STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056110	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Hills Health and Rehabilitation Center	24452 Health Center Drive Laguna Hills, CA 92653

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 facility P&P review, the facility failed to ensure one of 169 residents (nonsampled Resident 17) was provided care in a manner that promoted dignity and respect. * The facility failed to provide Resident 17 with privacy during bedside toileting. This failure had the potential for the resident to experience a decline in her psychosocial well-being. Findings: Review of the facility's P&P titled Dignity revised February 2021 showed the staff will maintain and protect resident privacy during personal cares. Medical record review for Resident 17 was initiated on 8/18/25. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's Order Summary Report showed a physician's order dated 2/4/21, for the resident to use a bedside commode. On 8/21/25 at 0928 hours, Resident 17 was observed being transferred to a bedside commode by CNA 1. Resident 17's privacy curtain was pulled closed but the basin, which was under the resident's commode and approximately six inches above the commode, was observed from the hallway due to the gap between the privacy curtain and the floor. CNA 1 was heard asking the resident if she wanted her room door closed, and the resident declined. On 8/21/25 at 0947 hours, Resident 17 was still observed sitting on the commode. The commode basin was still observed on the floor, where contents going into the commode could potentially be observed from the hallway. On 8/21/25 at 1004 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 17 just had a bowel movement while on the commode. On 8/21/25 at 1007 hours, an interview was conducted with Resident 17, who was now sitting in her wheelchair. Resident 17 stated she was not aware her commode basin was visible from the hallway, even with the privacy curtain pulled closed. The resident stated she just assumed the privacy curtain hid everything, and preferred her commode basin not be visible from the hallway during use. On 8/21/25 at 1048 hours, a follow-up interview was conducted with CNA 1. CNA 1 stated Resident 17's bedside commode was an over-the-toilet commode, and did not have place to attach a basin. CNA 1 stated she realized the resident's commode basin was viewable from the hallway under the privacy curtain, when the resident wanted her door to remain open. When asked if there was anything to block the view of the resident's commode basin during use, the CNA stated she did not think so. When asked about the trash receptacle located in the room, the CNA tested it by moving a trash receptacle next to the privacy curtain. CNA 1 verified the trash receptacle extended above the bottom of the privacy curtain and could have obstructed the view of the commode basin from the hallway.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were safely administered to two of 33 final sampled residents (Residents 158 and 174). * Resident 158 had a bottle of Total Beets (dietary supplement) 650 mg chewable at the bedside. Resident 158 did not have a physician's order to self-administer the Total Beets 650 mg or to keep any medication at the bedside. * Resident 174 had the bottle of Instaflex Advanced (dietary supplement) at the bedside. Resident 174 had no physician's order to keep any medication at the bedside. These failures had the potential to negatively impact Resident 158 and 174's physiological well-being and the potential for the residents to administer the medications inaccurately. Findings: Review of the facility's P&P titled Administering Medications revised 4/2023 showed the medications are administered in a safe and timely manner, and as prescribed. The residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. 1. On 8/18/25 at 0919 hours, an observation and concurrent interview was conducted with Resident 158. A bottle labeled Total Beets (supplement) 650 mg was observed on Resident 158's bedside table. The label on the bottle showed the supplement contained 10 mg of Niacin (vitamin B3), 2 mg of vitamin B6, and 25 mcg of vitamin B12 per serving. Resident 158 stated he took the Total Beets every day. Medical record review for Resident 158 was initiated on 8/18/25. Resident 158 was admitted to the facility on [DATE]. Review of Resident 158's MDS assessment dated [DATE], showed Resident 158 was cognitively intact. Review of Resident 158s Order Summary Report dated 8/26/25, failed to show a physician's order for the self-administration of the Total Beets 650 mg medication. Review of Resident 158's plan of care failed to show a care plan problem was initiated or developed to address the resident's self-administration of the Total Beets 650 mg medications. On 8/19/25 at 1027 hours, Resident 158 was observed in bed. The bottle of Total Beets 650 mg medication was observed on Resident 158's bedside table. On 8/20/25 at 1107 hours, an interview and concurrent medical record review for Resident 158 was conducted with LVN 1. LVN 1 stated for the self- administration of the medications, the IDT determined if the resident could safely self-administer the medication. LVN 1 stated there should be a physician's order specific to the medication the resident would self-administer and a care plan developed for the self-administration of the medication. LVN 1 further stated the medication would be kept in the medication carts and for the independent residents, the medication could be kept in the resident's room, however it should be locked so the other residents could not get access to the medication. LVN 1 reviewed Resident 158's medical record and verified Resident 158 had no physician's order or a care plan for the self-administration of the Total Beets 650 mg medication. LVN 1 stated the medication should not be left at the bedside. On 8/20/25 at 1130 hours, a follow-up interview was conducted with LVN 1. LVN 1 stated she went to Resident 158's room and verified the above findings. 2. On 8/18/25 at 1126 hours, an observation and concurrent interview was conducted with Resident 174. A bottle labeled Instaflex Advanced medication was observed at Resident 174's bedside. When asked about the medication, Resident 174 stated the medication was for her stomach and she self-administered the medication. Resident 174 further stated the medication inside the bottle was not what was on the bottle label. Medical record review for Resident 174 was initiated on 8/18/25. Resident 174 was admitted to the facility on [DATE]. Review of Resident 174's medical record failed to show a Self-Administration of Medication Assessment was done for Resident 174. Review of Resident 174's Order Summary Report dated 8/21/25, failed to show the physician's order for the self-administration of medications. Review of Resident 174's plan of care failed to show a care plan problem was initiated or developed to address the resident's self-administration of the medications. On 8/20/25 at 1032 hours, an interview and concurrent medical record review for Resident 174 was conducted with RN 5. RN 5 stated for the self- administration of medications by the residents, the resident needed to be assessed by the physician, as well as an assessment by the IDT, to ensure the resident could safely administer the medications. RN 5 stated there should be a physician's order for the self-administration of medications and the medication should be kept in a locked drawer. RN 5 reviewed Resident 174's medical record and verified the resident had no physician's order to self- administer medications and a self-administration of medication assessment was not done. When asked about the bottle labeled Instaflex Advanced medication at Resident 174's bedside, RN 5 stated the bottle was found by the CNA yesterday and was removed. On 8/25/25 at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the reasonable accommodation to meet the needs of two of two final sampled residents (Resident 8 and 49) reviewed for communication needs. * The facility failed to ensure the appropriate communication devices were used by staff to meet Residents 8 and 49's daily needs. This failure had the potential to negatively impact the resident's psychosocial well-being and result in delayed provision of care.Findings: Review of the facility's P&P titled Accommodation of Needs Communication revised 3/2021 showed the following: - In order to accommodate the individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with the residents’ wishes including interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication, and maintain dignity. Review of the facility's P&P titled Translation and/or Interpretation of Facility Services revised on 11/2020 showed the following: - The facility’s language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility; - When encountering LEP individuals, staff members will conduct the initial language assessment (e.g. “I Speak Cards”) and notify the staff person in charge of the language access program; - It is understood that providing meaningful access to services provided by this facility requires also that the LEP residents’ needs and questions are accurately communicated to the staff. Oral interpretation services therefore including interpretation from the LEP resident’s primary language back to English; and - Staff shall be trained upon hire and at least annually on how to provide language access services to LEP residents. 1. During an observation on 8/18/25 at 1225 hours, Resident 49 was lying in bed awake, alert, and verbally responsive. Resident 49 was greeted in English; however, Resident 49 did not speak and understand English. There were communication cards in the Chinese language available and posted on Resident 49’s wall. On 8/18/25 at 1240 hours, an observation and concurrent interview was conducted with CNA 4. CNA 4 spoke to Resident 49 in English while providing care. CNA 4 did not use the communication cards in Chinese language or request a Chinese speaking staff to communicate with the resident. CNA 4 stated she used gestures to communicate with Resident 49 and verified she did not speak any Chinese. CNA 4 further stated Resident 49 speaks and understands the Chinese language. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 49 was initiated on 8/20/25. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49’s care plan for communication dated 7/4/25, showed the following: - Resident 49 cannot communicate easily with staff; - Resident 49 wanted or needed an interpreter to communicate with a doctor or health care staff; and - Resident 49’s primary language is Chinese. Review of Resident 49's H&P examination dated 7/5/25, showed Resident 49 had the capacity to understand and make decisions. Review of Resident 49’s MDS assessment dated [DATE], showed Resident 49’s Brief Interview for Mental Status (BIMS) score was 8, indicating moderate cognitive impairment. On 8/19/25 at 1350 hours, an interview was conducted with CNA 5. CNA 5 stated Resident 49 spoke Chinese and could not understand English. On 8/19/25 at 1504 hours, an interview was conducted with the ADON. The ADON stated a non-English speaking residents must have communication cards in their preferred language available in each resident’s room provided by the Activities Department for any staff to use. The ADON further stated staff could call the language translation line if needed. In addition, the ADON stated the staff not using the appropriate communication devices would prevent the resident's needs to be met. On 8/25/25 at 1054 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 8/18/25 at 1231 hours, an observation of Resident 8 and concurrent interview was conducted with CNA 8. Resident 8 was lying on bed with head of the bed slightly elevated. CNA 8 communicated with Resident 8 in English using hand gestures, however there were communication card boards posted on Resident 8's wall. CNA 8 stated she thought Resident 8 spoke Japanese and she communicated with the resident by using hand gestures. CNA 8 further stated the staff additionally rely on the resident’s wife for translation. CNA 8 stated she only made herself understood by using hand gestures and added Resident 8's wife was usually present. On 8/20/25 at 1150 hours, an observation of Resident 8 and concurrent interview was conducted with CNA 10. Resident 8 was seated on his wheelchair and CNA 10 communicated with Resident 8 in English using hand gestures. CNA 10 asked Resident 8 about his dialysis appointment, however the resident did not answer. CNA 10 stated she uses only the hand gestures to communicate with Resident 8 and Resident 8's wife was usually available for translation. Medical record review for Resident 8 was initiated on 8/18/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's MDS assessment dated [DATE], showed Resident 8’s BIMS score was 10, indicating moderate cognitive impairment. Review of Resident 8's H&P examination dated 5/21/25, showed Resident 8 could make needs known. On 8/20/25 at 1252 hours, an interview was conducted with the ADON. The ADON stated Resident 8 spoke Korean, and the resident’s wife was always available at the bedside to translate. The ADON was informed two CNAs communicated with Resident 8 by using hand gestures. Resident 8’s wife was not at the bedside. The ADON verified the CNAs should have used the communication card boards posted on the wall and should have reached out to the charge nurses for oral interpretation services for clear interpretation and understanding when providing care to Resident 8. On 8/22/25 at 1443 hours, the DON was informed and verified the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to obtain and maintain a copy of the advance directives (a legal document stating a person's wishes about receiving medical care if the person is no longer able to make medical decisions) for one of two final sampled resident (Resident 61) reviewed for advance directives. * The facility failed to obtain a copy of Resident 61's advance directives. This failure had the potential for the resident's decisions regarding their healthcare and treatment options not to be honored.Findings: Review of the facility's P&P titled Advance Directive revised on 9/2022 showed the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. Medical record review for Resident 61 was initiated on 8/19/25. Resident 61 was admitted to the facility on [DATE]. Review of Resident 61's MDS assessment dated [DATE], showed Resident 61's BIMS score was 10, indicating moderate cognitive impairment. Review of Resident 61's H&P examination dated 12/16/24, showed Resident 61 had the capacity to understand and make decisions. Review of Resident 61's Advance Health Directive Acknowledgement form dated 12/27/24, showed Resident 61 had an Advance Health Directive and the facility requested a copy. Review of Resident 61's Multi-Interdisciplinary Care Conference dated 6/24/25, showed the Social Service department left a voicemail to Resident 61's sister. However. there was no follow up documented thereafter. On 8/20/25 at 0924 hours, an interview and concurrent medical record review were conducted with Social Service Staff 1. Social Service Staff 1 reviewed Resident 61's Advance Health Directive Acknowledgement form dated 12/27/24, and verified the above findings. Social Service Staff 1 showed Resident 61's Multi-Interdisciplinary Care Conference dated 6/24/25, which showed Social Service department left a voicemail to Resident 61's sister, however, there was no follow up documented thereafter. Social Service Staff 1 was asked to show a copy of Resident 61's advance directive, however, Social Service Staff 1 stated it was not available. Social Service Staff 1 stated a copy of Resident 61's Advance Directive must be available in the resident's medical record since the Social Service department was aware of it upon the resident's admission to the facility. On 8/20/25 at 0924 hours, an interview and concurrent medical record review were conducted with the SSD. The SSD was asked about the process of obtaining a copy of the advance directives from the responsible party. The SSD stated when the resident or responsible party informed the Social Service department of the availability of the resident's advance directive, the Social Service department must request a copy and document the request. The SSD stated if the requested copy was not received after a week, the Social Service department must follow up continuously up to three times and document the attempts. Furthermore, the SSD stated if the resident had an advance directive, a copy must be available in the resident's medication record a soon as possible. On 8/25/25 at 1054 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and facility P&P review, the facility failed to ensure the medical record was safeguarded to protect the confidential health information of the residents for one of eight medication carts (Medication Cart A). * The facility failed to ensure the computer monitor for Medication Cart A, which showed resident information, was not left unattended. This failure had the potential for the residents' personal and health information to be accessed by the unauthorized users.Findings: Review of the facility's P&P titled Confidentiality and Non-Disclosure Agreement (undated) showed the purpose of this policy is to maintain an adequate level of security to protect resident and facility information from unauthorized access, use or disclosure. Only authorized users are granted access to resident and facility information. Review of the facility's P&P titled Protected Health Information (PHI), Management and Protection of revised 4/2014 showed it is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure. On 8/19/25 at 0947 hours, Medication Cart A was observed in the hallway with the computer monitor turned on and unattended. The computer screen showed resident information. A facility staff and a resident were observed sitting in the hallway on the chairs adjacent to Medication Cart A. Six facility staff were observed walking in the hallway and passing by Medication Cart A. On 8/19/25 at 0953 hours, LVN 8 was observed turning Medication Cart A's computer off. LVN 8 stated she turned off the computer because it was showing a resident's photo and medication information. LVN 8 stated she did not know who was responsible for Medication Cart A. LVN 8 stated when leaving the medication cart unattended, the computer monitor should be locked so there was no resident information showing to provide resident's privacy. On 8/25/25 at 1000 hours, an interview was conducted with the DON. The DON stated all the PHI should be covered and the licensed nurses should log off the computer when leaving the medication cart. The DON was informed and acknowledged the findings.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, facility document review, and facility P&P review, the facility failed to ensure all grievances filed during 2025 were available for review to ensure they were followed up on appropriately. * The facility did not file and kept copies of the residents' grievances. This failure resulted in the state agency being unable to verify grievances were follow-up on per policy. Findings: Review of the facility's Grievance/Complaints, Filing P&P dated 2001 showed once a grievance is filed, the SSD will review and investigate the allegations and submit a written report of findings to the administrator withing five working days. The SSD, Administrator, and facility staff will take immediate action to prevent future potential violations of residents' rights while the grievance is being investigated. The Administrator will review the findings with the SSD to determine what corrective action is needed, if any. The resident, or person filing the grievance, will be informed of the investigation findings verbally, and in writing. A copy of the written summary will also be filed in the business office. The results of all grievances will be maintained on file for three years. On 8/19/25 at 1339 hours, an interview and concurrent facility document review was conducted with the SSD and Social Services Staff 1. The SSD stated she started working at the facility approximately one week. The SSD provided the grievance binder which had tabs labeled for each month. There were no grievance forms in the binder. Social Services Staff 1 stated there have been grievances this year, and they both would see if they could locate them. On 8/19/25 at 1427 hours, an interview was conducted with the Administrator. The Administrator stated both he and the SSD review grievances weekly and the binder should not be empty. The Administrator stated he did not keep a copy of the grievances. On 8/20/25 at 0820 hours, an interview was conducted with the Business Office Manager. The Business Office Manager stated she did not file copies of the residents' grievances. The Business Office Manager further stated she was not aware the P&P showed she should be filing copies of the grievance written summaries. On 8/20/25 at 0858 hours, a follow-up interview was conducted with the SSD. The SSD stated SS Staff 1 was able to locate one missing grievance dated 6/26/25, but there were still other missing grievances.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents reviewed for unnecessary medications (Residents 13 and 61) and one of one final sampled resident reviewed for behavioral-emotional management (Resident 133) were free from unnecessary psychotropic drugs. * Resident 13 did not have the monthly behavior summaries for the targeted behaviors for the Prozac (antidepressant) and divalproex sodium (an anticonvulsant medication also used for behaviors associated with bipolar disorder) medications. In addition, the facility failed to monitor the resident for orthostatic hypotension related to the resident's Zyprexa (antipsychotic medication) use when the resident was readmitted on [DATE]. * The facility failed to ensure the monthly behavioral summary was completed for Resident 61's Zyprexa medication. * Resident 133, who had a diagnosis of dementia, was prescribed Ativan (antianxiety medication and Seroquel (antipsychotic medication). For the Seroquel medication, there was no documented diagnosis, or diagnosis of bipolar disorder or psychosis prior to starting the routine Seroquel medication. Additionally, there was no informed consent obtained prior to starting the Seroquel medication. For the Ativan medication, there were no nonpharmacological interventions implemented during the administration of the PRN medication. For both the Ativan and Seroquel medications, there were no least restrictive measures attempted prior to the initiation of the medications, and no side effect monitoring or behavior monitoring was implemented upon the start of the medications. These failures had the potential to place the residents at risk of receiving unnecessary medications and increased risk of serious medication adverse reactions.Findings: Review of the facility’s P&P titled Antipsychotic Medication Use revised 7/2022 showed the residents will not receive medications that are not clinically indicated to treat a specific condition. The attending physician and other staff will gather and document information to clarify a resident’s behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident. For enduring psychiatric conditions, antipsychotic medications will not be used unless behavioral symptoms are not due to a medical condition or problem, persistent or likely to reoccur without continued treatment, not sufficiently relieved by non-pharmacological interventions, not due to environmental stressors, and not due to psychological stressors. The residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. The nursing staff shall monitor for and report side effects and adverse consequences of antipsychotic medication to the attending physician. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility’s P&P titled Psychotropic Medication Use/Informed Consent dated 3/2024 showed consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident’s signs and symptoms in order to identify underlying causes. The non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain written consent signed by the resident or the resident’s representative along with, the signature of the health care professional declaring the required material information has been provided. The signed written consent must be recorded in the resident’s medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident’s health record contains written informed consent with the required signatures. 1. a. Medical record review for Resident 133 was initiated on 8/18/25. Resident 133 was admitted to the facility on [DATE], with diagnoses including dementia. Review of Resident 133’s H&P examination dated 8/14/25, showed Resident 133 was not capable of decision making and had a diagnosis of dementia without behavioral disturbance. The H&P examination failed to show if Resident 133 was evaluated for and diagnosed with bipolar disorder or psychosis for the use of the Seroquel medication. Review of Resident 133’s Order Summary Report dated 8/22/25, showed the following physician’s orders: - dated 8/12/25, to admit to hospice with a diagnosis of senile degeneration of the brain; - dated 8/12/25 and discontinued on 8/13/25, to administer Ativan oral tablet 0.5 mg one tablet by mouth every six hours as needed for anxiety manifested by inability to relax; - dated 8/13/25 and discontinued on 8/19/25, to administer Ativan oral tablet 0.5 mg one tablet by mouth every six hours as needed for anxiety manifested by inability to relax for 14 days 8/27/25; - dated 8/19/25, to administer Ativan oral tablet 0.5 mg one tablet by mouth every six hours as needed for anxiety until 8/27/25, manifested by shortness of breath; - dated 8/15/25 and discontinued on 8/19/25, to administer Ativan oral tablet 0.5 mg, give 0.5 ml by mouth every eight hours for antianxiety agent; - dated 8/19/25, to administer Ativan oral tablet 0.5 mg, give 0.5 ml by mouth every eight hours for anxiety manifested by physical restlessness causing distress; - dated 8/19/25, to monitor for the antipsychotic medication side effects, every shift for Seroquel use; - dated 8/15/25 and discontinued on 8/19/25, to administer Seroquel 12.5 mg by mouth at bedtime for bipolar disorder manifested by angry outburst comfort measure; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 8/19/25, to administer Seroquel 12.5 mg by mouth at bedtime for psychosis manifested by sudden angry outburst; - dated 8/19/25, to monitor for for anxiety manifested by complaints of shortness of breath every shift until 8/27/25; - dated 8/19/25, to monitor for anxiety manifested by physical restlessness causing distress every shift for Ativan use; - dated 8/19/25, to monitor for psychosis manifested by sudden angry outburst, tally by hashmarks every shift; - dated 8/19/25, to monitor for side effects and adverse reactions for antipsychotic medication every shift; - dated 8/20/25, to monitor for side effects for antianxiety medication every shift; - dated 8/19/25, to monitor for side effects for antianxiety medication for the use of Ativan medication every shift; and - dated 8/202/25, to provide non-pharmacological behavioral interventions every shift. Further review of Resident 133’s medical record failed to show a documented evaluation and diagnosis of bipolar disorder or psychosis. b. Review of the Facility Verification of Informed Consent dated 8/20/25, showed Resident 133’s representative was not provided informed consent until 8/20/25, for the Seroquel medication. However, further review of Resident 133’s Facility Verification of Informed Consent forms failed to show an informed consent was obtained by the physician prior to initiation of the Seroquel medication. c. Review of Resident 133’s MAR dated 8/2025 showed Resident 133 was administered the Seroquel medication daily from 8/15 through 8/22/25, the Ativan medication 0.5 ml every eight hours daily from 8/16 through 8/22/25, and the PRN Ativan medication 0.5 mg tablet on 8/13 and 8/15/25. However, review of Resident 133’s medical record failed to show least restrictive measures were implemented prior to starting Resident 133 on the Ativan medication on 8/12/25, and prior to starting the Seroquel medication on 8/15/25. d. Further review of Resident 133’s medical record failed to show documented evidence of the side effects or behavioral monitoring was done upon starting the Ativan and Seroquel medications. The side effects and behavioral monitoring was not initiated until 8/19/25. In addition, there was no documented evidence Resident 133 received non-pharmacological interventions for the use of the PRN Ativan medication. On 8/18/25 at 1149 hours, Resident 133 was observed laying in bed, restless and fidgeting. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/25 at 0835 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON stated for psychotropic medications initiated in the facility, the licensed nurses monitored the resident’s behavior and informed the doctor of the behavior. The nurse practitioner would then come and evaluate the resident and obtain an informed consent for the medication. The ADON stated monitoring for the side effects and behaviors were done once the medication was given and the monitoring would be documented in the MAR. The ADON verified Resident 133 had no diagnosis of bipolar disorder or psychosis upon the initiation of the Seroquel medication. The ADON verified there was no informed consent obtained prior to initiating the Seroquel medication. The ADON verified there was no documented evidence to show the least restrictive measures were implemented prior to initiating the Seroquel or Ativan medication. The ADON verified there was no documented evidence the non-pharmacological interventions were provided until 8/19/25. The ADON additionally verified there was no documented evidence the side effect or behavioral monitoring was completed for the Seroquel or Ativan medications until 8/19/25. On 8/25/25 at 1000 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. 2. Medical record review for Resident 13 was initiated on 8/18/25. Resident 13 was readmitted to the facility on [DATE]. a. Review of Resident 13’s Order Summary Report showed a physician’s order dated 8/16/25, to administer divalproex sodium (used to treat bipolar disorder) delayed release 250 mg by mouth two times a day for a mood stabilizer. Review of Resident 13’s MAR for August 2025 showed a physician’s order dated 2/2/25, and discontinued on 8/16/25, to administer divalproex sodium 250 mg twice a day for mood stabilization manifested by episodes of agitation and yelling out. Review of Resident 13’s medical record failed to show any monthly behavior summaries for the targeted behaviors for the divalproex sodium medication were completed since February 2025. On 8/22/25 at 1452 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON stated the residents receiving psychotropic medications should have the monthly behavior summaries for the targeted behaviors of the psychotropic medication. The ADON verified she was unable to locate Resident 13’s monthly behavior summary for the resident's divalproex sodium medication use. b. Review of Resident 13’s Order Summary Report showed a physician order dated 8/16/25, to administer Prozac (antidepressant) 10 mg by mouth daily for depression manifested by verbalization of isolation as evidenced by a lack of interest or motivation. Review of Resident 13’s MAR for August 2025 showed a physician’s order dated 7/2/25, and discontinued on 8/16/25, to administer Prozac 10 mg by mouth daily for depression manifested by verbalization of isolation and evidenced by lack of interest or motivation. Review of Resident 13’s medical record failed to show a monthly behavior summary for the targeted behavior of the Prozac medication was completed for July 2025. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/25 at 1452 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified she was unable to locate Resident 13’s monthly behavior monitoring summary for July 2025 for the Prozac medication. c. Review of Resident 13’s Order Summary Report showed the following physician’s orders: - dated 8/16/25, to administer Zyprexa 2.5 mg by mouth, every morning for schizophrenia (chronic mental health condition characterized by a combination of positive, negative, and cognitive symptoms that significantly impair a person's daily functioning)- dated 8/16/25, to administer Zyprexa 5 mg by mouth, every evening for schizophrenia. Review of Resident 13’s MAR for August 2025 showed a physician’s order dated 4/16/25, and discontinued on 8/16/25, to check for orthostatic hypotension every Sunday due to the Zyprexa medication use, by checking the resident’s blood pressure while laying and sitting. On 8/22/25 at 1452 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the residents on antipsychotic medications should have weekly monitoring for orthostatic hypotension since hypotension was a side effect of the antipsychotic medications. The DON reviewed Resident 13’s physician’s orders and verified the facility failed to ensure an order was obtained during the resident's readmission to the facility for orthostatic monitoring related to the resident’s Zyprexa medication use. 3. Medical record review for Resident 61 was initiated on 8/19/25. Resident 61 was admitted to the facility on [DATE]. Review of Resident 61’s MDS assessment dated [DATE], showed Resident 61’s BIMS score was 10, indicating moderate cognitive impairment. Review of Resident 61's H&P examination dated 12/16/24, showed Resident 61 had the capacity to understand and make decisions. Review of Resident 61's Order Summary Report dated 8/20/25, showed a physician’s order dated 6/27/25, to administer Zyprexa 10 mg one tablet by mouth at bedtime for schizophrenia manifested by paranoid thoughts as evidence by stated of being left alone or abandoned. Review of Resident 61’s Psychoactive Summary for the Zyprexa medication showed the behavior manifestation of “anger outburst” from January to July 2025. However, the behavior manifestation for the Zyprexa medication was changed on 6/27/25, to monitor for paranoid thoughts as evidence by stated of being left alone or abandoned. Further review of Resident 61’s medical record failed to show any monthly behavior summaries of the targeted behavior of the Zyprexa medication were completed since 6/27/25, when the manifestation was changed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/25 at 1200 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 reviewed Resident 61’s medical record and verified the above findings. LVN 7 stated she was assigned to review the residents’ psychotropic medications, complete the monthly Psychoactive Summary, and attend the Gradual Dose Reduction (GDR) review with the IDT team. LVN 7 stated the physician’s orders must be carried out completely and accurately including completing a new Psychoactive Summary form when the behavior manifestation was changed. Furthermore, LVN 7 stated the importance of an accurate and complete monthly Psychoactive Summary would be vital because it showed the effectiveness of the medication prior to the GDR review. On 8/21/25 at 0923 hours, an interview was conducted with the DON. The DON stated the monthly Psychoactive Summary must be completed by the assigned licensed nurse. Furthermore, the DON stated the licensed nurses must complete a new monthly Psychoactive Summary when there were changes in the medication order including the dose, diagnosis, and/or manifestation. On 8/25/25 at 1054 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to thoroughly investigate an allegation of facility staff to resident physical abuse, for one of two residents (final sampled resident, Resident 73) reviewed for abuse * Resident 73's roommate (Resident 170) alleged she witnessed a female staff member hit Resident 73 on the arm during care. The facility failed to conduct an interview with the RN assigned to care for Resident 73, during the time in which the alleged incident occurred. Additionally, the facility failed to conduct an interview with the CNA assigned to the station, which Resident 73 resided in at the time of the allegation. * The facility failed to interview other residents residing in the facility to determine if other residents were potentially the victim of physical abuse. These failures potentially inhibited the facility's ability to determine if resident abuse occurred and posed the risk for further abuse. Findings: Review of the facility's P&P titled Abuse Investigation and Reporting revised 7/2017 showed all reports of resident abuse shall be thoroughly investigated by facility management. The individual conducting the investigation will, at a minimum: Interview any witnesses to the incident, interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. Interview other residents to whom the accused employee provides care or services. Upon the conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. Medical record review for Resident 170 was initiated on 8/18/25. Resident 170 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 170's H&P examination dated 8/20/25, showed Resident 170 was oriented and had capacity. On 8/20/25 at 0900 hours, an interview was conducted with Resident 170. Resident 170 was asked to describe the alleged incident she allegedly witnessed involving her roommate (Resident 73). Resident 170 stated Resident 73 had a behavior of striking out at the facility staff when Resident 73 was asked to do something she did not wish to do. Resident 170 stated early in the morning she witnessed Resident 73 sitting in her wheelchair in the hallway outside of their room. Resident 170 stated she saw Resident 73 hit a white female staff member, at which time the white female staff member then hit Resident 73 on the hand. Resident 170 stated she believed the white female staff member hit Resident 73 on the hand to teach Resident 73 not to strike out at the facility staff. Resident 170 stated she believed the white female was a staff member, however, was unsure and did know the white female staff member's name. Resident 170 stated the facility staff interviewed her regarding her allegation. Medical record review for Resident 73 was initiated on 8/18/25. Resident 73 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 73's Change of Condition notes dated 8/10/25 at 1600 hours, showed Residents 73's roommate (Resident 170) allegedly observed a female staff member hit Resident 73 at approximately 0530 hours. An interview with the alleged victim (Resident 73) was attempted, however, Resident 73 had impaired cognition and was not interviewable. On 8/20/25 at 1506 hours, an interview and concurrent facility document review was conducted with the DON. The DON stated Resident 170 alleged Resident 73 was hit on the arm by a white female staff member during care, on 8/10/25 at approximately 0530 hours. The DON stated the facility conducted an investigation specific to Resident 170's allegation and was unable to substantiate Resident 73 was abused. Review of the facility's investigation was conducted with the DON. The facility's investigation failed to show documentation an interview was conducted with the RN (RN 7) assigned to care for Resident 73, at the time of the allegation. The investigation also failed to show documentation an interview was conducted with a CNA (CNA 17), who was assigned to the station (Station B), in which Resident 73 resided at the time of the allegation. Further review of the facility's investigative findings failed to show interviews were conducted with other residents who resided in Station B, who may have potentially been victims of facility staff to resident abuse. The DON verified the findings. The DON verified there was no documentation contained within the facility's investigation to show RN 7 and CNA 17 were interviewed. The DON stated the facility failed to interview the other residents who resided in Station B, who may have potentially been victims of staff to resident abuse. The DON stated these interviews should have been conducted in accordance with the facility's practice and P&P for abuse. On 8/20/25 at 1520 hours, an interview and concurrent facility document review was conducted with the facility's Abuse Coordinator, the Administrator. The Administrator verified the findings and stated in accordance with the facility's P&P for abuse, the other residents who resided in Station B should have been interviewed during the course of the facility's investigation. The

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the PASRR Level 1 screening contained accurate information specific to mental illness for one of two final sampled residents (Resident 13) reviewed for PASRR. * Resident 13 had a diagnosis of schizophrenia (chronic mental illness that impairs thought, perception, and behavior, making it difficult to function in daily life) however, PASRR Level 1 screening showed Resident 13 had no diagnosis of a mental illness. This failure had the potential for Resident 13 not receiving a Level II Mental Health Evaluation, which posed the risk for Resident 13 not receiving recommendations for specialized services that supplement nursing facility care to address resident mental health needs. Findings: Medical record review for Resident 13 was initiated on 8/18/25. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's MAR showed a physician's order dated 4/15/25, for Zyprexa (antipsychotic medication) 5 mg orally to be administered at bedtime for schizophrenia. Review of Resident 13's PASRR Level I Screening results dated 7/31/25, showed Resident 13 had no diagnosis of a serious mental illness. On 8/25/25 at 0847 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator was asked to describe the purpose of a PASRR Level 1 Screening. The MDS Coordinator stated the PASRR Level 1 screening functioned to screen and evaluate residents for serious mental illness. Additionally, the results of the PASRR Level 1 screening may necessitate a Level II Mental Health Evaluation be conducted, to determine if a resident could benefit from specialized mental health services. The MDS Coordinator reviewed Resident 13's medical record and verified Resident 13's PASRR Level I Screening dated 7/31/25, showed Resident 13 had no diagnosis of a serious mental illness. The MDS Coordinator stated this information was incorrect as Resident 13 did have a diagnosis of schizophrenia. The MDS Coordinator stated she would complete a new PASRR Level 1 Screening to show Resident 13 did have a diagnosis of schizophrenia.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop and implement a plan of care to reflect the individual care needs for three of 33 final sampled residents (Residents 8, 158, and 174) and two nonsampled resident (Residents 52 and 166). * The facility failed to develop a comprehensive person-centered care plan addressing Resident 8's change of condition dated 8/12/25, regarding Resident 8's right posterior forearm with popped boils, and redness and tenderness on the surrounding site. * The facility failed to develop a comprehensive person-centered care plan to reflect the individualized care needs of Resident 52's abdominal fold moisture associated skin damage (MASD) and treatment. * The facility failed to ensure the interventions for Resident 158's plan of care to address the use of the Dexcom sensor (measures the glucose level at regular intervals) were implemented. * The facility failed to develop a plan of care to address the individualized care of Resident 166's behavior and presence of a safety hazard (scissors) at Resident 166's bedside. * The facility failed to develop a comprehensive person-centered care plan addressing Resident 174's pain and the use of the oxycodone (narcotic) medication for pain. These failures had the potential risk of not providing the appropriate, consistent, and individualized care to the residents. Findings: Review of the facility’s P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercise his or her rights, including the right to refuse treatment. 