STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056145	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Grove Post Acute	12882 Shackelford Lane Garden Grove, CA 92841

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the necessary discharge services was completed for two of four final sampled residents (Residents 6 and 41) reviewed for acute care hospitalization and one of three sampled residents (Resident 5) reviewed for closed records. * The facility failed to ensure the physician signed and dated the physician's discharge summary for Resident 5's transfer to the acute care hospital on 6/20/26. * The facility failed to ensure the physician signed and dated the physician's discharge summary for Resident 6's transfer to the acute care hospital on 4/15/26.* The facility failed to ensure the physician signed and dated the physician's discharge summary for Resident 41's transfer to the acute care hospital on 4/18/26. These failures had the potential for the residents to have an inappropriate discharge.Findings: Review of the facility's P&P titled Discharge Process revised 10/2017 showed the facility will provide and document sufficient preparation and orientation to the residents for transfer or discharge to ensure a safe and orderly transfer or discharge from the facility in a form and manner that the resident can understand. Review of the facility's P&P titled Documentation Principles revised 2/2018 showed the resident's clinical records shall be current and kept in detail consistent with good medical and professional practice based on the care provided to each resident. All entries in the clinical record must be authenticated by the person making the entry with the date, signature, and title. 1. Medical record review for Resident 6 was initiated on 6/22/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 2/6/25, showed that Resident 6 was able to make their needs known but was not capable of making their own medical decisions. Review of Resident 6's Order Summary Report showed a physician's order dated 4/18/26, to transfer Resident 6 to the acute care hospital via 911 for further evaluation. Review of Resident 6's Physician's Discharge summary dated [DATE], showed the transfer was necessary due to Resident 6's increased confusion and agitation. However, the documentation was missing the physician's signature and date. 2. Medical record review for Resident 41 was initiated on 6/22/26. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 4/23/26, showed Resident 41 was able to make their needs known but was not capable of making their own medical decisions. Review of Resident 41's Order Summary Report showed a physician's order dated 4/18/26, to transfer Resident 41 to the acute care hospital via 911 for further evaluation status post a fall incident. Review of Resident 41's Physician's Discharge summary dated [DATE], showed the transfer was necessary due to Resident 41's fall incident. However, the documentation was missing the physician's signature and date. 3. Medical record review for Resident 5 was initiated on 6/23/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 5/31/26, showed Resident 5 had the capacity to understand and make her own medical decisions. Review of Resident 5's Order Summary Report showed a physician's order dated 6/19/26, to discharge Resident 5 to home with 24/7 home health care per Resident 5's family member's request. Review of Resident 5's Physician's Discharge summary dated [DATE], showed the discharge was necessary due to Resident 5's family member's (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	request. However, the documentation was missing the physician's signature and date. On 6/25/26 at 1249 hours, an interview and concurrent medical record review for Residents 5, 6, and 41 was conducted with the ADON. The ADON stated when a resident was transferred to the acute care hospital, the facility had a transfer packet to complete which included documents such as physician summary discharge, notice of transfer/discharge, and relevant assessments. The ADON verified Resident 5, 6, and 41's respective transfer dates out of the facility. The ADON verified the physician's discharge summaries for Residents 5, 6, and 41 were not signed and dated by the physician. On 6/25/26 at 1605 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility P&P review, facility document review, and the California Code of Regulations, the facility failed to ensure a staff member was onsite during the night shift, who could provide respiratory services to the residents, in accordance with the residents' plan of care. * On 11/24/25, 11/25/25, 4/6/26, 4/12/26, 4/19/26, 6/8/26, 6/15/26, and 6/22/26, on the night shift, the facility failed to ensure a staff member was on site at the facility, who could provide respiratory services to the residents with oxygen titration orders. This failure had the potential to result in negative health outcomes for the residents. Findings: Review of California Code of Regulations, title 16, section 1399.365, showed the respiratory care services LVNs may perform in the long-term care setting. Respiratory services LVNs may not perform include the initial setup, change out, or replacement of a breathing circuit or adjustment of oxygen liter flow or oxygen concentration. Review of the Facility assessment dated [DATE], showed the facility assessment will enable each nursing home to thoroughly assess the needs of its resident population and the required resources to provide the care and services the residents need using evidence-based, data driven methods. The Facility Assessment resident profile showed the following resident respiratory system conditions/diseases which the facility can provide care for: COPD, pneumonia, asthma, chronic lung disease, and respiratory failure. The average number of residents receiving routine oxygen therapy at the facility was four. The average number of residents receiving oxygen therapy as needed at the facility was 14. The Facility Assessment included the facility's staffing consideration. The staffing considerations included a comprehensive assessment of all the residents, including medical history, current health status, care preferences, and any special requirements. The facility develops personalized care plans based on the resident assessments that are reviewed and updated as the residents' needs change. The facility maintains staff skills, qualifications, and certifications and match the residents to staff whose skills align with their needs. Review of the facility's P&P titled Oxygen Administration revised 3/2017 showed it is the policy of the facility to provide guidelines for the administration of oxygen. Verify that there is a physician's order for oxygen administration. Review the resident's care plan for any special needs of the resident. Assemble the equipment and supplies as needed. Review of the Order Listing Report dated 6/22/26, showed the residents with active orders for oxygen therapy. Fifteen of the 87 residents who resided at the facility had active orders for supplemental oxygen continuously and/or as needed. Fourteen of the residents had an order to titrate the oxygen as needed. Nine of the residents resided in the facility on 11/24/25, 11/25/25, 4/6/26, 4/12/26, 4/19/26, 6/8/26, 6/15/26, and 6/22/26 on the night shift, and had active oxygen titration orders, however, the facility failed to ensure a staff member was on site at the facility (on the night shift) who could provide respiratory services to the residents with oxygen titration orders. On 6/24/26 at 1434 hours, an interview, Facility Assessment review, and concurrent medical record review was conducted with the DON. The DON verified the 2026 Facility Assessment showed the facility could provide respiratory services to the residents, in accordance with the physician's orders and the residents' plan of care. The DON verified on 11/24/25, 11/25/25, 4/6/26, 4/12/26, 4/19/26, 6/8/26, 6/15/26, and 6/22/26, the facility did not have a RN assigned to work the night shift at the facility. The DON stated LVNs were assigned to work the night shift of those days. The DON was asked what respiratory services LVNs could provide to the residents at the facility. The DON stated the LVNs could provide basic respiratory tasks and services and administer oxygen in emergent situations. The DON stated the LVN basic respiratory tasks and services did not include the adjustment or titration of oxygen liter flow or oxygen concentration, in non-emergent situations. The DON verified on 11/24/25, 11/25/25, 4/6/26, 4/12/26, 4/19/26, 6/8/26, 6/15/26, and 6/22/26, on the night shift, the facility did have a nurse on site who could provide respiratory services to the residents with oxygen titration orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the cutting boards were maintained in sanitary condition and had smooth, cleanable surfaces. * The facility failed to ensure the heavy-duty blender used for puree preparation and three stainless steel square serving pans were air dried prior to stacking and storage. * The facility failed to maintain the hood over the stove in a clean and sanitary condition. * The facility failed to ensure the kitchen utensils had smooth, cleanable surfaces and were maintained in good repair. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the microwave utilized to warm up the residents' food was in a sanitary condition. * The facility failed to ensure the ice machine utilized for the residents and staff was maintained in a sanitary condition. These failures had the potential to cause cross-contamination and/or foodborne illness for the residents consuming the food prepared in the kitchen.Findings: Review of the facility's Diet Type Report dated 6/22/26, showed 76 of 87 residents consumed food prepared in the kitchen. 1. Review of the facility's P&P titled Sanitation dated 2023 showed separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized. According to the USDA Food Code 2022 Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 6/22/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. One brown, one white, one yellow, one blue and one red cutting boards were observed fuzzy, heavily marred and had deep grooves and pits. The DSS verified the findings and stated cutting boards should have been replaced. 2. Review of the facility's P&P titled Dishwashing dated 2023 showed dishes are to be racked loosely without overlapping. Dishes are to be air dried in racks before stacking and storing. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 6/22/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. One heavy duty blender used for puree preparation stored on the countertop shelf was observed to be wet with visible water inside. Three stainless steel square serving pans were observed stacked on top of each other and still wet with visible water. The DSS verified the findings and stated the blender and serving pans should have been air dried to prevent bacterial growth. 3. Review of the facility's P&P titled Hoods, Filters and Vents dated 2023 showed hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention the dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 6/22/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The kitchen hood over the stove had yellowish, greasy residue. The DSS acknowledged the findings and stated the dishwasher personnel cleaned the hood once a week and the hood was also cleaned by an outside company every three months. The sticker on the hood showed it was last serviced on 5/7/26. 4. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	open seams, cracks and chipped areas. Plastic ware, China and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining. Cracked or chipped dishes and glasses will be disposed of. Further review of the facility's P&P titled Brushes dated 2023 showed, if bristles become matted or fall out, the brush should be discarded and replaced. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 6/22/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed: - one basting brush used for barbecue meat was observed with frayed bristles and worn out; and - two stainless steel whisk was observed deformed. The DSS verified the findings and stated all worn out kitchen utensils and equipment should have been discarded and replaced. 5. Review of the facility's P&P titled Dishwashing dated 2023 showed all dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order. Gross food particles shall be removed by careful scraping and pre-rinsing in running water. Flatware is to be pre-soaked on a solution of water and detergent per manufacturer's instructions. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Nonfood- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 6/22/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following were observed: - three stainless steel spoons were dirty and had dry, crusted residue;- one stainless steel slotted spoon was dirty and had dry, crusted residue;- three stainless steel ladles were dirty and had dry, crusted residue;- five stainless steel serving scoops with yellow handles used for food portioning were dirty and had dry, crusted residue;- one stainless steel serving scoop used for food portioning was dirty and had dry, crusted residue;- two stainless steel serving scoops with green handles used for food portioning were dirty and had dry, crusted residue;- two stainless steel serving scoops with gray handles used for food portioning were dirty and had dry, crusted residue;- four stainless steel serving scoops with white handles used for food portioning were dirty and had dry, crusted residue; and- two stainless steel tongs were dirty and had dry, crusted residue. The DSS verified the findings and stated all dirty kitchen utensils should have been rewashed and cleaned for infection control purposes. 6. Review of the facility's P&P titled Sanitation dated 2023 showed all the equipment shall be maintained as necessary and kept in working order. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Further review of the facility's P&P titled Electrical Food Machines dated 2023 showed to keep and maintain all food machines in good operating, sanitary condition. This includes mixers, grinders, slicers and toasters. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 6/22/26 at 0830 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The kitchen microwave on a countertop shelf was observed to be dirty with dry food residue in the microwave door and had dry food splatters inside the microwave. The DSS verified the findings and stated the microwave was used to warm up the resident's food and it should have been cleaned after each use. 7. Review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2023 showed the ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufacturer's recommendations, and the date recorded when cleaned. The Maintenance Supervisor can keep this record or it can be posted on the ice machine. In addition, review of the facility's P&P titled Sanitation dated 2023 showed ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. According to the USDA Food Code 2017, Section 4-601.11, the equipment food-contact surfaces and utensils shall be clean to sight and touch. On 6/22/26 at 0912 hours, during the initial kitchen tour, an inspection of the ice machine and concurrent interview was conducted with the DSS. The DSS stated the ice machine was cleaned and sanitized by an outside company every six months, the filter was changed every year and was last replaced on 2/5/26. An observation of the internal panel of the ice machine was made with the DSS. The internal panel of the ice machine adjacent to the water curtain located directly above and lateral to the ice bin was observed with black dirt residue. The DSS verified the above findings and stated the ice machine was last cleaned on 6/10/26, but needs to be cleaned by the outside company and ice will not be served to the residents. On 6/25/26 at 1603 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage were properly stored in three of four garbage dumpsters. * The facility failed to ensure the lids of the three garbage dumpsters were fully closed. This failure had the potential to attract pest/rodents that carry diseases.Findings: Review of the facility's P&P titled Miscellaneous Areas, Garbage and Trash dated 2023 showed the garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. According to the 2022 FDA (Food and Drug Administration) Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 6/22/26 at 0924 hours, an observation and concurrent interview was conducted with the DSS of the facility's three of four outside garbage dumpsters. The garbage dumpsters were observed with the lids partially propped open by cardboard boxes and clear trash bags preventing the lids from fully closing. The DSS verified the findings and stated the dumpster lids should be closed at all times to prevent rodents and flies. On 6/25/26 at 1603 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and P&P review, the facility failed to ensure the medical record was complete and accurately maintained for six of 22 final sampled residents (Residents 3, 8, 11, 16, 48, and 79). * The facility failed to ensure Resident 3's POLST was completed accurately. * The facility failed to accurately document the administration of midodrine medication (medication used to low blood pressure) to Resident 8. In addition, the facility failed to ensure Resident 8's telephone orders were signed by the physician as per the facility's P&P. * The facility failed to ensure Resident 11's POLST was complete and contained the physician's printed name, phone number, license number, and date. * The facility failed to ensure Resident 16's POLST contained the physician's phone number and license number. * The facility failed to ensure Resident 48's POLST contained the physician's phone number. In addition, the facility failed to ensure Resident 48's blood pressure documentation was accurate. * Resident 79 formulated an advance directive; however, Resident 79's medical record showed Resident 79 had not formulated an advance directive. These failures had the potential to result in residents' care needs not being met due to incomplete and inaccurate medical records. Findings: Review of facility's P&P titled Documentation Principles date revised 2/2018 showed it is the policy of the facility that resident's clinical records shall be current and kept in detail consistent with good medical and professional practice based on the care provided to each resident. All entries in the clinical record must be authenticated by the person making the entry with the date, signature and title. The signature is to include the first initial, full last name and title. Entries must be accurate, timely, objective, specific, concise, legible, clear and descriptive. Each entry in the clinical record should be dated with the month, day and year. The time should include AM or PM, if military time is not used. Review of the facility's P&P titled POLST dated 1/2017 showed the POLST order is recorded on the facility's physician orders after the physician signs/dates and file in the resident's clinical record. 