STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056149	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Healthcare and Rehabilitation Center	6700 Sepulveda Blvd. Van Nuys, CA 91411

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of residents were protected by failing to ensure documents (diet typer report) containing protected information ([PHI]- any health information that can be used to identify specific individual which must remain confidential to prevent harmful consequences) were shredded prior to disposing in the waste container. This failure had the potential to violate 125 of 125 residents' rights for privacy and confidentiality of personal and medical records. Findings: During an observation on 4/20/2026 at 8:22 a.m., observed diet type report for all stations, dated 4/13/2026, which contained containing residents' names, room numbers, diet orders, and allergies were disposed of in the trash. During a concurrent observation and interview on 4/20/2026 at 9:13 a.m., with the Dietary Supervisor (DS), observed the trash can by the grill area containing diet type report. The DS confirmed that the diet type report was found in the trash and stated it should not have been discarded in the trash, as it constitutes violation of the Health Insurance Portability and Accountability Act ([HIPPA], a law that sets national standard to protect sensitive health information, making sure it stays private and secure) violation. The DS stated that the diet type report contains residents' information including names, diet orders, and room numbers, which are and these are considered protected information. The DS stated throwing the diet type report in the trash could potentially result in unauthorized exposure of the residents' information and creates a risk that the information could be stolen. During a review of the facility's policies and procedures (P&P) titled Notice of Privacy Practices, dated 11/25/2025, the P&P indicated, The facility adopts this policy requiring that the facility provide notice of the facility's privacy practices to facility patients and the public. The facility has adopted a Notice of Privacy Practices that describes the facility's privacy practices (the Privacy Notice), the use and disclosure of Protected Health Information (PHI) at the facility, and the patient's rights regarding PHI. Training a. Facility staff will be trained on the privacy notices of the facility, including practices outlined in the privacy notice upon hire and annually.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) by failing to:1. Develop a care plan that address monitoring of resident's behavior for three (Resident 1, Resident 8, Resident 14) of four sampled residents on physical restraints (any physical device attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of normal access to one's body) when the restraints were removed in accordance with the physician's order (called holidays). This failure had the potential for those residents to pull out their life sustaining tubes such as a tracheostomy tube (isˆa curved, hollow tube inserted into a surgically created opening in the neck [stoma] and trachea to provide an alternative airway for breathing) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube (GT). 2. Implement care plan interventions on oxygen use for two (Resident 191, Resident 90) of three sampled residents reviewed under respiratory care area. This deficient practice had the potential to negatively affect the provision of care and services related to oxygen therapy for Residents 191 and 90.3. Implement a care plan intervention to monitor and assess residents for signs and symptoms of bleeding for one of one sampled resident (Resident 191) on anticoagulant therapy. This deficient practice had the potential to delay timely intervention and result in health complications such as bleeding.4. Failing to develop a care plan for one of five sampled residents (Resident 76) investigated for immunizations (the process where a person is made resistant to a disease) when Resident 76 refused vaccination (medications used to prevent diseases usually given by injection or by mouth) for influenza (flu, a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs). This deficient practice had the potential to delay the delivery of necessary care and services to Resident 76, placing the resident at risk for respiratory disease. Findings: 1.a. During a review of Resident 14's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 14 to the facility on 9/20/2025 and re-admitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia (a long-term, ongoing condition where the lungs cannot adequately transfer oxygen into the blood, resulting in a low oxygen levels and requiring oxygen for bodily functions). During a review of Resident 14's Minimum Data Set (MDS-resident assessment tool) dated 4/04/2026, the MDS indicated Resident 14 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 14 was dependent (helper does all the effort; resident does none of the effort to complete the activity) on staff for toileting, dressing, and personal hygiene. The MDS indicated Resident 14 required the use of a limb restraint (physical restraint on an arm). During a review of Resident 14's Physician's Orders, dated 1/09/2026, the Physician's Orders indicated an order for a freedom splint (a soft, cushioned limb immobilizer designed to restrict elbow movement; used to prevent patients from pulling at tubes) to the left upper extremity (left arm) to minimize pulling out of life sustaining tubes; released every two hours for 15 minutes for circulation and to check skin integrity. Holidays off on Wednesdays and Sundays. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14's Supportive and Safety Devise/Physical Restraint Assessment, dated 1/16/2026, the assessment indicated Resident 14 had an order for a freedom splint to be applied to the left upper extremity due to interference with specific medical treatments (pulling out life sustaining devices such as tracheostomy, and GT. During a review of Resident 14's Care Plan Risk For Injury, initiated 1/25/2026, the care plan indicated Resident 14 is at risk for injury due to tendency to pull out life sustaining tubes. The care plan indicated a goal to minimize the risk of Resident 14 pulling out life sustaining tubes daily through the next assessment. The care plan indicated the interventions to apply freedom splints as ordered, and holiday off every Wednesdays and Sundays. During an observation of Resident 14 on 4/22/2026 at 10:50 a.m., observed Resident 14 in his bed not wearing the freedom restraint because it was his holiday day. Observed Resident 14 scratching his face. During an interview with the Assistant Director of Nursing 2 (ADON 2) for the subacute unit on 4/22/2026 at 11 a.m., the ADON 2 stated Resident 14 required the use of the freedom restraint on the left arm to prevent him from pulling at his tracheostomy and gastrostomy tubes. The ADON 2 stated Resident 14 does not wear restraints on the holiday days which are Wednesdays and Sundays. The ADON 2 stated that residents have holiday days so they can feel free and not feel restrained. The ADON 2 stated those residents on their holiday days have frequent visual checks but was unable to specify what frequent meant. The ADON 2 stated frequent visual checks are conducted both on the days restraints are on and when there is a holiday. The ADON 2 did not have an answer when asked what intervention(s) are done in addition to what licensed and unlicensed (such as certified nursing assistant) nursing staff already do on holiday days. During an interview with the Director of Nursing (DON) on 4/23/2026 at 12:10 p.m., she stated there are no additional interventions done on the holiday days for residents with orders for freedom restraints During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed 11/25/2025, the P&P indicated Care Plans should include interventions that recognize standards of practice for problem areas and conditions for residents to maintain highest physical, mental and psychosocial well-being. During a review of the facility's policy and procedure titled, Restraints: Holiday, last reviewed 11/25/2025, the policy indicated the following: This facility will provide a temporary break period or holiday from restraint use as appropriate for residents. The holiday from restraints is not required, nor intendent to replace assessments completed for use of restraints, effectiveness, or reduction as scheduled or needed. Its purpose is to provide those residents who are not appropriate for restraint reduction a temporary break as indicated/tolerated. 1. b. During a review of Resident 1's Face Sheet, the Face Sheet indicated Resident 1 was admitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia, tracheostomy, gastrostomy, and encephalopathy (a brain dysfunction often characterized by altered mental status, confusion, or memory loss). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 1 was dependent on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff for toileting hygiene, shower/bathe, dressing, sitting to lying, and lying to sitting on the side of bed. During a review of Resident 1's physician's order for freedom splints, dated 4/16/2026, the physician's order indicated to apply freedom splints to the right upper extremity to minimize pulling out of life sustaining tubes. The order further indicated to release the freedom splint every two hours for 15 minutes and holidays (Wednesday and Sunday) off restraints. During an observation on 4/22/2026 at 10:20 am in Resident 1's room, Resident 1 was lying in bed wearing a right upper extremity freedom splint. During a concurrent interview and record review on 4/22/2026 at 11:57 a.m. with the ADON 2, Resident 1's Care Plan Report, active through 4/22/2026 was reviewed. Resident 1's care plan did not indicate specific interventions on how to monitor the resident on Wednesdays and Sundays when the freedom splint is not in place. ADON 2 stated Resident 1's care plan needs to be updated with interventions for monitoring Resident 1's behavior when the freedom splint is not placed during holidays. During an interview on 4/23/2026 at 12:10 pm with the DON, the DON stated the facility should obtain guidance from the physician on how to monitor the residents more closely during holidays, when the restraints are not in the place and incorporate these interventions into the care plan. 1.c. During a review of Resident 8's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 8 on 5/04/2024 and readmitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia, tracheostomy, gastrostomy, and traumatic subdural hemorrhage (bleeding in the out lining of the