

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Avalon Villa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12029 Avalon Blvd Los Angeles, CA 90061	
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 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) for five of six sampled residents (Resident 37, 35, 5, 110, 114) with positioning, mobility, and restorative nursing ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) concerns.a. For Resident 37, the facility failed to:1. Measure Resident 37's ROM in the joints of both arms during the Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation, dated 9/17/2025. 2. Measure Resident 37's ROM in the joints of both legs during the Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation, dated 9/17/2025.3. Provide passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) exercises to both hands in accordance with Resident 37's physician orders and care plan, dated 11/11/2025.4. Provide pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position) to both of Resident 37's legs from 11/12/2025 to 1/8/2026 in accordance with Resident 37's physician orders and care plan, dated 11/11/2025. b. For Resident 5, the facility failed to:1. Measure Resident 5's ROM in both legs during the PT Evaluations, dated 4/20/2025 and 7/27/2025.2. Measure Resident 5's ROM in both arms during the OT Evaluations, dated 7/27/2025.3. Provide bicycle exercises three times per week, from 5/2025 to 7/2025 in accordance with physician orders, dated 4/30/2025.4. Provide Resident 35 with PROM exercises on both arms and legs, three times per week, from 10/2025 to 1/2026 in accordance with physician orders and care plan, dated 10/30/2025.c. For Resident 35, the facility failed to:1. Measure Resident 35's ROM in both arms during the OT Evaluations, dated 3/23/2025 and 11/2/2025.2. Measure Resident 35's ROM in both legs during the PT Evaluations, dated 3/23/2025 and 11/2/2025.3. Provide PROM exercises for both arms and legs, three times per week, from 7/2025 to 10/2025, in accordance with the physician orders, dated 6/30/2025.d. For Resident 110, the facility failed to measure Resident 110's ROM in both arms during the OT Evaluations, dated 9/24/2025 and 12/14/2025.e. For Resident 114, the facility failed to:1. Measure Resident 114's ROM in both arms during the OT Evaluation, dated 7/23/2025 and 12/14/2025.2. Measure Resident 114's ROM in both arms during the PT Evaluation, dated 7/23/2025. These failures resulted in Resident 37's further ROM limitations of both ankles into plantarflexion (ankle bent with toes pointing away from the body) from 12-22 degrees (normal 0-45 degrees) on the left ankle and 10-12 degrees on the right ankle upon discharge from PT on 11/11/2025, to 39-58 degrees on the left ankle and 40-59 degrees on the right ankle on 1/8/2026. These failures also had the potential to result in undetected and further ROM loss in both hands, placing Resident 37 at increased risk of developing pressure injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and further contractures (a stiffening/shortening at any joint that reduces the joint's range of motion). These failures also had the potential for Resident 5, 35, 110, and 114 to experience decreased mobility and further undetected (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056023
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F 0688 Level of Harm - Actual harm Residents Affected - Few	bones) for a period of time. MD 1 stated Resident 37's ankle contractures could worsen if the PRAFOs were not applied. During a concurrent interview and record review on 1/8/2026 at 1:37 p.m. with the DOR, the RNA Meeting Notes, dated 11/18/2025, 12/23/2025, 12/30/2025, and 1/6/2026, were reviewed. The RNA Meeting Notes did not include any notes regarding Resident 37's RNA program. The DOR stated Resident 37's RNA program was not discussed during the RNA Meetings. During a concurrent interview and record review on 1/8/2026 at 1:55 p.m. with the DOR, Resident 37's PT Treatment Encounter Notes from 9/15/2025 to 11/11/2025 and PT Discharge summary, dated [DATE], were reviewed. The PT Encounter Notes indicated the treatment provided to Resident 37 but did not include documentation of RNA training. The PT Discharge Summary also did not include RNA training regarding Resident 37's RNA program. The DOR stated the PT Treatment Encounter Notes and PT Discharge Summary did not indicate the RNAs were trained in Resident 37's recommended RNA Program. During an interview on 1/8/2026 at 2:47 p.m. with MD 1, MD 1 was informed that Resident 37's PRAFOs were not applied since 11/11/2025 and informed that the DOR stated Resident 37's ankle ROM has worsened into further plantarflexion since Resident 37's discharge from PT on 11/11/2025. MD 1 stated not applying the splint could have played a part in Resident 37's further ROM limitations. MD 1 stated contractures could not be reversed without surgical intervention. During an interview on 1/8/2026 at 4:17 p.m. with the Director of Staff Development (DSD), the DSD stated the DOR or the therapist placed the physician order for RNA into the electronic documentation system after discharge from therapy services. The DSD did not know whether there was a process for the nurses to check the RNA order after submission into the electronic documentation system. During an interview on 1/8/2026 at 5:10 p.m. with the Interim Director of Nursing (IDON) and the DSD, Resident 37's RNA Flow Sheets for 11/2025, 12/2025, and 1/2026 were reviewed. The IDON stated the physician order for the RNA to apply both of Resident 37's leg splints was entered in the computer documentation system in a manner that did not create the task on the RNA Flow Sheets. The IDON stated Resident 37 could potentially develop contractures if the leg splints were not applied. During an interview on 1/8/2026 at 5:15 p.m. with the IDON and the DSD, The IDON and the DSD stated the ROM in both of Resident 37's ankles had worsened since Resident 37's discharge from PT on 11/11/2025. The IDON stated contractures should be prevented to prevent a resident's discomfort and the development of pressure injuries. During a review of the facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P indicated residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. b. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted on [DATE] with diagnoses including hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following a cerebral vascular accident ([CVA] stroke, loss of blood flow to a part of the brain) affecting the right dominant side, dysphagia (difficulty swallowing), aphasia (disorder that makes it difficult to speak), muscle weakness, and chronic respiratory failure (airways carrying air to lungs become narrow and damaged, limiting air movement in the body) with hypoxia (body does not receive enough oxygen). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had unclear speech, had difficulty communicating some words or finishing thoughts, usually understood verbal content, and had intact cognition. The MDS indicated Resident 5 had limited ROM in both arms and arms. The MDS indicated Resident 5 required setup or clean-up assistance for eating, substantial/maximal assistance (helper does more than half the effort) for upper and lower body dressing, rolling to either side while lying in bed, transferring from lying in bed to sitting at the side of the, and chair/bed-to-chair transfers. During a review of Resident 5's JMS, signed on 4/20/2025 and completed by PT 1, the JMS indicated Resident 5 had minimal ROM loss in both shoulders, both elbows, the left wrist and fingers, both hips, both knees, and the left ankle. The JMS indicated Resident 5 had moderate ROM loss in the right wrist and fingers and the right ankle. The (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	JMS indicated Resident 5 maintained joint mobility and had a diagnosis/condition that puts the resident at risk for contracture development. During a review of Resident 5's OT Evaluation and Plan of Treatment, dated 4/20/2025, the OT Evaluation indicated the ROM in both of Resident 5's arms were within fun		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure coordination of the resident's PASRR Level II (PASRR II-a federally mandated screen for individuals for Serious Mental Illness [SMI], Intellectual Disabilities [ID], or Developmental Disabilities [DD] to ensure they get the right care in the least restrictive setting, preventing inappropriate nursing home placement and identifying needs for specialized services) determination with ongoing assessment, interdisciplinary review, care planning revisions, reconsideration of appropriate placement following significant changes in the residents behavioral condition for one of three sampled residents (Resident 27). This deficient practice had the potential to result in inaccurate care for Resident 27 while residing in the facility. Findings: During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was initially admitted to the facility on [DATE]. Resident 27's diagnoses included traumatic brain injury (damage to the brain from an external force), traumatic subarachnoid hemorrhage (brain bleed) with loss of consciousness, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The admission Record indicated, on 12/19/2025, Resident 27 was diagnosed with disorganized schizophrenia (a mental illness that is characterized by disturbances in thought) and brief psychotic disorder. During a review of Resident 27's Minimum Data Set ([MDS], a resident assessment tool), dated 12/22/2025, the MDS indicated Resident 27's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 27 was entirely dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 27's History and Physical (H&P), dated 9/14/2025, the H&P indicated Resident 27 had the capacity to understand and make decisions. During a review of Resident 27's Nursing Progress Note dated 10/3/2025, the note indicated on 10/3/2025, Resident 27 hit, punched, cursed, threw feces at staff, and threw his meal plates on staff and peers. The Nursing Progress Note also indicated redirection and medication for agitation and anxiety was not effective. During a review of Resident 27's Nursing Progress Note dated 10/16/2025, the note indicated on 10/16/2025, Resident 27 ripped off the curtains in his room and started yelling profanities. During a review of Resident 27's Nursing Progress Note dated 11/24/2025, the note indicated on 11/24/2025, Resident 27 was verbally and physically aggressive towards a certified nursing assistant (CNA). During a review of Resident 27's Nursing Progress Note dated 12/17/2025, the note indicated on 12/17/2025, Resident 27 grabbed a CNA by the jacket while the CNA attempted to provide peri-care, was verbally aggressive, and kicked the CNA in the chest. The Nursing Progress Note indicated 911 was called for increased agitation. During a review of Resident 27's Nursing Progress Note dated 12/30/2025, the note indicated on 12/30/2025, Resident 27 struck a charge nurse on the stomach while passing by her. During a review of Resident 27's Nursing Progress Note dated 12/31/2025, the note indicated on 12/31/2025, Resident 27 reached forward and grazed another resident with his hand and the resident's chair. The note indicated the Department of Mental Health was notified, and two members of the Psychiatric Mobile Response Team (PMRT) came to evaluate resident for a possible 5150 (a 72- hour psychiatric hospitalization when an adult exhibits a mental health crisis and is evaluated to be a danger to others, or to himself or herself, or gravely disabled) hold. The Nursing Progress Note indicated the PMRT members agreed that Resident 27 was not fit to be in facility, but he was not transferrable at that time. During a review of Resident 27's Nursing Progress Note dated 1/1/2026, the note indicated on 1/1/2026, Resident 27 displayed three episodes of aggression. During a review of Resident 27's Nursing Progress Note dated 1/3/2026, the note indicated on 1/3/2026, Resident 27 displayed one episode of aggression. During a review of Resident 27's Nursing Progress Note dated 1/4/2026, the note indicated on 1/4/2026, Resident 27 displayed three episodes of aggression. During (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a review of Resident 27's Nursing Progress Note dated 1/5/2026, the note indicated on 1/5/2026, Resident 27 displayed one episode of aggression. During a review of all of Resident 27's Interdisciplinary Team (IDT) Notes, dated 10/2025 to 1/6/2026, the IDT notes did not indicate an IDT Care Conference was held following each documented episode of physical and verbal aggression. The IDT Note, dated 12/23/2025, indicated on 12/19/2025, Resident 27 was readmitted to the facility from the General Acute Care Hospital (GACH) due to striking out at staff. There was no documentation to indicate there was a reassessment of Resident 27's behavioral management needs, consideration of increased interventions, initiation of PASRR Level II re-evaluation, or discussion of discharge to a more specialized setting despite continued aggressive behaviors. During a review of Resident 27's PASRR II Care Plan, dated 10/10/2025, the care plan indicated Resident 27 was to receive psychiatry (a branch of medicine concerned with the study, diagnosis, and treatment of mental illness) and psychology (the study of the human mind and its functions, especially those affecting behavior) evaluations as indicated and supportive visits from social services and other providers as tolerated. During a review of Resident 27's PASRR Individualized Determination Report, dated 10/14/2025, the report indicated Resident 27 was recommended the following specialized add on services: mental health rehabilitation activities, psychotherapy counseling, psychology consultation, and social services consultation. During a review of Resident 27's Order Summary, dated 1/7/2026, the Order Summary did not indicate an order for a psychologist consultation. During an interview on 1/5/2026 at 12:20 p.m. with CNA 2, CNA 2 stated Resident 27 grabbed her buttocks and private area (date unknown), causing her to feel uncomfortable. CNA 2 stated Resident 27 laughed during the incident. CNA 2 stated she notified Licensed Vocational Nurse (LVN) 2 and the Director of Staffing Development (DSD) of the incident. During a concurrent interview and record review on 1/7/2026 at 12:10 p.m. with the Director of Nursing Trainer (DONT), all of Resident 27's Progress Notes, Physician Orders, IDT Notes, Physician Progress Notes, and Nursing Progress Notes, dated 7/2025 to 1/7/2026, were reviewed. The Physician Orders lacked a psychologist consultation order. The Physician Progress Notes lacked evidence a psychologist visited Resident 27. The IDT notes indicated a lack of reconvening after each episode of physical and verbal aggression. The IDT Notes indicated the most recent Behavioral Management IDT was held in 7/2025, which occurred prior to the PASRR Individualized Determination Report (10/14/2025). The Nursing Progress Notes lacked documentation to indicate a PASRR reevaluation was requested. The DONT stated Resident 27 would have benefited from a psychologist consult to engage in purposeful psychotherapy and learn behavioral management techniques. The DON stated a PSARR reevaluation should have been conducted, particularly following the continued episodes of aggression and verbal issues. The DON stated the lack of IDT meetings, and lack of psychological health resources led to missed opportunities to address Resident 27's grave behavioral and mental health needs and placed Resident 27 at risk for continued episodes of aggression and deteriorating mental health. During a concurrent interview and record review on 1/7/2026 at 3:46 p.m. with the Social Services Director (SSD), Resident 27's Social Services Progress Notes, dated 10/2025 through 1/7/2026, and PASRR Individualized Determination Report, dated 10/14/2025, were reviewed. The Progress Notes lacked documentation to indicate Resident 27 received meaningful social services visits, mental health rehabilitation activities and psychotherapy counseling to support Resident 27's mental health. The SSD stated she visited Resident 27 but did not document her visits because she did not have the time. The SSD stated it was important to adhere the PASRR'S recommendations to ensure Resident 27 received mental supportive services to ensure his psychiatric needs were met and so that his mental health did not deteriorate. During a review of the facility's Policy and Procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR) (undated) the P&P indicated the facility would ensure the following:1. Not admit until the state issues a Level II determination confirming nursing facility services were appropriate, and whether specialized services were required.2. If specialized services were recommended, the facility would document ability and plan to provide or arrange them.3. If placement was not appropriate, the (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility would assist in identifying alternative community options.4. Incorporate PASRR recommendations into the comprehensive care plan, including any specialized services.5. Notify the interdisciplinary team of PASRR findings and required services.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care plans were initiated addressing a resident's diagnosis of stroke (loss of blood flow to a part of the brain) and cranial surgical incision, and the use of Apixaban (a type of blood thinner used to prevent and treat blood clot) for two of two sampled residents (Resident 65 and Resident 4). These deficient practices had the potential to place Resident 65 at risk for neurological deterioration, infection, and other life-threatening complications, and had the potential for Resident 4 to exhibit complications related to bleeding due to the lack of individualized monitoring, interventions and staff guidance related to anticoagulant (blood thinner) therapy. Findings: a. During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was initially admitted to the facility on [DATE]. Resident 65's diagnoses included nontraumatic intracerebral hemorrhage (a serious type of hemorrhagic stroke where a blood vessel within the brain bursts, causing bleeding directly into the brain tissue, leading to swelling and tissue damage), encephalopathy (any disease or damage that alters brain function), and chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately oxygenate the blood). During a review of Resident 65's Minimum Data Sets ([MDS], a resident assessment tool), dated 9/16/2025 and 12/16/2025, the MDS' indicated Resident 65's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS' indicated Resident 65 was entirely dependent on staff for toileting, showering, and lower body dressing. The MDS' indicated Resident 65 had an active diagnosis of a cerebrovascular accident (CVA) or a stroke. The MDS' indicated Resident 65 did not have any major surgical procedures during the prior inpatient hospital stay that required active care in the facility. During a review of Resident 65's History and Physical (H&P), dated 9/11/2025, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's General Acute Care Hospital (GACH) Physician Progress Note, dated 9/10/2025, the GACH note indicated Resident 65 was admitted to the intensive care unit (ICU) on 8/5/2025 for a diagnosis of intraventricular hemorrhage and required immediate intubation (a medical procedure where a tube is placed into the windpipe through the mouth or nose to secure an open airway). The GACH note indicated Resident 65 underwent ventriculostomy (a neurosurgical procedure where a catheter or small opening is placed in the brain's ventricles [fluid-filled cavities deep within the brain] to drain excess cerebrospinal fluid [CSF- brain fluid] or monitor intracranial pressure [ICP &ndash; pressure within the brain]) with EVD (a catheter is inserted into a ventricle, connected to an external drainage system to remove CSF and measure pressure) placement on 8/6/2025 and subsequent removal on 8/12/2025. The GACH note indicated Resident 65 was in the ICU for approximately 30 days. During a concurrent observation and interview on 1/6/2026 at 2:00 p.m., with Resident 65, in Resident 65's room, observed Resident 65 with three staples along a surgical incision to his scalp. There was no dressing in place. Resident 65 stated the staff had not assessed or treated the incision site. During an interview on 1/6/2026 at 2:42 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was also one of the facility's treatment nurses. LVN 1 stated she was not aware Resident 65 had (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a recent surgical incision. LVN 1 stated the facility had not been providing treatment or monitoring Resident 65's post-surgical incision. LVN 1 stated it was very important to monitor surgical incisions and ensure timely removal of staples because skin could potentially grow over the staples or an infection could occur. LVN 1 stated a care plan should have been initiated to address Resident 65's wound care to prevent infection and to ensure follow up orders were in place for staple removal. During a concurrent interview and record review on 1/6/2026 at 4:29 p.m. with Registered Nurse (RN) 1, Resident 65's GACH Record Physician Progress Note, dated 9/10/2025, and all of Resident 65's Care Plans, dated 9/2025 to 1/6/2026, were reviewed. RN 1 stated there were no care plans in place that addressed Resident 65's diagnosis of a stroke and the resident's surgical incision wound care. RN 1 stated care plans should have been started upon Resident 65's admission to the facility because the conditions were present upon admission, in 9/2025. RN 1 stated the absence of both care plans had the potential to lead to neurological decline, infection, seizures, and poor care of a stroke patient. During a concurrent interview and record review on 1/8/2026 at 3:23 p.m. with the Quality Assurance Nurse (QAN), Resident 65's MDS', dated 9/16/2025 and 12/16/2025, were reviewed. The QAN stated the MDS inaccurately indicated Resident 65 did not have any major surgical procedure during the prior inpatient hospital stay requiring active SNF care. The QAN stated the MDS should have reflected the resident's recent surgery so that the appropriate care area assessment could have been triggered, which would have assisted in the formulation of a care plan. The QAN stated the inaccurate assessment contributed to the absence of care planning for the resident's post-surgical and neurological needs. