessible to the resident when in bed to ensure timely responses to the resident's requests and needs.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the medical doctor (MD) was notified when one out of two residents (Resident 71) had multiple blood sugar levels that were over 400 milligram ([mg]unit of measure weight])/deciLiter (dl unit of measure of volume) (reference range 70 and 100 mg/dL). This deficient practice had the potential to cause a delay in treating the elevated blood sugar levels for Resident 7, and risk transfer to the general acute care hospital (GACH) for treatment of high blood sugar. Findings: During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood effectively, leading to a buildup of waste and excess fluid in the body), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), depression (mental illness that causes persistent feelings of sadness and loss of interest), and dementia (a progressive state of decline in mental abilities). During a review of Resident 71's Minimum Data Set ([MDS], a resident assessment tool) dated 4/4/2025, the MDS indicated Resident 71 was moderately impaired in cognitive (thinking process) skills and required set up assistance (helper sets up while resident completes the activity) with self-care skills like eating, required moderate assistance (helper does less than half the effort) with oral hygiene, and upper body dressing, required maximal assistance (helper does more than half the effort) with shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene, was dependent (helper does all of the effort) with toileting hygiene. The MDS also indicated Resident 71 required maximal assistance with mobility like rolling left and right, sitting to lying position, lying to sitting on side of bed, sitting to stand position, bed to chair transfer, and was dependent on shower transfers. During a review of Resident 71's Order Summary Report, the Order Summary Report indicated Humalog solution 100 units/milliliter (medication used to treat elevated blood sugars) inject as per sliding scale (physcian set criterea of how much insulin to administer) : if blood sugar level is 0-150= administer 0 units of Humalog call MD if blood glucose is less than 70; if blood sugar level is 151-200= administer 2 units; if blood sugar level is 201-250= administer 4 units; if blood sugar level is 251-300= administer 6 units; if blood sugar level is 301-350=administer 8 units; if blood sugar level is 351and above = administer 10 units. The Order Summary Report indicated to call MD immediately for further instruction Resident 71's blood sugar level is greater than 400, administer subcutaneously (right below first layer of skin tissue), adminster before meals and at bedtime for sliding scale insulin coverage for diabetes. must take finger stick (test administered to check blood sugar levels) blood glucose prior to administration, ordered on 7/28/2024. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 71's comprehensive care plan, initiated on 1/27/2025, the comprehensive care plan indicated a focus that Resident 71 has a high risk for hypo/hyperglycemia (low or high blood sugar) related to diagnosis of type 2 DM with a goal that Resident 71 would be free of all signs and symptoms of hypo-hyperglycemia such as sweating, trembling, thirst, fatigue, weakness, blurred vision through next review date with interventions to monitor for signs and symptoms of hyper/hypoglycemia and report abnormal findings to physician. During a review of Resident 71's Medication Administration Record (MAR) for April 2025, the MAR indicated Resident 71 had high blood sugar levels of 422 mg/dl on April 4th at 9 p.m., 451mg/dl on April 16th at 11:30 p.m., 401mg/dl on April 21st at 11:30 p.m., and 437 mg/dl on April 28th at 4:30 p.m During a review of Resident 71's Nurse Progress Notes for April 2025, the Nurse Progress Notes did not indicated that MD was notified of any high blood sugar levels for April 2025. During a review of Resident 71's medical records for change of condition assessments, Resident 71's medical records did not indicate there was any change of condition documentation and that the MD was notified of the high blood sugar levels for April 2025. During a concurrent interview and record review on 6/26/2025 at 10:35 a.m., with the MDS Coordinator (MDSC), the MAR for April 2025, the nurse progress notes and change of condition assessment were reviewed. The MDSC stated if a resident had a high blood sugar level, staff should check the physician's orders, and give insulin as needed. The MDSC stated staff should be checking vital signs (medical tests to assess basic body functions) to make sure residents were okay, call the MD, and do the change of condition assessment. The MDSC stated the staff did not notify the MD of Resident 71's high blood sugar levels and there was no change of condition documented for the high blood sugar levels even though there was an order to notify the MD immediately. The MDSC stated Resident 71 would have signs and symptoms of high blood sugar (such as unquenchable thirst, fatigue, etc) and the diabetes would be uncontrolled if not treated properly. During an interview on 6/26/2025 at 3:24 p.m., with the Director of Nursing (DON), the DON stated staff should be checking blood sugar levels to make sure blood sugars are within normal range and that the MD should be notified if two consecutive blood sugars were above 250. The DON stated staff should notify the MD of a change of condition, so the staff knows what to do and how to treat the residents based on what the MD orders are. The DON stated if the MD was not aware of the high blood sugar levels, the blood sugars would continue to be high, and the resident may have to be transferred out to the hospital to get treated for high blood sugar. During a review of the facility's policy and procedures (P/P) titled, Change in Condition: Notification of, dated 8/25/2021, indicated the purpose was to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition a facility must immediately inform the resident, consult with the Resident's physician and/or NP, and notify, consistent with his/her authority, Resident Representative where there is: 1. A significant change in the Resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). 2. A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on interview and record review, the facility failed to ensure one out of five sampled residents (Resident 38) had the mental capacity (the ability to make an informed decision based on understanding a situation, the options available, and the consequences of the decision) to sign an informed consent (permission granted in the knowledge of the possible consequences, typically that which is given by a patient to a doctor for treatment with full knowledge of the possible risks and benefits) for his psychotropic (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medications. This deficient practice had the potential for Resident 38 to sign consent for a psychotropic medication without being aware of the risks and benefits. B. Based on interview and record review, the facility failed to ensure Resident 69's clonazepam (a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) order indicated a clinical reason for extending it beyond 14 days, and indicated a specific duration of treatment and/or stop date for an as needed (PRN) order, affecting one of four residents reviewed for unnecessary medications. This deficient practice had the potential to place Resident 69 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug for an extended period, which could result in impairment or decline in the resident's mental, physical condition, functional, and psychosocial status. Findings: A.During a review of Resident 38's admission Record (face sheet), the admission Record indicated Resident 38 was admitted to the facility 12/17/2024 with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) unspecified intellectual disabilities (limitations on intelligence, learning and everyday abilities necessary to live independently), and cognitive communication deficit (trouble participating in conversations). During a review of Resident 38's History and Physical (H&P) dated 12/17/2024, the H&P indicated Resident 38 was incapable of making medical decisions. During a review of Resident 38's minimum data set (MDS, a minimum data set) dated 3/21/2025, the MDS indicated Resident 38 had severe cognitive impairment (have problems remembering things, concentrating, making decisions and solving problems) and was taking antipsychotic and antidepressant medications. During a review of Resident 38's Psychotropic Medication Administration Disclosure (Anti-psychotic (used to treat psychosis [lose some contact with reality]) dated 3/18/2025, the Psychotropic Medication Administration Disclosure indicated Resident 38 signed his own consent for Uzedy (medication used to treat schizophrenia) subcutaneous (just under the skin) injection 250 milligrams (mg, a unit of measurement)/ 0.7 milliliters (ml, a unit of measurement) every 60 days for schizophrenia. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 38's Psychotropic Medication Administration Disclosure (Anti-Depressant (helps treat depression [persistent feelings of sadness and loss of interest])) dated 6/1/2025, the Psychotropic Medication Administration Disclosure indicated Resident 38 signed his own consent for Mirtazapine (antidepressant medication) Oral Tablet 15 mg every night at bedtime (QHS) for depression. During an interview on 6/26/2025 at 4:06 p.m., with the Director of Nurses (DON), the DON stated Resident 38 signed his psychotropic informed consents, but he did not have capacity to do so according to Resident 38's H&P. The DON stated informed consents were important to understand because it explained the risks and benefits of the medication. The DON stated if residents do not have capacity and no family members to help with decisions, the interdisciplinary team (IDT, a group of healthcare providers from different fields who work together to provide the best care or best outcome for a patient) should be signing the consents. The DON stated the potential outcome of a resident signing an informed consent without capacity made the consent invalid. B. During a review of Resident 69's admission Record (a document containing demographic and diagnostic information), dated 6/26/2025, the admission record indicated, Resident 69 was originally admitted to the facility 5/30/2024 and then readmitted on [DATE] with diagnoses including but not limited to unspecified dementia (progressive state of decline in mental abilities) - unspecified severity without behavioral disturbance, psychotic disturbance or mood disturbance and anxiety, anxiety disorder and depression. During a review of Resident 69's History and Physical, dated 5/27/2025, the document indicated Resident 69 was not capable of making medical decisions. During a review of Resident 69's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/20/2025, the MDS indicated Resident 69 needed supervision level assistance from facility staff for Activities of Daily Living (ADLs) such as eating, maximal assistance for oral hygiene and dependent for toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. During a review of Resident 69's Order Summary Report (a document containing a summary of all active physician orders), dated 6/26/2025, the order summary report indicated but not limited to the following physician orders: Clonazepam oral tablet 0.5 milligrams ([mg] a unit of measurement for mass), give 0.5 mg by mouth every 8 hours as needed for manifested by (m/b) striking out at staff unprovoked for no apparent reason related to anxiety disorder, order date 5/1/2025, start date 5/1/2025. During a concurrent interview and record review on 6/26/2025 11:53 a.m. with Licensed Vocational Nurse (LVN) 1, the order details, dated 5/1/2025 for Resident 69's clonazepam 0.5 mg were reviewed. The order details for clonazepam 0.5 mg indicated, indefinite for end date and did not indicate any specific duration of treatment. LVN 1 stated there should have been a discontinuation date or a duration of 14 days for clonazepam 0.5 mg PRN and for any PRN orders. LVN 1 stated the prescriber should explain the reason if they needed to continue the PRN psychotropic medication beyond 14 days duration. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/2025 at 1:46 p.m. with the facility's Consultant Pharmacist (RPH 1), RPH 1 stated Resident 69's clonazepam 0.5 mg did not have a stop date which was started on 5/1/2025. RPH 1 stated there should have been a stop date after the facility decided to restart the medication as a new order after March 2025. RPH 1 stated she had informed the facility on previous order in March 2025 to indicate a stop date. RPH 1 stated the order for PRN clonazepam or an anxiolytic (a medication used to treat anxiety) must have a duration of 60 or up to 90 days per regulations and facility might have their own policy regarding 60 or 90 days. RPH 1 stated, There was no risk at the time for Resident 69, especially because facility still had 60 to 90 days. RPH 1 stated, if nobody caught the issue in 90 days, then there was a potential risk. At this time, in my opinion, there is no risk for the resident, because the resident is receiving the medication as needed and this resident has other psych issues. During an interview on 6/26/2025 at 4:07 p.m. with the Director of Nursing (DON), DON stated there should have been a stop date for PRN medication orders because the resident should be reevaluated and the physician must write the reason for continuation. DON stated Resident 69 would be at risk for adverse effects from the medication such as drowsiness and sedation, would not be able to attend activities or benefit from the programs offered at the facility. DON stated if the consultant pharmacist failed to identify this issue during the monthly medication regimen review, it was the facility's responsibility to identify that Resident 69's clonazepam failed to have a specific duration or discontinuation date beyond 14-day treatment. During a review of the facility's policy and procedure (P&P), titled Psychotropic Medication Use, dated 6/2021, the P&P indicated, PRN orders for psychotropic drugs are limited to 14 days. a. For psychotropic prn medications, excluding antipsychotics, if the attending physician or prescribing practitioner believes it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration of the PRN order. The P/P indicated the facility was to verify informed consent prior to the administration of psychotropic medications.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written 7-day bed hold notice for one of two sampled residents (Resident 87). This failure had the potential to result in violating Resident 87's right to be informed upon transfer of the bed-hold period permitting the resident to return to the facility. Findings: During a review of Resident 87's admission record, the admission record indicated Resident 87 was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including end stage renal disease (ESRD-irreversible kidney failure) with dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 87's History and Physical (H&P), dated 5/20/2024, the H&P indicated Resident 87 had the capacity to understand and make decisions. During a review of Resident 87's Minimum Data Set (MDS - a resident assessment tool), dated 5/27/2025, the MDS indicated Resident 87 was cognitively intact and required supervision when eating and toileting and required moderate assistance (helper does less than half the effort) for showering and dressing. During a review of Resident 87's census, the census indicated Resident 87 was transferred to the General Acute Care Hospital (GACH) on 6/13/2025. During an interview on 6/24/2025 at 3:01 p.m. with the Health Information Manager (HIM), the HIM stated there is no confirmation of transfer and bed hold provision (notification of bed hold) for the transfer of Resident 87 on 6/13/2025. During a concurrent interview and record review on 6/26/2025 at 12:47 p.m. with Registered Nurse (RN) 4, Resident 87's medical record was reviewed. RN 4 stated Resident 87 was transferred to the GACH on 6/13/2025. RN 4 stated there is no documentation indicating Resident 87 received a bed hold notice for 6/13/2025. RN 4 stated when a resident transfers to the GACH, a written bed hold notice is provided to the resident or responsible party, because it is the resident's right. During an interview on 6/26/2025 at 4:34 p.m. with the Director of Nursing (DON), the DON stated it is the residents' right to be informed in writing their bed in the facility will be held for 7 days. During a review of the facility's policy and procedure (P&P), titled Bed-Hold and Returns, dated October 2022, the P&P indicated All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided with written notice about these policies at least twice: (continued on next page)

