STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056008	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Rehabilitation Hospital	533 S. Fairfax Ave Los Angeles, CA 90036

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 3/2/2026 by failing to: 1.Ensure 13 residents (unidentified) on pureed diet (foods that do not require chewing and are easily swallowed, all food should be smooth and pureed to the consistency of pudding) received bread texture in form that meet their needs and in accordance with international Dysphagia Diet Initiative (IDDSI- a framework made up of levels and describes food textures and drink thickness) Level Four (pureed foods and extremely thick drinks) when the texture of the pureed bread was lumpy and liquid seeping out, not smooth and had small pieces of bread crust present requiring chewing before swallowing. 2.Ensure minced and moist texture bread was prepared according to the IDDSI- Level Five minced and moist foods- (all foods prepared for this diet must be soft, moist with all excess fluid drained, and minced to size no larger than 4mm fits through the gaps of fork prongs) when 16 residents (unidentified) received hamburger Bun/bread that was not small (minced) did not fit though the fork prongs and it was dry not moist. 3.Follow the food production recipe for 16 Residents (unidentified) on the soft and bite size diet (food particle are soft and chopped into 1/2 inch pieces) who received minced hamburger mixed with cheese instead of hamburger chopped into 1/2 inch pieces. These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake and increased choking risk for the 13 residents who received the pureed bread.Findings:1.During an observation of the tray line (tray line- a system of food preparation, in which trays move along an assembly line) service for lunch on 3/2/2026 at 11:50AM, the pureed bread looked lumpy, and milk floating on top while in a pan on the steam table. During the same observation and interview with Cook1 (Cook1) on 3/2/2026 at 11:55AM, Cook1 stated the pureed bread was bread mixed with milk and blended a little, it was like bread soaked in milk. During a concurrent interview and taste test of the pureed bread with Dietary Supervisor (DS), Cook1 and Cook2, on 3/2/2026 at 12:45PM, the pureed bread had a lumpy texture. There were small pieces of bread and residue stayed in the mouth requiring chewing. Cook1 stated Cook1 made a mistake and prepared bread soaked in milk instead of pureed bread. Cook2 stated it would need to be blended longer to make a smooth product. [NAME] 1 stated this can affect the swallowing of the bread and result in choking in residents on puree diet. During a concurrent interview on 3/2/2026 at 12:45PM with the Dietary Supervisor (DS), the DS stated the consistency of the pureed bead was not smooth and some bread stays in the mouth. The DS stated they would blend the bread mixture until it was soft and smooth and not sticky. During a review of the facility recipe titled Pureed (IDDSI Level 4)Breads, cakes, cookies, pancakes and other bread products (dated 2025) the recipe indicated, puree bread on low speed adding milk gradually.the finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test. 2. During an observation in the kitchen on 3/2/2026 at 11:40AM, Cook1 blended the hamburger buns until they were minced into (continued on next page)

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

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uneven sizes some bread particles larger than others. During a concurrent observation and interview on 3/2/2026 at 11:40AM, cook 1 stated the blended bread is for a minced moist bread. Cook1 stated there is nothing on the bread, no broth, water or any moisture. During an observation of the tray line (tray line- a system of food preparation, in which trays move along an assembly line) service for lunch on 3/2/2026 at 11:50AM, the minced and moist bread looked dry, not cohesive and crumbly, there were some larger pieces of bread. While serving the minced and moist bread observed the crumbly bread fell from the scoop spread out and was all over the plate. During a concurrent interview and taste test of the pureed bread with Dietary Supervisor (DS), Cook1 and Cook2, on 3/2/2026 at 12:45PM, Cook1 stated the bread was minced in the food processor and no moisture was added to it. Cook1 tested the texture of the bread using a fork and stated it was not moist and fell apart on the plate. [NAME] 1 stated some bread pieces were large and did not fit the gaps of the fork prongs per minced and moist size chart. Cook1 stated should have added moisture to the minced bread to make the bread moist and not crumbly. The DS stated not following the menu could cause not preparing the correct texture and potential for some residents to have difficulty swallowing and not liking the food. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 5 Minced and Moist is usually eaten with spoon or fork, for people who cannot bite off pieces of food safely but have some basic chewing ability. It is important that food is not sticky. You should be able to scoop food onto a fork, with no liquid dripping and no crumbles falling off the fork. Size of the food is 4mm, which is about the gap between the prongs of a standard dinner fork. Food testing method: Spoon tilt test and Fork drip test. 3. During an observation in the kitchen on 3/2/2026 at 11:50AM, Cook1 served minced hamburger meat mixed with melted cheese over a crumbly bread to residents who were on soft and bite size diet (food particle are soft and chopped into 1/2 inch pieces). During a concurrent observation and interview with Cook1 and Cook2 on 3/2/2026 at 12:45PM Cook1 stated [NAME] 1 did not follow the recipe to prepare the soft and bite size hamburger. Cook1 stated instead of serving hamburger cut into 1/2 inch size [NAME] 1 stated [NAME] 1 made a minced hamburger meat and mixed with cheese to make a minced and moist and served over the minced bread. Cook2 stated some residents may not like minced and not eat the food. During an interview with the DS on 3/2/2026 at 12:45PM, the DS stated cooks (in general) should always follow the menu and recipe to make sure correct texture and recipe were served. The DS stated not following the menu could make some residents not happy with the food and decrease intake. During a review of the facility's recipe titled Bacon Cheeseburger on a bun (dated 2026) the recipe indicated, Soft and Bite size IDDSI level 6: Tender meat, chop into pieces =1.5 cm by 1.5 cm in size serve with minced and moist bun, shaped/molded into a circle, meat on top, top with minced an moist bun. During a review of facility policy and procedures (p & p) titled, Menu Planning (dated 2023), the p & p indicated, The menus are planned to meet nutritional needs of residents in accordance with established national guidelines.Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. During a review of the facility's cook's job description (dated 2019), the job description indicated, General duties and responsibilities: Review menus prior to preparation of food, prepare meals in accordance with planned menus, and prepare food for therapeutic diets in accordance with planned menus.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when: 1.The dishware was not sanitized with adequate amount of sanitizer. Sanitizers and disinfectants were used on food contact surfaces such as dishes to prevent food borne illness (food poisoning). 2. The kitchen towel used to wipe food contact surfaces was not stored in the sanitizer solution bucket. 3. One medium container of sliced ham with use by date 2/25/2026 and one medium container of previously prepared tuna salad with use by date of 2/26/26 exceeding storage period for deli meat and tuna salad were stored in the walk-in refrigerator. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 75 out of 79 residents (unidentified) who received food from the facility.Findings:During an observation in the dishwashing area on 3/2/2026 at 9:30AM, Dishwasher (DW1) was rinsing the dirty dishes and loading them inside the dish machine and Dietary Aide (DA1) was removing the washed dishes and storing them on shelves. During the same observation and interview with DW and DA1 on 3/2/2026 at 9:30AM, the DW stated chlorine sanitizer was used to sanitize the dishes. DA1 was asked to demonstrate dish machine operation and sanitizer effectiveness. DA1 immersed the test strip on the dish surface and compared it to a color chart on the test strip bottle that showed sanitizer was not in range. The recommended concentration level for chlorine sanitizer is between 50-100 parts per million (PPM). The test strip compared to color chart indicated 0 no sanitizer. During the same observation and interview on 3/2/2026 at 9:30AM with DS and DA1, DA1 stated the machine was working the morning of 3/20/2026 and the sanitizer test was effective. During a concurrent review of the dishwashing sanitizer log record dated 3/2/2026, indicated the sanitizer was in normal range at 50 PPM.During a concurrent interview on 3/2/2026 at 9:30AM with the Dietary Supervisor (DS), the DS started the dishwasher and retested the sanitizer solution three times. The DS stated and verified that the sanitizer was 0 PPM and was not effective in sanitizing the dishes. The DS instructed the kitchen staff (unidentified) to remove all washed dishes from storage and contacted the repair company. The DS stated facility would use disposable plates and utensils. The DS stated dishes have not been sanitized and could result in cross contamination of dishes and make residents sick. During a review of facility Dish Machine Temperature Log dated March 2026, the log indicated Chlorine should be 50-100 PPM, Alert dietary supervisor if temperature and /or chlorine are not correct level. 2. During an observation in the kitchen on 3/2/2026 at 10:45 AM, [NAME] (Cook 1) used a kitchen towel stored on top of the counter to wipe food preparation counters. Then after finishing wiping the counter, [NAME] 1 left the towel on the counter. During a concurrent observation and interview with cook1 on 3/2/2026 at 10:50AM, Cook1 stated the kitchen towel should be stored in a sanitizer solution when not in use. Cook1 stated the kitchen towel was disposable and was going to discard it but forgot and left it on the counter. [NAME] 1 stated the towel did not have sanitizer on it. Cook1 stated it was important to clean the counters with kitchen cloth and sanitizer because it sanitized counters so there is no contamination.During a review of the 2022 U.S. Food and Drug Administration Food Code, Code 3-304.14 Wiping Cloths, use Limitation, indicated, (B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be:(1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114; 3.During an observation in the kitchen