1. Medical record review for Resident 11 was initiated on 6/22/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's POLST dated 3/18/25, under Section D for Information and Signatures, showed the physician's printed name, phone number, and license number were left blank and undated. On 6/24/26 at 1620 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the findings and stated the POLST should have been completed accurately and dated. On 6/25/26 at 1603 hours, the Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 16 was initiated on 6/22/26. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's POLST dated 5/19/26, under Section D for Information and Signatures, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the physician's phone number and license number were left blank. On 6/24/26 at 1331 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the findings and stated the Social Services was responsible for completing the POLST and should have been filled out completely. On 6/24/26 at 1634 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the findings and stated the POLST should have been completely filled out. On 6/25/26 at 1603 hours, the Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 48 was initiated on 6/22/26. Resident 48 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 48's H&P examination dated 5/12/26, showed Resident 48 was able to make their needs known but was not capable of making their own medical decisions. a. Review of Resident 48's POLST dated 5/9/24, under Section D for Information and Signatures, showed the physician's phone number was left blank. On 6/24/26 at 1533 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the findings and stated the Social Services was responsible for completing the POLST and should have been filled out completely. On 6/24/26 at 1634 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the findings and stated the POLST should have been completely filled out. On 6/25/26 at 1603 hours, the Administrator and DON were informed and acknowledged the above findings. b. Review of Resident 48's Blood Pressure Summary Reports for 6/23 to 6/25/26, showed a normal BP reading between 102/62 mmHg to 128/78 mmHg. However, the report dated 6/24/26 at 0734 hours, showed Resident 48's BP reading was 228/74 mmHg. Further review of Resident 48's medical record did not show evidence of interventions or follow-up assessments for Resident 48's elevated blood pressure reading. On 6/24/26 at 0918 hours, Resident 48 was observed seated in a wheelchair in the activities room watching television. On 6/24/26 at 0920 hours, an interview and concurrent medical record review for Resident 48 was conducted with RN 1. RN 1 stated for a resident's blood pressure reading of 228/74 mmHg, she would expect the licensed nurse would contact the physician, provide necessary care such as a PRN blood pressure medication, and then reassess the resident's blood pressure. RN 1 verified the above findings; however, RN 1 stated the blood pressure documentation could be inaccurate because Resident 48's BP readings had been stable. RN 1 further stated the documentation in a resident's medical record should be accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/26 at 1605 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. 4. Medical record review for Resident 79 was initiated on 6/22/26. Resident 79 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 79's POLST dated 5/8/23, under Section D for Information and Signatures, showed Resident 79 did not have an Advance Directive; however, a copy of the Advance Directive was in Resident 79's medical records. Review of Resident 79's Advance Directive Acknowledgement form dated 12/4/25, showed Resident 79 had executed an Advance Directive. On 6/25/26 at 1316 hours, an interview and concurrent medical record review was conducted with LVN 11. LVN 11 verified the findings and stated POLST should have been updated by the SSD to avoid conflicting information. On 6/25/26 at 1436 hours, an interview and concurrent medical record review was conducted with SSD 2. SSD 2 verified the above findings and stated Resident 79's POLST should have been revised and updated to reflect the Advance Directive. On 6/25/26 at 1603 hours, the Administrator and DON were informed and acknowledged the above findings. 5. Medical record review of Resident 3 was initiated on 6/23/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 3/24/26, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's POLST dated 1/17/25, showed the POLST was signed by the physician; however, the POLST did not include the physician's printed name or the date when the physician signed the POLST. On 6/24/26 at 1022 hours an interview and concurrent medical record review was conducted with LVN 10. LVN 10 verified Resident 3's POLST showed a physician's signature; however, the POLST did not include the physician's printed name or the date the POLST was signed by the physician. LVN 10 was asked how will others know if this was the physician's signature, LVN 10 responded this should have been completed with the physician's printed name and dated. On 6/25/26 at 804 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 acknowledged Resident's POLST dated 11/17/25, did not show the physician's printed name and dated of the physician's signature. 6. Review of the facility's P&P titled Medication and Treatment Administration Record dated 6/2004 showed medications and treatments shall be administered as prescribed by the physician and shall be recorded by the responsible licensed nurse as the medication or treatment is provided. Medical record review for Resident 8 was initiated on 6/24/26. Resident 8 was admitted to the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. Review of Resident 8's MDS assessment dated [DATE], showed a BIMS score of 15 (intact cognition). a. Review of Resident 8's Order Summary Report dated 6/23/26, showed a physician's order dated 11/23/25, to give midodrine HCl 10 mg to give one tablet by mouth three times a day for hypotension (low blood pressure) and to hold if the SBP was greater than 130mmHg. Review of Resident 8's MAR for June 2026 showed an order for midodrine HCl 10 mg oral tablet, give one tablet by mouth three times a day for hypotension, hold if the SBP was greater than 130mmHg. Resident 8's MAR showed Resident 8 was administered with midodrine medication when the SBP was greater than 130 mmHg on the following dates and times: - dated 6/11/26 at 1300 hours, for BP reading of 134/74 mmHg; - dated 6/13/26 at 1300 hours, for BP reading of 136/69 mmHg; and - dated 6/14/26 at 0900 hours, for BP reading of 131/80 mmHg; and Further review of Resident 8's MAR for June 2026 showed the midodrine medication was held on 6/21/26 at 1300 hours, when the BP reading was 130/73 mmHg. Reviewed of Resident 8's progress notes did not show documentation addressing midodrine medication administration on 6/11, 6/13, 6/14, and 6/21/26. On 6/24/26 at 1625 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON verified the MAR entries dated 6/11, 6/13, and 6/14/26, showed the midodrine medication was administered when the SBP was greater than 130 mmHg and the midodrine medication was withheld when the SBP was 130 mmHg on 6/21/26 at 1300 hours. The DON stated the midodrine medication should be held when the SBP was greater then 130 mmHg. The DON further stated the Medical Records did an audit, and the nurse showed in the bubble pack the medication was held. The DON was asked if there was a progress note documented during those affected days, the DON did not answer. b. Review of the facility's