STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056124	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tarzana Health and Rehabilitation Center	5650 Reseda Blvd Tarzana, CA 91356

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly when: 1. Two dumpsters (a movable waste container designed to be brought and taken away by special collection vehicles, or to a bin that specially designed garbage truck lifts) were overflowing with garbage and were not completely closed when not in use. 2. The area surrounding the dumpsters contained scattered debris on the ground including green beans, carrots, soiled gloves, empty food containers, and plastics. These failures had the potential to attract pests such as rats, cockroaches, flies, and ants, which may spread diseases to 165 of 165 residents living in the facility. Findings: During a concurrent observation and interview on 6/17/2026 at 8:43 a.m., of the dumpster area with the Dietary Supervisor (DS) outside the facility, observed two (2) black dumpsters overflowing with garbage, with their lids not completely closed while not actively being used by the facility staff. The DS stated the lids of the dumpsters were not completely closed. The DS stated the dumpsters need to be completely closed to prevent the trash from attracting flies and rats. The DS further stated pests such as rats carry germs and may potentially spread infection to the residents of the facility. During a concurrent observation and interview on 6/17/2026 at 8:48 a.m., of the dumpster surroundings with the DS outside the facility, observed the area surrounding the dumpsters contained scattered debris on the ground such as green beans, carrots, soiled gloves, empty food containers, and plastics. The DS stated there were food particles of green beans and carrots on the ground in front of the dumpsters and it is not acceptable because leftover foods may attract pests such as rats, which could spread infection to the residents. During a concurrent observation and interview on 6/17/2026 at 9:01 a.m., of the dumpster area with the Housekeeping Supervisor (HS) outside the facility, observed the area surrounding the dumpsters containing scattered debris on the ground such as green beans, carrots, soiled gloves, and trash bags. The HS stated there were food particles left on the ground. The HS stated they clean the dumpster surroundings using a leaf blower and they sweep it after. The HS stated they would not be able to clean the food debris on the ground with the use of a leaf blower. The HS further stated it is important to maintain the cleanliness of the dumpsters' surroundings to prevent the spread of germs to the residents and prevent the dumpster from attracting pests. The HS further stated that it was important for the dumpster lids to be closed to prevent the germs from spreading in the air because when it was open and it could smell. During a review of the facility's policy and procedure (P&P) titled, Disposal of Garbage and Refuse, dated 5/28/2026, the P&P indicated, The facility shall properly dispose of kitchen garbage and refuse Refuse containers and dumpsters are kept outside the facility shall be designed and constructed to have tight fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding areas shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside (continued on next page)

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of residents were protected by failing to ensure documents (menu tickets) containing protected information ([PHI]- any health information that can be used to identify specific individual which must remain confidential to prevent harmful consequences) were shredded prior to disposing in the waste container. This deficient practice had the potential to violate 157 of 167 residents' rights for privacy and confidentiality of personal and medical records. Findings: During an observation on 6/16/2026 at 9:16 a.m., of the dishwashing process in the dishmachine area, observed Dietary Aide 2 (DA 2) throwing the leftover foods, plastic and menu tickets into the grey trash can. During an observation on 6/16/2026 at 9:20 a.m., of DA 2 dishwashing process, observed DA 2 throw a menu ticket in the trash. During an observation on 6/16/2026 at 9:21 a.m., of DA 2 dishwashing process, observed DA 2 throw two (2) menu tickets in the trash. During an observation on 6/16/2026 at 9:22 a.m., of DA 2 dishwashing process, observed DA 2 throw 2 menu tickets in the trash. During an observation on 6/16/2026 at 9:24 a.m., of DA 2 dishwashing process, observed DA 2 throw a menu ticket in the trash. During a concurrent observation and interview on 6/16/2026 at 9:25 a.m., of the dishwashing process with the Dietary Supervisor (DS), observed DA 2 continue throwing the menu tickets in the trash while stripping the trays (removing trays from the cart and clearing from the solid waste and food leftovers). The DS stated DA 2 breaks down the tray from food leftovers, and trash. The DS stated the trash goes to the dumpster outside. The DS stated DA 2 threw the meal tickets in the trash and it was not okay as the meal tickets contained residents' names, food preferences, diet, room number, date, likes and dislikes. The DS further stated resident's name is personal information and it was not appropriate to throw it in the trash due to Health Insurance Portability and Accountability Act (HIPPA, a federal law designed to protect sensitive patient health information from being disclosed without the resident's consent). The DS stated HIPPA protects residents' information and they did not protect personal information of the residents by throwing the information in the trash. The DS stated the right process was for DA 2 to separate meal tickets for shredding prior to discarding. During a review of the facility's policy and procedure (P&P) titled, Safeguard of Resident Identifiable Information, dated 5/28/2026, the P&P indicated, It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the safety and confidentiality of the resident's identifiable information and to safeguard against destruction or unauthorized release of information and records. During a review of the facility's P&P titled, Confidentiality of Personal and Medical Records, dated 5/28/2026, the P&P indicated, This facility honors the resident's right to secure and confidential personal and medical records. This includes the right to confidentiality of all information contained in a residents' records, regardless of the form of storage or location of the record. Policy explanation and compliance guidelines: Personal and medical records include all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated, or other. Keep confidential is defined as safeguarding the content of information including written documentation, video, audio, or other computer stored information from unauthorized disclosure without the consent of the individual and/or individual's surrogate or representative.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: 1. Licensed nurses practiced professional standards of practice by failing to carry out the physician's orderˆtoˆhave the right arm sling (a supportive medical device designed to immobilize and protect the arm) on at all times during two observations for one ofˆthreeˆsampled residents (Resident 2) investigated under position and mobility.ˆ This deficient practiceˆresultedˆinˆthe residentˆnot receiving the necessary care and servicesˆin accordance withˆthe professional standards of practice.ˆˆˆˆ 2. One of one sampled resident (Resident 12) received treatment and care in accordance with professional standards of practice when a licensed nurse did not assess, document, notify the doctor, obtain orders, and initiate a care plan for a new wound to the resident's left lower leg. This deficient practiceˆresultedˆinˆthe residentˆnot receiving the necessary care and servicesˆin accordance withˆthe professional standards of practice and had the potential to result in Resident 12 experiencing complications including infection and poor wound healing. Findings: a. During a review of Resident 2's admission Record, the admission Recordˆindicated the facility admitted Resident 2 on 11/5/2025 with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and a history of falling. During a review of Resident 2's History and Physical (H&P) dated 11/3/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Residentˆ2's Minimum Data Set (MDS- a resident assessment tool) datedˆ5/15/2026, the MDS indicated the residentˆis usually understoodˆand usually understood by others.ˆThe MDS indicated that Residentˆ2ˆis dependent (helper does all the effort) on staff for bathing, upper/lower body dressing, and toileting.ˆˆ During a review of Resident 2's physician orders, the physician orders indicated an order for right arm sling at all time, every shift ordered on 5/22/2026. During aˆconcurrent observation and interview on 6/15/2026ˆatˆ9:18 a.m.,ˆwith Certified Nursing Assistant 2 (CNA 2) in Resident 2's room, CNA 2 stated Resident 2 used to wear a sling all the time on his right arm but has not noticed it lately. CNA 2 stated the sling is meant to help support the resident's arm and prevent pain. During a concurrent observation and interview on 6/16/2026 at 1:22 p.m., in Resident 2's room with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated there should be a sling on Resident 2's right arm at all times according to the physician's order and was not sure why it was not on at this time. LVN 3 stated the sling is used to immobilize the arm to support his arm and prevent pain. During an interview on 6/16/2026 at 1:26 p.m., with Family Member 2 (FM 2), who was visiting Resident 2, FM 2 stated Resident 2 needs to have his sling on at all times to prevent his arm from hurting. During an interview on 6/18/2026 at 11:46 a.m., with the Director of Nursing (DON), the DON stated licensed nurses and CNAs must follow the physician's orders and clarify if there is any confusion. The (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated her staff did not follow the physician's order by not applying Resident 2's right arm splint. During a review of the facility`s policy and procedure (P&P) titled, Prevention of Decline in Range of Motion, last reviewed on 5/28/2026, the P&P indicated that the facility will provide treatment and care in accordance with professional standards of practice including appropriate equipment (braces or splints). The P&P further indicates preventative care such as limb immobilization after an injury or surgical procedure to decrease a decline in range of motion. b. During a review of Resident 12's admission Record, the admission Record indicated the facility originally admitted the resident on 9/5/2025 and most recently readmitted the resident on 5/8/2026 with diagnoses including, but not limited to, toxic encephalopathy (brain dysfunction caused by toxic exposure), generalized muscle weakness, and cellulitis (a skin infection that causes swelling and redness) to both legs. During a review of Resident 12's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 12 was dependent (helper does all of the effort) on staff for dressing and putting on and taking off footwear and required substantial assistance (helper does more than half of the effort) from staff for toileting and bathing. During an observation and interview on 6/17/2026 at 1:35 p.m., with Certified Nursing Assistant 5 (CNA 5) at Resident 12's bedside, CNA 5 stated Resident 12 did not have any active open wounds that she knew of. CNA 5 then lifted the resident's blankets off her legs and Resident 12 had an adhesive dressing on her left lower leg. Resident 12 stated someone put the dressing on her leg over the weekend but no one had looked at the dressing since then. During a concurrent observation and interview on 6/17/2026 at 2:31 p.m., with Treatment Nurse 1 (TN 1) at Resident 12's bedside, observed Resident 12 had an open wound to the left lower leg. TN 1 stated when he removed the adhesive dressing, there was an open wound under the dressing with a moderate amount of serosanguinous drainage (clear, thin, and pale red liquid that comes from a wound). TN 1 measured the wound and stated the area of the wound was 3.0 x 2.0 centimeters (cm-unit of measurement) and 0.1 cm deep. TN 1 stated the wound type was an open wound due to the resident having fragile skin. TN 1 stated he had not seen the wound before, he did not know who put the adhesive dressing over the wound, and there was no documentation of the wound. TN 1 stated an adhesive dressing should not have been used on the resident's leg because Resident 12 has fragile skin and the adhesive risks causing further damage. TN 1 stated when the wound was first found it should have been measured, documented, and