on 3/2/2026 at 11AM there was one medium container of sliced ham with a date of 2/25/2026 and one container of previously prepared tuna salad with date 2/26/2026 stored in the walk-in refrigerator. During a concurrent observation and interview on 3/2/2026 at 11AM with [NAME] 1 and the DS, Cook1 stated the date on the label was when the tuna salad was prepared. Cook1 stated the ham was thawed in the refrigerator and then the package was opened and dated. Cook1 stated the kitchen staff (in general) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would keep the tuna salad and ham for three days. Cook1 stated if the tuna salad stayed too long then it could go bad and make the residents sick. The DS removed the ham and the tuna salad and stated the tuna salad and ham were expired and would discard.During a review of facility policy and procedures (P&P) titled, labeling and Dating of Foods (dated 2023) the P&P indicated, newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines. During a review of facility P&P titled, Procedure for Refrigerated Storage (dated 2023) the P&P indicated, All refrigerated foods are to be kept the amount of time per the Refrigerated Storage Guidelines . During a review of the facility Refrigerated Storage Guide, the maximum refrigeration time for tuna salad is 3 days; and the maximum refrigeration time once meat has thawed for luncheon meats, ham, bacon, and frankfurters is 5 days. During a review of the 2022 U.S. Food and Drug Administration Food Code 3-501.17 titled Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking indicated, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of two sampled residents (Resident 4) was free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) by failing to: -Ensure nursing staff (in general) released Resident 4's lap tray (is considered a physical restraint in a nursing home when it is attached to a wheelchair or chair in a manner that restricts a resident's freedom of movement, prevents them from rising, and cannot be easily removed by the resident) every two hours and reposition as indicated in Resident 4's Physical Restraint Care Plan and the facility's Physical Restraint policy and procedure (P&P). This failure restricted Resident 4's freedom of movement (the right of a person to change their position, stand up, walk around, or move their limbs as they wish). This failure also had the potential for Resident 4 to experience a decline in physical functioning, psychosocial harm (damage to a person's mental health, emotions, or social well-being), impaired circulation, and physical harm from entrapment (occurs when a person using a wheelchair becomes caught, wedged, or tangled in a restraint).Findings:During a review of Resident 4's admission Record, the admission Record indicated the facility originally admitted Resident 4 on 1/9/2022 and readmitted Resident 4 on 10/27/2025 with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), history of falling, dementia (a progressive state of decline in mental abilities), and adult failure to thrive (poor appetite, weight loss, fatigue, and overall progressive decline in a person's ability to carry out everyday activities). During a review of Resident 4's History and Physical (H&P) dated 10/28/2025, the H&P indicated Resident 4 could make some needs known but could not make medical decisions. During a review of Resident 4's informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) titled Proposed Treatment Physical Restraint: Lap Tray, dated 12/12/2025, the informed consent indicated Resident 5's responsible party, Family Member 1 (FAM 1) signed the consent for restraints. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 12/15/2025, the MDS indicated Resident 4 could sometimes make herself understood and rarely had the ability to understand others. The MDS indicated Resident 4's vision was impaired (sees large print but not regular print in newspapers/books). The MDS indicated Resident 4 had restraints that prevented Resident 4 from rising from a chair. During a review of Resident 4's Physical Restraint Care Plan dated 12/22/2025, the Care Plan indicated Resident 4 needed a physical restraint: lap tray to maintain proper body posture while in wheelchair and the nursing interventions were to release the lap tray at least every two hours and to reposition Resident 4. During a review of Resident 4's Restraint Review dated 12/22/2025, the Restraint Review indicated the facility started the use of a lap tray on 12/12/2025 for Resident 4 while Resident 4 was up in a wheelchair. During a review of Resident 4's Order Summary Report dated 2/28/2026, the Order Summary Report indicated a physician order to apply a lap tray while on wheelchair for proper trunk (chest area) control. During an observation on 3/2/2026 at 10:05 AM, Resident 4 was observed in the activity room sitting on her (Resident 4) wheelchair with a lap tray. During a concurrent interview and record review on 3/2/2026 at 9:27 AM with Registered Nurse 3 (RN 3), Resident 4's MDS dated [DATE] was reviewed. RN3 stated the MDS indicated Resident 4 had a chair restraint that prevented Resident 4 from rising. RN 3 stated she could not explain why Resident 4's MDS indicated Resident 4 had a restraint. During an interview on 3/4/2026 at 9:52 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the facility placed a lap tray on Resident 4 only when she (Resident 4) was on a wheelchair