P&P titled Physician Orders and Telephone Orders dated 1/2004 showed the physician's orders shall be obtained prior to the initiation of any medication or treatment from a person lawfully authorized to prescribe for and treat human illness. Telephone orders shall be signed within 5 days by the prescribing physician or his/her physician extender (physician's assistant or nurse practitioner) as permitted by law. Review of Resident 8's medical chart (hard copy) was conducted. The chart contained unsigned telephone orders for the following: - dated 5/19/26, for a follow-up appointment with the Cardiologist; - dated 5/15/26, for x-ray of bilateral knee; - dated 5/22/26, to use Medtronic Care link Monitoring system (used to monitor pacemaker) at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedside when machine is available; - dated 5/15/26, for acetaminophen (pain reliever) oral tablet to give 500 mg by mouth every eight hours as needed for mild pain of 1-4 (in a pain scale of 0-10, 0=no pain and 10=worst pain); - dated 5/15/26, for Lidocaine (pain reliever) external patch 4% apply to right and left knees topically for knee pain, 12 hours on and 12 hours off and remove per schedule; and - dated 5/15/26, to discontinue Lidocaine external patch 4% apply to right knee topically for knee pain -12 hours on and 12 hours off and remove per schedule. On 6/22/26 at 1212 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DSD. The DSD verified the above unsigned physician's orders. The DSD stated the orders should have been signed in seven days but will have to find out. On 6/22/26 at 1234 hours, an interview and concurrent medical record review for Resident 8 was conducted with the Medical Records Assistant. The Medical Records Assistant verified the unsigned physician orders and stated the physicians were aware and should have been signed in a week. On 6/25/26 at 1402 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview, facility document review, and facility P&P review, the facility failed to implement their infection control surveillance program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program for August 2025 through May 2026. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobial medications. The facility failed to determine whether residents who exhibited signs and symptoms of infection, and were not prescribed antimicrobial medications, met the facility's criteria for infection (McGeer's Criteria) and thus, failed to include these residents in the facility's infection control surveillance program. This failure posed the risk for not identifying residents' infections and thereby preventing the implementation of interventions to control the potential transmission of communicable diseases, to other residents within the facility. Findings: Review of the facility's P&P titled Infection Control dated 1/2017 showed the facility infection control program includes a system for preventing, identifying, reporting, investigating, and controlling infections and communicable disease for all the residents. The facility maintains written standards, polices, and procedures for the infection control program, which includes: A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other residents or persons in the facility. A system for recording incidents identified under the facility's infection control and prevention program. The IP manages the monitoring and tracking of the clinical status of the residents to detect and prevent the transmission of infection and disease. The IP collects data and analyzes the information, utilizing the facility's surveillance tools, to develop strategies to prevent further infection transmission. The IP utilizes the revised McGeer's Criteria for definitions of infection. On 6/23/26 at 0934 hours, an interview and concurrent facility document review was conducted with Infection Preventionist 2. IP 2 was asked to describe the facility's resident infection surveillance program. IP 2 stated when a resident at the facility exhibited signs and symptoms of an infection and was also prescribed antimicrobial medications, the facility would initiate a Surveillance Data Collection Form. IP 2 stated the Surveillance Data Collection Form contained information specific to McGeer's Criteria. IP 2 stated he would review the Surveillance Data Collection Forms and determine whether a resident had met the criteria for an infection (utilizing McGeer's Criteria). IP 2 stated for the residents who met McGeer's criteria, he would also make a determination as to whether the resident's infection was a hospital-associated infection (HAI) (nosocomial infection) or a community-associated infection (CAI). IP 2 stated this information was documented on the facility's monthly Infection Prevention and Control Surveillance Log, in order to conduct surveillance of resident infections in the facility. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from August 2025 through May 2026, showed the following infection surveillance data for HAIs, CAIs, residents who did not meet McGeer's Criteria (DNMC), and residents with clinical signs of infection without antimicrobial medications (CSIWAM):- 8/2025, HAI - 4, CAI - 3, DNMC - 6 , and CSIWAM - 0- 9/2025, HAI - 7 , CAI - 8 , DNMC - 9 , and CSIWAM - 5- 10/2025, HAI - 11 , CAI - 2, DNMC - 7, and CSIWAM - 7- 11/2025, HAI - 5, CAI - 7 , DNMC - 12 , and CSIWAM - 3- 12/2025, HAI - 17 , CAI - 7 , DNMC - 8 , and CSIWAM - 6- 1/2026, HAI -6, CAI - 7 , DNMC - 6 , and CSIWAM - 7- 2/2026, HAI - 21, CAI - 9 , DNMC - 13 , and CSIWAM - 3- 3/2026, HAI - 7, CAI - 6, DNMC - 7, and CSIWAM -8- 4/2026, HAI - 6 , CAI - 5, DNMC - 6, and CSIWAM - 4- 5/2026, HAI - 6, CAI - 3 , DNMC - 4, and CSIWAM - 0 Further review of the facility's monthly Infection Prevention and Control Surveillance Logs from August 2025 through May 2026 showed all the residents determined to have either HAI or CAI, were also prescribed antimicrobial medications. For the residents at the facility who presented with signs and/or symptoms of infection and were not prescribed antimicrobial medications (CSIWAM), IP 2 was asked if the facility made a determination as to whether the residents' condition met the McGeer's Criteria for HAI or CAI. IP 2 stated the facility did not make a determination specific to McGeer's criteria, for the residents who were not prescribed antimicrobial medications, and exhibited signs and symptoms of infection, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thus failed to determine if these residents had met the McGeer's Criteria for a HAI or CAI (from August 2025 through May 2026). IP 2 was asked how many residents in the facility had infections (met McGeer's Criteria) and were not prescribed antimicrobial medications from August 2025 through May 2026. IP 2 stated he was unable to make that determination.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to fully inform the resident or responsible party and obtain a completed informed consent prior to the use of the psychotropic medications for one of five final sampled residents (Resident 6) reviewed for unnecessary medications. * The facility failed to ensure Resident 6's consent form for the use of the hydroxyzine (a medication used for anxiety and itching caused by an allergic reaction) and temazepam (sedative medication) included the information about the medications' benefits and side effects. These failures had the potential for Resident 6 and the resident's responsible party to be unaware of the risks associated with the psychotropic medications.Findings: Review of the facility's P&P titled Psychotropic Drug Treatment revised 9/2017 showed the resident has the right to be free from unnecessary drugs and protection for medication errors. The resident or their representative will be given information regarding the need for, the desired effect, and the potential side effects of the medication. This enables the resident or their representative to make an informed decision regarding the use of any psychoactive medication. The resident or their representative should be involved in the medication management process and aware of the benefits and risks of medications and the goals of treatment. Medical record review for Resident 6 was initiated on 6/22/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 2/6/25, showed Resident 6 was able to make their needs known but was not capable of making their own medical decisions. Review of Resident 6's Order Summary Report, showed the following physician's orders:-dated 3/10/26, discontinued 3/27/26, to administer one hydroxyzine HCl 50mg tablet by mouth every 12 hours as needed for itching, feeling anxious, and aggression; and-dated 3/11/26, discontinued 3/27/26, to administer one 7.5 mg capsule by mouth as needed for sleep aid; and -dated 3/28/26, discontinued 4/12/26, to administer one hydroxyzine HCl 50mg tablet by mouth every 12 hours as needed for pruritic or severe anxiety. Review of Resident 6's