brain usually due to severe head injury such as accidents or falls). During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 8 was dependent on staff for toileting hygiene, showering/bathing, dressing, sitting to lying, and lying to sitting on the side of bed. During a review of Resident 8's Order Summary Report dated 4/22/2026, the Order Summary Report indicated an order dated 1/12/2026 for the following: -Apply hand mitten to left hand to prevent pulling out tracheostomy tube and scratching. Release every two (2) hours for 15 minutes for circulation and to check for skin integrity. Hand hygiene will be provided during release. Monitor placement (Holidays off on Wednesdays and Sundays). Check every shift every Monday, Tuesday, Thursday, Fri, and Saturday. During an observation on 4/22/2026 at 10:21 a.m. in Resident 8's room, Resident 8 was observed sleeping in bed with a left-hand mitten on. During a concurrent interview and record review on 4/22/2026 at 11:57 a.m. with the ADON 2, Resident 8's Care Plan Report, active through 4/22/2026, was reviewed. Resident 8's Care Plan Report did not indicate specific interventions on how to monitor the resident on Wednesdays and Sundays when the left-hand mitten is not in place. ADON 2 stated Resident 8's care plan does not indicate interventions for monitoring Resident 8's behavior when the left-hand mitten is not placed during holidays. ADON 2 stated that the family had requested for the hand mitten to be worn every day, but the order and care plan still needs to be updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2026 at 12:10 pm with the DON, the DON stated the facility should obtain guidance from the physician on how to monitor the residents more closely during holidays, when the restraints are not in the place and incorporate these interventions into the care plan. During a review of the facility's policy and procedures (P&P) titled, Restraints: Holiday, last reviewed 11/25/2025, the P&P indicated consideration for holiday from restraints should be in the care plan. During a review of the facility's P&P titled, Use of Restraints, last reviewed 11/25/2025, the P&P indicated care plans should include interventions and measures to reduce restraint usage. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed 11/25/2025, the P&P indicated Care Plans should include interventions that recognize standards of practice for problem areas and conditions for residents to maintain highest physical, mental and psychosocial well-being. 2. a. During a review of Residentˆ191'sˆFace Sheet, theˆFace Sheetˆindicated the facility originally admitted the residentˆon 10/23/2016ˆand re-admitted ˆtheˆresident on 2/20/2026, with diagnoses including hypertension (high blood pressure), chronic respiratory failure (long-term condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), and functional quadriplegia (complete loss of ability to move all four limbs—arms and legs). During a review of Residentˆ191's MDS, dated [DATE],ˆtheˆMDS indicated Residentˆ191's cognitive skills (mental abilities that enables a person to think, learn, remember, and solve problems) was severely impaired) for daily decision making was severely impaired. During a review of Resident 191'sˆPhysicianˆPhone Orderˆ Report, the report indicated an order with a start date of 2/21/2026for for humidified (passed through water to add moisture) oxygen at 5 liters per minute (L/min, a unit of measurement for oxygen). The scheduling detail indicated routine every day, every 6 hours. During a review of Resident 191`s care plan (CP) on oxygen, initiated on 1/14/2021 and last revised on 4/04/2026, the CP indicated Resident 191 is receiving oxygen therapy due to respiratory failure and the goal is for Resident 191 to remain free of adverse effects related to use of oxygen daily. The CP indicated interventions to change oxygen weekly or as needed and provide oxygen as ordered. During a concurrent observation and interview on 4/20/2026 at 10:55 a.m., with Respiratory Therapist (RT 1), inside Resident 191's room, Resident 191 was observed in bed without oxygen in place (use), while the oxygen concentrator (a medical device that provides continuous supply of oxygen through a nasal cannula or mask) was on and delivering oxygen at 5 L/min; the Resident 191's oxygen tubing (a flexible, clear hose that delivers oxygen to a patient during oxygen therapy) was not connected to the oxygen concentrator. The oxygen tubing was lying on the left side of Resident 191, touching the pillow and was not dated. RT 1 confirmed the observation and stated that Resident 191 oxygen was not connected to Resident 191; the oxygen tubing was placed on the bed next to Resident 191 and not dated. RT 1 stated Resident 191 has a physician order for continuous oxygen, and the oxygen should have been connected to the resident to prevent a decrease in oxygen levels, which could result in respiratory distress. RT 1 further stated that the oxygen tubing is disposable and should be dated to ensure staff replace it every seven days and to allow staff to easily verify when the tubing was last replaced. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/20/2026 at 10:58 a.m., with Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 191 is on continuous oxygen. CNA 1 stated she showered Resident at 8:45 a.m. today and forgot to ask a licensed staff to place Resident 191 back on oxygen. CNA 1 stated she was informed by RT 1 that Resident 191 is on continuous oxygen. CNA 1 stated Resident 191's oxygen saturation (measurement of oxygen in the blood) can go down and result in complications. During interview and record review on 4/21/2026 at 4:19 p.m., with RT 2, Resident 191's Physicianˆ Phone Orderˆ Report (PPOR), dated 2/21/12026,ˆ was reviewed. RT 2 stated the order indicated humidified oxygen at 5 L/min with the scheduling detail marked as routine. RT 2 stated routine mean Resident 191 should receive continuous oxygen at 5 L/min, and the every 6 hours instruction refers to documenting every 6 hours that the resident is receiving the oxygen. RT 2 stated if the order was intended to be administered every 6 hours, the scheduling detail would have been marked as PRN (as needed). RT 2 stated that continuous oxygen is important to prevent drops in oxygen levels, which could lead to respiratory distress. During a concurrent interview and record review on 4/22/2026 at 11:08 a.m. with ADON 1, Resident 191's CP report on oxygen, initiated on 1/14/2021 and last revised on 4/04/2026, was reviewed. ADON 1 stated the care plan indicated Resident 191 was receiving oxygen therapy due to respiratory failure and the CP interventions were to change oxygen tubing weekly or as needed and provide oxygen as ordered. ADON 1 stated, based on Resident 191's CP, Resident 191 should be receiving continuous oxygen as ordered and the oxygen should be changed weekly and as needed. ADON 1 stated that licensed nursing staff should date the oxygen tubing, so they (nursing staff) know when it is due for change, and to prevent Resident 191 from developing an infection. ADON 1 stated Resident 191's CP interventions were not implemented. During an interview on 4/22/2026 at 12:02 p.m. with the DON, the DON stated the oxygen tubing should be dated and change weekly per facility policy. During a review of the facility's P&P titled Oxygen Administration, last reviewed on 11/25/2025, the P&P indicated oxygen will be administered to a resident as needed per attending Physician's orders by licensed personal. The oxygen tubing should be changed weekly and as needed. The policy indicated the date time and initials should be noted on oxygen equipment when it is initially used and when changed. 2.b. Duringˆ aˆ review of Residentˆ 90'sˆ Face Sheet, theˆ Face Sheetˆ indicated the facility originally admitted Resident 90ˆ on 3/21/2023ˆ and re-admitted ˆ theˆ resident on 12/31/2025, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), dysphagia (difficulty swallowing), and encephalopathy. During a review of Residentˆ 90's MDS, dated [DATE],ˆ theˆ MDS indicated Resident 90's cognitive skills for daily decision making was severely impaired. During a review of Resident 90's Order Summary Report dated 4/21/2026, the Order Summary report indicated an order, dated 12/31/2026, for humidified oxygen at 5 L/min via TBar/Tmask (oxygen tracheostomy mask and T shaped connector to the tubing that is connected to the oxygen tank) every six hours. During a review of Resident 90`s CP on oxygen, initiated on 4/11/2023 and last revised on 2/26/2026, the CP indicated Resident 90 is receiving oxygen therapy due to respiratory failure and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the goal is for Resident 90 to remain free of adverse effects related to use of oxygen daily. The CP interventions were to change oxygen tubing weekly or as needed. During a concurrent observation and interview on 4/20/2026 at 10:44 a.m., with the ADON 2, inside Resident 90's room, Resident 90 was observed in bed receiving oxygen from the oxygen concentrator at 5 L/min via TBar/Tmask. Observed Resident 90's oxygen tubing was not dated. ADON 2 stated it was important to date the oxygen tubing so staff would know when the tubing is due for a change per policy and for infection control. During a concurrent interview and record review on 4/22/2026 at 11:00 a.m. with ADON 1, Resident 90's CP on oxygen initiated on 4/11/2023 and last revised on 2/26/2026, was reviewed. ADON 1 stated the CP indicated Resident 90 was receiving oxygen therapy due to respiratory failure. The care plan intervention indicated to change oxygen tubing weekly or as needed. ADON 1 stated that licensed nursing staff should date the oxygen tubing to ensure the tubing is changed weekly and to help prevent infection. During a concurrent interview and record review on 4/22/2026 at 12:02 p.m. with the DON, the DON stated oxygen tubing should be dated and change weekly per facility policy. During a review of the facility's P&P titled Oxygen Administration, reviewed on 11/25/202, the P&P indicated oxygen will be administered to residents as needed per attending Physician's orders by Licensed personal. The oxygen tubing should be changed weekly and as needed. The date, time, and initials should be noted on oxygen equipment when it is initially used and when changed. 