

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Seal Beach Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 N Gate Road Seal Beach, CA 90740	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure comfortable home like environment was provided for five of 35 final sampled residents (Residents 22, 50, 79, 93, and 142) and two nonsampled residents (Resident 177 and 204) reviewed for home like environment. * The facility failed to provide an environment with comfortable sound levels for Residents 50, 79, 93, 142, 177, and 204. * The facility failed to ensure Resident 22's room (Room A) was in good repair, when there was a large area of chipped paint and a non-penetrating hole on the wall near Resident 22's bed. These failures had the potential to prevent the residents from resting or sleeping, negatively impact their health and psychosocial wellbeing, and diminish their overall quality of life. Findings: Review of the facility's P&P titled Homelike Environment dated 2/2021 showed the residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasizes the resident's comfort, independence and personal needs and preferences. The facility staff and management maximize to the extent possible, the characteristics of the facility reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment, inviting colors and décor, and comfortable sound levels. 1.a. On 6/30/26 at 1055 hours, an interview was conducted with Resident 50 in Room B. Resident 50 stated the resident in Room C frequently screams and keeps the television volume excessively loud at all times, including during the night. Resident 50 reported the noise was bothering him and preventing him from sleeping and resting adequately. Resident 50 stated he informed the staff and they were aware of the noise, however nothing had been done to resolve the issue. Resident 50 stated this has been going on for a long time but could not recall the exact duration. Medical record review for Resident 50 was initiated on 6/30/26. Resident 50 was admitted to the facility on [DATE]. Review of Resident 50's H&P examination dated 4/24/26, showed Resident 50 had the capacity to make medical decisions. Review of Resident 50's MDS assessment dated [DATE] showed Resident 50 was cognitively intact. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for four of 35 final sampled residents (Residents 5, 96, 116, and 166) and one nonsampled resident (Resident 38). * The facility failed to ensure oxygen was administered to Resident 5 in accordance with the physician's order. * The facility failed to ensure Resident 38's nasal cannula for her portable oxygen and for the oxygen concentrator were both dated and labeled. * The facility failed to ensure Resident 96's oxygen set up was administered and was connected to a humidifier per physician's order. * The facility failed to obtain a physician's order or develop a care plan for Resident 116's use of CPAP. * The facility failed to ensure Resident 166's oxygen nasal canula tubing was labeled with a date. These failures posed the risk for the residents to develop complications related to oxygen use. Findings: 1. On 6/30/26 at 1039 hours, Resident 116 was observed lying in bed. A CPAP machine with a mask was observed stored on the right side of the bed. Medical record review for Resident 116 was initiated on 6/30/26. Resident 116 was admitted to the facility on [DATE]. Review of Resident 116's H&P examination dated 6/1/26, showed Resident 116 had the capacity to understand and make medical decisions. Review of the Resident 116's Order Summary Report dated 7/1/26, did not show an order for the CPAP. On 7/1/26 at 1208 hours, an observation and concurrent interview was conducted with Resident 116 and Resident Representative 1. Resident 116 stated she was using a CPAP machine since her admission to the facility, and the facility staff assisted her with putting the CPAP mask on each night and removing it each morning. Resident Representative 1 stated Resident 116 received the CPAP machine from an outside clinic prior to her admission to the facility. Resident 116 was observed lying in bed. A CPAP machine with mask was observed to be stored on the right side of the bed. Review of Resident 116's medical record failed to show a care plan was developed for the use of a CPAP for Resident 116. On 7/1/26 at 1210 hours, an observation, interview, and concurrent medical record review for Resident 116 was conducted with LVN 8. LVN 8 verified a CPAP machine was present at the resident's bedside. LVN 8 reviewed the medical records and confirmed there was no physician's order for the CPAP, nor was it addressed in the care plan. LVN 8 stated the use of a CPAP machine in the facility requires a physician's order and the staff must ensure the machine was functioning properly. 2. On 6/30/26 at 1025 hours, Resident 5 was observed lying in his bed eyes closed. The oxygen was observed running at 2 LPM via nasal cannula. The nasal cannula was observed on the resident's chin, not nose. Resident 5 was observed breathing normally. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 5 was initiated on 6/30/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 10/30/25, showed Resident 5 had no capacity to make decisions. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 had severe cognitive impairment and required substantial staff assistance for his activities of daily living. Review of Resident 5's Order Summary Report showed the following physician's orders: - dated 5/7/25, for oxygen to administer at 2 LPM via nasal cannula continuously every shift; and - dated 5/7/25, to monitor oxygen saturation every shift and to notify physician if oxygen saturation is less than 89%. On 7/1/26 at 0853 hours, Resident 5 was observed lying in his bed eyes closed. The oxygen was observed running at 2 LPM via nasal cannula. The nasal cannula was observed on the resident's chin, not nose. Resident 5 was observed breathing normally. On 7/2/26 at 0951 hours, an observation and concurrent interview was conducted with LVN 8. Resident 5 was observed lying in his bed eyes closed. The oxygen was observed running at 2 LPM via nasal cannula. The nasal cannula was observed on the resident's chin, not nose. Resident 5 was observed breathing normally. LVN 8 verified Resident 5's nasal cannula was positioned on his chin, resulting in the resident not receiving oxygen as ordered by the physician. LVN 8 checked Resident 5's oxygen saturation, which measured at 85% without oxygen. LVN 8 then repositioned the nasal cannula correctly, and Resident 5's oxygen saturation increased to 90% with 2 LPM of oxygen. LVN 8 stated Resident 5 had a habit of removing his nasal cannula. When asked whether the physician had been notified of this behavior and whether it was addressed in the care plan, LVN 8 was unable to provide documentation demonstrating that these steps had been taken. On 7/3/26 at 1019 hours, an interview was conducted with the DON. The DON was informed of and acknowledged the above findings. 3. Review of facility's P&P titled Oxygen Administration, revised October 2010 showed in part, the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify there is a physician's order for the procedure. Review the physician's order or facility protocol for oxygen administration. Review the resident's care plan to assess any special needs of the resident. Assemble the equipment and supplies as needed. The following equipment and supplies will be necessary when performing this procedure: Portable oxygen cylinder, nasal cannula, nasal catheter, mask, humidifier bottle, No Smoking /Oxygen in use signs, Regulator and personal protective equipment. On 6/30/26 at 0950 hours, during the initial tour, Resident 96 was observed lying on his bed receiving oxygen at 3 LPM via nasal cannula using the oxygen concentrator machine. There was no humidifier bottle on the oxygen machine connected to the oxygen tubing going to Resident 96 nose. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/30/26 at 1144 hours, during an observation, Resident 96's oxygen set up showed oxygen at 3 LPM via nasal cannula with no humidifier bottle on the oxygen machine connected to the oxygen source. Medical record review for Resident 96 was initiated on 7/1/26. Resident 96 was initially admitted to facility on 8/21/25 and readmitted on [DATE], with diagnosis of acute and chronic respiratory failure with hypoxia and hypercapnia, and COPD with acute exacerbation. Review of Resident 96's Order Summary report showed a physician order dated 2/27/26, for oxygen at 4 LPM via nasal cannula continuously every shift for respiratory failure and to change oxygen humidifier every week on Wednesday and as needed when consumed (with name and date label) every night shift every Wednesday. On 7/1/26 at 1500 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified Resident 96's oxygen was set at 2 LPM using the oxygen concentrator machine and there was no humidifier bottle on the oxygen machine. On 7/1/26 at 1518 hours, an interview and concurrent medical record review for Resident 96 was conducted with LVN 2. LVN 2 verified the physician's order for oxygen was for 4 LPM via nasal canula. On 7/3/26 at 1055 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings. 4. Medical record review for Resident 38 was initiated on 6/30/26. Resident 38 was re-admitted to the facility on [DATE]. Review of Resident 38's Order Summary Report showed the following physician's orders: - dated 2/10/26, to change the oxygen nasal cannula every Wednesday night and PRN with resident's name and date; and - dated 2/10/26, to administer oxygen at 2 LPM via nasal cannula continuously. On 6/30/26 at 0814 hours, Resident 38 was observed with two other residents, all in their wheelchairs, lined up against the hallway wall by the activity/dining room. Resident 38 was observed with a nasal cannula in use. On 6/30/26 at 1257 hours, Resident 38 was observed in her wheelchair in her room with CNAs 2 and 5 at her bedside. An oxygen cylinder was observed on the back of the resident's wheelchair with the nasal cannula tubing unlabeled and undated. Resident 38 was transferred to the bed, and a nasal cannula attached to the oxygen concentrator was applied to the resident. The nasal cannula tubing was also unlabeled and undated. LVN 1 then entered the room. LVN 1 stated oxygen tubing should be dated, labeled, and changed weekly. LVN 1 observed Resident 38's nasal cannula tubing, and verified both nasal cannulas used by Resident 38 were unlabeled and undated. (continued on next page)		