Psychotherapeutic Drug Informed Consent dated 3/10/26, for the use of one hydroxyzine 50mg tablet twice a day as needed for anxiety, failed to include the benefits, possible side effects, and significant risks of the medication. Review of Resident 6's Psychotherapeutic Drug Informed Consent dated 3/10/26, for the use of one temazepam 7.5 mg capsule at bedtime as needed for insomnia. The informed consent failed to include the benefits, possible side effects, and significant risks of the medication. Review of Resident 6's MAR for 3/2026 and 4/2026 showed the following dates and times the hydroxyzine 50mg tablet was administered: -on 3/16/26 at 1305 hours, -on 4/2/26 at 1718 hours, -on 4/5/26 at 1646 hours,-on 4/9/26 at 2233 hours,-on 4/10/26 at 1119 hours, and -on 4/11/26 at 0209 hours. On 6/24/26 at 1640 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 1. RN 1 stated the purpose of a consent form was to inform the resident and responsible party the purpose of the medication, side effects, and benefits of the medication. RN 1 verified the above findings. RN 1 further stated the consent forms were not completed because of the missing information. On 6/25/26 at 1605 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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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 and interview, the facility failed to maintain a homelike environment for one of 22 final sampled residents (Resident 67). * Resident 67 resided in Room A. The wall behind the resident's bed was observed in disrepair as evidenced by several areas of chipped and peeled paint. This failure had the potential to negatively impact the resident's quality of life and well-being. Findings: Medical record review for Resident 67 was initiated on 6/22/26. Resident 67 was admitted to the facility on [DATE]. On 6/22/26 at 0913 hours, an observation was conducted of Resident 67. Resident 67 was observed lying in bed in Room A. The wall behind Resident 67's bed was observed with several areas of chipped and peeled paint. On 6/25/26 at 1600 hours, an interview was conducted with the Administrator. The Administrator was shown a photo of the wall behind Resident 67's bed. The Administrator acknowledged the findings and stated the wall would be repaired.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided prior to the transfer to the acute care hospital for one of four residents (Resident 6) reviewed for hospitalizations. * The facility failed to ensure Resident 6 was assessment and/or change in condition documentation was completed prior to Resident 6's transfer to the acute care hospital on 4/15/26. This failure had the potential to result in the resident's change in condition not being assessed thoroughly and addressed in a timely manner.Findings: Review of the facility's P&P title Change in Condition Signs and Symptoms - SBAR revised 3/2021 showed the change in condition signs and symptoms SBAR was to assist in guiding the assessment and management of common changes in resident status that can result in acute care transfers. The tool is optional, however, the facility is responsible for a thorough assessment of the resident's change in condition signs and symptoms, ensure timely assessments, and contacts with primary care providers. The P&P further showed this tool should be utilized as a reference and guide when assessing residents with acute changes in status and determining when to contact the physician. Medical record review for Resident 6 was initiated on 6/22/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 2/6/25, showed Resident 6 was able to make needs known but was not capable of making medical decisions. Review of Resident 6's physician's telephone order dated 4/15/26, to transfer Resident 6 to ER (Emergency Room) of the acute care hospital due to increased confusion and agitation. Review of Resident 6's Physician's Discharge summary dated [DATE], showed the transfer was necessary due to Resident 6's increased confusion and agitation. Review of Resident 6's Progress Note dated 4/15/26 at 1330 hours, Resident 6 was admitted to the acute care hospital for metabolic encephalopathy and urinary retention. Further review of Resident 6's progress notes did not show an assessment regarding Resident 6's change in condition prior to his hospitalization. Further review of Resident 6's medical record failed to show the assessment documentation and/or the completed change in condition form prior to Resident 6's transfer to the acute care hospital. On 6/25/26 at 1249 hours, an interview and concurrent record review for Resident 6 was conducted with the ADON. The ADON stated Resident 6 was hospitalized on [DATE], because Resident 6 had increased confusion and agitation. The ADON stated a change in condition document should be completed if a resident was transferred to the acute care hospital. The ADON reviewed Resident 6's medical records and did not find the documentation. On 6/25/26 at 1605 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to provide the drink preference as per physician's order for one of one resident (Resident 8) reviewed. * The facility failed to provide a health shake with meals to Resident 8 as ordered by the physician. This failure had the potential to not meet the resident's nutritional needs and negatively impact the resident's well-being.Findings: On 6/22/26 at 1216 hours, a dining observation was conducted with Resident 8 in her room. Resident 8 was observed sitting on her bed with a lunch tray positioned in front of her on the overbed table. Resident 8's lunch tray was observed with a plate of rice, minced chicken, minced vegetable with gravy, a cup of soup and an empty milk container. Review of Resident 8's meal ticket (used to identify the resident's diet, allergies and food preferences) showed for Lunch, was to provide four ounces of milk and four ounces of diet shake. Resident 8 was shown the lunch meal ticket and when the diet shake was pointed out, Resident 8 stated no. On 6/22/26 at 1218 hours, an observation and concurrent interview were conducted with CNA 5. CNA 5 verified Resident 8's lunch meal tray did not include the diet shake. On 6/22/26 at 1235 hours, an interview was conducted with the DSS verified Resident 8's lunch meal tray did not include the diet shake. Medical record review for Resident 8 was initiated on 6/24/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's MDS assessment dated [DATE], showed a BIMS score of 15 (intact cognition). Review of Resident 8's Order Summary Report dated 6/23/26, showed the following physician's dietary orders:- date 12/15/25, for CCHO (Consistent or Controlled Carbohydrate diet- a meal plan designed to keep blood sugar levels stable) minced and moist texture (soft, fine mashed foods requiring minimal chewing), regular /thin liquid consistency; and- date 11/28/25, for health shake four ounces with meals, no sugar added. Review of Resident 8's Nutrition Risk care plan initiated on 11/23/25, showed Resident 8 was at risk for weight loss and dehydration related to dementia, chewing and swallowing problems and altered skin condition. The interventions included providing diet as ordered, adhering to food preferences, encouraging meal intake, and offering fluid as tolerated. On 6/25/26 at 1402 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 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, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous access for one of one sampled resident (Resident 16) reviewed for intravenous care. * The facility failed to ensure the peripheral IV line dressing for Resident 16 was labeled and dated. This failure had the potential for the use of the resident's outdated peripheral IV access and posed a risk for IV site complications. Findings: Review of the facility's P&P titled Peripheral Venous Catheter Insertion dated 3/2023 showed to obtain a physician's order for the peripheral venous catheter insertion. The peripheral IV catheter sites will be changed when clinically indicated. Under the procedures, showed to write the date, time, and initials on the dressing label. On 6/24/26 at 0949 hours, an observation was conducted with Resident 16. Resident 16 was observed lying on her back in bed with a peripheral IV line on the left hand and an IV antibiotic was infusing via a IV peripheral line. The IV site was observed with minimal redness and swelling. The transparent dressing was observed to be unlabeled and undated. Medical record review for Resident 16 was initiated on 6/22/26. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 5/16/26, showed Resident 16 had the capacity to understand and make decisions. Review of Resident 16's Order Summary Report for 6/2026 showed a physician's order dated 6/18/26, for Ceftriaxone Sodium (antibiotic) Solution reconstituted 2 gm, use two grams intravenously one time a day for UTI for seven days. Review of Resident 16's care plan date initiated 6/18/26, showed Resident 16 had a peripheral IV catheter due to a diagnosis of UTI requiring and IV antibiotic therapy. The approaches/intervention included to observe the IV site frequently for signs and symptoms of complications such as redness, swelling, pain, drainage and leakage. On 6/24/26 at 1331 hours, an interview was conducted with LVN 2. LVN 2 was informed of the findings and stated IV line dressing should have been labeled with the date, time and initial when it was inserted to monitor and be aware when it needed to be changed. LVN 2 stated the IV site should be rotated every 72 hours and as needed. On 6/24/26 at 0958 hours, an observation for Resident 16 and concurrent interview was conducted with RN 1. RN 1 verified Resident 16 peripheral IV dressing had no label and stated the dressing should have been labeled and dated. RN 1 was observed stopping the IV antibiotic infusion and stated a new IV line will be reinserted. On 6/25/26 at 1603 hours, the Administrator and DON were informed and acknowledged the above findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record, facility document review, and facility P&P review, the facility failed to ensure the pharmacist recommendations identified during the Drug Regimen Review were followed through in two of five residents reviewed for unnecessary medications (Residents 8 and 31). * The facility failed to ensure Resident 8's Drug pharmacy recommendation for levothyroxine (medication to treat underactive thyroid by replacing missing hormones), and Latanoprost (prescription eye drop used to treat open-angle glaucoma and ocular hypertension by lowering intraocular pressure) and cyclosporine (used to treat chronic dry eye disease by decreasing eye inflammation and increasing your natural tear production) medications were followed through in a timely manner. In addition, Resident 8's medical record failed to show the rationale when the physician continued Resident 8's BP medication despite multiple low blood pressure readings. * The facility failed to follow through with the pharmacist's recommendation for Resident 31's Lantus Solostar (medication to lower blood sugar) medication. These failures had the potential to negatively impact the residents' health outcomes. Findings Review of the facility's P&P titled Drug Regimen Review dated 10/2017 showed the Director of Nurses receives the Pharmacy Consultant's recommendations, a copy of the recommendations will be faxed to the residents' attending physician, and the physician will respond within 72 hours, or the licensed nurse will call the physician. The attending physician must document in the medical record the irregularity they reviewed, what action they took, and if no changes were made, what their rationale was. 1. Medical record review for Resident 8 was initiated on 6/24/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's MDS assessment dated [DATE], showed a BIMS score of 15 (intact cognition). a. Review of the facility's Consultant Pharmacist Recommendations to Nursing Staff created between 1/1/26 and 1/22/26, showed Resident 8 was currently prescribed levothyroxine 125 mcg daily at 0900 hours. The recommendation further showed to prevent potential drug interactions and ensure optimal absorption, the pharmacist recommended to adjust the administration of levothyroxine medication to 0630 hours. Review of Resident 8's physician's telephone order dated 1/27/26, showed levothyroxine sodium tablet 125 mcg to give one tablet by mouth one time for low thyroid hormone, schedule to be administered at 0630 hours daily. However, the levothyroxine administration time change was only carried out five days later. b. Review of the facility's Consultant Pharmacist Recommendations to Nursing Staff created between 2/1/26 and 2/26/26, showed to maximize efficacy and reduce adverse drug reactions, the pharmacist recommended to add wait five minutes between drops to the order of Latanoprost ophthalmic solution and cyclosporine 0.05% emulsion . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's physicians telephone order dated 3/13/26, showed an order of Latanoprost ophthalmic solution 0.005% instill one drop to both eyes at bedtime for glaucoma, to wait five minutes between eyedrops. However, the new order was made 17 days after the pharmacist's recommended change. c. Review of the facility's Consultant Pharmacist Recommendations to Physician (undated) showed Resident 8's medication had been on hold multiple times due to the resident's BP of less than110 mmHg. The recommendation showed to see if the adjustment need to be made on the blood pressure medications of metoprolol (a medication to treat high blood pressure medication) and midodrine (a medication to treat low blood pressure) medications. The Physician/Prescriber Response section showed continue current treatment, signed and dated by the physician on 5/15/26. However, the form failed to show the rationale why the physician did not make adjustments on the blood pressure medications. On 6/24/26 at 1523 hours, an interview and concurrent record review was conducted with the ADON. The ADON stated she was in-charge of the Drug Regimen Review follow-ups. The ADON stated she would send the documents to the physician, call the physicians directly or if the physician was in the building, she would hand the recommendations to the physicians. The ADON further stated the recommendations should be completed as soon as possible. The ADON verified the recommendations for Resident 8 dated 1/22/26 and 2/26/26, were not completed in a timely manner. On 6/25/26 at 0752 hours, an interview and concurrent record review was conducted with LVN 3. LVN 3 stated she would assist the ADON in handling the Drug Regimen Reviews. LVN 3 further stated once the drug regimen review recommendations were received, she would try to do her best to complete the recommendations within 72 hours. LVN 3 verified the recommendations for Resident 8 dated 1/22/26 and 2/26/26, were not followed as per the facility's policy and there were no physician's justification/clinical rationale why the BP medications were not changed in the progress notes or medical record. On 6/25/26 at 1402 hours, an interview with the Administrator and DON were conducted. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 31 was initiated on 6/22/26. Resident 31 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 31's H&P examination dated 6/27/24, showed Resident 31 had no capacity to make medical decisions. Review of Resident 31's Medication Regimen Review dated 5/30/26, showed the pharmacist recommended to add rotate site of injection to Resident 31's Lantus Solostar (used to lower blood sugar) medication order to maximize the therapeutic efficacy and reduce adverse drug reactions. The provider's follow-through section showed done 6/16/26. Review of Resident 31's Order Summary Report showed a physician's order dated 5/6/26, to inject 45 units of Lantus Solostar subcutaneous solution pen-injector 100 unit/ml subcutaneously one time a day for Type 2 diabetes and to inject 15 units subcutaneously at bedtime. Further review of Resident 31's Order Summary Report failed to show the changes of the Lantus Solostar order to include the rotation of the injection sites. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/26 at 1249 hours, an interview and concurrent medical record review for Resident 31 was conducted with the ADON. The ADON stated the physician should respond to the pharmacist's drug regimen recommendations within 72 hours. The ADON verified the above findings and acknowledged Resident 31's current Lantus Solostar medication order did not include to rotate the injection sites. On 6/25/26 at 1605 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage, labeling, and disposal of medications to one of three medication rooms and one of four medication carts inspected for labeling and storage of drugs and biologicals. * The facility failed to ensure Resident 55's opened vial of lidocaine HCl (medication used to temporarily numb specific areas of the body to block pain) was dated when the vial was opened. * The facility failed to ensure expired COVID-19 testing kits were removed from the medication supply room. These failures posed the risk for the resident's use of outdated medication and inaccurate testing results for the residents.Findings: Review of the facility's P&P titled Medication Storage in the Facility revised 1/2025 showed the medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from the stock. 