STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056117	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rowland	330 W. Rowland Street Covina, CA 91723

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for four resident of four sampled residents (Resident 1, 3, 4 and 5) by: 1. Not ensuring Resident 1 and 3 had floor mats at bedside. 2. Not ensuring Resident 1, 4, and 5 had a fall risk assessment (a comprehensive, non-invasive evaluation conducted to determine an individual's likelihood of falling, typically focusing on older adults or high-risk patients) after experiencing a fall. These deficient practices placed Residents 1, 3, 4 and 5 for recurring falls and increased the risk for the residents to sustain injuries after a fall from their beds. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included respiratory failure (serious condition that makes it difficult for a person to breathe on their own, lungs can't get enough oxygen into the blood) and heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath). During a review of Resident 1's Fall Risk Assessment (a comprehensive, non-invasive evaluation conducted to determine an individual's likelihood of falling, typically focusing on older adults or high-risk patients), dated 3/5/2026, the Fall Risk Assessment indicated Resident 1 had no history of falls and had a score of 16 ([High Risk], 16-20 range, requiring immediate fall alert protocols). During a review of Resident 1's Accident/Incident Report, dated 3/12/2026, the Accident/Incident Report indicated Resident 1 had a fall on 3/12/2026. During a review of Resident 1's Order Summery Report dated 3/12/2026, the Order Summary Report indicated Resident 1 had an order for bilateral floor mats. During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 3/14/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for lower body dressing, shower/bathing, toileting hygiene and putting on/off footwear. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for upper body dressing, oral hygiene and eating. During an observation on 4/21/2026 1:20 p.m. in Resident 1's room, Resident 1 did not have bilateral floor mats. During an interview on 4/22/2026 at 9:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had an order for bilateral floor mats because Resident 1 had a previous fall. LVN 1 stated Resident 1 should have bilateral mats to prevent fall injuries but did not know if Resident 1 had bilateral floor mats. LVN 1 stated the risk of not having floor mats was a fall with injuries. LVN 1 stated all residents that had an order for floor mats should have floor mats at their bedside. 2. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included end stage of renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3's cognitive skills for daily decision making was intact. The MDS indicated Resident 3 required supervision for eating and oral hygiene. The MDS indicated Resident 3 required moderate assistance for upper body dressing and personal hygiene. The MDS indicated Resident 3 required maximal assistance for toileting hygiene, shower/bathing, lower body dressing, and putting on/taking off shoes. During a review of Resident 3's Order Summery Report dated 4/10/2026, the Order Summary Report indicated Resident 3 had an order for bilateral floor mats. During an observation on 4/22/2026 11:48 a.m. in Resident 3's room, Resident 3 did not have bilateral floor mats. 3. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included respiratory failure and dependence on supplement oxygen. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making was intact. The MDS indicated Resident 4 was independent when eating. The MDS indicated Resident 4 required set up assistance for oral hygiene. The MDS indicated Resident 4 required supervision for upper body dressing and personal hygiene. The MDS indicated Resident 4 required moderate assistance for toileting hygiene and shower/bathing. The MDS indicated Resident 4 required maximal assistance for lower body dressing and putting on/off footwear. During a review of Resident 4's H&P, dated 2/23/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Accident/Incident Report, dated 3/7/2026, the Accident/Incident Report indicated Resident 4 had a fall on 3/7/2026 and sustained on a forehead laceration. During a review of Resident 4's Fall Risk Assessment, dated 4/16/2026, the Fall Risk Assessment indicated Resident 4 had history of one or two falls and had a score of 14 ([moderate Risk], 12-15 range, requiring standard care with fall risk factors). 4. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (a condition caused by a brain injury, that results in a varying degree of weakness, stiffness and lack of control in one side of the body) and hemiparesis (neurological condition characterized by weakness, reduced muscle strength, or partial paralysis on one side of the body, affecting the arm, leg, and sometimes the face). During a review of Resident 5's H&P, dated 9/1/2025, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was intact. The MDS indicated Resident 5 was independent for eating. The MDS indicated Resident 5 required set up assistance for oral hygiene and upper body dressing. The MDS indicated Resident 5 required supervision for personal hygiene. The MDS indicated Resident 5 required moderate assistance for toileting hygiene, shower/bathing, lower body dressing and putting on/taking off footwear. During a review of Resident 5's Fall Risk Assessment, dated 2/16/2026, the