for trunk support and to prevent her (Resident 4) from falling out of the wheelchair. During an interview on 3/4/2026 at 9:55 AM with (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2 and LVN 5, LVN 2 stated the facility staff (unidentified) needed to remove Resident 4's restraints for 15 minutes every two hours. LVN 2 and LVN 5 could not provide an answer if the facility released Resident 4's restraints for 15 minutes every two hours. During an observation on 3/4/2025 at 10:35 AM, a demonstration of the lap tray application to a wheelchair was observed. The lap tray was observed to be strapped to both wheelchair's arms and had a strap that locked into place behind the back rest of the wheelchair. The lap tray was observed to be restrictive and could not be removed when the straps were applied. During a concurrent interview and record review on 3/4/2026 at 10:43 AM with the Director of Nursing (DON), the facility's P&P titled, Lap Trays, dated 1/26/2026 was reviewed. The DON stated the P&P indicated the lap tray was to provide a safe and alternative to more restrictive physical restraints. The DON stated the P&P indicated the lap tray would assist in preventing residents (in general) from standing and falling while in a wheelchair. The DON was asked if the lap tray would restrict a resident's (in general) freedom of movement and if the lap could be considered a restraint, the DON answered yes. During a concurrent interview and record review on 3/4/2026 at 10:43 AM with the Director of Nursing (DON), the facility's P&P titled, Physical Restraints, dated 1/26/2026 was reviewed. The DON stated the P&P indicated if restraints were utilized, the opportunity for motion and exercise should be provided for a period of not less than ten (10) minutes during each two (2) hour period in which the restraints were utilized. The DON stated the facility did not have any documentation regarding restraint monitoring for and removal of restraints (in general). The DON stated the facility should have documented if the facility released Resident 4's restraints per the facility's policy. During a concurrent interview and record review on 3/4/2026 at 11:28 AM, with the DON and the facility's Administrator (ADM), Resident 4's Restraint Assessment, dated 12/12/2025 was reviewed. The Restraint Assessment indicated Resident 4 was confused, disoriented, had poor safety awareness, had poor trunk control when up in wheelchair, and had episodes of slouching and leaning forward. The Restrain Assessment indicated that an interdisciplinary team (IDT - a group of experts from different fields like doctors, nurses, and social workers who work closely together, sharing information to create a single, coordinated plan for a resident) recommended that Resident 4 would benefit from the use of a lap tray while on a wheelchair. The DON and ADM stated the lap tray was a restraint because it (lap tray) prevented Resident 4's freedom of movement.

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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. Based on interview and record review, the facility failed to provide care in accordance with professional standards for one of one sampled resident (Resident 33) by failing to rotate (a method to ensure repeated injections are not administered in the same area) the injection sites for subcutaneous (beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration. This failure had the potential for Resident 33 to experience complications such as hardening of the skin, pain, redness, itching, swelling, and inflammation at the skin injection sites.Findings:During a review of Resident 33's admission Record, the admission Record indicated the facility originally admitted Resident 33 on 10/6/2023 and readmitted Resident 4 on 6/7/2024 with diagnoses that included type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), adult failure to thrive (a syndrome is characterized by unexplained weight loss, malnutrition and disability), and peritoneal adhesions (bands of scar tissue that form between abdominal tissues and organs). During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool) dated 12/11/2025, the MDS indicated Resident 33 rarely/never could make herself (Resident 4) understood and rarely/never had the ability to understand others. During a review of Resident 33's History and Physical (H&P), dated 2/20/2026, the HP indicated Resident 33 did not have the capacity (ability) to understand and make decisions. During a review of Resident 33's Order Summary Report dated 2/28/2026, the Order Summary Report indicated a physician order for Insulin Glargine (a long-acting insulin injected once daily to manage blood sugar for 24 hours) subcutaneous with instructions to rotate injection sites. During a concurrent interview and record review on 3/4/2026 at 2:47 PM with Licensed Vocational Nurse 6 (LVN 6) and Registered Nurse 3 (RN 3), Resident 33's Location of Administration Report for Insulin Glargine dated 3/3/2026 was reviewed. The Location of Administration Report indicated the facility licensed nurses (unidentified) did not rotate insulin injection sites on the following dates, times, and skin locations:-2/1/26 at 9:18 PM subcutaneously Abdomen - RLQ (right lower quadrant - the bottom-right quarter of your abdomen, spanning from your belly button down to the right hip bone).