1. Review of the facility's P&P titled Blood Glucose monitoring devices (undated) showed to apply the sensor according to the manufacturer's instructions. The staff performing this procedure should record the following information in the resident's medical record: the date and time the sensor was applied. Review of the Dexcom G6 System User Guide revised 11/2022 under the section Choose Sensor Site showed do not use the same site for two sensors in a row. Precaution… change your insertion site with each sensor. Using the same site too often might not allow the skin to heal, causing scarring or skin irritation. Medical record review for Resident 158 was initiated on 8/18/25. Resident 158 was admitted to the facility on [DATE]. Review of Resident 158’s MDS assessment dated [DATE], showed Resident 158 was cognitively intact. Review of Resident 158s Order Summary Report dated 8/20/25, showed the following physician’s orders dated 8/14/24: - Resident 158 may use and self-administer the diabetic sensor (Dexcom 6 continuous glucose monitoring) every day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident 158 may use the diabetic sensor (Dexcom 6 continuous glucose monitoring) for blood glucose check. The licensed nurse to check and ask the resident the blood glucose result and document, before meals and at bedtime. Review of Resident 158’s plan of care showed the following care plan problems: - dated 8/14/24, addressing Resident 158’s risk for hypoglycemia/hyperglycemia related to Diabetes Mellitus. The interventions included the use of Resident 158’s personal insulin pump per the physician’s order, may use and self-administer the diabetic sensor every day, and to monitor and assure position changes. - dated 9/6/24, addressing Resident 158’s use of the diabetic Dexcom continuous glucose monitoring sensor. The interventions included monitoring for any complications to the device every shift. Further review of Resident 158’s medical record failed to show the documentation the licensed nurses were monitoring and assessing Resident 158’s diabetic sensor locations. On 8/18/25 at 0919 hours, during the initial tour of the facility, Resident 158 was observed lying in bed with a blood sugar monitoring device on his left arm. Resident 158 stated the sensor on his left arm transferred the blood sugar data to his telephone. On 8/21/25 at 1348 hours, an interview and concurrent medical record review for Resident 158 was conducted with LVN 4. LVN 4 stated Resident 158 had a special Dexcom blood sugar monitoring device. When asked, LVN 4 stated Resident 158’s Dexcom sensor was on his abdomen. LVN 4 stated she did not document the location of Resident 158’s Dexcom sensor. LVN 4 reviewed Resident 158’s medical record and stated there was no documentation to show the licensed nurses were documenting the location and monitoring the Dexcom sensor. On 8/21/25 at 1454 hours, a follow up interview was conducted with LVN 4. LVN4 stated she spoke with Resident 158 and the resident verified his Dexcom sensor was on his left arm. LVN 4 stated Resident 158 informed her the Dexcom sensor was recently changed about five days ago. On 8/25/25 at 1025 hours, an interview was conducted with the DON. The DON stated for a resident using the Dexcom sensor, there should be a physician’s order, a care plan, and the licensed nurse should check with the resident and document the blood sugar results in the resident's medical record. Additionally, the DON stated the licensed nurses should monitor the location of the sensor and whether the sensor site was being rotated. On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 8/18/25 at 0947 hours, during the initial tour of the facility, Resident 174 was observed in bed. Resident 174 stated she had pain in her back and knees and was administered the oxycodone pain medication as needed. Medical record review for Resident 174 was initiated on 8/18/25. Resident 174 was admitted to the facility on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 174’s Order Summary Report dated 8/21/25, showed the following physician’s orders dated 8/1/25: - to administer oxycodone 10 mg one tablet every four hours as needed for moderate pain (pain level between 4 to 6, on a pain scale with 0=no pain, and 10=severe pain), and - to administer oxycodone 15 mg one tablet every six hours as needed for severe pain (pain level from 8 to 10). Review of Resident 174’s MAR for 8/2025 showed Resident 174 was administered the oxycodone 10 mg and oxycodone 15 mg medications as needed for pain. Review of Resident 174’s plan of care failed to show a care plan problem to address Resident 174’s pain or the use of the oxycodone pain medication. On 8/20/25 at 1032 hours, an interview and concurrent medical record review for Resident 174 was conducted with RN 5. RN 5 stated Resident 174 complained of back pain and was administered the oxycodone 10 mg or 15 mg pain medication as needed. RN 5 reviewed Resident 174’s medical record and verified the above findings. RN 5 stated Resident 174 should have a care plan to address Resident 174’s pain and the use of the oxycodone narcotic pain medication. On 8/25/25 at 1025 hours, an interview was conducted with the DON. The DON stated a care plan should be initiated for any care issues that the residents had. On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Review of the facility’s P&P titled Charting and Documentation revised July 2017 showed all services provided to the resident, progress toward the care plan goal, or any changes in the resident’s medical, physical functional or psychosocial condition, shall be documented in the resident’s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident’s condition and response to care. Medical record review of Resident 52 was initiated on 8/24/25. Resident 52 was admitted to the facility on [DATE]. Review of Resident 52’s H&P examination date 4/27/25, showed Resident 52 had the capacity to make medical decisions. Review of Resident 52’s Order Summary Report dated 8/25/25, showed a physician’s order dated 4/25/25, to apply nystatin external powder (an antifungal medication used various fungal and yeast infections) to the resident's abdominal fold topically every day shift for MASD. Review of Resident 52’s Comprehensive Care Plans did not show a care plan problem addressing the MASD to Resident 52’s abdominal fold. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/24/25 at 0920 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified there was no care plan developed addressing the MASD on Resident 52’s abdominal fold. The IP further stated, “it should have been addressed. On 8/24/25 at 1113 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 52 had no care plan developed addressing the MASD on the resident's abdominal fold since the resident's admission to the facility. The ADON stated, “if there is an order there should be a care plan.” 4. Review of the facility's P&P titled Personal Property revised August 2022 showed if items that belong to a resident are in plain view, and these pose a risk for the residents' health and safety, the items may be confiscated by facility staff. The circumstances, description of the item and rationale for confiscating are documented in the resident's record. On 8/19/25 at 1018 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with LVN 2 and CNA 4 for Resident 166. Resident 166 was observed with a pair of scissors on top of the resident's overbed table. LVN 2 was asked if Resident 166 was allowed to have the pair of scissors at the bedside. LVN 2 stated no and that he would it remove it right away. CNA 4 was observed giving the scissors to LVN 2. CNA 4 was asked if Resident 166 could have the pair of scissors at the bedside. CNA 4 stated Resident 166 was not allowed to have the pair of scissors at the bedside and was unsure on how the resident got it. CNA 4 further stated Resident 166 was independent and walked around the facility. Medical record review was initiated on Resident 166 on 8/20/25. Resident 166 was admitted to the facility on [DATE]. Review of Resident 166’s MDS assessment dated [DATE], showed Resident 166 had a BIMS score of 10, indicating moderate cognitive impairment. Review of Resident 166’s plan of care did not show a care plan problem addressing the safety hazard related to the resident's use and storage of the pair or scissors at the bedside. On 8/20/25 at 1443 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator was informed and verified there was no care plan addressing the resident's use and storage of the pair of scissors at the bedside. The MDS Coordinator stated the licensed nurse who observed the pair of scissors needed to initiate the care plan for the resident. The MDS Coordinator further stated a daily communication dashboard was available for the IDT review for follow-up documentations, including the completion of care plans were done. On 8/22/25 at 1013 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was informed and verified there was no care plan developed addressing the resident's use and storage of the pair of scissors at the bedside. The ADON further stated the licensed nurse who observed the pair of scissors was responsible for initiating the care plan. On 8/24/25 at 1245 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Medical record review for Resident 8 was initiated on 8/18/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's MDS assessment dated [DATE], showed Resident 8’s BIMS score was 10, indicating moderate cognitive impairment. Review of Resident 8's H&P examination dated 5/21/25, showed Resident 8 could make needs known. Review of Resident 8's Change in Condition dated 8/12/25, showed Resident 8 was noted with two popped boils to right posterior forearm with redness and tenderness to surrounding site, and treatment was initiated. Review of Resident 8's plan of care failed to show a care plan problem was developed addressing Resident 8's change of condition dated 8/12/25. On 8/20/25 at 1230 hours, an interview and concurrent medical record review was conducted with the ADON for Resident 8. The ADON was asked if she could provide documentation to show the care plan problem addressing the resident's change in condition regarding the popped boils on the resident's posterior forearm. The ADON verified there was no care plan developed to address the resident's popped boils. On 8/22/25 at 1443 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care for two of 33 final sampled residents (Residents 8 and 42) were revised to reflect the residents' current care needs and interventions. * Resident 8's plan of care for dialysis site was not revised to address Resident 8's change of condition dated 8/11/25, to show the dialysis site was noted with green discharge. * Resident 42's care plan for respiratory problem was not revised to address the resident's shortness of breath condition and use of the oxygen. These failures posed the risk of not providing the residents with individualized and person-centered care. Findings: Review of the facility’s P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed assessment of the residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 1. Medical record review for Resident 8 was initiated on 8/18/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's MDS assessment dated [DATE], showed Resident 8’s BIMS score was 10, indicating moderate cognitive impairment. Review of Resident 8's H&P examination dated 5/21/25, showed Resident 8 could make their needs known. Review of Resident 8's Order Summary dated 8/21/25, showed a physician's order dated 2/8/25, to monitor the right upper arm dialysis site for tenderness, redness or bleeding every shift and to document findings outside of baseline and call primary physician. Review of Resident 8's Change in Condition documentation dated 8/11/25, showed Resident 8's right arm was swollen and the dialysis site was noted to be with green discharge. Review of Resident 8's Plan of Care dated 6/30/25, showed a care plan problem addressing Resident 8's renal insufficiency related to dialysis. The interventions included to monitor/document/report to the MD as necessary any signs and symptoms of infection to access site as redness, swelling, warmth or drainage. However, Resident 8's plan of care did not show it was revised to address Resident 8's change of condition on 8/11/25, when Resident 8's right arm was swollen and the dialysis site was noted with green discharge. On 8/20/25 at 1230 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was asked if she could provide documentation to show the revision of Resident 8's plan of care to address the resident's change of condition on 8/11/25 . The ADON verified the resident's plan of care was not revised. On 8/22/25 at 1443 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	2. On 8/18/25 at 1012 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 42. Resident 42 was observed in bed awake and stated she was doing fine but sometimes she needed the oxygen. Resident 42 was observed with a portable oxygen tank with a holder inside the room. Medical record review for Resident 42 was initiated on 8/16/24. Resident 42 was admitted to the facility on [DATE]. Review of Resident 42's H&P examination dated 7/22/25, showed Resident 42 had the capacity to understand and make decisions. Review of Resident 42's plan of care showed a care plan problem dated 8/1/25, addressing Resident 42's respiratory status of difficulty of breathing. The interventions included to provide necessary care for Resident 42's breathing problem. However, there was no documented evidence the administration of the oxygen was documented as an interventions for the respiratory problem of Resident 42. Review of Resident 42's Order Summary Report dated 8/19/25, showed the following physician's orders: - dated 8/12/25, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath, titrate to keep oxygen saturation above 92 %. - dated 8/12/25, to monitor the oxygen saturation every shift and to notify the physician if oxygen saturation is below 92 %. On 8/19/25 at 1357 hours, an interview and concurrent medical record for Resident 42 was conducted with RN 5. RN 5 was asked about Resident 42's use of the oxygen. RN 5 verified and acknowledged the resident had physician's order for the use of the oxygen as needed due to shortness of breath. RN 5 was asked about the resident's plan of care and RN 5 was able to show the care plan problem addressing the resident's respiratory status. However, when RN 5 was asked for the care plan intervention for the oxygen used for the resident's shortness of breath as needed, RN 5 verified the new physician's order for the oxygen and condition of the resident were not included in the care plan interventions. On 8/25/25 1305 hours, an interview and concurrent medical record review for Resident 42 was conducted with the DON. The DON was informed and verified the findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and medical record review, the facility failed to provide the necessary treatment and services for one of five final sampled residents (Resident 1) reviewed for unnecessary medications. * The facility failed to ensure Resident 1's orthostatic BP (blood pressure) was accurately monitored as ordered by the physician. This failure had the potential to negatively affect Resident 1's health and well-being. Findings: Medical record review for Resident 1 was initiated on 8/18/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report dated 8/22/25, showed the following physician's orders: - dated 8/8/25, to monitor for orthostatic BP lying and sitting every day shift, for lying blood pressure; and - dated 8/8/25, to monitor for orthostatic BP lying and sitting every day shift, for sitting blood pressure. Review of Resident 1's plan of care showed a care plan focus addressing Resident 1's altered cardiovascular status and risk for hypertension (high blood pressure) and hypotension (low blood pressure) dated 7/5/25. The interventions included to administer the antihypertensive medications as ordered and to monitor for side effects such as orthostatic hypotension and increased heart rate and effectiveness. Review of Resident 1's MAR for 8/2025 showed the following: - on 8/9/25, the BP readings were 115/67 mmHg for the sitting and lying positions;- on 8/13/25, the BP readings were 126/70 mmHg for the sitting and lying positions; - on 8/14/25, the BP readings were 131/64 mmHg for the sitting and lying positions; - on 8/16/25, the BP readings were 127/76 mmHg for the sitting and lying positions; - on 8/17/25, the BP readings were 127/85 mmHg for the sitting and lying positions; - on 8/19/25, the BP readings were 128/68 mmHg for the sitting and lying positions; - on 8/20/25, the BP readings were 132/76 mmHg for the sitting and lying positions; and- on 8/21/25, the BP readings were 137/76 mmHg for the sitting and lying positions. On 8/21/25 at 1317 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated Resident 1 was being monitored for orthostatic BP due to the antipsychotic drug side effects. LVN 2 stated he took the orthostatic BP by taking Resident 1's BP lying first, had the resident sit up, waited three minutes, then checked his BP again in a sitting position. LVN 2 stated the BP for the lying and sitting positions should be a little different. Upon review of Resident 1's orthostatic BP readings documented in the MAR for 8/2025, LVN 2 stated the matching BP readings were an error and documented the BP readings wrong. LVN 2 was unable to provide the documented evidence to show the accurate orthostatic BP readings were taken for the days that he was caring for Resident 1 (8/14, 8/17, 8/19, 8/20 and 8/21/25). On 8/25/25 at 1000 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated for the orthostatic BP monitoring, the BP readings could not be the same number for both lying and sitting positions every time the readings were taken.

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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 interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development or worsening of pressure injuries (localized area of skin damage and underlying tissues caused by prolonged pressure or shear forces) for two of three final sampled residents (Residents 7 and 37). * The facility failed to ensure Resident 7's low air loss (LAL) mattress setting was set for the resident's weight. * The facility failed to ensure Resident 37's LAL mattress unit was not on the statique mode and failed to ensure the LAL mattress setting was appropriate for Resident 37's weight. Additionally, the facility failed to ensure Resident 37's heel protectors were in place as per the resident's care plan. These failures placed the residents at risk of developing new pressure injuries and/or worsening of the existing ones.Findings: Review of the facility's P&P titled Pressure Ulcers/Skin Breakdown - Clinical Protocol dated 4/2018 showed the physician will order pertinent wound treatments, including pressure-reducing surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and the application of topical agents. Review of the facility’s P&P titled Support Surface Guidelines revised 2/2024 showed individuals at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed. Follow any air support mattress manufacture guidelines in conducting safety operations and use during care and or transfers. 1. Medical record review for Resident 7 was initiated on 8/19/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7’s Skin and Wound Evaluation dated 7/20/25, showed the resident had a Stage 3 pressure injury (full thickness skin loss that involves damage to the subcutaneous fat layer) on the sacrum, which was present on admission. The Stage 3 pressure injury had the following measurements: 0.8 cm (length) x 0.6 cm (width) and the depth was not applicable. The wound was composed of 10% epithelial tissue (forms the covering of all body surfaces) and 90% granulation tissue (a type of new, temporary tissue that forms in response to an injury or wound). Review of Resident 7’s plan of care showed a care plan problem dated 7/20/25, addressing the resident’s Stage 3 pressure ulcer on the sacrum. The interventions included providing a pressure-reducing mattress. Review of Resident 7's H&P examination dated 7/21/25, showed Resident 7 was non-weight bearing (restrictions to not place weight or pressure on a specific injured or surgically operated limb) on her left upper extremity due to a ligament tear. Review of Resident 7’s Skin and Wound Evaluation dated 8/4/25, showed the resident had a Stage 3 pressure injury on the sacrum, which was present on admission. The Stage 3 pressure injury had the following measurements: 3.6 cm (length) x 2 cm (width) and the depth remained not applicable. The wound was noted to have 80% slough (pale yellow dead tissue within a wound). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's Order Summary Report dated 8/19/25, showed a physician's order dated 8/4/25, for a LAL mattress for wound management. The order showed to keep the settings according to the manufacturer's recommendation or per the resident’s comfort and to monitor for functionality and placement every shift. However, further review Resident 7’s care plan for the resident’s Stage 3 pressure ulcer on the sacrum, the interventions failed to include the instructions to keep the LAL settings per the manufacturer’s recommendations or resident's comfort. In addition, the interventions failed to include the monitoring of the LAL mattress’ functionality and placement. On 8/18/25 at 0900 hours, Resident 7 was observed lying on her back on a LAL (low air loss mattress) mattress. The LAL mattress control panel was set to level 180. On 8/18/25 at 1235 hours, Resident 7 was observed sitting upright on the same LAL mattress, with the LAL mattress control panel still set to level 180. Review of Resident 7's Monthly Weight Report for August 2025 showed Resident 7 weighed 132 lbs on 8/4/25, and 128 lbs on 8/11/25. On 8/19/25 at 1055 hours, an observation and concurrent interview was conducted with LVN 8. Resident 7 was observed lying on her back on a LAL mattress. The LAL mattress control panel showed the comfort level setting was at level 190. LVN 8 stated according to the weight guidelines for the LAL mattress, the setting should have been at level 120, based on Resident 7’s weight. LVN 8 verified the LAL mattress was set 70 lbs higher than the appropriate setting for Resident 7. LVN 8 verified the findings. On 8/19/25 at 1530 hours, a follow-up interview and concurrent medical record review was conducted with LVN 8. LVN 8 was asked for the documentation to show the monitoring of the LAL mattress’ functionality or placement every shift, LVN 8 was unable to show the documentation. 2. On 8/18/25 at 0828 hours, during the initial tour of the facility, Resident 37 was observed lying on a LAL mattress. The LAL mattress unit was turned on and set on the eight light setting (out of ten 10 settings) for firmness, with the setting between 300 and 400 pounds. The sticker on the LAL mattress device showed ”250-300” and the “statique” setting was on. Additionally, Resident 37’s boot protectors were observed on the chair. Medical record review for Resident 37 was initiated on 8/18/25. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of paraplegia (a condition characterized by the loss or impairment of motor and sensory functions in both legs). Review of Resident 37’s plan of care showed a care plan problem dated 9/6/22, addressing Resident 37’s high risk for skin breakdown. The interventions included to apply the left and right heel protector and provide the LAL mattress for wound management. May keep the settings according to the manufacturer’s recommendation of per the resident’s comfort. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 37’s MDS assessment dated [DATE], showed Resident 37 was at risk for developing a pressure ulcer/injury. Further review of the MDS assessment showed Resident 37 required substantial/maximal assistance, where the helper does more than half the effort, for bed mobility to roll from left and right, and Resident 37 was dependent on the staff to move from the sit to lying position. Review of Resident 37’s Order Summary Report dated 8/20/25, showed a physician's order dated 8/30/23, for the LAL mattress for wound management. May keep the settings according to the manufacturer’s recommendation or per the resident’s comfort. Review of Resident 37’s Weights and Vitals Summary showed on 8/1/25, Resident 37 weighed 191 pounds. On 8/19/25 at 1016 and at 1311 hours, Resident 37 was observed in bed. The LAL mattress unit was observed on, set at the 8th light setting for firmness, and the “statique” light was observed on. Resident 37’s heel protector boots were observed on the linen hamper in Resident 37’s room. The staff was not observed in the room providing care to Resident 37. On 8/19/25 at 1317 hours, an interview and concurrent observation was conducted with CNA 2. CNA 2 stated for the residents on a special mattress, whenever CNA 2 entered the residents' room, he checked to see if the special mattress unit was on and the mattress was inflated. CNA 2 stated he did not touch the special mattress unit. CNA 2 stated Resident 37 could assist with turning and reposition while in bed and required two facility staff members for transfers. CNA 2 stated Resident 37 had a special mattress and the boot protectors which he applied for Resident 37 whenever the treatment nurse asked him. CNA 2 verified Resident 37’s heel protector boots were on the linen cart and stated he had not applied the boots for Resident 37 today. On 8/19/25 at 1340 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 stated the LAL mattress setting was set per the manufacturer's setting which was based off of the resident's weight or per the resident's comfort. LVN 5 stated if the LAL mattress setting was set per the resident’s comfort, there should be the documentation in the resident's medical record. LVN 5 stated every shift, the licensed nurses were responsible for checking the functionality of the LAL mattress unit and ensuring the LAL mattress setting was set appropriately for the resident. LVN 5 stated some residents had a sticker placed on the LAL unit to indicate the setting the LAL mattress should be set at. LVN 5 stated if there was a sticker, the licensed nurses should check the current LAL mattress setting and compare the numbers with the numbers on the sticker. Additionally, LVN 5 stated the licensed nurse should also check to ensure the numbers on the sticker accurately reflected the resident’s current weight. LVN 5 stated If the setting was set too firm there was a potential risk of affecting the resident's wound management or healing, or place the resident at risk for developing skin breakdown. When asked about the statique setting, LVN 5 stated the statique setting was used when providing wound treatments or incontinent care to the residents. LVN 5 stated in the statique setting, the air in the mattress would not be alternating. LVN 5 stated the LAL mattress setting should not be set at statique for a long period. LVN 5 stated Resident 37’s heel protector boots should be worn whenever the resident is in bed. LVN 5 verified the above findings and stated the LAL mattress setting should not be set at over 300 pounds and should not be in the statique mode. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/25 at 1022 hours, an observation and concurrent interview was conducted with LVN 5. Resident 37 was observed lying in bed and the LAL mattress unit was observed on and set at the sixth light setting, between 200 and 300 pounds. LVN 5 verified the above findings and stated the LAL mattress setting should be set around 190 lbs. LVN 5 stated she changed the LAL mattress setting yesterday and did not know who did changed the setting. On 8/25/25 at 1025 hours, an interview was conducted with the DON. The DON stated for the residents at risk for developing pressure ulcers, if there was a physician’s order for the use of a LAL mattress, the LAL mattress setting would be based on the manufacture's recommendation or adjusted according to the resident’s weight or comfort. The DON further stated the resident's weights were obtained at least monthly, and the LAL mattress setting should be changed accordingly. The DON stated the treatment nurse and the licensed nurses were expected to check the LAL mattress unit when entering the resident’s room, to ensure the settings were appropriate for the resident. On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for 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 interview, medical record review, and facility P&P review, the facility failed to ensure the treatment was provided to prevent the decline in the ROM functions for one of two final sampled resident (Resident 61) reviewed for ROM functions. * The facility failed to ensure the RNA services were provided as ordered by the physician for Resident 61. This failure had the potential for decline in the residents' ROM functions and mobility.Findings: Review of the facility's P&P titled Restorative Nursing Services (undated) showed the residents will receive restorative nursing care as needed to help promote optimal safety and independence. Review of the facility's P&P titled Restorative Nursing Services revised on 7/2017 showed documentation in the medical record will be objective, complete, and accurate. On 8/18/25 at 0959 hours, during the initial tour, Resident 61 was observed lying in bed. Resident 61 stated she received the ROM exercises three weeks ago. Medical record review for Resident 61 was initiated on 8/19/25. Resident 61 was admitted to the facility on [DATE]. Review of Resident 61's MDS assessment dated [DATE], showed Resident 61's BIMS score was 10, indicating moderate cognitive impairment. Review of Resident 61's H&P examination dated 12/16/24, showed Resident 61 had the capacity to understand and make decisions. On 8/19/25 at 1038 hours, an interview was conducted with RNA 1. RNA 1 was asked if Resident 61 was receiving RNA services. RN 1 stated Resident 61 started with the RNA services last week. RNA 1 stated Resident 61 was cooperative with the RNA services. On 8/20/25 at 0840 hours, a follow up observation and concurrent interview was conducted with Resident 61. Resident 61 was observed lying in bed with a blue splint on her left hand. Resident 61 was asked if she had been receiving RNA services and she stated she did not receive any RNA exercises last week. Review of Resident 61's Order Summary Report dated 8/20/25, showed the following physician's orders:- dated 7/24/25, for the RNA to provide PROM exercises for left upper extremity (LUE) and apply the hand splint to the resident's left hand for six to eight hours as tolerated every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday; and - dated 8/7/25, for the RNA to provide bilateral lower extremity (BLE) exercises using the Omnicycle bike (motorized rehabilitation system to help the resident exercise when they have limited strength, endurance or muscle control) as tolerated three times a week, every day shift, every Monday, Wednesday, and Friday. Review of Resident 61's medical record failed to show the RNA documentation for the following:- PROM on LUE and splint on 8/6-8/8/25, 8/11-8/15, and 8/18/25; and- Omnicycle bike on BLE three times a week on dates 8/8, 8/11, 8/13, and 8/18/25. On 8/21/25 at 0814 hours, an interview and concurrent medical record review was conducted with RNA 2. RNA 2 stated all the RNAs must document the RNA services provided in their assigned resident's medical record. RNA 2 stated if the RNA services were not documented, then it was not done. RNA 2 reviewed Resident 61's RNA orders and RNA tasks and verified the above findings. RNA 2 stated if not applicable was documented, then it meant the specific RNA service was not provided. On 8/21/25 at 0901 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 61's medical record and verified the above findings. The DON stated if not applicable was documented then it meant the specific RNA service was not provided. In addition, the DON stated if the RNA services were not documented, then it was not done. The DON stated the residents' RNA orders must be provided and documented accurately. Furthermore, the DON stated the negative outcome for the residents who failed to receive the ordered RNA services would include a decline in the residents' function. On 8/25/25 at 1054 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	056110	A. Building B. Wing	08/25/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 facility P&P review, the facility failed to ensure the environment remained free from accident hazards for one of four final sampled residents (Resident 42) and two nonsampled residents (Residents 26 and 166) reviewed for accidents. * The facility failed to post signage on Resident 42's room to indicate the oxygen was in use. * The facility failed to ensure the resident rooms contained secured closet/storage cabinets for 103 of 103 resident rooms. * A pair of long scissors was observed on Resident 166's overbed table. These failures posed the risk for injuries to the residents, staff, and visitors.Findings: 1. On 8/19/25 at 1010 hours, an observation was conducted of Resident Room E. Resident 26 resided in Room E. A closet/storage cabinet was observed adjacent to Resident 26’s wall and bed. The closet/storage cabinet was unsecured. On 8/19/25 at 1029 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified Resident 26’s room (Room E) contained an unsecured closet/storage cabinet. The Maintenance Director was asked how many resident rooms were within the facility. The Maintenance Director stated the facility consisted of 103 resident rooms. The Maintenance Director was then asked how many resident rooms contained unsecured closet/storage cabinets. The Maintenance Director stated all the 103 resident rooms contained unsecured closet/storage cabinets. The Maintenance Director stated the resident closet/storage cabinets were unsecured as the resident rooms were in the process of being refurbished. The Maintenance Director stated the facility ordered new resident closet/storage cabinets for all the resident rooms throughout the facility (103 rooms). The Maintenance Director stated all of the residents closet/storage cabinets would be secured, to prevent the possibility of tipping over during an earthquake, which could result in injuries to the residents. 2. Review of the facility’s P&P titled Personal Property revised August 2022 showed the residents are permitted to retain and use personal possessions as space permits, unless doing so would infringe on the right or health and safety of other residents. Medical record review was initiated on Resident 166 on 8/20/25. Resident 166 was admitted to the facility on [DATE]. Review of Resident 166’s MDS assessment dated [DATE], showed Resident 166 had a BIMS score of 10, indicating moderate cognitive impairment. Review of Resident 166’s plan of care showed a care plan problem dated 7/2/25, addressing Resident 166' risk for impaired cognitive function or impaired thought process related to the disease process and medications side effects. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/19/25 at 1018 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with LVN 2 and CNA 4 for Resident 166. Resident 166 was observed with a pair of scissors on top of the resident's overbed table. LVN 2 was asked if Resident 166 was allowed to have the pair of scissors at bedside. LVN 2 stated no and that he would it remove it right away. CNA 4 was observed giving the scissors to LVN 2. CNA 4 was asked if Resident 166 could have the pair of scissors at the bedside. CNA 4 stated Resident 166 was not allowed to have the pair of scissors at the bedside and was unsure on how the resident got it. CNA 4 further stated Resident 166 was independent and walked around the facility. On 8/19/25 at 1329 hours, an interview was conducted with RN 1. RN 1 was informed of the above findings and verified the pair of scissors was removed from Resident 166's bedside. RN 1 stated Resident 166 was not allowed to have the pair of scissors because I know how this resident is.” RN 1 further stated no residents in the facility were supposed to have scissors at the bedside. On 8/20/25 at 1013 hours, an interview and concurrent medical review was conducted with the ADON. The ADON was informed and verified the above findings. The ADON stated an immediate in service/training would be provided to the nursing staff regarding the safety hazard (scissors) observed at Resident 166's bedside. However, the ADON verified there was no in service/training provided to address the safety hazard observed at Resident 166's bedside on 8/19/25. On 8/24/25 at 1245 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and verified the above findings. 3. Review of facility's P&P titled Oxygen Administration dated 02/24 showed for portable oxygen cylinder should be strapped to the stand. When providing an oxygen therapy to the residents in the room who needed an oxygen, the licensed nurse should place a no smoking sign on the outside of the room entrance door and a Oxygen in Use sign should be placed over the resident's bed. On 8/18/25 at 1012 hours, Resident 42 was observed in bed. A portable oxygen cylinder tank with a holder was observed inside Resident 42's room. There was no posted signage observed for the use or presence of oxygen in Resident 42's room. Medical record review for Resident 42 was initiated on 8/19/25. Resident 42 was admitted to the facility on [DATE]. Review of Resident 42's Order Summary Report dated 8/19/25, showed a physician's order dated 8/12/25, to administer oxygen at two liters per minute via nasal cannula as needed for shortness of breath. On 8/18/25 at 1252 hours, an observation, interview and concurrent medical record review for Resident 42 was conducted with RN 5. RN 5 was summoned to Resident 42's room. RN 5 verified and acknowledged the presence of the portable oxygen tank with a holder in Resident 42's room. RN 5 was asked if there were any posted signage for the use of oxygen in the room doorway or inside the room. RN 5 verified and acknowledged there was no posted signage in the room for the use of oxygen. On 8/25/2025 at 1304 hours, an interview and concurrent medical record review for Resident 42 was conducted with the DON. The DON was informed and verified the findings.

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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, medical record review, and facility P&P review, the facility failed to ensure five of five final sampled residents (Residents 16, 47, 96, 108, and 158) and one nonsampled resident (Resident 115) reviewed for respiratory care were provided the appropriate respiratory care. * The facility failed to ensure Resident 16 was administered the continuous oxygen at two liters per minute via the nasal cannula as per the physician's order. * The facility failed to ensure Resident 47 was administered with oxygen as ordered by the physician. * The facility failed to ensure Resident 96's oxygen tubing was not touching the trash bin at the bedside. In addition, the facility failed to ensure the nebulizer mask and tubing were labeled, dated, and not touching the floor. * The facility failed to ensure the oxygen tubing and humidifier were labeled and dated for Resident 108. In addition, the facility failed to ensure the administration and effectiveness of oxygen per the physician's order were documented. The facility failed to ensure the oxygen delivery equipment was stored in sanitary manner. Resident 108's nasal cannula was observed lying on the portable oxygen tank, and not stored inside a clean bag when not in use. * The facility failed to ensure Resident 115's nasal cannula tubing was stored in a sanitary manner, not in a respiratory bag. * The facility failed to ensure Resident 158's CPAP (Continuous Positive Airway Pressure) mask was stored inside a plastic bag when not in use, and failed to clean the CPAP mask as per the physician's orders. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Review of the facility's P&P titled Oxygen Administration revised 2/2024 showed to verify that there is a physician's order for this procedure and to review the physician's orders or facility protocol for oxygen administration. Review of the facility's P&P titled CPAP/BiPAP Support revised 4/2025 under the section General Guidelines for Cleaning, showed masks, nasal pillows and tubing: to clean daily by placing in warm, soapy water and soaking/agitating for five minutes. Mild dish detergent is recommended Rinse with warm water and allow it to air dry between uses. 1. On 8/18/25 at 0919 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 158. The Resmed CPAP machine was observed on Resident 158’s bedside drawer. The CPAP mask was observed hanging on Resident 158’s grab bar and not stored inside a storage bag. When asked if the facility cleaned Resident 158’s CPAP mask, Resident 158 stated his CPAP mask was not cleaned daily and the licensed nurse may have cleaned the CPAP mask a while ago. Medical record review for Resident 158 was initiated on 8/18/25. Resident 158 was admitted to the facility on [DATE], with a diagnosis of obstructive sleep apnea (a sleep disorder characterized by repeated episodes of breathing cessation (apnea) or shallow breathing (hypopnea) during sleep). Review of Resident 158’s MDS assessment dated [DATE], showed Resident 158 was cognitively intact. Review of Resident 158's Order Summary Report dated 8/20/25, showed a physician’s order dated 9/8/23, to clean the nasal mask daily by placing the nasal mask in warm, soapy water and soaking/agitating for five minutes. To rinse with warm water and allow it to air dry between uses, every day shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 158’s MAR for 8/2025 showed the documentation by the licensed nurses (including LVN 1) for the cleaning of the nasal mask from 8/1/25 to 8/19/25 during the 0700 to 1500 hour shift. On 8/19/25 at 1027 hours, Resident 158 was observed in bed. Resident 158’s CPAP mask was observed hanging on Resident 158’s left-side grab bar. The CPAP mask was not observed stored inside a storage bag. On 8/20/25 at 0831 hours, an interview was conducted with CNA 16 for Resident 158. CNA 16 verified Resident 158’s use of the CPAP machine. CNA 16 stated he did not touch Resident 158’s CPAP mask. CNA 16 stated when he arrived on his shifts, the CPAP mask had already been removed and placed next to Resident 158. On 8/20/25 at 0917 hours, Resident 158 was observed in bed and the CPAP mask was observed hanging on Resident 158’s left-side grab bar. The CPAP mask was not observed stored inside a storage bag. Resident 158 stated he kept the CPAP mask nearby so he could wear the mask when he takes a nap during the day. On 8/20/25 at 1107 hours, an interview and concurrent medical record review for Resident 158 was conducted with LVN 1. LVN 1 stated for the residents with the CPAP machine, the CPAP mask was washed and cleaned with soap and water and the air dried. LVN 1 stated the CPAP mask should be stored in a plastic bag and kept at the resident’s bedside when not in use, for infection control purposes. LVN 1 verified Resident 158’s use of the CPAP machine. LVN 1 stated she had never cleaned Resident 158's CPAP mask. When asked about her documentation in the resident's MAR, LVN 1 stated she asked the CNA assigned for the shift, if they had cleaned Resident 158's CPAP mask, and if the CNA informed her the CPAP mask was cleaned, she would document in the MAR. LVN 1 reviewed Resident 158’s physician’s order and stated the licensed nurses should be responsible for the cleaning of Resident 158’s CPAP mask. On 8/20/25 at 1125 hours, an interview was conducted with CNA 2. CNA 2 stated he was assigned as Resident 158’s CNA on 8/19/25 (yesterday, during the 0700 to 1500 hours shift). CNA 2 stated he was not aware Resident 158 had a CPAP and denied ever cleaning Resident 158’s CPAP mask. On 8/20/25 at 1130 hours, a follow-up interview was conducted with LVN 1. LVN 1 stated she visited Resident 158’s room and spoke with Resident 158. LVN 1 verified the above findings. On 8/20/25 at 1202 hours, an interview was conducted with the DSD. The DSD stated the cleaning of the CPAP machine and CPAP masks was done by the licensed nurses and not by the CNAs. On 8/25/25 at 1025 hours, an interview was conducted with the DON. The DON stated the licensed nurses were responsible for the cleaning of the residents' CPAP masks. The DON stated the CPAP masks should be cleaned daily, after each use. The DON further stated after the CPAP mask was cleaned and air-dried, the CPAP mask should be placed inside of the storage bag for the next usage. The DON stated if the resident refused, the licensed nurse should explain the risk and benefits to the resident and if the resident still refused, then there should be a care plan to address the resident's refusal. The DON stated the licensed nurses should continue to offer to clean the CPAP mask. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. During the initial tour of the facility on 8/18/25 at 1044 hours, Resident 96 was observed receiving oxygen at two LPM via nasal canula from the oxygen machine. Resident 96's nasal canula tubing was touching the trash bin at the bedside. In addition, Resident 96's nebulizer machine was observed on top of the bedside drawer and the nebulizer tubing and mask were undated and placed inside the drawer with the nebulizer tubing touching the floor. Medical record review for Resident 96 was initiated on 8/19/25. Resident 96 was admitted to the facility on [DATE], with the diagnosis of chronic obstructive pulmonary disease (COPD, group of lung diseases that cause ongoing inflammation and damage to the airways and air sacs in the lungs). Review of Resident 96's H&P examination dated 8/5/25, showed Resident 96 had the capacity to understand and make decisions. Review of Resident 96's Order Summary Report dated 8/19/25, showed the following physician's orders: - dated 8/18/25, to administer oxygen at three LPM via nasal cannula continuously every shift. - dated 8/4/25, to administer albuterol (medication used to help relax the airways and improve breathing) sulfate inhalation solution 0.083 % inhalation orally via nebulizer machine one time a day for COPD. On 8/18/25 at 1244 hours, an observation and concurrent interview was conducted with RN 5 at Resident 96's bedside. RN 5 was asked about the resident's nebulizer machine tubing and mask. RN 5 verified Resident 96 was receiving oxygen therapy and the nebulizer medication. RN 5 was asked if the nebulizer tubing and mask were labeled, RN 5 verified there was no label on the nebulizer mask and tubing in place. RN 5 verified and acknowledged the oxygen tubing was touching the trash bin at the bedside. On 8/25/25 at 1304 hours, an interview and concurrent medical record review for Resident 96 was conducted with the DON. The DON was informed and verified the findings. 3. On 8/18/25 at 1138 hours, during the initial tour of the facility, Resident 47 was in bed receiving 3.5 LPM of oxygen via nasal cannula. Medical record review for Resident 47 was initiated on 8/18/25. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47’s Order Summary Report dated 8/20/25, showed a physician’s order dated 7/25/25, to administer oxygen at two to three LPM via nasal cannula continuously every shift for congestive heart failure (CHF, when the heart can't pump blood efficiently, leading to a buildup of fluid in the lungs and body). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/25 at 1151 hours, an interview and concurrent medical record review for Resident 47 was conducted with LVN 1. LVN 1 verified Resident 47 was receiving 3.5 LPM of oxygen. LVN 1 reviewed Resident 47’s physician's orders and verified the physician’s orders showed the oxygen was to be administered at two to three LPM via nasal cannula. LVN 1 verified Resident 47 was receiving the wrong rate of oxygen. On 8/22/25 at 1354 hours, an interview and concurrent medical record review for Resident 47 was conducted with the DON. The DON verified Resident 47’s oxygen order was for two to three LPM continuously via nasal cannula and a setting at 3.5 LPM would be incorrect. 