STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056127	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Rehab Center	537 W Live Oak San Gabriel, CA 91776

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide oxygen therapy (treatment that provides supplemental, or extra oxygen) as indicated on the physician's order for two (2) of two sampled residents (Resident 12 and 72) reviewed for respiratory and oxygen in accordance with the facility's policy and procedures (P&P) by failing to:Ensure Resident 12 received oxygen as ordered by the physician and the resident's oxygen tubing (a tubing that connects to the oxygen source used to deliver oxygen) was connected to the oxygen concentrator (a medical device that gives extra oxygen by taking and filtering air from the surroundings) was not lying on the floor. Ensure Resident 72 oxygen nasal cannula (a lightweight, flexible tube used to deliver supplemental oxygen to people with breathing difficulties) and nebulizer mask (a medical device that fits over the nose and mouth to deliver liquid medication directly into the lungs as a fine mist) were not lying on the floor These deficient practices had the potential to place Resident 12 and 72 at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) which could lead to irreversible damages of health and/or death.Findings: 1. During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 12's diagnoses included acute respiratory failure (occurs when you do not have enough oxygen in your blood) with hypoxia (a dangerous condition that happens when your body doesn't get enough oxygen), type II diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) with hyperglycemia (a condition where the blood glucose [sugar] levels are abnormally high), and pneumonia (an infection/inflammation in the lungs). During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool) dated 3/26/2026, the MDS indicated Resident 12 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 12 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit-to stand, chair/bed to chair transfer, toilet transfer and tub/ shower transfer. During a concurrent observation and interview on 4/9/2026 at 9:13 AM with Registered Nurse Supervisor 1 (RNS 1) inside Resident 12's room, Resident 12's oxygen tubing was lying on the floor and not connected to the oxygen concentrator. RNS 1 picked up the oxygen tubing from the floor, did not sanitize it and connected it to the oxygen concentrator. RNS 1 stated if the facility staff connects the oxygen tubing to the resident's oxygen concentrator that was lying on the floor it will be infection control issue because the tubing may have been contaminated with bacteria from the floor and Resident 12 can inhale whatever particles or bacteria were on the floor. (continued on next page)

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

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/9/2026 at 9:27 AM with RNS 1, Resident 12's Physician Order (PO) dated 3/24/2026 was reviewed. The PO indicated Oxygen 2 liters per minute (LPM, unit of measurement) via nasal cannula, may titrate up to 5 LPM for oxygen saturation (SpO2, is a measurement of how much oxygen your blood is carrying as a percentage of the maximum it could carry. Normal value is 95% to 100%) if less than 92% every shift for shortness of breath / wheezing, continuously. RNS 1 stated the oxygen order for Resident 12 indicated continuously and the resident's oxygen should be administered to Resident 12 at all times. RNS 1 stated licensed nurses should ensure the oxygen nasal cannula or oxygen tubing were properly connected to the resident and the oxygen concentrator. The licensed staff should monitor if Resident 12 had any incident of oxygen desaturation (a decrease in the oxygen levels in the blood). During a concurrent interview and record review 04/09/2026 9:28 AM with RNS 1, Resident 12's Care Plan (CP) for oxygen desaturation dated 3/19/2026 was reviewed. The CP interventions indicated monitor all vital signs (objective, measurable indicators of the body's most basic, life-sustaining functions, used by health professionals to assess physical health, identify acute medical issues, and monitor illnesses. This includes oxygen saturation) every shift, frequent visual checks throughout shifts. RNS 1 stated all staff should monitor Resident 12 frequently and if Resident 12's oxygen was connected at all times per the resident's CP. During a record review of facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2020, the P&P indicated: Check the tubing connected to the oxygen cylinder and assure that it is free of kinks Check the mask, tank, humidifying jar (oxygen humidifier - device designed to increase the moisture in the air), etc., to be sure they are in good working order and are securely fastened. Observe the resident upon set up and periodically thereafter to be sure oxygen is being tolerated. The P&P also indicated in the Documentation; after completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: The rate of oxygen flow, route, and rationale. The frequency and duration of the treatment. All assessment data obtained before, during, and after the procedure. 2. During a review of Resident 72 's admission Record indicated Resident 72 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included unspecified asthma, uncomplicate (a chronic, non-curable, yet manageable inflammatory lung disease causing wheezing, coughing, and breathing difficulties, not further specified as mild, moderate, or severe, and is not currently exacerbated or causing acute complications), and atrial fibrillation (chronic arrhythmia causing a rapid, irregular heart rhythm due to chaotic electrical signals in the heart's upper chambers). During a review of the Quarterly Minimum Data Set (MDS- a resident assessment tool) dated 2/25/2026, it indicated Resident 72 had intact cognitive skills for daily decision making. The MDS indicated Resident 72 need setup or clean-up assistance (helper sets up or cleans up) with eating, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	upper body dressing and oral hygiene. The MDS also indicated Resident 72 needs substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds the trunk or limbs but provides more than half the effort) for toileting hygiene, shower, bathe self, lower body dressing, and putting on/ taking off footwear. During an observation on 4/6/2026 at 11:46 AM in Resident 72's room, observed Resident 72's nasal cannula for her oxygen delivery was lying on the floor and the oxygen concentrator machine was running. Resident 72's nebulizer mask tubing was also touching the floor in front of the nightstand. During a review of Resident 72's PO dated 12/17/2025, it indicated Resident 72 has an order for Acetylcysteine (a prescription medication used to thin and loosen thick mucus in the airways) solution 20 % give10 milliliter inhale orally every 8 hours for mucous secretions, give via nebulizer. During a review of Resident 72's PO dated 11/30/2025 indicated order for oxygen to administer oxygen at 2LPMvia nasal canula and may titrate up to 4LPM for oxygen saturation less than 92% as needed for shortness of breath or wheezing. During an interview on 4/9/2026 at 11:05 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the nebulizer mask tubing and nasal cannula are supposed to be inside a clean set up bag when they are not in use and it should have been labeled, dated with date opened or first use and resident's name on it. LVN 2 stated the nebulizer mask tubing and nasal cannula must be changed once it touches the floor and this can help prevent infection and cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). During an interview on 4/9/2026 at 11:35 AM with RNS 1, RNS 1 stated nasal cannula tubing and nebulizer mask tubing were not supposed to be lying on the floor, and it needs to be changed right away to prevent Resident 72 from getting infection that could result in illness and potential hospitalization. During a record review of facility's P&P titled, Administering Medications through a Small Volume (Handheld) Nebulize Level III revised 3/2023, the P&P indicated: The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Rinse and disinfect the nebulizer equipment according to facility protocol, Change equipment and tubing every seven days, or according to facility protocol. During a record review of facility's P&P titled, Policies and Practices - Infection Control, revised 4/2023, the P&P indicated this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) and antibiotic (medication used to treat infection) for two (2) of 2 sampled residents (Residents 5 and 12) as indicated on the care plan and facility policy by failing to monitor: 1. Resident 5 for signs and symptoms (s/s) of hypoglycemia (an abnormally low level of sugar [glucose] in the blood) and hyperglycemia (a condition where the blood glucose [sugar] levels are abnormally high), while on Insulin Glargine (Lantus, a type of long-acting insulin) and Insulin Aspart (Novolog, fast-acting insulin [a hormone that works by lowering levels of glucose {sugar} in the blood]) from 2/16/2026 to 4/9/2026. 