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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, facility document review, and facility P&P review, the facility failed to ensure the menus were followed for 17 residents who received a fortified diet. * The facility failed to ensure one ounce of margarine was added to the lunch meal trays, and whole milk was provided to breakfast meal trays for the residents who were on fortified diets. This failure had the potential to not meet the resident's nutritional needs for the 17 of 173 residents who received a fortified diet. Findings: Review of the facility's matrix (undated) showed 173 residents consumed food prepared in the facility's kitchen. Review of the facility's P&P titled Enhanced Diet (Protein Enhanced) revised 4/2024 showed the diet is used when additional amounts of protein are needed but the resident is unable to ingest larger quantities of food or additional supplements. The diet includes the Enhancement of three menu items per day with a protein supplement. The Enhanced Diet is based on the regular diet with Whole Milk instead of 2%; thus, three meals per day. The diet features three enhanced menu items per day. a. Review of the facility's document titled Melted Margarine dated Spring 2026 showed to melt two tablespoons (one ounce) of margarine and pour over hot entree, starch, and/or vegetables. Review of the facility's document titled Therapeutic Spreadsheets dated 7/1/26, showed under the Week 4 Tuesday lunch, Fortified/High Protein diets should receive one ounce melted margarine. On 6/30/26 at 1145 hours, an observation of the lunch meal tray line and concurrent interview was conducted with Dietary Aide 1 in the kitchen. Resident 3 and 109's meal trays showed Fortified/High Protein diet. Resident 3 and 109's meal trays did not show the one ounce of melted margarine was added to their trays. The Dietary Aide 1 stated a Fortified/ High Protein diet gets whole milk, but Residents 3 and 109 did not like milk, so Resident 3 was given an alternative high protein nourishment and Resident 109 was given chocolate milk. On 6/30/26 at 1300 hours, an interview was conducted with the Dietary Services Supervisor. The Dietary Services Supervisor stated the residents on a fortified diet should have received one ounce of margarine on their meal trays. The Dietary Services Supervisor confirmed the one ounce of melted margarine was not visible on the tray and could not verify if the one ounce of melted margarine was added to the meals. b. Review of the facility's document titled Therapeutic Spreadsheets dated 7/1/26, showed under the Week 4 Wednesday breakfast, Fortified/High Protein diets should receive eight ounces of whole milk. On 7/1/26 at 0838 hours, an observation of the breakfast meal for Resident 10 was conducted in Resident 10's room. Resident 10's meal tray ticket listed Fortified/ High Protein Diet. Resident 10's breakfast meal tray was observed with juice, cereal, puree breakfast slider, and puree hashbrowns. There was no whole milk on Resident 10's breakfast meal tray. On 7/1/26 at 0924 hours, an interview was conducted with the Dietary Services Supervisor. The Dietary Services Supervisor confirmed the therapeutic spreadsheet should be followed. The Dietary Services Supervisor verified Resident 10 did not receive whole milk on her tray. The Dietary Services Supervisor confirmed Resident 10 was on a fortified diet and should have received whole milk or a substitute. On 7/1/26 at 0927 hours, an interview was conducted with the RD. The RD confirmed the therapeutic diet spreadsheets should be followed. The RD confirmed Resident 10 did not receive whole milk or an appropriate substitute to comply with the fortified diet therefore the diet was not fortified.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview, medical record review, and facility P&P review, the facility failed to ensure the resident's medical record was accurate for four of 35 final sampled residents (Residents 16, 59, 93, and 201). * Resident 16's POLST was incomplete and failed to show the resident had an inaccurate date for the resident's current Advance Directive. * Resident 59 and 201's MARs were incomplete. * The facility failed to ensure Resident 93 had signed a COVID-19 vaccine declination. These failures resulted in incomplete and inaccurate medical records, which have the potential to negatively impact continuity of care and clinical decision making. Findings: 1. Medical record review for Resident 16 was initiated on 6/30/26. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's AHCD dated 7/8/25, showed Health Care Agent 1 as the resident's chosen health care agent. Review of Resident 16's POLST form dated 6/10/25, showed the resident's AHCD dated 7/8/25, was reviewed. The form was left blank for the resident's health care agent's name and telephone number. On 7/1/26 at 1215 hours, an interview and concurrent record review was conducted with the SSD. The SSD reviewed Resident 16's AHCD and POLST, and verified the POLST was incomplete and failed to show the resident's designated Health Care Agent as shown in her AHCD. 2. Medical record review for Resident 59 was initiated on 6/30/26. Resident 59 was readmitted to the facility on [DATE]. Review of Resident 59's MAR for June 2026 showed the following were undocumented for the 11-7 (2300-0700 hours) shift on 6/21/26:- An order dated 10/3/25, to monitor the resident's hours of sleep for the trazodone (medication to treat depression) use.- An order dated 10/3/25, to monitor the resident for side effects for the mirtazapine (anti-depressant medication) use: nausea, vomiting, anxiety, sexual dysfunction, insomnia, dizziness, weight loss or gain, tremors, sweating, drowsiness, fatigue, dry mouth, diarrhea, constipation, headaches, and increased risk for fall every shift.- An order dated 10/3/25, to monitor the resident for signs and symptoms of opioid overdose including but not limited to pinpoint pupils, slow, shallow breathing, falling asleep, difficult to wake, unconscious, pale, blue, or cold skin, and choking or gurgling sounds every shift. Contact the physician or 911 immediately if noted.- An order dated 10/3/25, to monitor the resident's level of pain (0-10 scale) every shift. With 0 for no pain, 1-3 for mild pain, 4-6 for moderate pain, and 7-10 for severe pain.- An order dated 10/3/25, to implement and document the nonpharmacological interventions used for pain each shift.- An order dated 10/3/25, to monitor the resident for side effects for the trazadone (anti-depressant medication) use: nausea, vomiting, anxiety, sexual dysfunction, insomnia, dizziness, weight loss or gain, tremors, sweating, drowsiness, fatigue, dry mouth, diarrhea, constipation, headaches, and increased risk for fall every shift.- An order dated 10/3/25, to implement and document nonpharmacological behavioral interventions used each shift to alleviate behaviors and their effectiveness.- An order dated 2/10/26, to monitor the resident's oxygen saturation every shift for PRN oxygen use. Notify the physician if less than 89%.- An order dated 6/18/26, to administer oxygen 2 LPM via nasal cannula continuously every shift for shortness of breath. On 7/2/26 at 1110 hours, an interview and concurrent record review was conducted with the DON. The DON reviewed Resident 59's MAR and verified the above findings were undocumented, and should have been documented to show they were completed. 3. Medical record review for Resident 201 was initiated on 6/30/26. Resident 201 was admitted to the facility on [DATE]. Review of Resident 201 MAR for June 2026, showed the following:- A physician's order dated 6/29/26, for celecoxib (nonsteroidal anti-inflammatory drug used to relieve pain, stiffness, and inflammation) 200 mg, scheduled to be (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered at 0800 hours. The order was discontinued on 6/30/26 at 1040, however the MAR failed to show if the medication was administered or held on 6/30/26 at 0800 hours. - A physician's order dated 6/29/26, to monitor for orthostatic hypotension every day on the 7-3 (0700-1500 hours) shift, for the risperidone (antipsychotic medication) use. There was no documentation to show it was monitored on 6/30/26.- A physician's order dated 6/29/26, to record the resident's intake and output every shift for seven days. There was no documentation to show it was completed on the 3-11 (1500-2300 hours) shift on 6/29/26, and on the 7-3 shift on 6/30/26.- A physician's order dated 6/29/26, to monitor the resident for paranoid feelings every shift for lurasidone (an antipsychotic medication) use. There was no documentation to show it was completed for the 7-3 shift on 6/30/26.- A physician's order dated 6/29/26, to monitor the resident for side effects and adverse reactions for lurasidone use. There was no documentation to show it was completed for the 7-3 shift on 6/30/26.- A physician's order dated 6/29/26, to monitor the resident every shift for hyperglycemia including but not limited to increased thirst, frequent urination, confusion, blurred vision, fatigue, weight loss, or headache. If symptoms are present, check blood sugar and notify the physician. There was no documentation to show the monitoring was completed for the 7-3 shift on 6/30/26.- A physician's order dated 6/29/26, to monitor the resident every shift for hypoglycemia including but not limited to increased sweating, clammy skin, shaky, nervous, irritability, confusion, increased pulse, dizzy/lightheadedness, feeling weak, clumsiness, hunger, or nausea. If symptoms are present, check the resident's blood sugar and take steps to increase glucose levels. There was no documentation to show the monitoring was completed for the 7-3 shift on 6/30/26.- A physician's order dated 6/29/26, to monitor the resident every shift for signs and symptoms of opioid overdose including but not limited to pinpoint pupils, slow, shallow breathing, falling asleep, difficult to wake, unconscious, pale, blue, or cold skin, and choking or gurgling sounds. Notify the physician or 911 immediately if symptoms are noted. There was no documentation to show the monitoring was completed for the 7-3 shift on 6/30/26.- A physician's order dated 6/29/26, to monitor the resident's level of pain (0-10 scale) every shift. With 0 for no pain, 1-3 for mild pain, 4-6 for moderate pain, and 7-10 for severe pain. There was no documentation to show the monitoring was documented as completed for the 7-3 shift on 6/30/26.- A physician's order dated 6/29/26, to implement and document nonpharmacological behavioral interventions used each shift to alleviate behaviors and their effectiveness. There was no documentation to show the monitoring was documented as completed for the 7-3 shift on 6/30/26.- An order dated 6/29/26, to implement and document nonpharmacological interventions used for pain each shift. There was no documentation to show the monitoring was documented as completed for the 7-3 shift on 6/30/26.- An order dated 6/29/26, to monitor the resident for the inability to process external stimuli causing stress every shift for the risperidone (an antipsychotic medication) use. There was no documentation to show the monitoring was documented as completed for the 7-3 shift on 6/30/26.- An order dated 6/29/26, to monitor the resident for side effects and adverse reaction to the risperidone medication use. There was no documentation to show the monitoring was documented as completed for the 7-3 shift on 6/30/26.