3. During a review of Residentˆ191'sˆFace Sheet, theˆFace Sheetˆindicated the facility originally admitted Resident 191ˆon 10/23/2016ˆand re-admitted ˆtheˆresident on 2/20/2026, with diagnoses including hypertension, chronic respiratory failure, and functional quadriplegia. During a review of Residentˆ191's MDS, dated [DATE],ˆtheˆMDS indicated Residentˆ191's cognitive skills for daily decision making was severely impaired. During a review of Resident 191'sˆPhysicianˆOrderˆSummary Report dated 4/21/2026,ˆtheˆPhysician Orderˆ Summary Reportˆindicatedˆanˆorder dated 2/20/2026, with a start date of 2/21/2026 to administer apixaban (anticoagulant, medication to prevent blood clots) 2.5 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount) tablet, two times a day for deep vein thrombosis (DVT, a serious condition where a blood clot forms in a deep vein), prophylaxis (prevention). During a review of Resident 191`s CP on anticoagulant, initiated on 12/04/2023 and last revised on 4/04/2026, the CP indicated Resident 191 is at risk for bleeding and bruising due to anticoagulant therapy medication apixaban, with risk factors of gastrointestinal (GI) distress bleeding, abnormal bleeding, easy skin bruising or discoloration. The care plan indicated a goal that Resident 191 will have no unrecognized sign and symptoms of bleeding or GI distress daily until the next assessment. The care plan indicated an intervention to assess signs and symptoms of bleeding such as blood in the urine or stool and/or coffee ground emesis (vomit) and notify the physician. During a concurrent interview and record review on 4/22/2026 at 11:12 a.m. with the ADON 1, Resident 191's CP on anticoagulant, initiated on 12/04/2023 and last revised on 4/04/2026, was reviewed. ADON 1 stated that the care plan indicated Resident 191 is at risk for bleeding and bruising (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	due to anticoagulant therapy medication apixaban with an intervention to assess for sign and symptoms of bleeding such as blood in the urine or stool and/or coffee ground emesis and notify the physician. ADON 1stated she cannot provide any documentation to show that nursing staff assessed and monitored Resident 191 for signs and symptoms of bleeding. The ADON 1 stated monitoring should be done on the electronic medication administration record (eMAR, a computerized daily documentation record used by a licensed nurse to document medications and treatments given to a resident). The ADON 1 stated Resident 191's care plan intervention to assess and monitor the resident for signs and symptoms of bleeding was not implemented. During a review of the facility's P&P titled Anticoagulation - Clinical Protocol, last reviewed on 11/25/2025, the P&P indicated for licensed nurses to assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. The policy indicated the staff will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. The policy indicated if an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. The policy indicated that the physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated. During a review of the facility's policy and procedure titled Care Plans Comprehensive Person-Centered, last reviewed on 11/25/2025, indicated a comprehensive, person-centered care plan that includes measurable objective and timetables to meet the residents' physical, psychosocial, and functional needs is developed and implemented for each resident. 4. During a review of Resident 76's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/18/2025 with diagnoses including, but not limited to, benign neoplasm (a non-cancerous tumor that does not invade nearby tissue or spread to other parts of the body) of the meninges (protective layers that surround the brain and spinal cord) and intracerebral hemorrhage (bleeding inside the brain tissue). During a review of Resident 76's Physician Progress Note, dated 4/19/2025, the progress note indicated Resident 76 had the capacity to understand and make decisions. During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 was cognitively intact and required substantial assistance (helper does more than half of the effort) with most activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 4/23/2026 at 10:57 a.m. with the Infection Preventionist Nurse (IPN), Resident 76's Vaccine Consent Form, indicated Resident 76 refused the 2025/2026 influenza vaccine on 10/07/2025. The IPN stated when a resident refuses a vaccine, she should create a care plan that addresses the resident's vaccine refusal. The IPN stated there was no care plan documenting the resident's refusal of the flu vaccine. The IPN stated the care plan should include interventions to educate the resident about why the vaccination is needed and to monitor the resident for signs and symptoms of the flu. The IPN stated the care plan would also be needed so staff is aware that the resident refused the vaccine. During an interview on 4/23/2026 at 3:24 p.m. with the DON, the DON stated when a vaccine is refused there should be a care plan that includes education to the resident of why the vaccine is needed and for staff to reoffer the flu vaccine. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed 11/25/2025, 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. The P&P (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated care plans are revised as information about the residents and the residents' conditions change.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents with necessary respiratory care and services that is in accordance with professional standards of practice to two of three sampled residents (Resident 90 and Resident 191) reviewed under the respiratory care area by failing to:1.Ensure Resident 90 and Resident 191's oxygen tubing (a flexible, clear hose that delivers oxygen to a patient during oxygen therapy) was labeled with the date it was last changed.2. Administer oxygen to Resident 191 as ordered by the physician. These deficient practices had the potential to negatively affect the provision of care and services related to oxygen therapy and placed the residents at increased risk for respiratory distress and infection.Findings:1.a. Duringˆaˆreview of Residentˆ90'sˆFace Sheet, theˆFace Sheetˆindicated the facility originally admitted Resident 90ˆon 3/21/2023ˆand re-admitted ˆtheˆresident on 12/31/2025, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), dysphagia (difficulty swallowing), and encephalopathy. During a review of Residentˆ90's MDS, dated [DATE],ˆtheˆMDS indicated Resident 90's cognitive skills for daily decision making was severely impaired. During a review of Resident 90's Order Summary Report dated 4/21/2026, the Order Summary report indicated an order, dated 12/31/2026, for humidified oxygen at 5 L/min via TBar/Tmask (oxygen tracheostomy mask and T shaped connector to the tubing that is connected to the oxygen tank) every six hours. During a review of Resident 90`s CP on oxygen, initiated on 4/11/2023 and last revised on 2/26/2026, the CP indicated Resident 90 is receiving oxygen therapy due to respiratory failure and the goal is for Resident 90 to remain free of adverse effects related to use of oxygen daily. The CP intervention indicated to change the oxygen tubing weekly or as needed. During a concurrent observation and interview on 4/20/2026 at 10:44 a.m., with the ADON 2, inside Resident 90's room, Resident 90 was observed in bed receiving oxygen from the oxygen concentrator at 5 L/min via TBar/Tmask. Observed Resident 90's oxygen tubing was not dated. ADON 2 stated it was important to date the oxygen tubing so staff would know when the tubing is due for a change per policy and for infection control. During a concurrent interview and record review on 4/22/2026 at 11:00 a.m. with ADON 1, Resident 90's CP on oxygen initiated on 4/11/2023 and last revised on 2/26/2026, was reviewed. ADON 1 stated the CP indicated Resident 90 was receiving oxygen therapy due to respiratory failure. The care plan intervention indicated to change the oxygen tubing weekly or as needed. ADON 1 stated that licensed nursing staff should date the oxygen tubing to ensure the tubing is changed weekly and to help prevent infection. During a concurrent interview and record review on 4/22/2026 at 12:02 p.m. with the DON, the DON stated oxygen tubing should be dated and change weekly per facility policy to prevent infection. During a review of the facility's P&P titled Oxygen Administration, reviewed on 11/25/202, the P&P indicated oxygen will be administered to residents as needed per attending Physician's orders by Licensed personal. The oxygen tubing should be changed weekly and as needed. The date, time, and initials should be noted on oxygen equipment when it is initially used and when changed.During a review of the facility's policy and procedure(P&P) titled Changing Disposable Equipment, reviewed on 11/25/2025 the P&P indicated to minimize the risk of infection disposable equipment is for single patient use only and will be change as regularly scheduled and a PRN basis. 1.b.and 2.During a review of Residentˆ191'sˆFace Sheet, theˆFace Sheetˆindicated the facility originally admitted the residentˆon 10/23/2016ˆand re-admitted ˆtheˆresident on 2/20/2026, with diagnoses including hypertension (high blood pressure), chronic respiratory failure (long-term condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), and functional quadriplegia (complete loss of ability to move all four limbs-arms and legs). During a review of Residentˆ191's Minimum Data Setˆ(MDS - a resident assessment tool), datedˆ2/27/2026,ˆtheˆMinimum Data Set (MDS-resident assessment tool) indicated Residentˆ191's cognitive skills (mental abilities that enables a person to think, learn, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remember, and solve problems) was severely impaired. During a review of Resident 191'sˆPhysicianˆPhone OrderˆReport, the report indicated an order with a start date of 2/21/2026for for humidified (passed through water to add moisture) oxygen at 5 liters per minute (L/min, a unit of measurement for oxygen). The scheduling detail indicated routine every day, every 6 hours. During a review of Resident 191`s care plan (CP) on oxygen, initiated on 1/14/2021 and last revised on 4/04/2026, the CP indicated Resident 191 is receiving oxygen therapy due to respiratory failure and the goal is for Resident 191 to remain free of adverse effects related to use of oxygen daily. The CP indicated interventions to change oxygen weekly or as needed and provide oxygen as ordered. During a concurrent observation and interview on 4/20/2026 at 10:55 a.m., with Respiratory Therapist (RT 1), inside Resident 191's room, Resident 191 was observed in bed without oxygen in place (use), while the oxygen concentrator (a medical device that provides continuous supply of oxygen through a nasal cannula or mask) was on and delivering oxygen at 5 L/min; Resident 191's oxygen tubing was not connected to the oxygen concentrator. The oxygen tubing was lying on the left side of Resident 191, touching the pillow and was not dated. RT 1 confirmed