2. a. Resident 12 for s/s of hypoglycemia and hyperglycemia while on Insulin Glargine and Insulin Lispro (Humalog, a fast-acting insulin [a hormone that works by lowering levels of glucose {sugar} in the blood] from 3/24/2026 to 4/8/2026. b. Resident 12 for side effects of Ceftriaxone Sodium (is a third-generation cephalosporin antibiotic used for the treatment of a few bacterial infections) and Vancomycin hydrochloride (HCL) (a potent prescription antibiotic used to treat severe bacterial infections) from 3/24/2026 to 4/9/2026. These deficient practices have the potential for Residents 5 and 12 to experience episodes of hypoglycemia and hyperglycemia and not properly monitored while on insulin, and potential for Resident 12 to experience the side effects of using two antibiotics and not being monitored while on antibiotic therapy that may result in hospitalization and harm. Findings:1. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 5's diagnoses included metabolic encephalopathy (an alteration of brain function or consciousness due to failure of other internal organs), type II diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), and chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should) During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 5 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 5 was substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in eating, oral hygiene, upper and lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit-to stand, chair/bed to chair transfer, toilet transfer and tub/ shower transfer. The MDS also indicated seven insulin injections were administered to Resident 5 for the past seven days. During a concurrent interview and record review on 4/9/2026 at 8:30 AM with Registered Nurse Supervisor 1 (RNS 1), Resident 5's Physician's order (PO) dated 2/16/2026 was reviewed. The PO indicated:1. Insulin Glargine (Subcutaneous (SQ, a shot that delivers medicine into the fatty tissue layer just under the skin, above the muscle, using a short, small needle for slow, steady absorption) Solution 100 units per milliliter (ML, measure of volume) Inject 10 unit subcutaneously one time a day for Type 2 DM. Hold if Blood Sugar (BS) was less than (<) 100. 2. Insulin Aspart (Novolog, fast acting insulin [a hormone that works by lowering levels of glucose {sugar} in the blood]) Subcutaneous Solution 100 unit per ML Inject subcutaneously before meals for Type II DMInject as per sliding scale (method of adjusting medication doses, most commonly insulin, based on the resident's blood glucose level [amount of sugar present in the blood at a given time]):If BS< 70, administer glucagon, recheck Blood sugar in 15 minutes, notify physician, and Change of Condition (COC, is a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains).if 150 to 199 = 0 units;200 to 249 = 2 units;250 to 299 = 4 units;300 to 349 = 6 units;350 to 399 = 8 units;If BS more than (>) 400, give 10 units, notify physician for further orders, recheck sugar, conduct COC, subcutaneously before meals for Type II DM.RNS 1 stated there were no orders for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring the s/s of hypoglycemia and hyperglycemia while using insulin. During a concurrent interview and record review on 4/9/2026 at 8:42 AM with RNS 1, Resident 5's Nurses Progress Notes (NPN) dated 4/1/2026 to 4/9/2026 were reviewed. RNS 1 stated there was no documentation indicating that signs and symptoms of hypo- or hyperglycemia were being monitored. RNS 1 stated that because the staff did not document the monitoring, there was no evidence the staff had monitored Resident 5, which meant the licensed staff were not performing the required monitoring. RNS 1 stated if the licensed staff were not monitoring Resident 5, the resident could possibly require hospitalization due to the lack of proper monitoring. During a concurrent interview and record review on 4/9/2026 at 8:37 AM with RNS 1, Resident 5's Care Plan (CP) for Diabetes Mellitus revised on 3/10/2026 was reviewed. Resident 5's CP interventions indicated the following:Observe for s/s of hypoglycemia (diaphoresis, faintness, headache, palpitations, trembling, impaired vision, hunger, difficulty awakening, irritability, personality changes).Observe for s/s of hyperglycemia, polydipsia (excessive thirst or abnormally increase fluid intake), polyuria (excessive urination or producing unusually large amounts of urine), increased blood glucose and ketone levels, deep & rapid breathing, anorexia (a loss of appetite or reduced desire to eat), nausea & vomiting, fruity-smelling RN breath, warm & dry skin, weakness, abdominal pain, general aches.RNS 1 stated there was no documentation that the staff followed the care plan, which meant the staff were not monitoring Resident 5 while on insulin. During a review of the facility's policy and procedure (P&P) titled, Diabetes Clinical Protocol revised 3/2023, the P&P indicated, the Physician and staff will summarize factors that are contributing to, or conditions that are affected by, the resident's diabetes or glucose intolerance and will assess the impact of diabetes on the individual's function and quality of life. The P&P also indicated in Monitoring and follow- up. The P&P also indicated that the Physician will order desired parameters for monitoring and reporting information related to blood sugar management and the staff will incorporate such parameters into the Medication Administration Record and care plan. The P&P also indicated that the staff will identify and report issues that may affect, or be affected by, a patient's diabetes and diabetes management such as foot infections, skin ulceration, increased thirst, or hypoglycemia and the staff and Physician will manage hypoglycemia appropriately. 2.During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 12's diagnoses included methicillin-resistant staphylococcus aureus (MRSA, is a type of bacteria that's developed defense mechanisms resistance to antibiotics) wound of the right foot, type II diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) with hyperglycemia (a condition where the blood glucose [sugar] levels are abnormally high), cellulitis (a bacterial infection that enters your skin and tissue through a wound), and gangrene (a serious, potentially fatal condition involving tissue death [necrosis] caused by infection or lack of blood flow) of the right lower extremity During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 12 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit-to stand, chair/bed to chair transfer, toilet transfer and tub/ shower transfer. The MDS also indicated seven insulin injections were administered to Resident 12 for the past seven days. a. During a concurrent interview and record review on 4/8/2026 at 4:02 PM with Infection Preventionist Nurse (IPN), Resident 12's PO, dated 3/24/2026, was reviewed. The PO indicated:1. Insulin Glargine Subcutaneous Solution 100 units per ML Inject 10 units subcutaneously every 12 hours for Type 2 DM. Hold if BS <100. 