Fall Risk Assessment indicated Resident 5 had no history of falls and had a score of 13. During a review of Resident 5's Accident/Incident Report, dated 3/1/2026, the Accident/Incident Report indicated Resident 5 had a fall on 3/1/2026. During an interview on 4/23/2026 at 12:58 p.m. with the Director of Nursing (DON), the DON stated a fall risk assessment was a tool used to indicate if a resident was at risk for a fall. The DON stated a fall risk assessment was completed on admission, quarterly, yearly and after a fall. The DON stated residents that were at risk for falls were monitored and nursing staff care planned the risk for fall and developed interventions to keep residents safe. The DON stated a resident must have floor mats if they had order for floor mats. The DON stated it was important to provide floor mats to resident for their safety and to prevent injuries. During a review of facility's Policy and Procedure (P&P) titled, Fall Risk Assessment, undated, the P&P stated upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time. During a review of facility's P&P titled, Assessing Falls and Their Causes, undated, the P&P stated when a resident had a fall, the following information would be recorded in the resident's medical record: Completion of a falls risk assessment an appropriate interventions taken to prevent future falls. During a review of facility's P&P titled, Carrying out Physician's Orders, undated, the P&P (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated the objective of the policy was to ensure all physicians orders were carried out in a safe, timely, and accurate manner.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide safe oxygen administration practices ([oxygen therapy], is the medical practice of delivering oxygen at a concentration greater than ambient air) for three of four sampled residents (Residents 1, 3, 4) by: 1. Not ensuring Resident 1's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was dated with an open date and did not ensure nasal cannula was not touching the floor. 2. Not ensuring Resident 3 had a bag at the bedside for oxygen equipment and did not ensure nasal cannula was not touching the floor. 3. Not ensuring Resident 4 received oxygen administration when using motorized wheelchair and did not ensure the nasal cannula was not touching the floor and placed over the restroom doorknob. These deficient practices increased the risk for Resident 1, 3, and 4) to acquire a respiratory infection (infectious disease caused by bacteria, viruses, or fungi that affects the respiratory tract, including the nose, sinuses, throat, airways, and lungs) and placed resident 3 at risk of respiratory distress (difficulty breathing, shortness of breath, rapid breathing, and the use of accessory muscles to breathe). Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included respiratory failure (serious condition that makes it difficult for a person to breathe on their own, lungs can't get enough oxygen into the blood) and heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath). During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 3/14/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for lower body dressing, shower/bathing, toileting hygiene and putting on/off footwear. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for upper body dressing, oral hygiene and eating. During a review of Resident 1's Order Summery Report dated 3/17/2026, the Order Summary Report indicated Resident 1 had an order for oxygen 2 liters per minute (L/min) to maintain oxygen saturation ([O2 sat], a measurement of how much oxygen the blood is carrying as a percentage) greater than 91 percent (%). During an observation on 4/21/2026 at 1:20 p.m., in Resident 1's room, Resident 1 nasal cannula was not labeled with open date and was touching the floor. During a concurrent observation and interview on 4/22/2026 at 11:43 a.m. with the Infection Preventionist Nurse (IPN) in Resident 1's room, Resident 1's nasal cannula was not labeled with opened date and the nasal cannular was touching the floor. The IPN stated the nasal cannula should be labeled with the date it was opened for infection prevention. The IPN stated there was no way of knowing when or if the nasal cannula had been changed because it was not dated. 2. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included end stage of renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). During a review of Resident 3's Order Summery Report dated 3/31/2026, the Order Summary Report indicated Resident 3 had an order for oxygen 3 liters per minute (L/min) to maintain oxygen saturation greater than 92%. During a review of Resident 3's Medication Administration Record (MAR), dated 4/1/2026 - 4/30/2026, the MAR indicated to change and label oxygen tubing and plastic bag every night shift starting on the last day of the month and ending on the last day of the month. The MAR indicated from 4/1/2026 to 4/23/2026 oxygen tubing was not changed. During a review of Resident 3's electronic medical record, unable to locate Resident (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3's care plan for oxygen administration. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decision making was intact. The MDS indicated Resident 3 required supervision for eating and oral hygiene. The MDS indicated Resident 3 required moderate assistance for upper body dressing and personal hygiene. The MDS indicated Resident 3 required maximal assistance for toileting hygiene, shower/bathing, lower body dressing, and putting on/taking off shoes. During a concurrent observation and interview on 4/22/2026 at 11:47 a.m. with the IPN in Resident 3's room, Resident 3 did not have a bag for oxygen equipment and the nasal cannular was touching the floor. The IPN stated residents required a bag for their oxygen equipment for infection control and was touching the floor. The IPN stated when residents are not using the nasal cannula, the nasal cannula must be placed in the bag to prevent it from getting contaminated with germs. During an interview on 4/23/2026 at 12:46 p.m. with the Director of Nursing (DON), the DON stated Resident 3 should have a care plan for oxygen administration because it was a lifesaving issue. The DON stated an oxygen care plan would outline interventions for nursing staff to follow. The DON stated oxygen administration interventions would be to check residents' pulse, to follow doctor's oxygen order, to place oxygen tubing in a bag when not in use and to change oxygen tubing every two weeks. 3. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included respiratory failure and dependence on supplement oxygen. During a review of Resident 4's Order Summery Report dated 11/23/2025, the Order Summary Report indicated Resident 4 had an order for oxygen 2 L/min, three times a day for shortness of breath (SOB). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making was intact. The MDS indicated Resident 4 was independent when eating. The MDS indicated Resident 4 required set up assistance for oral hygiene. The MDS indicated Resident 4 required supervision for upper body dressing and personal hygiene. The MDS indicated Resident 4 required moderate assistance for toileting hygiene and shower/bathing. The MDS indicated Resident 4 required maximal assistance for lower body dressing and putting on/off footwear. During a review of Resident 4's H&P, dated 2/23/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions. During an observation on 4/21/2026 at 2:32 p.m., Resident 4 was observed on motorized wheelchair without oxygen administration. During an observation on 4/22/2026 at 9:33 a.m., Resident 4 was observed on motorized wheelchair without oxygen administration. During an interview on 4/22/2026 at 11:25 a.m. with the IPN, The IPN stated for infection prevention for resident receiving oxygen administration, nursing staff must label the nasal cannulas with open date, place nasal cannula in a bag when not in use and avoid the nasal cannula tubing to touch the floor. The IPN stated oxygen equipment had to be changed weekly or biweekly for infection prevention. The IPN stated it was important to change oxygen equipment for residents' safety. The IPN stated the risk of not dating oxygen cannulas was nursing staff would not know if oxygen equipment was old and would potentially cause an infection. During a concurrent interview and record review on 4/22/2026 at 11:39 a.m. with the IPN, Resident 4's Order Summary Report, dated 11/23/2025, was reviewed. The Order Summary Report indicated Resident 4 had an order for 2 L/min of oxygen three times day. The IPN stated three times a day meant Resident 4 required continuous oxygen and all three shifts had to monitor when Resident 4 received oxygen continuously. IPN stated Resident 4 required oxygen at all times and should not be without oxygen even when Resident 4 was using motorized wheelchair. The IPN stated it was important for Resident 4 to continuously receive oxygen to prevent Resident 4 from experiencing respiratory distress. During a concurrent observation and interview on 4/22/2026 at 11:53 a.m. with the IPN in Resident 4's room, Resident 4's nasal cannula was hanging off restroom doorknob and touching the floor. The IPN stated that was not acceptable practice because the nasal cannula had to be placed in a bag and not touching the floor. The IPN stated Resident 4 could not reuse that nasal cannula because it was contaminated. The IPN stated Resident 4 continuously removed the nasal cannula when Resident 4 used motorized wheelchair. During an interview on 4/23/2026 at 12:37 p.m. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the DON, the DON stated nursing staff were required to label oxygen equipment with open date, to change oxygen equipment every two weeks, and place unused oxygen equipment in a bag for infection prevention and for resident safety. The DON stated if infection prevention practices were not followed there was a risk for residents to get a respiratory infection. The DON stated residents were not allowed to remove their oxygen because it would potentially cause resident to experience respiratory distress. The DON stated all staff were responsible to make sure all infection prevention practices were followed and to make sure all residents were continuously receiving oxygen. During a review of facility's Policy and Procedure (P&P) titled, Oxygen Administration/Respiratory Supply, dated 4/1/2026, the P&P indicated all residents on oxygen either continuous or as needed, should be monitored by all nursing staff. The P&P indicated all oxygen supplies, including tubing, nasal cannula, mask, nebulizer, and nebulizer tubing should be changed biweekly, documenting the date and time. The P&P indicated all supplies not in use should be placed in a bag for infection prevention control.