the observation and stated that Resident 191 oxygen was not connected to Resident 191; the oxygen tubing was placed on the bed next to Resident 191 and not dated. RT 1 stated Resident 191 has a physician order for continuous oxygen, and the oxygen should have been connected to the resident to prevent a decrease in oxygen levels, which could result in respiratory distress. RT 1 further stated that the oxygen tubing is disposable and should be dated to ensure staff replace it every seven days and to allow staff to easily verify when the tubing was last replaced. During a concurrent observation and interview on 4/20/2026 at 10:55 a.m., with Respiratory Therapist (RT 1), inside Resident 191's room, Resident 191 was observed in bed without oxygen in place (use), while the oxygen concentrator (a medical device that provides continuous supply of oxygen through a nasal cannula or mask) was on and delivering oxygen at 5 L/min; the Resident 191's oxygen tubing (a flexible, clear hose that delivers oxygen to a patient during oxygen therapy) was not connected to the oxygen concentrator. The oxygen tubing was lying on the left side of Resident 191, touching the pillow and was not dated. RT 1 confirmed the observation and stated that Resident 191 oxygen was not connected to Resident 191; the oxygen tubing was placed on the bed next to Resident 191 and not dated. RT 1 stated Resident 191 has a physician order for continuous oxygen, and the oxygen should have been connected to the resident to prevent a decrease in oxygen levels, which could result in respiratory distress. RT 1 further stated that the oxygen tubing is disposable and should be dated to ensure staff replace it every seven days and to allow staff to easily verify when the tubing was last replaced.During an interview on 4/20/2026 at 10:58 a.m., with Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 191 is on continuous oxygen. CNA 1 stated she showered Resident at 8:45 a.m. today and forgot to ask a licensed staff to place Resident 191 back on oxygen. CNA 1 stated she was informed by RT 1 that Resident 191 is on continuous oxygen. CNA 1 stated Resident 191's oxygen saturation (measurement of oxygen in the blood) can go down and result in complications. During interview and record review on 4/21/2026 at 4:19 p.m., with RT 2, Resident 191's Physicianˆ Phone Orderˆ Report (PPOR), dated 2/21/12026,ˆwas reviewed. RT 2 stated the order indicated humidified oxygen at 5 L/min with the scheduling detail marked as routine. RT 2 stated routine mean Resident 191 should receive continuous oxygen at 5 L/min, and the every 6 hours instruction refers to documenting every 6 hours that the resident is receiving the oxygen. RT 2 stated if the order was intended to be administered every 6 hours, the scheduling detail would have been marked as PRN (as needed). RT 2 stated that continuous oxygen is important to prevent drops in oxygen levels, which could lead to respiratory distress. During a concurrent interview and record review on 4/22/2026 at 11:08 a.m. with ADON 1, Resident 191's CP report on oxygen, initiated on 1/14/2021 and last revised on 4/04/2026, was reviewed. ADON 1 stated the care plan indicated Resident 191 was receiving oxygen therapy due to respiratory failure and the CP interventions were to change oxygen tubing weekly or as needed and provide oxygen as ordered. ADON 1 stated, based on Resident 191's CP, Resident 191 should be receiving continuous (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen as ordered and the oxygen should be changed weekly and as needed. ADON 1 stated that licensed nursing staff should date the oxygen tubing, so they (nursing staff) know when it is due for change, and to prevent Resident 191 from developing an infection. ADON 1 stated Resident 191's CP interventions were not implemented. During an interview on 4/22/2026 at 12:02 p.m. with the DON, the DON stated the oxygen tubing should be dated and change weekly per facility policy to prevent infection.During a review of the facility's P&P titled Oxygen Administration, last reviewed on 11/25/2025, the P&P indicated oxygen will be administered to a resident as needed per attending Physician's orders by licensed personal. The oxygen tubing should be changed weekly and as needed. The policy indicated the date time and initials should be noted on oxygen equipment when it is initially used and when changed.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to maintain accurate and current daily nurse staffing postings for the Skilled Nursing Facility (SNF) and Subacute unit, in accordance with the facility's policy titled Posting Direct Care Daily Staffing Numbers. Specifically, the facility: 1. Failed to post the required daily staffing information for the SNF on 4/21/2026 and 4/22/2026. The form displayed on both dates was outdated and reflected 4/20/2026. 2. Failed to document and post the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care, per shift for 4/20/2026 on both the SNF and Subacute unit.3. Posted projected staffing hours labeled as Actual Hours Worked for the day, evening, and night shifts on 4/22/2026 in the Subacute unit.4. Completed the daily staffing forms in pencil, rather than black ink, for actual hours worked on 4/20/2026 and 4/22/2026 for both the SNF and Subacute unitThis deficient practice resulted in residents, visitors, and staff not having access to accurate and up-to-date staffing information, including the total number of staff on duty and the actual hours worked by licensed and unlicensed nursing personnel responsible for resident care. Findings: During a concurrent observation and interview on 4/22/2026 at 11:27 a.m. with the Director of Staff Development (DSD) in the SNF's Nurse's Station 1, a framed facility document titled Daily Staffing Posting, dated 4/20/2026, was observed posted. The DSD stated the form on display Daily Staffing Posting, is dated 4/20/2026 and it is the projected hours even though it is labeled as Actual Hours Worked and that the posting was missing the actual resident census and the actual total hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants for 4/20/2026 in the SNF and subacute unit. The DSD stated the facility's practice is to post projected nursing hours rather than actual hours, and the Accounts Payable/Payroll staff calculate actual hours on the following business day for filing. The DSD further stated the facility does not post the actual nursing hours worked by licensed and unlicensed nursing staff and who is responsible for resident care per shift and that she was not aware this was required. In addition, the DSD stated she did not post the nursing staffing information for 4/21/2026 and 4/22/2026 in the SNF area as required by facility policy. The DSD explained that she completes the sections for Date, Census at Start of Shift, Projected PPD, Actual Hours Worked, and staffing totals for both the SNF and Subacute unit using pencil for the date 4/20/2026.During a concurrent observation and interview on 4/22/2026 at 11:38 a.m. with the DSD in the Subacute Nurse's Station, a framed facility document titled Daily Staffing Posting, dated 4/22/2026, was observed posted. The DSD stated the form Daily Staffing Posting, in the section labeled Actual hours worked, for the day, evening, and night shifts in the Subacute unit was incorrect because it reflected projected hours rather than the actual hours worked by staff. The DSD confirmed that actual hours can only be entered after the shift is completed, and therefore the information posted for actual hours worked was inaccurate for 4/22/2026. The DSD explained that she completes the sections for Date, Census at Start of Shift, Projected PPD, Actual Hours Worked, and staffing totals for both the SNF and Subacute unit using pencil for 4/22/2026 for the subacute unit.During a concurrent observation and interview on 4/22/2026 at 11:44 a.m. with the Director of Nursing (DON) in Nurse's Station 1 of the SNF, a framed facility document titled Daily Staffing Posting, dated 4/20/2026, was observed posted. The DON stated that the staffing posting displayed was dated 4/20/2026 and that, according to facility policy, staffing must be posted daily. The DON stated Nurse's Station 1 of the SNF area is the designated area by the Administrator to post the form.During a concurrent interview and record review on 4/23/2026 at 10:14 a.m. with the DON, the Daily Staffing Posting dated 4/20/2026 was reviewed. The DON stated, the Daily Staffing Posting indicated a date of 4/20/2026. The DON stated that the nursing staffing information should be posted and updated daily within two hours of the beginning of each shift in Nursing Station 1, to inform the public of the total number of staff and the hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants for each shift in the SNF and the Subacute unit. The DON (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the DSD should have posted the staffing information for 4/21/2026 and 4/22/2026. The DON further stated the posting for 4/20/2026 was missing the actual resident census and the actual hours worked by licensed and unlicensed nursing staff. The DON reported the facility's practice is to post projected hours rather than actual hours.During concurrent interview and record review on 4/23/2026 at 10:20 a.m. with the DON, the Daily Staffing Posting dated 4/22/2026 was reviewed. The DON stated the Daily Staffing Posting dated 4/22/2026 indicated Actual Hours Worked for the day, evening, and night shifts in the Subacute unit. The DON stated the Actual Hours Worked was labeled incorrectly and it is projected hours. The DON stated actual hours worked cannot be entered prior to the shift's completion.During a concurrent interview and record review on 4/23/2026 at 10:28 a.m. with the DON, the facility's policy and procedure titled Posting Direct Care Daily Staffing Numbers was reviewed. The DON stated that based on the facility policy, the nursing staffing data must be posted daily within two hours of the beginning of each shift and must include the resident census and the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. The DON stated the facility did not follow policy, which resulted in residents, staff, and visitors being unable to determine how many staff worked on 4/21/2026 and 4/22/2026 in the SNF area. The DON stated the forms should have been completed in black ink rather than pencil to prevent any changes to the information, as required by policy.^ During a review of facility's policy and procedure titled, Posting Direct Care Daily Staffing Numbers, revised on 11/25/2025, the P&P indicated our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. 