2. Insulin Lispro Injection Inject SQ per Sliding Scale subcutaneously before meals for Type 2 DM.Inject as per sliding scale:if 0 to 149 = 0 If BS is <70 and conscious, give 4-6 oz of juice, then recheck BS in 15 minutes. Notify MD of change.150 to 199 = 4;200 to 249 = 6;50 to 299 = 8;300 to 349 = 10;350 to 399 = 12;If BS is 400 and above, notify MD IPN stated there was no monitoring order (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for signs and symptoms of hyperglycemia and hypoglycemia. Without an order, it means the staff were not monitoring the signs and symptoms of hyperglycemia and hypoglycemia for Resident 12. During a concurrent interview and record review on 4/8/2026 at 4:06 PM with IPN, Resident 12's Care plan (CP) for DM revised 4/2/2026 was reviewed. The CP indicated interventions including the following: Monitor for s/s of hypoglycemia (diaphoresis, faintness, headache, palpitations, trembling, impaired vision, hunger, difficulty awakening, irritability, personality changes). Monitor for s/s of hyperglycemia: polydipsia, polyuria, increased blood glucose and ketone levels, deep & rapid breathing, anorexia, nausea & vomiting, fruity-smelling breath, warm & dry skin, weakness, abdominal pain, general aches.IPN stated the staff did not have documentation for monitoring s/s hyperglycemia and hypoglycemia for Resident 12. The licensed staff did not have documentation showing they followed Resident 12's care plan. During a concurrent interview and record review on 4/8/2026 at 4:16 PM with IPN, Resident 12's Nurses Progress Notes (NPN) dated 3/24/2026 to 4/8/2026 were reviewed. IPN stated the licensed staff did not have a documentation that Resident 12 was monitored for s/s of hypoglycemia and hyperglycemia. IPN stated if there was no documentation, it means it was not done. b. During a concurrent interview and record review on 4/8/2026 at 4:17 PM with IPN, Resident 12's PO, dated 3/24/2026, was reviewed. The PO indicated:1. Ceftriaxone Sodium 2 grams (GMs) intravenously (refers to a way of giving a drug or other substance through a needle or tube inserted into a vein) one time a day for MRSA wound of the right foot until 4/30/20262. Vancomycin HCl 750 MG intravenously every 24 hours for MRSA wound on the right foot until 4/30/2026IPN stated there were no orders for monitoring the side effects (S/E) of Ceftriaxone and Vancomycin. During a concurrent interview and record review on 4/8/2026 at 4:19 PM with IPN, Resident 12's Care Plan (CP) risk for side effects related to vancomycin and ceftriaxone use dated 3/26/2026 was reviewed. The CP interventions indicated: Administer two IV antibiotics separately and flush the lines before and after the IV medications were administered. Monitor for side effects of vancomycin and ceftriaxone use, like Hives, shortness of breath, diarrhea, or DRESS syndrome (Drug Reaction with Eosinophilia and Systemic Symptoms, is a rare, severe, and potentially life-threatening drug-induced reaction) Stop the medication and notify the primary care provider if the resident experiences side effects.IPN stated they should monitor Resident 12 based on the care plan but there was no documentation of the monitoring, which means the Licensed staff did not follow the care plan. During a concurrent interview and record review on 4/9/2026 at 9:51 PM with Registered Nurse 1 (RNS 1), Resident 12's PO, dated 3/24/2026 was reviewed. RNS 1 stated the S/E of Ceftriaxone were diarrhea, rash, dizziness, headache, fatigue, severe abdominal pain, yellow skin eyes, and pale stools. RNS 1 stated the S/E of Vancomycin were rashes, hearing loss, nausea and vomiting, low blood pressure, swelling of extremity, and pain. RNS 1 stated Resident 12 did not have a monitoring order for these antibiotics. During a concurrent interview and record review on 4/9/2026 at 9:55 AM with RNS 1, Resident 12's Care Plan (CP) risk for side effects related to vancomycin and ceftriaxone use, dated 3/26/2026, was reviewed. RNS 1 stated since Resident 2 had two different kinds of antibiotics, the care plan interventions to monitor the side effects should have been specific for each antibiotic use. During a record review of facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised 3/2023, the P&P indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.3.The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan:a. includes measurable objectives and timeframes.b. describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, including:c. includes the resident's stated goals upon admission and desired outcomes.d. builds on the resident's strengths; ande. reflects currently recognized standards of practice for problem areas and conditions.10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.11. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions changes.

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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 prepare the correct amount of sweet and sour sauce served during lunch on 4/8/2026 in accordance with the facility's spring menu and policy and procedure (P&P).This deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake and weight loss for 81 residents. Findings: During a concurrent observation and interview on 4/8/2026 at 11:56 AM in the facility kitchen during lunch tray line assembly with [NAME] 1, [NAME] 1 was observed using a oneˆounce (oz) portion spoon to scoop the sweet and sour sauce with vegetables onto the residents' plates. During a concurrent interview and record review on 4/8/2026 at 11:56 AM with the Dietary Service Supervisor (DSS), the facility's 4/8/2026 spring menu, page 2, was reviewed. The facility's spring menu for 4/8/2026 indicated the serving size for sweet and sour sauce with vegetables is 2 oz. DSS stated it is important to use the correct portionˆsize spoon to ensure residents receive necessary nutrients and to enhance digestion. During a review of the facility's undated P&P titled, Food Preparation Policy, the P&P indicated food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. All meals must comply with the physician-ordered diet, approved menu, and portion control standards to ensure consistency, adequate nutrition, and regulatory compliance. It also indicated Portion Control During Meal Service:Standardized portion sizes must be followed for all food items, including meats, in accordance with the approved menu and diet manual.Portion utensils (e.g., scoops, serving utensils, ladles) must be labeled and used to ensure consistent portioning.e. Dietary Supervisor or Lead [NAME] must monitor the meal service to ensure correct portion is being served

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, the facility's kitchen staff failed to ensure the chicken on the facility's menu was prepared at a safe temperature on 4/8/2026 during lunch time, in accordance with the facility's Policy and Procedure (P&P). This deficient practice has the potential to cause 81 residents to have foodborne illness (foodborne diseases or food poisoning, illnesses caused by consuming food or beverages contaminated with harmful agents). Findings: During a concurrent observation and interview on 4/8/2026 at 11:51 AM in the facility kitchen during lunch tray line assembly with the Dietary Service Supervisor (DSS), DSS was observed checking the temperature of the cooked chicken, which measured 140 degrees Fahrenheit (F). DSS stated it is very important to keep the cooked chicken at 165 F to prevent residents from developing foodborne illness. During a review of the facility's P&P titled, Food Preparation and Service, revised November 2022, the P&P indicated the following internal cooking temperatures/times for specific foods are reached to kill or sufficiently inactivate pathogenic microorganisms: 165 F for poultry.