-2/2/26 at 9:23 PM subcutaneously Abdomen - RLQ-2/22/26 at 10:17 PM subcutaneously Abdomen - RLQ-2/23/26 9:47 PM subcutaneously Abdomen - RLQ During a concurrent interview on 3/4/2026 at 2:47 PM with LVN 6 and with RN3, LVN6 stated Resident 4's insulin injection sites were not rotated. RN 3 stated the licensed nursing staff (unidentified) should rotate the insulin injection sites to prevent hardening of the skin. RN 3 stated licensed nursing staff (in general) who administered insulin should be able to see in the electronic medical record where the previous insulin injection was given for staff (licensed nursing staff) to be able to rotate the injection sites. During a concurrent interview and record review on 3/4/2026 at 2:53 PM with the Director of Nursing (DON), Resident 33's Location of Administration Report for Insulin Glargine dated 3/3/2026 was reviewed. The Location of Administration indicated the facility's licensed nurses (unidentified) did not rotate insulin injection sites on the following dates, times and locations:-2/1/26 at 9:18 PM subcutaneously Abdomen - RLQ-2/2/26 at 9:23 PM subcutaneously Abdomen - RLQ-2/22/26 at 10:17 PM subcutaneously Abdomen - RLQ-2/23/26 9:47 PM subcutaneously Abdomen - RLQDuring a concurrent interview on 3/4/2026 at 2:53 PM with the DON, the DON stated the facility's licensed nurses (unidentified) should have rotated the insulin injection sites to prevent skin hardening at the injection sites. During a concurrent interview and record review on 3/4/2026 at 2:55 PM with the DON, the facility's policy and procedure (P&P) titled, Insulin Administration, dated 1/26/2026 was reviewed. The DON stated the P&P indicated Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). The DON stated the facility licensed nursing staff should have rotated insulin injection sites according to the facility's policy.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review the facility failed to provide proper care and treatment to help improve the communication abilities for one of one sampled resident (Resident 75) by failing to: -Ensure to provide Resident 75 with a communication board (is a device that displays photos, symbols, or illustrations to help people with limited language skills express themselves) and with interpreter services. This failure had the potential for Resident 75 not to be able to communicate her (Resident 75) needs with the facility's staff (in general) and had the potential to delay care/treatment. Findings:During a review of Resident 75's admission Record, the admission Record indicated the facility admitted the resident on 3/8/2024 with diagnoses that included primary open angle glaucoma (a chronic eye disease where fluid buildup slowly increases pressure, damaging the nerve connecting the eye to the brain causing gradual permanent side-vision loss), left eye, indeterminate (cannot accurately classify how severe the damage is) stage, unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance (acting out, agitated, aggressive or mood/personality changes). During a review of Resident 75's History and Physical (H&P) dated 3/9/2025, the H&P indicated Resident 75 did not have the capacity (ability) to understand and make decisions. During a review of Resident 75's Resident Care Plan titled Communication Deficit dated 5/20/2025, the Resident Care Plan indicated Resident 75 had a communication deficit and had difficulty making needs known. The Resident Care Plan indicated Resident 75 had difficulty understanding others and had a language barrier. The Resident Care Plan indicated the goals for Resident 75 included having activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) needs met every shift and would communicate with others daily. The Resident Care Plan indicated an intervention that staff would anticipate Resident 75's needs and use a communication device. The Resident Care Plan indicated an intervention which included translation by the same language speaking staff and family. During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool) dated 2/7/2026, the MDS indicated Resident 75 needed an interpreter to communicate with a doctor and health care staff. The MDS indicated Resident 75 had severe cognitive (ability to think, understand, and reason) impairment. The MDS indicated Resident 75 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear. During a concurrent observation and interview on 3/2/2026 at 12:09 PM with Resident 75 in Resident 75's room, Resident 75 stated, My English not good enough to understand, sorry. Resident 75 began to speak in another language (not English). There was no communication device, translator availability information, and communication board observed in Resident 75's room. The weekly menu and activity calendar posted in Resident 75's room was observed in English. During a concurrent observation and interview on 3/2/2026 at 12:16 PM with Resident 75 and Certified Nurse Assistant 1 (CNA1), in Resident 75's room, CNA 1 stated Resident 75 spoke a different language and could not respond in English. CNA 1 stated he (CNA1) would speak to Resident 75 in English, but Resident 75 would respond in another language. CNA 1 stated sometimes Resident 75 did not understand and CNA 1 would demonstrate using signals. CNA 1 stated Resident 75's family member (unidentified) would speak the same language and when Resident 75's family member (unidentified) visited, the facility would use Resident 75's family member (unidentified) as a translator, otherwise the facility would not know what Resident 75 would need. During a concurrent observation and interview on 3/2/2026 at 12:46 PM in Resident 75's room with Registered Nurse1 (RN1), RN 1 stated the facility did not have a method of contacting a translator for a resident (in general) who did not speak English. RN 1 stated the staff (in general) would use nonverbal cues to communicate with Resident 75. RN 1 stated if something was wrong with Resident 75, the staff would not be able to understand Resident 75, and the resident may (continued on next page)