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person- Centered , revised 3/2022, the P&P indicated the facility was to ensure a comprehensive, person-centered care plan, that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs, was developed and implemented for each resident. The P&P indicated the following: 1. The interdisciplinary team (IDT, group of different disciplines working together towards a common goal of a resident), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan was developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. b. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), and hyperlipidemia (high cholesterol). During a review of Resident 4's H&P, dated 11/15/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's physician order dated 11/7/2025, the physician order indicated to (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administer Apixaban Tablet 5 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) by mouth two times a day for acute embolism and thrombosis (blood clots that block blood vessels with potential blood clot breakage) of unspecified deep veins of the lower extremities (legs). During a concurrent interview and record review on 1/6/2026 at 3:05 p.m., with LVN 4, Resident 4's medical records were reviewed. The records did not indicate there was a care plan addressing the resident's use of Apibaxan. LVN 4 stated that residents receiving anticoagulants (medication to thin the blood) should have an individualized care plan. LVN 4 stated the care plan should include the monitoring for signs and symptoms of bleeding, medication precautions, and safety interventions. LVN 4 stated that the care plan omission was an oversight and acknowledged that the care plan should have been developed and implemented to properly monitor and assist Resident 4. During a concurrent interview and record review on 1/7/2026 at 9:28 a.m., with RN 3, Resident 4's physician orders dated 11/7/2025 were reviewed. RN 3 stated Resident 4 was currently receiving Apixaban as ordered by the physician. RN 3 stated that residents on anticoagulant therapy should have a care plan that included monitoring for signs and symptoms of bleeding, fall precautions, and notification parameters for abnormal findings. RN 3 stated that nursing staff rely on the care plan to guide the resident's monitoring and interventions and acknowledged that the absence of a care plan could result in inconsistent care delivery and potential adverse events. During a review of the facility's P&P titled, Care Plans &ndash; Baseline dated 3/2022, the P&P indicated, The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services to ensure a resident received appropriate post-stroke (loss of blood flow to a part of the brain) care and post-surgical wound monitoring for one of three sampled residents (Resident 65), when nursing staff failed to assess and monitor Resident 65's post-surgical cranial incision and staples since his admission on [DATE] and failed to advocate for a specialty follow-up appointment with a neurologist (a medical doctor specializing in the diagnosis and treatment of disorders affecting the brain). These deficient practices placed Resident 65 at risk for neurological (relating to disorders of the nervous system and brain) decline, infection, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and other life-threatening complications. Findings: During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was initially admitted to the facility on [DATE]. Resident 65's diagnoses included nontraumatic intracerebral hemorrhage (a serious type of hemorrhagic stroke where a blood vessel within the brain bursts, causing bleeding directly into the brain tissue, leading to swelling and tissue damage), encephalopathy (any disease or damage that alters brain function), and chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately oxygenate the blood). During a review of Resident 65's Minimum Data Sets ([MDS], a resident assessment tool), dated 9/16/2025 and 12/16/2025, the MDS' indicated Resident 65's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS' indicated Resident 65 was entirely dependent on staff for toileting, showering, and lower body dressing. The MDS' indicated Resident 65 had an active diagnosis of cerebrovascular accident (CVA) or a stroke (loss of blood flow to a part of the brain). The MDS' indicated Resident 65 did not have any major surgical procedures during the prior inpatient hospital stay that required active care in the facility. During a review of Resident 65's History and Physical (H&P), dated 9/11/2025, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's General Acute Care Hospital (GACH) Physician Progress Note, dated 9/10/2025, the GACH note indicated Resident 65 was admitted to the intensive care unit (ICU) on 8/5/2025 for a diagnosis of intraventricular [fluid-filled cavities deep within the brain] hemorrhage and required immediate intubation (a medical procedure where a tube is placed into the windpipe through the mouth or nose to secure an open airway). The GACH note indicated Resident 65 underwent ventriculostomy (a neurosurgical procedure where a catheter or small opening is placed in the brain's ventricles to drain excess cerebrospinal fluid [CSF- brain fluid] or monitor intracranial pressure [ICP - pressure within the brain]) with external ventricular drain (EVD-a catheter is inserted into a ventricle, connected to an external drainage system to remove CSF and measure pressure) placement on 8/6/2025 and subsequent removal on 8/12/2025. The GACH note indicated Resident 65 was in the ICU for approximately 30 days. During a review of Resident 65's Psychiatrist (a medical doctor specializing in mental health) Progress Notes, dated 12/16/2025 and 1/3/2026, the Psychiatrist Progress Notes indicated, in 10/2025, Resident 65 confirmed experiencing short-term memory loss likely related to the residual effects of a stroke. The Psychiatrist Progress Notes indicated to defer to neurology (a medical doctor specializing in the diagnosis and treatment of disorders affecting the brain, spinal cord, and nerves [the nervous system]) to address this issue. During a concurrent observation and interview on 1/6/2026 at 2:00 p.m., with Resident 65, in Resident 65's room, observed Resident 65 in bed with three staples along a surgical incision on the scalp. There was no dressing observed. Resident 65 stated staff had not assessed or treated his surgical incision site. During an interview on 1/6/2026 at 2:42 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was also the treatment nurse. LVN 1 stated she was not aware Resident 65 had a recent surgical incision related to neurosurgical intervention. LVN 1 stated the facility had not been providing treatment or monitoring (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to Resident 65's post-surgical incision. LVN 1 stated it was important to monitor surgical incisions and ensure timely removal of staples because skin could potentially grow over the staples or an infection could occur. LVN 1 stated a care plan should have been initiated to address Resident 65's wound care to prevent infection and to ensure follow up orders were in place for staple removal. During a concurrent interview and record review on 1/6/2026 at 4:29 p.m. with Registered Nurse (RN) 1, Resident 65's GACH Records, dated 9/2025, Resident 65's Psychiatrist Progress Notes, dated 12/16/2025 and 1/3/2026, Nursing Progress Notes, Skin Assessments, and all of Resident 65's Care Plans, dated 9/2025 to 1/6/2026, were reviewed. RN 1 stated Resident 65's medical record lacked documentation Resident 65's post-surgical incision and staples were assessed and monitored since admission on [DATE]. RN 1 stated there was no documentation to indicate a neurologist (a medical doctor specializing in the diagnosis and treatment of disorders affecting the brain) follow up appointment was scheduled on Resident 65's behalf, despite the psychiatrist documenting to defer to neurology. RN 1 stated the facility did not provide ongoing monitoring or follow-up care related to Resident 65's stroke diagnosis or post-surgical incision. RN 1 stated licensed nursing staff should have advocated for a follow up appointment with a neurologist for Resident 65 to ensure appropriate post-surgical and neurological care was provided. RN 1 stated the licensed nursing staff should have appropriately and carefully assessed Resident 65's skin upon admission and on an ongoing basis, thereafter. RN 1 stated the lack of a diligent skin assessment contributed to the lack of identification and management of Resident 65's surgical incision and staples. RN 1 stated these failures had great potential to lead to neurological decline, infection, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and poor care for a stroke patient. During an interview on 1/8/2026 at 8:23 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she provided routine daily care for Resident 65, which included bed baths. CNA 1 stated she had not noticed the surgical incision and staples on Resident 65's scalp and stated staff should have identified and reported the resident had staples. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person- Centered , revised 3/2022, the P&P indicated the facility was to ensure the following:1. Care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.2. When possible, interventions addressed the underlying source(s) of the problem area(s), not just symptoms or triggers.3. Assessments of residents were ongoing, and care plans were revised as information about the residents and the residents' conditions change. During a review of the facility's RN Supervisor Job Description, dated 2023, the Job Description indicated the RN Supervisor was to review the new admissions of the complete of the quality assessment and the appropriate plan of care of the resident and may make clinical corrections as deemed necessary appropriate.		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident received mental health and psychosocial treatment necessary to attain and maintain the highest practicable mental and psychosocial (focuses on emotions, thoughts, coping mechanisms, sense of self, and mental health) well-being for one of three sampled residents (Resident 27). This deficient practice led to Resident 27 continuing to exhibit repeated episodes of verbal and physical aggression without effective therapeutic mental health intervention. Findings: During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was initially admitted to the facility on [DATE]. Resident 27's diagnoses included traumatic brain injury (damage to the brain from an external force), traumatic subarachnoid hemorrhage (brain bleed) with loss of consciousness, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The admission Record indicated, on 12/19/2025, Resident 27 was diagnosed with disorganized schizophrenia (a mental illness that is characterized by disturbances in thought) and brief psychotic disorder. During a review of Resident 27's Minimum Data Set ([MDS], a resident assessment tool), dated 12/22/2025, the MDS indicated Resident 27's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 27 was entirely dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 27's History and Physical (H&P), dated 9/14/2025, the H&P indicated Resident 27 had the capacity to understand and make decisions. During a review of Resident 27's Nursing Progress Note dated 10/3/2025, the note indicated on 10/3/2025, Resident 27 hit, punched, cursed, threw feces at staff, and threw his meal plates on staff and peers. The Nursing Progress Note also indicated redirection and medication for agitation and anxiety was not effective. During a review of Resident 27's Nursing Progress Note dated 10/16/2025, the note indicated on 10/16/2025, Resident 27 ripped off the curtains in his room and started yelling profanities. During a review of Resident 27's Nursing Progress Note dated 11/24/2025, the note indicated on 11/24/2025, Resident 27 was verbally and physically aggressive towards a certified nursing assistant (CNA). During a review of Resident 27's Nursing Progress Note dated 12/17/2025, the note indicated on 12/17/2025, Resident 27 grabbed a CNA by the jacket while the CNA attempted to provide peri-care, was verbally aggressive, and kicked the CNA in the chest. The Nursing Progress Note indicated 911 was called for increased agitation. During a review of Resident 27's Nursing Progress Note dated 12/30/2025, the note indicated on 12/30/2025, Resident 27 struck a charge nurse on the stomach while passing by her. During a review of Resident 27's Nursing Progress Note dated 12/31/2025, the note indicated on 12/31/2025, Resident 27 reached forward and grazed another resident with his hand and the resident's chair. The note indicated the Department of Mental Health was notified, and two members of the Psychiatric Mobile Response Team (PMRT) came to evaluate resident for a possible 5150 (a 72- hour psychiatric hospitalization when an adult exhibits a mental health crisis and is evaluated to be a danger to others, or to himself or herself, or gravely disabled) hold. The Nursing Progress Note indicated the PMRT members agreed that Resident 27 was not fit to be in facility, but he was not transferrable at that time. During a review of Resident 27's Nursing Progress Note dated 1/1/2026, the note indicated on 1/1/2026, Resident 27 displayed three episodes of aggression. During a review of Resident 27's Nursing Progress Note dated 1/3/2026, the note indicated on 1/3/2026, Resident 27 displayed one episode of aggression. During a review of Resident 27's Nursing Progress Note dated 1/4/2026, the note indicated on 1/4/2026, Resident 27 displayed three episodes of aggression. During a review of Resident 27's Nursing Progress Note dated 1/5/2026, the note indicated on 1/5/2026, Resident 27 displayed one episode of (continued on next page)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aggression. During a review of Resident 27's Interdisciplinary Team (IDT) Notes, dated 10/2025 to 1/6/2026, there were no IDT Notes to indicate an IDT Care Conference was held following Resident 27's documented episodes of physical and verbal aggression. The most recent IDT Note, dated 12/23/2025, indicated Resident 27 was readmitted on [DATE] from the GACH due to striking out at staff. There was no documentation to indicate reassessment of Resident 27's behavioral management needs, consideration of increased interventions, initiation of PASRR Level II re-evaluation, or discussion of discharge to a more specialized setting despite continued aggressive behaviors. During a review of Resident 27's Preadmission Screening and Resident Review II (PASRR II-a federally mandated screen for individuals for Serious Mental Illness (SMI), Intellectual Disabilities (ID), or Developmental Disabilities (DD) to ensure they get the right care in the least restrictive setting, preventing inappropriate nursing home placement and identifying needs for specialized services) Care Plan, dated 10/10/2025, the care plan indicated Resident 27 was to receive psychiatry (a branch of medicine concerned with the study, diagnosis, and treatment of mental illness) and psychology (the study of the human mind and its functions, especially those affecting behavior) evaluations as indicated and supportive visits from social services and other providers as tolerated. During a review of Resident 27's PASRR Individualized Determination Report, dated 10/14/2025, the report indicated Resident 27 was recommended specialized add on services to address mental health needs. The recommendation included mental health rehabilitation activities, psychotherapy counseling, psychology consultation, and social services consultation. During a review of Resident 27's Order Summary, dated 1/7/2026, the Order Summary did not indicate an order for a psychologist consultation. During an interview on 1/5/2026 at 12:20 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 27 grabbed her buttocks and private area (date unknown), causing her to feel uncomfortable. CNA 2 stated Resident 27 laughed during the incident. CNA 2 stated she notified Licensed Vocational (LVN) 2 and the Director of Staffing Development (DSD) of the incident. During a concurrent interview and record review on 1/7/2026 at 12:10 p.m. with the Director of Nursing Trainer (DONT), all of Resident 27's Progress Notes, Physician Orders, IDT Notes, Physician Progress Notes, and Nursing Progress Notes, dated 7/2025 to 1/7/2026, were reviewed. The Physician Orders lacked a psychologist consultation order. The Physician Progress Notes lacked evidence a psychologist had visited Resident 27. The IDT notes indicated a lack of reconvening after each episode of physical and verbal aggression. The IDT Notes indicated the most recent Behavioral Management IDT was held in 7/2025, which occurred prior to the PASRR Individualized Determination Report (10/14/2025). The DONT stated Resident 27 would have benefited from a psychologist consult to engage in purposeful psychotherapy and learn behavioral management techniques. The DON stated the lack of IDT meetings, and lack of psychological health resources led to missed opportunities to address Resident 27's grave behavioral and mental health needs and placed Resident 27 at risk for continued episodes of aggression and deteriorating mental health. During a concurrent interview and record review on 1/7/2026 at 3:46 p.m. with the Social Services Director (SSD), Resident 27's Social Services Progress Notes, dated 10/2025 through 1/7/2026, and PASRR Individualized Determination Report, dated 10/14/2025, were reviewed. The Progress Notes lacked documentation to indicate Resident 27 received meaningful social services visits, mental health rehabilitation activities and psychotherapy counseling to support Resident 27's mental health. The SSD stated she visited Resident 27 but did not document her visits because she did not have the time. The SSD stated it was important to adhere the PASRR'S recommendations to ensure Resident 27 received mental supportive services to ensure his psychiatric needs were met and so that his mental health did not deteriorate. During a review of the facility's Facility Assessment (undated), the Facility Assessment indicated the facility had the capacity to provide mental health and behavior services that included the following: behavior management, psychotropic management, IDT meeting to identify if the use of psychotropic medications is warranted and medically justifiable, gradual dose reduction, behavior modification, psychiatrist and psychologist collaboration, medication review by the pharmacy consultant. Dementia (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care, psychiatric illness, intellectual or developmental disabilities. The Facility Assessment also indicated the IDT would develop and implement interventions in managing the resident's behavior and to help support individuals dealing with anxiety, cognitive impairment, depression and other psychiatric diagnoses. During a review of the facility's Policy and Procedure (P&P) titled, Behavioral Health Services, revised 2/2019, the P&P indicated the facility was to provide health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed staff practiced safe and effective medication administration practices for three out of 14 sampled residents (Residents 63, 138, and 137) by failing to: 1. Ensure Resident 63's vitamin D3 (a crucial fat-soluble vitamin that helps your body absorb calcium for strong bones, supports immune function, and aids muscle/nerve health) was available and administered timely, as ordered by the physician during a medication pass. 2. Clarify Resident 63's physician orders to specify the location of application of the prescribed lidocaine cream (a medication in the form of a cream applied topically to treat inflammation and pain) and lidocaine patch (a medication in the form of a patch used to treat inflammation and pain) to ensure there was no duplication of therapy, as well as documentation indicating removal of the old lidocaine patch prior to the application of a new one. 3. Ensure the registered nurses (RNs) administered meropenem (antibiotic) intravenously (IV, through a vein) to Resident 138 as ordered. 