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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 follow proper food storage handling practices in accordance with its policy and procedure (P&P) by: Failing to ensure eight (8) food items were labeled with preparation date, thaw date and/ or use by date. Failing to ensure Dietary Service Supervisor (DSS) perform handwashing and change gloves after picking up an alcohol wrap from the floor and then placed a thermometer into the tray of cooked chicken on the steam table. Failing to ensure three (3) food carts were free of white splattered stains on their doors. These deficient practices have the potential to result in food born illness (any sickness that is caused by the consumption of foods or beverages that are contaminated with certain infectious or noninfectious agents) to 81 residents receiving food from the kitchen. Findings: 1. During a concurrent observation and interview on 4/6/2026 at 7:52 AM in the facility kitchen with the DSS, the following food items were observed in the freezer: Four (4) bags of prepared sandwiches in the refrigerator have no label to indicate preparation date and use by date.Four (4) bags of chicken thighs in the refrigerator have no labels to indicate the name, date of thawing and use by date. DSS stated in accordance with the facility's P&P, all food items including the prepared 24 sandwiches should be labeled with a preparation date and a use by date once. DSS stated frozen items should be labeled with the item's specific name, thaw date and use by date. DSS stated, the 4 bags of chicken thighs in the refrigerator were placed there for thawing and it was not labeled with the item name, thaw date and use by date. DSS also stated it is very important to label, store, and discard food items per the facility's P&P to ensure that the food items are safe to eat for the residents. During a review of the facility's P&P titled Dating and Labeling, undated, the P&P indicated, to ensure food safety and prevent contamination within the facility, all food items should be properly covered, dated, and labeled in dry storage and refrigerator/ freezer areas. The P&P also indicated any frozen items should be labeled with the thaw date. 2. During a concurrent observation and interview on 4/8/2026 at 11:48 AM in the facility kitchen during tray line assembly with the DSS, observed DSS picked up an alcohol wrap from the floor without changing gloves and DSS did not perform hand hygiene (the act of cleaning hands to prevent the spread of germs, infections, and diseases, recognized as the most important method for infection control. It includes washing with soap and water [for 20 plus seconds] or using alcohol-based hand sanitizer). DSS then used the same hand with the same gloves to place a thermometer into the tray of cooked chicken on the steam table. DSS stated it is important to wash her (DSS) hand with soap and warm water for at least 20 seconds after picking up trash from the kitchen floor and changing gloves before moving to another task such as handling cooked food. This prevents the spread of pathogens from the floor to food preparation surfaces. 3. During a concurrent observation and interview on 4/8/2026 at 12:00 PM in the facility kitchen with the Dietary Consultant (DC), 3 food carts had dried white stains on their doors. DC stated kitchen staff should have maintained cleanliness of the 3 food carts to prevent food borne illnesses. During a review of the facility's P&P titled, Food Preparation and Service, revised November 2022, the P&P indicated, food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. The P&P also indicated:Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.All food service equipment and utensils will be sanitized according to current guidelines and manufacturers' recommendations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed in accordance with the facility's policy and procedure (P&P) when facility failed to ensure:1. Resident 3's tube feeding (the process of delivering liquid nutrition directly into the stomach or small intestine via a soft, flexible tube) machine was free of beige colored stains.2. Laundry staff followed infection control practices as evidenced by two used paper cups and paper towels left in the clean area of the laundry room, and by the presence of light brown splatter stains on the shelves where clean linens were stored.3. Facility staff observed infection control measures for Resident 89 who was on Enhanced Barrier Precautions (EBP- the use of gown and glove for nursing home residents with wounds and indwelling devices during specific-high contact resident care activities associated with multidrug-resistant organisms [MDRO] transmission) by failing to don (wear) personal protective equipment (PPE- a barrier precaution which includes use of gloves, gown, mask, face shield, shoe covers, head covers, respirators, etc. when you anticipate contact with blood or body fluids or other communicable toxins or agents) before checking for gastrostomy tube (G-tube- a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach) placement prior to medication administration. These deficient practices have potential to contaminate clean items and placed the residents at a higher risk for cross-contamination and increased spread of infection in the facility.Findings: 1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 3's diagnoses included metabolic encephalopathy (an alteration of brain function or consciousness due to failure of other internal organs), diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive state of decline in mental abilities) During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 2/13/2026, the MDS indicated Resident 3 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand and chair/ bed-to-chair transfer and tub/ shower transfer. During an observation on 4/6/2026 at 10:18 AM inside Resident 3's room, Resident 3 was awake and lying on her bed. The tube feeding (TF) machine was running and there were beige colored stains all over the TF machine. During an observation on 4/7/2026 at 9:15 AM inside Resident 3's room, Resident 3 was awake and lying on her bed. Resident 3's TF machine was turned on and the TF machine had beige colored stains. During a concurrent observation and interview on 4/7/2026 at 3:11 PM with Infection Preventionist Nurse (IPN), IPN stated the TF machine had beige colored stains. IPN stated the TF machine was dirty and the beige colored stains might be from the dried formula. IPN stated the staff should have cleaned the TF machine before using it for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, updated on 4/2023, the P&P indicated Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC, national public health agency of the United States) recommendations for disinfection and the Occupational Safety and Health Administration (OSHA, is a U.S. federal agency under the Department of Labor that ensures safe working conditions by setting and enforcing standards, providing training, and offering assistance to employers and workers) Blood-borne Pathogens Standard. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g., respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. 2. During a concurrent observation and interview on 4/7/2026 at 3:41 PM with the Environmental Services Supervisor (ESS) inside the laundry room, two disposable paper cups (1 cup filled with ice and 1 empty used cup) sitting on the tabletop in the laundry folding area, which was a clean area. ESS stated there should be no cups in the clean area because of infection control During a concurrent observation and interview on 4/7/2026 at 3:56 PM with the ESS inside the laundry room, there were light brown colored splatter stains observed on the lower shelf where folded clean linens were stored. The curtains covering the shelves showed grayish discoloration along the lower hem. ESS stated the curtains needed to be laundered. ESS also stated the dried brown colored stains on the bottom shelf were possibly from a spilled drink. ESS stated the laundry staff should keep the folding area clean to maintain proper infection control. During a concurrent observation and interview on 4/7/2026 at 4PM with ESS inside the laundry room, there were 2 used crumpled paper towels left on top of shelf where clean residents' clothes were hung and stored. ESS stated the laundry staff should not leave used paper towels in the clean area because of infection control. During review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces updated on 4/2023, the P&P indicated, Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities-and the OSHA Bloodborne Pathogens Standard. 8. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 9. Environmental surfaces will be disinfected (or cleaned) on a regular basis and when surfaces are visibly soiled. 