the physician should have been notified. TN 1 stated physician's orders should have been obtained for a treatment and the wound should have been followed up on. TN 1 stated the wound could have potentially become larger and risked becoming worse or infected as it wasn't monitored and treatment wasn't continued after the first bandage was placed. During an interview on 6/18/2026 at 11:28 a.m., with TN 2, TN 2 stated she had worked over the weekend and she was not aware of Resident 12's left lower leg wound until TN 1 told her about it. TN 2 stated there was no way to know when the wound started or who but the original dressing on it. TN 2 stated the doctor should have been notified and an order obtained before a dressing was put on the wound. TN 2 stated the wound could have become worse or gotten bigger since those things were not done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/18/2026 at 1:16 p.m., with the Director of Nursing (DON), the DON stated she was unaware of who put the first bandage on or why but they should have called the doctor, gotten a treatment order, assessed the wound, developed a plan of care, and reassessed the skin for any other problems. The DON stated those procedures need to be followed to make sure the wound is treated appropriately so the wound doesn't deteriorate or get infected. During a review of the facility's policy and procedure (P&P) titled, Skin Assessment, last reviewed 5/28/2026, the P&P indicated when assessing skin the following should be documented: type of wound, wound measurements, color, type of tissue in wound bed, drainage, odor, pain and other information as appropriate. During a review of the facility's P&P titled, Provision of Quality Care, last reviewed 5/28/2026, the P&P indicated each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receive proper assistive devices to maintain vision and hearing abilities for three of three sampled residents (Resident 43, Resident 79, and Resident 87) by failing to: 1. Ensure Resident 43 and Resident 79 wore hearing aids (a device worn in or behind the ear designed to amplify sound for individuals who have difficulty hearing) inserted in the ear canal (a small pathway that runs from the outer ear to the middle ear and helps a person hear) as ordered by the physician. This deficient practice had the potential to result in Resident 43 and Resident 79 inability to maintain hearing ability. 2. Ensure ophthalmology (branch of medicine dealing with the diagnosis, treatment, and surgery of eye disorders and visual diseases) consultation was arranged for Resident 87. This deficient practice resulted in a delay in care and potential for worsening vision for Resident 87. Findings: 1.a. During a review of Resident 43's admission Record, the admission Record indicated the facility admitted the resident on 5/1/2022 and re-admitted the resident on 7/5/2022 with diagnoses including but not limited to displaced fracture of surgical neck of left humerus (a break in the upper arm bone near the shoulder joint), urinary tract infection (UTI- an infection in the bladder/urinary tract), and metabolic encephalopathy (a brain dysfunction caused by illness or chemical imbalance). During a review of Resident 43's History and Physical (H&P) dated 12/11/2025, the H&P indicated Resident 43 had decreased hearing and dementia and can make needs known but cannot make medical decisions. During a review of Resident 43's Minimum Data Set (MDS- a resident assessment tool) dated 3/16/2026, the MDS indicated Resident 43 used hearing aids and had moderate difficulty hearing if hearing aids are normally used. The MDS further indicated that the resident was dependent on activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and needs substantial or maximal assistance from others. During a review of Resident 43's physician order dated 2/27/2026, the physician order indicated application of hearing aids daily or as needed, turn on at 8:00 a.m., and turn off at 8:00 p.m. Charge after removal one time a day and remove per schedule. During a review of Resident 43's Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) revised 1/6/2026, the Care Plan indicated interventions to ensure the availability and functioning of hearing aids and monitor hearing impairment. During a concurrent observation and interview on 6/18/2026 at 11:46 a.m., with Registered Nurse 1 (RN 1) 1 in the rehabilitation room, observed Resident 43 with both hearing aids not inserted in the ear canal. RN 1 stated the morning Charge Nurse puts the hearing aids on the resident in the morning, and nursing staff should monitor that the hearing aids are in place throughout the day to ensure the resident is able to hear. b. During a review of Resident 79's admission Record, the admission Record indicated the facility admitted the resident on 9/19/2023 with diagnoses including but not limited to conversion disorder with seizures and convulsions (a condition where a person experiences physical or neurological (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	symptoms that are unexplained), hyperlipidemia (high amounts of fats in the blood), and hypertension (HTN-high blood pressure). During a review of Resident 79's H&P dated 9/9/2025, the H&P indicated Resident 79 can make needs known but cannot make medical decisions. During a review of Resident 79's physician order, dated 5/1/2026, the physician order indicated to place hearing aids in ears every day shift; and remove hearing aids, store and charge, every evening shift. During a review of Resident 79's Care Plan dated 6/18/2026, the Care Plan indicated Resident 79 had potential for communication problems related to hearing impairment and wears hearing aids. During an interview on 6/18/2026 at 11:29 a.m., with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated the morning shift nurse administers the hearing aids when the residents wake up or during first morning medication administration pass; then the evening Charge Nurse collects them at bedtime, places them their case to store them in the medication cart or put them to charge. LVN 7 stated licensed nursing staff receive hearing aids training from the vendor/person who delivers the hearing aids to the facility. During a concurrent observation and interview on 6/18/2026 at 11:33 a.m., with Resident 79 in the hallway outside Resident 79's room, observed Resident 79 sitting in a wheelchair listening to music from a radio without wearing hearing aids; the resident requested increased volume on the radio and stated, I can't hear well, please increase the volume. During a concurrent observation and interview on 6/18/2026 at 11:36 a.m., with LVN 7 in Resident 79's hallway, observed Resident 79 not wearing hearing aids. LVN 7 stated the hearing aids were not administered to Resident 79 during that morning medication pass and should be provided as ordered. During a review of the facility's policy and procedure (P&P) titled, Care and Use of Hearing Aids, revised 4/20/2026, the P&P indicated it is the practice of the facility to assist residents who wear hearing aids with insertion into the ear, to monitor function, provide cleaning and care, and depending on the hearing aid, to routinely check for poor tubing connections. 2. During a review of Resident 87's admission Record, the admission Record indicated that the facility initially admitted Resident 87 on 4/8/2022 with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), hypertension (HTN- high blood pressure), and hyperlipidemia (abnormally high levels of fats in the blood).ˆ During a review of Resident 87's MDS dated [DATE], the MDS indicated that Resident 87's cognition (mental action or process ofˆacquiringˆknowledge and understanding) was intact. The MDS indicated that Resident 87's ability to see in adequate light was adequate (sees fine details, such as regular print in newspapers/books). The MDS indicated Residentˆ87ˆrequired ranging from supervision/touching assistance to maximal assistance (helper does more than half the effort) forˆphysicalˆassistanceˆfrom staff for activities of daily living (ADLs – activities related to personal care). (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 87's progress note dated 12/8/2025, the progress note indicated that Resident 87 had reported vision loss in the left eye and diminishing vision in the right eye, with a history of retinal detachment in the left eye. The progress note also indicated that the plan of care includes consultation with a specialist. During a review of Resident 87's Order Summary Report, the Order Summary Reportˆindicatedˆthe following physician orders:^^^ -May see ophthalmologist (medical doctor that specialized in eye and vision care), initiated on 2/28/2023. During a review of Resident 87's Social Service assessment dated [DATE], the Social Service Assessment indicated in the Optometry/Ophthalmology and Dental Consult status that resident was referred to ancillary services (supplemental or diagnostic services provided in support of, or in addition to, care delivered by a primary clinician). During a review of Resident 87's care plan (a document that summarizes a resident's needs, goals, and care/treatment) titled, Impaired Visual Function, initiated on 4/11/2022, the care plan indicated interventions including scheduling consultations with eye specialists as needed, identifying factors that may impact visual function, and regularly observing, recording, and reporting any signs or symptoms of acute eye problems. Such symptoms could involve changes in the ability to carry out daily activities, decreased mobility, sudden vision loss, dilated pupils, a gray or milky appearance in the eyes, seeing halos around lights, double vision, tunnel vision, blurred vision, or hazy vision. During an interview on 6/15/2026 at 10:33 a.m., with Resident 87, Resident 87 stated being blind in her left eye, able to see only shadows, and said her right eye's vision was deteriorating. During an interview on 6/17/2026 at 10:10 a.m., with the Social Service Director (SSD), the SSD stated her responsibilities were to interact with residents and collaborating with all departments. Additionally, the SSD stated she coordinates and assists with care planning and addresses residents' needs, including arranging ancillary referrals, transportation, and appointments. During a concurrent interview and record review on 6/17/2026 at 10:50 a.m., with the SSD, reviewed Resident 87's ophthalmology records titled, Evaluation and Management Report, dated 4/28/2026. The SSD stated that although the ophthalmologist was at the facility on 4/28/2026, Resident 87 was not seen because insurance authorization was required beforehand. The evaluation and management report indicated that, To be seen by contracted provider or with authorization. The SSD stated she admitted she missed this step and accepted full responsibility. The SSD stated she will start the insurance authorization process to make sure Resident 87 can be seen by the ophthalmologist, as completing referrals was important. The SSD also emphasized that maintaining vision is crucial for Resident 87's quality of life and failure to do so could risk loss of eyesight. During an interview on 6/18/2026 at 12:41 p.m., with the Director of Nursing (DON), the DON stated that social services are responsible for arranging and scheduling referrals for ancillary services. The DON emphasized the importance of timely ophthalmology consultations to ensure residents receive appropriate assessments and address their needs related to vision maintenance or corrective eyewear. Furthermore, the DON stated that delays in addressing these needs may lead to worsening visual problems. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Hearing and Vision Services, reviewed on 5/28/2026, the P&P indicated to ensure residents have access to hearing and vision services as well as adaptive equipment, when appropriate. The facility employs a comprehensive assessment process to identify and evaluate residents' sensory abilities to deliver person-centered care. This process involves gathering historical information from medical records, families, and residents; conducting MDS and care area assessments; ongoing observation of sensory issues; and developing, implementing, and evaluating individualized Care Plans. Staff members are required to refer any identified needs for hearing or vision services or devices to the social worker or social service designee. The social worker or designee is responsible for assisting residents and their families in locating and utilizing available resources to meet vision and hearing needs. Once such services are identified, the social worker or designee will support residents by scheduling appointments and arranging transportation as necessary.