4. Clarify blood pressure parameters (a numerical or other measurable factor) for Resident 137's administration of Amlodipine (medication to treat high blood pressure and certain heart conditions). These deficient practices led to the administration of medications not in accordance with physician orders, professional standards of practice and/or manufacturer specifications resulting in interruptions in treatments, and placed Residents 63, 138, and 137 at risk for medication errors and adverse health outcomes such as vitamin D deficiency, local site reactions such as skin irritation and redness, abnormal blood glucose levels, hypotension (low blood pressure) and/or uncontrolled blood pressure. Findings: 1. During a review of Resident 63's admission Record, the admission record indicated Resident 63 was admitted to the facility on [DATE]. Resident 63's diagnoses included generalized muscle weakness and other abnormalities of gait (way of walking) and mobility. During a review of Resident 63's History and Physical (H&P), dated 11/4/2025, the H&P indicated Resident 63 had the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool), dated 11/3/2025, the MDS indicated Resident 63's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 63 was independent in performing activities of daily living (ADLs &ndash; routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene, and needed setup or clean-up assistance from the facility staff for showering. During a medication reconciliation on 1/6/2026, Resident 63's Order Summary Report (a document containing a summary of all active physician orders), dated 1/6/2026, the order summary report indicated: 1. Lidocaine external cream 5 percent ([%] a measurement of strength or potency of medication) (Lidocaine), apply to affected areas topically three times a day for affected skin areas apply 1 application topical, order date 7/20/2025, start date 7/21/2025. 2. Lidocaine external patch 5% (Lidocaine), apply to left shoulder topically one time a day for pain, order date 8/12/2025, start date 8/13/2025. 3. Lidocaine external patch 5% (Lidocaine), apply to low back topically one time a day for lower back pain, remove after 12 hours, order date 8/12/2025, start date 8/13/2025. During a concurrent observation and interview on 1/6/2026 at 8:23 a.m. with Licensed Vocational Nurse (LVN) (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5, observed LVN 5 prepare nine medications to be administered to Resident 63 that included: a. One patch of lidocaine 5% with instructions to be applied to left shoulder and low back topically once daily for pain (on for 12 hours, and off for 12 hours). During a concurrent observation and interview on 1/6/2026 at 8:52 a.m. in Resident 63's room, observed LVN 5 write the date of application on the lidocaine patch and applied to Resident 63's lower back. LVN 5 stated Resident 63 refused to receive lidocaine 5% patch on the left shoulder and only wanted it to apply to his lower back. During a review of Resident 63's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/6/2026, the MAR indicated that on 1/6/2026, LVN 5 held the scheduled dose of Vitamin D3 capsule 25 mcg at 9:00 a.m. The MAR indicated, LVN 5 documented a 3 for the lidocaine patch administration on the lower back and left shoulder and for lidocaine cream 5%, which would mean that Resident 63 refused to receive lidocaine cream and lidocaine patch on both the lower back and left shoulder. During a review of Resident 63's MAR, dated 1/1/2026 to 1/31/2026, 12/1/2025 to 12/31/2025 and 11/1/2025 to 11/30/2025, the MAR did not indicate any documentation for the removal of the lidocaine patch 5%, 12 hours after its application. During a concurrent interview and record review on 1/6/2026 at 1:08 p.m. with LVN 5, Resident 63's administration details on the resident's electronic medication administration record (eMAR) for lidocaine patch 5% and lidocaine cream 5% for 1/6/2026 at 9:00 a.m. was reviewed. The administration details indicated Resident 63's lidocaine 5% patch was documented as 3 (drug refused) on 1/6/2026 at 8:52 a.m. The administration details for Resident 63's lidocaine cream 5% was documented as 3 (drug refused) on 1/6/2026 at 8:40 a.m. LVN 5 stated the lidocaine patch that was applied to Resident 63's lower back should have been documented as administered but it was documented as refused which was incorrect. LVN 5 stated it was important to document correctly so that the next nurse would have accurate records of the medications that were administered. LVN 5 stated Resident 63 refused to receive lidocaine cream at the same time when he was offered the lidocaine patch. LVN 5 stated she would usually apply the lidocaine cream to Resident 63's shoulder or lower back because that was where he was applying the lidocaine patch, and the physician order for lidocaine cream indicated apply to affected areas. LVN 5 stated if the resident wanted the lidocaine cream and lidocaine patch then it would be okay to apply the cream and patch to the lower back. LVN 5 then posed a question, Oh the cream could be for lower back and then patch for the shoulder? LVN 5 looked at the administration record and stated lidocaine cream 5% and lidocaine patch 5% were both applied to the lower back at the same time on the same days. LVN 5 stated the patch and cream applied at the same location at the same time could cause skin irritation. LVN 5 stated there was no documentation of the lidocaine patch being removed after 12 hours as per the instructions on the lidocaine patch order. LVN 5 stated she visually checked if the lidocaine patch was removed from Resident 63's shoulder and lower back. During an interview on 1/7/2026 between 2:50 p.m. and 3:13 p.m. with Resident 63, Resident 63 stated he usually did not like to get the lidocaine cream applied but prefers the lidocaine patch. Resident 63 stated the patch would come off by itself because it did not stick on his back well, either because it would rub against his shirt or when raising his arms or if he was sleeping in his bed, it would just come off. Resident 63 stated he did not see anyone stopping by specially to remove the patch after 12 hours. Resident 63 stated he would just take it off by himself or the patch fell off. Resident 63 stated sometimes the patch was placed on his left leg. Resident 63 stated he did not usually apply lidocaine patch to his shoulder. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 63's order summary report that included active, discontinued and completed lidocaine orders, there were no physician orders for lidocaine patch 5% with instructions to apply patch on resident's left leg. During a review of Resident 63's MAR, Location of Administration Report, for 1/1/2026 to 1/31/2026, the report indicated the following dates and times when lidocaine patch 5% and lidocaine cream 5% were applied at the same location (lower back):a. Lidocaine External Patch, scheduled time was 1/2/2026 at 9:00 a.m., administered on 1/2/2026 at 11:34 a.m. b. Lidocaine External Cream, scheduled time was 1/2/2026 at 9:00 a.m., administered on 1/2/2026 at 11:29 a.m.c. Lidocaine External Patch, scheduled time was 1/4/2026 at 9:00 a.m., administered on 1/4/2026 at 12:58 p.m.d. Lidocaine External Patch, scheduled time was 1/4/2026 at 9:00 a.m., administered on 1/4/2026 at 12:58 p.m. e. Lidocaine External Cream, scheduled time was 1/4/2026 at 9:00 a.m., administered on 1/4/2026 at 12:57 p.m.f. Lidocaine External Cream, scheduled time was 1/4/2026 at 1:00 p.m., administered on 1/4/2026 at 12:58 p.m. During a review of Resident 63's Medication Admin Audit Report, dated 1/1/2026 to 1/8/2026, the report indicated on 1/6/2026 at 8:57 a.m., LVN 5 documented a lidocaine patch was applied for lower back pain. The report also indicated on 1/6/2026 at 1:13 p.m. (1313, military time) a lidocaine patch was applied for lower back pain. LVN 5 stated she accidentally documented the lidocaine patch was refused by Resident 63 at 8:57 a.m. which she corrected at 1:13 p.m. During a review of Resident 63's MAR, Location of Administration Report for 12/1/2025 to 12/31/2025, the report indicated the following dates and times when the lidocaine patch and lidocaine cream were both applied to the resident's lower back (same location) around the same time:a. Lidocaine External Patch, scheduled time was 12/27/2025 at 9:00 a.m., administered on 12/27/2025 at 10:14 a.m. b. Lidocaine External Cream, scheduled time was 12/27/2025 at 9:00 a.m., administered on 12/27/2025 at 10:13 a.m.c. Lidocaine External Patch, scheduled time was 12/28/2025 at 9:00 a.m., administered on 12/28/2025 at 8:09 a.m.d. Lidocaine External Patch, scheduled time was 12/28/2025 at 9:00 a.m., administered on 12/28/2025 at 8:10 a.m.e. Lidocaine External Cream, scheduled time was 12/28/2025 at 9:00 a.m., administered on 12/28/2025 at 8:09 a.m.f. Lidocaine External Patch, scheduled time was 12/29/2025 at 9:00 a.m., administered on 12/29/2025 at 10:44 a.m.g Lidocaine External Cream, scheduled time was 12/29/2025 at 9:00 a.m., administered on 12/29/2025 at 10:43 a.m. During a review of Resident 63's MAR, Location of Administration Report for 11/1/2025 to 11/30/2025, dated 1/6/2026, the report indicated the following dates and times when lidocaine patch 5% was applied to the knee & front (left) and abdomen & left lower quadrant (LLQ), which were not in accordance with physician orders:a. Lidocaine External Patch, scheduled time was 11/14/2025 at 9:00 a.m., administered on 11/14/2025 at 8:10 a.m. (Abdomen & LLQ).b. Lidocaine External Patch, scheduled time was 11/20/2025 at 9:00 a.m., administered on 11/20/2025 at 11:26 a.m. (Left front knee). During a review of Resident 63's MAR, Location of Administration Report for 11/1/2025 to 11/30/2025, the report indicated the following dates and times when lidocaine patch 5% and lidocaine cream 5% were both applied on resident's lower back (same location) around the same time:a. Lidocaine External Patch 5%, scheduled time was 11/16/2025 at 9:00 a.m., administered on 11/16/2025 at 8:06 a.m.b. Lidocaine External Cream 5%, scheduled time was 11/16/2025 at 9:00 a.m., administered on 11/16/2025 at 8:05 a.m.c. Lidocaine External Patch 5%, scheduled time was 11/21/2025 at 9:00 a.m., administered on 11/16/2025 at 8:10 a.m.d. Lidocaine External Cream 5%, (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled time was 11/21/2025 at 9:00 a.m., administered on 11/21/2025 at 8:10 a.m.e. Lidocaine External Patch 5%, scheduled time was 11/22/2025 at 9:00 a.m., administered on 11/22/2025 at 10:26 a.m.f. Lidocaine External Cream 5%, scheduled time was 11/22/2025 at 9:00 a.m., administered on 11/22/2025 at 10:27 a.m.g Lidocaine External Patch 5%, scheduled time was 11/23/2025 at 9:00 a.m., administered on 11/23/2025 at 11:01 a.m.h. Lidocaine External Cream 5%, scheduled time was 11/23/2025 at 9:00 a.m., administered on 11/23/2025 at 11:02 a.m. During an interview on 1/7/2026 at 4:24 p.m. with the Director of Nursing Trainer (DONT) and Interim Director of Nursing (IDON), the IDON stated the lidocaine patch should be applied for 8 to 12 hours based on his experience or based on physician orders. The IDON stated if the physician instructed to remove the lidocaine patch after 8 hours instead of 12 hours, then the patch must be removed after 12 hours. The DONT stated there should have been a separate order for lidocaine patch 5% to indicate remove after 12 hours so that it could have been documented as removed after 12 hours. The DONT stated there was a possibility that the patch could fall off sooner than 12 hours during showers or other activities. The DON'T stated if the resident kept the patch on for longer than 12 hours then there was a risk of side effects such as rash, blisters and irritation, and rare instances of systemic reactions such as nausea. The IDON and DONT stated the lidocaine patch should be labeled with the date and time so that the licensed nurse would know when to remove it. The IDON and DONT stated if the resident received the lidocaine cream and lidocaine patch at the same time on the same location, there was a risk of overmedicating the resident and possibility that the patch would not stick on the resident's site of application. The IDON stated the orders should have been clarified with the physician before they were administered. The DONT stated there should have been two separate physician orders for the lidocaine patch for the shoulder and lidocaine patch for the back. 2. During a medication reconciliation on 1/6/2026, Resident 63's Order Summary Report (a document containing a summary of all active physician orders), dated 1/6/2026, the order summary report indicated Vitamin D3 oral capsule 25 micrograms ([mcg] a unit of measurement for mass) (1000 IU) (Cholecalciferol &ndash; the chemical name of vitamin D3), give 1 capsule by mouth one time a day for supplement, order date 7/20/2025, start date 7/21/2025. During an interview on 1/6/2026 at 8:23 a.m. with LVN 5, LVN 5 stated she did not have Resident 63's vitamin D3 in stock and could not administer. During an interview on 1/6/2026 at 1:08 p.m. with LVN 5, LVN 5 stated Resident 63's vitamin D3 was ordered through central supply. LVN 5 stated vitamin D helps with strong bones, and resident may get deficient in vitamin D if he did not receive it. During an interview on 1/7/2026 at 4:24 p.m. with the DONT and Interim Director of Nursing (IDON), the DONT stated staff should have checked the medication cart at the beginning of the shift to ensure medications were in stock. IDON stated an adverse effect of Resident 63 not getting Vitamin D could cause a vitamin level deficiency, sleepiness and bone deficiency. 3. During a review of Resident 138's admission Record, the admission Record indicated Resident 138 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 138's H&P, dated 9/20/2025, the H&P indicated Resident 138 was alert and oriented times two (x2, medical assessment that indicates a person knows who they are and (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	where they are, but not what time it is or what is happening to them). During a review of Resident 138's MDS, dated [DATE], the MDS indicated Resident 138's cognitive skills for daily decision making was intact. The MDS indicated Resident 138 required supervision for eating. The MDS indicated Resident 138 required supervision for eating. The MDS indicated Resident 138 required moderate assistance for oral hygiene and personal hygiene. The MDS indicated Resident 138 required maximal assistance for upper body dressing. The MDS indicated Resident 138 was dependent on staff for lower body dressing, putting on and taking off footwear, toileting hygiene, and showering and bathing. During a review of Resident 138's Order Summary Report, dated 1/3/2025, the Order Summary Report indicated to administer meropenem IV solution 1 gram (gm, unit of measurement) every 12 hours for sepsis (a life-threatening blood infection) for seven days. During a review of Resident 138's IV MAR, dated 1/1/2026 &ndash; 1/31/2026, the IV MAR did not indicate Resident 138 received meropenem on 1/3/2026 at 9:00 a.m., on 1/5/2026 at 9:00 p.m., and on 1/6/2026 at 9:00a.m. and 9:00 p.m. During an interview on 1/8/2026 at 10:35 a.m. with the Infection Prevention Nurse (IPN), the IPN stated she was not aware of Resident 138's missed doses of meropenem. The IPN stated it was important to administer the medication as ordered to help Resident 138 receive the treatment he needed. During a concurrent interview and record review on 1/8/2026 at 10:49 a.m. with the IPN, Resident 138's MAR, dated 1/1/2026 &ndash; 1/31/2026, was reviewed. The MAR did not indicate Resident 138 received meropenem on 1/3/2026 at 9:00 a.m., on 1/5/2026 at 9:00 p.m., and on 1/6/2026 at 9:00 a.m. and 9:00 p.m. The IPN stated she was not notified Resident 138 missed multiple doses which caused an interruption to the resident's antibiotic therapy. The IPN stated nursing staff needed to notify the doctor and inquire if the medication would be extended due to the missing doses. During an interview on 1/8/2026 at 3:56 p.m. with RN 2, RN 2 stated Resident 138 did not receive his antibiotics on several days. RN 2 stated Resident 138's doctor was not notified. RN 2 stated Resident 138's antibiotic therapy course was not extended because Resident 138's doctor was not notified. 4. During a review of Resident 137's admission Record, the admission Record indicated the facility admitted Resident 137 on 11/11/2022 with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing, hyperlipidemia (high cholesterol) and polyneuropathy (damage or disease affecting nerves). During a review of Resident 137's H&P, dated 10/4/2025, the H&P indicated Resident 137 has the capacity to understand and make decisions. During a review of Resident 137's MDS, dated [DATE], the MDS indicated Resident 137 was independent with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 137's physician order dated 3/3/2025, the physician order indicated to administer amlodipine besylate oral tablet 10 mg by mouth one time a day for HTN. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 137's MAR for the months of 12/2025 and 1/2026, the MAR indicated amlodipine was administered to Resident 137 without blood pressure parameters. During a concurrent interview and record review on 1/6/26 at 3:05 p.m., with LVN 4, Resident 137's physician orders dated 3/3/2025 and MAR for the months of 12/2025 and 1/2026, were reviewed. LVN 4 stated the physician order for amlodipine lacked documented parameters identifying when the medication should be administered or withheld based on the resident's blood pressure reading. LVN 4 stated the absence of parameters limited nursing staff's ability to determine when the medication should be administered or held. LVN 4 stated antihypertensive medications (used to lower blood pressure) require clearly defined blood pressure parameters to ensure safe administration and to prevent potential adverse effects related to hypotension (low blood pressure). During an interview on 1/7/2026 at 09:18 a.m., with RN 3, RN 3 stated blood pressure medications required parameters to avoid causing significant drops in blood pressure. RN 3 stated that a severe decrease in blood pressure could increase a resident's chances of developing hypovolemic shock (a life-threatening emergency from severe blood or fluid loss). During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated 12/2012, the P&P indicated all medications would be administered in a safe, timely manner and as prescribed. The P&P indicated if a dosage was believed to be inappropriate for a resident, the person administering medication should contact doctor to discuss concerns. During a review of the facility's P&P titled, Medication Orders, dated 11/2014, the P&P indicated, 1. Medication Orders &ndash; when recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered. During a review of the facility's P&P titled, Administration Medications dated 4/2019, the P&P indicated If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. The P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The P&P indicated as required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered.c. the route of administration.g. the signature and title of the person. the drug.		