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	055995	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. notice 1: well in advance of any transfer (e.g. in the admission packet); and b. notice 2: at the time of transfer (or, if the transfer awas an emergency, within 24 hours).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document the Minimum Data Set (MDS - a resident assessment tool) for three of 12 sampled residents by failing to: a. Ensure Resident 87's hemodialysis status was reflected on the MDS. b. Ensure Resident 111's accurate discharge destination was documented. c. Ensure the accuracy of information in the MDS assessment for one of three sampled residents (Resident 32) who was on oxygen therapy. This failure had the potential to negatively affect resident's plan of care and delivery of necessary care and services. Findings: During a review of Resident 87's admission record , the admission record indicated Resident 87 was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including end stage renal disease (ESRD-irreversible kidney failure) with dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 87's History and Physical (H&P), dated 5/20/2024, the H&P indicated Resident 87 had the capacity to understand and make decisions. During a review of Resident 87's MDS, dated [DATE], the MDS indicated Resident 87 required supervision when eating and toileting and required moderate assistance (helper does less than half the effort) for showering and dressing. During a review of Resident 87's Physician Order Summary, the Order Summary indicated Resident 87 received hemodialysis outside of the facility every Monday, Wednesday, and Friday. During a concurrent interview and record review on 6/25/2025 at 3:46 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 87's medical record was reviewed. The MDSC stated the MDS dated [DATE] did not indicate that Resident 87 was receiving dialysis. The MDSC stated Resident 87 receives hemodialysis and the MDS should have reflected it. The MDSC stated it was a miscoding on our part. The MDS stated it is important that the MDS reflects the resident's status at the time to ensure proper care planning for the resident. b. During a review of Resident 111's admission record , the admission record indicated Resident 111 was admitted to the facility on [DATE] with diagnoses including aortic dissection (a tear in the inner layer of the aorta [larges vessel that delivers blood form the heart to the rest of the body]) and nontraumatic subarachnoid hemorrhage (bleeding in space around the brain that is not caused by an injury). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 111's Minimum Data Set (MDS - a resident assessment tool), dated 4/12/2025, the MDS indicated was able to understand and be understood by others, required supervision when toileting, bathing, and dressing, and required setup assistance when eating. During a concurrent interview and record review on 6/25/2025 at 3:37 p.m. with the MDSC, Resident 111's medical record was reviewed. The MDSC stated the Discharge Plan Documentation indicated Resident 111 was discharged to the community (examples include home, apartment, board and care, assisted living, group home, or transitional living) on 4/12/2025. The MDSC stated the MDS dated [DATE] indicated that Resident 111 was discharged to an Acute Hospital. The MDSC stated the MDS should have reflected Resident 111 was discharged to home/community and it was a miscoding on our part. The MDS stated it is important that the MDS reflects the resident's status at the time to ensure proper care planning for the resident. c. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was originally admitted on [DATE] with a re-admission date of 12/13/2019 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (HTN-high blood pressure), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality. During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32 was rarely or never understood so the brief interview for mental status could not be conducted and was dependent (helper does all of the effort to complete the task) on self-care abilities like eating, oral hygiene, toileting and personal hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear. The MDS also indicated Resident 32 was dependent on mobility functions like rolling left and right, bed to chair transfers, and shower transfers. The MDS also indicated Resident 32 did not require oxygen therapy and did not need suctioning. During a review of Resident 23's Order Summary Report, the Order Summary Report indicated oxygen: oxygen at 1-5 liters/minutes ([L/min], unit of measurement) via nasal cannula (a medical device used to deliver oxygen through the nose) as needed for shortness of breath or wheezing (breathing with a whistling or rattling sound in the chest) every shift ordered on 1/17/2025. The Order Summary Report also indicated suction, oral as needed, secretions with tonsillar/yankauer (a medical device designed to suction fluids, blood, saliva, and debris from the oral cavity and airway) suction no deep suction ordered on 1/17/2025. During an observation on 6/23/2025 at 11:01 a.m. in Resident 32's room, Resident 32 was resting in bed with eyes closed. Resident 32 did not open their eyes when surveyor greeted the resident. Resident 32 was on 3.5 L of oxygen with breathing treatments and suctioning equipment at the bedside for use in which it was being utilized. During an interview and record review on 6/25/2025 at 3:17 p.m., with the MDS Coordinator (MDSC), the MDS dated [DATE] and Order Summary Report were reviewed. The MDSC stated that Resident 32 was on oxygen therapy according to the Order Summary Report. MDSC stated the MDS assessment for Resident 32 should have been coded yes for oxygen therapy use and suctioning use. MDSC stated if the MDS assessment was not coded correctly, the MDS assessment does not represent the care provided for the residents here at the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/2025 at 3:24 p.m., with the Director of Nursing (DON), the DON stated the importance of coding MDS assessment correctly for residents was the MDS was a representation of the care the resident's required and recieved at the facility and the type of care they need. DON stated if the MDS assessment was not coded accurately, it does not reflect the type of care needed for the residents and Center for Medicare Services ([CMS], a federal agency within the U.S. Department of Health and Human Services responsible for administering the Medicare and Medicaid programs) would not be receiving accurate information on the residents. During an interview on 6/26/2025 at 4:34 p.m. with the Director of Nursing (DON), the DON stated the MDS should be an accurate representation of the resident's health status and the care we provide. The DON stated if the MDS is not accurate, the care may be affected. During a review of the facility's policy and procedure titled, Resident Assessments, revised 10/2023, indicated, the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments .all members of the care team, including licensed and unlicensed staff members, are asked to participate in the resident assessment process .assessments are completed by staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of decline .all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information .information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement care plans for two of six sampled residents (Resident 60, Resident 67) when: a. The facility failed to ensure a care plan for Divalproex (medication to treat outbursts of aggression related to dementia and other behavioral disturbances) was developed and implemented for one of four sampled residents (Resident 60). This deficient practice placed Resident 60 at risk for physical harm and injury and had the potential to delay necessary monitoring and safety interventions. b. Resident 67 did not have a care plan in place for his use of Quetiapine Fumarate (Seroquel, medication used to treat psychosis [a mental state characterized by a loss of contact with reality]). These deficient practices had the potential for Resident 60, Resident 67 to not receive personalized care. Findings: a.During a review of Resident 60's admission Record, the admission Record indicated the facility admitted Resident 60 on 12/27/2022 and was re-admitted on [DATE], with a diagnoses including dementia (progressive state of decline of mental abilities), depression (a mental health condition characterized by persistent sadness and a loss of interest or pleasure in activities) and anxiety disorder (characterized by feelings of worry, nervousness, or unease, typically about an event or something with an uncertain outcome). During a review of Resident 60's Minimum Data Set (MDS - a resident assessment tool), dated 4/4/2025, the MDS indicated Resident 60's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 60 required minimal (helper sets up or cleans up; resident completes activity) assistance from staff for Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 60's History and Physical (H&P), dated 6/11/2025, the H&P indicated Resident 60 was unable make own decisions but can make needs known. During a review of Resident 60's physician order dated 10/23/2025, the physician order indicated an order for Divalproex oral tablet 250 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) by mouth three times a day for sudden angry outburst related to unspecified dementia with other behavior disturbances. During a concurrent interview and record review on 6/25/2025 at 3:09 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 60's care plans were reviewed. LVN 4 stated each resident needed to have care plans in place to be able to properly care and assess each resident. LVN 4 was uncare plan for Divalproex within Resident 60's chart. LVN 4 stated having a care plan for Divalproex was important to monitor parameters, potential side effects and have the appropriate interventions in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/26/2025 at 12:26 p.m. with the Director of Nursing (DON), the DON stated care plans are required for the entire care of the residents while at the facility. The DON care plans are required for every diagnosis a resident might have, and medications are incorporated into the care plans. The DON stated a care plan was needed for Divalproex to be able to appropriately monitor Resident 60 for any side effects or behavior changes while on Divalproex. DON stated without a care plan for Divalproex, Resident 60 cannot be monitored for potential side effects properly. During a review of the facility's policy and procedure (P&P) titled Care Planning- Interdisciplinary Team, dated 8/25/2021, the P&P indicated Our facility's Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .2. The care plan is based on the resident's comprehensive assessment and is developed by an Interdisciplinary Team which includes but is not necessarily limited to the following personnel .b. A Registered nurse with responsibility for the resident .h. The Charge Nurse responsible for the resident. b. During a review of Resident 67's admission Record, the admission record indicated Resident 67 was admitted to the facility 5/18/2025 with diagnoses of bipolar disorder (a mental illness that causes dramatic shifts in a person's mood, energy, and ability to think clearly) and restlessness and agitation. During a review of Resident 67's minimum data set (MDS, a minimum data set) dated 5/24/2025, the MDS indicated Resident 67 had severe cognitive impairment (have problems remembering things, concentrating, making decisions and solving problems) and was taking antipsychotic medications. During a review of Resident 67's Order Summary Report, the Order Summary Report indicated an order was placed 6/14/2025 for Quetiapine Fumarate Oral Tablet 25 milligrams (mg, a unit of measurement), give one tablet two times a day for bipolar disorder manifested by (m/b) disorganized thought process. During a concurrent interview and record review of Resident 67's care plans on 6/26/2025 at 2:26 p.m., with the Director of Nursing (DON), the DON stated Resident 67 did not have a care plan for the use of Seroquel but should have one because he was taking the medication. The DON stated care plans for antipsychotic medication were important so the facility could monitor side effects of the medication and to check if interventions were effective. During a review of the facility's policy and procedure (P/P) titled Care Plan Comprehensive dated 8/25/2021, the P/P indicated each resident's comprehensive care plan was designed to incorporate identified problem areas, and reflect treatment goals, timetables, and objectives in measurable outcomes.