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Tarzana Health and Rehabilitation Center	5650 Reseda Blvd Tarzana, CA 91356

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs when: 1. Staff did not follow the recipe for green beans. 2. Staff did not follow the portion size of three (3) ounces (oz, unit of measurement) and served two (2) oz for pork roast recipe to regular and therapeutic diets (a specialized meal plan prescribed by a healthcare provider or registered dietician to treat a medical condition, manage symptoms, or aid in recovery). 3. Staff did not follow the portion size for large portion diet and served five (5) oz instead of 4.5 oz and for small portion diet served 1.5 oz instead of two (2) oz. This failure had the potential to result in decrease in food flavor, decrease and increase in food and nutrient intake to 157 of 167 residents on regular, therapeutic diets, resulting in unplanned weight loss or unplanned weight gain. Findings: 1. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Diet Spreadsheet Spring 2026, dated 6/15/2026, the spreadsheet indicated residents on regular texture diet would include the following foods on the tray: Pork roast with gravy three (3) oz Oven roasted potatoes 1/2 cup (c, a household measurement) [NAME] beans 1/2 c Bread or roll with margarine one each French silk pie 1/12 pie Choice of beverage eight (8) fluid oz During an observation on 6/15/2026 at 12:01 p.m., observed dietary staff adding three (3) scoops of butter on the green beans on trayline (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates). During a concurrent interview and record review on 6/15/2026 at 12:28 p.m., with the Dietary Supervisor (DS), reviewed the facility's standardized recipe titled, [NAME] Beans, dated 5/28/2026. The recipe indicated, to add 1 1/2 pounds (lbs., a unit of measurement) to four (4) gallon and three (3) quarts of green beans. The recipe further indicated the steps of cooking were as follows: Add green beans to large stockpot or saucepan Add margarine stir to combine [NAME] 8-10 minutes or until heated through. The DS stated it is important to follow the recipe to provide the right nutrition for the residents. The DS stated they follow the recipe for 150 portions of green beans by using 4 gallon and 3 quarts of green beans then adding 1 1/2 lbs. of butter. The DS further stated adding 3 scoops of butter is not okay as it would be good to measure it to make sure it's the right amount of butter. The DS stated the potential outcome for not measuring ingredients would be not providing the right nutrition to the residents and it could be more nutrients or less nutrients given to the residents. The DS stated the taste would be affected if recipes were not followed. During a review of the facility's policy and procedure (P&P) titled, Standardized Recipes, dated 5/28/2026, the P&P indicated, Standardized recipes will be used for all products prepared and will note appropriate seasonings in order to assure acceptance from the residents. Procedure: Use standardized recipes provided with menu cycle. Standardized recipes will have adjustments for yields needed. Standardized recipes will be adjusted for therapeutic and consistency modifications. 2. During a concurrent observation and interview on 6/15/2026 at 12:09 p.m., of the roast pork in trayline with [NAME] 1, observed one pan of pork roast on the steamtable. [NAME] 1 stated she cooked the roast pork from scratch, and she weighed it after cooking it. During a concurrent observation and interview on 6/15/2026 at 12:10 p.m., of roast pork portion sizes with [NAME] 1, observed [NAME] 1 place the scale to zero (0) then placed the following random pieces of roast pork on the scale with the readings of: first roast pork 2.2 oz second roast pork 2.4 oz third roast pork 2.2 oz During an interview on 6/15/2026 at 12:21 p.m., with the DS, the DS stated the portion size of the roast pork is three (3) oz and two (2) oz for the gravy which are indicated on the spreadsheet and recipes. The DS stated they cut the meat themselves and [NAME] 1 weighed it today to ensure that it is in the right portion size. The DS further stated after [NAME] 1 cuts the roast pork into portions, they are placed back in the oven, so it shrinks. During a review of the facility's standardized recipe titled, Roast Pork with Gravy, dated 5/28/2026, the recipe indicated, portion size 3 oz + gravy. During a review of the facility's menu (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spreadsheet titled, Diet Spreadsheet Spring 2026, dated 6/15/2026, the spreadsheet indicated residents on small portion diet (diet providing less calorie and protein by reducing portion sizes of food intended for residents needing to lose weight) would include two (2) oz of pork roast with gravy. During a review of the facility's menu spreadsheet titled, Diet Spreadsheet Spring 2026, dated 6/15/2026, the spreadsheet indicated residents on large portion diet (diet providing more calorie and protein by increasing the portion sizes of food intended for residents needing to gain weight) would include 4.5 oz of pork roast with gravy. 3. During an observation on 6/15/2026 at 12:12 p.m., of the roast pork portions, observed there was only one pan of roast pork and there were no separate pans for small portions of roast pork and large portions of roast pork. During an interview on 6/15/2026 at 12:32 p.m., with the DS, the DS stated small and large portion diets roast pork pieces should be in a separate pan to easily identify what to serve small and large portion diets. During an interview on 6/15/2026 at 12:36 p.m., with [NAME] 1 and the DS, [NAME] 1 stated the way she serves large portion diets is getting two (2) oz portion of meat and then another portion of meat. [NAME] 1 stated this meat portions would add up to four (4) oz. [NAME] 1 placed both roast pork portions on the facility food weighing scale, and it read five (5) oz. [NAME] 1 stated she serves a small piece of roast pork for small portion diets and placed it on the scale, and it was two (2) oz. The DS stated [NAME] 1 did not measure the pork roast correctly and the expectation is for [NAME] 1 to follow the spreadsheet. The DS further stated [NAME] 1 should have large and small portions of pork roast separated so she already knows what to serve the residents versus eyeballing. The DS stated eyeballing would lead to inaccurate serving portions. During a review of the facility's P&P titled, Diet Manual, dated 5/28/2026, the P&P indicated, A current therapeutic diet manual approved by the Registered Dietician (RD) and medical director is readily available to attending physicians, nursing, and dining services department personnel in order to ensure that all therapeutic diets are prepared as ordered by the attending physician. During a review of the facility's diet manual titled, Small Portions, dated 5/28/2026, the diet manual indicated, Small portions maybe requested by residents with small appetites or who are overwhelmed by regular portions. Small portions must be physician ordered. Ensure residents are being met and the weight can be sustained. Meat suggested portion two (2) oz. During a review of the facility's diet manual titled, Large or Double Portions, dated 5/28/2026, the diet manual indicated, Large portions area available for residents whose calorie or preference needs require larger quantities of food. Large portions must be physician ordered. Meat suggested portion size four (4) oz.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Reach in refrigerator gasket was torn. 2. Kitchen and storage areas were not free from dirt and debris. a. Reach-in refrigerator bottom shelves contained bread, cheese and other food debris. b. The walk-in refrigerator shelves had dust buildup. c. Reach-in freezer had dirt and food debris. d. Condiment container had salt, sugar, pepper and artificial sweeteners debris accumulation. e. The can opener has metal shaving residues f. Ice scoop storage had brownish particles. 3. Four (4) of 4 dented cans (a packaged metal food containers that have been physically deformed or crushed) were found with non-dented cans. 4. Dietary Aide 1 (DA 1) did not handwash after touching the lid of the trash can and before touching the packaged bread. 5. Pans were stacked wet in the storage area. 6. Kitchen equipment and surfaces are not of cleanable surface. a. Can opener has black electrical tape b. Knife container had cracks and dirt debris. c. Ten (10) of 10 resident's tray had cracks and chips d. Ice scoop holder is not a cleanable surface 7. The lid container was not covered, and it was stored near the red bucket with sanitizer. 8. Refrigerator in the water room was at 50 degrees Fahrenheit (F, a scale of temperature). 9. Resident's refrigerator and freezer thermometers were broken. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 157 of 167 medically compromised residents who received food and ice from the kitchen. Findings: 1. During an initial kitchen tour observation on 6/15/2026 at 8:25 a.m., of the snack reach-in refrigerator, observed a torn gasket. During an interview on 6/15/2026 at 8:41 a.m., with the Dietary Supervisor (DS), the DS stated they maintain the refrigerator gasket and ensure it was not ripped and there were no holes to maintain the cold refrigerator temperatures. The DS further stated gasket prevents air from going inside the refrigerator resulting in temperatures going up. The DS stated food could get spoiled and residents could potentially get sick from eating spoiled food. During a review of the facility's policies and procedure (P&P) titled, Equipment Maintenance, dated 5/28/2026, the P&P indicated, The maintenance department is responsible for foodservice equipment maintenance. Procedure. 1. The maintenance department is responsible for inspecting equipment annually, or more often, if needed to ensure proper working order. 2. The food and nutrition department should notify maintenance if equipment is not working properly. 2. a. During an initial kitchen tour observation on 6/15/2026 at 8:25 a.m., of the snack reach-in refrigerator, observed bread and cheese debris on the bottom shelves and bread debris on the trays. During an interview on 6/15/2026 at 8:33 a.m., with the DS, the DS stated the dietary staff cleans the refrigerator at the end of the shift but if the staff seen debris they should clean it right away. The DS stated the bread debris on the shelves and crumbs on the trays were probably from the staff who prepared the sandwiches. The DS further stated it was important to maintain the cleanliness of the refrigerator to prevent cross-contamination. The DS stated when food gets contaminated and consumed by the residents, residents could get sick of possible stomach pain and diarrhea. b. During an observation on 6/15/2026 at 8:52 a.m., of the walk-in refrigerator, observed the two (2) silver shelves had dust buildup. During an interview on 6/15/2026 at 11:45 a.m., with the DS, the DS stated there was dust accumulation on the silver shelves inside the walk-in refrigerator and it was not okay due to cross-contamination to food. c. During an observation on 6/15/2026 at 11:26 a.m., of the reach-in freezer, observed food and dust debris on the bottom shelves. During an interview on 6/16/2026 at 11:46 a.m., with the DS, the DS stated there were boxes debris on the bottom of the freezer shelves and it needed to be cleaned to prevent cross contamination of food. The DS stated the dietary staff last cleaned the freezer yesterday because it was delivery day. d. During an observation on 6/15/2026 at 8:42 a.m., of the brown condiment container, observed accumulation (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of sugar, salt, pepper and artificial sweeteners particles. During an interview on 6/16/2026 at 11:48 a.m., with the DS, the DS stated the condiment container must be clean so it would not contaminate the food and does not attract insects, roaches in the kitchen. The DS stated there were loose condiments accumulation in the containers, so the dietary staff probably did not clean it. e. During an observation on 6/15/2026 at 8:46 a.m., of the can opener, observed dirt and hair-like particles near its blade. During an interview on 6/15/2026 at 8:53 a.m., with the DS, the DS stated the can opener was last used this morning before breakfast and the dietary staff clean it before breakfast serving time. The DS stated there is metal shavings debris on the can opener and it was not okay as it could be a physical contaminant. f. During a concurrent observation and interview on 6/17/2026 at 9:14 a.m., of the ice scoop container with the DS, observed brown residue on the container. The DS stated there should not be brown residue in the scoop container because it could contaminate the ice. During a review of the facility's P&P titled Cleaning Schedules, dated 5/28/2026, the P&P indicated, The Food and Nutrition Service staff shall maintain the sanitation of the Food and Nutrition Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinically qualified nutrition professional. During a review of the facility's P&P titled, Sanitation Inspection, dated 5/28/2026, the P&P indicated, It is the policy of this facility, as part of the department's sanitation program to conduct inspection to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. 1. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. 5. Inspections will be conducted but not limited to the following areas: a. dry storage b. freezer c. refrigerator d. dishroom e. compartment sink area f. main production area g. food production area h. general dietary observations. During a review of the facility's P&P titled, Ice Machine, dated 5/28/2026, the P&P indicated, Clean and sanitize ice scoop daily. During a review of Food Code 2022, the Food Code 2022 indicated, 4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. During a review of Food Code 2022, dated 1/18/2022, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At anytime when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. 