1. On [DATE] at 1449 hours, Medication Cart D inspection was conducted with LVN 4. During the medication cart inspection, an open and undated vial of lidocaine HCl 1% 200 mg per 20 ml vial for Resident 55 with expiration date of [DATE], was observed the medication cart. On [DATE] at 1459 hours, an interview was conducted with LVN 4. LVN 4 verified the lidocaine HCl vial for Resident 55 was opened and undated. LVN 4 stated once the vial was opened, we should put a date on the vial, and we could keep the vial open for 28 days. On [DATE] at 1501 hours, an interview was conducted with LVN 7. LVN 7 verified the lidocaine HCl vial for Resident 55 was opened and undated. LVN 7 stated we put the date after we open the vial, and this had no date. Medical record review for Resident 55 was initiated on [DATE]. Resident 55 was admitted to the facility on [DATE]. Review of Resident 55's H&P examination dated [DATE], showed Resident 55 does not have the capacity to understand and make decisions. Review of Resident 55's MAR for [DATE] showed a physician's order for lidocaine injection solution (per pharmacy dosing) in the morning for diluent of ertapenem sodium (medication to treat moderate to severe bacterial infections) until [DATE]. On [DATE] at 1402 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On [DATE] at 1533 hours, an inspection of the Medication Supply Room A and concurrent interview was conducted with the ADON and IP 1. During the inspection of the medication supply room, a box containing 24 COVID-19 testing kits with an expiration date [DATE], was observed in the medication supply room. The ADON and IP 1 verified the above findings. The IP 1 stated the COVID 19 testing kits should not be stored in the medication supply room because they were expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1605 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for two of 22 final sampled residents (Residents 68 and 88) who received hospice services. * The facility failed to ensure the hospice skilled nurse visit notes and CHHA notes were available and included in Resident 68's medical records. Furthermore, the facility failed to ensure the staff awareness of the facility's hospice designee/coordinator. * The facility failed to ensure the hospice skilled nurse visit notes and CHHA notes were available and included in Resident 88's medical records. Furthermore, the facility failed to ensure staff awareness of the facility's hospice designee/coordinator. These failures posed the risk of delay in communication between the hospice provider and facility which may affect resident care. Findings: Review of the facility's P&P titled Hospice Services date revised 1/2017 showed a communication process, including how the communication will be documented between the facility and the hospice provider, so that the needs of the resident are addressed and met 24 hours a day. The facility staff should provide orientation in the policies and procedures of the facility, including resident rights, appropriate forms and record keeping requirements to hospice staff furnishing care to the residents. Further review of the facility's P&P titled Hospice Care date revised 9/2018 showed the facility must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the facility staff and hospice staff. 1. Medical record review for Resident 68 was initiated on 6/22/26. Resident 68 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 68's H&P examination dated 8/21/25, showed Resident 68 had the ability to make needs known but can not make medical decisions. Review of Resident 68's Significant Change in Status MDS dated [DATE], showed Resident 68 had a BIMS of 10 (8-12 suggests moderate cognitive impairment). Review of Resident 68's Order Summary Report for 6/2026 showed a physician's order dated 4/21/26, to admit to Hospice Agency 1 with a diagnosis of Chronic Systolic Congestive Heart Failure on routine level of care. Review of Resident 68's care plan dated 4/21/26, showed the resident was under the care of Hospice Agency 1 services on routine level of care. Review of Resident 68's hospice binder and medical records failed to show the skilled nurse hospice progress notes and CHHA notes for June 2026. On 6/24/26 at 1458 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the above findings and stated the hospice binder was kept at the nurses' station. LVN 2 stated the hospice documents should have been in the binder or Resident 68's medical records for communication purposes and awareness of what to follow through for Resident 68. Furthermore, LVN 2 was asked who the facility's hospice designee/coordinator was, LVN 2 stated it was the DON. 2. Medical record review for Resident 88 was initiated on 6/22/26. Resident 88 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 88's H&P examination dated 12/18/25, showed Resident 88 had no capacity to make medical decisions. Review of Resident 88's Quarterly MDS assessment dated [DATE], showed Resident 88 had a short-term and long-term memory problem with severely impaired cognitive skills. Review of Resident 88's Order Summary Report for 6/2026 showed a physician's order dated 7/22/24, to admit to the facility under the services of Hospice Agency B with a diagnosis of Alzheimer's Dementia on routine level of care. Review of Resident 88's care plan dated 7/22/24 showed the resident is under the care of Hospice Agency B on routine level of care. Review of Resident 88's hospice binder and medical records failed to show the skilled nurse hospice progress notes and CHHA notes for May and June 2026. On 6/24/26 at 1408 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified the above findings and stated the hospice binder was kept at the nurses' station. LVN 2 stated the hospice documents should have been in the binder or Resident 88's medical records for (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication purposes and awareness of what to follow through for Resident 88. Furthermore, LVN 2 was asked who the facility's hospice designee/coordinator was, LVN 2 stated it was the DON. On 6/24/26 at 1634 hours, an interview was conducted with RN 1. When asked who the facility's hospice coordinator was, RN1 verified the ADON was the facility's hospice coordinator. On 6/25/26 at 1603 hours, the Administrator and DON were informed and acknowledged the above findings.

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F 0695 Level of Harm - Potential for minimal 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, medical record and facility P&P review, the facility failed to ensure the appropriate respiratory care and services were provided for three of six residents (Residents 3, 7, and 80) reviewed for respiratory care. * The facility failed to ensure Resident 3 and 7's oxygen concentrators were free of dust like particles. * The facility failed to ensure Resident 80's nebulizer machine was maintained in a sanitary condition. These failures had the potential to negatively impact the residents' health outcomes.Findings: Review of the facility's P&P titled Maintenance, Cleaning and Repair of Resident Equipment dated 1/20/19, showed the residents equipment shall be cleaned and disinfected according to manufacturer guidelines and facility infection control policies. Cleaning shall occur after each use of equipment, daily or as needed for resident assigned equipment. 1. a. On 6/22/26 at 0922 hours, during the initial tour of the facility, Resident 3 was observed lying in bed with oxygen being administered via nasal cannula from oxygen concentrator at bedside. The oxygen concentrator was observed to have dust- like materials in front of the concentrator below the oxygen concentrator flow meter and on top of the oxygen concentrator. Medical record review for Resident 3 was initiated on 6/23/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 3/24/26, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report showed a physician's order dated 5/5/26, to administer oxygen at a rate of two liters per minute via nasal cannula continuous to keep the oxygen saturation above 92% for shortness of breath and wheezing Review of Resident 3's Care Plan dated 3/23/26, showed Resident 3 was at risk for altered breathing pattern and risk for respiratory distress. The interventions included oxygen administration at a rate of two liters per minute via nasal cannula. On 6/23/26 at 1535 hours, a follow-up observation and interview was conducted with LVN 5. LVN 5 verified Resident 3's oxygen concentrator at bedside had dust like materials in the front, below the oxygen concentrator flow meter and the top of the oxygen concentrator. LVN 5 stated the oxygen concentrator should be clean. On 6/23/26 at 1600 hours, an interview was conducted with LVN 3. LVN 3 verified the presence of dust like particles on Resident 3's oxygen concentrator. LVN 3 stated the oxygen company would come and check the concentrators. LVN 3 further stated the oxygen company was cleaning outside two months ago. b. On 6/22/26 at 0852 hours, during the initial tour of the facility, Resident 7 was observed asleep in bed with oxygen being administered via nasal cannula from the oxygen concentrator. The oxygen concentrator was observed to have cream-colored stains and dust like particles in the front and top of the concentrator. Medical record review for Resident 7 was initiated on 6/23/26. Resident 