2). Directly responsible for resident care means that individuals are responsible for residents' total care or some aspect of the residents' care including but not limited to: assisting with activities of daily living (ADLs), administering medications, supervising care provided by CNAs, and performing nursing assessments. Medication aides, feeding assistants, hospice staff, private duty aides and administrative staff are not calculated in direct care staffing numbers. Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following:a. The name of the facility;b. The current date (the date for which the information is posted);c. The resident census at the beginning of the shift for which the information is posted;d. Twenty-four (24)-hour shift schedule operated by the facility.e. The shift for which the information is posted;f. Type (RN, LPN, L VN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff);g. The actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non-licensed nursing staff working for the posted shift.3) Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.4) The form may be typed or handwritten. If the information is handwritten, it must be legibly printed in black ink and written so that staffing data can be easily seen and read by residents, staff, visitors or others who are interested in our facility's daily staffing information.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review the facility failed to: 1.Have an available supply of oyster shell calcium (a medication used as a dietary supplement to provide support to bones) in the facility affecting 1 (one) of six (6) observed residents (Resident 87) for medication administration. As a result, Resident 87 did not receive oyster shell calcium on 4/21/2026 at 9:45 a.m. 2. Have an available supply of menthol-methyl salicylate cream (a medication used for pain) and glipizide (a medication used to lower blood sugar levels,) in the facility affecting 1 (one) of six (6) observed residents (Resident 201) for medication administration. As a result, Resident 201 did not receive menthol-methyl salicylate cream between 4/9/2026 and 4/20/2026 and did not received glipizide between 4/16/2026 and 4/20/2026. 3. Resident 84 did not have previous lidocaine (a medication used to relieve pain) topical (on the skin) patch removed 12 hours after application, for 1 (one) of six (6) observed residents for medication administration, as ordered by Resident 84's physician. These deficient practices had the potential to result in Resident 84 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and in Residents 87's and 201's health and well-being to be negatively impacted. Cross referenced with F759 and F760 Findings: During an observation on 4/20/2026 at 9:40 a.m., in Medication Cart Station 3, Licensed Vocational Nurse (LVN) 2 was observed removing a lidocaine five (5) % patch labeled 4/19/2026 with a black pen from Resident 84's right shoulder. During a concurrent interview, LVN 2 stated the lidocaine patch labeled 4/19/2026 was still on Resident 84's right shoulder that day (4/20/2026) at 9:40 a.m. LVN 2 stated lidocaine patches needed to be removed 12 hours after administration, per Resident 84's physician orders. LVN 2 stated LVN 5 failed to remove the lidocaine patch from Resident 84's right shoulder on 4/19/2025 at 9 p.m. LVN 2 stated not removing the lidocaine patch 12 hours after administration increases the risk of adverse effects, such as receiving too much medication, skin irritation and rash for Resident 84. LVN 2 stated LVN 2 will not administer the new patch and need to contact the physician and obtain any new orders as necessary. During an observation on 4/20/2026 at 10:10 a.m. in Medication Cart Station 3, LVN 2 was observed administering gabapentin (a medication used for nerve damage) and metformin (a medication used for high blood sugar level) orally to Resident 201. Resident 201 was observed swallowing the gabapentin and metformin tablets with a glass of water. LVN 2 was observed not administering glipizide (a medication used for high blood sugar levels) and menthol-methyl salicylate cream (a medication used for pain) to Resident 201. During a concurrent interview and record review on 4/20/2026 at 2:25 p.m. with LVN 2, LVN 2 reviewed Resident 201's April 2026 Medication Administration Record ([MAR] - a record of mediations administered to residents.) LVN 2 stated LVN 2 did not administer menthol-methyl salicylate and glipizide that day (4/20/2026) at 10:10 a.m. to Resident 201, as prescribed by Resident 201's physician, since menthol-methyl salicylate and glipizide were not available in Medication Cart Station 3 or in the facility. LVN 2 stated that medications should be ordered four (4) to seven (7) days in advance of last dose, and followed up as needed with pharmacy, to ensure timely availability of medications and prevent missing doses. LVN 2 stated menthol-methyl salicylate cream was a medication used to relieve pain and not administering can harm Resident 201 by not relieving the pain leading to worsening of the pain. LVN 2 stated glipizide was a medication used to control blood sugar levels and not administering and/or missing a dose could harm Resident 201 by causing high or low blood sugar levels, and unresponsiveness resulting in potential hospitalization. LVN 2 stated facility failed to ensure glipizide and menthol-methyl salicylate were readily available in the facility at time of scheduled dose, resulting in omission of doses for Resident 201. LVN 2 also acknowledged the April 2026 MAR indicated Resident 201 was not administered glipizide between 4/16/2026 and 4/20/2026. LVN 2 stated LVN 2 will follow up with pharmacy to expedite the refills and notify Resident 201's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician the morning doses were not administered and obtain additional orders as necessary. During an observation on 4/21/2026 at 9:45 a.m. in Medication Cart Subacute Cart 2, LVN 4 was observed administering amlodipine (a medication used for high blood pressure,) cholecalciferol (a medication used as a dietary supplement to provide support to bones,) docusate (a medication used for constipation,) polyethylene glycol (a medication used for constipation,) levetiracetam (a medications used for epilepsy,) potassium chloride (a medication used for low blood potassium levels,) and acetaminophen (a medication used for pain) via gastrostomy tube ([G-tube] - a tube inserted through the belly that delivers nutrition and medications directly to the stomach) to Resident 87, and was observed not administering oyster shell calcium to Resident 87. During an interview on 4/21/2026 at 10 a.m., with LVN 4, LVN 4 stated LVN 4 did not administer oyster shell calcium earlier at 9:45 a.m. to Resident 87, as prescribed by Resident 87's physician, since oyster shell calcium was not available in Medication Cart subacute Cart 2 or in the facility. LVN 4 stated that medications should be readily available in the facility to ensure timely administration at the scheduled times and prevent missed administration. LVN 4 stated oyster shell calcium was house supply (supply intended for facility resident use) medication used for bone strength and not administering can place Resident 87 at risk of osteoporosis (a condition with fragile bones and fractures.) During an interview on 4/21/2026 at 11:57 a.m., with the Director of Nursing (DON,) the DON stated per facility policies medications should be ordered seven (7) days in advance and be readily available in the facility for administration of doses at their scheduled times as prescribed. The DON stated that licensed nurses should follow medication administration guidelines and five (5) rights of medication administration to ensure physician orders were followed and medications were administered to residents as prescribed. The DON stated that LVN's were expected to re-order medications timely and follow-up on the refills to ensure medications were available to residents. During the same interview, the DON stated LVN 4 failed to administer oyster shell calcium to Resident 87 on 4/21/2026 at 9:45 a.m. since oyster shell calcium was not available in the facility. The DON stated that the DON was not notified that oyster shell calcium was unavailable for ordering as house supply and that the facility failed to notify the physician to obtain an alternate order of calcium for Resident 87. The DON added that LVN 2 failed to administer glipizide and menthol-methyl salicylate to Resident 201 on 4/20/2026 at 10:10 a.m. since glipizide and menthol-methyl salicylate were not available in the facility. The DON stated menthol-methyl salicylate was prescribed for pain and glipizide was prescribed for high blood sugar levels by Resident 201's physician, and not administering both medications can potentially harm Resident 201 by not relieving the pain and increasing or decreasing the blood sugar levels. The DON stated the facility failed to follow policy and procedures for medication reordering and administration resulting in significant medication errors, unavailability and interruption of medication administration and continuity of care for Resident 87 and 201, thereby increasing the risk of worsening pain, imbalance in blood mineral levels, uncontrolled blood sugar levels and potential hospitalization. During a concurrent interview and record review on 4/21/2026 at 3:48 p.m., the DON reviewed the Manifest records from pharmacy for the delivery of glipizide dated 3/13/2026 and electronic prescription transmission record for menthol-methyl salicylate cream dated 4/9/2026. The DON stated the Manifest indicated glipizide for Resident 201 was last delivered to the facility on 3/13/2026 with quantity 31 (a 31-day supply.) The DON acknowledged pharmacy had not provided additional manifests for glipizide for Resident 201. The DON acknowledged the facility had not received and pharmacy had not delivered glipizide since 3/13/2026 for Resident 201. The DON stated as a result, Resident 201 did not have a supply of glipizide for administration after the 31-day supply finished on 4/15/2026, therefore missing doses between 4/16/2026 and 4/20/2026. The DON stated there were no manifests or record of delivery for menthol-methyl salicylate cream from pharmacy. The DON acknowledged the facility had not received and pharmacy had not delivered menthol-methyl salicylate cream for Resident 201 since 4/9/2026. The DON stated as a result, Resident 201 did not have a supply of menthol-methyl salicylate cream for administration, therefore missing doses between (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/9/2026 and 4/20/2026. The DON stated that there was no consistent system in place to ensure timely re-ordering and follow-up of medications. The DON stated