3. During an observation on 6/15/2026 at 11:30 a.m., of the dry storage area, observed a designated area for dented cans, labeled dented cans. During a concurrent observation and interview on 6/15/2026 at 11:40 a.m., of the canned foods with the DS, found four (4) dented cans stored with non-dented cans. The DS stated it was important to separate the dented cans from non-dented cans because the food inside a dented can is contaminated and it was not safe to eat. During an interview on 6/16/2026 at 8:39 a.m., with the DS, the DS stated dented cans caused toxins and botulism (rare but serious illness caused by bacteria leading to difficulty breathing, muscle paralysis and it could be (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fatal if not treated promptly) that is why it was not safe for consumption. During a review of the facility's P&P titled, Dented or Damaged Cans, dated 5/28/2026, the P&P indicated, Upon delivery, all canned food products should be inspected for safe transport and quality upon receipt. Procedure: Inspect all canned food products for safety and quality upon receipt. Evaluate any dented or damaged cans and return to distributor for credit as needed. During a review of the facility's P&P titled, Dented or Damaged Cans, dated 5/28/2026, the P&P indicated, Cans with Class 1 and 2 defects should be placed on Damaged Goods Shelf. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 4. During an observation on 6/15/2026 at 12:52 p.m., of the food preparation, observed Dietary Aide 1 (DA 1) hold the trash can cover then went to the dry storage area and got the bread without washing her hands. During an interview on 6/15/2026 at 1:00 p.m., with the DS, the DS stated staff should wash their hands when: changing task, as needed when coming from outside, they start cooking they pick up something from the floor hands become dirty. The DS stated dietary staff need to clean and sanitize their hands to prevent cross-contamination and DA 1 should have washed her hands after touching the lid of the trash can before touching the bread to prevent cross-contamination. During a review of the facility' P&P titled, Dietary Employee Personal Hygiene, dated 5/28/2026, the P&P indicated, It Is the policy of this facility to utilize the following as guidelines for employee personal hygiene to prevent contamination of food by food service employee. 3. Hand and Fingernails. a. Hands must be washed prior to beginning of work. b. Hands must always be washed after using the restroom, eating or drinking, smoking, coughing, sneezing, blowing nose, before putting on gloves and after removing gloves. During a review of the facility's P&P titled, Handwashing Guidelines for Dietary Employees, dated 5/28/2026, the P&P indicated, Handwashing is necessary to prevent the spread of bacteria that may cause foodborne illnesses. Dietary employees shall clean their hands in a handwashing sink or approved automatic handwashing facility and may not clean hands in a sink used for food preparation, warewashing, or in a service sink used for the disposal of mop water or similar waste. 6. Frequency of handwashing: dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and single use articles and also in the following situations: after hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc. while preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing task. 5. During an observation on 6/16/2026 at 8:44 a.m., of the pots and pans storage area, observed pans were stacked wet. During an interview on 6/16/2026 at 8:49 a.m., with the DS, the DS stated there were still water droplets on the pans and it was not appropriate to stack the pans wet. The DS stated it was important to air dry the pots and pans before storing because bacteria could grow if they are stacked wet. During a review of the facility's P&P titled, Dish and Utensil Procedure, dated 5/28/2026, the P&P indicated, 6. Dishes, trays and utensils shall be air dried before storage. Do not towel dry. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. 6.a. During an observation on 6/16/2026 at 8:46 a.m., of the can opener, observed an electrical tape on the body of the can opener. During an interview on 6/16/2026 at 8:53 a.m., with the DS, the DS stated the electrical tape was used to cover the pointed edges because the staff could bump into it and they replaced the tape every week. The DS stated the electrical tape is not a cleanable surface and if they do not clean the surface, it could build bacteria resulting in cross contamination. During a review of the facility's P&P titled, Manual Warewashing, dated 5/28/2026, the P&P indicated, when cleaning fixed equipment (example: mixers, slicers, and other equipment that cannot be readily be immersed in water): remove parts will be washed and sanitized. b. non-removable parts will be cleaned with detergent and hot water, rinsed, air-dried and sprayed with sanitizing solution. b. During an observation on 6/16/2026 at 8:48 a.m., the knife container had cracks and dirt debris. During an interview on 6/16/2026 at 9:02 a.m., with the DS, the DS stated there was white particles coming off from the knife container when she touched it. The DS stated the knife container has chips and it was not a cleanable surface which could build bacteria. During a review of the facility's P&P titled, Manual Warewashing, dated 5/28/2026, the P&P indicated, Ware washing is the cleaning and sanitizing of utensils and food-contact surfaces of equipment. c. During a concurrent observation and interview on 6/16/2026 at 9:33 a.m., of the resident's trays with the DS, observed 10 of 10 trays with cracks and chips. The DS stated the residents' trays were cracked, broken and had chips and it was not a cleanable surface. The DS stated the trays should not be cracked or chipped because they could cause bacterial contamination of food. During a review of the facility's P&P titled, Dish and Utensil Procedure, dated 5/28/2026, the P&P indicated, 7. Chipped or cracked dishes shall be discarded. d. During an interview on 6/17/2026 at 9:23 a.m., with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated he used cloth-like material as an ice scoop holder but it was not a good scoop holder because it was open and its infection control. CNA 6 stated they do not clean the scoop holder and he was not sure how to clean it. During an interview on 6/17/2026 at 9:25 a.m., with the DS, the DS stated the cloth-like material scoop holder was not a good scoop holder because they do not clean it and it could cause cross contamination to ice and spread infection to the residents. During a review of the facility's P&P titled, Ice Machine, dated 5/28/2026, the P&P indicated, 5. Store ice scoop free from ice in sanitary closed container . Clean and sanitize ice scoop daily. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. 7. During a concurrent observation and interview on 6/16/2026 at 9:13 a.m., of the lid storage area with the DS, observed the lid storage was not covered and there was a red bucket with QUAT sanitizer near it. The DS stated the container where the lids were stored was not covered and the chemical could contaminate the lids and it was not okay due to chemical contamination. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306. 8. During an observation on 6/17/2026 at 9:07 a.m., of the refrigerator at the water room, observed the inside thermometer refrigerator was at 50 F and the DS placed a new thermometer inside the refrigerator. During an interview on 6/17/2026 at 10:12 a.m., with the DS, the DS stated the thermometer in the refrigerator was not working and it's important to have a working thermometer in the refrigerator to maintain food temperature and not for the food to spoil. During a review of the facility's P&P titled, Calibrating Thermometers, dated 5/28/2026, the P&P indicated, The purpose of this policy is to prevent foodborne illness by ensuring that the appropriate type of thermometer is used to measure internal (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	product temperatures and that thermometers used are correctly calibrated for accuracy. If a thermometer cannot be calibrated, stop using it and replace it with a new thermometer. 9. During a concurrent observation and interview on 6/17/2026 at 9:39 a.m., of the resident's refrigerator with the DS, observed the thermometer inside of the freezer was broken. The DS stated she checked the temperature of the resident's freezer at 5 a.m. this morning and it was important to have a working thermometer in the freezer and refrigerator to check the temperature of the food storage for infection control. The DS stated it was important to maintain the temperature of the refrigerator and freezer so food could not be spoiled. The DS stated residents could potentially get sick and have stomach issues when consuming spoiled foods. During an observation on 6/17/2026 at 9:56 a.m., of the resident's refrigerator, observed the resident's refrigerator temperature at 62 F. During an interview on 6/17/2026 at 10:13 a.m., with the DS, the DS stated the refrigerator thermometer is not working. During a review of the facility's P&P titled, Monitoring of Refrigerator and Freezer Temperature, dated 5/28/2026, the P&P indicated, It is the policy of this facility to maintain temperatures of refrigerator and freezers at the appropriate temperature to promote food safety. This policy also addresses refrigerated storage. All refrigerated storage must be maintained at or below 45 F. All frozen storage must be maintained at a temperature of 0 F. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-204.112 Temperature Measuring Devices.^^ (A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit. (B) Except as specified in (C) of this section, cold or hot holding equipment used for time/temperature control for safety food shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices for three of thirty-three sampled residents (Resident 1, Resident 10, and Resident 87) by failing to maintain complete and accurate documentation when: 1. Resident 1's 2025 influenza (a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs) vaccine (medications used to prevent diseases usually given by injection or by mouth) status was not in the medical record.ˆ 2. Resident 10 was incorrectly documented as English speaking instead of Spanish speaking.ˆˆ 3. Resident 87's active medical diagnosis for vision loss and retinal detachment of the left eye was nit documented on the resident's admission Record. These deficient practicesˆresulted inˆResident 1, Resident 10, and Resident 87's medical recordˆcontainingˆincomplete and inaccurate informationˆwhichˆhad the potential to negatively affect Resident 1, Resident 10, and Resident 87's care in the facility.ˆˆ Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted the resident on 2/15/2025 and most recently readmitted the resident on 4/2/2026 with diagnoses including, but not limited to, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction (an obstruction of blood flow in the brain that leads to tissue damage) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with exacerbation (a sudden flare up of symptoms).ˆ During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool) dated 4/7/2026, the MDS indicated the resident had moderately impaired cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) and required substantial assistance (helper does more than half of the effort) from staff for most activities of daily living (ADLs- activities related to personal care). During a concurrent interview and record review on 6/17/2026 at 3:57 p.m., with the Infection Prevention Nurse (IPN), reviewed Resident 1's vaccine record. The IPN stated there was no record of Resident 1 receiving the influenza vaccine in 2025 in the facility medical record. ˆˆ During an interview on 6/18/2026 at 10:02 a.m., with the IPN, the IPN stated Resident 1 received the influenza vaccine at an outside hospital on 7/18/2025 but this was not reflected in Resident 1's facility medical record. The IPN stated the date Resident 1 received the influenza vaccine should be documented so staff are aware the resident got the vaccine and so they don't accidentally administer the vaccine again when it is not needed. ˆˆ During an interview on 6/18/2026 at 12:59 p.m., with Assistant Director of Nursing 1 (ADON 1), ADON 1 stated the facility should have a record of Resident 1's vaccine administration so the facility can provide the record to the resident if they request it and so they don't accidentally give the vaccine to the resident twice. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During a review of the facility's policy and procedure (P&P) titled, Influenza Vaccination, last reviewed 5/28/2026, the P&P indicated the resident's medical record will include that the resident received or did not receive the vaccination due to medical contraindication or refusal. ^^ 2. During a review of Resident 10's admission Record, the admission Record indicated the facility admitted the resident on 1/27/2026 with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). The admission Recordˆindicatedˆthe resident's primary language was English.ˆ ^^ During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had severe cognitive impairment. The MDS indicated Resident 10 was dependent (helper doesˆall ofˆthe effort) on staff for toileting, bathing, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 10 required supervision or touchingˆassistanceˆ(helper provides verbal cues and/or touching/steadying and/or contact guardˆassistance) for oral hygiene and personal hygiene. The MDS indicated Resident 10's preferred language was Spanish and that she needed or wanted an interpreter to communicate with health care staff.ˆ ^^ During an interview on 6/15/2026 at 11:29 a.m. with Resident 10, Resident 10ˆstatedˆshe only speaks Spanish.