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Guardian Rehabilitation Hospital	533 S. Fairfax Ave Los Angeles, CA 90036

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not have been able to understand the staff without a translator. RN 1 stated she (RN1) would use her (RN1) phone and would use google translate (an artificial intelligence tool that acts as a digital interpreter) to understand what Resident 75 tried to communicate (in general). RN1 stated she (RN1) should not be using her (RN1) own phone. RN 1 stated Resident 75 spoke a different language and there were no signs posted in Resident 75's language inside Resident 75's room. RN 1 stated a Resident 75 would feel more comfortable to express her (Resident 1) needs in her (Resident 75) own language. During a concurrent observation and interview on 3/2/2026 at 1:02 PM in Resident 75's room with the Director of Nursing (DON), the DON stated the facility did not have a formal translation system and should have one in place. The DON stated if a resident (in general) needed anything, the facility's staff (in general) would not be able to communicate. The DON stated anything complex such as a nursing assessment (step of care that checks a resident's physical and emotional health to identify needs) and no formal translation system, the staff would not be able to communicate with Resident 75 because she (Resident 75) would not understand. The DON stated the facility would call the family but if the family did not pick up the phone or if it was in the middle of the night the facility needed to have a formal translating system in place. The DON stated the facility should not rely on Resident 75's family. The DON stated Resident 75's message board with menus and activities posted were all in English. The DON stated Resident 75 would not be able to understand what activities or menu were in place. During a review of the facility's policy and procedure (P&P) titled Translation or Interpretation Services, dated 1/26/2026, the P&P indicated The facility provides assistance to residents with limited English proficiency.through translation and interpretation services. The P&P indicated When encountering Limited English Proficiency (LEP) individuals, staff members will conduct an initial language assessment and notify the Social Services Department of the resident's need for translation or interpreter services. The P&P indicated The facility provides competent oral translation of vital information that is not available in written translation, and non-vital information in a timely manner and at no cost to the resident through one or more of the following means;.contracted interpreter services, voluntary community interpreters who are trained and competent in the skill of interpreting, telephone interpretation service. The P&P indicated Providing meaningful access to services provided by the facility requires that the limited English proficient resident's needs and questions are accurately communicated to the facility staff. During a review of the facility's policy and procedure (P&P) titled Residents Who Present with Communication Barriers, dated 1/26/2026, the P&P indicated It is the policy of this facility to meet the needs of residents who present with communication barriers. Ref. S483.lO(a) Resident Rights. S483.l0(c)(l), (4), (5) rights to be informed. The P&P indicated Communication supports psychosocial well-being by enabling residents to participate in their care and interact with others. The P&P indicated Communication boards will be provided at no charge to the resident so that non-English speakers. can use pictograms to communicate needs and desires. During a review of the facility's policy and procedure (P&P) titled Resident Rights, dated 1/26/2026, the P&P indicated To reside and receive services with reasonable accommodation of resident needs and preferences.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to set the appropriate setting for a Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries, localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) for one of four sampled residents (Resident 8) reviewed for pressure ulcers/injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) This failure had the potential to cause harm to Resident 8 by increasing the risk of skin breakdown and development of pressure ulcers/injuries.Findings:During a review of Resident 8's admission Record, the admission Record indicated the facility initially admitted the resident on 10/20/2025, with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities),unspecified protein-calorie malnutrition (a state of nutritional deficiency where inadequate intake of protein and calories leads to body composition changes), diabetes mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Order Summary Report dated 10/20/2025, the Order Summary Report indicated