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility did not ensure dietary staff followed the dietary menus for two of two meals: 1. Facility did not ensure residents received meals according to dietary menu (a structured, planned selection of food items tailored to meet specific nutritional, health, lifestyle, or cultural needs) on 4/21/2026 and 4/22/2026. 2. Facility did not ensure the Dietary Services Supervisor (DSS) checked food before food left the kitchen. 3. Facility did not notify residents there was a change in food that was served on 4/21/2026 and 4/22/2026. These deficient practices had the potential to impact on resident's nutritional status and placed all (112) residents at risk for unintentional weight loss. Findings: During an observation on 4/21/2026 at 12:20 p.m., residents received meat, a salad, and broccoli for lunch. During a review of facility's lunch menu titled [NAME] Nutrition consulting Spring Menu Week Seven, dated 4/21/2026, the lunch menu indicated residents were scheduled to receive Chicken cacciatore, garlic noodles, sauteed squash, French bread, margarine, and ice cream. During an observation on 4/22/2026 at 12:25 p.m., residents received pizza and a salad for lunch. During a review of facility's lunch menu titled [NAME] Nutrition consulting Spring Menu Week Seven, dated 4/22/2026, the lunch menu indicated residents were scheduled to receive country fried steak with gravy, mashed potatoes, seasoned peas, and cherry cheesecake. During an interview on 4/22/2026 at 2:43 p.m. with the Dietary Services Supervisor (DSS), the DSS stated dietary staff, cooks, and DSS were responsible to check food before it left the kitchen. The DSS stated DSS had provided dietary menus (a structured, planned selection of food items tailored to meet specific nutritional, health, lifestyle, or cultural needs) and food spreadsheets (a tool used by dietary staff to track and manage the specific nutritional needs, dietary restrictions, food allergies, and preferences of each resident) to dietary staff and dietary staff had to follow that for every meal. The DSS stated on 4/22/2026 residents were supposed to receive country fried chicken. The DSS stated the DSS was not aware the [NAME] did not follow the menu until the food was served to the residents. The DSS stated the [NAME] had not informed the DSS about the menu change and the [NAME] was supposed to notify the DSS of any changes. The DSS stated the DSS was in the kitchen when the [NAME] prepared food but the DSS did not check what the [NAME] prepared for lunch and the DSS stated the DSS was not aware of what was on the menu for that day. During an interview on 4/23/2026 at 8:32 a.m. with the Cook, the [NAME] stated the [NAME] reviews the book of menus weekly and gives a list of what needs to be ordered to the DSS. The [NAME] stated the [NAME] served pizza on 4/22/2026 to residents because the chicken that was ordered did not arrive in time. the [NAME] stated on 4/21/2026 the meat company informed the [NAME] the delivery of chicken was delayed. The [NAME] stated the [NAME] decided to cook pizza for lunch and did not notify the DSS. The [NAME] stated the [NAME] was allowed to make changes to the menu and did not have to notify the DSS of menu changes. The [NAME] stated the [NAME] was required to notify the DSS of the menu change because the DSS needed to inform residents of the menu change. The [NAME] stated it was important to follow dietary menus and food spreadsheet to honor residents' diets and nutritional values (providing nutrient-dense, appetizing, and individualized meals that manage chronic conditions, support wound healing, prevent malnutrition, and maintain the physical/cognitive function of aging residents). the [NAME] stated serving pizza did not offer the same nutrition and calories as the scheduled meal did. During an interview on 4/23/2026 at 8:49 a.m. with the Cook, the [NAME] stated on 4/21/2026 he did not serve what was on the dietary menu. the [NAME] stated the [NAME] was supposed to serve chicken on 4/21/2026 but instead the [NAME] looked at what food was in the refrigerator and cooked something else. the [NAME] stated the chicken did not arrive on time and he decided to cook something else and did not inform the DSS that the chicken was not available. The [NAME] stated one month ago the [NAME] received new food menus but did not look over them. The [NAME] stated the [NAME] was supposed to follow the (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	new menus this week but the [NAME] did not. The [NAME] stated the [NAME] did not follow the food menus on 4/21/2026 and 4/22/2026 and the [NAME] should have followed the dietary menus. During an interview on 4/23/2026 at 9:20 a.m. with the DSS, the DSS stated the DSS did not know the food menu was not followed until food had left the kitchen. The DSS stated the DSS was present in the kitchen while the [NAME] was preparing food but the DSS did not notice what the [NAME] served for lunch. The DSS stated residents were not notified of the dietary menu change and residents were supposed to be notified of all menu changes two to three hours ahead of mealtime. the DSS stated the DSS did not know dietary menu was not followed on 4/21/2026 and 4/22/2026. The DSS stated the DSS was supposed to monitor dietary staff, monitor the food that was served and make sure all food plates were served according to doctor's orders but the DSS did not do that. The DSS stated the DSS did not know what food was served to residents on 4/21/2026. During an interview on 4/23/2026 at 1:50 p.m. with Director of Nursing (DON), the