- An order dated 6/29/26, to monitor the resident for depression manifested by verbalizing the extreme feeling of sadness every shift. There was no documentation to show the monitoring was documented as completed for the 7-3 shift on 6/30/26.- An order dated 6/29/26, to monitor for side effects for the venlafaxine (anti-depressant medication) medication use to include nausea, vomiting, anxiety, sexual dysfunction, insomnia, dizziness, weight loss or gain, tremors, sweating, drowsiness, fatigue, dry mouth, diarrhea, constipation, headaches, and an increased risk for fall every shift. There was no documentation to show the monitoring was documented as completed for the 7-3 shift on 6/30/26. On 7/2/26 at 1110 hours, an interview and (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concurrent record review was conducted with the DON. The DON reviewed Resident 201's MAR for June 2026 and verified the above findings, and stated the MAR documentation should have been completed. 4. Medical record review for Resident 93 was initiated on 6/30/36. Resident 93 was admitted to the facility on [DATE]. Review of Resident 93's medical record showed the resident had not received a COVID-19 vaccine. However, the resident's records failed to show the resident declined the COVID-19 vaccine. On 7/3/26 at 0809 hours, an interview and record review was conducted with the IP. The IP stated she recalled she provided Resident 93 with COVID-19 vaccine information and consent form, but the resident declined the COVID-19 vaccine. The IP stated she left the consent form with the resident to sign, but she was unable to locate the consent form but will see if she can locate it. On 7/3/26 at 0940 hours, a follow up interview and record review was conducted with the IP. The IP provided Resident 93's Vaccine Consent form undated, which showed the COVID-19 vaccine was declined by the resident. The form was incomplete and not signed by the resident or by staff to show the resident provided a verbal declination. The IP verified the form was incomplete.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were followed for two of two final sampled residents (Residents 7 and 22) and six nonsampled residents (Residents 29, 65, 99, 130, 176, and 202) reviewed for infection control. * The facility failed to ensure the staff performed hand hygiene after administering a GT medication and before administering a Lovenox (blood thinner) injection to Resident 202. * The facility failed to ensure the staff sanitized the inhalers after administering a dose to Resident 7 and before storing it in the medication cart. * The facility failed to ensure Resident 99, who had an active C-diff infection, was properly isolated and not cohorted with Resident 29, who had a history of C-diff. * The facility's infection control program reporting inaccurately showed Residents 65, 130, and 176's suspected UTIs met the criteria for a true infection. This failure resulted in inaccurate infection control data for April and May 2026, being reported to the monthly QA Committee. * The facility failed to ensure Resident 22's indwelling foley catheter drainage bag was not lying on the floor. These failures posed the risk for transmission of disease-causing microorganisms and infections. Findings: 1. Review of the facility's P&P titled Handwashing/Hand Hygiene dated 10/2023 showed the facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. The hand hygiene is indicated in the following instances: - immediately before touching a resident; - before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); - after contact with blood, body fluids, or contaminated surfaces; - after touching a resident; - after touching the resident's environment; - before moving from work on a soiled body site to a clean body site on the same resident; and - immediately after glove removal. On 7/1/26 at 0920 hours, a medication administration observation for Resident 202 was conducted with LVN 8. LVN 8 was observed preparing medications for administration through the GT and preparing a Lovenox medication (anticoagulant) injection for Resident 202. LVN 8 performed hand hygiene, donned gloves, and administered the GT medication. LVN 8 was then observed removing her gloves, donning a new pair, and administering the Lovenox medication injection subcutaneously to Resident 202's right lower abdomen. LVN 8 did not perform hand hygiene after administering the GT medication and before donning the new pair of gloves for the Lovenox injection. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/26 at 0946 hours, an interview was conducted with LVN 8. LVN 8 verified the above observations and acknowledged she did not perform hand hygiene after administering the GT medication and before putting on the new pair of gloves for the Lovenox medication injection. LVN 8 stated she should have performed hand hygiene between glove changes after administering the GT medication and before administering the Lovenox medication injection to Resident 202. 2. On 7/1/26 at 0958 hours, a medication administration observation for Resident 7 was conducted with LVN 5. The following was observed: - LVN 5 was observed preparing oral medications and the multi-dose inhaler Incruse Ellipta (used to relax the airway muscles in adults with chronic obstructive pulmonary disease) 62.5 mcg; - LVN 5 performed hand hygiene, entered the room, administered the oral medication and one puff of the Incruse Ellipta inhaler, and instructed the resident to rinse his mouth; - LVN 5 then performed hand hygiene and placed the Incruse Ellipta inhaler back into the medication cart without sanitizing it; - LVN 5 was next observed preparing a second multi-dose inhaler, fluticasone propionate (corticosteroid that treats inflammation, itching, and allergy symptoms) 250 mcg/50 mcg; - LVN 5 performed hand hygiene, entered the room, administered one puff of the fluticasone propionate inhaler to Resident 7, instructed the resident to rinse his mouth, and then performed hand hygiene; and - LVN 5 then stored the fluticasone propionate inhaler in the medication cart without sanitizing it. On 7/1/26 at 1029 hours, an interview was conducted with LVN 5. LVN 5 verified the above observations and stated he forgot to sanitize the Incruse Ellipta and fluticasone propionate inhalers after administering the doses and before placing them back in the medication cart. LVN 5 stated he should have sanitized both inhalers before storing them in the cart. 3. Review of facility's P&P titled Clostridium Difficile dated 10/2018 showed Clostridium Difficile infection is suspected in residents with acute, unexplained onset of diarrhea (three or more unformed stools within 24 hours). Resident considered at high risk of developing symptoms associated with C. Diff includes those with advancing age, previous confirmed infection with C Diff. the primary reservoir for C-diff are infected people and surfaces. Resident with diarrhea and suspected CDI (i.e. residents who are colonized and symptomatic) are placed on contact precautions while awaiting laboratory results. Resident who are colonized with C-diff but are asymptomatic do not require contact precaution. Resident with CDI are placed in a private room if available. If private room is not available, resident will be cohorted with a dedicated commode for each resident. Review of CDPH HAI Program titled Clostridium Difficile Infection (CDI) prevention for Public Health and Healthcare Providers dated 4/16/25, showed to isolate the resident with diarrhea pending CDI confirmation. Use contact precautions for the duration of diarrhea plus 48 hours. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the CDC article titled Clinical Guidance for C-diff infection prevention in Acute care facilities dated 5/13/26, showed patient with a diarrhea should be isolated while evaluation for the cause is ongoing. For example, the resident remains isolated for trials off laxatives. Place symptomatic patients on contact precautions in a single patient room with a dedicated toilet. If single-patient room is not available, room patient with confirmed CDI test together. On 6/30/26 at 0845 hours, an observation of Room G and concurrent interview was conducted with LVN 9. Room G was observed closed and a contact isolation sign was posted outside the room. LVN 9 stated the contact isolation was in place for C-diff infection. LVN 9 further stated Resident 99 resided Room G and had an active C-diff infection. LVN 9 stated Resident 29 (who also resided in Room G) had a history of C-diff infection and was not currently symptomatic. a. Medical record review for Resident 29 was initiated on 6/30/26. Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 29's Lab Results dated 5/16/26, showed the C-diff toxin was detected. Review of Resident 29's Documentation Survey report for June 2026 showed Resident 29 had three episodes of loose/diarrhea on 6/16/26. b. Medical record review for Resident 99 was initiated on 6/30/26. Resident 99 was admitted to the facility on [DATE]. Review of Resident 99's acute care hospital face sheet dated 6/4/26, showed C-diff as the admitting diagnosis. Review of Resident 99's Documentation Survey report for June 2026 showed Resident 99 had three episodes of loose/diarrhea/watery bowel movement on 6/17/26. Review of Resident 99's Lab Results dated 6/19/26, showed the C. diff toxin and antigen were detected. On 7/9/26 at 0916 hours, an interview and medical record review for Residents 29 and 99 was conducted with the IP and IP Resource. The IP stated any resident experiencing three or more loose stools within a 24-hour period was required to be isolated to rule out C-diff infection. When asked whether a resident with a history of C-diff who develops more than three loose stools in 24 hours should also be isolated, the IP confirmed isolation is required; however, testing is not recommended because such residents may produce false-positive results. The IP verified Resident 29 tested positive for C-diff on 5/16/26 and remained in isolation until 5/30/26. The IP verified Resident 29 was transferred to an acute-care hospital on 5/30/26, and was readmitted on [DATE] to Room G, where Resident 99 resided. Upon readmission, Resident 29 had no loose stools and was not placed on isolation. The IP verified Resident 29 experienced more than three loose stools within 24 hours on 6/16/26. When asked if Resident 29 was placed on isolation at that time, the IP stated the resident was not isolated. The IP verified Resident 29 should have been isolated for suspected C-diff due to the resident's history and symptoms, and should have remained in isolation until free of loose stools (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for 48 hours. The IP stated Resident 29 had no further loose stools after 6/16/26. The IP then verified Resident 99 was admitted to the facility on [DATE] to Room G, sharing a room with Resident 29. The IP stated upon admission, Resident 99 did not have three or more loose stools in 24 hours and did not require