ˆ ^^ During an interview on 6/15/2026 at 12:37 p.m., with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 10 only speaks Spanish. LVN 5 stated she is able to communicate with Resident 10 because she speaks a little bit of Spanish, and she understands Resident 10 enough to provide her care. ^^ During a concurrent interview and record review on 6/18/2026 at 12:59 p.m., with ADON 1, reviewed Resident 10's admission Record. ADON 1 stated Resident 10's admission Record should indicate that the resident speaks Spanish, not English. ADON 1 stated there could be miscommunication since Resident 10's language is not listed on the admission Record. During a review of the facility's P&P titled, Documentation in Medical Record, last reviewed on 5/28/2026, the P&P indicated documentation in the medical record will be accurate, relevant, complete, and timely. 3. During a review of Resident 87's admission Record, the admission Record indicated that the facility initially admitted Resident 87 on 4/8/2022 with diagnoses including type two (2) diabetes mellitus (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), hypertension (HTN- high blood pressure), and hyperlipidemia (abnormally high levels of fats in the blood).ˆ During a review of Resident 87's MDS dated [DATE], the MDS indicated that Resident 87's cognition (mental action or process ofˆacquiringˆknowledge and understanding) was intact. The MDS indicated that Resident 87's ability to see in adequate light was adequate (sees fine details, such as regular print in newspapers/books). The MDS indicated Residentˆ87ˆrequired ranging from supervision/touching assistance to maximal assistance (helper does more than half the effort) forˆphysicalˆassistanceˆfrom staff for activities of daily living (ADLs – activities related to personal care).ˆThe MDS also indicated Resident 87 had no vision related active diagnosis. The MDS also indicated that Resident 87 had no broken or loose teeth, mouth or facial pain. During a review of Resident 87's progress note dated 12/8/2025, the progress note indicated that Resident 87 had reported vision loss in the left eye and diminishing vision in the right eye, with a history of retinal detachment in the left eye. The progress note also indicated that the plan of care includes consultation with a specialist. During a review of Resident 87's Order Summary Report, the Order Summary Reportˆindicatedˆthe following physician orders:ˆˆˆ -May see dentist (medical doctor that specialized in oral care), initiated on 2/28/2023. -May see ophthalmologist (medical doctor that specialized in eye and vision care), initiated on 2/28/2023. During a review of Resident 87's Social Service assessment dated [DATE], the Social Service Assessment indicated in the Optometry/Ophthalmology and Dental Consult status that resident was referred to ancillary services (supplemental or diagnostic services provided in support of, or in addition to, care delivered by a primary clinician). During a review of Resident 87's record titled, Onsite Skilled Dental Care, dated 5/22/2026, the record indicated in the treatment notes that Resident 87 had loose upper bridge teeth. During a review of Resident 87's care plan (a document that summarizes a resident's needs, goals, and care/treatment) titled, Impaired Visual Function, initiated on 4/11/2022, the care plan indicated interventions including scheduling consultations with eye specialists as needed, identifying factors that may impact visual function, and regularly observing, recording, and reporting any signs or symptoms of acute eye problems. Such symptoms could involve changes in the ability to carry out daily activities, decreased mobility, sudden vision loss, dilated pupils, a gray or milky appearance in the eyes, seeing halos around lights, double vision, tunnel vision, blurred vision, or hazy vision. During a concurrent observation and interview on 6/15/2026 at 10:33 a.m., with Resident 87, Resident 87 was awake, attentive, and capable of expressing her needs. Observed Resident 87's upper three left teeth were loose. Resident 87 stated being blind in her left eye, able to see only shadows, and said her right eye's vision was deteriorating. During a concurrent interview and record review on 6/17/2026 at 10:10 a.m., with the MDS Nurse (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(MDSN), reviewed Resident 87's MDS dated [DATE], progress notes dated 12/8/2025, and admission Record. The MDSN stated that her responsibilities include conducting assessments and evaluations and completing both the MDS and care plan documentation. The MDSN stated that according to the MDS assessment, Resident 87's vision and dental status showed no concerns, and there was no active diagnosis of vision loss or retinal detachment. However, the MDSN stated that there should have been an active diagnosis for Resident 87's vision loss and retinal detachment along with proper documentation of vision and dental status. The MDSN stated the importance of documenting the resident's active medical diagnoses in both the admission Record and the MDS, is so that the healthcare team remains informed about the resident's medical history and can monitor ongoing treatments. Additionally, the MDSN stated that if medical diagnoses, along with current vision and dental status, are not documented accurately, necessary care for residents' vision and dental needs might be missed. During an interview on 6/18/2026 at 12:41 p.m., with the Director of Nursing (DON), the DON stated that there were inaccuracies in both the assessment and documentation of vision and dental status for Resident 87, and the resident's active medical diagnoses for vision and dental health were not reflected. The DON stated that inaccuracies in documentation may hinder Resident 87 from obtaining essential services and could result in delayed care. During a review of the facility's Policy and Procedure (P&P) titled, Documentation in Medical Record, reviewed 5/28/2026, the P&P indicated that licensed staff and interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) members must record all assessments, observations, and services in the resident's medical record according to state law and facility policy. The P&P outlines documentation principles such as being factual, objective, and focused on the resident; prohibiting false entries; and requiring descriptive, objective information based on direct knowledge of the assessment or service provided. It also emphasizes that documentation should be accurate, relevant, and complete, with enough detail about the resident's care or responses to care. During another review of the facility's P&P titled, Dental Services, reviewed 5/28/2026, the P&P indicated that the residents' dental needs are identified through both physical and MDS assessments, and subsequently incorporated into each resident's care plan. The P&P further stated that oral and dental status must be documented based on assessment 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 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, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) for two of 33 sampled residents (Resident 3 and Resident 10) by failing to: 1. Address Resident 3's communication impairment. 2. Address Resident 10's primary language (Spanish). This deficient practice had the potential for Resident 3 and Resident 10 to be unable to make their needs known, understand staff, or receive adequate care. Findings:^ a. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 3 on 3/23/2026 and re-admitted the resident on 5/11/2026 with diagnoses that included toxic encephalopathy (damage to the brain caused by exposure to a harmful substance), acute (sudden onset) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood)^with hypoxia (an insufficient amount of oxygen in your body tissues), and dysphagia (difficulty swallowing) following a cerebral infarction (a stroke, loss of blood flow to a part of the brain). During a review of Resident 3's Minimum Data Set (MDS – a resident assessment tool) dated 5/15/2026, the MDS indicated Resident 3 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident had unclear speech (slurred or mumbled words), usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversations). The MDS indicated vision is adequate and does not wear corrective lenses (contacts, glasses, or magnifying glass). The MDS indicated Resident 3 was dependent (helper does all of the effort) with activities of living (ADL – routine activities such as bathing, dressing, and toileting a person performs daily) and mobility. During a review of Resident 3's History and Physical (H&P) dated 5/13/2026, the H&P indicated Resident 3 was non-verbal. The H&P indicated Resident 3 does not have the capacity to understand and make decisions. During an observation on 6/16/2026 at 10:08 a.m., observed Resident 3 lying in bed looking at the television. Resident 3 made eye contact when greeted and offered no verbal response. Observed a sign above Resident 3's head of bed which indicated, Use Communication Board, (a physical or digital communication tool that displays pictures, symbols, letters, or words). Observed there was no communication board present in Resident 3's room. During a concurrent interview and record review on 6/17/2026 at 10:30 a.m., with Assistant Director of Nursing 1 (ADON 1), reviewed Resident 3's care plan titled, The resident has a communication problem and has a communication board related to dysphagia following cerebral infarction, initiated 6/16/2026. ADON 1 stated Resident 3's communication impairment was present before 6/16/2026. ADON 1 stated that Resident 3 would make eye contact with her and nod her head to communicate yes or no. ADON 1 stated a communication care plan for Resident 3 should have been developed when the communication problem was first identified so the appropriate resident specific interventions (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could have been identified and implemented timely. ADON 1 stated that not having a communication care plan for Resident 3 until 6/16/2026 delayed identifying Resident 3's communication needs and implementing interventions addressing Resident 3's condition. During an interview on 6/18/2026 at 2:07 p.m., with the Director of Nursing (DON), the DON stated care plans are for all the staff to know resident's needs and be able to provide the appropriate care. The DON stated that if care plan is not developed for a specific problem, there is a potential for the problem to be unaddressed or necessary care to be delayed. The DON stated that Resident 3's care plan had not been comprehensive when there was no care plan developed for Resident 3's communication impairment. The DON stated care plans should be comprehensive and personalized for each resident to ensure person-centered care. b. During a review of Resident 10's admission Record, the admission Record indicated the facility admitted the resident on 1/27/2026 with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 10's MDS, dated [DATE],ˆthe MDS indicated Resident 10 had severe cognitive impairment. The MDS indicatedˆResidentˆ10ˆwas on staff forˆtoileting, bathing, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 10 requiredˆsupervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance)ˆfor oral hygiene and personal hygiene. The MDS indicated Resident 10's preferred language was Spanishˆand that she needed or wanted an interpreter to communicate with health care staff.ˆ During an interview on 6/15/2026 at 11:29 a.m. with Resident 10, Resident 10 stated she only speaks Spanish.ˆ During an interview on 6/15/2026 at 12:37 p.m., with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 10 only speaks Spanish. LVN 5 stated she is able to communicate with Resident 10 because she speaks a little bit of Spanish, and she understands Resident 10 enough to provide her care. During a concurrent interview and record review on 6/18/2026 at 12:59 p.m., with Assistant Director of Nursing 1 (ADON 1), reviewed Resident 10's care plans. ADON 1 stated Resident 10's care plan did not identify the resident's primary language as Spanish and did not indicate any interventions staff should take regarding the resident's language. ADON 1 stated there should be a care plan addressing Resident 10's language and interventions staff should take. ADON 1 stated for example staff may misunderstand the residentˆand she might notˆget her needs met.ˆ During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, last reviewed 5/28/2026, the P&P indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the resident's comprehensive assessment.The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care.The comprehensive care plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will describe, at a minimum, the following: The services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non English speaking, the facility will identify how communications will occur with the resident. The care plan will identify the language spoken and tools used to communicate.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide proper care and treatment to maintain or improve a resident's communication abilities for one of one sampled residents (Resident 3) investigated under communication-sensory care area by failing to ensure Resident 3 had a communication board. This deficient practice had the potential to cause psychological distress for Resident 3 and delayed the provision of necessary care and treatment. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 3 on 3/23/2026 and re-admitted the resident on 5/11/2026 with diagnoses that included toxic encephalopathy (a general malfunction, disease, or damage to the brain caused by exposure to a harmful substance), acute (sudden onset) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) with hypoxia (an insufficient amount of oxygen in your body tissues), and end stage renal disease (ESRD- chronic irreversible kidney failure). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 5/15/2026, the MDS indicated Resident 3 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident had unclear speech (slurred or mumbled words), usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversations). The MDS indicated vision is adequate and does not wear corrective lenses (contacts, glasses, or magnifying glass). The MDS indicated Resident 3 was dependent (helper does all of the effort) with activities of living (ADL - routine activities such as bathing, dressing, and toileting a person performs daily) and mobility. During a review of Resident 3's History and Physical (H&P) dated 3/15/2026, the H&P indicated Resident 3 was non-verbal. The H&P indicated Resident 3 does not have the capacity to understand and make decisions. During an observation on 6/16/2026 at 10:08 a.m., observed Resident 3 lying in bed looking at the television. Resident 3 made eye contact when greeted and offered no verbal response. Observed a sign above Resident 3's head of bed which indicated, Use Communication Board, (a physical or digital communication tool that displays pictures, symbols, letters, or words). Observed there was no communication board present in Resident 3's room. During a concurrent observation and interview on 6/16/2026 at 10:12 a.m., with Certified Nursing Assistant 4 (CNA 4), in Resident 3's room, CNA 4 stated that a communication board is a book used to help with communications when a resident is non-verbal or speech cannot be understood. CNA 4 stated that Resident 3 had been moved two (2) days prior from another room and was not sure if the sign above Resident 3 indicating to use communication board was meant for Resident 3. CNA 4 stated that if the sign above the head was for Resident 3, there should have been a communication board placed with the sign. CNA 4 stated there was no communication board found in Resident 3's room. During an interview on 6/16/2026 at 10:30 a.m., with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated a communication board is a paper laminated tool used for communication by residents who have language deficit or impairment. LVN 6 stated that if residents need to use a communication board and it is not available, the residents would not be able to communicate their needs. LVN 6 stated that the communication board is very important for Resident 3, who is non-verbal, to be able to pinpoint on the communication board that has pictures what Resident 3 needs. LVN 6 stated that not having a communication board to communicate can cause frustration and stress to Resident 3. LVN 6 stated that as a result, there may be delays in the delivery of care from Resident 3's increased frustration and stress, leading to reluctance in accepting care. During an interview on 6/17/2026 at 10:30 a.m., with Assistant Director of Nursing 1 (ADON 1), ADON 1 stated that Resident 3 is non-verbal and communicates by nodding her head to communicate yes or no. ADON 1 stated that a communication board would help Resident 3 communicate by pointing to the pictures on the board. During an interview on 6/18/2026 at 2:07 p.m., with the Director of (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON), the DON stated that Resident 3, who is non-verbal, was not provided with a communication board. The DON stated that the communication board is essential for understanding Resident 3's thoughts, such as if the resident is experiencing pain or has specific requests. The DON stated that without the communication board, staff would not know what Resident 3 wants or needs, causing delays in care and preventing timely assistance. The DON further emphasized the importance of the communication board, noting that lack of communication can contribute to feelings such as frustration, depression, sadness, and embarrassment, thereby negatively impacting Resident 3's self-esteem. During a review of the facility's policy and procedure (P&P) titled, Effective Communication - Deaf Resident, last reviewed 5/28/2026, the P&P indicated, ?Effective communication' describes a process of dialogue between individuals. The skills including speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response.Adaptive techniques include, but are not limited to: Using communication boards or writing materials. During a review of the facility's P&P titled, Promoting/Maintaining Resident Dignity, last reviewed 5/28/2026, the P&P indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. During a review of the facility's P&P titled, Resident Rights, last reviewed 5/28/2026, the P&P indicated, The resident has a right to be treated with respect and dignity, including: the right to receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would infringe upon the rights or health and safety of other residents.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Registered Nurse 2 (RN 2) maintained aˆcurrent cardio-pulmonary resuscitationˆ(CPR -ˆan emergency, life-saving technique performed when someone's breathing or heartbeat has stopped)ˆcertificationˆfromˆa CPR provider whose training includes a hands-on session in accordance with accepted national standardsˆfor one of six staff members investigated under competent nurse staffing task. This deficient practiceˆallowed for staff without theˆappropriate CPRˆcertificationˆto work alongside 165 medically vulnerable residents.ˆˆ Findings: During an employee file review on [DATE] at 1:34 p.m., with the Director of Staff Development (DSD), reviewed RN 2's employee file. The DSD stated RN 2's Basic Life Support (BLS- a sequence of foundational medical procedures used to sustain life during critical emergencies) certification was obtained from an online CPR provider. The DSD stated she (DSD) did not know if RN 2's CPR certification was all web based withoutˆthe requiredˆin-personˆhands on component.ˆ During an interview on [DATE] at 3:24 p.m., with RN 2, RN 2 stated that the BLS course she completed was entirely online. RN 2 stated the BLS training consisted of reading materials, watching videos, and answering questions. RN 2 stated there was no hands-on component or requirement to demonstrate CPR skills. During an interview on [DATE] at 12:46 p.m., with the DSD, the DSD stated RN 2 needed to obtain BLS certification that had the hands-on component where skills are validated. The DSD stated this ensures competency of staff with performing CPR. During a review of the facility's policy and procedure (P&P) titled, Cardiopulmonary Resuscitation (CPR), last reviewed [DATE], the P&P indicated, Staff will maintain current CPR certifications for healthcare providers through a CPR provider whose training include a hand-on session either in physical or virtual instructor lead setting in accordance with accepted national standards. CPR certification which includes an online knowledge component yet still requires in-person skills demonstrations to obtain certification or recertification is also acceptable.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facilityˆfailed toˆprovide an environment that is free from accident hazards forˆthree ofˆeight sampled residents (Residentˆ36,ˆResidentˆ58, and Resident 168) investigated for accidents by failing to:ˆˆ 1. EnsureˆResidentˆ36ˆdid not haveˆa nightstandˆand bedside commode (portable toilet chair)ˆon theˆfloorˆmatˆ(a mat placed on the floor next to a resident's bed or chair to minimize the impact of a fall).ˆ This deficient practice placed Resident 36 at increased risk for injury in the event of a fall. 2. Ensure aˆwater pitcher and food wereˆnotˆat Resident 168's bedside who had a gastrostomy tube (g-tube -feeding tube surgically placed directly into the stomach) and a physician's order for nothing by mouth (NPO-not to eat or drink anything).ˆ This deficient practice had the potential to place Residentˆ168ˆatˆincreased risk of aspiration (accidentally inhaling food or liquids into the airway and lungs, potentially causing lung infection) and choking (foreign body airway obstruction) and potential to have serious health complications.ˆˆˆ 3. Ensure Resident 58 had a floor mat placed atˆResident 58'sˆbedside.ˆ This deficient practice placed Resident 58 at increased risk for injury in the event of a fall. Findings:ˆ ˆ 1. During a review of Resident 36's admission Record, the admission Record indicated that the facility initially admitted Resident 36 to the facility on [DATE] with diagnoses including unsteadiness on feet, lack of coordination, nondisplaced comminuted (broken bone that has shattered in at least two places) fracture (a break, crack or crush injury) of right tibia (shin bone) and fibula (calf bone) and nondisplaced fracture of lateral (sideways) malleolus (ankle bone) of left fibula.ˆ During a review of Resident 36's Minimum Data Set (MDS- a resident assessment tool) datedˆ6/3/2026, the MDS indicated that Resident 36's cognition (mental action or process ofˆacquiringˆknowledge and understanding) was moderately impaired. The MDS indicated Residentˆ36 required ranging from supervision (helper provides touching or contact guard assistance) to dependent (helper does all of the effort) physical assistanceˆfrom staff for activities of daily living (ADLs – activities related to personal care). The MDS also indicated that Resident 36 used a wheelchair and walker (walking support tool) for mobility devices.ˆˆˆ During a review of Resident 36's Order Summary Report, the Order Summary Report indicated an order to apply floor safety mat at bedside, dated 12/5/2025. During a review of Resident 36's Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) titled, At risk for falls, revised on 6/15/2026, the care plan identified Resident 36 as being at high risk for falls. The care plan interventions included maintaining a safe environment by keeping floors free from spills and clutter, providing adequate lighting, ensuring that floor mats are properly positioned and flat to avoid tripping hazards, and placing the call light and personal items within easy reach. ˆ During a concurrent observation and interview on 6/15/2026 at 11:01 a.m., with Certified Nursing Assistant 1 (CNA 1) in Resident 36's room, observed a nightstand and bedside commode placed on top of the left side floor mat. CNA 1 stated that the floor mat was used for fall precautions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/15/2026 at 12:14 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that there should not be any objects on top of the floor mats, as these items could create tripping hazards, and cause injuries if the resident hit themselves with it. LVN 1 stated that all nursing staff are responsible for ensuring that floor mats are free from any object or furniture. During an interview on 6/18/2026 at 12:41 p.m., with the Director of Nursing (DON), the DON stated that the floor mat is utilized as a preventative measure for fall precautions. The DON indicated that positioning the floor mat may reduce injury should a resident fall out of bed. Furthermore, the DON stated that nothing should be placed on top of the floor mat, as doing so would negate its intended purpose and could potentially increase the risk of harm if a fall were to occur. During a review of facility's Policy and Procedure (P&P) titled, Fall Prevention Program, reviewed on 5/28/2026, the P&P indicated implement universal environmental interventions that decrease the risk of resident falling, including but not limited to a clear pathway to the bathroom and bedroom doors. The P&P also indicated that each resident's risk factors and environmental hazards will be assessed when creating their comprehensive care plan. ˆ ˆ 2. During a review of Resident 168's admission Record, the admission Record indicated that the facility initially admitted Resident 168 on 5/21/2025, with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and cerebral infarction (loss of blood flow to part of the brain).ˆ During a review of Resident 168's MDSˆdatedˆ5/28/2026, the MDS indicated that Resident 168's cognition (mental action or process ofˆacquiringˆknowledge and understanding) was intact. The MDS alsoˆindicatedˆResidentˆ168 required ranging from setup or clean-upˆassistanceˆto supervision/touchingˆassistanceˆfor physical assistance from staff forˆADLs. The MDS indicated that Resident 168 was on feeding tube.ˆ During a review of Resident 168's Order Summary Report dated 6/17/2026, the Order Summary Reportˆindicatedˆthe following physician orders:ˆˆˆ -NPO diet, initiated on 5/21/2025. -Enteral feed (tube feeding) order every shift continuous enteral feeding formula rate: 50 milliliter (ml-unit of measurement) per hour times 20 hours. Start at: On at 2 p.m., off at 10 a.m. or until specify ml has infused to provide 1000ml/1500 kilocalories (kcal-unit of measurement for energy) per day, initiated on 10/17/2025. -Enteral feed order every six (6) hours flush enteral tube with 180 ml of free water via feeding pump every six hours total flush of 720 ml per day. -Enteral feed order every shift enteral feeding: flush enteral tube with 15-30 ml water before and after medication administration, initiated on 5/21/2025. ˆˆ (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 168's record titled, speech video swallow study, dated 7/18/2025, the speech video swallow studyˆfindings indicated mild oral and severe pharyngeal phase dysphagia (difficulty swallowing in the throat) observed during thin liquid trials, with evidence of potential aspiration events following swallowing. The recommended course was toˆmaintainˆg-tube feeding as the primary method for nutrition and hydration.ˆ During a review of Resident 168's record titled, esophagramˆ(video X-ray of throat and esophagus when you swallow), dated 5/29/2026, the esophagram impression indicated, incompleteˆesophagramˆdue to determination of the procedure after the patient aspirated contrast into his trachea (windpipe) and left lung bronchi (main breathing tubes inside the lungs).