7 was admitted on [DATE]. Review of Resident 7's H&P examination dated 11/8/25, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's Order Summary Report showed a physician's order dated 11/7/25, to administer oxygen at two liters per minute via nasal cannula continuously to keep the oxygen saturation above 92% for wheezing and shortness of breath. Review of Resident 7's Care Plan dated 11/7/25, showed a care plan problem for respiratory treatment. The goal was to improve and will show no episode of shortness of breath at the end of respiratory therapy. The interventions included to administer oxygen via nasal cannula at rate of two liters per minute. On 6/23/26 at 1600 hours, an observation and concurrent interview was conducted with LVN 3 and Infection Preventionist 1. LVN 3 and IP 1 verified Resident 7's oxygen concentrator was observed to have cream stains and dust like particles in front and on top of the oxygen concentrator. LVN 3 further stated there was no facility cleaning schedule, the staff had to check if the cleaning was done regularly and should not be only paper compliant, the oxygen concentrators need to be physically checked for cleanliness. On 6/24/26 at 912 hours, an interview and facility record review was conducted with the Team Leader of Central Supply. The Team Leader of Central Supply stated she was in charge of cleaning the outside of the oxygen concentrators with Clorox wipes. When asked what happened to Resident 3 and 7's oxygen (continued on next page)

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	concentrators, the Team Leader of Central Supply stated she did not know what happened and stated maybe she did not clean them. The Team Leader of Central Supply further stated if she did not clean the oxygen concentrators for some reason, the nurses could tell her because she was supposed to clean it. The Team Leader of Central Supply added it was important to clean the concentrators because the residents were sick people and the residents were inhaling the dusts. 2. On 6/23/26 at 0916 hours, during the initial tour of the facility, Resident 80 was asleep in his bed and a nebulizer machine was observed on top of his nightstand. Medical record review Resident 80 was initiated on 6/24/26. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's H&P examination dated 6/4/25, showed Resident 80 could make needs known but could not make medical decisions. On 6/23/26 at 1611 hours, an observation for Resident 80 and concurrent interview was conducted with CNA 4. CNA 4 verified Resident 80's nebulizer was dirty. During an observation for Resident 80 with CNA 4, IP1 came in Resident 80's room. IP 1 verified Resident 80's nebulizer machine had dust like particles all over the nebulizer machine and stated it should have been cleaned. On 6/26/26 at 1053 hours, an interview was conducted with LVN 6. LVN 6 acknowledged Resident 80's nebulizer machine was dirty. LVN 6 stated the nebulizer machine tubing were changed every Sunday and cleaned. LVN 6 further stated the nurses would clean the nebulizer machine using a wet towel and wipes. When asked why it was important for the nebulizer machine to be clean, LVN 6 stated for infection control, the dust could contaminate the tubing and make the resident sick. On 6/25/26 at 1603 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON was made aware and acknowledged the above findings.

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F 0711 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the physician signed the telephone orders for two out of 22 final sampled residents (Residents 6 and 41). * The physician failed to sign Resident 6's telephone orders on a timely manner. * The physician failed to sign Resident 41's telephone orders on a timely manner. These posed the risks for inaccurate treatment for the residents. Findings: Review of the facility's P&P titled Physician Orders and Telephone Orders dated 1/2004 showed the telephone orders shall be signed within five days by the prescribing physician or their extender as permitted by law. 1. Medical record review for Resident 6 was initiated on 6/22/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 2/6/25, showed Resident 6 was able to make their needs known but was not capable of making their own medical decisions. Review of Resident 6's physician's telephone orders for the following dates, did not show a physician's signature to show these telephone orders had been reviewed and approved by the physician:- dated 5/27/26, to instill one drop of moxifloxacin 0.5% HCl (medication to treat eye infections) ophthalmic solution to Resident 6's left eye four times a day for post-op for one week, - dated 5/27/26, to instill one drop of bromfenac sodium 0.07% (medication to reduce inflammation and pain) to Resident 6's left eye one time a day for left eye swelling for four weeks, - dated 5/27/26, to instill one drop of prednisolone acetate 1% (medication to reduce eye swelling, redness, and itching) to Resident 6's left eye four times a day for left eye swelling for one week, then to instill one drop in the left eye three times a day for seven days on week two, then to instill one drop in the left eye two times a day for seven days on week three, and then to instill one drop in the left eye one time a day for seven days on week four, - dated 6/9/26, to clean with normal saline, pat dry, and apply xeroform gauze (medical dressing for wound care) with a foam dressing daily for fourteen days every day shift to Resident 6's right posterior skin tear over an ecchymotic area, - dated 6/16/26, to administer one finasteride (medication to improve urinary flow) 5 mg oral tablet by mouth at bedtime for BPH (benign prostatic hyperplasia enlarged prostate gland), - dated 6/16/26, to administer one mycophenolate mofetil (immunosuppressant medication) 1000 mg oral tablet by mouth two times a day for bullous pemphigoid (autoimmune disease that causes large, fluid-filled, itchy blisters), - dated 6/17/26, to apply clobetasol propionate 0.05% external ointment to Resident 6's left foot for a rash every day shift until 7/17/26, - dated 6/17/26, to apply clobetasol propionate 0.05% (steroid) external ointment to Resident 6's right foot for a rash every day shift until 7/17/26, - dated 6/17/26, to apply clobetasol propionate 0.05% external ointment to Resident 6's left palm for a rash every day shift for thirty days, and - dated 6/19/26, to administer 5 cc of nystatin (antifungal medication) mouth/throat suspension by mouth three times a day for oral thrush (fungal infection) for two weeks. 2. Medical record review for Resident 41 was initiated on 6/22/26. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 4/23/26, showed Resident 41 was able to make their needs known but was not capable of making their own medical decisions. Review of Resident 41's physician's telephone orders for the following dates, did not show a physician's signature to show these telephone orders had been reviewed and approved by the physician: - dated 5/21/26, to continue physical therapy five times a week for four weeks for therapeutic exercises, therapeutic activity, and gait training until 6/17/26, - dated 5/28/26, to administer one metoprolol tartrate (blood pressure medication) 50 mg tablet by mouth two times a day with meals for hypertension (high blood pressure), to hold if the systolic blood pressure was less than 110 mmHg or heart rate was less than 60 beats per minute, - dated 6/16/26, to continue occupational therapy five times a week for four weeks for therapeutic exercises, therapeutic activity, ADL (activities for daily living) retraining for generalized muscle weakness, - dated 6/17/26, to continue physical therapy five times a week for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056145	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Grove Post Acute	12882 Shackelford Lane Garden Grove, CA 92841

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 0711 Level of Harm - Potential for minimal harm Residents Affected - Some	four weeks for therapeutic exercises, therapeutic activities, and gait training until 7/14/26; - dated 6/17/26, to obtain the following lab tests: CBC (complete blood count), BMP (basic metabolic panel), BNP (B-type natriuretic peptide), PT/PTT/INR (prothrombin time / partial thromboplastin time / international normalized ratio), and A1C (blood test to measure average sugar levels), and - dated 6/17/26, to hold all medications except blood pressure, heart, and seizure medication in the morning of 7/2/26, and - dated 6/17/25, to hold Eliquis (blood thinner medication) two days before a procedure until 7/2/26. On 6/25/26 at 1249 hours, an interview and concurrent medical record review for Residents 6 and 41 was conducted with the ADON. The ADON acknowledged and verified the physician's orders were not signed as per the facility's P&P. On 6/25/26 at 1605 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.