that the facility and pharmacy needed to create a better communication system to prevent these failures from affecting other residents in the future. During the same interview, the DON stated LVN 5 failed to remove the lidocaine patch from Resident 84's right shoulder on 4/19/2026 at 9 p.m. The DON stated leaving the lidocaine patch on the skin longer than 12 hours may place Resident 84 at risk for overdose (receiving more than the intended dose) and developing skin irritation. The DON stated that LVN's should follow facility medication administration guidelines and the five (5) rights of medication administration to ensure physician orders are followed. During a review of Resident 84's admission Record (a document containing demographic and diagnostic information,) dated 4/20/2026 the admission Record indicated Resident 84 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including multiple fractures. During a review of Resident 84's Order Summary Report (a report listing the physician order for the resident,) dated 4/19/2026, the report indicated Resident 84 was prescribed lidocaine patch 5 % apply to right shoulder in a.m. off at HS (bedtime) for pain management and remove per schedule, starting 2/25/2026. During a review of Resident 84's MAR for April 2026, the MAR indicated Resident 84 was prescribed lidocaine patch 5 % apply to right shoulder for pain management, to apply at 9 a.m. and remove at 9 p.m. During a review of Resident 87's admission Record, dated 4/21/2026, the record indicated Resident 87 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis including dysphagia (difficulty swallowing.) During a review of Resident 87's Order Summary Report, dated 4/20/2026, the report indicated Resident 87 was prescribed oyster shell calcium 500 MG one (1) tablet via G-tube once a day for supplement, starting 5/25/2024. During a review of Resident 87's MAR for April 2026, the MAR indicated Resident 87 was prescribed oyster shell calcium 500 MG one (1) tablet via G-Tube once a day for supplement, to give at 9 a.m. During a review of Resident 201's admission Record, dated 4/20/2026, the record indicated Resident 201 was originally admitted to the facility on [DATE] with a diagnosis including type two (2) diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control), and low back and right hip pain. During a review of Resident 201's Order Summary Report, dated 4/19/2026, the report indicated Resident 201 was prescribed glipizide 2.5 mg one (1) tablet orally once a day for DM Type 2, starting 1/13/2025, and menthol-methyl salicylate cream to left hand twice a day for left hand middle and ring finger pain, starting 4/9/2026. During a review of Resident MAR for April 2026, the MAR indicated Resident 201 was prescribed glipizide 2.5 mg one (1) tablet orally once a day for DM Type 2, to give at 9 a.m., and menthol-methyl salicylate cream to left hand twice a day for left hand middle and ring finger pain, to give at 9 a.m. and 5 p.m. During a review of the facility's Policy and Procedures (P&P,) titled Medication Administration -General Guidelines, last reviewed 11/25/2025, the P&P indicated: Medications are administered as prescribed in accordance with good nursing principles and practices. -Medications are administered in accordance with written orders of the attending physician. -The Individual who administers the medication dose records the administration on the resident's MAR after the medication is given. During a review of the facility's P&P titled Transdermal Drug Delivery System (Patch) Application, last reviewed 11/25/2025, the P&P indicated: Remove old patch from body and cleanse site if necessary. During a review of the facility's P&P titled Ordering and Receiving Medications from the dispensing Pharmacy, last reviewed 11/25/2025, the P&P indicated: Medications and related products are received from the dispensing pharmacy on a timely basis. 2.a. Reorder medications five days in advance of need to assure an adequate supply is on hand. During a review of the facility's P&P titled House-Supplied (Floor Stock) Medications, last reviewed 11/25/2025, the P&P indicated: The facility maintains a supply of commonly used over-the-counter medications considered as floor stock or house medications as permitted by state regulation. C. Floor stock medications are ordered from the provider/dispensing pharmacy or other provider according to facility policy. During a review of the facility's P&P titled Ordering of Supplies and Equipment, last reviewed 11/25/2025, the P&P indicated: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. If supplies are not available, the facility will make reasonable efforts including but are not limited to: Contact available resources for the requested items Notify the physician and provide alternatives as indicated. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, last reviewed 11/25/2025, the P&P indicated: 1. An ?adverse consequence' refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. Side effect; 2. The staff and practitioner strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication. During a review of facility provided lidocaine patch 5% medication package (unopened package containing medication,) the manufacturer indicated on the back of the package Apply the prescribed number of patches only once for up to 12 hours within a 24-hour period.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Four (4) medication errors out of 26 total opportunities contributed to an overall medication error rate of 15.38% affecting three (3) of six (6) residents observed for medication administration (Resident 84, 87 and 201.) The medication errors were as follows: 1.Resident 84 did not receive sevelamer (a medication used for hyperphosphatemia [having high blood levels of phosphate, a mineral] for people on dialysis [treatment that removes waste and excess fluid from the blood,]) on 4/20/2026, as prescribed by Resident 84's physician. 2. Resident 87 did not receive oyster shell calcium (a medication used as a dietary supplement to provide support to bones), on 4/20/2026, as prescribed by Resident 87's physician. 3.Resident 201 did not receive menthol-methyl salicylate cream (a medication used for pain) and glipizide (a medication used to lower blood sugar levels,) on 4/20/2026, as prescribed by Resident 201's physician. These failures had the potential for Residents 84, 87 and 201 to experience adverse effects (unwanted, uncomfortable, or dangerous effects,) and health complications such as continuous and unrelieved pain, uncontrolled blood sugar levels, and blood mineral imbalance resulting in Resident 84's, 87's and 201's health and well-being to be negatively impacted. Cross referenced with F755 and F760.Findings: During an observation on 4/20/2026 at 9:40 a.m., in Medication Cart Station 3, Licensed Vocational Nurse (LVN) 2 was observed administering amlodipine (a medication used for high blood pressure,) aspirin (a medication used for deep vein thrombosis [DVT - formation of one or more blood clots] prophylaxis [PPX - measures designed to preserve health,]) clopidogrel (a medication used for DVT PPX,) cranberry (a supplement used for urinary tract infection PPX,) gabapentin (a medication used for neuropathy [nerve damage,]) cinacalcet (a medication used for hypercalcemia [having high blood levels of calcium,) Rena Vite (a medication used for vitamin deficiencies for people on dialysis) tablets orally and Cosopt (a medication used for glaucoma [a condition of increased pressure in the eyeball,]) eye drops to Resident 84 . Resident 84 was observed swallowing the amlodipine, clopidogrel, cranberry, gabapentin, cinacalcet, Rena Vite tablets with a glass of water. LVN 2 was not observed administering sevelamer tablet orally to Resident 84. During an observation on 4/20/2026 at 10:10 a.m. in Medication Cart Station 3, LVN 2 was observed administering gabapentin and metformin (a medication used for high blood sugar level) orally to Resident 201. Resident 201 was observed swallowing the gabapentin and metformin tablets with a glass of water. LVN 2 was observed not administering glipizide (a medication used for high blood sugar levels) and menthol-methyl salicylate cream (a medication used for pain) to Resident 201. During an interview on 4/20/2026 at 2:25 p.m. with LVN 2, LVN 2 acknowledged that Resident 84's physician order specified to administer sevelamer at 9 a.m. LVN 2 stated that LVN 2 failed to follow five (5) rights of medication administration and failed to prepare and administer sevelamer as prescribed by Resident 84's physician that day (4/20/2026) at 9:40 a.m., even though LVN 2 documented as administered. LVN 2 stated omitting the administration of sevelamer to Resident 84 may not be beneficial to Resident 84's health and may cause adverse effects such as further imbalance of phosphate by increasing blood phosphate levels. LVN 2 stated this was considered a medication error. During the same interview, LVN 2 stated LVN 2 did not administer menthol-methyl salicylate and glipizide that day (4/20/2026) at 10:10 a.m. to Resident 201, as prescribed by Resident 201's physician, since menthol-methyl salicylate and glipizide were not available in Medication Cart Station 3 or in the facility. LVN 2 stated that medications should be ordered four (4) to seven (7) days in advance of last dose, and followed up as needed with pharmacy, to ensure timely availability of medications and prevent missing doses. LVN 2 stated missing administration of doses were considered medication errors. LVN 2 stated menthol-methyl salicylate cream was a medication used to relieve pain and not administering can harm Resident 201 by not relieving the pain leading to worsening of the pain. LVN 2 stated glipizide (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was a medication used to control blood sugar levels and not administering and/or missing a dose could harm Resident 201 by causing high or low blood sugar levels, and unresponsiveness resulting in potential hospitalization. LVN 2 stated the facility failed to ensure glipizide and menthol-methyl salicylate were readily available in the facility at time of scheduled dose, resulting in omission of doses and medication errors for Resident 201. LVN 2 stated LVN 2 will follow up with pharmacy to expedite the refills and notify Resident 201's physician the morning doses were not administered and obtain additional orders as necessary. During an observation on 4/21/2026 at 9:45 a.m. in Medication Cart Subacute Cart 2, LVN 4 was observed administering amlodipine (a medication used for high blood pressure,) cholecalciferol (a medication used as a dietary supplement to provide support to bones,) docusate (a medication used for