4. Review of the facility's P&P titled Oxygen Administration revised on 2/2024, showed the following under the Documentation section: - The date and time the procedure was performed; - The name and title of the individual who performed the procedure; - The rate of oxygen flow, route, and rationale; - The frequency and duration of the treatment; - The reason for prn administration; - All assessment data obtained before, during, and after the procedure; and - How the resident tolerated the procedure. a. On 8/18/25 at 1044 hours, during the initial tour, Resident 108 was observed lying in bed awake and receiving oxygen two LPM via nasal cannula with an empty humidifier. Resident 108’s nasal cannula tubing and humidifier were observed without a label and date. On 8/18/25 at 1054 hours, an observation and concurrent interview was conducted with the ADON. The ADON verified Resident 108 was receiving an oxygen at two LPM via nasal cannula with an empty humidifier. Resident 108’s nasal cannula tubing and humidifier were observed without a label and date. The ADON verified the above findings. In addition, The ADON stated the oxygen tubing was scheduled to be changed every Sunday during the night shift. Medical record review for Resident 108 was initiated on 8/19/25. Resident 108 was admitted to the facility on [DATE]. Review of Resident 108's H&P examination dated 6/18/25, showed Resident 108 had no capacity to make decisions. Review of Resident 108’s MDS assessment dated [DATE], showed Resident 108’s BIMS score was 7, indicating severe cognitive impairment. Review of Resident 108's Order Summary Report dated 8/20/25, showed the following physician’s orders: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 6/16/25, to change the oxygen nasal cannula every week on Sunday during the night shift and as needed with a name and label date; and - dated 6/19/25, to administer oxygen at one to two LPM via nasal cannula as needed for shortness of breath and to maintain oxygen saturation at 92% and above. b. Review of Resident 108’s MAR failed to show documented evidence of the oxygen administration as ordered on 8/18/25, and the effectiveness for the oxygen therapy. Review of Resident 108’s progress notes dated 8/18-8/19/25, failed to show documented evidence of Resident 108’s use of oxygen as needed, its indication, and effectiveness. On 8/19/25 at 1309 hours, an interview and concurrent medical record review were conducted with RN 6. RN 6 reviewed Resident 108's MAR dated 8/2025 and progress notes dated 8/18-8/19/25, and verified there was no documentation to show the PRN oxygen administration and its effectiveness on 8/18/25. On 8/19/25 at 1455 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON reviewed Resident 108’s MAR and verified there was no documentation to show the PRN oxygen administration and its effectiveness on 8/18/25. The ADON stated the licensed nurses must document the PRN administration of oxygen and its effectiveness. Furthermore, the ADON stated the oxygen tubing and humidifier must be labeled and dated. On 8/25/25 at 1054 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. c. On 8/18/25 at 1117 hours, an observation and concurrent interview was conducted with Resident 108 and LVN 4. Resident 108 was observed lying in bed. A portable oxygen tank was observed adjacent to Resident 108’s bed. Resident 108 stated she used the portable oxygen tank when she utilized her wheelchair. A nasal cannula was observed attached to the oxygen tank. The nasal cannula was observed hanging from the oxygen tank and touching the side of the oxygen tank. LVN 4 verified the findings and stated Resident 108’s nasal cannula should have been stored in a clean plastic bag when not in use, to promote infection control. LVN 4 stated she would discard the nasal cannula. 5. On 8/18/25 at 1019 and 1128 hours, an observation was conducted in Resident 115’s room. Resident 115’s oxygen nasal cannula was observed hanging from the top of Resident 115’s oxygen concentrator. The tubing was labelled, however, was open to air and not stored in a respiratory bag. On 8/18/25 at 1135 hours, a observation and interview was conducted with LVN 6 in Resident 155’s room. LVN 6 stated Resident 115 received oxygen depending on her oxygen saturation level and had a PRN order for oxygen if her oxygen saturation was less than 92%. Resident 115’s oxygen set-up was observed, with the nasal cannula hanging from the top of Resident 115’s oxygen concentrator. LVN 6 stated administered oxygen to Resident 115 earlier that morning. LVN 6 acknowledged the findings. LVN 6 stated the nasal cannula should be stored in a storage bag to prevent infection control problems. LVN 6 stated she could not use the nasal cannula again and proceeded to throw the oxygen set-up away. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 115 was initiated on 8/18/25. Resident 115 was admitted to the facility on [DATE]. Review of Resident 115’s Order Summary Report dated 8/20/25, showed a physician’s order dated 3/24/25, to administer oxygen two to five LPM via nasal cannula every eight hours as needed for shortness of breath or oxygen saturation less than 92%. On 8/25/25 at 1000 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings. The DON stated the nasal cannula should be stored in a storage bag when not in use. 6. On 8/18/25 at 0856 hours, during the initial tour of the facility, an observation was conducted with Resident 16. Resident 16 was observed lying on her bed with the head of bed slightly elevated. Resident 16 was observed receiving oxygen at 3.5 LPM via nasal cannula. Medical record review for Resident 16 was initiated on 8/18/25. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 6/4/25, showed Resident 16 had no capacity to make medical decisions. Review of Resident 16's Order Summary dated 8/21/25, showed a physician's order dated 6/2/2025, to administer oxygen at two LPM via nasal cannula continuously. On 8/18/25 at 1142 hours, an observation, interview, and concurrent medical record review for Resident 16 was conducted with the MDS Assistant. The MDS Assistant verified Resident 16's oxygen rate was at 3.5 LPM. The MDS Assistant reviewed Resident 16's physician's order for the oxygen and verified the oxygen rate should be at two LPM continuously as ordered by the physician. The MDS Assistant stated she would adjust the oxygen rate immediately as per the physician's order. On 8/18/25 at 1221 hours, a follow-up an observation and concurrent interview was conducted with the MDS Assistant. Resident 16 was observed lying on the bed and receiving oxygen rate of two LPM via nasal cannula. The MDS Assistant was asked to assess Resident 16's oxygen saturation and stated the resident's oxygen saturation was at 100%. On 8/22/25 at 1443 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laguna Hills Health and Rehabilitation Center	24452 Health Center Drive Laguna Hills, CA 92653

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care was provided for two of two final sampled residents (Residents 8 and 58). * The facility failed to ensure Resident 8's physician's order for 1000 ml fluid restriction was followed and carried out accordingly. * The facility failed to ensure Resident 58's physician's order for 1500 ml fluid restriction was followed and carried out accordingly. In addition, the facility failed to monitor the resident's fluid intake accurately. These failures had the potential for the residents not being provided with the appropriate care and treatment, and the possibility of medical complications related to dialysis. Findings: Review of the facility's P&P titled Encouraging and Restricting Fluids revised on 10/2010 showed the purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids. Under the General guidelines section included the following: - Follow specific instructions concerning fluid intake or restrictions. - Be accurate when recording fluid intake. - When a resident has been placed on restricted fluids, remove the water pitcher and cup from the room. - Be sure an intake and output record is maintained in the resident's room. Under the Restricting fluids section showed to record the amount of fluid consumed on the intake side of the intake and output record. Record fluid intake in ml. Additionally, under the Documentation section showed the amount (in ml) of fluids consumed by the resident during the shift and the type of liquid consumed (i.e., tea, milk, coffee, soup, etc.). 1. Medical record review for Resident 8 was initiated on 8/18/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's H&P examination dated 5/21/25, showed Resident 8 could make their needs known. Review of Resident 8's MAR for July 2025 showed a physician's order dated 2/8/25, for fluid restriction of 1000 ml per day as follows: * Nursing to provide 160 ml of fluids: - 80 ml for the 7-3 shift; -80 ml for 3-11 shift; and (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 0 ml for 11-7 shift, for a total of 160 ml. * Dietary to provide 840 ml of fluids: - 360 ml for breakfast - 240 ml for lunch - 240 ml for dinner, for a total of 840 ml. Review of Resident 8's MAR for July 2025 showed the licensed nurses' documentation showed checked marks every shift to monitor for Resident 8's fluid intake, however the MAR did not indicate the specific amount in ml for Resident 8's fluid consumption. Review of Resident 8's progress notes did not show any documentation of the specific amount of fluid intake the resident consumed for each shift and the total amount of fluid intake per day for July 2025. On 8/20/25 at 1150 hours, an observation and concurrent interview was conducted with CNA 10 for Resident 8. The resident's bedside table was observed with one opened can of carbonated drink. CNA 10 was asked if she was aware Resident 8 was on a fluid restriction. CNA 10 stated she was not aware and the outgoing CNA did not endorse to her about the resident's fluid restriction. CNA 10 stated she was not informed by the charge nurses about the resident's fluid restriction. On 8/20/25 at 1252 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON was asked to provide documentation from the licensed nurses to show the amount of fluid the resident consumed per day for July 2025. The ADON verified she could not find any documentation to show the resident's fluid intake per day. The ADON further verified the licensed nurses should have documented the amount of fluid the resident consumed in milliliters instead of a check mark in Resident 8’s MAR. Additionally, the ADON verified the CNAs and charge nurses should have communicated with each other when the residents were on fluid restriction. The ADON was informed and acknowledged there should not be any unmonitored fluids on the resident's bedside table when the resident had fluid restrictions. On 8/22/25 at 1443 hours, an interview was conducted with the DON. The DON verified the above findings. 2. On 8/20/25 at 0839 hours, an observation and concurrent interview was conducted with Resident 58. Resident 58 was observed in bed awake and stated she went to dialysis yesterday and it was tiring. Resident 58 was observed with a dry dressing bandage to Resident 58's left forearm dialysis access site. Resident 58 was observed with a glass of water with a straw on top of the over the bed table and a full water pitcher. There were also two cans of soda on top of the bedside drawer and two bottles of flavored drink. Medical record review for Resident 58 was initiated on 8/19/25. Resident 58 was admitted to the facility on [DATE], with end stage renal disease (condition when the kidneys can no longer adequately filter waste and excess fluids from the blood) and required hemodialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 58's H&P examination dated 6/3/25, showed Resident 58 had the capacity to understand and make decisions. Review of Resident 58's MAR for August 2025 showed a physician's order dated 8/19/25, for fluid restriction of 1500 ml per day as follows: * Nursing to provide 660 ml of fluid: - 220 ml for the 11-7 shift; - 220 ml for the 7-3 shift; and - 220 ml for the 3-11 shift. * Dietary to provide 840 ml of fluid: - 360 ml at breakfast; - 240 ml at lunch; and - 240 ml at dinner. Review of Resident 58's Fluid Intake Task for the past 30 days showed the documented the daily total fluid intake (only from the meal trays during meals) from the CNAs ranged from [PHONE NUMBER] ml, which exceeded the prescribed dietary fluid intake of 840 ml of fluid. For example:- On 7/23/25, Resident 58 had a total of 1440 ml fluid intake. - On 7/31/25, Resident 58 had a total of 1440 ml fluid intake.- On 8/4/25, Resident 58 had a total of 1440 ml fluid intake. Review of Resident 58's MAR for August 2025 showed the licensed nurses' documentation had checked marks every shift to monitor for Resident 58's fluid intake, however, the MAR did not indicate the specific amount of Resident 58's fluid consumption. On 8/20/25 at 1112 hours, an observation and concurrent interview was conducted with CNA 12 at Resident 58's bedside. CNA 12 stated she aware Resident 58 have a limit on for the resident's fluid intake but did not know what the resident's fluid intake limit was. CNA 12 verified Resident 58 had a water pitcher, bottle of flavored drinks and soda cans at the resident's bedside. CNA 12 stated the charge nurse informed her about the resident's fluid intake limit. CNA 12 stated she measured the resident's fluid intake after the resident ate her meals and record the amount in the computer. On 8/20/25 at 1154 hours, an interview and concurrent medical record review for Resident 58 was conducted with RN 5. RN 5 was asked about Resident 58's fluid restriction. RN 5 verified and acknowledged Resident 58 had an physician's order for 1500 ml per day fluid restriction. RN 5 was asked on how the facility made sure the facility staff followed the physician's order for the fluid restriction. RN 5 stated she instructed the CNAs to measure and record the fluid intake for the resident. RN 5 was asked to review the recorded amount of fluid intake of the resident for the past 30 days. RN 5 verified the recorded amount of fluid were not accurate because the CNAs only recorded the dietary fluids per meal and the allocated fluids for the nursing staff were not documented. RN 5 also verified the fluid amount recorded were not consistent. RN 5 was asked about the resident's fluids at the bedside. RN 5 verified the presence of the water pitcher, soda cans, and flavored liquids at the resident's bedside. RN 5 stated Resident 58 should not have more than the fluids ordered at the bedside. RN 5 instructed the resident regarding the fluid intake limit she could drink. On 8/25/2025 at 1304 hours, an interview and concurrent medical record review for Resident 58 was conducted with the DON. The DON was informed and verified the findings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of four final sampled residents (Residents 10 and 130) reviewed for grab bar use remained free from accident hazards associated with the use of elevated grab bars. *The facility failed to ensure the less restrictive interventions were used prior to the installation of the grab bars for Residents 10 and 130. This failure had the potential to put the residents at risk for entrapment and serious injuries.Findings: Review of the facility's P&P titled Bed Safety and Bed Rails revised on 8/2022, showed the following: - For the purpose of this policy “bed rails” include side rails, safety rails, and grab or assist bars; - The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent; and - Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include roll guards, foam bumpers, lowering the bed and/or use of concave mattresses to reduce rolling off the bed. 1. During the initial tour observation on 8/18/25 at 1014 hours, Resident 130 was lying in bed awake, alert, and verbally responsive. Resident 130’s bed had elevated bilateral grab bars. Resident 130 stated he used the grab bars to turn and reposition in bed. On 8/18/25 at 1032 hours, an observation and concurrent interview was conducted with CNA 6 and LVN 4. Resident 130’s bed had elevated bilateral grab bars. CNA 6 and LVN 4 verified the above findings. CNA 6 stated Resident 130 used the grab bars to turn in bed. Medical record review for Resident 130 was initiated on 8/20/25. Resident 130 was admitted to the facility on [DATE]. Review of Resident 130's Order Summary Report showed a physician’s order dated 4/21/24, for bilateral grab bars for mobility, positioning, and transfer. Review of Resident 130's H&P examination dated 4/17/25, showed Resident 130 had the capacity to understand and make decisions. Review of Resident 130’s MDS assessment dated [DATE], showed the resident’s Brief Interview for Mental Status (BIMS) score was 10, indicating moderate cognitive impairment. In addition, Resident 130’s mobility assessment under Section GG dated 6/5/25, showed Resident 130 required moderate to dependent assistance from staff. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 130’s Side Rail Utilization assessment dated [DATE], failed to show a less restrictive alternative was used and Resident 130’s description of response to less restrictive alternatives was left blank. On 8/20/25 at 1100 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 130’s Side Rail Utilization assessment failed to show a less restrictive alternative was used and Resident 130’s description of response to less restrictive alternatives was left blank. The ADON stated since Resident 130 was alert, she did not attempt to use less restrictive measures and Resident 130 requested the grab bars. In addition, the ADON stated the less restrictive alternatives must be offered and attempted on initial and quarterly assessments prior to applying the grab bars. On 8/21/25 at 0950 hours, an interview was conducted with the DON. The DON stated the licensed nurses must assess the residents for appropriateness and benefits of the grab bar use, offer and use less restrictive alternatives, complete the Side Rail Utilization assessment, obtain physician's order and responsible party’s consent, check for bed entrapment, and formulate a care plan. Furthermore, the DON stated negative outcome for inappropriate use of grab bars would be entrapment and considered a restraint. On 8/25/25 at 1054 hours, an interview was conducted wit the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 10 was initiated on 8/19/25. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10’s Order Summary Report showed a physician’s order dated 7/31/25, for the use of bilateral grab bars for bed mobility, transfers, and repositioning. Review of Resident 10’s Side Rail Utilization assessment dated [DATE], showed the section on side rail usage for “less restrictive alternatives used” was left blank. The section describing the resident’s response to less restrictive alternatives to side rails was also left blank. On 8/18/25 at 0815 hours, Resident 10 was observed lying in bed with the bilateral grab bars in place. On 8/18/25 at 1230 hours, Resident 10 was observed sitting upright with bilateral grab bars. On 8/19/25 at 1045 hours, an interview and concurrent medical record review was conducted with LVN 7. When asked whether any least restrictive measures were offered to the resident prior to the use of the grab bars, LVN 7 stated that the resident requested the grab bars, and no other alternatives were offered. LVN 7 further stated other less restrictive alternatives should have been offered prior to implementing the use of grab bars. LVN 7 verified the findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services for four of 33 final sampled residents (Residents 8, 37, 58, and 174) to ensure the accurate administration of the medications. * The facility failed to ensure the accurate documentation of the controlled medications for Resident 174. This failure posed the risk of diversion of controlled medications and medication administration errors. * The facility failed to ensure Resident 8, 37, and 58's insulin injection sites were rotated. These failures had the potential to negatively affect the residents' health conditions and posed the risk for possible complications.Findings: Review of the facility’s P&P titled Controlled Substances revised 11/2022 showed the controlled substance inventory is monitored and reconciled to identify loss or potential diversion manner that minimized the time between loss/diversion and detection/follow-up. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records c. Declining inventory records; and d. Destruction, waste, and return to pharmacy records. The nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the Director of Nursing Services. Review of the facility’s P&P Administering Medications revised 4/2023 showed the individual administering the medication initials the resident’s MAR on the appropriate line or eMAR after giving each medication and before administering the next ones. 1. Medical record review for Resident 174 was initiated on 8/18/25. Resident 174 was admitted to the facility on [DATE]. Review of Resident 174’s Order Summary Report dated 8/21/25, showed the following physician’s orders dated 8/1/25: - to administer oxycodone (narcotic pain medication) 10 mg one tablet every four hours as needed for moderate pain (pain level between 4 to 6, on a pain scale with 0=no pain, and 10=severe pain); and - to administer oxycodone 15 mg one tablet every six hours as needed for severe pain (pain level from 8 to 10). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 174’s Antibiotic or Controlled Drug Record for the oxycodone 10 mg showed the medication was removed on 8/15/25 at 2235 hours. However, review of Resident 174’s MAR for 8/2025 failed to show the documented evidence the oxycodone 10 mg medication was administered on 8/15/25 at 2235 hours. Review of Resident 174’s Antibiotic or Controlled Drug Record for the oxycodone 15 mg showed the medication was removed on the following dates and times: - on 8/9/25 at 0000 hours; and - on 8/16/25 at 1758 hours. However, review of Resident 174’s MAR for 8/2025 failed to show the documented evidence the oxycodone 15 mg medication was administered for the above dates and times the medication was documented removed. On 8/21/25 at 1259 hours, an interview and concurrent medical record review for Resident 174 was conducted with the DON. The DON stated for the administration of the narcotic medications, the licensed nurses should document on the controlled drug record, the date, time, and licensed nurse’s initials upon removal of the narcotic medication. The DON stated after the licensed nurse completed the administration of the narcotic medication to the resident, the licensed nurse should document in the resident’s MAR. The DON reviewed Resident 174’s medical records and verified the above findings. On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility’s P&P titled Subcutaneous Injections revised 3/2011 showed to select the appropriate injection sites and to assists the resident to a comfortable position and ask him/her to relax the arm, leg, or abdomen, depending on the site chosen for the injections. According to the DailyMed- National Library of Medicine, the administration instructions for the approved routes of administration for the Humalog (insulin medication) insulin injections, showed to rotate the injection site within the same region from one injection to the next to reduce the risk of lipodystrophy (a complete or partial loss of and/or abnormal distribution of adipose (fat) tissue in certain areas of your body) and localized cutaneous amyloidosis (a rare condition where abnormal proteins called amyloid proteins accumulate in various organs and tissues, leading to damage and dysfunction). Medical Record Review for Resident 37 was initiated on 8/18/25. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37’s Order Summary Report dated 8/20/25, showed the following physician’s orders : (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 12/17/23, to administer Humalog Kwik Pen 100 unit/ml subcutaneously before meals and at bedtime as per the sliding scale: if the blood sugar was: 0 to 150 mg/dL = 0 units; 151 to 200 mg/dL = 2 units; 201 to 250 mg/dL = 4 units; 251 to 300 mg/dL = 6 units; 301 to 350 mg/dL = 8 units; 351 to 400 mg/dL = 10 units. If the blood sugar level was greater than 401 mg/dL, administer 10 units and inform the physician. Review of Resident 37’s MAR for 8/2025 showed the following dates and times when Resident 37 was administered the insulin injections on the same location/injection sites: - on 8/1/25 at 2013 and 2237 hours, the licensed nurse documented the insulin administration sites in the left lower quadrant of the abdomen; - on 8/2/25 at 1611 and 2128 hours, 8/4/25 at 1630 and 2136 hours, 8/8/25 at 1826 and 2127 hours, and 8/15/25 at 1657 and 2141 hours, the licensed nurse documented the insulin administration sites in the right under arm, axilla; - on 8/16/25 at 0611 and 1123 hours, the licensed nurses documented the insulin administration sites in the right arm; and - on 08/16/25 1730 and 2142 hours, the licensed nurse documented the insulin administration sites in the left arm. On 8/21/25 at 1326 hours, an interview and concurrent medical record review for Resident 37 was conducted with LVN 4. LVN 4 stated for the administration of the insulin injections, the licensed nurses should check the resident’s MAR to determine the last administered injection site. LVN 4 stated the residents were asked where they wanted the insulin injection to be administered, however if the resident chose the same site as the most recent previous injection, the licensed nurse should explain the risk and benefits of rotating the injection sites and suggest another site. LVN 4 stated if the resident refused to rotate the injection site, the licensed nurse would document in the progress notes. LVN 4 reviewed Resident 37’s medical record and verified the above findings. LVN 4 stated there were no progress notes to show the documentation Resident 37 refused to rotate his insulin injection sites. On 8/25/25 at 1025 hours, an interview was conducted with the DON . The DON stated for the administration of insulin, the licensed nurses were expected to review the resident’s medical records to determine the last administration site. The DON stated the insulin injection sites should be rotated to prevent atrophy or complications related to continued use of that site. On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 58 was initiated on 8/19/25. Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's Order Summary Report dated 8/19/25, showed a physician's order dated 6/1/25, to administer Lispro (insulin medication) Insulin solution as per the sliding scale subcutaneously before meals and at bedtime. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 58’s Location of Administration Report for July 2025 for Resident 58’s Lispro insulin injection showed the injection sites were not rotated on the following dates and times: - on 7/1/25 at 1713 hours, and 7/3/25 at 1149 hours, the insulin medication was administered subcutaneously to the left upper quadrant of the abdomen. -on 7/21/25 at 2047 hours, 7/22/25 at 1803 hours, and 7/22/25 at 2023 hours, the insulin medication was administered subcutaneously to the right under arm (axilla). On 8/20/2025 at 1154 hours, an interview and concurrent medical record review for Resident 58 was conducted with RN 5. RN 5 was asked about the administration of the insulin to Resident 58. RN 5 stated Resident 58 was on insulin medication as ordered by the physician. RN 5 reviewed the location of administration for the insulin on Resident 58's in MAR. RN 5 verified and acknowledged the injection site for the insulin were not rotated for Resident 58 on the above dates and times. RN 5 stated the injection sites should be rotated to prevent complication on the injection sites. On 8/25/2025 at 1304 hours, an interview and concurrent medical record review for Resident 58 was conducted with the DON. The DON was informed and verified the findings. 4. Medical record review for Resident 8 was initiated on 8/18/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's H&P examination dated 5/21/25, showed Resident 8 could their make needs known. Review of Resident 8's Order Summary dated 8/21/25, showed a physician's order dated 5/9/25, to administer 12 units of Lantus (insulin medication) insulin solution subcutaneously at bedtime for diabetes mellitus and to rotate the site of injection. Review of Resident 8’s Location of Administration Report for July and August 2025 for Resident 8’s Lantus insulin injection showed the injection sites were not rotated on the following dates and times: - on 7/4/25 at 2242 hours, 7/5/25 at 2248 hours, 7/25/25 at 2028 hours, 7/26/25 at 2139 hours, 8/1/25 at 2200 hours, 8/2/25 at 2031 hours, 8/9/25 at 2042 hours, 8/10/25 at 2043 hours, 8/14/25 at 2136 hours, 8/15/25 at 2229 hours, and 8/16/25 at 2139 hours, the insulin medication was administered subcutaneously to the left lower quadrant of the abdomen. Review of Resident 8's progress notes did not show documentation if the non rotated location sites of the Lantus injection were preferred by Resident 8 and no documentation to show the licensed nurses explained the risks and benefits to Resident 8 and the resident's legal representative for the non rotated injection sites for the Lantus medication. On 8/20/25 at 1230 hours, an interview and concurrent medical record review was conducted with the ADON for Resident 8. The ADON reviewed the location of the Lantus injection sites in the MAR for July and August 2025. The ADON verified the above findings and stated the Lantus injection sites should have been rotated. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/25 at 1443 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure one of five residents (Resident 1) reviewed for unnecessary medications were properly monitored for the signs and symptoms of bleeding related to the use of anticoagulant (prevents blood clots) medication. * The facility failed to ensure Resident 1 was monitored for the signs and symptoms of bleeding for the use of heparin (anticoagulant medication) medication. This failure had the potential for the resident to develop significant side effect of bleeding and negatively affect the resident's health condition and well-being. Findings: According to DailyMed, an online reference for clinical drug information, the most common adverse reactions to heparin are hemorrhage (bleeding), thrombocytopenia (a serious antibody-mediated reaction), heparin-induced thrombocytopenia and heparin-inducted thrombocytopenia and thrombosis (blood clotting), injection site irritation, and general hypersensitivity reactions. Medical record review for Resident 1 was initiated on 8/18/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report dated 8/22/25, showed the following physician's orders:- dated 8/8/25, to administer heparin sodium injection solution 5000 unit/ml, inject 5000 units subcutaneously every 12 hours for DVT; and- dated 8/18/25, to monitor for any signs of bleeding every shift for the use of heparin medication. Review of Resident 1's plan of care showed a care plan focus for Resident 1's altered cardiovascular status dated 7/5/25. The interventions included to administer the anticoagulant medication per the physician's order and to monitor for signs and symptoms of bruising, bleeding, and to notify the physician if noted. Further review of Resident 1's medical record failed to show documented evidence Resident 1 was being monitored for bleeding from 8/8/25 through 8/17/25. On 8/21/25 at 1317 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated Resident 1 was receiving the heparin medication for DVT prophylaxis. LVN 2 stated for the residents on heparin injections, the licensed nurses would monitor the resident for signs and symptoms of bleeding and document the monitoring on the electronic MAR. LVN 2 stated Resident 1 should have had a physician's order for the monitoring of the signs and symptoms of bleeding when the medication was started. LVN 2 verified there was no documented evidence Resident 1 was being monitored for bleeding from 8/8 through 8/17/25. On 8/25/25 at 1000 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the licensed nurses would monitor for bleeding and bruising for the residents who had a heparin injection. The DON further stated the monitoring for bleeding should have been done as soon as the medication was started. The DON was informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage, labeling, and disposal of medications. * The facility stored the tuberculin (used in a skin test to help diagnose tuberculosis (TB) infection in persons at increased risk of developing active disease) solutions past the 30 days from the time it was opened. * The tuberculin solutions stored in the refrigerator in Medication Room A and B were not labeled with an open date. * A container of Super Sani Cloth Wipes was observed with faded expiration date inside Medication Room A * Resident 1's ice cream was stored inside the medication refrigerator in Medication Room A. * Three insulin (medication to lower blood sugar levels) pens did not have a pharmacy prescription labels for one nonsampled resident (Resident 167). One of two medication refrigerators' (Medication Room B) temperature was not kept under proper temperature controls. In addition, an ice buildup was observed along the back wall of the medication refrigerator. * The oral medications were stored with IV supplies inside Medication Cart B. * Medication Cart D contained single use dressings and skin staple remover stored in opened packaging. In addition, there were opened packaging of steri-strips; and steri-strips exposed without its original packaging. * Expired medications/supplies were not removed from Medication Carts B and D. * The facility failed to properly discard the refused/discontinued medications from Medication Cart C. These failures had the potential for the medications to not be effective, medications getting misplaced, ruining the integrity of the drugs and biologicals stored inside the medication refrigerator, cross contamination, and using wipes which may no longer be effective to protect against infection.Findings: Review of the facility’s P&P titled Pharmacy Services Overview revised 4/2019 showed medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice. Review of the facility's P&P titled Medication Labeling and Storage revised 2/2023 showed if the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Review of the solution information shown on the box of Tuberculin Purified Protein Derivative showed once entered, the vial should be discarded after 30 days. 1. a. On 8/19/25 at 1052 hours, an inspection of Medication Room A and concurrent interview was conducted with LVN 7. Inside the medication refrigerator, the following was observed: - one vial of tuberculin solution was labeled with an open date of 7/15/25. The box of the tuberculin vial showed “Once entered, the vial should be discarded after 30 days.” A second tuberculin solution did not have an open date on it. LVN 7 verified the findings and stated the solutions should be discarded.- two jars of ice cream belonging to Resident 1 were stored inside the ice compartment of the medication refrigerator.- a total of three insulin pens for Resident 167 were observed without the pharmacy prescription labels on the individual pens. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition, a container of Super Sani Cloth Wipes (alcohol-free, ready-to-use wipes, disposable wipes designed for both cleaning and disinfection in healthcare environments) was observed with a faded expiration date. LVN 7 verified the expiration date on the container was not legible. LVN 7 verified all the above findings. b. On 8/19/25 at 1107 hours, an inspection of Medication Room B and concurrent interview was conducted with LVN 7. During the inspection, the following was observed:- the medication refrigerator was observed to have a temperature of 32 degrees Fahrenheit.- one tuberculin solution with an open date of 6/25/25, was observed inside this refrigerator. LVN 7 verified the findings and stated the tuberculin solution should not be in the refrigerator. In addition, an ice buildup was observed along the back wall of the medication refrigerator. LVN 7 verified the above findings. Review of the facility’s 8/2025 Refrigerator Temperature Log showed the refrigerator temperature range was to be kept between 36- and 46-degrees Fahrenheit. On 8/19/25 at 1333 hours, a follow-up inspection of the refrigerator inside Medication Room B was conducted with LVN 2. LVN 2 verified the refrigerator’s internal temperature was 28 degrees Fahrenheit, which was out of the normal temperature range. 2. On 8/22/25 at 0800 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 1. During the inspection, Medication Cart B was observed with one bottle of nitroglycerin (medication to treat chest pain) sublingual tablets stored with the IV supplies inside the first drawer of the medication cart. When asked if the bottle of the nitroglycerin tablets should have been stored with the IV supplies, RN 1 stated her presumption was the NOC (night) supervisor may have kept the bottle of medications inside Medication Cart B, in case, and was not sure where the supervisor obtained the medication. RN 1 further stated the nitroglycerin sublingual tablets should be kept inside the medication cart with medications if ordered by physician or in the cubex for emergency use. 3. On 8/22/25 at 0845 hours, an inspection of Medication Cart D and concurrent interview was conducted with LVN 5. During the inspection, the following was observed:- two opened packaging of steri-strips;- two half sized steri-strips exposed, without its original packaging; and- an opened packaging of skin staple remover. LVN 5 verified the above findings and stated these items should have been discarded and should have not been there. Review of the packaging of the Skin Staple Remover with gauze sponge showed Caution: check packaging; not sterile if damaged, wet, seal is broken or passed expiration date. 4. On 8/22/25 at 0800 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 1. During the inspection, Medication Cart B was observed to have a universal male to female white Luer lock cap. RN 1 was not able to read the expiration date on the packaging. On 8/22/25 at 0833 hours, an interview and concurrent verification of the expiration date of the Luer lock was conducted with RN 4. RN 4 verified the expiration date was 11/3/24, and stated there should be no expired supplies inside the carts. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. On 8/22/25 at 0901 hours, an inspection of Medication Cart D and concurrent interview was conducted with LVN 5. During the inspection, Medication Cart D was observed with two packs of Puracol Ultra Powder Collagen wound dressing with an expiration date of 7/20/25. LVN 5 verified the findings and stated the expired wound dressing should not be in the cart. 6. On 8/22/25 at 930 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 4. During the inspection, the bottom drawer of the medication cart was a plastic container, like a sharps container, filled with different colored melted substances, with visible blue capsule appearance on the top portion of the container, and formed oblong, dry, pinkish appearance tablets, not immersed in water. LVN 4 verified the findings. When asked about the facility’s process of discarding discontinued and refused medications, LVN 4 stated she did not know. LVN 4 further stated there was a big container inside the medication room in Station B to discard refused medications. On 8/22/25 at 1013 hours an interview was conducted with the DON. The ADON was informed of the following findings: - nitroglycerin sublingual tablets were stored with IV supplies in Medication Cart B in the IV cart; - opened skin staple remover, opened packaging of steri-strips and exposed steri-strips without packaging inside Medication Cart D; - expired IV Luer lock from Medication Cart B; and- expired Puracol Powder Collagen Wound Dressing from Medication Cart D. The ADON verified the above findings and stated the nitroglycerin sublingual tablets should have been kept inside a medication cart, no opened packaging left inside the cart, unused content of staple remover should have been discarded right away, and expired items should have been removed from the medication carts. On 08/22/25 at 1245 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of 166 residents who received food from the kitchen during the dining observation received the appropriate diet as ordered by the physician. * The facility failed to ensure Resident 132 was served the super soup with lunch as ordered by the physician. This failure posed the risk of the resident's nutritional needs not being met. Findings: Review of the facility's P&P titled Therapeutic Diets revised 10/2017 showed a therapeutic diet is considered a diet ordered by a physician, practitioner, or dietician as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. Review of the facility's document titled Diet Roster Rollup (undated) showed 166 of 168 residents residing in the facility received food prepared in the kitchen. Medical record review for Resident 132 was initiated on 8/18/25. Resident 132 was readmitted to the facility on [DATE]. Review of Resident 132's Nutrition assessment dated [DATE], showed a recommendation by the registered dietician to place Resident 132 on a fortified diet for weight stabilization. Review of Resident 132's Order Summary Report dated 8/22/25, showed a physician's order dated 7/2/25, to provide Resident 132 with a fortified, high protein diet with regular texture and thin liquids consistency. On 8/18/25 at 1203 hours, LVNs 5 and 8 were observed outside of the kitchen checking the residents' lunch trays on the meal cart. LVN 5 stated she was checking if the diet was correct and if the resident got the correct drinks. On 8/18/25 at 1323 hours, Resident 132 was in her room with her lunch tray placed in front of her. Resident 132's lunch meal ticket showed she would receive a fortified, high protein diet with regular texture. Resident 132's lunch meal ticket additionally showed she would receive the soup [NAME] jour (soup of the day) and the super soup. Resident 132's meal tray was only observed with one soup, the soup [NAME] jour. On 8/18/25 at 1328 hours, an observation and concurrent interview was conducted with CNA 15. CNA 15 verified Resident 132 did not receive the super soup as shown on her meal ticket. On 8/18/25 at 1322 hours, an observation and concurrent interview was conducted with the DSS. The DSS stated Resident 132 should have received the super soup instead of the soup of the day, and the super soup was served to the residents with the fortified diets. The DSS stated if the resident had both the soup of the day and the super soup ordered, then the resident should only receive the super soup.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure Station A ice machine drainpipe maintained an air gap (space between the water outlet and the flood level of the drain that prevents backflow of waste water from the drain) at the floor sink drain. This failure had the potential to result in waterborne illnesses in a highly susceptible resident population. * The facility failed to ensure proper storage of refrigerated food in the kitchen. * The facility failed to ensure the kitchen equipment was clean and in good condition. * The facility failed to ensure the broom and dustpan were stored in a sanitary manner. * The facility failed to ensure proper covering, labeling, and dating of foods in the refrigerator used for the residents' food brought in by visitors and failed to ensure the expired foods were discarded. * The facility failed to ensure the freezer used for the residents' food brought in by the visitors had a thermometer and was monitored for temperature. * The facility failed to ensure the ice machine in the kitchen had an airgap. These failures had the potential to cause foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen.Findings: Review of the facility’s document titled Cambridge Laguna Hills Diet Roster Rollup (undated) showed 166 of 168 residents residing in the facility received food prepared in the kitchen 1. Review of the facility’s P&P titled Food Receiving and Storage revised 11/2022 showed foods shall be received and stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator or freezer are covered, labeled and dated. During the initial tour of the kitchen with the DSS on 8/18/25 at 0813 hours, there were two uncovered sheet pans filled with cake in the walk-in refrigerator. The DSS verified the findings. 2. Review of the facility’s P&P titled Sanitization revised 11/2022 showed all utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. According to the USDA Food Code 2022 Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022 Section 4-101.11 Multiuse, Characteristics, materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food under normal use conditions shall be safe, durable, corrosion-resistance and nonabsorbent, sufficient in weight an thickness to withstand repeated ware washing, resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. During the initial tour of the kitchen with the DSS on 8/18/25 at 0813 hours, the following was observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- one stand mixer with a chipped, rusted, and corroded base; - one can opener with dried yellow food residue on the blade; - two drawers containing utensils with dried yellow food residues and crumbs inside of the drawer. - one whisk with a corroded handle; - one whisk with dried brown food residues; - one pot and one pan with corroded rubber handles; and - one pancake dropper with built-up black and gray dust. The DSS verified the above findings. 3. According to the USDA Food Code 2022 Section 6-501.113 Storing Maintenance Tools, Maintenance tools such as brooms, mops, vacuum cleaners, and similar items shall be stored so they do not contaminate food, equipment, utensils, linens, and single-service and single-use articles; and stored in an orderly manner that facilitates cleaning the area used for storing the maintenance tools. During the initial tour of the kitchen with the DSS on 8/18/25 at 0813 hours, there was one broom and one dustpan stored on the floor in the area leading to the facility’s dining room. On 8/25/25 at 1014 hours, the DSS, DON, and Administrator acknowledged the above findings. 