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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, and record review the facility failed to follow recipes when:a. The cook (Cook 1) altered the ingredients in beef patties by adding unindicated ingredients.b. Ingredients for preparing texture-modified versions of the beef patty recipe were omitted.c. [NAME] 2 used a garnish for three of 26 soft-and-bite-sized texture diets when not indicated. These deficient practices had the potential to alter nutrition, provide the inappropriate therapeutic texture, and introduce allergens to resident meal trays.Findings:a. During a concurrent interview and initial kitchen tour on 1/5/2026 at 9:10 a.m., with Dietary Services Supervisor (DSS) and [NAME] 1, [NAME] 1 was observed preparing patties of ground beef from a large tub with large chunks of green bell peppers visible in the mixture and patties. The Dietary Services Supervisor (DSS), the DSS stated he did not know why green bell peppers were included in the patties. The DSS stated there may be a risk for an allergic reaction or offering a resident a food item that may be listed as a dislike. [NAME] 1 stated she was aware bell peppers were not included in the recipe. [NAME] 1 stated, I just wanted to add more flavor. [NAME] 1 stated this action could result in offering residents disliked food preferences or potentially causing an allergic reaction.During a record review of the recipe titled Southern Style Pattie, the recipe did not indicate green bell peppers in the ingredient list. b. During a concurrent observation of lunch service in the kitchen and interview with [NAME] 1 on 1/5/2026 at 11:45 a.m., observed texture-modified versions (changes in the physical form of original food intended as therapy for people with chewing difficulty or swallowing disorders) of beef patty were of a different texture than the ground beef. [NAME] 1 stated that it was the same recipe with a different beef that was already chopped.During a record review of the recipe titled Southern Style Pattie, the recipe indicated to follow all steps in the original recipe for regular texture, which included ground beef mixed with egg, milk, breadcrumbs, and spices, formed into patties, then to chop into 1.5 x 1.5 centimeter (cm, unit of measurement) pieces. During an interview on 1/6/2026 at 3:05 p.m., with the DSS, the DSS stated that they did not follow the recipe correctly by substituting ground beef for cubed beef stew meat and the omission of eggs, milk, and breadcrumbs. The DSS stated, The taste and texture will be different. Calories are going to be different. The DSS stated the correct steps would be to make it with ground beef, then chop. c. During an observation of lunch service on 1/6/2026 at 12:05 p.m., [NAME] 2 was observed assembling three plates of Soft-and-Bite-Sized textures. [NAME] 2 included a parsley sprig as garnish. During a review of a document titled Cooks Spreadsheet, the document indicated there was to be no garnish included for any texture modified diets. During an interview on 1/6/2026 at 3:05 p.m., with the DSS, the DSS stated the spreadsheet the [NAME] was intended to follow indicated no garnish. During a review of an in-service dated 9/5/2025, the in-service indicated the topic of the in-service included the need for cooks to follow recipes and spreadsheets. The in-service was signed by both [NAME] 1 and [NAME] 2 indicating they attended the in-service.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to provide appropriate texture-modified diets when:a. The cook (Cook 2) used a garnish for three of 26 soft-and-bite-sized textures when not indicated. b. [NAME] 2 used a food-processor to mince pork instead of chopping to indicated size for 26 of 114 diets. These deficient practices had the potential to cause residents with swallowing disorders to choke, and prevent the progression of residents' meals by voluntarily downgrading textures.Findings:a. During an observation of lunch service in the kitchen on 1/6/2026 at 12:05 p.m., [NAME] 2 was observed assembling three plates of Soft-and-Bite-Sized textures. [NAME] 2 included a parsley sprig as garnish. During a review of a document titled Cooks Spreadsheet, the document indicated no garnish was to be included for any texture modified diets. During an interview on 1/6/2026 at 3:05 p.m., with the Dietary Services Supervisor (DSS), the DSS stated adding a parsley sprig as garnish posed a risk for choking. The DSS stated the spreadsheet the [NAME] was intended to follow indicated no garnish. b. During a concurrent observation and interview on 1/6/2026 at 9:45 a.m., with [NAME] 2, in the kitchen, observed [NAME] 2 slice cooked pork in preparation for lunch. [NAME] 2 then placed the sliced pork into a food processor where she pulsed the machine to produce a minced texture. [NAME] 2 stated this was in preparation for Soft-and-Bite-Sized texture. During a review of the recipe, the recipe indicated to follow all the steps of the original recipe for regular texture and then to chop into 1.5 x 1.5 centimeters (cm, unit of measurement) pieces. During an interview on 1/6/2026 at 3:05 p.m., with the DSS, the DSS stated the texture provided appeared more like Minced-and-Moist texture rather than Soft-and-Bite-Sized. During a review of an in-service dated 9/5/2025, the in-service indicated topics covered with kitchen staff included the need for cooks to follow recipes and spreadsheets. The in-service was signed by [NAME] 2 indicating [NAME] 2 attended the in-service training.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation practices when:a. The stand mixer observed with heavy debris was not cleaned and sanitized.b. The countertop was covered with crumbs. c. The steam table had eggs remnants.These deficient practices had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 114 of 117 medically compromised residents who received food from the kitchen.Findings:a. During a concurrent brief initial kitchen tour and interview on 1/5/2026 at 8:50 a.m., with [NAME] 1, a stand-mixer was observed with dried, light-yellow colored debris on the safety guard (a curved metal grill designed to prevent access to the mixer while operating). The stand-mixer had similar light-yellow debris and dried white, powdery substances observed underneath the splash guard (a curved, solid piece of sheet metal designed to prevent splashing of food out of the mixing bowl during operation) which faced downward toward the mixing bowl where food was being prepared. [NAME] 1 stated, We rarely use that. Sometimes when we're making pudding. During a concurrent observation and interview on 1/5/2026 at 11:10 a.m., with the Dietary Services Supervisor (DSS), in the kitchen, the stand-mixer was observed with dried, light-yellow colored debris on the safety guard and light-yellow debris and dried white, powdery substances observed underneath the splash guard. The DSS stated, We hardly use that. The cooks usually whisk by hand. The DSS stated the stand-mixer was to be deep cleaned along with other kitchen equipment on delivery days, when additional staff was available to stock inventory and perform deep cleaning duties. During a review of the deep cleaning log dated 1/2026, in the presence of the DSS, the deep cleaning log did not identify the stand-mixer as an item to be deep cleaned. The DSS confirmed It is not there. During a concurrent interview and record review on 1/6/2026 at 3:05 p.m. with the DSS, the in-service document dated 9/5/2025, was reviewed. The document indicated topics covered during the in-service training with kitchen staff included, Make sure we are wiping down Robocoupe (food processor), blenders, microwaves daily. The DSS stated that debris observed from the stand-mixer could fall into the mixing bowl where it could potentially contaminate food served to the residents of the facility. The DSS stated this in-service included directives to clean the stand-mixer, indicated as blenders. During a review of a policy document titled Sanitation, dated 2023, the document indicated that the Food & Nutrition Director (DSS) is responsible for instructing staff in the use of equipment, including how to clean all equipment in their specific area. b. During a brief initial kitchen tour on 1/5/2026 at 8:58 a.m., the countertop near the steam table where meal trays were assembled was observed covered in crumbs spanning an area approximately 8 by (x) 12 inches. A review of the cleaning log titled AM Trayline indicated Trayline Area (after each meal) was signed off by a kitchen staff member. During a secondary kitchen tour on 1/5/2026 at 11:30 a.m., the countertop near the steam table where meal trays were assembled was observed covered in crumbs. Food was held on the steam tables in preparation for lunch service. During an interview on 1/6/2026 at 3:05 p.m. with the DSS, the DSS stated the debris observed on the countertop was a risk for contamination. During review of a policy document titled Sanitation, dated 2023, the document indicated that kitchen staff was responsible for all cleaning except for ceiling vents, light fixtures, and the hood over the stove. During a review of an in-service dated 9/5/2025, the in-service indicated topics covered with kitchen staff including Sanitizing surfaces after being wiped down when cleaning. c. During a brief initial kitchen tour on 1/5/2026 at 8:59 a.m., the steam table where meal trays were assembled was observed with chunks of yellow debris. During a review of the cleaning log titled AM Trayline, the cleaning log indicated Trayline Area (after each meal) was signed off by a kitchen staff member. During a secondary kitchen tour on 1/5/2026 at 11:30 a.m., the chunks of yellow debris was visible as food was held on the steam tables in preparation for lunch (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	service. During an interview on 1/6/2026 at 3:05 p.m. with the DSS, the DSS stated that debris observed on the steam tables at lunchtime were eggs from breakfast service. The DSS stated this was a risk for contamination. During a review of a policy document titled Sanitation dated 2023, the document indicated kitchen staff is responsible for all cleaning except for ceiling vents, light fixtures, and the hood over the stove.		