Resident 8 was incapable of participating in her treatment plan. During a review of Resident 8's Physician Progress Note dated 10/21/2025, the Physician Progress Note indicated Resident 8 was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 1/26/2026, the MDS indicated the resident had severe cognitive impairment (impaired ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 8 was dependent on the staff (helper does all of the effort) for sitting to stand, chair/bed to chair transfer, and tub/shower transfer. The MDS indicated Resident 8 was at risk of developing pressure ulcers/injuries. The MDS indicated Resident 8 utilized a pressure reducing device for bed.During a review of Resident 8's Weights and Vitals Summary, the Weights and Vitals Summary indicated the resident weighed 104 pounds (lbs., a unit of weight) on 2/4/2026. During a review of Resident 8's Order Summary Report dated 2/24/2026, the Order Summary Report indicated may apply LALM for skin integrity without any documented specific parameters for settings. During a review of Resident 8's Risk for Skin Breakdown/Pressure Ulcer Care Plan dated 2/25/2026, the Risk for Skin Breakdown/Pressure Ulcer Care Plan indicated Resident 8 was at risk for the development of pressure ulcers related to fragile skin. The Risk for Skin Breakdown/Pressure Ulcer Care Plan indicated the intervention was a LAM. During a concurrent observation, interview, and record review on 3/2/2026 at 3:38 PM, with Licensed Vocational Nurse4 (LVN 4), in Resident 8's room, Resident 8 was observed on a Drive LALM with settings set between 0 and 80 lbs. LVN 4 stated Resident 8's LALM settings were set at 0 to 80 lbs. LVN 4 stated the LALM settings were based on a resident's weight (in general). LVN 4 verified Resident 8's weight in the medical record and stated Resident 8's weight was currently 104 lbs. LVN4 stated the resident could have developed redness, skin problems and a pressure ulcer because the mattress was at the wrong setting. During a concurrent observation and interview on 3/2/2026 at 3:45 PM, with Registered Nurse 1 (RN 1) in Resident 8's room, RN 1 stated Resident 8's LALM was set between 0-80lbs. RN 1 stated an incorrect setting would have defeated the purpose of the LALM and Resident 8 could have developed problems with skin integrity. RN 1 stated a wrong setting would not have managed what the LALM was supposed to do. During a concurrent observation and interview on 3/2/2026 at 3:49 PM, with the Director of Nursing (DON), in Resident 8's room, the DON stated LALMs were set according to the residents' weight and stated Resident 8's LALM was set between 0-80lbs. The DON stated Resident 8's LALM was not at the correct setting, and if the LALM was not at the correct pressure the resident could have developed a pressure ulcer if the LALM was too soft.During a review of the facility's policy and procedure (P&P) titled, Low Air Loss Mattress dated 1/26/2026, the P&P indicated It is the policy of the facility to provide for the proper placement and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	management of a low air loss mattress when utilized by a resident. During a review of the user manual titled Med-Aire Assure 8 Alternating Pressure Mattress Replacement System with Low Air Loss undated, the user manual indicated This manual should be used for the initial set up of the system and for future reference. The user manual indicated Support surfaces or specialized mattress systems are used as part of an overall, multi-disciplinary, multi-dimensional care plan intended to prevent and treat pressure injuries. The user manual indicated This analog control unit includes an easy-to-use pressure dial that is adjustable to the patient's weight and comfort.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure to administer one of six medications correctly to one of three sampled residents (Resident 79) as prescribed in the morning of 3/3/2026. This failure had the potential of medication errors that might cause adverse reactions (a harmful, unintended result caused by taking medication).Findings:During an observation on 3/3/2026 at 9:26 AM, the Licensed Vocational Nurse 2(LVN 2) prepared six medications for Resident 79. One of those six medications was one tablet of cetirizine (generic for Zyrtec, an antihistamine used to relieve symptoms of allergies) 10 milligrams (mg, unit to measure mass), administered orally (by mouth).During a review of Resident 79's medication orders, the order, dated 2/7/2026 at 6:52 PM, indicated to give cetirizine 5 mg one tablet by mouth two times a day for allergy.During an interview and an observation on 3/3/2026 at 12:52 PM with LVN 2 at the medication cart 1, the surveyor asked to see the cetirizine bottle for Resident 79. LVN 2 pulled out a bottle of cetirizine 10 mg and stated that it was the bottle. When asked to see Resident 79's medication order, LVN 2 reviewed the electronic health record system and stated Resident 79's medication order indicated cetirizine 5 mg. LVN 2 stated she (LVN2) made a mistake, and the medication error reporting process included to alert the supervisor and the resident's (Resident 79) physician.During an interview on 3/3/2026 at 3:55 PM, the Director of Nursing (DON) stated the adverse reactions for cetirizine included dizziness and the facility would be monitoring the resident (Resident 79). During a review of the facility's policy and procedures (P&P) dated October 2017, the P&P indicated Medications are administered as prescribed. Prior to administration, . the physician's orders are checked for the correct dosage schedule.