3. During a review of Resident 89's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (loss of motor function on the left side of the body caused by a blockage of a blood vessel in the right side of the brain), attention to gastrostomy, and essential hypertension (high blood pressure). During a review of Resident 89's MDS, dated [DATE], the MDS indicated Resident 89 was assessed having severely impaired (never/rarely made decisions) cognitive skills for daily decision making. The MDS indicated Resident 89 was dependent with oral/toileting hygiene, upper/lower body dressing, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shower/bathe self, roll left and right, sit to lying, and tub/shower transfer. The MDS indicated Resident 89 had a feeding tube. During a review of Resident 89's Order Summary Report, dated 4/9/2026, the Order Summary Report indicated the following physician's orders: Enhanced Barrier Precautions due to g-tube, with an order date of 2/28/2025. Clonazepam 0.5 milligrams (mg- unit of measurement), give 0.25 mg via G-tube three times a day for seizure (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) prophylaxis (prevention), with an order date of 3/30/2025. Enteral feed (the delivery of liquid nutrition directly into the gastrointestinal [GI] tract via a feeding tube) order five times a day via gravity or bolus (set amount of formula is given at one time through the feeding tube): Nutren 2.0 237 milliliters (ml- unit of measurement)/can per G-tube for weight management, with an order date of 7/16/2025. During a review of Resident 89's Care Plan titled, Enhanced Barrier Precautions due to G-tube, the Care Plan indicated interventions were to provide Enhanced Barrier Precautions: gloves, gowns, masks. During a concurrent observation and interview on 4/6/2026, at 12:24 PM, in Resident 89's room, an EBP sign was observed posted above Resident 89's bed. Licensed Vocational Nurse 5 (LVN 5) entered Resident 89's room and stated she was going to administer Resident 89's medication through his G-tube. LVN 5 donned gloves, unclamped Resident 89's G-tube and checked it for placement. LVN 5 administered clonazepam and Nutren 2.0 via G-tube and flushed Resident 89's G-tube with 30 ml of water. LVN 5 doffed (removed) her gloves and washed her hands. LVN 5 stated she forgot to wear a gown before checking Resident 89's G-tube residual and administering his medications. During an interview on 4/7/2026, at 1:41 PM, with LVN 6, LVN 6 stated residents with G-tubes were placed on EBP. LVN 6 stated facility staff had to wash their hands and wear PPEs before administering medications and providing G-tube care. LVN 6 stated it was important for facility staff to wear PPEs when providing care for residents on EBP to protect the residents and staff from infection and contamination. During an interview on 4/8/2026, at 10:51 AM, with Registered Nurse Supervisor 1(RNS 1), RNS 1 stated facility staff were supposed to follow EBP and don the appropriate PPEs before providing direct care to residents. RNS 1 stated direct care included changing diapers, wound care, G-tube care and G-tube medication administration. RNS 1 stated facility staff were required to don gloves and gown before providing G-tube care and G-tube medication administration. RNS 1 stated donning PPE prevents the spread of infection to residents in the facility. During a review of the facility's undated P&P titled, Enhanced Barrier Precaution, the P&P indicated the following: Enhanced Barrier Precaution is an infection control intervention designed to reduce transmission of MDROs. Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents known to be infected or colonized with an MDRO as well as those at increased risk of MDRO acquisition (example: residents with wounds or indwelling medical devices) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform hand hygiene, wear gowns and gloves while performing the following tasks associated with residents who require Enhance Barrier Precautions: Device care, for example, feeding tube Any care activity where close contact with the resident is expected to occur

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 two (2) of 2 sampled residents (Residents 47 and 48) reviewed for environment were provided with a homelike environment by failing to maintain a scratch- free, non-discolored wall surface in the residents' room, in accordance with the facility's policy. This deficient practice had the potential for an unsafe and unclean environment and had the potential to negatively affect the residents' quality of life.Findings: 1. During a review of Resident 47's admission Record, the Admissions Record indicated Resident 47 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia with anxiety (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities, specific cause or type has not been determined, with symptoms like restlessness, fear, or panic), muscle weakness (a reduced ability of one or more muscles to generate force, making it harder to perform tasks that require strength), and repeated falls (more than one fall per year or multiple incidents within six months). During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool), dated 2/5/2026, indicated Resident 47 had moderately impaired cognitive skills (mental processes that allow people to think, learn, and solve problems) for daily decision making. Resident 47 needed partial or moderate assistance, (helper does less than half the effort) with shower/bathe self, lower body dressing and putting on/taking off footwear. Resident 47 needs supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, upper body dressing and personal hygiene. MDS also indicated Resident 47 needs set up or clean-up assistance, (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating, oral hygiene, and toilet transfer. During an observation of Resident 47's room on 4/7/2026 at 12:42 PM, the wall behind Resident 47's headboard was observed to have discoloration and multiple scratches. During an interview with Resident 47 on 4/7/2026 at 12:47 PM in his room, Resident 47 shook his head and pointed toward the wall to indicate his dislike of the discoloration and multiple scratches on the wall behind his headboard. 2. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 48's diagnoses included adult failure to thrive (a syndrome characterized by unintended weight loss, malnutrition (serious condition that occurs when a resident's diet does not contain the right amount of nutrients), dehydration (condition that occurs when the loss of body fluids, mostly water, exceeds the amount that is taken in), and unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) with anxiety (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities, specific cause or type has not been determined, with symptoms like restlessness, fear, or panic). During a review of Resident 48's Minimum Data Set (MDS, resident assessment tool) dated 3/23/2026, the MDS indicated Resident 48 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills. The MDS indicated Resident 48 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on/ taking off footwear and sit to lying. Resident 48 needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunks or limbs but provides more than half the effort) with eating (via TF). During an observation of Resident 48's room on 4/8/2025 at 9:33 AM, the wall behind Resident 48's headboard was observed to have discoloration and multiple scratches on the wall.During an interview with the Maintenance Supervisor (MS) on 4/8/2025 at 3:15 PM, MS stated the discoloration and scratches on the wall were caused by the bed hitting the wall multiple times during bed transfers. MS stated this was not a homelike (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	environment for the residents. MS also stated the residents appreciate it when everything in their rooms is fixed and well maintained.During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, revised 3/2024, the P&P indicated Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment:

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the confidentiality of the information of one (1) of five sampled residents (Resident 38) observed during medication administration in accordance with the facility's policy and procedure when Licensed Vocational Nurse 1 (LVN 1), left the laptop screen switched on with Resident 38's electronic medication administration record (eMAR, is the digital version of the traditional paper medication administration records used in healthcare facilities) displayed on the screen. This deficient practice had the potential to violate the resident's right to confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the resident's representative) and privacy and misuse of Resident 38's Protected Health Information (PHI, any information that relates to an individual's health status, medical history, or treatment).Findings:During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 38's diagnoses included renal insufficiency (is a condition where kidneys cannot adequately filter waste, balance electrolytes, or manage blood pressure) , asthma (is a condition in which your airways narrow and swell and may produce extra mucus), chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and colon cancer (a cancer of the large intestine, which may affect the colon or rectum) During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 38 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 38 was independent (resident completes the activity by themself with no assistance from a helper) in eating, oral hygiene, upper body dressing, personal hygiene, roll left and right, sit to lying, and lying to sitting on the side of the bed. During a concurrent observation and interview on 4/8/2026 at 9:46 AM with LVN 1, LVN 1 dispensed Resident 38's medication and left the laptop screen turned on with Resident 38's eMAR was displayed on the screen and the monitor was left facing towards the hallway while there were three residents and four staff walking by the hallway. During an interview on 4/8/2026 at 3:26 PM with LVN 1, LVN 1 stated the staff need to make sure the laptop was turned off to secure privacy of Resident 38's information. LVN 1 also stated the staff need to turn off the laptop monitor when the staff need to step away from the medication cart because anyone including residents or staff might see Resident 38's information about the resident's medications and other medical problems on the screen. During a record review of facility's Policy and Procedure (P&P) titled, Protected Health Information (PHI), Management and Protection of, revised 4/2014, the P&P indicated it is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 47) reviewed for environment was provided a homelike environment