isolation. The IP also confirmed Resident 99 developed more than three loose stools on 6/17/26, and tested positive for C-diff on 6/19/26. When asked whether Resident 99's C-diff infection may have been transmitted from Resident 29, who had symptoms on 6/16/26 and was not isolated, the IP and IP Resource stated no, citing Resident 29's history of C-diff. The IP resource added facility staff follow hand hygiene, and infection control practices. The IP verified when Resident 99 was admitted to the facility the Resident 99 did not require isolation and had no loose stool more than three episodes in 24-hour period, so Resident 99 was placed in the room of Resident 29. The IP further stated both Residents 29 and 99 did not require isolation at that time. The IP further stated that when Resident 99 tested positive for C-diff, the facility did not move the resident to a private room because one was not available at that time. The IP stated Resident 99 remained in the shared room with Resident 29, who did not have active infection or diarrhea. When asked whether she attempted to move Resident 99 to a private room once one became available, the IP stated she did not attempt to do so. On 7/3/26 at 1019 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. On 7/3/26 at 0940 hours, an interview, medical record review, and review of the Facility's Infection Control Program binder was conducted with the IP and IP Resource. The IP stated she started as an IP at the facility in the end of February 2026 and the IP Resource trained her. The IP Resource stated the process is to use Loeb's criteria prior to initiating antibiotics, and once all diagnostic test results are in, to use McGeer's criteria to determine if it is a true infection. The facility's Infection Screening Evaluation tool is Loeb's and McGeer's criteria merged into one tool. However, the tool should always be reviewed to ensure the data is correct and to use McGeer's criteria to verify the tool's findings. The IP stated the infection control data, to include infections that met and did not meet criteria, are presented in the monthly QA Committee. a. Review of the facility's Infection Surveillance Report for April 2026 showed Resident 176 had a UTI. The IP stated the resident's infection did meet the criteria for infection. Review of Resident 176's medical record failed to show an Infection Screening Evaluation tool was completed. In addition, the resident's medical record failed to show the resident's symptoms met McGeer's criteria for a UTI. The IP verified the resident's infection did not meet McGeer's Criteria for a UTI, and had been incorrectly reported to the QA Committee. b. Review of the facility's Infection Surveillance Report for April 2026 showed Resident 130 had a UTI. The IP stated the resident's infection did meet the criteria for infection. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 130's medical record failed to show an Infection Screening Evaluation tool was completed. In addition, the resident's medical record failed to show the resident's symptoms met McGeer's criteria for a UTI. The IP verified the resident's infection did not meet McGeer's Criteria for a UTI, and had been incorrectly reported to the QA Committee. c. Review of the facility's Infection Surveillance Report for May 2026 showed Resident 65 had a UTI. The IP stated the resident's infection did meet the criteria for infection. Review of Resident 65's medical record failed to show an Infection Screening Evaluation tool was completed. In addition, the resident's medical record failed to show the resident's symptoms met McGeer's criteria for a UTI. The IP verified the resident's infection did not meet McGeer's Criteria for a UTI, and had been incorrectly reported to the QA Committee. 5. Review of facility's P&P titled Catheter Care, Urinary, revised August 2022 showed in part, the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Under General Guidelines-Infection Control, use aseptic technique (specific practices used in healthcare and laboratory settings to prevent the spread of harmful microorganisms to protect patients from infection during procedures) when handling or manipulating the drainage system. Be sure the catheter tubing and drainage bag are kept off the floor. On 6/30/26 at 0926 hours, an observation was conducted of Resident 22. Resident 22 was lying in bed in a low position. Resident 22's indwelling urinary foley catheter bag was observed touching the floor. Medical record review for Resident 22 was initiated on 6/30/26. Resident 22 was initially admitted to facility on 7/25/23, and readmitted on [DATE], with diagnoses including Neuromuscular Dysfunction of the Bladder. Review of Resident 22's Order Summary Report showed a physician order dated 5/19/26, for foley catheter size FR # 16/10 cc to bed side drainage due to diagnosis of hydronephrosis and neurogenic bladder. On 6/30/26 at 1136 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 22's entire indwelling urinary foley catheter bag was lying on the floor. LVN 5 stated the indwelling urinary foley catheter bag should not touch the floor. On 7/3/26 at 1102 hours, an interview was conducted with the DON. The DON verified and acknowledged the above finding, and stated the staff should always make rounds to ensure the indwelling urinary foley catheter bag was kept off the floor.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their antibiotic stewardship program to ensure physician notification for three nonsampled residents (Residents 65, 130, and 176) who received antibiotics for infections that did not meet McGeer's criteria. * The facility failed to notify Resident 65's physician to reassess the need for continued antibiotic therapy after the resident's symptoms failed to meet the criteria for a UTI. * The facility failed to notify Resident 130's physician to reassess the need for continued antibiotic therapy after the resident's symptoms failed to meet the criteria for a UTI. * The facility failed to notify Resident 176's physician to reassess the need for continued antibiotic therapy after the resident's symptoms failed to meet the criteria for a UTI. These failures created a potential risk to the residents' well-being by exposing them to unnecessary antibiotic therapy, which could contribute to the development of multidrug-resistant organisms (MDROs). Findings: Review of the facility's Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes revised December 2016 showed all clinical infections treated with antibiotics will be reviewed by the IP. The IP will identify any situations not consistent with appropriate antibiotic use, and will notify the provider. On 7/3/26 at 0940 hours, an interview, medical record review, and review of the Facility's Infection Control Program binder was conducted with the IP and the corporate IP Resource. The IP stated the facility uses McGeer's criteria to determine if the resident has a true infection. For infections that do not meet McGeer's Criteria, the physician is notified to reassess the resident's need for antibiotics. a. Review of the facility's Infection Surveillance Report for April 2026 showed Resident 176 had a UTI. The IP stated the resident's infection did meet the criteria for infection. Review of Resident 65's IV Administration Record for April 2026 showed an order dated 4/5/26, for ertapenem sodium 1 gm intravenously, daily for five days, for a UTI. The record showed the resident received five days of antibiotic therapy. Review of Resident 176's medical record failed to show the resident's symptoms met McGeer's criteria for a UTI. The IP verified the resident's infection did not meet McGeer's Criteria for a UTI, and the physician had not been notified to reassess the need for antibiotics. b. Review of the facility's Infection Surveillance Report for April 2026 showed Resident 130 had a UTI. The IP stated the resident's infection did meet the criteria for infection. Review of Resident 130's MAR for April 2026 showed an order dated 4/28/26, for Cipro (an antibiotic) 500 mg by mouth twice a day for a UTI. The Resident EHR showed the resident received the antibiotics for five days. Review of Resident 130's medical record failed to show the resident's symptoms met McGeer's criteria for a UTI. The IP verified the resident's infection did not meet McGeer's Criteria for a UTI, and the physician had not been notified to reassess the need for antibiotics. c. Review of the facility's Infection Surveillance Report for May 2026 showed Resident 65 had a UTI. The IP stated the resident's infection did meet the criteria for infection. Review of Resident 65's IV Administration Record for May 2026 showed an order dated 5/15/26, for Meropenem (an antibiotic) 1 gm intravenously every eight hours for ESBL in the urine. The record showed the resident received 10 days of antibiotic therapy. Review of Resident 65's medical record failed to show the resident's symptoms met McGeer's criteria for a UTI. The IP verified the resident's infection did not meet McGeer's Criteria for a UTI, and the physician had not been notified to reassess the need for antibiotics.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the needs for one of 35 final sampled residents (Resident 8) * The facility failed to ensure Resident 8's call light was within the resident's reach. This failure had the potential to delay care and negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Answering the Call Light (undated) showed to ensure the call light is accessible to the resident when in bed, from the toilet, from shower or bathing facility and from the door. On 6/30/26 at 1042 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was lying in bed. Resident 8's call light was on the floor on left side of the bed, about two feet away from the resident. Resident 8 stated the call light was always on the floor and staff did not pick it up. CNA 1 walked in to assist Resident 8's roommate, but did not notice Resident 8's call light was on the floor and out of Resident 8's reach. CNA 1 walked out of the room. On 6/30/26 at 1051 hours, an observation and concurrent interview was conducted with CNA 1 in Resident 8's room. CNA 1 verified Resident 8's call light was on the floor on the left side of the resident's bed, and was out of the resident's reach. CNA 1 was observed about to pick the call light up, but Resident 8 then leaned his body to the left side to reach the call light. Resident 8's body was halfway out of bed. CNA 1 asked the resident to not to reach because he could fall out of bed, but Resident 8 still insisted to reach it. CNA 1 assisted Resident 8 to pick up the call light, cleaned it with wipes and placed on the bed for the resident. Medical record review for Resident 8 was initiated on 6/30/26. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's care plan for risk for falls related to having a history of a fall initiated on 1/13/25 and last revised on 6/25/26, showed interventions including to keep the call light within reach and answer promptly. On 7/1/26 at 0905 hours, an interview was conducted with the DON. The DON was informed of the above observation including how Resident 8 was leaning over and was halfway out of the bed attempting to retrieve his call light. The DON verified Resident 8's call light should have been within reach for the resident to use when he needed assistance. The DON verified and acknowledged the above findings.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to maintain a copy of an advance directive in the medical record for two of five sampled residents (Residents 50 and 154) reviewed for advance directives. * The facility failed to follow up and obtain a copy of Resident 50 and 154's advance directive, and did not maintain it in the medical record. These failures had the potential to prevent Resident 50 and 154's healthcare and treatment decisions from being honored. Findings: Review of the facility's P&P titled Advance Directives revised 9/2022 showed if the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident medical record and are readily retrievable by any facility staff. 1. Medical record review for Resident 50 was initiated on 6/30/26. Resident 50 was admitted to the facility on [DATE]. Review of Resident 50's POLST dated 4/21/26, showed Resident 50 had no advance directive. Review of Resident 50's Social Services assessment dated [DATE], showed Resident 50 had an advance directive and the facility had requested a copy from the resident. Review of Resident 50's H&P examination dated 4/24/26, showed Resident 50 had the capacity to make medical decisions. Review of Resident 50's medical record failed to show a copy of the advance directive was maintained in Resident 50's medical record. On 7/2/26 at 1044 hours, an interview and concurrent medical record review for Resident 50 was conducted with the SSD. The SSD confirmed there was no copy of Resident 50's advance directive in the medical record, nor was it uploaded into the EHR. The SSD further verified she was unable to find documentation indicating whether the staff had followed up to obtain the resident's advance directive. The SSD stated a copy of the advance directive should have been maintained in Resident 50's medical record and should be readily retrievable by facility staff. On 7/2/26 at 1135 hours, an interview was conducted with Resident 50. Resident 50 stated he had an advance directive. Resident 50 could not recall if the facility had requested a copy, and stated he would ask his family to bring a copy of the advance directive during their next visit. On 7/3/26 at 1019 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings. 2. Medical record review for Resident 154 was initiated on 6/30/26. Resident 154 was admitted to the (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE], and readmitted on [DATE]. Reviewed of Resident 154's Social Services assessment dated [DATE], showed Resident 154 had an advance directive and facility requested a copy from the resident's daughter. Review of Resident 154's H&P examination dated 5/29/26, showed Resident 154 had the capacity to make medical decisions. Review of Resident 154's medical record failed to show a copy of the advance directive was maintained in Resident 154's medical record. On 7/1/26 at 1113 hours, an interview and concurrent medical record review for Resident 154 was conducted with the SSD. The SSD verified there was no copy of Resident 154's advance directive in the medical record, nor was it uploaded in Resident 154's EHR. The SSD stated Resident 154 had an advanced directive according to the resident's family member. The SSD stated she should have documented the follow up with the family member and obtained a copy of the resident's advance directive. The SSD further stated a copy of the advance directive should have been maintained in the Resident 154's medical record and should be readily retrievable by the facility staff so the facility can follow the plan of care and honor the resident wishes. On 7/3/26 at 1155 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON further stated the SSD should have documented the follow up and obtain a copy of the advanced directive and place in the chart.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to follow the resident's plan of care and document behavior monitoring for one of two final sampled residents (Resident 79) investigated for behavior and emotional status. * Resident 79's medical record did not show behavior monitoring for the resident's behaviors targets valproic acid (a psychotropic medication used for mood-stabilizing). This failure resulted in a lack of data available for monitoring the resident's behavioral trends, to evaluate the effectiveness of nursing and medical interventions, and the potential to negatively impact the resident's health outcomes and psychosocial well-being. Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 7/2022 showed psychotropic medication management includes adequate monitoring for efficacy. Medical record review for Resident 79 was initiated on 6/30/26. Resident 79 was admitted to the facility on [DATE]. Review of Resident 79's H&P examination dated 12/16/25, showed the resident was diagnosed with bipolar disorder, schizoaffective disorder, and Alzheimer's Disease. Further review showed the resident received valproic acid 250 mg twice a day. Review of Resident 79's Care Plan Report showed a focus plan initiated 3/30/26 and revised 3/31/26, for bipolar disorder and recurrent behavior fluctuations from depressed behaviors to manic behaviors and vice versa. Further review of the care plan showed interventions included to monitor and record the resident's mood to determine if problems may be related to external causes, for example medications, treatments, concern over diagnosis. Review of Resident 79's Psychiatric SNF Follow Up Note dated 4/15/26, showed the resident continued to experience ongoing symptoms of mood swings, with episodes of irritability and agitation, and reports of verbal and physical aggression towards staff. Further review showed a plan to increase the resident's valproic acid. Review of Resident 79's MAR for June 2026 showed a physician's order dated 4/16/26, to administer valproic acid 250 mg every morning, and 500 mg every evening, for bipolar disorder manifested by recurrent behavior fluctuations from depressed to manic behaviors. Review of Resident 79's medical record failed to show routine monitoring and documentation of the resident's behaviors target by valproic acid. On 6/30/26 at 0927 hours, Resident 79 was observed in bed, shouting help please! and help me! intermittently. On 7/1/26 at 0842 hours, during an observation, Resident 79 started shouting out help me, what do you want, and help me! A CNA entered the room to check on the Resident 79. Resident 79 stated she did not want anything and did not know what was going on. When the CNA left the room, Resident 79 started to shout out again help me! On 7/1/26 at 0845 hours, during an observation, Resident 79 yelled out help me! repeatedly. LVN 7 was observed informing Resident 79 would be there in a minute and sent a CNA to see what the resident needed. Resident 79 shouted for LVN 7 by name, and insisted she talk with LVN 7. As soon as the CNA left the room, Resident 79 started shouting out help me, help me, please intermittently. On 7/1/26 at 1536 hours, an interview was conducted with CNA 7. CNA 7 stated Resident 79 would constantly call out for help and when you go to assist the resident, she replies she just needs help without giving more information. CNA 7 stated sometimes Resident 79's roommate complains about Resident 79's behaviors being disruptive. On 7/2/26 at 1501 hours, an interview and concurrent medical record review for Resident 79 was conducted with ADON 2. ADON 2 stated the Resident 79's valproic acid dose was changed in April 2026. ADON 2 verified Resident 79's care plan showed to monitor and document behaviors, and Resident 79's medical record failed to show it was routinely completed. On 7/2/26 at 1530 hours, an interview and concurrent medical record review for (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 79 was conducted with LVN 7. LVN 7 stated the behavior monitoring was documented in the MAR. LVN 7 reviewed Resident 79's MAR and verified there was no documentation to show the behavior monitoring tracking was completed.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and P&P review, the facility failed to develop a comprehensive person-focused care plan for one of 35 final sampled residents (Resident 112). * The facility failed to develop a care plan to address Resident 112's use of positioning pillows (a device used to help prevent bedsores, reduce pain, and improve circulation for elderly individuals). This failure posed the risk of not providing appropriate, consistent, and individualized care to the resident. Findings: Review of facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed in part, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. Medical record review for Resident 112 was initiated on 7/1/26. Resident 112 was admitted to the facility on [DATE]. On 6/30/26 at 0928 hours, during the initial tour, Resident 112 was observed in bed covered with light blanket up to level of his chin, bed in a low position with floor pad on the right side of bed, and an overbed table on the left side. Resident 112 was observed with a positioning pillow device on the mattress at the right side of his bed. On 7/1/26 at 1125 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 verified Resident 112 had positioning pillow devices on both sides of the bed. LVN 2 stated Resident 112's family member had requested the pillows for comfort. LVN 2 stated she had seen the positioning pillows on Resident 112 before during her shift. LVN 2 was asked a care plan was developed for the use of the positioning pillow devices. LVN 2 stated she was not sure but would check the resident's record. Review of Resident 112's medical record failed to show a care plan for the use of positioning pillow devices was initiated. On 7/1/2026 at 1143 hours, an interview and concurrent medical record review for Resident 112 was conducted with ADON 2. ADON 2 reviewed Resident 112's medical record and verified there was no care plan or monitoring completed for the resident's use of the positioning pillow devices.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries for one of two final sampled residents (Resident 97) reviewed for pressure injuries. * The facility failed to ensure Resident 97's LAL mattress is not set in static mode while resident in bed. This failure had the potential for Resident 97 to develop pressure injuries or worsening of the existing pressure injuries. Findings: Review of the facility's document titled Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System Operator's manual (undated) showed the mattress provides a firm surface that makes it easier for the patient to transfer or reposition in static mode. The static mode prevents the patient from bottoming out when in a sitting position. On 6/30/26 at 0936 hours, an observation of Resident 97 was conducted in the resident's room. Resident 97 was in bed and lying on a LAL mattress. The mattress setting was set at normal pressure and on static mode. Resident 97 stated he believed he has a bed sore, and he receives treatment every day. Resident 97 did not know the stage of his bedsore. Medical record review for Resident 97 was initiated on 6/30/26. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's H&P examination dated 4/17/26, showed the resident had capacity to make medical decisions. Review of Resident 97's Order Summary Report showed the following physician's orders:- dated 4/17/26, may have LAL mattress; and- dated 5/29/26, may have LAL mattress due to unstageable pressure ulcer of sacral region. On 6/30/26 at 1114 hours, an observation and concurrent interview was conducted with LVN 1 in Resident 97's room. LVN 1 verified Resident 97's LAL setting on the mattress was in static mode. LVN 1 further stated the LAL mattress setting should not be on static mode. LVN 1 stated Resident 97 was a high risk for developing a pressure ulcer due to immobility and having a preexisting unstageable pressure injury. LVN 1 stated the static mode should only be used when providing care and when get resident out of bed. LVN 1 stated if Resident 97 was in bed, the static mode should be turned off. On 7/2/26 at 0848 hours, an interview was conducted with the DON. The DON stated the static mode should not be on when a resident was in bed and lying on a LAL mattress. The DON further stated the static mode on the LAL was only used during ADL care and when transfer. The DON was informed and acknowledged Resident 97's LAL mattress setting was inaccurate.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure appropriate care and services for the use of the GT for one of one nonsampled resident reviewed for tube feeding. * The facility failed to ensure LVN 1 elevated Resident 202's head of bed (HOB) to 30 degrees or higher during GT feeding and prior to administering the medication through the GT. This failure posed a potential risk for aspiration, which could result in respiratory complications, including aspiration pneumonia. Findings: Review of the facility's P&P titled Enteral Tube Feeding Via Gravity Bag dated 11/2018 showed to position the head of the bed at 30-45 (semi-Fowler's position) for feeding, unless medically contraindicated. Medical record review for Resident 202 was initiated on 7/1/26. Resident 202 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 202's Care Plan dated 1/21/26, showed a plan of care addressing the feeding tube and Resident 202 was at risk for complication such as aspiration. The Intervention included to elevate the head of the bed at 30-45-degree angle during feeding. Review of Resident 202's MDS assessment dated [DATE], showed Resident 202 had a feeding tube. Review of Resident 202's H&P examination dated 6/29/26, showed Resident 202 was a GT dependent and had no capacity to make decisions. On 7/1/26 at 0910 hours, Resident 202 was observed in bed receiving an enteral feeding via the GT. The head of the bed was not elevated to at least a 30° degree angle. Using the phone application Measure, the head of bed angle showed as 22-degrees. On 7/1/26 at 0920 hours, medication administration observation for Resident 202 was conducted with LVN 8. Resident 202 was observed receiving an enteral feeding via the GT. LVN 8 was observed pausing the feeding and administering Resident 202's medication through the GT while the head of the bed remained at a 22° degree angle. LVN 8 was not observed elevating the head of the bed to more than a 30° degree angle prior to administering the medication. On 7/1/26 at 0946 hours, an observation and concurrent interview was conducted with LVN 8. LVN 8 stated the head of the bed for the residents should be elevated to at least a 30° degree angle during the enteral feeding and medication administration via GT. The angle of the head of the bed for Resident 202 was measured using the phone application Measure and was showed as 22 degrees. LVN 8 verified this measurement and confirmed the head of the bed for Resident 202 was not elevated to more than a 30° degree angle during tube feeding and medication administration via GT. On 7/3/26 at 1019 hours, an interview was conducted with the DON. The DON was informed of and acknowledged the above findings. The DON stated the head of the bed of the resident should be elevated to more than a 30° degree angle during the GT feeding and medication administration via GT.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the vascular access device was maintained consistent with professional standards of practice for two of 35 final sampled residents (Residents 6 and 154). * The facility failed to provide IV heplock dressing changes every seven days and as needed to Resident 6. * The facility failed to change Resident 154's IV fluid bag of normal saline within 24 hours. These failures had the potential to compromise the effectiveness of the IV therapy, and negatively impact the residents' health outcomes. Findings: Review of the facility's P&P titled General Policies for IV Therapy dated 3/2023 showed in part, only an RN or IV certified LVN may start intravenous infusions or administer approved IV solutions. IV medications may be administered by RNs. IV peripheral sites will be rotated when clinically indicated (e.g., unresolved complication, discontinuation of infusion therapy, or when no longer necessary for the care plan). Dressing change performed at least every 7 days and PRN. No IV solution will hang for period greater than 24 hours. 1. On 6/30/26 at 0910 hours, an observation was conducted of Resident 6 in the resident's room. Resident 6 was observed lying in bed. A CNA was observed preparing Resident 6 for shower. Resident 6's IV heplock on his right arm had a dressing dated 6/16. The dressing was covering most of the tubing. On 6/30/26 at 1122 hours, an observation was conducted of Resident 6 in the resident's room. The dressing on Resident 6's IV heplock on right arm was still dated 6/16. Medical record review for Resident 6 was initiated on 6/30/26. Resident 6 was initially admitted to the facility on [DATE], and readmitted on [DATE]. On 6/30/26 at 1149 hours, an observation and concurrent interview was conducted with RN 1. RN 1 stated the purpose of the IV heplock was to keep the vein open for antibiotic administration or IV hydration. RN 1 verified the dressing was dated 6/16. RN 1 further stated the dressing should have been changed at least every seven days and when soiled. On 7/3/26 at 1048 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings. 2. On 6/30/26 at 1000 hours, an observation was conducted in Resident 154's room. Resident 154 had an IV fluid bag of Sodium Chloride Intravenous solution 0.9% connected via IV access running at 50 ml/hr. The IV fluid bag label was dated 6/28/26 at 1800 hours. Medical record review for Resident 154 was initiated on 6/30/26. Resident 154 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 154's IV Administration Record for June 2026 showed Resident 154 had the following orders: - dated 6/28/26, to give Sodium Chloride Intravenous Solution 0.9%, use 1000 ml intravenously one time only for hydration until 6/28/26 at 2359 hours; and - dated 6/29/26, to give Sodium Chloride Intravenous Solution 0.9%, use 50 ml/hr intravenously every shift for hydration for one liter for one day. Review of Resident 154's Order Summary Report showed a physician's order dated 6/29/26, to administer Sodium Chloride Intravenous Solution 0.9%, use 50 ml/hr intravenously every shift for hydration for one liter for one day. On 6/30/26 at 1106 hours, an observation and concurrent interview was conducted with RN 1 in the Resident 154's room. RN 1 verified the resident's IV fluid bag of Sodium Chloride was dated 6/28/26, which was more than 24 hours. RN 1 stated IV bags should be changed every 24 hours. On 7/3/26 at 1120 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility record review, the facility failed to ensure the administration of the oxygen was not performed by a CNA for one nonsampled resident (Resident 38). * CNA 2 was observed removing Resident 38's portable oxygen via nasal cannula, and administering oxygen with an oxygen concentrator via nasal cannula. This failure had the potential for the resident to experience a negative outcome due to oxygen being administered by non-licensed nursing staff. Findings: Medical record review for Resident 38 was initiated on 6/30/26. Resident 38 was readmitted to the facility on [DATE]. Review of Resident 38's Order Summary Report showed:- A physician's order dated 2/10/26, to administer oxygen at 2 LPM via nasal cannula continuously. On 6/30/26 at 0814 hours, Resident 38 was observed with two other residents, all in their wheelchairs, lined up against the hallway wall by the activity/dining room. Resident 38 was observed with a nasal cannula in use. On 6/30/26 at 1257 hours, Resident 38 was observed in her wheelchair in her room, with CNAs 2 and 5 at her bedside. An oxygen cylinder was observed on the back of the resident's wheelchair and the resident's nasal cannula was removed. CNA 2 stated she removed Resident 38's nasal cannula to transfer the resident back to bed. CNAs 2 and 5 then transferred the resident to bed. CNA 2 was observed putting the nasal cannula attached to the oxygen concentrator on to the resident. When CNA 2 was asked a question about the resident's oxygen, she replied the nurse would be able to answer. CNA 2 left the room briefly and returned with LVN 4. LVN 4 was asked who can change the oxygen over from the portable oxygen cylinder to the oxygen concentrator, the LVN replied only LVNs and RNs could. On 7/1/26 at 0941 hours, an interview and concurrent record review was conducted with the DSD. The DSD stated only LVNs and RNs can change the oxygen delivery from the portable oxygen tank to the oxygen concentrator. CNAs were only able to readjust the nasal cannula if it slips or fix an ear loop. The DSD stated she did a CNA in-service on 2/2/26, to go over the CNA's scope of practice and specifically informed the CNAs they could not touch the oxygen unless the nasal cannula ear loop slips off. The DSD stated she also did a CNA in-service on 5/4/26, also informing the CNAs they could not touch the oxygen. Review of CNA 2's Skills Checklist - CNA Performance Skill Check dated 4/18/26, was conducted with the DSD. The checklist showed CNA 2 met the skills for the oxygen tubing care. However, the skills check failed to show the CNA was reviewed for the oxygen administration, or changing the oxygen supply from a portable oxygen cylinder to the oxygen concentrator.