DON stated the DSS and the Registered Dieticians were allowed to make menu changes and not the Cook. The DON stated if there was a dietary menu change, nursing staff must be informed to notify residents of the change. The DON stated residents were required to be informed of menu changes because it was their right to be informed of the food that will be served. The DON stated she was not informed that on 4/21/2026 and 4/22/2026 the diet menu was not followed and DON should have been informed. The DON stated on 4/21/2026 and 4/22/2026, the residents did not receive the correct nutritional value because the dietary menu and dietary spreadsheet was not followed. During a review of facility's job description, titled Director of Food and Nutrition Services, undated, the Job description indicated Director of food and nutrition services would effectively manage the operation of the department of food and nutrition services. The job description indicated the Director of Food and Nutrition Services would supervise the preparation of food and food service for resident/patient meals according to established menus and standardized recipes. The job description indicated the Director of Food and Nutrition Services would keep turning, organizing, controlling, coordinating, directing and evaluating all aspects of the food service along with data collection for clinical charting cool. The job description indicated the director of food and nutrition services would ensure food was prepared by methods that conserve nutritional value and is powerful and attractive to residents and patients. The job description indicated the director of food nutrition services would ensure residents/patients received the proper food items to meet the department of food and nutrition services needs and that food was served at the appropriate temperatures for safety and palatability. The job description indicated the Director of Food and Nutrition Services would purchase food and supplies according to the facility menu. During a review of facility's job description, titled Cook, undated, the job description indicated the cook would prepare and serve food including texture modified and therapeutic diets according to the facility menu. The job description indicated the cook would prepare food by methods that conserve nutritive value, flavor, and palatability. The job description indicated the cook would follow instructions from dietary services supervisor in the preparation of meals and would maintain meal schedules. During a review of facility's Policy and Procedure (P&P) titled, Menu Substitutions, undated, the P&P indicated the director of food and nutrition services was responsible for supervising meal preparation and service to assure the menu is followed and served as planned. The P&P indicated menu substitutions must be made from the same food group as the omitted item.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the correct food texture-modified diet (alters the consistency of food and liquids to make swallowing safer and easier for people with chewing or swallowing difficulties) for two of four sampled residents (Residents 1 and 2) when: 1. The facility did not ensure Resident 1 and Resident 2 received the correct food texture. 2. The facility did not ensure Dietary Supervisor checked for food texture for Resident 1 and Resident 2 before the food leaving the kitchen. These deficient practices had the potential for Residents 1 and 2 to have problems chewing and swallowing and increased the risk of choking for Residents 1 and 2 while eating. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included respiratory failure (serious condition that makes it difficult for a person to breathe on their own, lungs can't get enough oxygen into the blood) and heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath). During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 3/14/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Care Plan for nutrition, dated 3/14/2026, the Care Plan indicated Resident 1 required a therapeutic diet (meal plan that modifies a regular diet to manage medical conditions, treat illnesses, or alter nutritional intake). The care plan indicated Resident 1's intervention was to monitor Resident 1 for food pocketing, choking, coughing, drooling, holding food in mouth and several attempts at swallowing. During a review of Resident 1's Nutrition/Dietary Note, dated 4/14/2026, the Nutrition/Dietary note indicated Resident 1 was to receive a mechanical soft texture/easy to chew food texture. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for lower body dressing, shower/bathing, toileting hygiene and putting on/off footwear. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for upper body dressing, oral hygiene and eating. During a review of resident 1's Order Summary Report, dated 4/17/2026, the Order Summary report indicated Resident 1 had an order for mechanical soft easy to chew diet. During an interview on 4/21/2026 at 12:48 p.m. with Resident 1, Resident 1 stated he received meat in one piece and staff cut into smaller pieces. Resident 1 stated the broccoli was hard and was not soft when he chewed it. Resident 1 stated Resident 1 had to chew food longer to be able to swallow the food more easily. During an observation on 4/21/2026 at 12:50 p.m. in Resident 1's room, Resident 1 had a food tray with broccoli and meat. Resident 1's dietary slip indicated mechanical soft diet (nutritionally adequate foods that are physically altered-chopped, ground, mashed, or pureed-to require minimal chewing)/easy to chew. During an observation on 4/22/2026 at 8:11 a.m. in Resident 1's room, Resident 1 had a bowl of grapes, cut in half with skin on and melon cut in rectangle shape. During an interview on 4/22/2026 at 8:15 a.m. with Resident 1, Resident 1 stated grapes and melons looked big in size and would not eat them. During an interview on 4/22/2026 at 2:13 p.m. with the Dietary Supervisor (DS), The DS stated a mechanical soft diet was soft, easy to chew food texture, food in ground meat consistency, and soft vegetables. The DS stated broccoli needed to be chopped up into small pieces and did not know the size of food should be cut into. During a review of facility's P&P titled, Level 7 Regular Easy to Chew, undated, the P&P indicated it was a mechanical altered diet that consist of food that were soft and easy to chew and swallow. The P&P indicated the diet excluded hard, sticky or crunchy food. The P&P indicated meats should be moist and chopped into 1/2 inch or smaller or ground to cottage cheese size. 2. During a review of Resident 2's admission Record (AR), (continued on next page)

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	056117	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rowland	330 W. Rowland Street Covina, CA 91723

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease (a group of conditions affecting the blood vessels that supply the brain, causing temporary or permanent damage due to restricted blood flow, blockage, or rupture) and dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). During a review of Resident 2's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 4/25/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions due to vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). During a review of Resident 2's Order Summary Report, dated 11/11/2025, the Order Summary Report indicated Resident 2 had an order for minced and moist diet (consists of soft, cohesive foods finely minced to roughly, designed for individuals with chewing or swallowing difficulties. Foods are moist, hold together without separating into liquid, and are easily mashed with a fork or tongue) three times a day. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 2/7/2026, the MDS indicated Resident 2's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 2 required supervision for eating. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) for upper body dressing, personal hygiene and oral hygiene. The MDs indicated Resident 2 required maximal assistance (helper does more than half the effort) for shower/bathing and lower body dressing. The MDS indicated Resident 2 was dependent on staff for toileting hygiene and putting on/taking off shoes. During a review of Resident 2's Quarterly Nutritional Progress Note, dated 2/6/2026, the Quarterly Nutritional Progress Note indicated Resident 2 had an order for minced and moist diet. During a review of Resident 2's Care Plan for nutrition indicated Resident 2 had a diagnosis for dysphagia. The care plan indicated Resident 1 required a therapeutic diet and required a mechanically altered diet (a therapeutic, texture-modified eating plan designed for individuals with chewing or swallowing difficulties, typically consisting of moist, finely chopped, ground, or mashed foods to ensure safe swallowing). The care plan indicated Resident 2's intervention was to monitor Resident 2 for food pocketing, choking, coughing, drooling, holding food in mouth and several attempts at swallowing. During an observation on 4/21/2026 at 12:43 p.m. in Resident 2's room, Resident 2 had a plate with bread with edges and cheese sandwich. Resident 2's food tray had apple pie with crust and vegetable soups with bacon and carrots. During an interview on 4/21/2026 at 12:45 p.m. with Resident 2, Resident 2 stated Resident 2 received a cheese sandwich and nursing staff cut it into pieces. Resident 2 stated it was not easy to swallow because the pieces were big. Resident 2 stated Resident 2 received food that was not easy to chew and was not cut into little pieces. During an interview on 4/21/2026 at 12:54 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 2's sandwich was supposed to be cut into bite size. CNA 1 stated Resident 2's sandwich arrives from the kitchen in whole and CNA 2 cuts it into bite size. CNA 1 stated the pie served to Resident 2 was too hard for Resident 2 to chew and needed to be cut into smaller pieces to swallow. During an interview on 4/22/2026 at 1:43 p.m. with CNA 2, CNA 2 stated residents received food from the kitchen and CNA 2 had to cut the food into smaller pieces. CNA 2 stated CNA 2 did not know how small to cut food and CNA 2 cut food to the size that was easier to eat. CNA 2 stated residents with an order for mechanical soft diet had problems chewing and swallowing and needed their food to be safe when eating. During an interview on 4/22/2026 at 2:07 p.m. with DS, DS stated a minced/moist diet required food to be wet and chopped into tiny pieces. DS stated food consistency must be ground and moist. DS stated an apple pie had to be minced to avoid residents from choking. DS stated a sandwich cut into bite size was not acceptable for a resident that had an order for a minced/moist diet and it could potentially cause resident to choke. DS stated serving bread with edges was not acceptable because edges were hard to chew and could potentially cause a resident to choke. During an