ˆ During a review of Resident 168's care plan titled, gastrostomy tube related to dysphagia, revised on 5/30/2025, the care plan indicated that the primary goal is for the resident to remain free from aspiration. Interventions include administering tube feeding as prescribed, addressing any concerns regarding tube feeding with the resident and their family, discussing advantages, disadvantages, and potential complications, monitoring tolerance of tube feeding, arranging for speech therapist evaluation and treatment as ordered, and appropriately observing, documenting, and reporting any signs or symptoms of aspiration. During a concurrent observation and interview on 6/15/2026 at 9:51 a.m., with Certified Nursing Assistant 2 (CNA 2) in Resident 168's room, observed Resident 168 with three water pitchers at Resident 168's bedside table. Resident 168 stated he wants to eat. CNA 2 stated Resident 168 was always requesting to eat. CNA 2 stated that Resident 168 was not allowed to eat anything by mouth and was on g-tube feeding. CNA 2 asked Resident 168 if he was drinking water and Resident 168 stated yes. During aˆsubsequentˆinterview on 6/15/2026 at 2:49 p.m., with CNA 2, CNA 2ˆstatedˆthat about a month ago, heˆobservedˆResident 168 drinking water from the pitcher. CNA 2ˆstatedˆthat he reported this to the charge nurse but does not remember which member of the nursing staff he notified.ˆ During an interview on 6/16/2026 at 11:24 a.m., with Resident 168, Resident 168 stated that he had previously received water from the nursing staff, but nursing staff removed it. Resident 168 alsoˆstatedˆthat he was drinking about a pitcher of water daily. Resident 168 stated that he had a recentˆesophagram/swallow evaluation but had not been informed of the results. Resident 168 furtherˆstatedˆthat although aware of the physician's order prohibiting oral intake, he believed he could eat now.ˆ During an interview on 6/16/2026 at 1:23 p.m., with the Speech Therapist (ST-assess and treat issues related to speech and swallowing disorder), the ST stated that Resident 168 had threeˆpreviousˆvideo swallow evaluations but did not pass for all of them. The STˆstatedˆthat Resident 168 should continue to be NPO and stay on enteral feeding. The STˆstatedˆthat he has potential to develop aspiration pneumonia (lung infection caused by inhaling something other than air into your lungs) due to severe aspiration risk from his medical diagnosis.ˆ During a concurrent observation and interview on 6/17/2026 at 12:24 p.m., with Resident 168, Resident 168 wasˆobservedˆwith an unopened bag of chips and crackers placed on his bedside table.ˆResident 168 stated that heˆpurchasedˆboth the chips and the crackers.ˆ During an interview on 6/17/2026 at 12:31 p.m., withˆthe DONˆandˆADONˆ1, the DON reported that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders issued or if hospital transport becomes necessary.ˆ 3.ˆDuring review of Resident 58's admission Record, the admission Record indicated the facility originally admitted the resident on 12/17/2025 and re-admitted the resident on 5/23/2026 with diagnosis that included acute respiratory failure (sudden inability of the lungs to maintain normal respiratory function) with hypoxia (body tissue and organs do not receive enough oxygen to function properly) atelectasis (a partial or complete collapse of a lung) and chronic obstructive pulmonary disorder (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). ˆ During review of Resident 58's History and Physical (H&P) dated 5/24/2026, the H&PˆindicatedˆResident 58 does not have the capacity to understand and make decisions.ˆ During review of Resident 58's MDS dated [DATE], the MDS indicated Resident 58 had severely impaired cognition; usually made self-understood and sometimes understood others. The MDS indicated that Resident 58 required partial/moderate assistance (helper does less than half the effort) with dressing, shower/bathe self, toileting hygiene and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying/contact guard assistance as resident completes activity) with personal hygiene and oral hygiene. The MDS indicated Resident 58ˆrequiredˆpartial/moderateˆassistanceˆwith functional mobility. During an observation on 6/16/2026 at 11:20 a.m.,ˆobservedˆResident 58 lying in bed, wearing a risk for falls wrist band. There was no floor matˆobservedˆat Resident 58's bedside.ˆ During an interview on 6/16/2026 at 4:08 p.m., withˆCNAˆ3, CNA 3 stated that Resident 58 is at risk for falls. CNA 3 stated that interventions for residents at risk for falls include ensuring call light within reach. CNA 3 stated that Resident 58 did not have floor mats, what she described as a cushion placed by resident's bed to prevent injury during fall, as she does not find that the facility uses floor mats.ˆ During a concurrent interview and record review on 6/17/2026 at 8:37 a.m., with the Assistant Director of Nursing 1 (ADON 1), reviewed Resident 58's Fall Risk Assessment dated 5/23/2026, and care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) titled, Resident at risk for re-occurrence of fall and injury due to the following. initiated 12/17/2025 and last revised 4/21/2026. The Fall Risk Assessment indicated a score of 18. ADON 1 stated that score meant Resident 58 is at risk for falls. The care plan indicated an intervention to apply floor mat at bedside. ADON 1 stated that no floor mats were present in Resident 58's bedside. ADON 1 stated that Resident 58 may sustain injuries in the event of a fall without floor mats applied at Resident 58's bedside. During an interview on 6/18/2026 at 2:15 p.m., with the Director of Nursing (DON), the DON stated the floor mats should have been placed at Resident 58's bedside because it was part of the fall prevention intervention when resident was identified at risk for falls. The DON stated that the floor mat's function is to lessen the impact of the fall in case of a fall incident. The DON stated that the absence of the floor mat during a fall can result in severe injury to Resident 58. During a review of the facility's policy and procedure (P&P) titled, Fall Prevention Program, last reviewed 5/28/2026, the P&P indicated, Each resident will be assessed for fall risk and will receive (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care and services in accordance with their individualized level of risk to minimize the likelihood of falls.The nurse and/or interdisciplinary team will initiate interventions on the resident's care plan, in accordance with the resident's level of risk. During a review of the facility's P&P titled, Resident Rights, last reviewed 5/28/2026, the P&P indicated, Safe environment: The resident has a right to safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 49 and Resident 187) did not have a loop or kink (unwanted twist or bend) in their urinary catheter tubing (a hollow tube inserted into the bladder to drain or collect urine). This deficient practice had the potential for the residents to develop a urinary tract infection (UTI- an infection in the bladder/urinary tract). Findings: a. During a review of Resident 187's admission Record, the admission Record indicated the facility admitted the resident on 6/14/2026 with diagnoses including but not limited to metabolic encephalopathy (a brain dysfunction caused by illness or chemical imbalance), severe sepsis with septic shock (a life-threatening blood infection), and abnormalities of gait and mobility (an irregular and unsteady pattern of walking or moving). During a review of Resident 187's History and Physical (H&P) dated 6/16/2026, the H&P indicated Resident 187 had fluctuating capacity to understand and make decisions. During a review of Resident 187's Order Summary Report, dated 6/14/2026, the Order Summary Report indicated a physician order for urinary catheter for 45 days from admission, unless otherwise specified. During an observation on 6/15/2026 at 10:51 a.m., in Resident 187's room, Resident 187's urinary catheter tube was observed with a loop and urine not draining into the urine drainage bag. During a concurrent observation and interview on 6/15/2026 at 11:32 a.m., with Licensed Vocational Nurse 1 (LVN 1), in Resident 187's room, observed Resident 187's urinary catheter tube. LVN 1 stated the urinary catheter tubing should not have a loop because urine will not flow into the urine drainage bag; and the accumulation of urine in the tubing may cause infection. During a concurrent observation and interview on 6/15/2026 at 11:36 a.m., with LVN 5, in Resident 187's room, observed Resident 187's urinary catheter tube. LVN 5 stated Resident 187's urinary catheter tubing should not have loops because the accumulation of urine can cause bacteria growth and infection. b. During a review of Resident 49's admission Record, the admission Record indicated the facility admitted the resident on 5/29/2026 with diagnoses including but not limited to chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), hemiplegia and hemiparesis (a condition that affects the body movement, muscle use, and partial weakness), and functional quadriplegia (paralysis [complete or partial loss of muscle function] of all four limbs). During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 6/10/2026, the MDS indicated Resident 49 is dependent on activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and had an urinary catheter and UTI in the last 30 days. During a review of Resident 49's Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) initiated 6/9/2026, the care plan indicated an intervention to monitor and report any signs and symptoms of urinary tract infections. During a review of Resident 49's physician order dated 6/9/2026, the physician order indicated an order for urinary catheter due to neurogenic bladder dysfunction (when a person lacks bladder control due to brain, spinal cord or nerve problems). During an observation on 6/15/2026 at 2:14 p.m., in Resident 49's room, Resident 49's urinary catheter tube was observed with a loop and urine not draining into the urine drainage bag. During a concurrent observation and interview on 6/15/2026 at 2:20 p.m., with LVN 7, in Resident 49's room, Resident 49's urinary catheter tube was observed with a loop and urine not draining into the urine drainage bag. LVN 7 stated the urinary catheter should not have loops because urine can back up and cause UTI. During a review of the facility's policy and procedure (P&P) titled, Appropriate Use of Indwelling Catheters, revised on 4/30/2026, the P&P indicated that indwelling urinary catheters will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible.including but not limited to urinary tract infection.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and services to provide respiratory care for two of two sampled residents (Resident 14 and Resident 58) investigated under respiratory care area by: 1. Failing toˆensure Resident 58 and 14's oxygen nasal cannula (NC - a device that delivers supplemental oxygen directly into the nostrils through two small prongs that rest inside the nostril) was correctly applied. 2. Failing toˆassess Resident 14's baseline oxygen saturation level before applying PRN (given as needed) oxygen and re-assess oxygen saturation level post-application of PRN oxygen. These deficient practices had the potential to cause Resident 14 and Resident 58 complications associated with oxygen therapy, such as causing oxygen desaturation (the condition of a low blood oxygen concentration and unmonitored oxygen toxicity (too high of blood oxygen concentration), that may result in tissue or organ failure. Findings: a. During review of Resident 58's admission Record, the admission Record indicated the facility originally admitted the resident on 12/17/2025 and re-admitted the resident on 5/23/2026 with diagnosis that included acute respiratory failure (sudden inability of the lungs to maintain normal respiratory function) with hypoxia (body tissue and organs do not receive enough oxygen to function properly) atelectasis (a partial or complete collapse of a lung) and chronic obstructive pulmonary disorder (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). During review of Resident 58's History and Physical (H&P) dated 5/24/2026, the H&P indicated Resident 58 does not have the capacity to understand and make decisions. During review of Resident 58's Minimum Data Set (MDS - a resident assessment tool) dated 3/25/2026, the MDS indicated Resident 58 had severely impaired cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses); usually made self-understood and sometimes understood others. The MDS indicated that Resident 58 required partial/moderate assistance (helper does less than half the effort) with dressing, shower/bathe self, toileting hygiene and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying/contact guard assistance as resident completes activity) with personal hygiene and oral hygiene. The MDS indicated Resident 58 required partial/moderate assistance with functional mobility. The MDS indicated Resident 58 is on oxygen treatment while a resident at the facility. During a review of Resident 58's physician orders dated 5/23/2026, the physician orders indicated an order for oxygen via NC two (2) liters per minute (LPM- unit of measurement for oxygen), may titrate (adjust) to maintain SPO2 (measurement of oxygen circulating in the blood) greater or equal to 92% every shift. During a review of Resident 58's care plan (a document that summarizes a resident's needs, goals, and care/treatment) titled, The resident has continuous oxygen therapy related to acute respiratory failure, initiated 1/7/2026, the care plan indicated an intervention to monitor for sign and symptoms of respiratory distress and report to MD PRN: Respirations, pulse oximetry (measure of oxygen saturation). During a concurrent observation and interview on 6/16/2026 at 11:32 a.m., with Licensed Vocational Nurse 4 (LVN 4), in Resident 58's room, Resident 58 was observed wearing oxygen at two (2) LPM via NC. The NC tubing was looped and secured around Resident 58's ears, with one prong inserted into the left nostril and the other resting externally against the left nostril. LVN 4 stated both prongs should be inside Resident 58's nose for the oxygen to be properly delivered to the resident. LVN 4 stated that improper placement of the oxygen NC prevents Resident 58 from receiving the supplemental oxygen she requires. LVN 4 stated that insufficient oxygen could lead to hypoxia, resulting in inadequate oxygen supply to the body and organs, potential loss of consciousness (state of being aware of one's surroundings), and other complications due to reduced oxygenation of the brain. During an interview on 6/18/2026 at 2:19 p.m., with Director of Nursing (DON), the DON stated the oxygen NC must be placed correctly, with both prongs inside the resident's nose, with the tubing securely looped around the resident's ears. The DON stated that improper placement of the NC may (continued on next page)