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and the facility's P&P review, the facility failed to ensure the medications were administered as ordered by the physician for three of 35 final sampled residents (Residents 7, 53, and 201). * Resident 201's glipizide (medication to lower blood sugar level), Mobic (nonsteroidal anti-inflammatory drug to relieve pain, swelling, and stiffness), and pantoprazole (medication to reduce excess acid in the stomach) medications were not administered as ordered. * The facility failed to ensure the licensed staff did not cut the divalproex (medication used to treat epilepsy/seizure, prevent migrained headaches, and manage manic episodes in bipolar disorder) sodium delayed-release tablets in half, prior to the administration to Resident 7. * The facility failed to ensure full dose of the IV antibiotic was administered to Resident 53. These failures had the potential to compromise the medications' therapeutic effectiveness; posed the risk of treatment failure causing the infection to worsen, return, or spread by failure to eliminate the strong bacteria driving the development of antimicrobial resistance; and to develop adverse outcomes to the residents due to improper alteration of a delayed-release formulation. Findings: Review of the facility's P&P titled Administering Medications (undated) showed medications are administered in accordance with the prescriber's orders. 1. Medical record review for Resident 201 was initiated on 6/30/26. Resident 201 was admitted to the facility on [DATE]. On 6/30/26 at 0932 hours, an interview was conducted with Resident 201. Resident 201 stated she was admitted to the facility yesterday (6/29/26), and still has not received all her medications. Review of Resident 201's MAR for 6/2026 showed: - Chart Codes table showed 10=Other (specify) - A physician's order dated 6/29/26 at 1810 hours, to administer glipizide 5 mg by mouth at bedtime. On 6/30/26 at 1043 hours, the medication order was discontinued, with a new physician's order to administer glipizide 5 mg by mouth daily at lunch. The MAR was coded 10 for both 6/29 at 2000 hours, and 6/30/26 at 1200 hours. - A physician's order dated 6/30/26 at 1040 hours, to administer Mobic 15 mg by mouth daily for pain management, may give with lunch. The MAR was coded 10 for the administration scheduled on 6/30/26 at 1200 hours. - A physician's order dated 6/29/26 at 1810 hours, to administer pantoprazole sodium 40 mg delayed release tablet by mouth in the morning 30 minutes before breakfast. The MAR was coded 10 for the administration scheduled on 6/30/26 at 0630 hours. Review of Resident 201's MAR for 7/2026 showed: (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A physician's order dated 6/30/26 at 1040 hours, to administer Mobic (nonsteroidal anti-inflammatory drug used to relieve pain, swelling, and stiffness) 15 mg by mouth, daily for pain management, may give with lunch. The MAR was coded 10 for the scheduled dose on 7/1/26 at 1200 hours. - A physician's order dated 6/30/26 at 1043 hours, to administer glipizide 5 mg by mouth daily at lunch. The MAR was coded 10 for the scheduled dose on 7/1/26 at 1200 hours. Review of Resident 201's Progress Notes *NEW* showed: - An eMAR &ndash; Medication Administration Note dated 6/30/26 at 0542 hours, for pantoprazole sodium, 40 mg delayed release tablet, showed the medication was pending pharmacy delivery. - An eMAR &ndash; Medication Administration Note dated 7/1/26 at 1316 hours, for glipizide 5 mg, showed the medication has not arrived. - An eMAR &ndash; Medication Administration Note dated 7/1/26 at 1316 hours, for Mobic 15 mg, showed the medication has not arrived. On 7/1/26 at 1541 hours, an interview and concurrent medical record review for Resident 201 was conducted with the DON. The DON stated for new admissions, medications should be available from the pharmacy to administer within four hours after the order was obtained. The DON stated once the order was entered in the EHR, the orders automatically pushed through to the pharmacy to be processed and filled. The DON reviewed Resident 201's MARs for June and July 2026, and verified the above medications were coded with a 10, and were not administered. The DON stated the glipizide and pantoprazole medications should have been available to administer on 6/30 and 7/1/26, and the Mobic should have been available to be administered on 7/1/26. The DON stated if the medications did not arrive timely, the licensed nurse was expected to follow-up with the pharmacy. On 7/1/26 at 1603 hours, an interview was conducted with ADON 2. ADON 2 brought three medication bubble packs. The ADON stated he checked the medication cart and located Resident 201's pantoprazole, pantoprazole sodium, and Mobic medications in the cart, but in the section for bedtime medications. Review of the medication bubble packs' pharmacy labels showed the following: - glipizide 5mg tablets, 14 tablets were filled by the pharmacy on 6/29/26. - pantoprazole sodium 40 mg delayed release tablets, 14 tablets were filled by the pharmacy on 6/29/26. - Mobic 15 mg tables, 14 tablets were filled by the pharmacy on 6/30/26. On 7/2/26 at 1140 hours, an interview was conducted with LVN 3. LVN 3 stated they had Resident 201 yesterday, and used code 10 in the MAR because the medication was not administered. LVN 3 stated yesterday he thought the Mobic and glipizide medications were still pending delivery from the pharmacy and did not realize the medications were in the medication cart with medications to be (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered on the following 1500-2300 hours shift (PM shift). 2. Review of the facility's P&P titled Administering Medication (undated) showed the individual administering the medication checks the label three times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication. On 7/1/26 at 0955 hours, a medication pass observation and concurrent interview was conducted with LVN 5. LVN 5 was observed preparing oral medications for Resident 7 including a divalproex sodium delayed-release tablet 500 mg. LVN 5 was observed cutting the delayed-release tablet into two halves using a pill cutter. LVN 5 stated Resident 7 complained the tablet was too large to swallow and requested that medication to be cut in half. LVN 5 was then observed administering the medication to Resident 7. Medical record review for Resident 7 was initiated on 7/1/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Order Summary Report showed a physician's order dated 2/6/26, for divalproex sodium oral tablets delayed-release 500 mg to give one tablet by mouth every 12 hours for mood disorder/depression. On 7/1/26 at 1224 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 5. LVN 5 verified he cut the divalproex sodium delayed-release tablet for Resident 7 prior to administering the medication and confirmed the existing medication order for the delayed-release tablets. LVN 5 further stated he cut the medication into two halves each time he administered it to Resident 7. When asked whether the delayed-release tablets could be cut, LVN 5 acknowledged the medication should not be cut. LVN 5 further stated he should have notified the physician about the resident was unable to swallow the delayed-release tablets and requested a different formulation which would be easier for Resident 7 to take. On 7/3/26 at 1019 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. On 7/3/26 at 1023 hours, a telephone interview was conducted with the Pharmacist Consultant. The Pharmacist Consultant stated the licensed staff should not cut the divalproex sodium delayed-release tablet medication into halves, as doing so would alter the medication's intended therapeutic effect. The Pharmacist Consultant further explained if a resident reported difficulty swallowing the tablet medication due to its size, the staff should notify the physician or pharmacy to request an alternative formulation which was easier for the resident to swallow. 3. According to the journal AMR Action, Antimicrobial Resistance dated 11/22/25, when antibiotics are given through an IV line, the full dose needs to reach the patient. If the IV line isn't properly flushed after the antibiotic is given, some of the medicine can stay sitting in the tube, that means the patient may not actually receive the full dose they were prescribed. Up to a third of IV antibiotics never reach the patient if lines aren't flushed properly. This isn't just a small detail. It's about (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recovery, preventing hospital readmission, and reducing antibiotic resistance. When doses are incomplete, infections can linger, and bacteria can become harder to treat. No patient should leave hospital worse off because of something as basic as their antibiotic being stuck in a tube. On 6/30/26 at 0836 hours, during the initial tour of the facility, Resident 53 was observed alert, oriented, and in his wheelchair facing the window where the IV pole was located. The IV bottle was labeled Piperacillin-Tazobactam (a brand of powerful, broad spectrum intravenous antibiotic) still containing approximately 1/4 level of the bottle. Resident 53 stated the antibiotic was for his right leg infection. Resident 53 was asked about the bottle with the remaining solution attached to the plastic bag. Resident 53 stated, It is not the first time. I can see sometimes water in the bottle when it's hanging there after nurse removed the connection. On 6/30/26 at 1126 hours, a follow up visit to Resident 53's room and concurrent observation was conducted. The IV bag with the attached bottle of antibiotic, was no longer on the IV pole. Medical record review for Resident 53 was initiated on 6/30/26. Resident 53 was admitted to facility on 5/29/26, with diagnosis of Arthritis (swelling of the joints) due to other bacteria, right ankle and foot; and Cellulitis (common, potentially serious bacterial infection of the skin and underlying tissues) of the right lower limb. On 6/30/26 at 1305 hours, an interview was conducted with RN 1 regarding the administration of the IV antibiotics. RN 1 stated the entire solution in the bottle after reconstitution should be inside the bag and the bottle must be empty after the medication was consumed. There should be no solution left inside the bottle of the antibiotics. The photo of the bottle labeled Piperacillin-Tazobactam was shown to RN 1. RN 1 verified and stated almost 1/4 of the solution was left inside the bottle and further stated, the full dose of antibiotic was not given to Resident 53. On 7/1/26 at 0918 hours, review of Resident 53's physician's orders was conducted. The physician's order dated 5/29/26, showed Piperacillin-Tazobactam-NaCl (sodium chloride) Intravenous Solution Reconstituted 4.5 gm/100 ml (Piperacillin Sodium-Tazobactam Sodium-Sodium Chloride) -Use 4.5 gram intravenously every eight hours for RLE Cellulitis/Strep Septicemia until 6/29/26 at 2359 hours continuation from the acute care hospital until 6/29/26. On 7/3/26 at 1115 hours, an interview and concurrent discussion of Resident 53's antibiotic order and the administration of the IV antibiotics medication was conducted with the DON. The DON acknowledged and verified the above findings.		