by failing to ensure Resident 47's call light (a communication device that allows residents to alert staff for assistance) was within arm's reach, and the resident's television (TV) was plugged in, and the TV's remote control was functioning. These deficient practices had the potential to negatively affect the residents' quality of life.Findings: During a review of Resident 47's admission Record indicated Resident 47 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia with anxiety (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities, specific cause or type has not been determined, with symptoms like restlessness, fear, or panic) muscle weakness (a reduced ability of one or more muscles to generate force, making it harder to perform tasks that require strength), and repeated falls (more than one fall per year or multiple incidents within six months). During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool), dated 2/5/2026, indicated Resident 47 had moderately impaired (decisions poor: cues/supervision required) for cognitive skills (mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS also indicated Resident 47 needed partial or moderate assistance, (helper does less than half the effort) with shower/bathe self, lower body dressing and putting on/taking off footwear and the resident needs supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, upper body dressing and personal hygiene. In addition, the MDS indicated Resident 47 needs set up or clean-up assistance, (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating, oral hygiene, and toilet transfer. During a review of Resident 47's care plan for risk for fall/ injury, revised on 2/16/2026, the care plan indicated intervention to keep the call light within reach. During an observation on 4/6/2026 at 8:36 AM in Resident 47's room, Resident 47's call light was observed located near the resident's feet area which was not within Resident 47's reach. Resident 47 was observed reaching for the call light using the resident's feet but was unsuccessful. During a concurrent observation and interview on 4/6/2026 at 8:41 AM in Resident 47's room with Certified Nurse Assistant (CNA) 2, CNA 2 stated the call light and the TV's cord was near the resident's feet. CNA 2 stated the call light should be within Resident 47's reach so that the resident can request assistance when the resident needs it and to switch on the resident's TV. CNA 2 also stated the TV should be plugged in so the resident can watch the TV anytime the resident wants it CNA 2 added keeping the call light accessible can help prevent the resident from falling or other accidents. During an interview on 4/9/2026 at 9:49 AM with Registered Nurse Supervisor (RNS), RNS stated Resident 47's call light was not supposed to be left near the resident's feet area. RNS stated that the call light should be within the resident's reach so the resident can use it to request assistance in a timely manner, which can also help prevent falls. RNS stated power cord for Resident 47's TV as not supposed to be unplugged. During an observation on 4/8/2026 at 10:22 AM in Resident 47's room, observed Resident 47's TV was off, Resident 47 handed his TV remote control to the surveyor and pointed to the power button. The surveyor tried to switch on the TV using the remote control and the remote control did not work. During a concurrent observation and interview on 4/9/2026 at 10:49 AM with Maintenance Supervisor (MS) in Resident 47's room, MS stated Resident 47's TV was not supposed to be unplugged from the wall, and he should replace the batteries for the TV remote control to ensure it remains in working condition. During a review of the facility's P&P titled, Maintenance Service revised 12/2009, it indicated: maintenance service shall be provided to all areas of the building, grounds, and equipment. During a (continued on next page)

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Live Oak Rehab Center	537 W Live Oak San Gabriel, CA 91776

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's P&P titled, Homelike Environment revised 02/2021, it indicated, staff provides person-centered care that emphasizes the resident's comfort, independence and personal needs and preferences. During a review of the facility's Policy and Procedure (P&P) titled, Call System, Resident revised 03/2023, the P&P indicated each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide oral care for one (1) of three (3) sampled residents (Residents 103) reviewed for activities of daily living (ADL) as indicated on the facility policy. This deficient practice had the potential to cause dry mouth, infection mouth soreness, discomfort and reduce Resident 103's quality of life. Findings:During a review of Resident 103's admission Record, the admission Record indicated Resident 103 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 103's diagnoses included occlusion and stenosis of right middle cerebral artery (the main blood vessel supplying the right side of the brain is either severely narrowed [stenosis] or completely blocked [occlusion], interrupting blood flow) and dysphagia oral pharyngeal phase (difficulty initiating a swallow, where food or liquid cannot move properly from the mouth to the top of the esophagus). During a review of Resident 103's Minimum Data Set (MDS, resident assessment tool), dated 1/12/2026, the MDS indicated Resident 103 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 103 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and sitting to lying. During observations on 4/6/2025 at 11:47 AM, in Resident 103's room, Resident 103's mouth was observed with white crust. During observations on 4/7/2025 at 1:02 PM in Resident 103's room, Resident 103's mouth was observed with white crust. During an interview on 4/8/2026 at 4:46 PM, Certified Nurse Assistant 5 (CNA 5) it was very important to provide oral care to dependent residents to prevent infection, and to maintain their overall dignity. During an interview on 4/9/2026 at 9:41 AM with Registered Nurse Supervisor (RNS), RNS stated CNAs were expected to provide oral care to Resident 103 each shift. The RNS further stated that it is very important to provide oral care to dependent residents to prevent serious infections such as aspiration pneumonia (lung infection that occurs when a person inhales [aspirates] something other than air-such as food, liquid, saliva, or stomach contents-into the lungs, leading to inflammation and infection of the air sacs), other infections, and oral diseases, and to maintain the resident's overall dignity. During a review of the facility's Policy and Procedure (P&P) titled, Supporting Activities of Daily Living, revised 3/2023, the P&P indicated Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to cany out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:hygiene (bathing, dressing, grooming, and oral care)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the tube feeding (TF, a medical method of delivering liquid nutrition, formula, and medications directly into the stomach or small intestine) order for one of four sampled Residents (Resident 48) reviewed for tube feeding, was administered on 4/8/2026 in accordance with the physician's order. This deficient practice had the potential to cause Resident 48 to lose weight and for his health condition to decline. Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 48's diagnoses included adult failure to thrive (a syndrome characterized by unintended weight loss, malnutrition (serious condition that occurs when a resident's diet does not contain the right amount of nutrients), dehydration (condition that occurs when the loss of body fluids, mostly water, exceeds the amount that is taken in), and unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) with anxiety (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities, specific cause or type has not been determined, with symptoms like restlessness, fear, or panic). During a review of Resident 48's Minimum Data Set (MDS, resident assessment tool) dated 3/23/2026, the MDS indicated Resident 48 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills. The MDS indicated Resident 48 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on/ taking off footwear and sit to lying. Resident 48 needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunks or limbs but provides more than half the effort) with eating (via TF). During a review of Resident 48's Physician Order, dated 2/13/2026, the Physician Order indicated Jevity (a type of enteral [a form of nutrition that is delivered into the digestive system as a liquid] feeding) 1.2 at 55 milliliters (ml, a unit of volume measurement) per hour for 20 hours via pump to provide 1100 ml/ 1320 kcal (a unit of energy equal to 1,000 small calories) per day via enteral feeding pump starting at 12 PM and off at 8 AM (or until dose is completed). During a concurrent observation in Resident 48's room and interview with Licensed Vocational Nurse 2 (LVN 2) on 4/8/2025 at 8:35 AM, observed Resident 48 in bed. Resident 48's tube feeding formula bottle was observed to be full, at a level of 1500 ml. LVN 2 stated Resident 48's Jevity 1.2 tube feeding was observed to be at the 1500 ml level. LVN 2 stated that the Jevity container had been labeled by the previous LVN on 4/8/2026 at 1 AM. LVN 2 stated that a full container of Jevity 1.2 is marked at 1500 cc, and if Resident 48's feeding began on 4/8/2026 at 1 AM at a rate of 55 ml/hr, the container should reflect approximately seven hours' worth of feeding used by 8:35 AM on 4/8/2026, not remain full at 1500 ml. LVN 2 stated that Resident 48 had not received any feeding since the Jevity 1.2 container was hung at 1 AM on 4/8/2026. During a concurrent observation in Resident 48's room and interview with LVN 3 at 3:35 PM, LVN 3 stated that the feeding bottle level was still at 1500ml. LVN 3 stated that Resident 48 was not receiving the tube feeding as ordered for 10 hours' worth of the feeding. LVN 3 stated that a resident can lose weight, fail to receive adequate nutrition, and experience a gradual decline in health if tube feedings are not administered as ordered. During a concurrent interview and record review on 4/8/2026 at 4:16 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Enteral Nutrition - Safety Precautions, revised date March / 2023 was reviewed. The P&P indicated its purpose is to ensure the safe administration of enteral nutrition. It also indicated that the facility will remain current in and follow accepted best practices in enteral nutrition.