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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 observation, interview, and record review, the facility failed to maintain complete and accurate medical records for five of 16 sampled residents (Resident 63, 12, 138, 37, and 110) by: 1. Not ensuring licensed nursing staff maintained an accurate recording of the lidocaine patch (a medication in the form of a patch used to treat inflammation and pain) in Resident 63's medication administration record (MAR). 2. Not ensuring Resident 12's nursing progress notes, change of condition (COC) and transfer/discharge notes were completed and signed as required following the resident's transfer to the general acute care hospital (GACH) on 1/2/2026. 3. Not documenting Resident 138's missed doses of meropenem and the resident's dislodgement of his intravenous (IV) administering fluids, medicine, blood, or nutrients directly into the bloodstream via a needle or catheter) line. 4. Not providing accurate documentation for Resident 37 and 110's Restorative Nursing Aide (RNA) nursing aide program that helps residents to maintain their function and joint mobility) services on 1/6/2026. These deficient practices resulted in an incomplete resident medical care record and placed Residents 63, 12, 138, 37, and 110 at risk for misunderstanding in the provision of care and services, missed medications and/or treatments and potential medical complications due to medication errors and/or interruption of treatment, leading to an overall diminished quality of life. Findings: 1. During a review of Resident 63's admission Record, dated 1/6/2026, the admission record indicated the facility admitted Resident 63 on 11/3/2022 with diagnoses that included generalized muscle weakness and other abnormalities of gait (way of walking) and mobility. During a review of Resident 63's History and Physical (H&P), dated 11/4/2025, the H&P indicated Resident 63 had the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool), dated 11/3/2025, the MDS indicated Resident 63's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 63 was independent in performing activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene, and needed setup or clean-up assistance from the facility staff for showering. During a concurrent observation and interview on 1/6/2026 at 8:23 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 prepared nine medications to be administered to Resident 63 that included but not limited to one patch of lidocaine (a medication in patch form used to treat pain) 5 percent ([%] a measurement of strength or potency of medication) (removed from package) with instructions to be applied to left shoulder and low back topically once daily for pain (on for 12 hours, and off for 12 hours). During an interview on 1/6/2026 at 8:52 a.m. in Resident 63's room, LVN 5 stated Resident 63 refused the lidocaine 5% patch to the left shoulder. LVN 5 stated Resident 63 only wanted the patch applied to his lower back. LVN 5 wrote the date of application on the lidocaine patch and applied the patch to Resident 63's lower back. During a medication reconciliation review on 1/6/2026, Resident 63's Order Summary Report (a document containing a summary of all active physician orders), dated 1/6/2026 was reviewed. The order summary report indicated but not limited to the following physician orders:Lidocaine external patch 5% (Lidocaine), apply to left shoulder topically one time a day for pain, order date 8/12/2025, start date 8/13/2025.Lidocaine external patch 5% (Lidocaine), apply to low back topically one time a day for lower back pain, remove after 12 hours, order date 8/12/2025, start date 8/13/2025. During a concurrent interview and record review on 1/6/2026 at 1:08 p.m. with LVN 5, Resident 63's administration details on the electronic medication administration record (eMAR) for lidocaine patch 5% for 1/6/2026 at 9:00 a.m. was reviewed. The administration details for Resident 63's lidocaine 5% patch was documented as 3 (drug refused) on 1/6/2026 at 8:52 a.m. The administration details for (continued on next page)		

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Printed: 07/18/2026
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No. 0938-0391

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/2026 at 11:30 a.m. with RNA 3, RNA 3 stated RNA 4 helped RNA 3 with the documentation for Resident 37's RNA session on 1/6/2026. During an interview on 1/8/2026 at 4:06 p.m. with the Director of Staff Development (DSD), the DSD stated the RNA providing the treatment should document in the resident's clinical record. The DSD stated the resident's clinical record was not accurate if another RNA signed for the resident's RNA session. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised on 7/2017, the P&P indicated documentation of procedures and treatment will include care-specific details, including the name and title of the individual(s) who provided the care. 5. During a review of Resident 110's admission Record, the admission Record indicated the facility admitted Resident 110 on 7/13/2020 with diagnoses including hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side, paralytic syndrome following unspecified cerebrovascular (blood vessels in the brain) disease affecting unspecified side, personal history of traumatic brain injury (TBI) a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), and contracture of unspecified hand. During a review of Resident 110's MDS, dated [DATE], the MDS indicated Resident 110 had unclear speech, had difficulty communicating some words or finishing thoughts, understood verbal content, and had intact cognition. The MDS indicated Resident 110 had ROM impairments in both arms and legs. The MDS indicated Resident 110 was independent for eating, rolling to either side while lying in bed, transferring from lying in bed to sitting at the edge of the bed, and chair/bed-to-chair transfers and partial/moderate assistance for upper body and lower body dressing. During a review of Resident 110's physician orders, dated 11/20/2019, the physician orders indicated for RNA to apply the right-hand splint for four to six hours, five times per week as tolerated. Another physician order, dated 9/14/2020, indicated RNA for PROM to the right arm, three times per week as tolerated. During an observation on 1/6/2026 at 10:17 a.m. with Restorative Nursing Aide 2 (RNA 2), Resident 110's RNA session was observed. RNA 2 performed ROM exercises to Resident 110's right shoulder, elbow, wrist, and fingers. RNA 2 retrieved a black, cylindrical hard foam from the back of Resident 110's wheelchair. RNA 2 placed the cylindrical foam in Resident 110's right palm and secured it with a stretchable cloth. During a review of Resident 110's RNA Flow Sheet for 1/2026, the RNA Flow Sheet indicated RNA 4 signed for the provision of Resident 110's RNA services on 1/6/2026 including the PROM to the right arm and application of the right-hand splint. During an interview on 1/7/2026 at 11:55 a.m. with RNA 4, RNA 4 stated the RNA providing the RNA treatment to a resident (in general) was supposed to document in the resident's clinical record. RNA 4 stated she signed Resident 110's RNA documentation for 1/6/2026 because RNA 2 had difficulty accessing Resident 110's RNA documentation. During an interview on 1/8/2026 at 10:27 a.m. with RNA 2, RNA 2 stated RNA 4 documented for Resident 110's session on 1/6/2026 because RNA 4 was Resident 110's usual RNA. During an interview on 1/8/2026 at 4:06 p.m. with the Director of Staff Development (DSD), the DSD (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the RNA providing the treatment should document in the resident's clinical record. The DSD stated the resident's clinical record was not accurate if another RNA signed for the resident's RNA session. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised on 7/2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition, shall be documented in the resident's [NAME] record. The P&P indicated documentation in the resident's medical record was required to be complete and accurate and include the signature and title of the individual documenting. The P&P indicated the following should be documented in the resident medical record: 1. Objective observations, medications administered, treatments or services performed, changes in the resident's condition, events, incidents or accidents involving resident, and progress toward or changes in the care plan goals and objectives. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P indicated, The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. The P&P indicated as required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered.c. the route of administration.g. the signature and title of the person.the drug. During a review of the P&P titled Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated the nurse was responsible for recording information related to changes in the resident's medical condition or status in the resident's medical record. The P&P indicated a hospital transfer constituted a change of condition requiring documentation and that required notifications and documentation were to occur within twenty-four (24) hours of the change. During a review of the facility's P&P titled, Documentation of Medication Administration, dated 11/2022, the P&P indicated, 2. Administration of medication is documented immediately after it is given. 3. Documentation of medication administration includes, as a minimum: a. the resident's name; b. name and strength of the drug; c. dosage; d. route of administration; e. date and time of administration.i. the condition.(. intravenously).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform hand hygiene (act of cleaning hands with soap and water or an alcohol-based sanitizer to remove or destroy germs, preventing the spread of infections) before and after direct contact with three of 28 sampled residents (Resident 37, 114, 48). This deficient practice had the potential to continue the spread of infection, including influenza (flu) a contagious respiratory infection caused by viruses). Findings: During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE]. Resident 37's diagnoses included paralytic syndrome (broad term for conditions causing rapid muscle weakness) following cerebral infarction (brain damage due to a loss of oxygen to the area), paraplegia (loss of movement and/or sensation, to some degree, of the legs), muscle weakness, and contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) to both hands and the right thigh. During a review of Resident 37's physician orders, dated 11/11/2025, the physician orders indicated for the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to apply both hand splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) for two hours, three times per week or as tolerated. Apply both leg splints for two hours, three times per week or as tolerated. Provide passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) to both arms in all planes (planes of joint motion, including forward and backward, side to side, and rotation), three times per week or as tolerated. During a review of Resident 114's admission Record, the admission Record indicated the facility admitted Resident 114 on 1/25/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction affecting the right dominant side, dysphagia, and contractures of the unspecified shoulder, elbow, wrist, hand, knee, ankle, and foot. During a review of Resident 114's physician orders, dated 10/21/2025, the physician order indicated for RNA to provide PROM to both legs in all planes, three times per week as tolerated. During a review of Resident 48's admission Record, the admission Record indicated the facility admitted Resident 48 on 1/2/2026 with diagnoses including anxiety disorder (mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities) and extrapyramidal and movement disorder (drug-induced or disease-related movement disorders causing tremors, stiffness, restlessness). During an interview on 1/5/2026 at 1:20 p.m. with the Infection Prevention Nurse (IPN), the IPN stated the facility had a flu outbreak and the facility staff was required to wear N-95 respirators (a disposable face mask that covers the user's nose and mouth which offers protection from small solid or liquid droplets found in the air). During an observation on 1/6/2026 at 2:01 p.m. in Resident 37's room, with Restorative Nursing Aide 3 (RNA 3), Resident 37's RNA session was observed. Resident 37 performed exercises on both shoulders, elbows, wrists, and hands. RNA 3 wore disposable gloves and provided ROM exercises to both of Resident 37's hips, knees, ankles, and toes. RNA 3 applied Resident 37's hand splints. During an observation on 1/6/2026 at 2:15 p.m., RNA 3 threw away both disposable gloves but did not perform hand hygiene. During a concurrent observation and interview on 1/6/2026 at 2:18 p.m. in the resident's room with RNA 3, Resident 114's RNA session was observed. RNA 3 wore disposable gloves and provided ROM exercises on both of Resident 114's hips, the left knee, and both ankles. The Certified Nursing Assistant (CNA, unknown) came into the room during Resident 114's RNA session and placed a package of honey graham crackers on Resident 114's bedside table. RNA 3 threw away the disposable gloves and readjusted Resident 114 position in bed at the end of the RNA session. RNA 3 did not perform hand hygiene. RNA 3 walked to the nursing station to retrieve a paper towel for Resident 114 and returned to Resident 114's room to open the package of crackers. RNA 3 did not perform hand hygiene. RNA 3 walked to Resident 48's room, switched on the bedroom lights, briefly (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spoke with Resident 48, and readjusted Resident 48's pillow. RNA 3 did not perform hand hygiene. RNA 3 walked to the nursing station and sat down. During an interview on 1/6/2026 at 2:29 p.m. with RNA 3, RNA 3 stated she forgot to wash or sanitize hands in-between contact with Resident 37, 114, and 48. RNA 3 stated the germs, including the flu virus, could transmit between the residents without performing hand hygiene. During an interview on 1/8/2026 at 4:01 p.m. with the IPN, the IPN stated The IPN stated the facility's flu outbreak was identified on 1/3/2026 and had 10 residents who tested positive for the flu. The IPN stated the staff should perform hand hygiene before and after direct care with residents to prevent the spread of infection. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, revised 10/2023, the P&P indicated hand hygiene was the primary means to prevent the spread of healthcare-associated infections. The P&P indicated hand hygiene was indicated immediately before touching a resident, after touching a resident, after touching the resident's environment, and immediately after glove removal.		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Avalon Villa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12029 Avalon Blvd Los Angeles, CA 90061	
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity, privacy, and respect were maintained for one of eight sampled residents (Resident 3), when the indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag was not covered with a dignity bag (a privacy cover placed over a urinary catheter drainage bag to help maintain a resident's dignity and privacy by preventing exposure of the bag and its contents). This deficient practice had the potential to compromise Resident 3's dignity, privacy, and respect due to the indwelling urinary catheter drainage bag being left uncovered. Findings: During a review of Resident 3's admission Record, dated 1/9/2025, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included acute kidney failure (a sudden loss of kidney [organs that filter waste from the blood] function), urinary tract infection (UTI- an infection in the bladder/urinary tract), neuromuscular dysfunction of the bladder (a problem where the bladder [the organ that stores urine] does not function normally, causing difficulty with bladder emptying or control), myocardial infarction (MI- heart attack) and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's History and Physical (H&P), dated 12/5/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 3's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 3 required maximal assistance (helper does more than half the effort) for eating and was dependent (helper does all of the effort) for toileting, bathing, and personal hygiene. The MDS also indicated Resident 3 had an indwelling catheter. During a concurrent observation and interview on 1/8/2026 at 8:57 a.m., with Licensed Vocational Nurse (LVN) 3, in Resident 3's room, observed Resident 3's indwelling urinary catheter. The indwelling catheter was uncovered. LVN 3 stated Resident 3's urinary catheter drainage bag did not have a dignity cover. LVN 3 stated Resident 3 should have a dignity bag because other residents, visitors, and staff could see the catheter. LVN 3 stated not covering the indwelling catheter drainage bag was a dignity issue. LVN 3 stated the lack of privacy could make Resident 3 feel different, out of place, or embarrassed. During a review of the facility's policy and procedures (P&P), titled Quality of Life - Dignity, revised August 2009, the P&P indicated residents were to be treated with dignity and respect at all times. The P&P indicated staff were to promote and protect resident dignity, including helping residents keep urinary catheter drainage bags covered.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity, privacy, and treatment were provided in a respectful manner for one of eight sampled residents (Resident 105) during a toileting request. This deficient practice resulted in Resident 105 becoming visibly frustrated and had the potential to cause psychosocial harm, including emotional distress and loss of dignity. Findings: During a review of Resident 105's admission Record, dated 1/9/2025, the admission record indicated Resident 105 was admitted to the facility on [DATE]. Resident 105's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke, blocked blood flow to a part of the brain) affecting the left dominant side, history of falling, syncope and collapse (episodes of fainting), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 105's History and Physical (H&P), dated 10/25/2025, the H&P indicated Resident 105 had the capacity to understand and make decisions. During a review of Resident 105's Minimum Data Set (MDS - a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 105's cognitive skills (ability to think, remember, and reason) were severely impaired. The MDS indicated Resident 105 required maximal assistance (helper does more than half the effort) for toilet hygiene and toilet transfer (the ability to get on and off a toilet or commode). The MDS indicated Resident 105 required moderate assistance (helper does less than half the effort) for oral and personal hygiene. During a review of Resident 105's care plan titled, Activities of Daily Living (ADL - routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) initiated on 10/24/2025, the care plan indicated Resident 105 required extensive assistance by one staff member for toileting. During a review of Resident 105's care plan titled Fall risk initiated on 10/24/2025, the care plan indicated staff were to encourage the resident to maintain functional independence through safety-awareness. The care plan also indicated staff were to anticipate Resident 105's needs and complete a fall risk assessment. During an observation on 1/6/2026 at 1:04 p.m., of lunch service, staff were observed in the hallway pulling meal trays from the meal carts and delivering them to resident rooms. Resident 105, who was Spanish speaking, was observed independently propelling his wheelchair from his room into the hallway. Resident 105 was observed repeatedly calling out bano to Licensed Vocational Nurse (LVN) 5 who was standing nearby at a medication cart. A Spanish-speaking visitor (Visitor 1) was observed translating for Resident 105. Visitor 1 informed the nurse Resident 105 was requesting to use the restroom but there was no toilet paper in the bathroom. In the presence of Resident 105, LVN 5 was observed shaking her head and rolling her eyes. LVN 5 then stated, He wears briefs, he can't use the restroom. LVN 5 then proceeded to a nearby closet and retrieved a box of facial tissue. LVN 5 attempted to give the facial tissues to Resident 105, however, the resident declined and shook his head No. LVN 5 then flagged Certified Nursing Assistant (CNA) 4 from the hallway and asked the CNA to get toilet paper for Resident 105. LVN 5 then returned to the medication cart. Resident 105 returned to his room to wait for the toilet paper. CNA 4 was then observed passing meal trays in the hallway without returning to the assist Resident 105 with toileting. Resident 105 became frustrated, spoke an unknown word in Spanish, took his hat off and threw it to the floor. LVN 5 called out from the medication cart that the toilet paper was in the bathroom but never left her cart to assist Resident 105. Resident 105 independently maneuvered his wheelchair toward the bathroom and used his cane to open the door. Resident 105 entered the shared bathroom by backing into the space in his wheelchair without assistance. The adjoining bathroom door on the opposite side remained open. Residents from the adjoining room were able to look directly into the restroom. Due to space limitations, Resident 105 was unable to turn himself around or close the adjoining door while in the wheelchair. No staff member entered the (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathroom to assist Resident 105 with toileting or ensure his privacy. While Resident 105 attempted to use the bathroom, the resident's roommate stated he frequently assisted Resident 105 into the restroom because the staff were busy. Resident 105's roommate stated the resident would occasionally get locked inside the bathroom and would have to assist him with opening the bathroom door. Resident 105 exited the bathroom without assistance. LVN 11 approached and asked if assistance was needed, however, Resident 105 had already completed toileting without assistance. During an interview on 1/6/2026 at 1:11 p.m., with LVN 11, LVN 11 stated when a resident needed to use the restroom, staff should assist the resident promptly. LVN 11 stated CNA 4 should not have continued passing meal trays but should have assisted Resident 105 with toileting. LVN 11 stated either LVN 5 or CNA 4 should have assisted Resident 105 immediately. LVN 11 stated Resident 105's dignity was not respected when the resident was not assisted in a timely manner. LVN 11 stated staff were present to assist residents, and the residents must come first. During an interview on 1/6/2026 at 1:24 p.m., with CNA 4, CNA 4 stated LVN 5 asked her to obtain toilet paper for Resident 105. CNA 4 stated she obtained the toilet paper and gave it to LVN 5. CNA 4 stated she then resumed passing meal trays. CNA 4 stated she did not assist Resident 105 because she thought LVN 5 was assisting the resident. During an interview on 1/6/2026 at 2:54 p.m., with LVN 5, LVN 5 stated she had done all she could for Resident 105 when the resident requested assistance with toileting. LVN 5 stated she was not Resident 105's assigned nurse. LVN 5 stated she told CNA 4 to obtain toilet paper and stated she placed the toilet paper on the roll in the restroom through the adjoining bathroom. LVN 5 stated she thought CNA 4 was assisting the resident. LVN 5 stated she initially thought Resident 105 used briefs, but stated CNA 4 indicated the resident could use the restroom independently, which was why she did not provide further assistance. LVN 5 stated she felt she had done all she could do for Resident 105 and stated, If it were me, I would have just used the tissue I provided, but he refused. LVN 5 stated she believed the issue was the lack of toilet paper but later realized Resident 105 required additional toileting assistance. LVN 5 stated she should have followed through to ensure the resident was assisted, as the resident became frustrated. LVN 5 stated Resident 105 deserved privacy and dignity. During an interview on 1/8/2026 at 3:55 p.m., with the Director of Nursing Trainer (DONT), the DONT stated LVN 5's actions were unacceptable. The DONT stated when residents needed help, staff were expected to assist them. The DONT stated residents could feel unattended and uncared for when staff did not respond to their needs which could cause psychological and emotional stress. The DONT stated the facility was the residents' home and staff were responsible for providing care to the residents. During a review of the facility's policy and procedure (P&P) titled Quality of Life - Dignity, revised 8/2009, the P&P indicated residents were to be treated with dignity and respect at all times. The P&P indicated staff were required to promptly respond to a resident's request for toileting assistance and to promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care. The P&P also indicated demeaning practices or standards of care that compromise resident dignity were prohibited. During a review of the facility's P&P titled Resident Rights, revised 12/2016, the P&P indicated residents had the right to be treated with respect, kindness, and dignity. The P&P indicated to maintain privacy during care. The P&P indicated residents were entitled to a dignified existence and to receive care that is free from neglect and practices that compromise dignity. The P&P also indicated staff were responsible for supporting residents in the exercise of these rights and for treating residents in a manner that preserved dignity and privacy at all times. During a review of the facility's P&P titled Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated residents were to be provided care, treatment, and services to maintain or improve their ability to carry out activities of daily living. The P&P indicated appropriate support and assistance were to be provided with elimination (toileting) for residents unable to carry out activities of daily living independently, in accordance with the resident's plan of care.		