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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 facility P&P review, the facility failed to ensure the medications were safely and securely stored for one of 35 final sampled residents (Resident 187). * A bottle of Medline Remedy antifungal powder was found at Resident 187's bedside. This failure posed the risk of an unauthorized access to the medications and had the potential to lead to medication errors. In addition, the failure had the potential to place the resident at risk for receiving the wrong type of medication. Findings: Review of the facility's P&P titled Storage of Medications (undated) showed the drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medication have access to locked medications. On 6/30/26 at 0935 hours, Resident 187 was observed lying in bed. A bottle of Medline Remedy antifungal powder was observed on the resident's bedside table. Resident 187 stated the staff had left the medication on the bedside table since the previous night. He added that he did not apply the medication himself; rather, the staff applied it to his arm. On 6/30/26 at 0940 hours, LVN 6 was called to the room of Resident 187. LVN 6 verified the observation and stated the bottle of Medline Remedy antifungal powder should not have been left at the resident's bedside. LVN 6 was then observed removing the bottle of antifungal powder from the room. Medical record review for Resident 187 was initiated on 6/30/26. Resident 187 was admitted to the facility on [DATE]. Review of Resident 187's MDS assessment dated [DATE], showed Resident 187 was cognitively intact. Review of Resident 187's Order Summary Report dated 7/2/26, failed to show a physician's order for Medline Remedy antifungal powder. On 7/3/26 at 1019 hours, an interview and concurrent medical record review for Resident 187 was conducted with the DON. The DON was informed of the above findings and verified Resident 187 did not have a physician's order for the Medline Remedy antifungal powder. The DON further stated the staff should not apply the medication without a physician's order and should not leave medication unattended at the resident's bedside.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 facility document review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen when the facility failed to ensure the kitchen equipment was maintained and cleaned properly. * Six plastic food bowls had numerous cuts, scratches and permanent staining. This failure had the potential to pose a risk of exposure to food-borne illnesses in a medically vulnerable population of 173 residents who received food prepared in the kitchen. Findings: Review of the facility's matrix showed 173 residents consumed food prepared in the facility's kitchen. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 06/30/26 at 1145 hours, an observation and concurrent interview was conducted with the Dietary Services Supervisor in the main kitchen. Six plastic food bowls were observed to have numerous cuts, scratches and permanent staining. The Dietary Services Supervisor acknowledged the findings and stated the bowls should not be used in that condition.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview, facility document review, and facility P&P review, the facility failed to ensure education was provided to the staff on safe food handling of outside food. * The facility failed to ensure the staff were aware of the proper temperatures to reheat food brought from outside sources. This failure had the potential to cause foodborne illnesses for the medically vulnerable resident population who consumed food brought from outside sources. Findings: According to the USDA Food Code 2022, Section 3-403.11 (B) and (D), food that is reheated in a microwave oven, minimum temperature 74 C (165 F), minimum holding time at the specified temperature and hold for two minutes after reheating. Review of the facility's P&P titled Foods Brought by Family/Visitors dated August 2024 showed facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. staff will assist residents in accessing and consuming their personal food. On 7/1/26 at 0910 hours, an interview was conducted with CNA 3. CNA 3 stated the family members and friends may bring food for the residents from home. CNA 3 stated food brought from home should be labeled, dated, and stored in the refrigerator. CNA 3 stated she reheats the residents' food from outside sources in the microwave. CNA 3 stated she has not received training on safe food handling and was unaware of the proper temperature for reheating food. CNA 3 stated she would ask the kitchen staff for the proper temperature for reheating food. On 7/1/26 at 0920 hours, an interview was conducted with LVN 2. LVN 2 stated CNAs reheat residents' food from outside sources in the microwave in the staff lounge. LVN 2 was unaware of the proper reheating temperature and stated a thermometer was not available to verify the food temperature. LVN 2 stated knowing the proper reheating temperature was unnecessary because the microwave automatically reheats food to the proper temperature. On 7/1/26 at 1115 hours, an interview was conducted with CNA 4. CNA 4 stated food from home is labeled, dated and placed in the refrigerator. CNA 4 stated if the food needs to be reheated, staff will reheat to 140 degrees. On 07/1/26 at 1117 hours, an interview and facility document review was conducted in the conference room with the DSD. The DSD stated CNAs reheat food brought from home to 140 degrees F and staff had received an in-service. When asked to provide documentation safe food reheating instructions were provided to staff, the DSD confirmed she did not provide education to the staff regarding safe food handling practices. The DSD later clarified she misspoke and 140 degrees F applies to food service, not reheating food. Review of the in-service materials and policy confirmed the safe reheating temperature was not included.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and P&P review, the facility failed to ensure the lid of a garbage dumpster bin located outside on the facility grounds was tightly closed. * The green food scraps dumpster bin had an ill-fitting lid with a gap. There was additional refuse, including dirty gloves and food waste, scattered on the ground beneath and around the bin. This failure had the potential to cause unsafe sanitary conditions and potential to harbor pests and rodents. Findings: Review of the facility's P&P titled Food-Related Garbage and Refuse Disposal revised 10/2017 showed outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. On 6/30/26 at 0830 hours, an observation of the dumpster area and concurrent interview was conducted with the Dietary Services Supervisor. The green food scraps dumpster bin was observed to have an ill-fitting lid with a gap of three inches between the lid and the bin. When the Dietary Services Supervisor opened the lid, flies were noted to be inside the bin. Additionally, there was old equipment, cardboard boxes, scraps of wood, a black plastic trash can, a crate and a mop were on the ground surrounding the green food scraps dumpster bin. There was trash and paper observed under the green food scraps dumpster bin. The Dietary Services Supervisor acknowledged the findings.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observations, interviews, medical record review, and facility P&P review, the facility failed to ensure the bilateral grab bars attached to the resident's bed was properly installed for one of 35 final sampled residents (Resident 137). * Resident 137's bilateral grab bars were observed to be loosely installed as evidenced by them moving sideways, backward, and forward. Upon inspection by the Maintenance Director, it was determined that both grab bars with screws at the bases were loosely attached to the bed frame. This failure posed the risk for accidental fall and/or entrapment between the grab bar and bedframe and/or mattress, potentially causing serious injury to the resident. Findings: Review of facility's P&P titled Maintenance Service revised December 2009 showed in part, maintenance service shall be provided to all areas of the buildings, grounds and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner always. Functions of the maintenance personnel include but are not limited to: maintaining the building in compliance with current federal, state, and local laws, regulations and guidelines. Maintaining the building in good repair and free from hazards. Providing routinely scheduled maintenance service to all areas. On 6/30/26 at 0855 hours, an observation and concurrent interview was conducted with Resident 137. Resident 137 was observed awake and lying in bed. When asked, Resident 137 stated she used the grab bars all the time daily to get out of bed and to reposition herself from lying to sitting position, but it was moving. Resident 137 further stated they could have fixed it so it would be firm and not move. On 6/30/26 at 1128 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified Resident137's two grab bars were moving sideways, backward, and forward. Upon further inspection by the Maintenance Director, he determined the bases of the grab bar screws were loosely attached to the bed frame. The Maintenance Director stated he would fix and tighten it right away. Medical record review for Resident 137 was initiated on 7/1/26. Resident 137 was admitted to facility on 12/26/24. On 7/3/26 at 1142 hours, an interview was conducted with the Administrator and DON. The Administrator acknowledged the findings and stated the Maintenance Director and his team will conduct routine checks on the beds and other devices to ensure they were properly installed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2026
NAME OF PROVIDER OR SUPPLIER Seal Beach Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 N Gate Road Seal Beach, CA 90740	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure resident equipment was maintained in a clean and sanitary condition for one of 35 final sampled resident (Resident 15). * Resident 15's fan was observed with heavy dust and lint. This failure had the potential to expose the resident to airborne contaminants, increasing the risk of respiratory irritation or infection. Findings: Review of the facility's P&P titled Homelike Environment dated 2/2021 showed the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, home like setting. These characteristics include clean sanitary and orderly environment. On 6/30/26 at 0912 hours, Resident 15 was observed lying in bed. A portable fan was positioned on the left side of the bed, blowing air toward the resident's face. Heavy dust and lint were visibly accumulated on the fan. Resident 15 stated he stated he did not know when the fan was last cleaned. On 6/30/26 at 0630 hours, an observation and concurrent interview was conducted with LVN 6. LVN 6 verified the condition and stated the fan had collected dust and lint and should have been cleaned. On 7/3/26 at 1019 hours, an interview was conducted with the DON. The DON was informed of and acknowledged the above findings.		