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	056124	A. Building B. Wing	06/18/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevent the resident from receiving the intended amount of oxygen, which could result in decreased oxygen saturation (the amount oxygen circulating in the blood) and shortness of breath. b. During review of Resident 14's admission Record, the admission Record indicated the facility originally admitted the resident on 3/8/2016 and re-admitted the resident on 4/10/2026 with diagnosis that included pneumonia (an infection/inflammation in the lungs), pleural effusion (water in the lungs), and COPD. During review of Resident 14's H&P dated 5/14/2026, the H&P indicated Resident 14 does not have the capacity to understand and make decisions. During review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 had severely impaired cognition; usually made self-understood and sometimes understood others. that Resident 14 was dependent (helper does all of the effort) with activities of daily living and functional mobility. The MDS indicated Resident 14 is on oxygen treatment while a resident at the facility. During a review of Resident 14's care plan titled, The resident has PRN oxygen therapy related to respiratory failure, unspecified with hypoxia, initiated 5/14/2026, the care plan indicated an intervention of oxygen via NC at two (2) liters per minute, may titrate oxygen to maintain SPO2 greater or equal to 92% as needed and to monitor for sign and symptoms of respiratory distress and report to MD (physician) PRN: respirations, pulse oximetry (measure how much oxygen in the blood), increased heart rate. During a concurrent observation and interview on 6/17/2026 at 10:15 a.m., with Assistant Director of Nursing 1 (ADON 1), observed Resident 14 lying in bed with oxygen NC tubing looped around Resident 14's ears, with the oxygen prongs resting on Resident 14's chin. The oxygen concentrator was turned on and set at one (1) liter per minute. The ADON stated the oxygen cannula is not positioned correctly and the prongs should be placed inside Resident 14's nose. During a concurrent interview and record review on 6/17/2026 at 10:17 a.m., with ADON 1, reviewed Resident 14's physician order dated 5/14/2026 and pulse oximetry reading dated 6/17/2026 at 00:22. The physician order indicated an order for oxygen at one (1) LPM via NC PRN to keep SPO2 greater or equal to 92% every shift. The pulse oximetry reading dated 6/17/2026 at 00:22 indicated 93% Room Air. The ADON stated a measurement of Resident 14's oxygen saturation should have been assessed by the nurse before applying the PRN oxygen and re-assessed after it was applied. The ADON stated that these were not done. During an interview on 6/17/2026 at 10:25 a.m., with LVN 4, LVN 4 stated that she received Resident 14 from the night shift (11 p.m.-7 a.m. shift) wearing oxygen. LVN 4 stated she did not know when the prn oxygen was applied. During an interview on 6/17/2026 at 10:41 a.m., with the ADON, the ADON stated that Resident 14's oxygen saturation should have been checked at the start of the day shift. The ADON stated that since the order for oxygen was PRN, Resident 14 needed to be evaluated to determine whether supplemental oxygen was necessary or not. The ADON explained that PRN oxygen is administered only as needed; if the resident doesn't require it, it shouldn't be used. The ADON stated to make this determination, the resident's oxygen saturation must be assessed. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, last reviewed 5/28/2026, the P&P indicated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.The residents care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, but not limited to:.d. Monitoring of SPO2 (oxygen saturation) levels and/or vital signs, as ordered.The equipment needed for oxygen administration will depend on the type of delivery system ordered. Types of delivery systems include: a. Nasal Cannula - Oxygen is administered through plastic cannulas in the nostrils. Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a window screen did not have a gap in a shared resident room affecting two of five sampled residents (Residents 67 and 91) investigated under the Environment task. This deficient practice created an entry point and access for insects to get inside the building which can potentially transmit insect borne illnesses and negatively affect the residents' quality of life. Findings: During a review of Resident 67's admission Record, the admission Record indicated the facility originally admitted the resident on 3/2/2016 and most recently readmitted the resident on 4/12/2026 with diagnoses including, but not limited to, encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs). During a review of Resident 67's Minimum Data Set (MDS - a resident assessment tool) dated 5/22/2026, the MDS indicated the resident was cognitively intact (able to think, learn, and remember clearly). The MDS indicated Resident 67 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 91's admission Record, the admission Record indicated the facility originally admitted the resident on 3/7/2017 and most recently readmitted the resident on 11/11/2021 with diagnoses including, but not limited to, atherosclerotic heart disease (a condition where plaque builds up in the arteries of the heart, reducing blood flow to the heart muscle) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both hips. During a review of Resident 91's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 91 required substantial assistance (helper does more than half of the effort) for most ADLs. During an observation on 6/17/2026 at 11:15 a.m., in Resident 67 and Resident 91's shared room, observed the window screen for the window facing outside the facility was bent creating a gap between the window screen and the window. During a concurrent observation and interview on 6/18/2026 at 12:25 p.m., with the Maintenance Supervisor (MS) outside the facility next to the window of Resident 67 and Resident 91's shared room, the MS validated the window screen was bent. The MS stated there was an approximate inch wide gap at the side of the screen. The MS stated the window does slide open and the screen shouldn't be like that because pests could get into the room. During an interview on 6/18/2026 at 12:59 p.m., with Assistant Director of Nursing 1 (ADON 1), ADON 1 stated the screen should be intact and not have a gap to ensure the residents are safe and comfortable. During a review of the facility's policy and procedure (P&P) titled, Pest Control Program, last reviewed on 5/28/2026, the P&P indicated the facility will maintain an effective pest control program utilizing a variety of methods to control certain seasonal pests such as flies. During a review of the facility's P&P titled, Preventative Maintenance Program, last reviewed on 5/28/2026, the P&P indicated a preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The P&P indicated the Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review,ˆthe facility failed to ensure theˆMinimum Data Set (MDS - a resident assessment tool) assessment accurately reflected the vision and dental status and activeˆdiagnosis of vision loss and retinal detachment (the thin layer of tissue at the back of the eye [retina] pulls away from its usual position) of the left eye and diminishing vision of the right eye was reflected for one of thirty-three sampled residents (Resident 87). Thisˆdeficient practiceˆresulted in Residentˆ87ˆhaving an inaccurate MDS assessmentˆand had the potential to negatively affect in the plan of care and treatment.ˆˆˆ Findings:ˆ During a review of Resident 87's admission Record, the admission Record indicated that the facility initially admitted Resident 87 on 4/8/2022 with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), hypertension (HTN- high blood pressure), and hyperlipidemia (abnormally high levels of fats in the blood).ˆ During a review of Resident 87's MDS dated [DATE], the MDS indicated that Resident 87's cognition (mental action or process ofˆacquiringˆknowledge and understanding) was intact. The MDS indicated that Resident 87's ability to see in adequate light was adequate (sees fine details, such as regular print in newspapers/books). The MDS indicated Residentˆ87ˆrequired ranging from supervision/touching assistance to maximal assistance (helper does more than half the effort) forˆphysicalˆassistanceˆfrom staff for activities of daily living (ADLs - activities related to personal care).ˆThe MDS also indicated Resident 87 had no vision related active diagnosis. The MDS also indicated that Resident 87 had no broken or loose teeth, mouth or facial pain. During a review of Resident 87's progress note dated 12/8/2025, the progress note indicated that Resident 87 had reported vision loss in the left eye and diminishing vision in the right eye, with a history of retinal detachment in the left eye. The progress note also indicated that the plan of care includes consultation with a specialist. During a review of Resident 87's Order Summary Report, the Order Summary Reportˆindicatedˆthe following physician orders:ˆˆˆ -May see dentist (medical doctor that specialized in oral/mouth care), initiated on 2/28/2023. -May see ophthalmologist (medical doctor that specialized in eye and vision care), initiated on 2/28/2023. During a review of Resident 87's Social Service assessment dated [DATE], the Social Service Assessment indicated in the Optometry/Ophthalmology and Dental Consult status that resident was referred to ancillary services (supplemental or diagnostic services provided in support of, or in addition to, care delivered by a primary clinician). During a review of Resident 87's record titled, Onsite Skilled Dental Care, dated 5/22/2026, the record indicated in the treatment notes that Resident 87 had loose upper bridge teeth. During a review of Resident 87's care plan (a document that summarizes a resident's needs, goals, and care/treatment) titled, Impaired Visual Function, initiated on 4/11/2022, the care plan indicated interventions including scheduling consultations with eye specialists as needed, identifying factors that may impact visual function, and regularly observing, recording, and reporting any signs or symptoms of acute eye problems. Such symptoms could involve changes in the ability to carry out daily activities, decreased mobility, sudden vision loss, dilated pupils, a gray or milky appearance in the eyes, seeing halos around lights, double vision, tunnel vision, blurred vision, or hazy vision. During a concurrent observation and interview on 6/15/2026 at 10:33 a.m., with Resident 87, Resident 87 was awake, attentive, and capable of expressing her needs. Observed Resident 87's upper three left teeth were loose. Resident 87 stated being blind in her left eye, able to see only shadows, and said her right eye's vision was deteriorating. During a concurrent interview and record review on 6/17/2026 at 10:10 a.m., with the MDS Nurse (MDSN), reviewed Resident 87's MDS dated [DATE], progress notes dated 12/8/2025, and active medical diagnosis.ˆThe MDSN stated that her responsibilities include conducting assessments and evaluations and completing both the MDS and care plan documentation. The MDSN stated that the (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	assessment process involves seeing each resident to conduct the MDS assessment, which covers vision, dental, and hearing status. The MDSN added that to ensure accuracy, she reviews physician progress notes and orders, comparing them with medical diagnoses in the records. The MDSN stated that according to Resident 87's MDS assessment dated [DATE], Resident 87's vision and dental status showed no concerns, and there was no active diagnosis of vision loss or retinal detachment. The MDSN stated that Resident 87's MDS assessment was not accurate and there should have been an active diagnosis for Resident 87's vision loss and retinal detachment along with proper documentation of vision and dental status. The MDSN further stated that failing to produce an accurate MDS assessment may lead to missing a targeted care plan and delayed care delivery. During an interview on 6/18/2026 at 12:41 p.m., with the Director of Nursing (DON), the DON stated that MDSNs are responsible for conducting MDS assessments. The DON explained that there were inaccuracies in both the assessment and documentation of vision and dental status for Resident 87, and the resident's active medical diagnoses for vision and dental health were not reflected. The DON stated that the MDSN failed to validate the assessment, which could result in delayed care and potentially prevent Resident 87 from receiving necessary services due to these inaccuracies. During a review of the facility's P&P titled, Documentation in Medical Record, reviewed 5/28/2026, the P&P indicated that licensed staff and interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) members must record all assessments, observations, and services in the resident's medical record according to state law and facility policy. The P&P outlines documentation principles such as being factual, objective, and focused on the resident; prohibiting false entries; and requiring descriptive, objective information based on direct knowledge of the assessment or service provided. It also emphasizes that documentation should be accurate, relevant, and complete, with enough detail about the resident's care or responses to care. During another review of facility's P&P titled, Dental Services, reviewed 5/28/2026, the P&P indicated that the residents' dental needs are identified through both physical and MDS assessments, and subsequently incorporated into each resident's care plan. The P&P further stated that oral and dental status must be documented based on assessment findings.