4. Review of the facility’s P&P titled Food Receiving and Storage revised 11/2022 showed foods shall be received and stored in a manner that complies with safe food handling practices. All foods belonging to residents are labeled with the resident’s name, the item and the “use by” date. Other opened containers are dated and sealed or covered during storage. Review of the facility’s P&P titled Foods Brought by Family/Visitors revised 8/2024 showed food brought by family/visitors is labeled, dated and stored in a manner that is clearly distinguishable from facility prepared food. The nursing staff and/or designee will discard perishable foods weekly on or before the “use/best by” date. The nursing and/or food service staff will discard any foods prepared for the residents that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). During an observation of the residents’ refrigerator inside Medication Room A with RN 1 on 8/18/25 at 0850 hours, the following was observed: - two bottles of immunity drink labeled with “good”, not labeled with a name, room number, or date; - one bottle of protein drink, unlabeled; - one opened bag of tamales, unsealed, exposing the tamales; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- one sealed package of Klondike bars and three individual bars, unlabeled; - two bottles of sealed Sprite, unlabeled; - one container of cottage cheese with no expiration date; - one container of cut fruits, labeled with two dates, 8/15/25 and 8/17/25; - one opened carton of milk, unlabeled; and - one bag containing an In-N-Out burger and fries, not fully sealed, dated 8/16/25. RN 1 stated they labeled the residents’ food with name, room number, and the date they received the food item. RN 1 stated they threw the perishable food items away after 24 hours. RN 1 verified the above findings. 5. Review of the facility’s P&P titled Food Receiving and Storage revised 11/2022 showed foods shall be received and stored in a manner that complies with safe food handling practices. Refrigerators must have working thermometers and are monitored for temperature according to state-specific guidelines. Review of the facility’s P&P titled Refrigerators and Freezers revised 11/2022 showed this facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening. During an observation of the residents’ refrigerator inside Medication Room A with RN 1 on 8/18/25 at 0850 hours, the freezer portion of the residents’ refrigerator had residents’ food items inside. There was no freezer temperature log and no thermometer in the freezer. RN 1 verified the findings. RN 1 stated the evening and night shift charge nurse or supervisor was responsible for checking the refrigerator temperatures. On 8/18/25 at 1014 hours, the DSS, DON, and Administrator acknowledged the above findings. The DON stated the perishable foods should not be kept for longer than 24 hours. The DON stated they labeled the residents’ food with the name and date it was brought in. 6. a. According to the USDA Food Code 2022 Section 5-202.13, Backflow Prevention, Air Gap, an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment stall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (one inch). Providing an air gap between the water supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow. During the initial tour of the kitchen with the DSS on 8/18/25 at 0813 hours, the kitchen ice machine’s drainpipe was on the floor and touching the drainage inlet, surrounded by a puddle of water. The DSS stated the drainpipe was knocked over and proceeded to fix the drainpipe. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/19/25 at 1340 hours, a concurrent observation and interview was conducted with the DSS. The kitchen ice machine’s drainage pipe was observed touching the drainage inlet. The DSS verified the findings and proceeded to fix the drainpipe. b. On 8/21/25 at 1307 hours, an observation and concurrent interview was conducted with the Maintenance Director. Station A resident ice machine had a pipe draining water from the ice storage compartment of the ice machine into a floor sink drain. The air gap between the pipe outlet and the flood level of the floor sink drain was not maintained, as evidenced by the pipe outlet extending into the floor sink drain. The Maintenance Director verified the findings and stated an air gap needed to be maintained, to ensure no backflow of contaminated drain water entered the ice machine. The Maintenance Director stated he had ordered a new pipe.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in two of three garbage dumpsters. * Two of three garbage dumpsters were observed overfilled with trash, causing the lids to not fully close. This failure had the potential to attract pests/rodents that carry diseases.Findings: According to the USDA Food Code 2022, 5-501.113, Covering Receptacles, receptacle and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the food establishment. Review of the facility's P&P titled Food-Related Garbage and Refuse Disposal revised 10/2017 showed the outside dumpsters provided by the garbage pickup services will be kept closed and free of surrounding litter. On 8/19/25 at 1356 hours, an observation and concurrent interview was conducted with the Maintenance Director. Two of three garbage dumpsters located outside of the facility were observed with trash overfilled, causing the lids to not be able to fully close. In addition, there were scattered trash items in the area surrounding the garbage dumpsters, such as used gloves, paper, masks, corn, and condiment packets. The Maintenance Director acknowledged the findings and stated the garbage dumpster lids did not fully close all the way because there were trash on the inside. On 8/25/25 at 1014 hours, an interview was conducted with the DON, Administrator, and DSS. The DON, Administrator, and DSS were informed and acknowledged the above findings.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following:1. Active involvement of required individuals in developing the Facility Assessment;2. A plan to maximize recruitment and retention of direct care staff; and3. A contingency plan for staffing needs. This failure had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed.Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation dated 8/8/24, the CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 8/25/25 at 0859 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with Administrator. The Administrator verified the Facility Assessment was dated 7/1/24, and acknowledged he was not aware of the new update of the Facility Assessment from the CMS. The Administrator verified there were no direct care staff, direct care representatives, residents, resident representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest update from the CMS.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for three of 33 final sampled residents (Residents 3, 169 and 174) were accurate. * The facility failed to ensure Resident 3's physician's orders for tube feeding specified a start time. * The facility failed to ensure Resident 169's RNA documentation was coded accurately. * The facility failed to ensure Resident 174's MAR was accurate. These failures had the potential for the residents' care needs not being met as their medical information was inaccurate.Findings: Review of the facility’s P&P titled Charting and Documentation revised 7/2017 showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident’s medical, physical, functional, or psychosocial condition shall be documented in the resident’s medical record. The following information is to be documented in the resident’s medical record: a. Objective observations; b. Medications administered, c. Treatments or services performed, d. Changes in the resident’s condition, e. Events, incidents or accidents involving the resident, and f. Progress toward or changes in the care plan goals and objectives Documentation in the medical record will be objective (not opinionated or speculative) complete, and accurate. 1. Medical record review for Resident 174 was initiated on 8/18/25. Resident 174 was admitted to the facility on [DATE]. Review of Resident 174’s Order Summary Report dated 8/21/25, showed the following physician’s orders dated 8/1/25: - to administer oxycodone (narcotic pain medication) 10 mg one tablet every four hours as needed for moderate pain (pain level between 4 to 6, on a pain scale with 0=no pain, and 10=severe pain); and - to administer oxycodone 15 mg one tablet every six hours as needed for severe pain (pain level from 8 to 10). Review of Resident 174’s Antibiotic or Controlled Drug Record for the oxycodone 15 mg showed the oxycodone 15 mg medication was removed on the following dates and times: - on 8/9/25 at 1425 hours, and (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	- on 8/10/25 at 1030 hours. However, review of Resident 174’s MAR for 8/2025 showed Resident 174 was administered the oxycodone 10 mg (instead of the oxycodone 15 mg) on 8/9/25 at 1425 hours. Further review of the MAR showed the licensed nurse documented the administration of the oxycodone 15 mg medication to Resident 174 on 8/10/25 at 0859 hours (an hour and 31 minutes before the documented time of the removal of the medication on the Antibiotic or Controlled Drug Record). On 8/21/25 at 1259 hours, an interview and concurrent medical record review for Resident 174 was conducted with the DON. The DON stated for the administration of the narcotic medications, the licensed nurses should document on the controlled drug record, the date, time, and licensed nurse’s initials upon removal of the narcotic medication. The DON stated after the licensed nurse completed the administration of the narcotic medication to the resident, the licensed nurse should document the administration of the medication in the resident’s MAR. The DON reviewed Resident 174’s medical record and verified the above findings. On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 169 was initiated on 8/19/25. Resident 169 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 169's Documentation Survey Report dated 8/19/25, showed the following: - On 7/8, 7/10, and 7/29/25, the RNA Active Range of Motion (AROM) for the right upper extremity (RUE) and left extremity, scheduled three times per week, was documented with code 97 (Not Applicable) for Resident 169. - On 7/2, 7/8, 7/10, and 7/29/25, the RNA Passive Range of Motion (PROM) for the left upper extremity, scheduled three times per week, was documented with code 97. - On 7/29/25, the RNA application of a resting hand splint to the left hand for 6 to 8 hours as tolerated, five times per week, was documented with code 97. On 8/19/25 at 1015 hours, an interview and concurrent medical record review were conducted with RNA 1. When asked about the RNA documentation for Resident 169, RNA 1 stated he provided the following interventions to Resident 169: AROM for the right upper extremity, PROM for the left upper extremity, and application of a hand splint to the left hand. RNA 1 was asked about the use of code 97 in the documentation. RNA 1 stated that it was likely miscoded and should have been documented as code 98, indicating the resident refused the interventions. RNA 1 further explained the CNA documentation was marked as not applicable because the tasks were not within the CNA's scope. When the CNAs documented code 97, the RNA staff were unable to override or correct it. RNA 1 acknowledged this was an ongoing issue at the facility and verified the above findings. 3. Medical record review for Resident 3 was initiated on 8/19/25. Resident 3 was readmitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 3’s H&P examination dated 7/20/25, showed Resident 3 had no capacity to make medical decisions. Review of Resident 3’s Order Summary Report showed a physician’s order dated 7/29/25, to provide Nepro (enteral feeding formula) via G-tube for a total of 700 ml/20 hr 1260 Kcal at rate of 35 cc/hr x 20 hrs or until dose met for every shift. On 8/18/25 at 1226 hours, Resident 3 was observed sitting in a wheelchair with a disconnected GT feeding. The enteral feeding pump (GT machine) was turned off. On 8/19/25 at 1325 hours, Resident 3 was observed in bed with the GT connected, but the enteral feeding pump was turned off. On 8/19/25 at 1330 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated Resident 3’s enteral feeding pump was off because almost all the enteral GT feedings for the residents in the facility are started at 1400 hours. LVN 1 reviewed Resident 3’s enteral feeding orders and verified the order should have had a specified start time. On 8/20/25 at 1130 hours, an observation of Resident 3 and a concurrent interview was conducted with LVN 1. LVN 1 verified the GT feeding was still running for Resident 3. LVN 1 stated on the prior evening, new enteral feed orders were entered for Resident 3 adjusting the feeding rate. LVN 1 showed the new enteral feeding rate was set on the enteral feeding pump. LVN 1 stated the GT feeding was paused several times throughout the night, so the GT feeding would continue until dose was complete or change the bottle at 1400 hours and start the new GT feeding per the physician’s order. On 8/21/25 at 0934 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified there was no start time specified in Resident 3’s enteral feeding order. RN 3 verified all the enteral feeding orders should have a start time. On 8/21/25 at 1002 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was no start time specified in Resident 3’s enteral feeding order. The DON verified Resident 3’s enteral feeding order was incorrect because it did not specify the start time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program and practices to help prevent the development and transmission of diseases and infections. * The line listings for May and June 2025 which documented residents who received antibiotics and were listed as not meeting McGeer's Criteria were inaccurately reported during the Infection Control Committee meeting. In addition, a resident with an MDRO (Multidrug-Resistant Organism) infection was not accurately documented in the report. In addition, the facility failed to identify, track and monitor infections in the facility from January to April 2025. * There was no documented evidence of recommendations to address the high incidence of of E. Coli and proetues miraabilis. Additionally, the Infection Control Committee Minutes failed to show documented evidence of follow up post report of MDRO infections from May to July 2025. * The facility failed to discuss during the Infection Control Committee meeting about the June 2025 antibiogram and the correlation with the organism E. coli and the cases of UTIs in the facility, and failed to show documentation of protocols in place to attempt to decrease or address the MDRO infection rate in the facility. * There were brown stains in Resident 1's room. * The facility failed to ensure basins and bed pans found in shared restrooms in Rooms B, C and D were labeled. Additionally, the facility failed to ensure Resident 2's urinal was labeled. * The facility failed to ensure Resident 6's urinary catheter tubing was kept off the floor. * The facility failed to ensure EBP were followed for Resident 7 when performing the wound and indwelling urianry catheter care. * The facility failed to ensure a clean diaper was placed on Resident 37 post urinary catheter care. * The facility failed to ensure proper infection control techniques were followed when handling the clean linens for Resident 49. * The facility failed to ensure CNA 11 donned the appropriate PPE upon entering Resident 174's contact isolation room. These failures had the potential for the transmission of communicable diseases to other residents and employees throughout the facility. Findings: 1. Review of the facility's P&P titled Surveillance for Healthcare-Associated Infections revised 4/2012 showed the purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to permit interventions, and to prevent future infections. After removing duplicates and negative reports, prioritize the reports as follows: a. Multidrug-resistant reports (All multidrug-resistant reports require immediate attention. Ensure that appropriate precautions, if needed, are in place. If this is a new or unexpected report notify the Administrator, Director of Nursing Services, and Medical Director, b. Blood cultures. Wound cultures if there are corresponding signs and symptoms that indicate infection, d. Appropriately collected positive sputum cultures. e. Urine cultures combined with urinalysis results that show a urinary tract infection, and corresponding signs and symptoms of infection are present. a. Review of the facility’s line listing for May 2025 showed seven residents were listed as not meeting McGeer’s criteria. In addition, 17 residents were identified as having MDROs. Review of the facility’s line listing for June 2025 showed five residents were listed as not meeting McGeer’s criteria. In addition, 18 residents were identified as having MDROs. Review of the facility’s Infection Control Committee Meeting minutes dated 6/4/25, showed mapping data indicating four residents were listed as not meeting McGeer’s criteria. There were no in-house residents with MDROs, and one case was community-acquired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility’s Infection Control Committee Meeting minutes dated 7/30/25, showed mapping data indicating four residents were listed as not meeting McGeer’s criteria. There were no in-house residents with MDROs, and four cases were community-acquired. On 8/21/25 at 0900 hours, an interview and concurrent medical record review was conducted with the IP. The IP stated she conducted rounds, reviewed new antibiotic orders, and monitored infections to determine whether they originated upon admission or developed in-house. The IP stated she documented this information on the line listing. The IP verified she was unable to locate the infection surveillance log or line listings for January, February, March, and April 2025. The IP further stated she began documenting antibiotic use and infections starting 5/16/25. The IP stated during the Infection Control Committee Meeting on 6/4/25, there were four residents identified whose antibiotic use did not meet McGeer’s criteria. The IP further stated during the Infection Control Committee Meeting on 7/30/25, there were two residents identified whose antibiotic use did not meet McGeer’s criteria. The IP acknowledged the discrepancies for the May and June 2025 line listings not matching the number of residents on the committee meeting minutes. The IP stated for June 2025, there were three residents given antibiotics for prophylaxis, but the computer system incorrectly categorized them as not meeting McGeer’s criteria and did not allow her to make corrections. The IP further stated she reported MDRO cases for May and June 2025 and acknowledged the discrepancies between the MDRO line listing and the number of MDRO infections reported to the Infection Control Committee. The IP stated there were challenges in navigating and analyzing the data collection entered in the line listings for May, June, and July 2025, due to the automatic data generated by the computer system. The IP stated she included the MDRO override under the resident who had a UTI. The IP verified the findings. On 8/21/25 at 1100 hours, an interview was conducted with the DON. The DON stated she was unable to locate the antibiotic line listings or infection surveillance logs from January through April 2025. The DON verified these findings. On 8/25/25 at 1000 hours, an interview was conducted with the Administrator and DON. The DON and the Administrator were informed of the above findings. b. On 8/19/25 at 1215 hours, a concurrent interview and facility document review was conducted with the IP. Review of the facility's May, June, and July 2025 QAPI minutes with the IP showed the facility had MDRO infections. The Infection Control Monitoring Graphs related to the organisms showed a high incidence of the E. Coli organism and the proteus mirabilis organism. There was no documented evidence of any recommendations to address the high incidence of E. Coli and proetues miraabilis in the residents. Furthermore, there was no documented evidence of follow up post report of MDRO infections from May to July 2025 in the Infection Control Committee Minutes. The IP verified the findings. 2. Review of facility's P&P titled Enhanced Barrier Precaution BLUE DOT Program, undated, showed to initiate EBP:iv. Place blue dot at the door by the name.v. Place EBP signage and personal protective equipment: gowns and gloves, and eye protection as indicated.vi. Ensure alcohol-based hand rub and disinfectant wipes are readily available. Medical record review for Resident 7 was initiated on 8/19/25. Resident 7 was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7’s care plan for EBP related to indwelling urinary catheter dated 7/21/25, showed interventions including the following: - Place EBP signage at the door - Provide gowns and gloves at door entry - Use gown and gloves during high contact resident care activities (dressing, bathing, transfers, hygiene, toileting, brief changes, changing linens, device care, wound care. On 8/19/25 at 1110 hours, an observation was conducted outside Resident 7’s room. There was no EBP sign posted on the wall outside Resident 7's door. Additionally, there was no storage organizer for the isolation cart with PPE by the front of the door. On 8/19/25 at 1120 hours, a wound care observation was conducted for Resident 7. RN 2 and LVN 8 entered the room and prepared to provide care for Resident 7 without wearing disposable gowns. RN 2 assisted LVN 8 to provide wound treatment and indwelling catheter care. LVN 8 removed the old dressings from the sacrum and placed the soiled dressings in a plastic bag. LVN 8 doffed her gloves, performed hand hygiene, donned new gloves, and proceeded with wound care on the sacrum. The sacral wound had yellowish slough, moderate serous drainage. LVN 8 was not wearing a disposable gown. After applying a dry dressing to cover Resident 7's wound, LVN 8 doffed her gloves, performed hand hygiene, and proceeded to clean the perianal area and urinary catheter. LVN 8 and RN 2 were not wearing gowns during or after the completion of wound and indwelling urinary catheter care. On 8/19/25 at 1140 hours, an interview was conducted with LVN 8 and RN 2. LVN 8 stated the resident was on EBP and there was a blue dot next to the resident’s name by the door. LVN 8 acknowledged she should have worn a gown when providing wound and indwelling urinary catheter care. RN 2 confirmed Resident 7 was on EBP due to the indwelling urinary catheter. RN 2 and LVN 8 both verified there was no EBP sign and isolation cart outside of Resident 7’s room. LVN 8 stated signage and an isolation PPE cart should have been posted for visitors and staff. LVN 8 and RN 2 verified the findings. 