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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 ensure that Licensed Vocational Nurse (LVN) 1 did not crush delayed release ([DR] medication released over an extended time) divalproex (a medication used to treat seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) and did not administer crushed divalproex delayed release and crushed lorazepam (a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) together for one of three sampled residents (Resident 2) during medication administration observation. This deficient practice had the potential to place Resident 2 at risk for drug interactions (occur when two or more drugs taken simultaneously affect each other's actions in the body) or intolerability to one or more medications without possibly knowing which medication caused intolerability. Findings: During a review of Resident 2's admission Record dated 6/24/2025, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including, but not limited to, dysphagia (difficulty swallowing) oral phase. During a review of Resident 2's History and Physical, dated 6/19/2025, the document indicated Resident 2 was unable to make medical decisions for herself but could make needs known. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 3/24/2025, the MDS indicated Resident 2 was dependent on the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. During a concurrent observation and interview on 6/24/2025 at 8:38 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared the following two medications for Resident 2. 1. One tablet of lorazepam 0.5 milligrams ([mg] a unit of measurement for mass) 2. One tablet of divalproex sodium DR 125 mg LVN 1 stated she would need to crush both medications for the resident. LVN 1 was observed crushing divalproex DR and lorazepam separately using a crushing device. LVN 1 then mixed the powders of divalproex DR and lorazepam together in one cup and administered with applesauce to Resident 2. During a medication reconciliation review on 6/24/2025 at 10:58 a.m., Resident 2's Order Summary Report (a document containing a summary of all active physician orders), dated 6/24/2025, the order summary report indicated, but not limited to the following physician orders: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Depakote (generic name - divalproex) oral tablet delayed release 125 mg, give 1 tablet by mouth two times a day for manifested by (m/b) rapid mood cycling related to schizophrenia (a mental illness that is characterized by disturbances in thought), unspecified as evidenced by (AEB) rapid shifts in mood from pleasant to extreme anger AEB yelling/screaming, order date 4/29/2025, start date 4/29/2025. Ativan (generic name - lorazepam) oral tablet 0.5 mg, give 1 tablet by mouth every 6 hours as needed for anxiety until 7/8/2025 23:59 for behavior manifestation by yelling and screaming, order date 6/23/2025, start date 6/23/2025, end date 7/8/2025. During a review of Resident 2's Speech Therapy Treatment Encounter Note(s), dated 5/14/2025, the document indicated, Precautions: soft bite size textures; aspiration/penetration risk. Patient has met baseline function given tolerance of soft bite size diet across consecutive sessions and will not be discharged from ST services. Current Diet = Mechanical Soft textures, Current Liquids = Thin liquids. During an interview on 6/24/2025 at 2:41 p.m., with LVN 1, LVN 1 stated she realized right after she was questioned about the crushing that it was not supposed to be crushed. LVN 1 stated the medications should have been given separately to be able to differentiate medications if Resident 2 did not tolerate one of the medications. LVN 1 stated divalproex was a delayed release tablet and should not have been crushed. LVN 1 stated the medication would not be as effective for the resident's condition and had the possibility to cause throat irritation. During an interview on 6/25/2025 at 3:14 p.m., with the Director of Nursing (DON), DON stated Resident 2 should have received divalproex delayed release and lorazepam tablets as whole tablets. DON stated it was not safe to crush delayed release divalproex and Resident 2 should have been able to swallow this medication because she was sitting upright. DON stated the two different crushed medications should not have been given together because of possible drug interactions. DON stated if the resident did not tolerate one of the medications, and they were given together, facility would not have known which medication was not tolerated by the resident. During a review of the facility's policy and procedure (P&P) titled Appendix 5: Medication Crushing Guidelines, undated, the P&P indicated, Timed Release Tablets are designed to release medication over a sustained period, usually 8 to 24 hours. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases. In either case these tablets should not be crushed. During a review of the facility's P&P titled, Administering Medications, undated, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P indicated, If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified the person preparing or administering the medication will contact the prescriber discuss the concerns. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time before giving the medication.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: A. One of six sampled residents (Resident 41) was sitting upright when eating lunch. This deficient practice placed Resident 41 at risk for aspiration (inhaling small particles of food or drops of liquid into the lungs) and choking. B. Two of three residents (Resident 45) were transferred by two persons in a mechanical lift (a mechanical device used to safely transfer individuals who have limited mobility from one place to another). This deficient practice had the potential to result in Resident 45 falling from the mechanical lift and causing injury. Findings: A. During a review of Resident 41's admission Record, the admission Record indicated the facility admitted Resident 41 on 5/10/2025 with diagnoses including Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), diaphragmatic hernia (birth defect where there is an abnormal opening in the diaphragm [muscle separating the chest and abdomen]), and lack of coordination (ability to use different parts of the body together smoothly and efficiently). During a review of Resident 41's Minimum Data Set (MDS, a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 41 had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 41 required supervision or touching assistance for eating, substantial/maximal assistance for oral hygiene, personal hygiene, and rolling to both sides and was dependent for bathing, dressing, and toilet hygiene. The MDS indicated Resident 41 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms (shoulder, elbow, wrist, hand). During a concurrent observation and interview on 6/25/2025 at 12:29 pm, in the resident's room, Resident 41 was lying in bed. Certified Nursing Assistant 6 (CNA 6) walked into Resident 41's room, placed a lunch tray on Resident 41's bedside table, angled the table toward Resident 41's bed, asked Resident 41 if she could reach the food, and left the room. Resident 41's body was positioned low in the bed with the upper body slouched forward. The head of Resident 41's bed was slightly elevated to less than 30 degrees. While lying in bed, Resident 41 drank water and ate a hashbrown from the plate and coughed. Resident 41 stated she was uncomfortable and tried to elevate the head of bed using the bed control but was unable since Resident 41's body was positioned very low in the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/25/2025 at 12:35 pm, CNA 6 confirmed Resident 41 was eating lunch laying down with the head of bed slightly elevated. CNA 6 confirmed she saw Resident 41 laying down before dropping off the lunch tray and did not ask Resident 41 if she wanted to be repositioned into an upright position. CNA 6 stated Resident 41 should be seated in an upright position and should not be laying down with the head of bed slightly elevated while eating because she could choke. During a telephone interview on 6/25/2025 at 2:54 pm, the Speech Therapist 1 (ST 1) stated residents should always be seated upright while eating. ST 1 stated the ideal and recommended body position for eating was the upper body fully upright with the head of bed at a 90-degree angle and no slouching to minimize the risk of aspiration and choking. ST 1 stated eating while laying down could potentially cause choking and aspiration. During an interview on 6/26/2025 at 4:14 pm, the Director of Nursing (DON) stated all residents should be seated upright while eating to prevent choking and aspiration. During a review of the facility's Policy and Procedure (P/P) titled Preparing and Positioning a Resident for a Meal, revised 9/2010, the P/P indicated residents whose meals were served in bed should be properly positioned by using wedges and pillows to achieve an upright position. B.During a review of Resident 45's admission Record, the admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including unspecified atrial fibrillation (an irregular heartbeat present but the type is not specified), contracture of muscle, multiple sites (several of the muscles became permanently tight and shortened restricting movements of joints), and abnormal posture. During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were severely impaired. The MDS indicated Resident 45 was dependent on eating, chair/bed to chair transfer, lying to sitting on side of bed, sitting to lying, upper and lower body dressing and oral hygiene. During review of Resident 45's care plan (CP) initiated on 4/18/2024, the CP indicated Resident 45 has functional limitation in range of motion (a reduced ability to move a joint through its normal range) Bilateral (both) Upper Extremities (BUE both arms , shoulders, elbows and hands) impaired and Bilateral Lower Eextremities (both legs from the hips down to the feet) impaired with interventions for chair / bed to chair transfer- dependent assist using mechanical lift transfer with 2 person assist. During an observation on 6/23/2025 at 2:06 p.m., Certified Nursing Assistant (CNA 4) lift Resident 45 from her bed with the mechanical lift transferred her to the wheelchair then Resident 45 was placed in the activity room . During an interview on 6/23/2025 at 2:18 p.m., with CNA 4, CNA 4 stated she thought I could handle transferring Resident 45 as I have done before when nurses are busy. CNA 4 stated the reason we are to transfer a resident using two people, is because the resident can fall from the mechanical lift and have a seizure. CNA stated there was an incident before where a resident fell from a mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/23/2025 at 2:30 p.m., with CNA 5 , CNA 5 stated when using a mechanical lift, every time there needs to be two people transferring the resident to prevent accidents. During an interview on 6/25/2025 at 2:45 p.m., with the Department Staff Development (DSD), the DSD stated a mechanical lift is used to transfer residents from bed to wheelchair or bed to shower chair. DSD stated there should always need to be two people assisting in the transfer for the resident's safety. If not, the resident can be at risk of a fall and sustain an injury. During an interview on 6/26/2025 at 1:30 p.m., with the Director of Nursing (DON), DON stated our process when working with the mechanical lift is there must be two persons when transferring a resident. DON stated one person assisting the resident and the other person operating the machine. DON stated if not done the outcome can be injury to the patient or the staff. During a review of the facility's P&P titled Lifting Machine, Using a Mechanical undated, the P&P indicated : At least two (2) nursing assistance are needed to safely move a resident with a mechanical lift.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, the facility failed to perform a trauma informed care assessment for one of two sampled residents (Resident 64) who was diagnosed with post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). This deficient practice had the potential for Resident 64 to experience triggers (memories tied to the traumatic event) in the facility and had the potential for re-traumatization (the experience where past traumatic memories are triggered, leading to further physical and psychological harm, often due to inadequate care or inappropriate situations). Findings: During a review of Resident 64's admission Record (face sheet), the admission Record indicated Resident 64 was admitted to the facility 12/6/2023 with diagnosis including PTSD and dementia (a condition characterized by progressive or persistent loss of intellectual functioning). During a review of Resident 64's Minimum Data Set (MDS, a minimum data set) dated 5/22/2025, the MDS indicated Resident 64 had severe cognitive impairment (have problems remembering things, concentrating, making decisions and solving problems) and was diagnosed with PTSD. During an interview and concurrent record review of Resident 64's Trauma Assessment on 6/26/2025 at 12:59 p.m. with the Social Services Director (SSD), the SSD stated the trauma assessment was usually done upon admission to assess the residents for any trauma with a diagnosis of PTSD. The SSD stated she reviewed the Trauma assessment dated 12/2023 and it was not done due to Resident 64 declining to answer. The SSD stated if Resident 64 declined the assessment, they should retry the assessment later. The SSD stated she reviewed Resident 64's chart and there was no reassessment done. The SSD stated the Trauma Assessment was not completed for Resident 64, so the facility does not know Resident 64's triggers for his PTSD. The SSD stated the Trauma Assessment was important because it identified the residents' triggers if they have PTSD and to help the residents feel safe and keep them from known triggers. During a review of the facility's policy and procedure (P/P) titled Trauma Informed Care dated 8/20/2023, the P/P indicated it was the policy of the facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, and trauma informed, taking into account experiences and Resident preferences. The P/P indicated the facility would address the needs of trauma survivors by eliminating and/or minimizing triggers that might result in re-traumatization. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure hydrocodone-acetaminophen (a controlled medication [medications that the use and possession of are controlled by the federal government] in combination with acetaminophen [a medication used to treat pain] used to relieve pain) was administered to Resident 12 only for the prescribed severe pain level and as per physician orders, affecting one of three sampled residents during medication administration (Resident 12). 2. Maintain accurate documentation of lorazepam (a controlled medication used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) oral solution on accountability record or controlled medication count sheet/controlled drug record ([CDR] - a document indicating perpetual inventory and administration of controlled substances, as per facility's policy and procedure (P&P) titled, Controlled Medications, dated 4/2008, affecting one resident (Resident 32) in one of three inspected medication carts (Medication Cart 1B). 3. Ensure disposal of discarded medications in an irretrievable, safe and secure manner, as per P&P titled, Medication Destruction, dated 1/2025 and Discontinued Medications, dated 1/2025, affecting two of three inspected medication carts (Medication Cart 1B and Station 3 Medication Cart). These deficient practices failed to provide medications in accordance with the physician orders or professional standards of practice, maintain accurate documentation of controlled medications, and had the potential risk for drug overdose, drug misuse, accidental exposure, hospitalization, and/or potential diversion of prescription medications. Findings: 1. During a review of Resident 12's admission Record (a document containing demographic and diagnostic information), dated 6/24/2025, the admission record indicated, Resident 12 was admitted to facility on 12/17/2018 with diagnoses including but not limited to, primary generalized arthritis (a chronic disease causing inflammation in the joints resulting in pain), low back pain, migraine (a neurological condition that can cause severe, throbbing headaches), not intractable, without status migrainosus (a term used for severe and prolonged migraine attack that lasts for more than 72 hours) and chronic pain syndrome. During a review of Resident 12's Minimum Data Set ([MDS], a resident assessment tool) dated 3/19/2025, the MDS indicated, Resident 12's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated Resident 12 needed setup or clean-up assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, and was dependent on facility staff for oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 6/24/2025 at 8:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered 13 medications to Resident 12 including hydrocodone-acetaminophen. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/24/2025 at 8:57 a.m. with LVN 1, Resident 12's medication card/bubble pack for hydrocodone with acetaminophen, dated 5/1/2025 was reviewed. The medication card indicated, hydrocodone/acetaminophen 5/325 milligrams ([mg] a unit of measurement for mass), give 1 tablet by mouth every 12 hours as needed for severe pain (8-10) not to exceed (NTE) 3-gram ([g] a unit of measurement for mass) acetaminophen per 24 hours. LVN 1 stated Resident 12 stated her pain level was at 6. LVN 1 stated she would administer Resident 12's hydrocodone-acetaminophen because resident was supposed to receive therapy. During a medication reconciliation review on 6/24/2025 at 2:17 p.m., Resident 12's Order Summary Report (a document containing a summary of all active physician orders), dated 6/24/2025, the order summary report indicated, but not limited to the following physician orders: Norco (generic name - hydrocodone with acetaminophen) 5-325 mg, give 1 tablet by mouth every 12 hours as needed for severe pain (8-10) NTE 3 g/24 hours of APAP sources, order date 5/29/2024, start date 5/29/2024. Acetaminophen oral tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for mild pain (1-4) NTE 3 gm of any acetaminophen (APAP) sources in 24 hours (2 tabs = 650 mg), order date 3/1/2024, start date 3/1/2024. Fioricet ([generic name - butalbital-APAP-caffeine] a medication used to treat headache) capsule 50-300-40 mg, give 1 capsule by mouth every 12 hours as needed for 7 moderate pain (5-7) NTE (3 gm/6 tabs) in 24 hours from all APAP sources, order date 6/18/2025, start date 6/18/2025. During a review of Resident 12's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/1/2025 to 6/30/2025, 5/1/2025 to 5/31/2025 and 4/1/2025 to 4/30/2025, the MAR indicated there were 15 times when the facility administered hydrocodone-acetaminophen to Resident 12 outside of the prescribed pain parameters. During a concurrent interview and record review on 6/24/2025 at 2:45 p.m. with LVN 1, the Resident 12's MAR for June 2025 was reviewed. The June 2025 MAR indicated there were five times when resident was given hydrocodone-acetaminophen outside of pain parameters for severe pain level. LVN 1 stated Norco (generic name: hydrocodone-acetaminophen) was supposed to be for severe pain as needed, pain level of 8-10 and the resident's pain level was at 6, and 6 was considered to be moderate pain. LVN 1 stated it was important to follow physician orders as per pain level and she should have clarified with physician if they needed to change orders due to resident's complaint of severe pain after therapy. LVN 1 stated Resident 12 would be at increased risk for dependency, nausea, vomiting, dizziness, sedation, breathing difficulty due to not following physician orders. During an interview on 6/25/2025 at 3:14 p.m. with the Director of Nursing (DON), the DON stated Resident 12 should not have received the hydrocodone-acetaminophen for pain level of 6 because it was prescribed for severe pain. DON stated that nurses should look at the physician orders to determine which pain medication should be given for the pain level that resident was experiencing. DON stated the resident was at increased risk for side effects of constipation, dependency, drowsiness, and receiving unnecessary medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 32's admission record, dated 6/26/2025, the admission record indicated Resident 32 was originally admitted to facility on 11/30/2017 with diagnoses including but not limited to, encounter for palliative care and anxiety disorder. During a review of Resident 32's History and Physical, dated 9/4/2024, the document indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 was dependent on the facility staff for ADLs such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 32's order summary report, dated 6/26/2025, the document indicated but not limited to the following physician order: Lorazepam oral concentrate 2 mg/milliliters ([mL] a unit of measurement for volume), give 0.25 mL by mouth every 12 hours for manifested by (m/b) anxiety/agitation, tremors related to anxiety disorder, unspecified (0. 25 mL = 0.5 mg), order date 5/27/2025, start date 5/27/2025. During a concurrent inspection, interview and record review on 6/25/2025 at 2:00 p.m., with LVN 1 of Medication Cart 1B, Resident 32's medication container, the facility's controlled medication count sheet (CDR) and the medication administration details in electronic medical record (eMAR) for lorazepam oral concentrate 2 mg/mL were reviewed. Resident 32's lorazepam oral concentrate container had approximately 4.5 mL. The facility's CDR indicated a quantity of 4.75 mL remaining with the last dose administered on 6/24/2025 at 9:00 p.m. The administration details in eMAR indicated the last dose of 0.25 mL was documented as administered on 6/25/2025 at 9:06 a.m. LVN 1 stated she administered lorazepam oral concentrate to Resident 32 on 6/25/2025 but she forgot to document in CDR. LVN 1 stated it should have been documented right away after medication was administered to prevent medication errors. During an interview on 6/25/2025 at 2:54 p.m. with the DON, the DON stated a controlled medication should have been documented after it was administered to account for the medication. The DON stated it was important to document to prevent confusion about medication administration and to prevent medication errors. 3a. During a concurrent observation and interview on 6/25/2025 at 1:40 p.m., with LVN 1, of Medication Cart 1B, the medication cart contained one red container filled with several tablets and capsules with an open lid in the bottom drawer such that the medications were retrievable. LVN 1 stated the container was in the cart before she started her shift. LVN 1 stated she did not know why the previous nurse would leave the medications in the container like that. LVN 1 stated the medications in the red container should have been removed or discarded otherwise there was a risk of accidental exposure and/or drug misuse. 3b. During a concurrent observation and interview on 6/25/2025 at 2:22 p.m., with LVN 5, of Station 3 Medication Cart, the medication cart contained one red container filled with several tablets and capsules with an open lid. LVN 5 stated they were not supposed to have that in the cart because of the risk of contamination. LVN 5 stated the red bin was open and accessible to anyone if the medication cart was not locked, which posed a risk for misuse or accidental exposure. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/25/2025 at 2:54 p.m. with the DON, the DON stated the red bins filled with tablets and capsules in the medication cart should have been emptied out in the incineration bin. DON stated if the bins with medications were accessible, there was a risk for drug misuse and accidental exposure. During a review of the facility's P&P titled, Administering Medications, undated, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P indicated, If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified the person preparing or administering the medication will contact the prescriber discuss the concerns. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time before giving the medication. During a review of the facility's P&P titled, Storage of Medications, dated 1/2025, the P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers . are immediately removed from stock, disposed of according to procedures for medication disposal exists. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. During a review of the facility's P&P titled, Controlled Medications, dated 4/2008, the P&P indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration, 2) Amount administered 3) Signature .supply, 4) Initials of the nurse . administered. During a review of the facility's P&P titled, Medication Destruction, dated 1/2025, the P&P indicated, All medications are placed in the proper waste container per facility policy Date of first use to be recorded on the waste container.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility and consultant pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) failed to identify that Resident 69's clonazepam (a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) did not indicate a specific duration of treatment and did not indicate a stop date, affecting one of four sampled residents for unnecessary medications (Resident 69). The deficient practice of failing to identify and report irregularities resulted in Resident 69 receiving clonazepam unnecessarily without a specific duration of treatment possibly resulting in medication side effects (a secondary, typically undesirable effect of a drug or medical treatment) and leading to a decrease in resident's physical, mental, or psychosocial well-being. Findings: During a review of Resident 69's admission Record (a document containing demographic and diagnostic information), dated 6/26/2025, the admission record indicated, Resident 69 was originally admitted to the facility 5/30/2024 and then readmitted on [DATE] with diagnoses including but not limited to unspecified dementia (progressive state of decline in mental abilities) - unspecified severity without behavioral disturbance, psychotic disturbance or mood disturbance and anxiety, anxiety disorder and depression. During a review of Resident 69's History and Physical, dated 5/27/2025, the document indicated Resident 69 was not capable of making medical decisions. During a review of Resident 69's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/20/2025, the MDS indicated Resident 69 needed supervision level assistance from facility staff for Activities of Daily Living (ADLs) such as eating, maximal assistance for oral hygiene and dependent for toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. During a review of Resident 69's Order Summary Report (a document containing a summary of all active physician orders), dated 6/26/2025, the order summary report indicated but not limited to the following physician orders: Clonazepam oral tablet 0.5 milligrams ([mg] a unit of measurement for mass), give 0.5 mg by mouth every 8 hours as needed for manifested by (m/b) striking out at staff unprovoked for no apparent reason related to anxiety disorder, order date 5/1/2025, start date 5/1/2025. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/2025 11:53 a.m. with Licensed Vocational Nurse (LVN) 1, the order details, dated 5/1/2025 for Resident 69's clonazepam 0.5 mg were reviewed. The order details for clonazepam 0.5 mg indicated, indefinite for end date and did not indicate any specific duration of treatment. LVN 1 stated there should have been a discontinuation date or a duration of 14 days for clonazepam 0.5 mg PRN and for any PRN orders. LVN 1 stated the prescriber should explain the reason if they needed to continue the PRN psychotropic medication beyond 14 days duration. During an interview on 6/26/2025 at 1:46 p.m. with the facility's Consultant Pharmacist (RPH 1), RPH 1 stated Resident 69's clonazepam 0.5 mg did not have a stop date which was started on 5/1/2025. RPH 1 stated there should have been a stop date after the facility decided to restart the medication as a new order after March 2025. RPH 1 stated she had informed the facility on previous order in March 2025 to indicate a stop date. RPH 1 stated the order for PRN clonazepam or an anxiolytic (a medication used to treat anxiety) must have a duration of 60 or up to 90 days per regulations and facility might have their own policy regarding 60 or 90 days. RPH 1 stated, There was no risk at the time for Resident 69, especially because facility still had 60 to 90 days. RPH 1 stated, if nobody caught the issue in 90 days, then there was a potential risk. At this time, in my opinion, there is no risk for the resident, because the resident is receiving the medication as needed and this resident has other psych issues. During an interview on 6/26/2025 at 4:07 p.m. with the Director of Nursing (DON), DON stated there should have been a stop date for PRN medication orders because the resident should be reevaluated and the physician must write the reason for continuation. DON stated Resident 69 would be at risk for adverse effects from the medication such as drowsiness and sedation, would not be able to attend activities or benefit from the programs offered at the facility. DON stated if the consultant pharmacist failed to identify this issue during the monthly medication regimen review, it was the facility's responsibility to identify that Resident 69's clonazepam failed to have a specific duration or discontinuation date beyond 14-day treatment. During a review of the facility's policy and procedure (P&P), titled Medication Regimen Review (Monthly Report), dated 6/2021, the P&P indicated, The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The P&P indicated, Resident specific irregularities and/or clinically significant risks resulting from and associated with medications are documented and reported to the Director of Nursing and/or prescriber as appropriate.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication administration and adequate monitoring of side effects for one of two sample residents (Resident 53) who was receiving an anticoagulant (a medication used to prevent and treat blood clots that can cause severe health issues in the blood vessels and the heart) medication and were at high risk for bleeding. This deficient practice had the potential to cause a delay in necessary care and services resulting in injury or death. Findings: During a review of Resident 53's admission Record, the admission Record indicated Resident 53 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation ([a-fib], a type of heartbeat where the heart beats fast and irregularly), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 53's Minimum Data Set ([MDS], a resident assessment tool) dated 4/15/25, the MDS indicated Resident 53 had intact cognitive skills and required supervision assistance (helper provides verbal cues as resident completes activity) for self-care abilities like eating, required moderate assistance (helper does less than half the effort while) with oral hygiene, and upper body dressing, was maximal assistance (helper does more than half of the effort) with toileting and personal hygiene, shower/bathe self , lower body dressing, and putting on and taking off footwear. The MDS also indicated Resident 53 required moderate assistance with mobility like rolling left and right, sitting to lying position, lying to sitting on side of the bed, sitting to stand position, walking 10 to 50 feet, and was maximal assistance with bed to chair transfers, toileting transfers, and shower transfers. During a review of Resident 53's Order Summary Report, the Order Summary Report indicated Eliquis: monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath, nose bleeds-document N if monitored and one of the above was observed. Y if monitored and observed notify medical doctor every shift for the use of Eliquis notify medical doctor if any signs or symptoms is present ordered on 8/21/2024. During a review of Resident 53's Order Summary Report, the Order Summary Report indicated Eliquis oral tablet (pill) 5 milligrams ([mg], a unit of measurement) (apixaban) give one tablet by mouth two times day for a-fib hold for signs of bleeding ordered on 5/19/2023. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's comprehensive care plan dated 5/19/23, the comprehensive care plan indicated Resident 53 had arrhythmia a-fib on Eliquis with goals to remain in normal sinus rhythm with interventions to monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath, nose bleeds-document N if monitored and one of the above was observed. Y if monitored and observed notify medical doctor. The comprehensive care plan also indicated administer medications as ordered and monitor for side effects. During a review of Resident 53's electronic medication administration records ([MAR], a legal document that provides a comprehensive account of all medications administered to a patient) for May 2025, the MAR indicated Eliquis oral tablet five milligrams (apixaban) give one tablet by mouth two times day for a-fib hold for signs of bleeding start date 5/19/2023. The medication was given twice a day at 9:00 a.m. and 5:00 p.m. from 5/1/2025 to 5/31/25 but there was no documentation on 5/22/2025 that it was given. The MAR also indicated Eliquis: monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath, nose bleeds-document N if monitored and one of the above was observed. Y if monitored and observed notify medical doctor every shift for the use of Eliquis notify medical doctor if any signs or symptoms is present started on 8/21/2024. The monitoring was done three times a day for day, evening and night shift but there was no documentation on 5/22/2025 for day shift that resident was monitored. During an interview on 6/26/2025 at 1:02 p.m., with Registered Nurse (RN) 4, RN 4 stated it was important to monitor residents who are on blood thinners to make sure residents do not have bleeding or bruising issues (as a side effect of the Elequis). The RN 4 stated staff should be following the medical doctor's orders when the orders ask to administer the medication and monitor signs or symptoms of bleeding. RN 4 stated staff should be receiving the medication daily as ordered and monitored daily as ordered. RN 4 stated if the documentation was left blank, then the medication was not given, and monitoring was not done. RN 4 stated residents can bleed out when given blood thinners so they should be monitored daily every shift. During an interview on 6/26/2025 at 3: 30 p.m. with Director of Nursing (DON), the DON stated the importance of staff following the medical doctor's orders and administering medication as ordered was that it was a part of the medication regimen to stabilize the residents while in the facility and residents should be getting their medication daily as ordered. The DON stated the importance of administering blood thinners and monitoring the residents on blood thinners was because the residents are high risk for bleeding, and monitoring should be done daily every shift. DON stated if residents are not monitored daily every shift, it can affect their health and residents can bleed out. During a review of the facility's policy and procedure titled, Physician Orders, dated 3/22/2022, indicated, whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record .supplies/medications required to carry out the physician order will be ordered documentation pertaining to physician orders will be maintained in the resident's medical record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for two of three sampled residents (Residents 2 and 12) by failing to: 1. Ensure Resident 2's divalproex (a medication used to treat seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) delayed release ([DR] medication released over an extended time) was not crushed. 2. Ensure Resident 2's crushed divalproex delayed release tablet and crushed lorazepam (a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) tablet were administered separately. 3. Ensure Resident 12's hydrocodone-acetaminophen (a controlled medication [medications that the use and possession of are controlled by the federal government] in combination with acetaminophen [a medication used to relieve pain] used to relieve pain) was administered to Resident 12 only for the prescribed severe pain level and as per physician orders. These deficient practices of medication administration error rate of 11.11% exceeded the five (5) percent threshold. Findings: 1 and 2. During a review of Resident 2's admission Record (a document containing demographic and diagnostic information), dated 6/24/2025, Resident 2 was admitted to the facility on [DATE] with diagnosis including, but not limited to, dysphagia (difficulty swallowing) oral phase. During a review of Resident 2's History and Physical, dated 6/19/2025, the document indicated Resident 2 was unable to make medical decisions for herself but could make needs known. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 3/24/2025, the MDS indicated Resident 2 was dependent on the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. During a concurrent observation and interview on 6/24/2025 at 8:38 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared the following two medications for Resident 2. 1. One tablet of lorazepam 0.5 milligrams ([mg] a unit of measurement for mass) 2. One tablet of divalproex sodium DR 125 mg LVN 1 stated she would need to crush both medications for the resident. LVN 1 was observed crushing divalproex DR and lorazepam separately using a crushing device. LVN 1 then mixed the crushed divalproex DR and lorazepam together in a cup and administered the mixture with applesauce to Resident 2. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication reconciliation review on 6/24/2025 at 10:58 a.m., Resident 2's Order Summary Report (a document containing a summary of all active physician orders), dated 6/24/2025, the order summary report indicated, but not limited to the following physician orders: Depakote (generic name - divalproex) oral tablet delayed release 125 mg, give 1 tablet by mouth two times a day for manifested by (m/b) rapid mood cycling related to schizophrenia (a mental illness that is characterized by disturbances in thought), unspecified as evidenced by (AEB) rapid shifts in mood from pleasant to extreme anger AEB yelling/screaming, order date 4/29/2025, start date 4/29/2025. Ativan (generic name - lorazepam) oral tablet 0.5 mg, give 1 tablet by mouth every 6 hours as needed for anxiety until 7/8/2025 23:59 for behavior manifestation by yelling and screaming, order date 6/23/2025, start date 6/23/2025, end date 7/8/2025. May crush crushable meds, order date 3/18/2025. During an interview on 6/24/2025 at 2:41 p.m. with LVN 1, LVN 1 stated she realized right after she was questioned about the crushing that it was not supposed to be crushed. LVN 1 stated the medications should have been given separately to be able to differentiate medications if Resident 2 did not tolerate one of the medications. LVN 1 stated divalproex was a delayed release tablet and should not have been crushed. LVN 1 stated the medication would not be as effective for the resident's condition and had the possibility to cause throat irritation. During an interview on 6/25/2025 at 3:14 p.m. with the Director of Nursing (DON), DON stated Resident 2 should have received divalproex delayed release and lorazepam tablets as whole tablets. DON stated it was not safe to crush delayed release divalproex and Resident 2 should have been able to swallow this medication because she was sitting upright. DON stated the two different crushed medications should not have been given together because of possible drug interactions. DON stated if the resident did not tolerate one of the medications, and they were given together, facility would not have known which medication was not tolerated by the resident. 3. During a review of Resident 12's admission record, dated 6/24/2025, the admission record indicated, Resident 12 was admitted to facility on 12/17/2018 with diagnoses including but not limited to, primary generalized arthritis (a chronic disease causing inflammation in the joints resulting in pain), low back pain, migraine (a neurological condition that can cause severe, throbbing headaches), not intractable, without status migrainosus (a term used for severe and prolonged migraine attack that lasts for more than 72 hours) and chronic pain syndrome. During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated Resident 12 needed setup or clean-up assistance from the facility staff for performing ADLs such as eating, and was dependent on facility staff for oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. During an observation on 6/24/2025 at 8:57 a.m., LVN 1 prepared and administered the following 13 medications to Resident 12. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. One puff of Advair (a medication used to treat breathing difficulty) 250 micrograms ([mcg] a unit of measurement for mass)/50 mcg 2. One tablet of hydrocodone-acetaminophen 5-325 mg 3. One tablet of meclizine (a medication used to treat dizziness) 12.5 mg 4. One tablet of baclofen (a medication used to treat muscle spasms) 10 mg 5. One tablet of famotidine (a medication used to treat acid-reflux) 20 mg 6. One capsule of gabapentin (a medication used to treat neuropathy [a condition resulting from nerve damage])100 mg 7. One tablet of topiramate (a medication used to treat migraine) 100 mg 8. One tablet of chewable aspirin (a medication used to prevent blood clot) 81 mg 9. One tablet of vitamin C (a vitamin used to treat low level of vitamin C) 500 mg 10. Two tablets of vitamin D3 (a vitamin used to treat low level of vitamin D) 2000 international units ([IU] a unit of measurement for mass) 11. One tablet of Rybelsus ([generic name - semaglutide] a medication used to treat Type 2 Diabetes Mellitus [a disorder characterized by difficulty in blood sugar control and poor wound healing]) 14 mg 12. One tablet of magnesium oxide (a supplement used to treat low level of magnesium) 400 mg 13. A pea-size amount of lidocaine 3% cream applied to left shoulder During a concurrent interview and record review on 6/24/2025 at 8:57 a.m. with LVN 1, Resident 12's medication card/bubble pack for hydrocodone with acetaminophen, dated 5/1/2025 was reviewed. The medication card indicated, hydrocodone/acetaminophen 5/325 mg, give 1 tablet by mouth every 12 hours as needed for severe pain (8-10) not to exceed (NTE) 3-gram ([g] a unit of measurement for mass) acetaminophen per 24 hours. LVN 1 stated Resident 12 stated her pain level was at 6. LVN 1 stated she would administer Resident 12's hydrocodone-acetaminophen because the resident was supposed to receive therapy. During a medication reconciliation review on 6/24/2025 at 2:17 p.m., Resident 12's order summary report, dated 6/24/2025, the order summary report indicated, but not limited to the following physician orders: Norco (generic name - hydrocodone with acetaminophen [APAP]) 5-325 mg, give 1 tablet by mouth every 12 hours as needed for severe pain (8-10) NTE 3 g/24 hours of APAP sources, order date 5/29/2024, start date 5/29/2024. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Acetaminophen oral tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for mild pain (1-4) NTE 3 gm of any acetaminophen (APAP) sources in 24 hours (2 tabs = 650 mg), order date 3/1/2024, start date 3/1/2024. Fioricet ([generic name - butalbital-APAP-caffeine] a medication used to treat headache) capsule 50-300-40 mg, give 1 capsule by mouth every 12 hours as needed for 7 moderate pain (5-7) NTE (3 gm/6 tabs) in 24 hours from all APAP sources, order date 6/18/2025, start date 6/18/2025. During a concurrent interview and record review on 6/24/2025 at 2:45 p.m. with LVN 1, Resident 12's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for June 2025 was reviewed. The June 2025 MAR indicated there were five times when resident was given hydrocodone-acetaminophen outside of pain parameters for severe pain level. LVN 1 stated Norco (generic name: hydrocodone-acetaminophen) was supposed to be for severe pain as needed, pain level of 8-10 and the resident's pain level was at 6, and 6 was considered to be moderate pain. LVN 1 stated it was important to follow physician orders as per pain level and she should have clarified with physician if they needed to change orders due to resident's complaint of severe pain after therapy. LVN 1 stated Resident 12 would be at an increased risk for dependency, nausea, vomiting, dizziness, sedation, breathing difficulty due to not following physician orders. During a review of Resident 12's MAR dated 6/1/2025 to 6/30/2025, 5/1/2025 to 5/31/2025 and 4/1/2025 to 4/30/2025, the MAR indicated there were 15 times when hydrocodone-acetaminophen was administered to Resident 12 outside of the prescribed pain parameters. The MAR indicated: a. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/1/2025 for pain level of 7. b. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/9/2025 for pain level of 7. c. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/11/2025 for pain level of 4. d. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/17/2025 for pain level of 4. e. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/24/2025 for pain level of 6. f. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/15/2025 for pain level of 7. g. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/20/2025 for pain level of 5. h. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/21/2025 for pain level of 7. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/23/2025 for pain level of 6. j. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/27/2025 for pain level of 7. k. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/4/2025 for pain level of 7. l. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/6/2025 for pain level of 5. m. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/18/2025 for pain level of 6. n. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/23/2025 for pain level of 6. o. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/29/2025 for pain level of 6. During an interview on 6/25/2025 at 3:14 p.m. with the DON, DON stated Resident 12 should not have received the hydrocodone-acetaminophen for pain level of 6 because it was prescribed for severe pain. DON stated that nurses should look at the physician orders to determine which pain medication should be given for the pain level that resident was experiencing. DON stated the resident was at increased risk for side effects of constipation, dependency, drowsiness, and receiving unnecessary medication. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, undated, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P indicated, If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified the person preparing or administering the medication will contact the prescriber discuss the concerns. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time before giving the medication. During a review of the facility's P&P, titled Appendix 5: Medication Crushing Guidelines, undated, the P&P indicated, Timed Release Tablets are designed to release medication over a sustained period, usually 8 to 24 hours. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases. In either case these tablets should not be crushed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 12) was free from significant medication error during medication administration, by failing to ensure hydrocodone-acetaminophen (a controlled medication [medications that the use and possession of are controlled by the federal government] in combination with acetaminophen [a medication used to treat pain] used to relieve pain) was administered to Resident 12 only for the prescribed severe pain, on the pain level scale (a tool used to measure the intensity of pain 1-4 mild pain, 5-7 moderate pain, 6-10 severe pain) and as per physician orders. This deficient practice failed to provide hydrocodone-acetaminophen in accordance with physician orders or professional standards of practice and had the potential to result in drug overdose, drug misuse and hospitalization. Findings: During a review of Resident 12's admission Record (a document containing demographic and diagnostic information), dated 6/24/2025, the admission record indicated, Resident 12 was admitted to facility on 12/17/2018 with diagnoses including but not limited to, primary generalized arthritis (a chronic disease causing inflammation in the joints resulting in pain), low back pain, migraine (a neurological condition that can cause severe, throbbing headaches), not intractable, without status migrainosus (a term used for severe and prolonged migraine attack that lasts for more than 72 hours) and chronic pain syndrome. During a review of Resident 12's Minimum Data Set ([MDS], a resident assessment tool) dated 3/19/2025, the MDS indicated, Resident 12's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated Resident 12 needed setup or clean-up assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, and was dependent on facility staff for oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 6/24/2025 at 8:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared and administered the following 13 medications to Resident 12. 1. One puff of Advair (a medication used to treat breathing difficulty) 250 micrograms ([mcg] a unit of measurement for mass)/50 mcg 2. One tablet of hydrocodone-acetaminophen 5-325 mg 3. One tablet of meclizine (a medication used to treat dizziness) 12.5 mg 4. One tablet of baclofen (a medication used to treat muscle spasms) 10 mg 5. One tablet of famotidine (a medication used to treat acid-reflux) 20 mg 6. One capsule of gabapentin (a medication used to treat neuropathy [a condition resulting from nerve damage])100 mg (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. One tablet of topiramate (a medication used to treat migraine) 100 mg 8. One tablet of chewable aspirin (a medication used to prevent blood clot) 81 mg 9. One tablet of vitamin C (a vitamin used to treat low level of vitamin C) 500 mg 10. Two tablets of vitamin D3 (a vitamin used to treat low level of vitamin D) 2000 international units ([IU] a unit of measurement for mass) 11. One tablet of Rybelsus ([generic name - semaglutide] a medication used to treat Type 2 Diabetes Mellitus [a disorder characterized by difficulty in blood sugar control and poor wound healing]) 14 mg 12. One tablet of magnesium oxide (a supplement used to treat low level of magnesium) 400 mg 13. A small amount of lidocaine 3% cream applied to left shoulder During a concurrent interview and record review on 6/24/2025 at 8:57 a.m. with LVN 1, Resident 12's medication card/bubble pack for hydrocodone with acetaminophen, dated 5/1/2025 was reviewed. The medication card indicated, hydrocodone/acetaminophen 5/325 milligrams ([mg] a unit of measurement for mass), give 1 tablet by mouth every 12 hours as needed for severe pain (8-10) not to exceed (NTE) 3-gram ([g] a unit of measurement for mass) acetaminophen per 24 hours. LVN 1 stated Resident 12 stated her pain level was at 6. LVN 1 stated she would administer Resident 12's hydrocodone-acetaminophen because the resident was supposed to receive therapy. During a medication reconciliation review on 6/24/2025 at 2:17 p.m., Resident 12's Order Summary Report (a document containing a summary of all active physician orders), dated 6/24/2025, the order summary report indicated, but not limited to the following physician orders: Norco (generic name - hydrocodone with acetaminophen [APAP]) 5-325 mg, give 1 tablet by mouth every 12 hours as needed for severe pain (8-10) NTE 3 g/24 hours of APAP sources, order date 5/29/2024, start date 5/29/2024. Acetaminophen oral tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for mild pain (1-4) NTE 3 gm of any acetaminophen (APAP) sources in 24 hours (2 tabs = 650 mg), order date 3/1/2024, start date 3/1/2024. Fioricet ([generic name - butalbital-APAP-caffeine] a medication used to treat headache) capsule 50-300-40 mg, give 1 capsule by mouth every 12 hours as needed for 7 moderate pain (5-7) NTE (3 gm/6 tabs) in 24 hours from all APAP sources, order date 6/18/2025, start date 6/18/2025. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/24/2025 at 2:45 p.m., with LVN 1, Resident 12's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for June 2025 was reviewed. The June 2025 MAR indicated there were five times when resident was given hydrocodone-acetaminophen outside of pain parameters for severe pain level. LVN 1 stated Norco (generic name: hydrocodone-acetaminophen) was supposed to be for severe pain as needed, pain level of 8-10 and the resident's pain level was at 6, and 6 was considered to be moderate pain. LVN 1 stated it was important to follow physician orders as per pain level and she should have clarified with physician if they needed to change orders due to resident's complaint of severe pain after therapy. LVN 1 stated Resident 12 would be at an increased risk for dependency, nausea, vomiting, dizziness, sedation, breathing difficulty due to not following physician orders. During a review of Resident 12's MAR dated 6/1/2025 to 6/30/2025, 5/1/2025 to 5/31/2025 and 4/1/2025 to 4/30/2025, the MAR indicated there were 15 times when hydrocodone-acetaminophen was administered to Resident 12 outside of the prescribed pain parameters. The MAR indicated: a. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/1/2025 for pain level of 7. b. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/9/2025 for pain level of 7. c. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/11/2025 for pain level of 4. d. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/17/2025 for pain level of 4. e. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 6/24/2025 for pain level of 6. f. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/15/2025 for pain level of 7. g. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/20/2025 for pain level of 5. h. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/21/2025 for pain level of 7. i. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/23/2025 for pain level of 6. j. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 5/27/2025 for pain level of 7. k. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/4/2025 for pain level of 7. (continued on next page)

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	055995	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	l. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/6/2025 for pain level of 5. m. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/18/2025 for pain level of 6. n. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/23/2025 for pain level of 6. o. One tablet of hydrocodone-acetaminophen 5-325 mg was administered on 4/29/2025 for pain level of 6. During an interview on 6/25/2025 at 3:14 p.m., with the Director of Nursing (DON), the DON stated Resident 12 should not have received the 5-325 mg hydrocodone-acetaminophen for pain level of 6 because the 5-325 mg hydrocodone-acetaminophen was prescribed for severe pain.The DON stated that nurses should look at the physician orders to determine which pain medication should be given for the pain level that resident was experiencing. DON stated the resident was at increased risk for side effects of constipation, dependency, drowsiness, and receiving unnecessary medication. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, undated, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P indicated, If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified the person preparing or administering the medication will contact the prescriber discuss the concerns. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time before giving the medication.