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure one of three sampled kitchen staff (Dietary Aide 2 [DA2]) was routinely trained and evaluated for competency related to their kitchen duties when: -DA2 did not know the proper sanitizer test strip to use for the manual dishwashing sanitizer solution. On 3/2/2026 at 10AM, DA2 tested the sanitizer solution using the wrong test strip and procedure. These deficient practices had the potential to result in unsafe and unsanitary food production that could place 75 out of 79 residents in the facility who received food at risk for food borne illness (food poising). Findings: During an observation in the kitchen on 3/2/2026, at 10AM Dietary Aide (DA2) was sanitizing dishes in the sanitizer solution made with QUAT sanitizer (quaternary ammonium-QUAT, a type of sanitizing solution used to sanitize food contact surfaces). During a concurrent observation and interview on 3/2/2026, at 10AM with DA2, DA2 was asked to check the sanitizer solution concentration. DA2 attempted to use the dish machine sanitizer (chlorine sanitizer) test strip to test the sanitizer concentration for the manual dish washing sanitizer solution. DA2 stated the test strip was not working, he (DA2) said the normal range is 100 PPM and color change should be blue. During the same observation and interview on 3/2/2026 at 10AM, the Dishwasher staff (DW) gave the correct sanitizer test strip to DA2. DA2 immersed the test strip in the sanitizer solution and counted for 20 seconds to read the results. DA2 then stated the dishes must be submerged in the sanitizer solution for five to ten minutes before the dishes were removed to air dry. During an interview on 3/2/2026 at 10:30AM with the Dietary Supervisor (DS), the DS stated DA2 was using the wrong test strip to test the sanitizer solution concentration. The DS stated staff (kitchen staff in general) needed to know how to check solutions. The DS stated if the kitchen staff (in general) did not check the sanitizer correctly, the dishes could potentially be contaminated and not sanitized. During an interview on 3/2/2026 at 10:55AM with the DS, the DS stated that he (DS) had provided in-services to staff (unidentified) on sanitizer solutions and how to check for concentration. The DS stated he (DS) did not know if the annual competency review included the sanitizer solution testing. During a review of Dietary Aide's job description not dated, the job description indicated, General Duties and Responsibilities: wash and clean utensils as directed. During a review of facility's Annual Dietary Competency evaluation for dietary Aide manual dishwashing and checking sanitizer concentration was not listed for review. During a review of manufacturer procedure titled manual pot and pan washing procedure, the manufacturer procedure indicated, submerge in sanitizer sink for one minute or as specified by product label. During a review of the Manufacturer recommendation for the sanitation range testing posted on the sanitizer dispensing area, indicated, 1.Testing solution should be at room temperature 65-75 degrees Fahrenheit, 2.Withdraw and tear off approximately 2 inches of the paper from dispenser, dip test paper for 10 seconds in the test solution, 3.compare colors immediately with colors on the test paper package to determine PPM (ALWAYS COMPARE AGAINST PACKAGE SCALE), 4.testing solution should be between 150-400PPM parts per million.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 32 sampled residents' rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) met the minimum space requirements of 80 square feet for each resident. This failure had the potential to result in inadequate space to provide safe nursing care and privacy for the residents in room [ROOM NUMBER] and room [ROOM NUMBER]. Findings:During an initial observation tour of the facility on 3/4/2026 from 10:10 AM to 11:30 AM, the facility staff (unidentified) were observed with enough space to provide care and services to the residents in each of the facility's rooms. During a review of the facility's room waiver request letter dated 3/6/2026, the room waiver request letter indicated the facility requested a room waiver for room [ROOM NUMBER] and room [ROOM NUMBER]. The room waiver request letter indicated there was enough space to provide for each resident's care dignity and privacy. The room waiver request letter indicated the rooms were in accordance with the special needs of the residents and would not have an adverse effect (undesirable effect) on residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. The room waiver request letter indicated the following measurements:Room Number of Beds Square Feet102 2 158.35 (13'5.04 X 11 '9.6)114 4 287 (20' X 14'4.2) During an interview on 3/4/2026 at 2:05 PM with the Director Rehabilitation Services (DRB), the DRB stated most of the therapy provided by the facility was done in the residents' rooms. The DRB stated there was enough room for therapy in all of the rooms at the facility. During an interview on 3/4/2026 at 2:26 PM with Resident 89, Resident 89 stated she (Resident 89) did not have any issues with the size of room [ROOM NUMBER]. The Department is recommending continuation of the room waiver request.