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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 and interview, the facility failed to ensure one of eight sampled residents (Resident 118) had access to a call light system to summon assistance. This deficient practice had the potential to prevent Resident 118, who was unable to communicate verbally, from requesting assistance or communicating needs in a timely manner. Findings: During a review of Resident 118's admission Record, dated 1/9/2025, the admission record indicated Resident 118 was admitted to the facility on [DATE]. Resident 118's diagnoses included compression of the brain (pressure on the brain that can affect thinking, movement, or speech), cerebral infarction (loss of blood flow to a part of the brain also known as a stroke), encephalopathy (a condition that affects how the brain works, causing changes in thinking, alertness, or behavior), encephalitis (inflammation of the brain that can affect thinking, alertness, speech, or behavior) and encephalomyelitis (inflammation of the brain and spinal cord that can affect movement, speech, and brain function), dysphagia (difficulty swallowing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 118's History and Physical (H&P), dated 4/26/2025, the H&P indicated Resident 118 had fluctuating capacity to understand and make decisions. During a review of Resident 118's Minimum Data Set (MDS - a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 118 cognitive skills (ability to think, remember, and reason) for daily decision making were severely impaired. The MDS indicated Resident 118 had short-term and long-term memory problems. The MDS indicated Resident 118 had no speech (absence of spoken words) and rarely or never had the ability to be understood to express ideas and wants. The MDS indicated Resident 118 was dependent (helper does all the effort) with toileting, bathing, oral and personal hygiene. During a review of Resident 118's care plan with a focus on communication limitations related to cognitive deficits, nonverbal status, impaired mobility, and the need for adaptive devices, initiated on 10/30/2025, the care plan indicated Resident 118 was nonverbal and had difficulty communicating needs verbally. The care plan indicated Resident 118 communicated needs through nonverbal methods, including eye contact, touch, and pointing. The care plan further indicated Resident 118 required a flat call light to be able to communicate needs. During a concurrent observation and interview on 1/5/2026 at 12:58 p.m., with Licensed Vocational Nurse (LVN) 8 and Resident 118, while in Resident 118's room, the resident was observed lying in bed, alert and oriented. Resident 118 was unable to respond verbally when questions were asked. Resident 118's call light was observed dangling on the left side of his bed. Resident 118 shook his head no when asked if he could reach his call light. LVN 8 acknowledged Resident 118's call light was not within reach. LVN 8 stated she should always ensure the resident's call light was within arm's reach. LVN 8 further stated if Resident 118 was in distress or needed assistance in the event of an emergency, he would need his call light, especially since the resident was nonverbal. During an interview on 1/8/2026 at 3:55 p.m., with the Director of Nursing Trainer (DONT), the DONT stated if the resident needed assistance, he could not call for help. The DONT further stated the call light was Resident 118's lifeline for emergencies. During a review of the facility's policies and procedures (P&P), titled Answering the Call Light, revised 9/2022, the P&P indicated staff were to explain and demonstrate use of the call light to residents upon admission and as needed. The P&P further indicated the call light was to be plugged in, functioning, and accessible to residents at all times, including when the resident was in bed, in the bathroom, or on the floor. The P&P also indicated staff were to respond promptly to resident call light requests and report any defective call lights to the nurse supervisor.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician was notified of a significant change in condition when a resident exhibited inappropriate sexual behavior for one of eight sampled residents (Resident 27). This deficient practice resulted in a delay in physician evaluation and the development of an appropriate plan of care for Resident 27's behavioral needs. Cross reference F644 and F742. Findings: During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was initially admitted to the facility on [DATE]. Resident 27's diagnoses included traumatic brain injury (damage to the brain from an external force), traumatic subarachnoid hemorrhage (brain bleed) with loss of consciousness, disorganized schizophrenia (a mental illness that is characterized by disturbances in thought), brief psychotic disorder, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 27's Minimum Data Set ([MDS], a resident assessment tool), dated 12/22/2025, the MDS indicated Resident 27's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 27 was entirely dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 27's History and Physical (H&P), dated 9/14/2025, the H&P indicated Resident 27 had the capacity to understand and make decisions. During an interview on 1/5/2026 at 12:20 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 27 grabbed her buttocks and private area (date unknown) which caused her to feel uncomfortable. CNA 2 stated Resident 27 laughed during the incident. CNA 2 stated she notified Licensed Vocational (LVN) 2 and the Director of Staffing Development (DSD) of the incident. During an interview on 1/6/2026 at 2:13 p.m. with LVN 2, LVN 2 stated any change in a resident's condition should be relayed to the physician so orders could be placed to direct the resident's plan of care. LVN 2 recalled being notified of Resident 27's inappropriate sexual behaviors and stated the physician should have been notified because the behavior constituted a serious change in behavioral condition that required a psychiatric evaluation, possible medication adjustments, or a 5150 (a 72- hour psychiatric hospitalization when an adult exhibits a mental health crisis and is evaluated to be a danger to others, or to himself or herself, or gravely disabled). LVN 2 stated she knew Resident 27 to have a longstanding history of behavioral concerns. LVN 2 stated she did not complete a change of condition note or notify the physician because she did not think of it. During a concurrent interview and record review on 1/7/2026 at 12:10 p.m. with the Director of Nursing Trainer (DONT), the DONT stated Resident 27's inappropriate sexual behavior should have been reported by the physician so that the resident could have a psychiatric evaluation. The DONT stated that the lack of physician notification placed all the residents and the staff in danger of physical harm by Resident 27 and placed the resident at risk of worsening behavior. During a review of the facility's Policy and Procedure (P&P) titled, Change in Resident's Condition or Status, revised 2/2021, the P&P indicated the nurse would notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly. The P&P also indicated to notify the resident and/or representative, the state mental health agency or state intellectual disability agency will be notified within 24 hours of a significant change in the mental or physical condition of a resident with a mental disorder.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess and code a resident's recent surgery on the Minimum Data Set (MDS), a resident assessment tool) for one of eight sampled residents (Resident 65). This deficient practice led to a delay in proper care area assessment identification, which affected the facility's ability to address Resident 65's post-surgical and neurological needs. Cross reference F656 and F684. Findings: During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was initially admitted to the facility on [DATE]. Resident 65's diagnoses included nontraumatic intracerebral hemorrhage (a serious type of hemorrhagic stroke where a blood vessel within the brain bursts, causing bleeding directly into the brain tissue, leading to swelling and tissue damage), encephalopathy (any disease or damage that alters brain function), and chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately oxygenate the blood). During a review of Resident 65's Minimum Data Sets ([MDS], a resident assessment tool), dated 9/16/2025 and 12/16/2025, the MDS' indicated Resident 65's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS' indicated Resident 65 was entirely dependent on staff for toileting, showering, and lower body dressing. The MDS' indicated Resident 65 had an active diagnosis of cerebrovascular accident (CVA) or stroke (loss of blood flow to a part of the brain). The MDS' indicated Resident 65 did not have any major surgical procedures during the prior inpatient hospital stay that required active care in the facility. During a review of Resident 65's History and Physical (H&P), dated 9/11/2025, the H&P indicated Resident 65 had the capacity to understand and make decisions. During a review of Resident 65's General Acute Care Hospital (GACH) Physician Progress Note, dated 9/10/2025, the GACH note indicated Resident 65 was admitted to the intensive care unit (ICU) on 8/5/2025 for a diagnosis of intraventricular (fluid-filled cavities deep within the brain) hemorrhage and required immediate intubation (a medical procedure where a tube is placed into the windpipe through the mouth or nose to secure an open airway). The GACH note indicated Resident 65 underwent ventriculostomy (a neurosurgical procedure where a catheter or small opening is placed in the brain's ventricles to drain excess cerebrospinal fluid [CSF- brain fluid] or monitor intracranial pressure [ICP - pressure within the brain]) with external ventricular drain (EVD-a catheter is inserted into a ventricle, connected to an external drainage system to remove CSF and measure pressure) placement on 8/6/2025 and subsequent removal on 8/12/2025. The note indicated Resident 65 was in the ICU for approximately 30 days. During a concurrent interview and record review on 1/8/2026 at 3:23 p.m. with the Quality Assurance Nurse (QAN), Resident 65's MDS' dated 9/16/2025 and 12/16/2025, were reviewed. The QAN stated the MDS Nurse inaccurately indicated Resident 65 did not have any major surgical procedures during the prior inpatient hospital stay requiring active skilled nursing care. The QAN stated the MDS should have reflected the resident's recent surgery so that the appropriate care area assessment could have been triggered, which would have assisted in the formulation of a care plan. The QAN stated the inaccurate assessment contributed to the absence of care planning for Resident 65's post-surgical and neurological needs. During a review of the facility's Policy and Procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, revised 11/2019, the P&P indicated the facility was to ensure any person completing a portion of the Minimum Data Set/MOS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a communication board for three of three residents with language barriers (Residents 6, 57 and 118). This deficient practice interfered with Residents 6, 57 and 118's ability to communicate effectively with staff and had the potential to impact their care, safety and ability to exercise their rights. Findings: a. During a review of Resident 6's admission Record, the admission Record indicated the facility admitted Resident 6 on 7/30/2025. Resident 6's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), visual hallucinations (a vivid visual experience of seeing things that are not there), depression (a serious mood disorder causing persistent sadness and loss of interest, affecting how you feel, think, and behave), dysphagia (difficulty swallowing), and muscle weakness (a reduced ability to contract or exert force with muscle). During a review of Resident 6's History and Physical (H&P), dated 7/30/2025, the H&P indicated Resident 6 did not have the capacity to understand and make medical decisions. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 11/6/2025, the MDS indicated Resident 6's cognition (ability to think, remember, and reason) was severely impaired. During a concurrent observation and interview on 1/5/2026 at 12:18 p.m., with Resident 6, in Resident 6's room, observed there was no communication board. Resident 6 stated, Korean. Resident 6 was unable to answer other questions. During a telephone interview on 1/5/2026 at 2:21 p.m., with Resident 6's family member (FM) 1, FM 1 stated Resident 6 was [NAME]-speaking. FM 1 stated that her concern was that the staff could not effectively communicate with Resident 6 due to the language barrier. FM 1 stated that Resident 6 understood very basic words in English but not enough to properly explain his needs, symptoms or concerns. During an observation on 1/6/2026 at 11:30 p.m., of Resident 6's room, observed there was no communication board. b. During a review of Resident 57's admission Record, the admission record indicated Resident 57 was admitted to the facility on [DATE]. Resident 57's diagnoses included DM, muscle weakness, chronic pulmonary edema (a buildup of fluid in the lungs causing shortness of breath) and atrial fibrillation (a common irregular heartbeat). During a review of Resident 57's H&P, dated 8/20/2025, the H&P indicated Resident 57 had the capacity to understand and make decisions. During a review of Resident 57's MDS dated [DATE], the MDS indicated Resident 57's cognition was intact. During a concurrent observation and interview conducted on 1/5/2026 at 12:39 p.m., in Resident 57's (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room, there was no communication board observed. Resident 57 stated that Spanish was her primary language and that she did not understand English. Resident 57 stated that she found it difficult to communicate with staff who did not speak Spanish. Resident 57 stated that she has not been provided with, nor has she seen, a communication board to assist her in communicating her basic needs to staff. During an interview on 1/5/2026 at 2:36 p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated that Resident 57 was a Spanish speaker. CNA 4 stated that when needing to communicate with Resident 57, she attempted to locate another staff who spoke Spanish. CNA 4 stated that if a Spanish-speaking staff was not available, CNA 4 would communicate with the resident using hand gestures and facial expressions. CNA 4 stated that she was not aware of communication boards within the facility to assist residents with language barriers. CNA 4 stated that the lack of a communication board made it difficult to accurately assess Resident 57's needs. CNA 4 stated that without proper communication tools, residents could be at risk for unmet needs or delay in care. During an interview on 1/7/2026 at 1:17 p.m., with CNA 3, CNA 3 stated that communicating with residents who have language barriers was challenging. CNA 3 stated that having a communication board in the rooms of residents with language barriers would improve the ability to assess and provide care. CNA 3 stated she did not know where the facility's communication boards were located. CNA 3 stated the inability to effectively communicate with residents due to language barriers placed them at risk for incomplete or inaccurate health assessments. During an interview on 1/7/2026 at 1:35 p.m., with Registered Nurse Supervisor (RN) 3, RN 3 stated that staff often face challenges when residents did not speak English, like Residents 6 and 57. RN 3 stated that without effective communication tools, residents were at risk for incomplete assessments, delayed care, and potential adverse outcomes. RN 3 stated residents that have a language barrier should have a communication board in their room. RN 3 stated that ensuring communication boards were accessible and staff were trained to use them was essential for resident safety and quality of care. b. During a review of Resident 118's admission Record, dated 1/9/2025, the admission record indicated Resident 118 was admitted to the facility on [DATE]. Resident 118's diagnoses included compression of the brain (pressure on the brain that can affect thinking, movement, or speech), cerebral infarction (loss of blood flow to a part of the brain also known as a stroke), encephalopathy (a condition that affects how the brain works, causing changes in thinking, alertness, or behavior), encephalitis (inflammation of the brain that can affect thinking, alertness, speech, or behavior) and encephalomyelitis (inflammation of the brain and spinal cord that can affect movement, speech, and brain function). During a review of Resident 118's H&P, dated 4/26/2025, the H&P indicated Resident 118 had fluctuating capacity to understand and make decisions. During a review of Resident 118's MDS, dated [DATE], the MDS indicated Resident 118's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 118 had short-term and long-term memory problems. The MDS indicated Resident 118 had no speech (absence of spoken words) and rarely or never had the ability to be understood to express ideas and wants. The MDS indicated Resident 118 was dependent (helper does all the effort) with toileting, bathing, oral and personal hygiene. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 118's care plan with a focus on communication limitations related to cognitive deficits, nonverbal status, impaired mobility, and the need for adaptive devices, initiated on 10/30/2025, the care plan indicated Resident 118 was nonverbal and had difficulty communicating needs verbally. The care plan indicated Resident 118 communicated needs through nonverbal methods, including eye contact, touch, and pointing. The care plan further indicated Resident 118 required the use of a communication board for communication. During a concurrent observation and interview on 1/5/2026 at 12:58 p.m., with Licensed Vocational Nurse (LVN) 8 and Resident 118, while in Resident 118's room, Resident 118 was observed lying in bed. Resident 118 was unable to respond verbally when questions were asked. LVN 8 stated Resident 118 could not speak but was able to answer questions by nodding his head yes or shaking his head no. LVN 8 stated Resident 118 did not have a communication board because staff communicated with the resident through yes or no responses and understood his needs. LVN 8 further stated a communication board would assist the resident in communicating needs, including emergencies, pain, discomfort, or requests for assistance, and stated when a resident could not communicate needs, the resident could become agitated (feeling of unease). LVN 8 acknowledged a communication board would have been helpful for Resident 118. Resident 118 shook his head yes when asked if a communication board would have been helpful with communicating his needs. During an interview on 1/7/2026 at 3:00 p.m., with the Social Services Director (SSD), the SSD stated residents with communication issues, including inability to speak or language barriers, were provided a communication board. The SSD stated communication boards were kept in a binder at the resident's bedside. The SSD stated upon admission, she completed an evaluation to assess a resident's ability to communicate to determine whether a communication board was needed. The SSD stated Resident 118 should have had a communication board to communicate needs due to his inability to speak. During an interview on 1/8/2026 at 3:55 p.m., with the Director of Nursing Trainer (DONT), the DONT stated residents with communication problems should have a communication board. The DONT stated nursing staff should be in-serviced regarding the importance of communication boards and identifying residents who required a communication board. During a review of the facility's policies and procedures (P&P), titled Activities of Daily Living, revised 3/2018, the P&P indicated residents unable to carry out activities of daily living independently were to receive appropriate care and services, including support with communication through speech, language, or functional communication systems. The P&P indicated appropriate care, and services were to be provided based on resident needs. During a review of the facility's P&P, titled Accommodation of Needs, revised 3/2021, the P&P indicated resident needs, including the need for adaptive devices, were to be evaluated upon admission and reviewed on an ongoing basis. The P&P further indicated staff were to interact with residents in ways that accommodated physical or sensory limitations. During a review of the facility's P&P, titled Residents Who Present with Communication Barriers, revised 1/2025, the P&P indicated the facility was to meet the needs of residents who present with communication barriers. The P&P indicated the resident's primary method of communication, including primary language, was to be documented in the medical record, including the face sheet, Minimum Data Set (MDS), care plan, and interdisciplinary team assessments. The P&P indicated communication boards were to be provided at no charge to residents who were non-English speaking or aphasic to allow residents to use pictograms to communicate needs and desires. The P&P further indicated (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who speak a language other than English were to be assigned staff who speak their language as frequently as possible, and residents may choose to use a family member or friend to interpret.