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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: 1. Ensure discontinued lorazepam (a controlled substance [a medication with a high potential for abuse] used to treat anxiety [a medical condition described by feeling of fear or uneasiness]) 2 milligrams (mg - a unit of measurement for mass) per milliliters (mL - a unit of measurement for volume) oral solutions for Residents 44 and 63 were removed from Station 1 Medication Room Refrigerator and disposed of in accordance with the facility's policy and procedures (P&P) titled, Disposal of Medications and Medication-Related Supplies - Controlled Medication Disposal, dated 1/2025, Medication Destruction, dated 1/2025 and Discontinued Medications, dated 1/2025, affecting one of one inspected medication room (Station 1 Medication Room). 2. Ensure Resident 44's ondansetron (a medication used to treat nausea and vomiting) orally disintegrating tablets ([ODT] fast dissolving in mouth), hyoscyamine (a medication used to provide symptomatic relief of spasms), acetaminophen suppositories (suppository form of the medication used to treat fever and pain), ipratropium with albuterol inhalation solution (a medication used to treat breathing difficulty) and bisacodyl suppositories (suppository form of medication used to relieve constipation) were stored in accordance with manufacturer's specifications, affecting one of one inspected medication room (Station 1 Medication Room). 3. Maintain a clean and safe environment for medication storage in two out of three inspected medication carts, by failing to remove and dispose discarded medications in unsealed red biohazard containers (Medication Cart 1B and Station 3 Medication Cart). These deficient practices resulted in an unclean and unsecure environment for medication storage in medication carts, had the potential to result in medication errors, and Residents 44 and 63 receiving medications that were discontinued, expired, ineffective, or toxic due to improper storage and labeling possibly leading to adverse health consequences such as breathing problems, nausea, vomiting and fever. Findings: 1 and 2. During a concurrent observation and interview on [DATE] at 3:27 p.m. with Licensed Vocational Nurse (LVN) 5 and Registered Nurse Supervisor (RNS) 1, in Station 1 Medication Room, the medication refrigerator contained discontinued medications and/or medications not stored according to manufacturer's specifications as follows: a. Approximately 10 mL of lorazepam oral solution 2 mg/mL for Resident 63 b. Approximately 12 mL of lorazepam oral solution 2 mg/mL for Resident 44 According to the manufacturer's product labeling, lorazepam oral solution 2 mg/mL should be stored in refrigerator at 2-to-8 degrees Celsius ([°C] is a unit of temperature [36-to-46 degrees Fahrenheit ([°F] is a unit of temperature) and an opened bottle should be discarded after 90 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Four tablets of hyoscyamine sublingual ([SL] under the tongue) 0.125 mg for Resident 44 According to the manufacturer's product labeling, hyoscyamine SL 0.125 mg should be stored at controlled room temperature 15-to-30°C (59-to-86°F). d. Two suppositories of bisacodyl 10 mg for Resident 44 According to the manufacturer's labeling, bisacodyl 10 mg suppository should be stored at temperatures below 77 °F (25°C) and excessive humidity should be avoided. e. Two suppositories of acetaminophen 650 mg for Resident 44 According to the manufacturer's labeling, acetaminophen 650 mg suppositories should be stored between 8 and 25°C (46 and 77°F). f. Five vials of ipratropium and albuterol inhalation solution 0.5 mg - 3 mg per 3 mL for Resident 44 According to the manufacturer's labeling, ipratropium with albuterol should be stored at controlled room temperature, between 20 and 25°C (68 and 77°F), with excursions permitted between 15 and 30°C (59 and 86°F). LVN 5 needed to leave for something so RNS 1 stayed to show Station 1 Medication Room. During a concurrent interview and record review on [DATE] at 4:30 p.m. with RNS 1, the current and discontinued lorazepam physician orders for Residents 44 and 63 were reviewed. The documents indicated Resident 63's lorazepam oral concentrate/solution order ended on [DATE] and Resident 44's lorazepam solution order ended on [DATE]. RNS 1 stated Resident 63's lorazepam oral solution was discontinued on [DATE] and Resident 44's lorazepam oral solution was discontinued on [DATE]. RNS 1 stated there was a risk for lorazepam to be accidentally administered and residents to experience unwanted side effects such as sedation, drowsiness, dependency, drug misuse and diversion. RNS 1 stated the discontinued controlled medications should have been removed from the stock and given to the Director of Nursing (DON) for disposal. RNS 1 stated hyoscyamine SL tablets, bisacodyl suppositories, acetaminophen suppositories and ipratropium with albuterol inhalation solution vials were not supposed to be stored in the refrigerator per manufacturer requirements and would not be safe or effective to administer to residents. 3a. During a concurrent observation and interview on [DATE] at 1:40 p.m. with LVN 1, of Medication Cart 1B, the medication cart contained one red container filled with several tablets and capsules with an open lid in the bottom drawer such that medications could be retrievable. LVN 1 stated the container was in the cart before she started her shift. LVN 1 stated she did not know why the previous nurse would leave the medications in the container like that. LVN 1 stated the medications in the red container should have been removed or discarded otherwise there was a risk of accidental exposure and/or misuse. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3b. During a concurrent observation and interview on [DATE] at 2:22 p.m. with LVN 5, of Station 3 Medication Cart, the medication cart contained one red container filled with several tablets and capsules with an open lid. LVN 5 stated they were not supposed to have that in the cart because of the risk of contamination. LVN 5 stated the red bin was open and accessible to anyone if the medication cart was not locked, which posed a risk for misuse or accidental exposure. During an interview on [DATE] at 2:54 p.m. with the DON, DON stated the red bins filled with tablets and capsules in the medication cart should have been emptied out in the incineration bin. DON stated if the bins with medications were accessible, there was a risk for drug misuse and accidental exposure. DON stated the comfort pack medications for Resident 44 that included lorazepam liquid, were overlooked because lorazepam was automatically discontinued, and resident was enrolled in hospice. DON stated that the discontinued lorazepam oral solution for Residents 63 and 44 should have been documented in the controlled substance disposition book and discarded with the DON and consultant pharmacist. DON stated the facility staff should check the refrigerator for discontinued orders. DON stated the discontinued controlled medication should have been brought to the DON and the discontinued non-controlled medication should have been discarded with a witness. DON stated there was a risk for drug misuse. During a review of the facility's P&P, titled Controlled Medication Disposal, dated 1/2025, the P&P indicated, Schedule II-V controlled substances remaining in the facility after a resident has been discharged , or the order discontinued, are disposed of in the facility by the director of nursing or designated facility registered nurse in conjunction with the pharmacist. The P&P indicated, The director of nursing and the consultant pharmacist are responsible for the facility's compliance with the federal and state laws and regulations in the handling of controlled medications. During a review of the facility's P&P titled, Discontinued Medications, dated 1/2025, the P&P indicated, If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified as shall be stored in a separate location designated solely for this purpose. The date the medication was discontinued shall be indicated on the medication container. During a review of the facility's P&P titled, Medication Destruction, dated 1/2025, the P&P indicated, Medication is destroyed within 90 days from the date the medication was discontinued. Discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed. During a review of the facility's P&P titled, Storage of Medications, dated 1/2025, the P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers . are immediately removed from stock, disposed of according to procedures for medication disposal exists. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 food in a sanitary manner to prevent growth of microorganisms that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as toxins for residents who eat food from the kitchen by not: 1.Checking the chemical sanitation of the dish washer and documenting the results. 2.Ensuring to store food with label and open date. 3.Ensure facility staff was not wearing jewelry while preparing pudding. These deficient practices had the potential for facility residents' exposure to pathogens (germ) and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization. Findings : During an initial tour observation interview and record review of the kitchen on 6/23/2025 at 08:20 a.m., with the Dietary [NAME] (DC) , in the refrigerator next to the back door there was one 46 fluid ounce (Fl oz- unit of measurement) of Sysco Imperial thickened apple juice from concentrate with on open date , one cup of prepared applesauce with no date, and five small prepared containers of cottage cheese with no date. During a tour of the dry food area on 6/23/2025 at 08:30 a.m., with the DC there was one large plastic container of white beans without a date. During an interview on 6/23/2025 at 08:30 a.m., with the DC, DC agreed that the containers of apple sauce, carton of apple juice, and cottage cheese should have been dated when it was prepared . DC stated the large container of beans should have a date when opened. DC stated the importance of dating opened and prepared foods is so we can know when to throw it out. During an observation, interview DW stated the sanitation of the dishwasher is checked before washing the breakfast dishes , before lunch time and before dinner. During a record review of the Dishwasher Temperature/ Sanitizer Record log with the DW and DC the last entry was on 6/23/2025 . The DW stated she forgot to check and record the sanitation of the dishwasher and record the sanitation fluid. The DW stated it is important to check the sanitation of dishwasher to make sure the dishes are properly disinfected to prevent residents from getting sick. During an interview on 6/24/2025 at 08:40 a.m., with the DS, the DS stated the container of apple juice , cup of apple sauce should have an open date. The DS stated the five cups of cottage cheese should have a prepared date and a use by date to keep track of it, he stated because it is a dairy product when it is open the quality of the cottage cheese is susceptible to spoilage. The DS stated the white dried beans have a shelf life of 1 year and needs a date and use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/24/2026 at 08:46 a.m., with the DS, DS stated it is important to check the sanitation of the dishwasher because we are using high chlorine and want to make sure no feed born illness can live while washing. If the sanitation is not effective the residents can get sick. During an observation and interview of the tray line on 6/24/2025 at 12:40 p.m. with the DS, Tray Person (TP), was observed mixing white pudding placing them in separate cups for the residents TP was wearing gloves and hanging out of the gloves there was a total of three yellow-colored bracelets hanging over the pudding, she was preparing. TP stated I know I should not wear jewelry while preparing food, she stated I was in a hurry and forgot to take it off. TP stated it is important to keep jewelry off because something can fall off and a resident could eat the pudding and choke. During an interview with the DS, DS stated it is important to not wear jewelry while in the kitchen like that bracelet is it a physical contaminate the resident can get bacteria from this, and if swallowed someone can choke. During a review of the facility's P&P titled Sanitizing undated, the P&P indicates: The food service area is maintained in a clean and sanitary manner. 1.The chemical solution is maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufactures guidelines. 2.Dry foods are labeled, dated and monitored so they are used by their use- by date date or discarded. Such foods are rotated using a first in -first out system. 3.All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). During a review of the facility's undated policy and procedures (P&P) titled Dress Code, the P&P indicated: All employees dress and groom in a manner that is appropriate to their working conditions. 1.Jewlrey should be limited to watches and wedding rings.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide specialized rehabilitative (rehab) services (services that require specialized training and experience of a licensed therapist or therapy assistant) to two of six sampled residents (Residents 16 and 41) by failing to: 1.Ensure Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function), Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities), and Speech Therapy (ST, profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) evaluations were provided in accordance with physician's orders for Resident 16. 2.Ensure a ST evaluation was provided in accordance with physician's orders for Resident 41. These deficient practices prevented Residents 16 and 41 from receiving skilled rehab services to potentially maintain or achieve their highest practicable level of function. Findings: 1. During a review of Resident 16's admission Record, the admission Record indicated the facility initially admitted Resident 16 on 4/25/2024 and re-admitted Resident 16 on 1/24/2025 with diagnoses including aphasia (loss of ability to understand or express speech, caused by brain damage), cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death), dysphagia (difficulty swallowing), and contractures (loss of motion of a joint associated with stiffness and joint deformity) of multiple sites. During a review of Resident 16's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/31/2025, for PT to evaluate Resident 16 as recommended. During a review of Resident 16's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/31/2025, for OT to evaluate Resident 16 as recommended. During a review of Resident 16's Order Summary Report, the Order Summary Report indicated a physician's order, dated 3/31/2025, for ST to evaluate Resident 16 as recommended. During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 16 had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 16 required partial/moderate assistance for eating and was dependent for hygiene, bathing, dressing, and rolling to both sides. The MDS indicated Resident 16 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both legs. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/24/2025 at 10:15 a.m., in Resident 16's room, Resident 16 was lying in bed. Resident 16 stated she was unsure how long she had been at the facility. Both of Resident 16's legs were straight with both feet pointing downwards. Resident 16 slightly bent both knees and both hips and could not move both ankles. During a concurrent interview and record review on 6/26/2025 at 11:36 am, the Director of Rehabilitation (DOR) stated the facility provided skilled PT, OT, and ST services to the residents in the facility per physician's orders. The DOR reviewed Resident 16's medical record and confirmed Resident 16 had physician's orders for Resident 16 to be evaluated by PT, OT, and ST on 3/31/2025. The DOR reviewed Resident 16's clinical record and confirmed PT, OT, and ST evaluations were not conducted as ordered by the physician. The DOR stated PT, OT, and ST evaluations should have been completed since they were ordered by the physician but were not for unknown reasons. The DOR stated it was important physician's orders were followed and the residents received rehab evaluations as ordered to ensure the residents received a comprehensive (complete, including all or nearly all elements or aspects of something) assessment to determine the appropriate type of care and services needed to reach their highest functional level and return home safely with caregivers and family. b. During a review of Resident 41's admission Record, the admission Record indicated the facility admitted Resident 41 on 5/10/2025 with diagnoses including Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), diaphragmatic hernia (birth defect where there is an abnormal opening in the diaphragm [muscle separating the chest and abdomen]), and lack of coordination (ability to use different parts of the body together smoothly and efficiently). During a review of Resident 41's Order Summary Report, the Order Summary Report indicated a physician's order, dated 5/10/2025, for ST to evaluate Resident 41 as recommended. During a review of Resident 41's Rehab Screen, dated 5/12/2025, the Rehab Screen, completed by Speech Therapist 1 (ST 1), indicated a ST evaluation was not needed. During a review of Resident 41's MDS, dated [DATE], the MDS indicated Resident 41 had moderately impaired cognition. The MDS indicated Resident 41 required supervision or touching assistance for eating, substantial/maximal assistance for oral hygiene, personal hygiene, and rolling to both sides and was dependent for bathing, dressing, and toilet hygiene. The MDS indicated Resident 41 had functional limitations in ROM in both arms. During a concurrent observation and interview on 6/24/2025 at 10:27 p.m., in Resident 41's room, Resident 41 was lying in bed wearing a nasal canula (plastic tube inserted into the nostrils of the nose to deliver supplemental oxygen). Resident 41's right hand was positioned in a fist and the left hand was positioned with all fingers bent at the knuckle joints. Resident 41's both legs were straight. Resident 41 bent both legs at the hip joint with effort and bent the right knee to about 60 degrees but stopped due to pain. Resident 41 stated she was able to feed herself, but it was very messy and recently felt generally weaker due to a recent illness. During a concurrent observation on 6/25/2025 at 12:29 p.m., in Resident 41's room, Resident 41 was lying in bed. Resident 41's body was positioned low in the bed with the upper body slouched forward. The head of Resident 41's bed was slightly elevated to less than 30 degrees. While lying in bed, Resident 41 drank water and ate a hashbrown from the plate and coughed. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 6/25/2025 at 2:54 p.m., Speech Therapist 1 (ST 1) stated ST services evaluated and treated residents per physician's orders with swallowing, communication, and cognitive disorders. ST 1 stated ST did not always provide ST evaluations when ordered by the physician. ST 1 stated it was the practice of the Rehab department to initially complete a Rehab Screen, which was a limited, hands off (therapist does not physically touch or formally assess a resident) screen that consisted primarily of a comprehensive review of the resident's clinical records and interviews with the resident and staff to determine if a formal, skilled rehab evaluation was warranted. ST 1 stated ST only completed a ST evaluation if the findings from the Rehab Screen indicated a need for a formal evaluation despite physician's orders for a formal ST evaluation. ST 1 stated the ST evaluation was a comprehensive assessment of the resident's ST needs which included a physical, hands-on assessment of eating and trialing different food textures with the goal of advancing the resident to the safest and most appropriate diet. ST 1 stated a Rehab Screen, and an ST evaluation were different. During a concurrent interview and record review on 6/26/2025 at 11:36 a.m., with the Director of Rehabilitation (DOR), Resident 41's clinical records were reviewed. The DOR stated ST services were provided per physician's orders. The DOR stated the Rehab department did not always complete rehab evaluations when ordered by the physician. The DOR stated the licensed therapist initially performed a Rehab Screen, which was generally a brief, hands-off screen that involved a review of the resident's medical records and history, observation of the resident, and interviews to determine if a formal rehab evaluation was warranted. The DOR stated a skilled rehab evaluation was a comprehensive, physical assessment of the resident which varied in content depending on the discipline (PT, OT, or ST). The DOR stated a Rehab Screen and a skilled rehab evaluation were different. The DOR reviewed Resident 41's clinical record and confirmed Resident 41 had a physician's order for an ST evaluation on 5/10/2025. The DOR confirmed ST conducted a Rehab Screen for Resident 41 on 5/12/2025 and did not complete an ST evaluation as ordered by the physician. The DOR stated if an ST evaluation was ordered by the physician, an ST evaluation should have been done but was not. The DOR stated it was important physician's orders were followed and the residents received rehab evaluations as ordered to ensure the residents received a comprehensive assessment to determine the appropriate type of care and services needed to reach their highest functional level and return home safely with caregivers and family. During an interview on 6/26/2025 at 4:14 p.m., with the Director of Nursing (DON), the DON stated the facility provided rehab services which included PT, OT, and ST per physician's orders. The DON stated it was important residents receive skilled rehab evaluations as ordered by the physician to ensure the residents received the appropriate care and services they needed while in the facility. During a review of the facility's Policy and Procedure (P/P) titled, Specialized Rehabilitative Services, revised 12/2009, the P/P indicated the facility provided specialized rehabilitative services, which included PT, ST, and OT. The P/P indicated therapy services were provided upon the written order of the resident's attending physician. During a review of the facility's Job Description titled, Physical Therapist, dated 5/19/2023, the job description indicated the PT responsibilities and duties included to evaluate patients promptly, and per policies and expectations, upon receiving a physician's referral for treatment. During a review of the facility's Job Description titled, Occupational Therapist, dated 5/23/2023, the job description indicated the OT responsibilities and duties included to evaluate patients promptly, and per policies and expectations, upon receiving a physician's referral for treatment. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Job Description titled, Speech-Language Pathologist, dated 5/23/2021, the P/P indicated the ST responsibilities and duties included to evaluate patients promptly, and per policies and expectations, upon receiving a physician's referral for treatment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure; a. The medical record for one of six sampled residents (Resident 71) was accurate by failing to ensure the physician's orders for Resident 71's right leg weight bearing restrictions were accurately documented. This deficient practice had the potential to negatively impact the provision of necessary care and services, cause miscommunication among staff, and cause a decline in range of motion (ROM, full movement potential of a joint), mobility, and overall function. b. Restorative Nursing Aide ([RNA], nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) services provided were accurately documented for one of three sampled residents (Resident 48). These deficient practices had the potential to negatively impact the provision of necessary care and services and portray an inaccurate reflection of services provided. Findings: a.During a review of Resident 71's admission Record, the admission Record indicated the facility admitted Resident 71 on 12/21/2022 with diagnoses including a displaced fracture (break in the bone where the bone fragments are no longer aligned and have moved out of their normal position) of the right femur (thigh bone), unspecified right hip injury, and abnormal gait (manner of walking). During a review of Resident 71's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/27/2024, for Resident 71's right leg to be weightbearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance). During a review of Resident 71's Order Summary Report, the Order Summary Report indicated a physician's order, dated 2/13/2025, for Resident 71's right leg to be non-weight bearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part). During a review of Resident 71's Minimum Data Set (MDS, a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 115 had moderately impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 71 required set-up or clean up assistance for eating, partial/moderate assistance for oral hygiene and upper body dressing, substantial/maximal assistance for bathing, lower body dressing, personal hygiene, rolling to both sides, and transfers and was dependent in tub/shower transfers and toileting hygiene. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/25/2025 at 1:51 p.m., in Resident 71's room, Resident 71 was lying in bed with both legs straight and a heel protector (boot-like device used to relieve pressure on the heel and prevent pressure ulcers in persons who have limited mobility) on the right foot. Resident 71 moved both ankles up and down minimally and stated he was instructed to put weight through both legs when walking. During a concurrent interview and record review on 6/25/2025 at 1:27 p.m., with Registered Nurse 4 (RN 4), Resident 17's physician's orders dated 12/27/2024 and 2/13/2025 were reviewed. RN 4 stated he was unsure what Resident 71's right leg weightbearing precautions were since the medical record indicated two active, conflicting physician's orders related to the weightbearing status of Resident 71's right leg. RN 4 stated it was important the outdated physician's order was discontinued to avoid confusion and inappropriate provision of care. During a concurrent interview and record review on 6/25/2025 at 2:28 p.m., with the Director of Rehabilitation (DOR), Resident 17's medical record was reviewed. The DOR stated Resident 71's medical record was inaccurate and confusing because Resident 71 had two, conflicting physician's orders related to the weightbearing status of Resident 71's right leg. The DOR confirmed Resident 71 was initially WBAT on the right leg but was later changed to NWB on the right leg due to a wound on the right heel of Resident 71's foot. The DOR stated the physician's order, dated 12/27/2024, which indicated Resident 71 was WBAT on the right leg should have been discontinued when the weightbearing status changed but was not. The DOR stated it was important documentation in the medical record was accurate to avoid staff confusion and to ensure staff provided the appropriate precautions when providing care to the residents. During an interview on 6/26/2025 at 4:14 pm, the Director of Nursing (DON) stated it was important documentation in the medical record was accurate to ensure staff knew how to appropriately address the resident's needs based on his or her current condition. The DON stated inaccurate documentation could lead to staff confusion and inappropriate provision of care and services to the residents. b. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including congestive heart failure ([CHF]-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive state of decline in mental abilities), and post-traumatic stress disorder ([PTSD], a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 48's Minimum Data Set (MDS, dated [DATE], the MDS indicated Resident 48 had severely impaired cognitition and required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with self-care abilities like eating, was dependent (helper does all of the effort to complete the task) with oral hygiene toileting and personal hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 48 required moderate assistance (helper does more than half the effort to complete the task) with mobility like rolling left and right, sitting to lying position, lying to sitting on side of bed, and was dependent with sit to stand position, chair/bed to chair transfer, and shower transfers. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 48's Order Summary Report, the Order Summary Report indicated Restorative Nursing Aide (RNA) program for passive range of motion ([PROM], a type of range of motion exercises that involves a helper moving a person's joint through its range of motion) to left upper extremity ([LUE], left arm) five times a week as tolerated every day-shift Tolerance: G=Good, F=Fair, P=Poor ordered on 1/11/2025, RNA for sit to stand with hallway railing or parallel bars five times a week as tolerated every day shift ordered on 12/16/2024, RNA to apply wrist hand finger orthosis ([WHFO], ideal support, protection, and positioning of the wrist, hand and fingers) to left hand five times a week for four to six hours as tolerated with skin check every day shift ordered on 1/11/2025. During a review of Resident 48's comprehensive care plan, dated 11/14/2018, the comprehensive care plan indicated Resident 48 was at risk of decline in ADLs due to contractures with goals that resident will remain free of complications related to immobility including contractures, skin break down and fall related injuries with interventions to provide gentle range of motion as tolerated with daily care, RNA for application for left resting hand splint up to four hours every day, five times a week as tolerated with skin check daily. During a review of Resident 48's Restorative Nursing Weekly/Monthly Progress Report for February 2025, the document indicated for the end of the week of 2/6/2025, Resident 48 was receiving RNA services of PROM to LUE five times a week but no repetition was indicated, no resistance to movement was indicated, and no average time spent per day for the PROM was indicated, Resident 48 was receiving mobility services sit to stand five times a week using the hallway rails but no indication for balance nor speed was documented and the average time spent per day providing services was not documented, Resident 48 was receiving splint services five times a week on the left hand for about four to six hours per day with skin check every two hours but no average time spent per day for this program was documented. For the end of the week 2/27/2025, Resident 48 was receiving RNA services of PROM to LUE five times a week but no repetition was indicated, no resistance to movement was indicated, and no average time spent per day for the PROM was indicated in the documentation, Resident 48 was receiving mobility services sit to stand five times a week using hallway rails but no speed was indicated and no average time spent per day providing the services was documented, Resident 48 was receiving splint services five times a week on the left hand for about four to six hours per day with skin check every two hours but no average time spent per day for this program was documented. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 48's Restorative Nursing Weekly/Monthly Progress Report for March 2025, the document indicated for the end of the week 3/6/2025, Resident 48 was receiving RNA services of PROM but there was no indication of how many times per week for the LUE was provided, no repetition was indicated, no resistance to movement was indicated, and no average time spent per day for the PROM was indicated, Resident 48 was receiving mobility services sit to stand five times a week using the hallway rails but no indication for speed was documented and the average time spent per day providing services was not documented, Resident 48 was receiving splint services five times a week on the left hand for about four to six hours per day with skin check every two hours but no average time spent per day for this program was documented. For the end of week 3/13/2025, Resident 48 was receiving RNA services of PROM to the LUE five times a week, but no repetition was indicated, no resistance to movement was indicated, and no average time spent per day for the PROM was indicated, Resident 48 was receiving mobility services sit to stand five times a week using the hallway rails but the average time spent per day providing services was not documented, Resident 48 was receiving splint services on the left hand but no indication of how many days per week were documented for about four to six hours per day with skin check every two hours but no average time spent per day for this program was documented. For the end of the week 3/20/2025, Resident 48 was receiving RNA services of PROM to LUE five times a week was provided, but no repetition was indicated, no resistance to movement was indicated, and no average time spent per day for the PROM was indicated, Resident 48 was receiving mobility services sit to stand five times a week using the hallway rails but the average time spent per day providing services was not documented, Resident 48 was not receiving splint services five times a week on the left hand for about four to six hours per day with skin check every two hours with average time spent per day for this program. For the end of the week 3/27/2025, Resident 48 did not receive splint services five times per week on the left hand for about four to six hours per day with skin check every two hours with average time spent per day for this program. During an interview and record review on 6/25/2025 at 3:30 p.m., with RNA 2, the Restorative Nursing Weekly/Monthly Progress Report for February 2025 and March 2025 was reviewed. RNA 2 stated Resident 48 was getting the services as ordered because on another form, the RNA Flowsheet attached to this document showed the staff are initiating that the services were provided but stated there should have been clear documentation of services provided to Resident 48 on the Weekly/Monthly Progress Report. RNA 2 stated if not clearly documented, it was not done and if services were not provided, resident can have a decline in mobility, ROM, sit to stand, and splinting. RNA 2 stated if the services were not documented correctly, the next person who views the document won't see that the services were being provided. RNA 2 stated documentation of services should be clear and accurate. During an interview and record review on 6/25/2025 at 3:39 p.m. with the MDS Coordinator (MDSC), the Restorative Nursing Weekly/Monthly Progress Report for February and March 2025 was reviewed. the MDSC stated the RNA staff should be documenting that Resident 48 was receiving services as ordered on the Restorative Nursing Weekly/Monthly Progress Report. MDSC stated documentation of a service should be clear and accurate and if it was not documented, the services were not done. MDSC stated if services were not provided, there could be a decline in the residents' mobility and functioning. During an interview on 6/26/2025 at 3:38 p.m., with the Director of Nursing (DON), the DON stated the importance of clear and accurate documentation was that documents are a reference that resident was receiving the services as ordered. DON stated staff should be making sure all services provided to residents are documented accurately and receive credit for the services provided. DON stated if documents are not accurate, it can lead to other documentation being inaccurate. (continued on next page)