constipation,) polyethylene glycol (a medication used for constipation,) levetiracetam (a medications used for epilepsy,) potassium chloride (a medication used for low blood potassium levels,) and acetaminophen (a medication used for pain) via gastrostomy tube ([G-tube] - a tube inserted through the belly that delivers nutrition and medications directly to the stomach) to Resident 87, and was observed not administering oyster shell calcium to Resident 87. During an interview on 4/21/2026 at 10 a.m., with LVN 4, LVN 4 stated LVN 4 did not administer oyster shell calcium earlier at 9:45 a.m. to Resident 87, as prescribed by Resident 87's physician, since oyster shell calcium was not available in Medication Cart subacute Cart 2 or in the facility. LVN 4 stated that medications should be readily available in the facility to ensure timely administration at the scheduled times and prevent missed doses. LVN 4 stated missing the administration of oyster shell calcium was an omission due to the medication not being available and was considered a medication error. LVN 4 stated oyster shell calcium was house supply (supply intended for facility resident use) medication used for bone strength and not administering can place Resident 87 at risk of osteoporosis (a condition with fragile bones and fractures.) During an interview on 4/21/2026 at 11:57 a.m., with the Director of Nursing (DON,) the DON stated per facility policies medications should be ordered seven (7) days in advance and be readily available in the facility for administration of doses at their scheduled times as prescribed. The DON stated that licensed nurses should follow medication administration guidelines and five (5) rights of medication administration to ensure physician orders were followed and medications were administered to residents as prescribed. The DON stated that LVN 2 failed to prepare and administer sevelamer to Resident 84, according to the physician orders, leading to an omission of the scheduled dose on 4/20/2026. The DON stated that not receiving a dose places Resident 84 at risk of having further increase in blood phosphate levels. The DON stated this was considered a medication error. During the same interview, the DON stated that LVN's were expected to re-order medications timely and follow-up on the refills to ensure medications were available to residents. The DON stated LVN 4 failed to administer oyster shell calcium to Resident 87 on 4/21/2026 at 9:45 a.m. since oyster shell calcium was not available in the facility. The DON stated this was considered a medication error. The DON stated that the DON was not notified that oyster shell calcium was unavailable for ordering as house supply, and that the facility failed to notify the physician to obtain an alternate order of calcium for Resident 87. During the same interview, the DON stated that LVN 2 failed to administer glipizide and menthol-methyl salicylate to Resident 201 on 4/20/2026 at 10:10 a.m. since glipizide and menthol-methyl salicylate were not available in the facility. The DON stated these were considered medication errors, and a significant error for not receiving glipizide. The DON stated menthol-methyl salicylate was prescribed for pain and glipizide was prescribed for high blood sugar levels by Resident 201's physician, and not administering both medications could potentially harm Resident 201 by not relieving the pain and increasing or decreasing the blood sugar levels. The DON stated the facility failed to follow policy and procedures for medication reordering and administration resulting in significant medication errors, unavailability and interruption of medication administration and continuity of care for Resident 84, 87 and 201, thereby increasing the risk of worsening pain, imbalance in blood mineral levels, uncontrolled blood sugar levels and potential hospitalization. During a review of Resident 84's admission Record (a (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document containing demographic and diagnostic information,) dated 4/20/2026 the admission Record indicated Resident 84 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including kidney (pair of organs responsible for filtering waste materials out of the blood) disease and dependence on dialysis. During a review of Resident 84's Order Summary Report (a report listing the physician order for the resident,) dated 4/19/2026, the report indicated Resident 84 was prescribed sevelamer 800 milligram ([mg-unit of measure of mass]) one (1) tablet orally three (3) times a day for hyperphosphatemia, starting 3/30/2026. During a review of Resident 84's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for April 2026, the MAR indicated Resident 84 was prescribed sevelamer 800 mg, one (1) tablet orally three (3) times a day for hyperphosphatemia, to give at 9 a.m. During a review of Resident 87's admission Record, dated 4/21/2026, the record indicated Resident 87 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis including dysphagia (difficulty swallowing.) During a review of Resident 87's Order Summary Report, dated 4/20/2026, the report indicated Resident 87 was prescribed oyster shell calcium 500 MG one (1) tablet via G-tube once a day for supplement, starting 5/25/2024. During a review of Resident 87's MAR for April 2026, the MAR indicated Resident 87 was prescribed oyster shell calcium 500 MG one (1) tablet via G-Tube once a day for supplement, to give at 9 a.m. During a review of Resident 201's admission Record, dated 4/20/2026, the record indicated Resident 201 was originally admitted to the facility on [DATE] with a diagnosis including type two (2) diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control), and low back and right hip pain. During a review of Resident 201's Order Summary Report, dated 4/19/2026, the report indicated Resident 201 was prescribed glipizide 2.5 mg one (1) tablet orally once a day for DM Type 2, starting 1/13/2025, and menthol-methyl salicylate cream to left hand twice a day for left hand middle and ring finger pain, starting 4/9/2026. During a review of Resident MAR for April 2026, the MAR indicated Resident 201 was prescribed glipizide 2.5 mg one (1) tablet orally once a day for DM Type 2, to give at 9 a.m., and menthol-methyl salicylate cream to left hand twice a day for left hand middle and ring finger pain, to give at 9 a.m. and 5 p.m. During a review of the facility's Policy and Procedures (P&P,) titled Medication Administration -General Guidelines, last reviewed 11/25/2025, the P&P indicated: Medications are administered as prescribed in accordance with good nursing principles and practices. 2.Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after). 1.The Individual who administers the medication dose records the administration on the resident's MAR after the medication is given. During a review of the facility's P&P titled Ordering and Receiving Medications from the dispensing Pharmacy, last reviewed 11/25/2025, the P&P indicated: Medications and related products are received from the dispensing pharmacy on a timely basis. 2.a. Reorder medications five days in advance of need to assure an adequate supply is on hand. During a review of the facility's P&P titled House-Supplied (Floor Stock) Medications, last reviewed 11/25/2025, the P&P indicated: The facility maintains a supply of commonly used over-the-counter medications considered as floor stock or house medications as permitted by state regulation. C. Floor stock medications are ordered from the provider/dispensing pharmacy or other provider according to facility policy. During a review of the facility's P&P titled Ordering of Supplies and Equipment, last reviewed 11/25/2025, the P&P indicated: 7. If supplies are not available, the facility will make reasonable efforts including but are not limited to: Contact available resources for the requested items Notify the physician and provide alternatives as indicated. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, last reviewed 11/25/2025, the P&P indicated: 1. An ?adverse consequence' refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. Side effect; 2. The staff and practitioner strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dose, administration, duration, and monitoring of the medication; 1. An adverse drug reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic and helpful effects of the drug; or any response to a medication that is noxious and unintended. 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medications errors include: a. Omission - a drug is ordered but not administered; b. Unauthorized drug- a drug is administered without a physician's order; 3. A significant medication-related error is defined as: b. Requiring hospitalization, or extending a hospitalization. f. Life threatening.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings: During an observation on 4/20/2026 at 10:10 a.m. in Medication Cart Station 3, Licensed Vocational Nurse (LVN) 2 was observed administering gabapentin (a medication used for neuropathy [nerve damage,]) and metformin (a medication used for high blood sugar level) orally to Resident 201. Resident 201 was observed swallowing the gabapentin and metformin tablets with a glass of water. LVN 2 was observed not administering glipizide (a medication used for high blood sugar levels) to Resident 201. During a concurrent interview and record review on 4/20/2026 at 2:25 p.m. with LVN 2, LVN 2 reviewed Resident 201's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record]) for April 2026. LVN 2 stated that LVN 2 did not administer glipizide that day (4/20/2026) at 10:10 a.m. to Resident 201, as prescribed by Resident 201's physician, since glipizide was not available in Medication Cart Station 3 or in the facility. LVN 2 stated that medications should be ordered four (4) to seven (7) days in advance of last dose, and followed up as needed with pharmacy, to ensure timely availability of medications and prevent missing doses. LVN 2 stated missing administration of doses was considered a medication error. LVN 2 stated glipizide was a medication used to control blood sugar levels and not administering and/or missing a dose could harm Resident 201 by causing high or low blood sugar levels and unresponsiveness resulting in potential hospitalization. LVN 2 acknowledged the April 2026 MAR indicated Resident 201 was not administered glipizide between 4/16/2026 and 4/20/2026. LVN 2 stated facility failed to ensure glipizide was readily available in the facility at time of scheduled doses, resulting in omission of doses between 4/16/2026 and 4/20/2026 and medication errors for Resident 201. LVN 2 stated LVN 2 will follow up with pharmacy to expedite the refills