3. Review of the facility's P&P titled Laundry and Bedding revised on 9/2022 showed the following: - Clean linen is stored separately, away from soiled linens at all times; and - Clean linen is kept separate from contaminated linen On 8/18/25 at 0852 hours, during an initial tour observation, Resident 49 was asleep in bed. CNA 4 entered the room and placed towels, linens, and a brief on top of Resident 49’s pillow prior to assisting Resident 49’s roommate. The clean towels, linens and brief were not covered with a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/25 at 0858 hours, an observation and concurrent interview was conducted with the DSD. The DSD verified the clean towels, linens and brief were placed on top of Resident 49’s pillow and were not covered with a plastic bag. The DSD stated clean linens and towels must be placed in a plastic bag or clean surface to follow infection control. The DSD stated the clean linens including towels must not touch the used linens. In addition, dirty linens must also be placed inside a plastic bag. On 8/18/25 at 1240 hours, an interview was conducted with CNA 4. CNA 4 verified she placed the clean towels and linens on top of Resident 49’s used pillow. CNA 4 stated clean linen must be handled and placed inside a plastic bag to prevent transfer of germs. Furthermore, CNA 4 stated her last in-service for infection control was 5/2025 from a different facility. On 8/20/25 at 0823 hours, an interview was conducted with the IP. The IP stated the clean linen includes towels, pillowcases, blankets, and gowns. The IP stated the clean linen must be handled and placed by staff in a plastic bag or on a clean surface. In addition, the IP stated clean linen must not be placed on top of the bed with used linen. The IP stated following the infection control policy is a must to prevent the transmission of pathogens to residents. On 8/25/25 at 1054 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. 4. Review of the facility’s P& P titled, Cleaning, Disinfection and Storage of Resident-Care Items and Equipment revised 9/2022 showed resident- care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. Single resident-use items are cleaned/disinfected between uses by a single resident. a. On 8/18/25 at 0848 hours, an observation was conducted of Room B’s restroom. Two unlabeled basins were found on top of a chair in the bathtub, two unlabeled basins were found on the sink and one unlabeled bedpan was found uncleaned with used, wet toilet paper. Residents 8 and 52 resided in Room B and shared the restroom. b. On 8/18/25 at 0915 hours, an observation was conducted of Room D’s restroom. Two unlabeled basins were found under the sink and two labeled bedpans were on the bathtub. Residents 23 and 34 resided in Room D and shared the restroom. c. On 8/18/25 at 0922 hours, an observation was conducted of Room C’s restroom. Two unlabeled basins were found on a metal shelf of the sink. Residents 93 and 164 resided in Room C and shared the restroom. On 8/18/25 at 0923 hours, an observation and concurrent interview was conducted with the Case Manager. The Case Manager verified all the basins and bedpans in Rooms B, C and D should have been labeled, cleaned and stored properly for infection prevention and control. d. On 8/18/25 at 0947 hours, an initial tour observation was conducted. There was an unlabeled urinal on Resident 2’s bedside table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/25 at 0950 hours, an observation and concurrent interview was conducted with the ADON. The ADON verified Resident 2’s urinal should had been labeled for infection control prevention. On 8/22/25 at 1443 hours, an interview was conducted with the DON. The DON verified the above findings. 5. Review of the facility’s P&P titled Isolation- Categories of Transmission-Based Precautions, revised 9/2022 showed contact precautions are implemented or residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environment surfaces or resident-care items in the resident’s environment. Staff and visitors wear gloves (clean, non-sterile) when entering the room. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after the gown is removed. Medical record review for Resident 174 was initiated on 8/18/25. Resident 174 was admitted to the facility on [DATE]. Review of Resident 174’s Order Summary Report showed a physician’s order dated 8/5/25, to place Resident 174 on contact isolation for MRSA, Carbapenem Resistant Enterobacterales (gram-negative bacteria, that have developed resistance to carbapenem antibiotics). Resident 174 on transmission-based precautions: contact isolation room placement, single room isolation with all services to be brought to the resident every shift. a. On 8/18/25 at 1051 hours, Resident 174 observed was sleeping in bed. There was a contact precautions sign posted at Resident 174’s door. The sign showed “Stop, Contact Precautions, see nurse before entering the room: Clean hands on room entry, wear a gown on room entry, wear gloves on room entry, clean hands when exiting. On 8/18/25 at 1257 hours, CNA 11 was observed, entered and exited Resident 174’s room with Resident 174’s lunch tray. CNA 11 did not don a gown upon entering the room. On 8/18/25 at 1258 hours, an interview and concurrent facility document review of the Contact Precautions sign posted outside Resident 174’s room was conducted with CNA 11. CNA 11 stated she thought she only needed to don a gown if she was providing direct care to the resident. CNA 11 reviewed the sign again and verified she should have worn a gown before entering the room. On 8/21/25 at 0923 hours, an interview was conducted with the IP. The IP stated the facility staff were in-serviced on the signages outside of the residents’ doors and the appropriate PPE to don when entering the residents’ room. The IP stated the signage applied to all facility staff entering the room. The IP stated for the residents on contact isolation, the facility staff were expected to don a gown upon entry into the room. On 8/22/25 at 1354 hours, an interview was conducted with the DON. The DON verified all facility staff should don full PPE upon entering any contact isolation room. b. On 8/20/25 at 0758 hours, CNA 3 was observed, entered and exited Resident 174’s room with Resident 174’s breakfast tray. CNA 3 did not don a gown upon entry into the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/25 at 0802 hours, an interview concurrent facility document review of the Contact Precautions sign posted outside Resident 174’s room was conducted with CNA 3. CNA 3 stated Resident 174 informed her she needed to be changed. CNA 3 stated she saw Resident 174 was done with her breakfast tray, so she entered the room to pick up Resident 174’s tray. CNA 3 reviewed the sign outside of Resident 174’s door and stated the sign showed to wear a gown and gloves on room entry. CNA 3 verified she did not wear a gown or gloves and stated she should have. On 8/21/25 at 0923 hour, an interview was conducted with the IP. The IP stated the facility staff were in-serviced on the signages outside of the residents’ doors and the appropriate PPEs to don when entering the residents’ room. The IP stated the signage applied to all facility staff entering the room. The IP stated for the residents on contact isolation, the facility staff was expected to don a gown upon entry into the room. On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 6. Review of the facility’s P&P titled Catheter Care, Urinary revised 8/2024 showed the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Under the section titled infection control, showed to be sure the catheter tubing and drainage bag are kept off the floor. On 8/18/25 at 1024 hours and 1229 hours, and on 8/19/25 at 0941 hours, an observation was conducted in Resident 6’s room. Resident 6’s urinary catheter tubing was lying on the floor. On 8/19/25 at 0954 hours, an observation and concurrent interview was conducted with the ADON. The ADON verified Resident 6’s catheter tubing was on the floor. The ADON proceeded to raise Resident 6’s bed higher to lift the urinary catheter tubing off the floor. The ADON stated the urinary catheter tubing should be off the floor for infection control. On 8/25/25 at 1000 hours, an interview was conducted with the DON. The DON acknowledged the findings. 7. On 8/19/2025 at 1031 hours, an observation of Medication Room C and concurrent interview was conducted with the DON. There was a soiled band aid and a used open vial on the floor. The DON stated Medication Room C was no longer used to store medications and verified the finding. The DON further stated the items should not be on the floor. 8. On 8/22/25 at 808 hours, an observation was conducted of Resident 1’s room. There were brown stains on the floor tiles and lower wall to the left of Resident 1's bed. Resident 1’s room was on contact precautions. On 8/22/25 at 1118 hours, an interview was conducted with Housekeeper 1. Housekeeper 1 verified the finding. Medical record review for Resident 1 was initiated on 8/22/25. Resident 1 was readmitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's H&P examination dated 7/6/25, showed Resident 1's diagnoses included urinary tract infection and sepsis related to E. Coli. 9. Medical record review for Resident 37 was initiated on 8/18/25. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37’s Order Summary Report showed a physician’s order dated 4/3/24, to administer indwelling urinary foley catheter care every shift, and as needed. Review of Resident 37’s H&P examination dated 8/24/25, showed Resident 37 had neurogenic bladder (a condition where the nerves that control the bladder do not function properly, leading to difficulty with urination) and frequent urinary tract infections. On 8/21/25 at 0958 hours, an observation of Resident 37’s urinary catheter care and concurrent interview was conducted with LVN 5. LVN 5 opened Resident 37’s diaper and cleaned the urinary catheter with soap and water. After LVN 5 was done with the urinary catheter care, LVN 5 attempted to cover Resident 37 with the used diaper. LVN 5 did not apply a new diaper. LVN 5 verified the diaper had pinkish-colored drainage. LVN 5 then asked the CNA to assist her to change Resident 37’s diaper. On 8/21/25 at 1022 hours, an interview was conducted with LVN 5. LVN 5 stated she did not notice the pinkish-colored drainage on the diaper, and she should have checked prior to attempting to reapply the used diaper. LVN 5 stated she should have used a new diaper to prevent any contamination. On 8/25/25 at 0958 hours, an interview was conducted with the IP. The IP stated for the residents who wear a diaper, the licensed staff cleaning the urinary catheter should check the diaper before reapplying to see if the diaper was clean or if there was any drainage observed. The IP stated if drainage was observed on the diaper, a new diaper should be used to prevent any contamination. On 8/25/25 at 1044 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record, facility document review, and facility P&P review, the facility failed to implement the facility's antibiotic stewardship program. * The facility failed to ensure the residents' physicians were informed when the residents who received antibiotics (Residents 190 and 191) did not meet the McGeer's Criteria, as documented for May 2025 line listing. In addition, the facility failed to follow-up on the urine laboratory results for one sampled resident (Resident 37) and one nonsampled resident (Resident 28), as documented for June 2025 line listing to determine if the antibiotic use met the McGeer's criteria. This failure had the potential for inaccurately identifying for true infections and potentially inhibiting the residents' physicians from discontinuing unnecessary antibiotic treatments.Findings: Review of the facility's P&P titled Antibiotic Stewardship dated 12/2024 showed the purpose of the antibiotic stewardship program is to monitor the use of antibiotics in our residents. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Further review of the facility’s P&P showed when a resident is admitted from the emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders. Review of the facility’s surveillance log for May 2025 showed two nonsampled residents (Residents 190 and 191) received antibiotics when the residents did not meet the McGeer’s Criteria for true infection. Review of the surveillance log for June 2025 showed one nonsampled resident (Residents 28) and one sampled resident (Resident 37) also received antibiotics when the residents did not meet the McGeer’s Criteria for true infection. For example, Resident 28 had a positive UA result, and the culture results reported “multiple organisms isolated, probable contaminant; repeat culture if indicated. ” Resident 37 was documented as awaiting UA culture results. Medical record review for Resident 28 was initiated on 8/18/25. Resident 28 was admitted to the facility on [DATE], and readmitted on [DATE]. Medical record review for Resident 37 was initiated on 8/18/25. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Medical record review for Resident 190 was initiated on 8/18/25. Resident 190 was admitted to the facility on [DATE], and readmitted on [DATE]. Medical record review for Resident 191 was initiated on 8/18/25. Resident 191 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/25, at 0900 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated the infection surveillance log or line listing was used to monitor for the appropriate antibiotic use, and to reduce unnecessary treatments. When the IP was asked to provide the surveillance logs for January, February, March, and April 2025 which included the antibiotic use in the facility, the IP stated she had asked the DON and other staff, however, they were unable to locate the surveillance logs for those months. The IP further stated the previous IP did not provide her with any documentation. The current IP began documenting antibiotic use and infections as of 5/16/25. In addition, the IP was asked whether Residents 190 and 191’s physicians were informed about the residents who received antibiotics when the residents did not meet the McGeer’s Criteria for true infection. The IP stated the licensed nurses should have informed the physician in such cases, however, the IP was unable to locate any documentation to confirm the information provided. The IP was also asked whether the physicians were informed about the urine culture results for Residents 28 and 37, and whether there was any follow-up about repeat urine culture for Resident 28 and awaiting UA results for Resident 37. The IP stated the licensed nurses should have informed and followed up with the physician, however, the IP was not able to find documentation the physicians were notified. The IP verified the findings. On 08/21/25 at 1100 hours, an interview was conducted with the DON. The DON stated she was unable to locate the antibiotic line listings or infection surveillance logs for January through April 2025. The DON verified the findings. On 08/25/25 at 1000 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of the above findings.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate and complete for three of four final sampled residents (Residents 8, 72, and 130) reviewed for the grab bar use. * The facility failed to ensure the entrapment assessments of the grab bars were accurate and complete for Residents 8, 72, and 130. In addition, the quarterly entrapment assessments were not completed for the listed residents. This failure had the potential to negatively impact the residents, resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment by the Food and Drug Administration issued on 3/10/06, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapment may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Safety and Bed Rail revised on 8/2022 showed the following: - Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail, and mattress will leave no gap wide enough to entrap a resident’s head or body. Any gaps in the bed system are within the safety dimensions established by the FDA; - Maintenance staff routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks; - The maintenance department provides a copy of inspections to the administrator and report results to the QAPI committee for appropriate action. Copies if the results and QAPI committee recommendations are maintained by the administrator and /or safety committee. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 8/18/25 at 0914 hours, during the initial tour, Resident 72 was observed lying in bed with the bilateral grab bars elevated. Resident 72 stated she used the grab bars to help reposition in bed. On 8/18/25 at 0924 hours, an observation and concurrent interview was conducted with CNA 7. Resident 72 was observed lying in bed with the bilateral grab bars elevated. CNA 7 verified the findings and stated Resident 72 used the grab bars to help turn and reposition while in bed. On 8/19/25 at 1111 hours, an observation and concurrent interview was conducted with RN 6. Resident 72 was observed lying in bed with the bilateral grab bars elevated. RN 6 verified the findings and stated Resident 72 used the grab bars to help reposition while in bed. Medical record review for Resident 72 was initiated on 8/20/25. Resident 72 was admitted to the facility on [DATE]. Review of Resident 72’s MDS assessment dated [DATE], showed Resident 72’s BIMS score was 7, indicating severe cognitive impairment. In addition, Resident 72’s mobility assessment under Section GG showed Resident 72 required moderate to dependent assistance from the facility staff. Review of Resident 72's Order Summary Report dated 8/20/25, showed a physician’s order dated 9/7/23, may apply the bilateral grab bars as an enabler for bed mobility and positioning. Review of Resident 72’s Bed Entrapment assessment dated [DATE], showed the following: - Bed inspected and determined for risk of entrapment marked Yes; - Zone 3 showed zero gap; - Zone 6 showed 22 inches; and - Zone 7 showed 2 inches. However, Resident 72’s Bed Entrapment assessment dated [DATE], failed to show if Zones 6 and 7 passed or failed the assessment. In addition, Resident 72’s grab bars were not assessed for entrapment every quarter. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/25 at 1330 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director stated the maintenance staff was responsible for checking for entrapment. The Maintenance Director stated when the maintenance staff receive the physician’s order for the grab bars from by the licensed nurses, the maintenance staff would install the grab bars and measure for the bed entrapment using a tape measure. In addition, the Maintenance Director stated after the measurements and assessment form were completed, the Bed Entrapment assessment form would be placed in the Bed Entrapment binder. The Maintenance Director was asked if the maintenance staff reported the outcome of the entrapment assessment to the licensed nurses. The Maintenance Director stated the maintenance staff did not report the results to the licensed nurses. The Maintenance Director stated the bed entrapment assessment must be done every three months. The Maintenance Director reviewed Resident 72’s Bed Entrapment assessment dated [DATE] and verified the above findings. Furthermore, the Maintenance Director stated he had not seen this kind of bed entrapment assessment form before. 2. On 8/18/25 at 1014 hours, during the initial tour, Resident 130 was observed lying in bed with the bilateral grab bars elevated. Resident 130 stated he used the grab bars to help turn and reposition while in bed. On 8/18/25 at 1032 hours, an observation and concurrent interview was conducted with CNA 6 and LVN 4. Resident 130 was observed with the bilateral grab bars elevated. CNA 6 and LVN 4 verified the findings and CNA 6 stated Resident 130 used the grab bars to help turn in bed. Medical record review for Resident 130 was initiated on 8/20/25. Resident 130 was admitted to the facility on [DATE]. Review of Resident 130's H&P examination dated 4/17/25, showed Resident 130 had the capacity to understand and make decisions. Review of Resident 130’s MDS assessment dated [DATE], showed Resident 130’s BIMS score was 10, indicating moderate cognitive impairment. In addition, Resident 130’s mobility assessment under Section GG showed Resident 130 required moderate to dependent assistance from the facility staff. Review of Resident 130's Order Summary Report dated 8/20/25, showed a physician’s order dated 4/21/24, for the bilateral grab bars for mobility, positioning, and transfer. Review of Resident 130’s Bed Entrapment assessment dated [DATE] showed the following: - Bed inspected and determined for risk of entrapment marked Yes; - Zone 3 showed zero gap; - Zone 6 showed 28 inches; and - Zone 7 showed 2.5 inches. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, Resident 130’s Bed Entrapment assessment dated [DATE], failed to show if Zones 6 and 7 passed or failed the assessment. In addition, Resident 130’s grab bars were not assessed for entrapment every quarter. On 8/21/25 at 1330 hours, interview and concurrent facility document review were conducted with the Maintenance Director. The Maintenance Director reviewed Resident 130’s Bed Entrapment assessment dated [DATE], and verified the above findings. On 8/25/25 at 0957 hours, an interview and concurrent facility record review was conducted with the ADON. The ADON reviewed Resident 130’s Bed Entrapment assessment dated [DATE]. The ADON was asked what it meant if it was marked, “Yes” under the question Bed inspected and determined for risk of entrapment. The ADON stated it meant there was risk of entrapment. The ADON verified the above findings. In addition, the ADON stated the Maintenance Director, and the maintenance staff were responsible for completing the bed entrapment assessments. The ADON stated the entrapment assessment must be completed initially and then quarterly at the same time when the Side Rail Utilization Assessment for grab bars was completed. Furthermore, the ADON stated there should have neem a Bed Entrapment assessment completed on 5/25/25, three months after the previous assessment, however, it was not completed. On 8/25/25 at 1054 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 8 was initiated on 8/18/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's Bed Entrapment assessment dated [DATE], showed the following: -Bed inspected and determined for risk of entrapment assessment was marked “Yes.” -Zone 3 showed 1 inch on each side, -Zone 6 showed 16 inches on each side and -Zone 7 showed 1 inch on each side. However, further record review of Resident 8's Bed Entrapment Assessment failed to show if Zones 6 and 7 passed or failed the assessment. Additionally, there was no documentation to show the Bed Entrapment Assessment was completed quarterly for Resident 8. Review of Resident 8's Order Summary dated 8/21/25, showed a physician's order dated 3/27/25, for the bilateral grab bars to assist with bed mobility, positioning, and transfer. On 8/21/25 at 1330 hours, an interview and a concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director verified the quarterly Bed Entrapment Assessment was not completed for Resident 8. The Maintenance Director further verified there was the Bed Entrapment Assessment form dated 3/6/25, failed to show if Zones 6 and 7 had passed or failed the assessment. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/22/25 at 1443 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.