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the peripherally inserted central catheter (PICC line- a long flexible catheter that is inserted through a vein in the upper arm) care was provided in accordance with standards of practice for one (1) of 19 sampled residents (Resident 100) by: Failing to ensure Resident 100's PICC line was assessed and documented upon admission.Failing to ensure the physician's telephone order to remove the PICC line (inserted from General Acute Care Hospital [GACH]) was followed.Failing to ensure Resident 100's PICC line dressing was changed upon admission and weekly as indicated in the facility's policy and procedure (P&P). These deficient practices had the potential to result in Resident 100 developing an infection on the PICC line insertion site.Findings: During a review of Resident 100's admission Record, the admission Record indicated Resident 100 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), gastro-esophageal reflux disease without esophagitis (when stomach acid flows back into the esophagus causing uncomfortable symptoms), and anxiety disorder (fear characterized by behavioral disturbances). During a review of Resident 100's Clinical admission Form, dated 4/3/2026, the Clinical admission Form indicated Resident 100 had mildly impaired (some confusion) cognitive skills (problems with thinking, memory, judgement). The Clinical admission Form did not indicate Resident 100 had a PICC line upon admission. During an observation on 4/6/2026, at 8:46 AM, in Resident 100's room, Resident 100 was asleep in bed. Resident 100 had a PICC line inserted on the resident's left upper arm covered with a clear dressing dated 3/27/2026. During a concurrent observation and interview on 4/7/2026, at 12:55 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 100 arrived from the GACH on 4/3/2026 with the PICC line. LVN 1 stated Resident 100's PICC line dressing was dated 3/27/2026 and the PICC line dressing should have been changed 72 hours after admission to the facility. During a concurrent interview and record review on 4/7/2026, at 12:59 PM, with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated any RNS in charge to assess the residents upon admission and accurately document the assessment in the Clinical admission Form. RNS 1 stated it was important to have a complete and accurate assessment of the condition of the resident upon admission. RNS 1 stated that Resident 100's PICC line was not documented in the Clinical admission Form. RNS 1 stated Resident 100's PICC line was not documented in any of the assessments or resident's progress notes. RNS 1 stated Resident 100 did not have a care plan for the resident's PICC line. RNS 1 stated the RNS should have assessed and documented Resident 100's PICC line in the Clinical admission Form if Resident 100 was admitted to the facility with a PICC line. RNS 1 stated that inaccurate assessment and documentation of residents prevent staff from having a clear understanding of what is going on with the residents, which could affect the care provided. RNS 1 stated he did now know Resident 100 had a PICC line. During the same concurrent interview and record review on 4/7/2026, at 12:59 PM, with RNS 1, Resident 100's Progress Note, dated 4/3/2026, at 9:30 PM, was reviewed. RNS 1 stated the Progress Note indicated, Physician (MD) said that Resident does not need antibiotics (ATBs) and gave the okay to discontinue (d/c- remove) resident's midline (a tube inserted into a vein in the upper arm with the tip ending near the armpit). RNS 1 stated the MD's telephone order should have been put in or added in Resident 100's physician's order and Resident 100's PICC line should have been removed as ordered by MD. RNS 1 stated keeping the PICC line inserted longer than needed could cause Resident 100 to get an infection. During the same interview on 4/7/2026, at 12:59 PM, with RNS 1, RNS 1 stated if the resident has a PICC line, the PICC line dressing should be changed upon admission and every seven days or as needed. RNS 1 stated Resident 100's PICC line dressing should have been changed on 4/3/2026. RNS 1 stated not changing the PICC line dressing can cause infection and accidental pulling which could cause Resident 100 to get sick and hospitalized . During an interview on (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/9/2026, at 11:23 AM, with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated Resident 100 was admitted from the GACH on 4/3/2026 with a PICC line on the resident's left upper arm. LVN 7 stated he received a telephone order from the MD on 4/3/2026 at around 9 PM to remove Resident 100's PICC line since it was no longer needed. LVN 7 stated he forgot to write and communicate the PICC line removal order to the RNS because he was busy working on Resident 100's admission. During an interview on 4/9/2026, at 12:05 PM, with the Director of Nursing (DON), the DON stated the RNS who assessed Resident 100 upon admission should have documented Resident 100's PICC line in the Clinical admission Form. The DON stated the Treatment Nurse (TN) was also responsible for assessing Resident 100's skin and should have seen Resident 100's PICC line on the resident's left upper arm. The DON stated it was important to document the PICC line to ensure proper care was provided and infection was prevented. The DON stated LVN 7 was not able to communicate the MD's order to remove the PICC line and the PICC lines should be changed every 7 days and as needed in accordance with the facility's policy. During a review of the facility's policy and procedure (P&P), titled, Physician Orders and Telephone Orders, dated 1/2004, the P&P indicated, telephone orders shall be noted promptly. During a review of the facility's P&P, titled, PICC Dressing Change, dated 3/2010, the policy indicated:Dressing changes using transparent dressings are performed 24 hours post-insertion or upon admission, at least weekly, and if the integrity of the dressing has been compromised (wet, loose, or soiled).Assessment of venous access site is performed at least once every shift when not in use.Length of external catheter and upper arm circumference (3 inches or 10 centimeters above insertion site) is obtained upon admission. During a review of the facility's P&P, titled, Quality of Care, revised on 3/2017, the P&P indicated, The facility will provide and implement comprehensive, person-centered care for all residents. All residents will receive treatment and care in accordance with professional standards of practice. During a review of the facility's P&P, titled, Charting and Documentation, revised on 7/2017, the P&P indicated the following:All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed staff used two (2) person identifiers (the individual's name, an assigned identification number, date of birth or another person-specific identifier) prior to administering medications to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for one (1) of 5 sampled residents (Residents 38) observed for medication administration in accordance with the facility's policy and procedure (P&P) . This deficient practice had the potential for medication errors (any preventable event that may cause or lead to inappropriate medication use) result in harm to Resident 38.Findings:During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included renal insufficiency (is a condition where kidneys cannot adequately filter waste, balance electrolytes, or manage blood pressure), asthma (is a condition in which your airways narrow and swell and may produce extra mucus), chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and colon cancer (a cancer of the large intestine, which may affect the colon or rectum) During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 38 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 38 was independent (resident completes the activity by themself with no assistance from a helper) in eating, oral hygiene, upper body dressing, personal hygiene, roll left and right, sit to lying, and lying to sitting on the side of the bed. During an interview on 4/8/2026 at 9:49 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the licensed nurse always have to use 2-person identifier before administering medications to the residents to make sure the licensed nurse is giving the correct medication to the correct resident. LVN 1 stated she checked Resident 38's electronic medication administration record (eMAR, is the digital version of the traditional paper medication administration records used in healthcare facilities) with the resident's picture on it, but she did not check Resident 38's armband to ensure it is the same name and correct resident. LVN 1 also stated she should have checked Resident 38's armband to verify the resident's identity as part of the process of the medication administration. During an interview on 4/8/2026 at 3:20 PM with the Director of Nursing (DON), the DON stated the licensed nurses need to use 2-person identifier before medication administration. The DON also stated the licensed nurses can use the e-MAR with the resident's picture and check the armband of the resident to check name and medical records number or have another licensed staff identify to verify it is the same and correct resident before giving the medication. The DON stated they have to make sure we give the right medication to the right Resident. During review of the facility's P&P titled, Medication Administration- General Guidelines, dated on 10/2017, the P&P indicated Residents are identified before medications are administered. Methods of identification include:a. checking identification bandb. checking photographs attached to medical record; andc. if necessary, verifying resident identification with other facility personnel.