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 13) received bathing assistance as needed and failed to ensure refusals of showers were reported, documented, and communicated to the interdisciplinary team (IDT - a group of healthcare professionals from different healthcare roles who work together to plan and provide resident care). This deficient practice had the potential to result in compromised skin integrity, infection, and psychosocial distress and prevented the IDT from evaluating and intervening to address Resident 13's ongoing refusal of bathing services. Findings: During a review of Resident 13's admission Record, dated 1/9/2025, the admission record indicated Resident 13 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included encephalopathy (a condition that affects how the brain works, which can cause confusion, difficulty thinking clearly, problems with attention, or changes in behavior or alertness), age related physical debility (general physical weakness and reduced strength or endurance related to aging, resulting in decreased ability to perform daily activities independently), morbid obesity (excessive body weight), muscle weakness, abnormality of gait and mobility (difficulty with walking, balance, or movement that affects the ability to move safely or independently), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 12/23/2025, the MDS indicated Resident 13's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 13 was independent (completes the activity with no assistance) with eating, oral hygiene, toileting, and bathing, oral and required setup/clean up assistance with personal hygiene. During a review of Resident 13's care plan with a focus of bathing preferences and personal hygiene, initiated on 9/18/2025, the care plan indicated Resident 13 preferred sponge baths versus showers. The care plan indicated Resident 13 was to remain clean and odor free daily. The care plan interventions indicated to honor Resident 13's bathing preference, provide privacy as needed, and provide soap, a clean washcloth, and towel daily. During a review of Resident 13's care plan with a focus of activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and personal hygiene, initiated on 10/29/2025, the care plan indicated Resident 13 had bathing and hygiene needs. The care plan indicated the Resident 13 preferred sponge bathing in the bathroom and refused showers. The care plan interventions indicated to honor the resident's bathing preferences, provide privacy as needed, and provide the resident with soap, clean washcloths, and towels daily to maintain cleanliness and hygiene. During a review of Resident 13's IDT Conference Note dated 12/11/2025, the IDT note indicated Resident 13 required set-up to limited assistance with ADLs. The IDT note indicated Resident 13 was placed on an observation period with plans to reevaluate ADL needs. During an observation on 1/5/2026 at 12:05 p.m., in Resident 13's room, Resident 13 was observed sleeping in bed wearing a red shirt with visible stains on the front. Resident 13 was also observed wearing a long-sleeved shirt underneath. The long-sleeved shirt was visibly stained along the sleeves. During a concurrent observation and interview on 1/6/2026 at 9:50 a.m., with Resident 13, Resident 13 was observed lying in bed confused. Resident 13's appearance was unkempt, and the resident was observed wearing the same soiled shirts and pants as the previous day. Resident 13 stated she had not had a shower recently and complained it was difficult to get a shower because the lines were too long. During an observation on 1/7/2026 at 9:15 a.m., in Resident 13's room, Resident 13 was observed lying in bed wearing the same clothing as the previous day. During a concurrent observation and interview on 1/8/2026 at 9:35 a.m., with Certified Nursing Assistant (CNA) 5, in Resident 13's room, Resident 13 was observed sleeping in bed wearing the same clothing as the previous day. CNA 5 stated residents were assigned showers based on bed assignment. CNA 5 stated (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 13 was scheduled for showers on Mondays and Thursdays and showers were typically provided on the 3 pm -11 pm shift. CNA 5 stated showers were not routinely scheduled on Sundays; however, if a resident requested a shower, nursing staff were required to provide one. CNA 5 stated Resident 13 consistently refused showers and clothing changes. CNA 5 stated when a resident refused a shower, the refusal was required to be reported to the charge nurse. CNA 5 acknowledged she was aware Resident 13 had not received a shower but did not report the refusal to the charge nurse. CNA 5 further acknowledged if the refusal had been reported, the charge nurse would have intervened and educated the resident regarding the importance of bathing. CNA 5 stated bathing was important for skin integrity and the resident's emotional well-being. CNA 5 stated failure to bathe could place a resident at risk for skin breakdown. CNA 5 further stated when residents were not bathed regularly, residents could feel staff did not care about them. CNA 5 acknowledged she should have reported Resident 13's refusal of showers to the charge nurse. During an interview on 1/8/2026 at 9:47 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she was unaware Resident 13 had not received a shower. LVN 3 stated if a resident went days without a shower CNAs were expected to notify the charge nurse. LVN 3 stated once notified of a resident's refusal to shower, she would have explained the importance of regular bathing and attempted to encourage the resident to accept a shower. LVN 3 stated if Resident 13 continued to refuse, the refusal would have been documented in the progress notes. LVN 3 stated Resident 13's refusal to shower should have been reported to her on the first day of refusal. LVN 3 stated regular bathing was important to maintain skin integrity and prevent skin breakdown. During an interview on 1/8/2026 at 3:55 p.m., with the Director of Nursing Trainer (DONT), the DONT stated the CNA should have reported Resident 13's refusal to shower to the charge nurse. The DONT stated once notified, the facility could have involved the IDT or a family member to encourage the resident to bathe. The DONT stated regular bathing was important to help prevent infection, maintain skin integrity, and support the resident's self-esteem. During a review of the facility's policy and procedure (P&P), titled Quality of Life - Dignity, revised 8/2009, the P&P indicated residents were to be treated with dignity and respect at all times. The P&P indicated staff were responsible for promptly responding to residents' requests for toileting assistance and assisting residents in maintaining dignity, privacy, and self-worth. During a review of the facility's P&P titled Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated residents who were unable to carry out activities of daily living independently were to receive appropriate care and services to maintain grooming and personal hygiene. The P&P further indicated staff were to provide support and assistance with hygiene needs, including bathing, dressing, and grooming, and to monitor, evaluate, and revise interventions based on the resident's response. During a review of the facility's P&P, titled Requesting, Refusing and/or Discontinuing Care or Treatment, revised 2/2021, the P&P indicated residents had the right to refuse care or treatment. The P&P indicated when a resident refused care or treatment, staff were to inform the resident of the purpose of the care and the potential outcomes of refusal, attempt to address the resident's concerns, offer alternative interventions when available, notify appropriate members of the interdisciplinary team as indicated, and document the refusal, including the care offered and follow-up actions taken. During a review of the facility's P&P titled Accommodation of Needs, revised 3/2021, the P&P indicated the facility was responsible for accommodating residents' individual needs and preferences to assist residents in maintaining independence, dignity, and well-being. The P&P indicated residents' needs and preferences, including the need for assistance with activities of daily living, were to be evaluated upon admission and reviewed on an ongoing basis. The P&P further indicated staff were to assist residents with personal care needs, including hygiene and grooming, and to interact with residents in ways that accommodated physical or sensory limitations while maintaining dignity.		

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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, and record review, the facility failed to ensure the low air loss mattress ([LALM], a mattress that provides airflow to help keep skin dry, as well as to relieve pressure, treat pressure sores and prevents pressure sores) settings were set to accurately reflect the resident's weight for two of eight sampled residents (Resident 24 and Resident 100), who were at risk for developing pressure injuries (localized area of tissue damage that develops when prolonged pressure or shear forces are applied to the skin and underlying tissues). This deficient practice placed Residents 24 and 100 at risk for pressure injury development. Findings: a. During a review of Patient 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE]. Resident 24's diagnoses included diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic kidney disease (gradual loss of kidney function. Kidneys are unable to filter wastes and excess fluids from blood). During a review of Resident 24's History and Physical (H&P), dated 10/7/2025, the H&P indicated Resident 24 had fluctuating capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set ([MDS] a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 24's cognitive skills for daily decision making (ability to think and reason) was moderately impaired. The MDS indicated Resident 24 required setup assistance for eating. The MDS indicated Resident 24 required maximal assistance (helper does more than half the effort) for dressing and personal hygiene. The MDS indicated Resident 24 was dependent on staff for toileting hygiene and shower/bathing. The MDS indicated Resident 24 weighed 130 lbs. During a review of Resident 24's Order Summary Report, dated 12/2/2025, the order summary report indicated to provide a low air loss mattress for skin maintenance. During a review of Resident 24's Weight and Vitals summary, dated 12/7/2025, the weight and Vitals summary indicated Resident 24 weighed 130 lbs. During an observation on 1/5/2026 at 10:52 a.m., in Resident 24's room, Resident 24's LALM settings was observed at 250 lbs. b. During a review of Patient 100's admission Record, the admission Record indicated Resident 100 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 100's diagnoses included DM and hypertension ([HTN] high blood pressure). During a review of Resident 100's H&P, dated 9/8/2025, the H&P indicated Resident 100 had fluctuating capacity to understand and make decisions. During a review of Resident 100's MDS, dated [DATE], the MDS indicated Resident 100's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 100 required setup assistance for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 100 required supervision for toileting hygiene and putting on /taking off shoes. The MDS indicated Resident 100 required moderate assistance for upper body dressing and showering/bathing. The MDS indicated Resident 100 required maximal assistance for lower body dressing. The MDS indicated Resident 100 weighed 131 lbs. During a review of Resident 100's Order Summary Report, dated 9/9/2025, the order summary report indicated to provide a low air loss mattress every shift for wound management. During a review of Resident 100's Weight and Vitals summary, dated 12/4/2025, the Weight and Vitals summary indicated Resident 100 weighed 131lbs. During an observation on 1/5/2026 at 10:27 a.m., in Resident 100's room, Resident 100's LALM was set to 180 lbs. During an interview on 1/8/2026 at 2:42 p.m. with Licensed Vocational Nurse (LVN) 9, LVN 9 stated a LALAM was used to prevent and heal wounds. LVN 9 stated the LALM must be set according to the resident's weight. LVN 9 stated if a LALM was not set to the residents' weight, the LALM would not be beneficial to the resident and instead could potentially harm the resident. LVN 9 stated if the LALM was underinflated the resident could suffer from more skin breakdown. LVN 9 stated if the LALM was overinflated it would not benefit the resident and skin breakdown would not be prevented. LVN 9 stated she did not know how to set the LALM to the correct settings as she was not in charge of doing so. During an interview on 1/8/2026 at 4:00 p.m. with Registered Nurse (RN) 2, (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN 2 stated a LALM was a mattress that distributed air to prevent pressure and skin breakdown. RN 2 stated a LALM was set according to the physician's order and according to the resident's weight. RN 2 stated if a LALM was underinflated it would be uncomfortable for the resident and place the resident at a high risk of developing skin breakdown. RN 2 stated if a LALM was over inflated it would be stiff and uncomfortable. RN 2 stated the resident would not be able to move easily in bed and would be at risk of developing skin breakdown. RN 2 stated for a LALM to be beneficial, it needed to be set according to the residents' weight. RN 2 stated she was not sure who was in charge of setting up the residents' LALM but she did not know how to do it.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe environment for two out of eight sampled residents (Resident 40 and Resident 65), when Resident 40's lighter was left on his bedside table in close proximity to Resident 65's oxygen concentrator (a medical device that gives you extra oxygen). This deficient practice placed Residents 65 and 40 at risk for harm related to an oxygen-accelerated fire. Findings: a. During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was initially admitted to the facility on [DATE]. Resident 65's diagnoses included nontraumatic intracerebral hemorrhage (a serious type of hemorrhagic stroke where a blood vessel within the brain bursts, causing bleeding directly into the brain tissue, leading to swelling and tissue damage), encephalopathy (any disease or damage that alters brain function), and chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately oxygenate the blood). During a review of Resident 65's Minimum Data Set ([MDS], a resident assessment tool), 12/16/2025, the MDS indicated Resident 65's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 65 was entirely dependent on staff for toileting, showering, and lower body dressing. During a review of Resident 65's Physician Orders, dated 9/10/2025, the Physician Orders indicated to administer oxygen at two liters per minute (LPM- a unit of measurement) continuously every shift. b. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was initially admitted to the facility on [DATE]. Resident 40's diagnoses included displaced trimalleolar fracture (broken bone of the ankle) of the lower right leg, initial encounter for closed fracture and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 40's MDS, dated [DATE], the MDS indicated Resident 40's cognitive skills for daily decision making were intact. The MDS indicated Resident 40 required supervision for personal and oral hygiene, showering, and dressing. During a review of Resident 40's History and Physical (H&P), dated 8/29/2025, the H&P indicated Resident 40 had the capacity to understand and make decisions. During a review of Resident 40's Smoking Assessment, dated 12/10/2025, the Smoking Assessment indicated Resident 40 was able to safely smoke with supervision. During a review of Resident 40's At Risk for a Smoking Related Injury Care Plan, dated 12/10/2025, the care plan indicated the lighter and cigarettes would be kept with the Activities Department. During a concurrent observation and interview on 1/6/2026 at 7:54 a.m., in Resident 40's room, observed Resident 40's lighter and cigarette on his bedside table. Resident 40 stated he bought the lighter for himself at the liquor store. During an interview on 1/6/2026 at 8:04 a.m. the Activities Director Assistant (ADA), the ADA stated the facility's usual practice was that residents who smoked had their cigarettes lit for them by activities staff while outside. The ADA stated smoking residents were not permitted to carry their own lighters. During a concurrent observation and interview on 1/6/2026 at 2:42 p.m. with Licensed Vocational Nurse (LVN) 1, a photograph, dated 1/6/2026, and time-stamped at 7:48 a.m., was reviewed. The photograph revealed Resident 40's lighter on his bedside table in the shared room with Resident 65. LVN 1 stated she was Resident 40 and Resident 65's assigned nurse and was not aware Resident 40 had possession of a lighter. LVN 1 stated it was important to ensure Resident 40 did not keep lighters because Resident 65 required continuous oxygen therapy. LVN 1 stated this placed Resident 40 and Resident 65 at risk of injury from an increased risk of a fire. During a review of the facility's Policy and Procedure (P&P) titled, Smoking Policy - Residents, revised 10/2023, the P&P indicated the facility was to establish and maintain safe resident smoking practices. The P&P indicated residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2023, the P&P indicated the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility staff were to remove all potentially flammable items (e.g., lotions, oils, alcohol, smoking articles, etc.) from the immediate area where the oxygen is to be administered.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen delivery equipment functioned properly to provide oxygen therapy for one out of one sampled residents (Resident 65), when the oxygen concentrator (a medical device that gives you extra oxygen) regulator lacked a visible metal ball (flow indicator) to confirm oxygen was flowing at the prescribed rate). This deficient practice led to the inability for licensed nursing staff to verify effective oxygen delivery and placed Resident 65 at risk for hypoxia (when the lungs cannot adequately oxygenate the blood) and respiratory compromise. Findings: During a review of Resident 65's admission Record, the admission Record indicated Resident 65 was initially admitted to the facility on [DATE]. Resident 65's diagnoses included nontraumatic intracerebral hemorrhage (a serious type of hemorrhagic stroke where a blood vessel within the brain bursts, causing bleeding directly into the brain tissue, leading to swelling and tissue damage), encephalopathy (any disease or damage that alters brain function), and chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot adequately oxygenate the blood). During a review of Resident 65's Minimum Data Set ([MDS], a resident assessment tool), 12/16/2025, the MDS indicated Resident 65's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 65 was entirely dependent on staff for toileting, showering, and lower body dressing. During a review of Resident 65's Physician Orders, dated 9/10/2025, the Physician Orders indicated to administer oxygen at two liters per minute (LPM- a unit of measurement) continuously every shift. During a review of Resident 65's Chronic Respiratory Failure Care Plan, dated 9/16/2025, the care plan indicated interventions included to have oxygen at two LPM continuously every shift. During observations made on 1/5/2026 at 11:10 a.m. and 1/6/2026 at 11:12 a.m., in Resident 65's room, Resident 65's oxygen concentrator lacked a visible flow indicator. During a concurrent observation and interview on 1/6/2026 at 2:42 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 65's oxygen concentrator was observed. The oxygen concentrator regulator lacked a visible flow indicator. LVN 1 stated the normal process was to check the oxygen regulators at the start of each shift to ensure residents were receiving oxygen at the prescribed rate. LVN 1 stated she had not checked the oxygen concentrator for Resident 65. LVN 1 stated she could not determine how much oxygen Resident 65 was receiving and stated the lack of a visible flow indicator placed Resident 65 at risk for over- or under-oxygenation. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2023, the P&P indicated the licensed nursing staff were to review the physician's orders or facility protocol for oxygen administration, and were to check the mask, tank, humidifying jar, etc., to be sure they were in good working order.		