interview on 4/22/2026 at 2:21 p.m. with DS, DS stated dietary staff and DS were responsible to check food served before it left the kitchen. The DS stated it was important to serve the correct food (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diet and food texture for residents' safety and to make sure residents receive the correct nutrition. During an interview on 4/23/2026 at 1:35 p.m. with the Director of Nursing (DON), the DON stated therapeutic diets were ordered for residents' safety.The DON stated dietary staff were responsible to provide the correct food texture to residents. The DON stated nursing staff was responsible to check al residents' food before delivering it to residents. The DON stated it was important to serve the correct food texture to prevent residents from choking. During a review of facility's P&P titled Level 5 Minced and Moist, undated, the P&P indicated diet consisted of food that were moist, soft textured and easily form into a bolus. The P&P indicated meat must be finely minced or chopped, tender mince (pieces 2-4mm), cottage cheese size; they must be moist with some cohesion.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not provide a working call light to one of four sampled residents (Resident 2). This deficient practice had the potential to cause a delay or the inability in obtaining necessary care and services for Resident 2. Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease (a group of conditions affecting the blood vessels that supply the brain, causing temporary or permanent damage due to restricted blood flow, blockage, or rupture) and dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). During a review of Resident 2's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 4/25/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions due to vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 2/7/2026, the MDS indicated Resident 2's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 2 required supervision for eating. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) for upper body dressing, personal hygiene and oral hygiene. The MDs indicated Resident 2 required maximal assistance (helper does more than half the effort) for shower/bathing and lower body dressing. The MDS indicated Resident 2 was dependent on staff for toileting hygiene and putting on/taking off shoes. During an observation on 4/21/2026 at 12:30 p.m. in Resident 2's room, Resident 2 pushed the call light. The call light did not turn on inside and outside of room. During an interview on 4/21/2026 at 12:37 p.m. with Resident 2, resident 2 stated he pushed call light for assistance and staff did not come to his room to offer assistance. Resident 2 stated he did not know why staff did not come to offer assistance when he pushed his call light because he needed help with his lunch. During an observation on 4/22/2026 at 8:15 a.m. in Resident 2's room, Resident 2 pushed the call light. The call light did not turn on inside and outside of room. During an interview on 4/22/2026 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was all staff responsibility to check on residents' call lights. LVN 1 stated staff was responsible to answer call lights and to check if call lights were working. LVN1 stated the call light system was a way for residents to communicate with staff if they needed assistance. LVN 1 stated it was important to provide a call light that worked to residents for communication and residents' safety. LVN 1 stated if residents call light did not work, residents would not be able to call for help if they had a medical emergency. During an interview on 4/22/2026 at 1:50 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated at the start of his shift he did rounds to all resident rooms and made sure residents call light were working. CNA 2 stated Resident 2's call light was checked today and it was working. CNA 2 stated it was important for all residents to have a working call light because that was the way residents requested for help. During an observation and interview on 4/22/2026 at 1:55 p.m. in Resident 2's room, CNA 2 pushed Resident 2's call light and call light did not turn on inside Resident 2's room and outside of room. CNA 2 stated Resident 2's call light should be working and was not aware that it was not working. CNA 2 stated there was a potential of Resident 2 not receiving the assistance or help that Resident 2 required because the call light did not work. CNA 2 stated it was important to make sure all call lights were working to be able to assist residents if they had a medical emergency. During an interview on 4/23/2026 at 12:37 p.m. with the Director of Nursing (DON), the DON stated call lights were used to help residents with their needs and were used to facilitate the delivery of care. The DON stated all staff were responsible to answer call lights and to check what residents needed. The DON stated maintenance was responsible to check if the call lights were working and nursing staff were responsible to check them every shift. The DON stated if residents' call lights are not working, the (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents' needs would not be met. During a review of facility's Policy and Procedure (P&P) titled, Call Light, undated, the P&P indicated the purpose was to ensure prompt, safe, and respectful response to residents call lights. The P&P indicated all call lights would be answered within 5 to 6 minutes without undue delay.