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F 0842 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, Charting and Documentation, revised July 2017, indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care documentation in the medical record may be electronic, manual or a combination .the following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the facility's Policy and Procedure (P/P) titled Charting and Documentation, revised 7/2017, the P/P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychological condition shall be documented in the resident's medical record. The P/P indicated documentation in the medical record would be objective (not opinionated or speculative), complete, and accurate.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to identify and implement corrective action on repeated systemic problems that were identified from the last survey process, affecting 102 of 102 residents: a. Ensure staff were notifying the medical doctor of any change in condition in residents. b. Ensure the accuracy of Minimum Data Set (MDS, a resident assessment tool) for residents. The deficient practices placed the residents at risk of not receiving the quality treatment necessary to adequately meet their highest practicable well-being. Findings: During an interview on 6/26/2025 at 4:20 p.m., with the Administrator (ADM), the ADM stated the following systemic issues identified were not identified by the QAA committee during this survey process: a. Ensure staff were notifying the medical doctor of any change in conditions in residents. b. Ensure the accuracy of Minimum Data Set (MDS, a resident assessment tool) for residents. During a record review of the facility's policy and procedure (P/P) titled, Quality Assurance and Performance Improvement (QAPI) Program, revised 2/2020, the QAPI Program indicated the facility shall develop, implement, and maintain ongoing, facility wide, data driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents .the objectives of the QAPI Program are to provide a means to measure current and potential indicators of outcomes of care and quality of life, provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators, reinforce and build upon effective systems and processes related to the delivery of quality of care and services, establish systems through which to monitor and evaluate corrective actions .the committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan. Cross Reference F580, F641

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 maintain and observe infection control measures by failing to: a.Ensure Restorative Nursing Aide 1 changed isolation gowns (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) in between provision of direct, high contact care for Resident 13 and Resident 30 who were both on Enhanced Barrier Precautions (EBP, infection control intervention using gown and gloves during high contact resident care activities designed to reduce the transmission of multi-drug-resistant organisms). b.Sanitize (to reduce or eliminate bacteria on the surfaces of something) the mechanical lift (a mechanical device used to safely transfer individuals who have limited mobility from one place to another) between using it for 2 of 3 sample residents (Residents 1 and 45) Resident 1 and Resident 45. These failures had the potential to transmit infectious microorganisms and increase the risk of infection among the residents and staff members. Findings: a. During a review of Resident 13's admission Record, the admission Record indicated the facility initially admitted Resident 13 on 5/9/2019 and re-admitted Resident 13 on 7/18/2024 with diagnoses including malnutrition (condition that occurs when the body does not receive or use enough nutrients to maintain health), dysphagia (difficulty swallowing), and Type 2 Diabetes Mellitus (condition in which the body does not metabolize blood sugar correctly). During a review of Resident 13's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/22/2025, for Resident 13 to be placed on Ehnhanced Barrior Precaution (EBP an infection control strategy that aims to reduce the spread of multidrug-resistant organisms). During a review of Resident 30's admission Record, the admission Record indicated the facility initially admitted Resident 30 on 3/10/2025 and re-admitted Resident 30 on 2/7/2024 with diagnoses including malnutrition, dysphagia, and heart failure (condition in which the heart has difficulty pumping enough blood to keep up with demands of body). During a review of Resident 30's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/22/2025, for Resident 30 to be placed on EBP precautions. During an observation on 6/25/2025 at 9:26 a.m., Restorative Nursing Aide 1 (RNA 1) entered Resident 13's room and put on gloves and an isolation gown. RNA 1 assisted Resident 13 with range of motion (ROM, full movement potential of a joint) exercises to both arms and applied splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to both elbows. After the RNA session was complete, RNA 1 walked to the door and saw Resident 30 laying sideways in bed. RNA 1 removed gloves, performed hand hygiene, put on new gloves, and did not change his isolation gown. RNA 1 walked to Resident 30's bed, put his left arm under Resident 30's neck and his right arm under Resident 30's knees, and repositioned Resident 30 in bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/25/2025 at 9:47 a.m., RNA 1 stated he did not change his isolation gown after providing RNA exercises to Resident 13 and before repositioning Resident 30. RNA 1 stated he should have changed his isolation gown in between providing care to Resident 13 and Resident 30 because they were on EBP precautions. RNA 1 stated it was important to follow infection control protocols to prevent the spread of infection. During an interview on 6/26/2025 at 3:05 pm, the Infection Preventionist Nurse (IPN) stated the purpose of EBP was to minimize the risk of infection for residents with invasive devices (medical tools that enter the body either through a break in the skin or an opening in the body) such as foley catheters (thin, flexible rube inserted into the bladder to drain urine), gastronomy tubes (a tube placed directly into the stomach for long-term feeding), wounds, and surgical sites. The IPN stated all staff providing direct patient care which included RNA exercises and repositioning of residents on EBP precautions must wear the appropriate personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) which included an isolation gown and gloves to prevent the spread of infection. The IPN stated staff must change his or her isolation gown and gloves in between the provision of direct, high contact care of multiple residents to prevent the spread of infection and prevent cross contamination. During an interview on 6/26/2025 at 4:14 p.m., the Director of Nursing (DON) stated all staff must change PPE which included an isolation and gloves for residents on EBP precautions in between provision of direct care of multiple residents. The DON stated it was important all staff followed the proper infection control protocols to prevent the spread of infection. During a review of the facility's Policy and Procedure (P/P) titled, Infection Prevention and Control Program, dated 9/18/2023, the P/P indicated an infection control program was established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P/P indicated the program was based on accepted national infection prevention and control standards. During a review of the facility's P/P titled, Enhanced Standard/Barrier Precautions, revised 2/21/2025, the P/P indicated the purpose of EBP was for the prevention of transmission of Multi-Drug-Resistant Organisms (MRDO, bacteria resistant to many antibiotics). The P/P indicated EBP was an infection control intervention designed to reduce the transmission of MDRO that employed targeted gown and glove use during high contact resident care activities. During a review of the California Department of Public Health (CDPH) Enhanced Standard Precautions for Skilled Nursing Facilities (ESP for SNF), dated 2019, the ESP for SNF indicated the purpose of the document was to update and clarify recommendations to prevent the spread of MDRO in skilled nursing facilities. The ESP for SNF indicated .in multi-bed rooms, consider each bed space as a separate room and change gowns and gloves and perform hand hygiene when moving from contact with one resident to contact with another resident. b. During a review of Resident 45's admission Record, the admission Record indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including unspecified atrial fibrillation (an irregular heartbeat present but the type is not specified), contracture of muscle (several of the muscles became permanently tight and shortened restricting movements of joints) multiple sites, and abnormal posture. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 45's MDS (MDS- a resident assessment tool) dated 4/21/2025, the MDS indicated Resident 45's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills were severely impaired. The MDS indicated Resident 45 was dependent on staff for eating, chair/bed to chair transfer, lying to sitting on side of bed, sitting to lying, upper and lower body dressing and oral hygiene. During review of Resident 45's untitled care plan (CP) initiated on 4/18/2024, the CP indicated Resident 45 had functional limitation in range of motion (a reduced ability to move a joint through its normal range) bilateral (both) upper extremities (both arms, shoulders, elbows and hands) impaired and bilateral lower extrem (both legs from the hips down to the feet) impaired with interventions for chair / bed to chair transfer-dependent assist using mechanical lift transfer with 2 person assist. b1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including history of falling, Charcot's joint (nerve damage where absence of pain allows injuries to progress unnoticed and caused joint destruction and joint deformity), and contracture (changes in the body's soft tissues that cause them to stiffen and shorten), unspecified joint . During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) were severely impaired. The MDS indicated Resident 1 was dependent on staff for eating, chair/bed to chair transfer, lying to sitting on side of bed, sitting to lying, upper and lower body dressing and oral hygiene. During review of Resident 1's untitled care plan (CP) initiated on 3/29/2018, the CP indicated Resident 1 had functional limitation in ranges of motion (a reduced ability to move a joint through its normal range) BUE impaired BLE with interventions to transfer. The resident requires dependent assist up to total assist with 2 staff participation with transfers may use mechanical lift . During an observation on 6/23/2025 at 2:06 p.m., Certified Nursing Assistant (CNA 4) placed Resident 45 in the mechanical lift transferred her to the wheelchair and placed Resident 45 in the activity room. CNA 4 and CNA 5 arrived at Resident 1's bedside with the mechanical lift both proceeded to place the harness under Resident 1, lift Resident 1 and place her on the wheelchair. During an interview on 6/23/2025 at 2:18 p.m. with CNA 4, CNA 4 stated she did not clean the mechanical lift after she finished working with Resident 45. CNA 4 stated the mechanical lift was cleaned earlier in the day. CNA 4 stated the mechanical lift should have been cleaned after she worked with Resident 45 to decrease the risk of contamination. During an interview on 6/23/2025 at 2:21 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated mechanical lift needs to be cleaned like all equipment before and after use to prevent possible cross contamination. During an interview on 6/23/2025 at 2:30 p.m., with CNA 5 , CNA 5 stated when using a mechanical lift, we clean before using it, in-between residents and going from room to room to prevent the spread of germs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Convalescent Center of North Long Beach	260 E Market St Long Beach, CA 90805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/23/2025 at 3:04 p.m., the director of staff development (DSD) stated the mechanical lift is used to transfer from bed to wheelchair or bed to shower-chair, therefore you must disinfect the mechanical lift for infection precautions to prevent passing germs. During an interview on 6/26 2025 at 1:30 p.m., with the Director of Nursing (DON), the DON stated the process when using a mechanical lift for one resident after another (general), staff using the mechanical lift must disinfect the equipment after each resident's use. The DON stated this is how you can prevent cross contamination from one resident to another. During a review of the facility's P&P titled Cleaning and Disinfection of Residents Care- Items and Equipment, revised September 2022, the P&P indicated , Residents- care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to the current CDC recommendations for disinfection and the OSHA Blood Born Pathogen Standard.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055995	A. Building B. Wing	06/26/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to offer and educate coronavirus ([Covid-19] n infectious disease caused by the SARS-CoV-2 virus) vaccinations to staff per facility's policy for six of seven sampled employees. This failure had the potential to place all residents at risk for infection of Covid-19. Findings: During a concurrent interview and record review on 6/25/2025 at 9:49 a.m. with the Infection Preventionist Nurse (IPN), the Employee Vaccine Tracker Log was reviewed. The IPN stated Covid-19 vaccine booster and vaccines are encouraged to all employees. The IPN stated the facility accepts verbal declinations for vaccinations. The IPN stated the facility does not use vaccine declination forms and does not have documentation indicating staff were offered and educated about the Covid-19 vaccination for the 2024-2025 season. During an interview on 6/26/2025 at 4:34 p.m. with the Director of Nursing (DON), the DON stated it is important to educate and document staff coronavirus vaccinations to protect residents and staff from a Covid-19 outbreak. The DON stated there should be an employee acknowledgement form indicating the employee was educated about the risks and benefits, as well as the refusal of the vaccination. During a review of the facility's policy and procedure (P&P), titled Coronavirus Disease (Covid-19) Policy, undated, the P&P indicated all staff are required to be fully vaccinated for COVID-19.