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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 interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 8 maintained current certification in cardiopulmonary resuscitation (CPR- an emergency procedure used when a person's breathing or heartbeat stops). The facility also failed to clarify a physician order prior to administering pain medication, and failed to clarify an insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) sliding scale (amount of insulin to be administered changes or slides up or down based on the person's blood sugar) order for two of two sampled residents (Resident 22 and Resident 54). These deficient practices had the potential to result in delayed or inappropriate emergency response for all residents residing in the facility, unsafe medication administration, and increased risk of adverse outcomes including medication errors, untreated changes in condition, and compromised resident safety for Residents 22 and 54. Findings: a. During a concurrent interview and record review on [DATE] at 2:42 p.m., with the Director of Staff Development (DSD), LVN 8's employee file was reviewed. The DSD stated LVN 8's CPR certification expired in 11/2025. The DSD stated licensed staff should not work without a current CPR certification. The DSD stated once LVN 8's CPR certification expired, LVN 8 should have been removed from the schedule until the CPR certification was updated. The DSD stated in the event of a medical emergency, LVNs must be certified in CPR. During an interview on [DATE] at 3:55 p.m., with the Director of Nursing Trainer (DONT), the DONT stated CPR training was required to ensure licensed staff could appropriately respond to a resident's change in condition, including performing CPR during a medical emergency. During a review of the facility's policy and procedure (P&P) titled Staffing, Sufficient and Competent Nursing, revised [DATE], the P&P indicated all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law and demonstrate competency to safely respond to resident needs, including changes in condition. During a review of the facility's P&P titled Emergency Procedure & Cardiopulmonary Resuscitation and Basic Life Support, revised [DATE], the P&P indicated nursing staff were required to obtain and maintain CPR and basic life support (BLS) certification to respond to resident medical emergencies. b. During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE]. Resident 22's diagnoses included right femur (long bone of the lower limb extending from the hip to the knee) internal fixation device (surgical implant, like plates, screws, rods, or wires, used to hold fractured bones in their correct alignment while they heal) and neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a review of Resident 22's History and Physical (H&P), dated [DATE], the H&P indicated Resident 22 had fluctuating capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set ([MDS] a resident assessment tool), dated [DATE], the MDS indicated Resident 22's cognitive skills for daily decision making (ability to think (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and reason) was intact. The MDS indicated Resident 22 was independent with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 22 required maximal assistance (helper does more than half the effort) with dressing and shower/bathing. The MDS indicated Resident 22 was dependent on staff for putting on and taking off shoes. During a review of Resident 22' s Order Summary Report, dated [DATE], the order summary report indicated to administer tramadol oral tablet 50 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) for moderate pain (5-7 pain level out of 10) every six hours. During a concurrent interview and record review on [DATE] at 3:04 p.m. with LVN 10, Resident 22's Medication Administration Record (MAR), dated [DATE] - [DATE] was reviewed. The MAR indicated on [DATE] and on [DATE], Resident 22 received tramadol 50 mg for a pain level of eight out of ten. LVN 10 stated she did not know tramadol was only indicated for a pain level of 5- 7 out of 10. LVN 10 stated she should not have administered the medication to Resident 22 because his pain was higher than 5- 7 out of 10. LVN 10 stated she should have informed Resident 22's physician that the resident had a higher pain level than what the medication was ordered for. LVN 10 stated it was important to administer the correct medication to alleviate Resident 22's pain. During an interview on [DATE] at 4:00 p.m. with Registered Nurse (RN) 2, RN 2 stated medication should not be administered if a resident did not meet the medication parameters. RN 2 stated it was not acceptable to administer medication ordered for 5- 7 pain if the resident's pain was not within the parameter of 5- 7. RN 2 stated licensed staff must notify the physician and request pain medication for a stronger level of pain. RN 2 stated it was important to alleviate Resident 22's pain and prevent the pain from getting worse. c. During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 54's diagnoses included diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension ([HTN] high blood pressure). During a review of Resident 54's H&P, dated [DATE], the H&P indicated Resident 54 did not have the capacity to understand and make decisions. During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 54 was independent with eating. The MDS indicated Resident 54 required supervision for oral hygiene. The MDS indicated Resident 54 required moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 54 required maximal assistance for toileting hygiene, shower/bathing, lower body dressing and putting on and taking off footwear. During a review of Resident 54' s Order Summary Report, dated [DATE], the order summary report indicated Resident 54 was to receive insulin aspart (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection 100 unit/milliliters (a standardized international measure of the drug's biological effect)/([ml] metric unit of measurement, used for medication dosage and/or amount). The order summary report indicated to inject subcutaneously (under the skin) before meals and at bedtime. The Order Summary Report did not indicate how many units to administer if Resident 54's blood sugar was between 351 to 450 milligrams per deciliter (mg/dL). The order summary report indicated to inject as per sliding scale, if blood sugar was as follows:1. 201 &ndash; 250 mg/dL, inject 4 units.2. 251 &ndash; 300 mg/dL, inject (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6 units.3. 301 &ndash; 350 mg/dL, inject 8 units.4. 451 &ndash; 500 mg/dL, inject 10 units. During a review of Resident 54's MAR dated [DATE] - [DATE], the MAR indicated Resident 54 did not have a sliding scale for a blood sugar of 351 to 400 mg/dL. During an interview on [DATE] at 2:48 p.m. with LVN 9, LVN 9 stated some medications have parameters for the resident's safety. LVN 9 stated if a resident did meet the parameters, the resident should not receive the medication. LVN 9 stated licensed staff were responsible for clarifying the physician's orders and medication parameters for resident safety and to prevent medication errors. During an interview on [DATE] at 3:45 p.m. with RN 2, RN 2 stated all insulin orders must be complete with sliding scales. RN 2 stated licensed staff were responsible for reviewing orders and to clarify orders with the physician. RN 2 stated it was unacceptable to have an order for insulin without a complete sliding scale because nursing would not know how much medication to administer to residents. During a review of the facility's job description titled Charge Nurse, dated 2012, the job description indicated nursing staff would prepare and administer medications as ordered by the physician. The job description indicated nursing staff would report all discrepancies noted concerning doctor's orders. The job description indicated nurses must review the residents' chart for specific treatments and medication orders. During a review of the facility's Policy and Procedure (P&P) titled Administering Medications, dated 12/2012, the P&P indicated all medications would be administered in a safe, timely manner and as prescribed. The P&P indicated if a dosage was believed to be inappropriate for a resident, the person administering medication should contact doctor to discuss concerns.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a clean, sanitary and safe environment for medication storage in the bottom drawer of one of two inspected medication carts (West Station Medication Cart), and failed to ensure the facility's licensed nurse did not leave medications unattended for one of 28 sampled residents (Resident 37) for self-medication administration. These deficient practices resulted in an unsafe and unsecured environment for medication storage, which had the potential to increase the risk of cross contamination of prescription and non-prescription medications in the medication cart, and Resident 37's unsupervised storage and ingestion of medications, which had the potential to result in choking and medication administration errors. Findings: a. During an observation on 1/6/2026 at 1:47 p.m. with the Quality Assurance Nurse (QAN), of the [NAME] Station Medication Cart, observed the storage space in the bottom drawer of the medication cart. The drawer contained a spillage of liquid with sticky consistency, some of which was clear liquid and some of it was yellow colored crusty formation. There were nine prescription and nonprescription bottles placed on the top of this sticky liquid. During an interview on 1/7/2026 at 3:44 p.m. with the Interim Director of Nursing Interim (IDONI), the IDON stated the facility's medication carts should have been clean, secure and well organized. The IDON stated the charge nurses should be checking the medication carts proactively for cleanliness. The IDON stated the sticky liquid in the bottom drawer could attract pests and pose as a risk for contamination. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 02/2023, the P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. b. During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including paralytic syndrome (broad term for conditions causing rapid muscle weakness) following cerebral infarction (brain damage due to a loss of oxygen to the area), paraplegia (loss of movement and/or sensation, to some degree, of the legs), muscle weakness, and contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) to both hands and the right thigh. During a review of Resident 37's Minimum Data Set ([MDS] a resident assessment tool), dated 12/11/2025, the MDS indicated Resident 37 expressed ideas and wants, understood verbal content, and had intact cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 37 had range of motion (ROM) limitations in both arms and legs. The MDS indicated Resident 37 was independent for eating, required setup or clean-up assistance for oral hygiene, required substantial/maximal assistance (helper does more than half the effort) for upper body dressing and rolling to both sides while lying in bed, and was dependent for toileting, lower body dressing, bathing, transferring from lying in the bed to sitting at the side of the body, and chair/bed-to-chair transfers. During a review of Resident 37's Self Administration of Medication Assessment, dated 10/5/2024, the Self Administration of Medication Assessment indicated Resident 37 was not a candidate for safe (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administration of medications. During a concurrent observation and interview on 1/8/2026 at 10:39 a.m. with the Director of Rehabilitation (DOR), in Resident 37's room, observed Licensed Vocational Nurse 7 (LVN 7) place a small medicine cup with multiple medications on Resident 37's bedside table and walk to the medication cart in the hallway. Resident 37's bedside table had one small medicine cup of liquid medication, one small medicine cup with multiple medications, and one cup of water. Resident 37 drank the liquid medication. Resident 37 then placed all the medications in the mouth and swallowed all the medications with water. Resident 37 did not know the name and purpose of the liquid medication. The DOR called LVN 7 back into the room, and LVN stated the liquid medication was lactulose (prescription used to treat constipation). During an interview and record review on 1/8/2026 at 1:04 p.m. with LVN 7, Resident 37's Self Administration of Medication Assessment, dated 10/5/2024, was reviewed. LVN 7 reviewed Resident 37's which indicated Resident 37 was not a candidate for self-administration. LVN 7 stated the nursing standard of practice for medication administration included to explain the medications to the resident and to ensure the resident takes the medication. LVN 7 stated Resident 37's medications were usually left on the bedside table and LVN 7 would return to Resident 37 after two to three minutes to ensure all medications were taken. LVN 7 stated she was not physically present while Resident 37 took medications because the resident was alert, oriented (person aware of self, time, location, and situation), and was allowed to take medications independently. LVN 7 stated she was technically supposed to be present when Resident 37 took medication. LVN 7 stated risks of leaving the medications on Resident 37's bedside table included choking or incomplete self-administration of the medications. During a review of the facility's policy and procedure (P&P) titled, Administering Oral Medications, dated 2001, the P&P indicated the licensed nurse was to Remain with the resident until all medications have been taken.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide one of six residents (Resident 110) with range of motion ([ROM] full movement potential of a joint) and positioning concerns with Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) in accordance with the established treatment plan of three times per week and Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) services in accordance with the established treatment plan frequency of five times per week. This deficient practice had the potential for Resident 110 to experience a decline in mobility and ability to perform activities of daily living ([ADLs] basic tasks that individuals perform to maintain their daily lives and independence). During a review of Resident 110's admission Record, the admission Record indicated Resident 110 was admitted to the facility on [DATE] with diagnoses including hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side, paralytic syndrome following unspecified cerebrovascular (blood vessels in the brain) disease affecting unspecified side, personal history of traumatic brain injury ([TBI] a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), and contracture of unspecified hand. During a review of Resident 110's Minimum Data Set (MDS, a resident assessment tool) dated 12/30/2025, the MDS indicated Resident 110 had unclear speech, had difficulty communicating some words or finishing thoughts, understood verbal content, and had intact cognition (ability to think and reason). The MDS indicated Resident 110 had ROM impairments in both arms and legs. The MDS indicated Resident 110 was independent for eating, rolling to either side while lying in bed, transferring from lying in bed to sitting at the edge of the bed, and chair/bed-to-chair transfers and partial/moderate assistance (helper does less than half the effort) for upper body and lower body dressing. During a review of Resident 110's OT Evaluation and Plan of Treatment, dated 12/14/2025, the OT Evaluation indicated Resident 110 had a fall and demonstrated a decline in ADL and mobility. The OT Plan of Treatment included therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular reeducation (technique used to restore movement patterns through repetitive motion to retrain the brain), therapeutic activities (tasks that improve the ability to perform ADLs), and self-care management, five times per week for four weeks. During a review of Resident 110's PT Evaluation and Plan of Treatment, dated 12/14/2025, the PT Evaluation indicated Resident 110 had a recent fall, a history of falling five times without injury in the past year, and presented with generalized weakness, low activity tolerance, and impaired functional mobility. The PT Plan of Treatment included therapeutic exercises, neuromuscular reeducation, gait (manner of walking) training, therapeutic activities, and wheelchair management training (training on proper positioning and ability to propel the wheelchair), three times per week for four weeks. During a review of Resident 110's OT Treatment Encounter Notes, the OT Treatment Encounter Notes indicated OT provided therapy services to Resident 110 on 12/23/2025, 12/25/2025, 12/26/2025, 12/30/2025, 1/1/2026, and 1/2/2026. During a review of Resident 110's PT Treatment Encounter Notes, the PT Treatment Encounter Notes indicated PT provided therapy services to Resident 110 on 12/23/2025, 12/24/2025, 12/25/2025, 12/26/2025, 12/30/2025, 12/31/2025, 1/1/2026, and 1/2/2026. During an interview on 1/5/2026 at 9:39 a.m. with the Director of Rehabilitation (DOR), the DOR stated the purpose of PT services (in general) was for residents to regain strength and balance for ambulation (the act of walking) and movement. The DOR stated the purpose of OT services (in general) was or residents to regain independence with ADLs. During an observation on 1/6/2026 at 10:17 a.m., observed Resident 110 sitting on the wheelchair in the hallway. The large knuckles and middle joints of Resident 110's right-hand fingers were bent completely while the tip joints of the right-hand fingers were (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hyperextended (bent away from the palm). During a concurrent interview and record review on 1/7/2026 at 10:26 a.m. with the Director of Rehabilitation (DOR), Resident 110's OT Evaluation and Plan of Treatment, dated 12/14/2025, PT Evaluation and Plan of Treatment, dated 12/14/2025, and OT Treatment Encounter Notes, dated 12/23/2025, 12/25/2025, 12/26/2025, 12/30/2025, 1/1/2026, and 1/2/2026, and PT Treatment Encounter Notes, dated 12/23/2025, 12/24/2025, 12/25/2025, 12/26/2025, 12/30/2025, 12/31/2025, 1/1/2026, and 1/2/2026. The DOR stated Resident 110's OT Plan of Treatment included intervention five times per week for four weeks. The DOR stated Resident 110 did not receive OT and PT treatment from 12/14/2025 to 12/23/2025 in accordance with the OT and PT treatment plans. The DOR stated Resident 110 could experience a decline in mobility and inconsistent performance without OT and PT intervention. During a review of the facility undated policy and procedure (P&P) titled, Rehabilitation Services, the P&P indicated therapy service delivery was based on the resident's needs, tolerance, and care plan.		

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the Infection Preventionist Nurse (IPN) completed 10 hours of continuing education (CE), post-secondary learning for adults to update or enhance professional skills, meet licensure requirements, or for personal growth) in the field of infection prevention and control on an annual basis. This deficient practice had the potential to result in the IPN not having the knowledge to educate facility staff on updated information regarding infection prevention control and the knowledge of infection prevention in residents. Findings: During a review of the IPN's infection control training certificate, dated 12/2025, the certificate indicated IPN received 1 hour of CE. During a concurrent interview and record review on 1/7/2026 at 11:51 a.m., with the IPN, the IPN's Infection Training Certificate, dated 2025 was reviewed. The IPN stated in 2022, she received training to become an IPN. The IPN stated in 2023, she received infection control training and received 16 CE hours. The IPN stated in 2024, she did not receive infection control training. The IPN stated in 2025, she received infection control training and received one CE hour. The IPN stated she took another infection control training in 12/2025 which totaled 2 CE hours. The IPN stated she did not know there was a requirement of 10 CE hours on an annual basis. The IPN stated it was important for her to have those 10 hours to be able to serve the residents and to be able to train the staff on updated infection control practices. During a review of the California Department of Public Health All Facilities Letter (AFL) 20-84, dated 11/4/2020, AFL 20-84 indicated IPN's must complete 10 hours of continuing education in the field of infection prevention control on an annual basis. AFL 20-84 indicated IPN must stay updated on current news and training sourced through a nationally recognized infection prevention and control association. AFL 20-84 indicated the IPN should be able to make recommendations and implement facility policies to support infection prevention and control adherence. During a review of the facility's job description titled Infection Preventionist, dated 2023, the job description indicated the IPN must receive infection preventionist education and complete the infection preventionist certification training class. The Job description indicated the IPN must attend and participate in continuing education programs designed to keep the IPN updated of changes in the profession.		