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medication was provided for one (1) of five sampled residents (Resident 38) observed during the medication administration as indicated in the facility's Policy and Procedure (P&P) by failing to ensure one opened bottle of Promethazine (an antihistamine medication that prevents and treats the symptoms of an allergic reaction) was properly labeled with date opened and expiration date was legible and the Promethazine bottle was stored in a locked compartment. These deficient practices have the potential for Resident 38 to have an adverse reaction (an undesired, harmful, or unpleasant effect resulting from a medication) from the potentially expired medication. Findings:During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 38's diagnoses included renal insufficiency (is a condition where kidneys cannot adequately filter waste, balance electrolytes, or manage blood pressure) , asthma (is a condition in which your airways narrow and swell and may produce extra mucus), chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and colon cancer (a cancer of the large intestine, which may affect the colon or rectum) During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 38 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 38 was independent (resident completes the activity by themself with no assistance from a helper) in eating, oral hygiene, upper body dressing, personal hygiene, roll left and right, sit to lying, and lying to sitting on the side of the bed. During a concurrent observation on [DATE] at 9:44 AM with Licensed Vocational Nurse 1 (LVN 1), Promethazine bottle was taken inside the Medication Cart 2 (MC 2) and the Promethazine bottle did not have a label with the open date and it was not labeled with the expiration date. LVN 1 dispensed the Promethazine 10 milliliter (ML, measure of volume) to a medicine cup without checking the Promethazine bottle for the open date and expiration date. During a concurrent observation and interview on [DATE] at 9:52 AM with LVN 1, LVN 1 checked the Promethazine bottle and cannot find the open date and expiration date. LVN 1 stated maybe it got erased from the bottle. LVN 1 stated she did not check the Promethazine's expiration date and there was no open date labeled on the bottle. LVN 1 also stated she did not know when the medication bottle was opened and the expiration date. LVN 1 stated the licensed nurses have to check the expiration date to make sure the licensed nurse is not giving potentially expired medication to the resident because it may cause adverse reaction to the resident. LVN 1 also stated the medication bottle should be labeled with the date it was opened. During a concurrent observation and interview on [DATE] at 3:23 PM with the Director of Nursing (DON), the DON checked the Promethazine bottle from MC 2 and the DON was not able to find the label for the open date and the expiration date on the bottle. The DON stated the medication bottle was sticky, it did not have a label indicating the open date and expiration date. The DON also stated the licensed nurses needed to check the medication bottles for expiration dates before giving medications to make sure it is safe to give to the resident. In addition, the DON stated the licensed nurse should have ordered a new medication to replace the bottle and discard the Promethazine bottle since they do not know if it is still safe to use or expired already. The DON stated it is important for the licensed nurse to make sure the medication was not expired to avoid potential adverse reaction to the residents. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy dated 4/2014, the P&P indicated Medications are labeled in accordance with facility requirements and state and federal laws. The P&P also indicated only the dispensing pharmacy can modify or change (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescription labels. The P&P indicated:Labels are permanently affixed to the outside of the prescription container.Each prescription medication label includes date dispensed and expiration date.Improper or inaccurately labeled medications are rejected and returned to the dispensing pharmacy.Medication containers having soiled, damaged, incomplete, illegible, confusing, or makeshift labels are returned to the dispensing pharmacy for re-labeling or destroyed in accordance with the medication destruction policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056127	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Live Oak Rehab Center	537 W Live Oak San Gabriel, CA 91776

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the diet order for one (1) of 1 sampled resident (Residents 92) reviewed for food in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to result in choking (medical emergency that occurs when a foreign object such as food becomes lodged in the upper airway blocking airflow and preventing normal breathing) and for Resident 92 not to receive the required amount of nutrition, which could lead to weight loss.Findings:During a review of Resident 92's admission Record, the admission Record indicated Resident 92 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 92's diagnoses included hypertension (high blood pressure), history of small bowel obstruction (SBO, is a critical blockage in the small intestine that prevents food, fluids, and gas from passing through the digestive tract), chronic obstructive pulmonary disease (COPD, is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and dementia (a progressive state of decline in mental abilities) During a review of Resident 92's Minimum Data Set (MDS, a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 92 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 92 needed setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) on eating. Resident 92 also needed supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) in oral hygiene and personal hygiene. The MDS also indicated Resident 92 was on mechanically altered diet (is a texture-modified diet designed for individuals who have difficulty chewing or swallowing) and therapeutic diet (a meal plan tailored to meet an individual's medical needs, prescribed by a physician and developed by a dietitian. It involves modifying the type, amount, or texture of food to help manage or treat specific health conditions) During a review of Resident 92's Physician's order (PO) dated 1/8/2026, the PO indicated No Added Salt (NAS, leaves out all salt in preparing and cooking food) diet, soft and bite-sized (are tender, moist, and easily broken apart with a fork) texture, fluids: Thin consistency (a fluid, watery texture that flows easily and rapidly, similar to water, milk, or juice), add rice soup with meals. During an observation and record review on 4/6/2026 at 12:53 PM with Resident 92 in the dining room, Resident 92 was observed attempting to leave the dining room and did not attempt to eat the food served to her during lunch. Resident 92's plate had a whole quarter-size chicken. Resident 92's meal ticket indicated soft and bite-sized, NAS, and thin fluids. During an interview on 4/8/2026 at 11:55 AM with [NAME] 2, [NAME] 2 stated that Resident 92 was served a whole, regularˆsize piece of chicken. [NAME] 2 stated the biteˆsized pieces should have been cut into smaller portions so it would be easier for the resident to chew. [NAME] 2 stated Resident 92 needed smaller pieces to chew her food better, and serving whole pieces could potentially pose a choking risk. During a concurrent interview and record review on 4/8/2026 at 11:58 AM with Dietary Consultant (DC), Resident 92's meal ticket indicated soft and bite-sized, NAS dated 4/6/2026 was reviewed. DC stated Resident 92's chicken was served whole. The kitchen staff did not follow the dietary order for small bite sized. Resident 92's meal ticket indicated soft and bite-sized, NAS, and thin fluids. Resident 92 may have some difficulty chewing her food. During a concurrent interview and record review on 4/8/2026 at 11:58 AM with the Dietary Consultant (DC), Resident 92's meal ticket, dated 4/6/2026, indicating soft and bite-sized and NAS was reviewed. DC stated Resident 92's chicken was served whole. DC stated the kitchen staff did not follow the dietary order for small biteˆsized pieces. DC stated Resident 92's meal ticket indicated soft and biteˆsized, NAS, and thin fluids. DC added Resident 92 may have difficulty chewing her food. During a record review of an undated facility's P&P titled, Resident Food Preferences, the P&P indicated individual food (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the residents' or representative's consent.Dietary Service Supervisor (DSS) will update meal ticket according to resident food preferences, diet order and nourishments.DSS will complete documentation in point click care (PCC). A narrative dated entry on the Nutritional Assessment Form stating that the Dietary Service Supervisor saw the residents and obtained food preferences.Compliance to the prescribed dietDSS will visit residents periodically to ensure food preferences are being honored.