and notify Resident 201's physician the morning dose was not administered and obtain additional orders as necessary. During a concurrent interview and document review on 4/21/2026 at 11:57 a.m., with the Director of Nursing (DON,) the DON reviewed Resident 201's April 2026 MAR. The DON stated per facility policies medications should be ordered seven (7) days in advance and be readily available in the facility for administration of doses at their scheduled times as prescribed. The DON stated LVN's are expected to re-order medications timely and follow-up on the refills to ensure medications were available to residents. The DON stated that LVN 2 failed to administer glipizide to Resident 201 on 4/20/2026 at 10:10 a.m. since glipizide was not available in the facility. The DON stated glipizide was prescribed for high blood sugar levels by Resident 201's physician, and not administering can potentially harm Resident 201 by increasing or decreasing the blood sugar levels. The DON acknowledged the April 2026 MAR indicated Resident 201 was not administered glipizide between 4/16/2026 and 4/20/2026. The DON stated not administering glipizide since 4/16/2026 were considered significant medication errors. The DON stated the facility failed to follow policy and procedures for medication reordering and administration resulting in significant medication errors, unavailability and interruption of medication administration and continuity of care for Resident 201, increasing the risk of uncontrolled blood sugar levels and potential hospitalization. During a concurrent document review and interview on 4/21/2026 at 12:17 p.m. with Registered Nurse (2,) RN 2 reviewed Resident 201's April 2026 MAR. RN 2 acknowledged the documentation on the MAR between 4/16/2026 and 4/20/2026 indicated that glipizide was not administered to Resident 201. RN 2 stated not administering glipizide daily to Resident 201 between 4/16/2026 and 4/20/2026 were considered significant medication errors. During a review of Resident 201's admission Record (a document containing demographic and diagnostic information,) dated 4/20/2026, the record indicated Resident 201 was originally admitted to the facility on [DATE] with a diagnosis including DM Type 2 and low back and right hip pain. During a review of Resident 201's Order Summary Report (a report listing the physician order for the resident,) dated 4/19/2026, the report indicated Resident 201 was prescribed glipizide 2.5 mg one (1) tablet orally once a day for DM Type 2, starting 1/13/2025, and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	menthol-methyl salicylate cream to left hand twice a day for left hand middle and ring finger pain, starting 4/9/2026. During a review of Resident MAR for April 2026, the MAR indicated: 1.Resident 201 was prescribed glipizide 2.5 mg one (1) tablet orally once a day for DM Type 2, to give at 9 a.m. 2. Glipizide 2.5 mg was documented as not administered daily by several licensed vocational nurses between 4/16/2026 and 4/20/2026. During a review of the facility's Policy and Procedures (P&P,) titled Medication Administration -General Guidelines, last reviewed 11/25/2025, the P&P indicated: Medications are administered as prescribed in accordance with good nursing principles and practices. Medications are administered in accordance with written orders of the attending physician. 2. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after). 10. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, last reviewed 11/25/2025, the P&P indicated: 1. An ?adverse consequence' refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. Side effect; 2. The staff and practitioner strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; 1. An adverse drug reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic and helpful effects of the drug; or any response to a medication that is noxious and unintended. 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medications errors include: a. Omission - a drug is ordered but not administered; b. Unauthorized drug- a drug is administered without a physician's order; 3. A significant medication-related error is defined as: b. Requiring hospitalization, or extending a hospitalization. f. Life threatening.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to: 1.Remove and discard from use one (1) expired latanoprost (a medication used for glaucoma [a condition of increased pressure in the eyeball]) eye drop bottle for Resident 26, in accordance with manufacturers' requirements and facility policies, in one (1) of five (5) inspected medication carts (Medication Cart 2B). 2. Label one (1) levalbuterol (a medication used to treat and prevent shortness of breath) inhalation solution foil pouch (a package made of foil protecting the inhalation solution from light and degradation) with a date open for Resident 99, in accordance with the manufacturer's requirements in one (1) of five (5) Medication Carts (Medication Cart 1B.) These deficient practices increased the risk that Residents 26 and 99 could have received medications that had become ineffective or toxic due to improper storage or labeling, accidentally used due to improper labeling, possibly leading to health complications resulting in infections, hospitalization or death. Cross referenced to F880.Findings: During an observation on 4/20/2026 at 12:10 p.m., in Medication Cart 1B with Licensed Vocational Nurse (LVN) 14, the following medication was found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: One (1) open levalbuterol inhalation solution foil pouch for Resident 99, was found stored at room temperature and not labeled with a date indicating when the foil pouch was opened. According to the manufacturer's product storage and labeling, opened foil pouch of levalbuterol inhalation solutions should be stored between 68 to 77 degrees Fahrenheit and once the foil pouch is opened to be used within two (2) weeks. During a concurrent interview, LVN 14 stated the levalbuterol inhalation solution foil pouch for Resident 99 in Medication Cart station 1B was not labeled with a date indicating when the foil pouch was opened. ˆLVN 14 stated that per facility policy multi-dose (containing more than one dose) products such as inhalation solutions should be labeled with the date when first opened to know when they expire.ˆ LVN 14 stated that expired medications have lost potency (strength) and will not be effective in treating residents' condition, in this case wheezing. LVN 14 stated according to the manufacturer guidelines, the inhalation solutions should be used within two (2) weeks of opening the pouch.ˆ LVN 14 stated LVN 14 was unaware when the pouch was opened therefore unaware when it would expire.ˆ LVN 14 stated failing to record the date of first use could lead to Resident 99 receiving potentially expired and ineffective levalbuterol. ˆLVN 14 stated this could cause Resident 99 harm by not treating or preventing the wheezing (whistling sound during breathing when airways are narrowed, inflamed, or blocked making it difficult for air to move freely) and bronchospasm (a condition where airways are narrowed making breathing more difficult) requiring immediate treatment and potential transfer toˆthe hospital. During an observation on 4/20/2026 at 12:50 p.m., in Medication Cart 2B, with Licensed Vocational Nurse (LVN) 12 the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, and/or not removed/discarded from use: One (1) open latanoprost eye drop bottle for Resident 26 was found stored at room temperature and labeled with a date indicating use began on 3/1/2026, and pharmacy instructions printed on the bottle indicating to discard unused portion after 28 days. According to the manufacturer's product storage and labeling, opened latanoprost bottles may be stored at room temperature up to 77 degrees Fahrenheit and used or discarded within six (6) weeks of opening/use. During a concurrent interview, LVN 12 stated that the latanoprost eye drop bottle was not stored properly for Resident 26.ˆ LVN 12 stated multi-dose (containing more than one dose) medications, such as eye drop bottles, have a shorter expiration date once opened, than the one printed on the bottle by the manufacturer. LVN 12 stated the label on the bottle indicated the bottle was opened on 3/1/2026 and that to discard after 28 days.ˆ ˆLVN 12 stated that eye drop medications used beyond the 28-day expiration date have lost (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potency (effectiveness,) maybe contaminated (contain bacteria) and will not be effective in treating the residents' glaucoma, in addition to causing eye infections because of loss of sterility (free from bacteria.)ˆ LVN 12 stated the latanoprost eye drop bottle was used between 3/1/2026 and 4/19/2026, placing Resident 26 at increased risk of experiencing adverse effects (unwanted, uncomfortable, or dangerous effects,) not effectively treating the glaucoma, causing further nerve damage, infections, and potential blindness.ˆ LVN 12 stated medications that are expired must be removed from the medication cart to prevent accidental use. LVN 12 stated the latanoprost bottle was expired and needed to be immediately removed from the medication cart and discarded to prevent further use and replaced with a new one from pharmacy. During a concurrent interview and record review on 4/21/2026 at 3:48 p.m., with the Director of Nursing (DON,) the DON stated eye drop bottles were considered multi-dose medications and opened latanoprost bottles had six (6) week expiration dates to ensure the medication was potent, sterile and not contaminated. The DON stated the latanoprost eye drop bottle for Resident 26 was opened on 3/1/2026 and expired on 4/12/2026 and was not removed from use from medication Cart 2B on 4/12/2026. The DON stated this failure led to the administration of expired and ineffective latanoprost to Resident 26 between 4/13/2026 and 4/19/2026, increasing the risk of not effectively treating the glaucoma, and leading to eye nerve damage, infections and possible blindness. The DON stated that severed licensed nurses failed to remove expired latanoprost for Resident 26 from Medication Cart 2B. During the same interview, the DON stated that breathing inhalation solutions stored in foil pouches should be labeled with a date when removed from pouch to know when the beyond use date is (a date identifying an expiration date after opening a multi-dose product,) otherwise unable to determine the expiration date. The DON stated once the pouch was opened, the inhalation solutions expire within two (2) weeks. The DON stated that expired inhalation treatments have lost effectiveness and when administered in error will not treat wheezing or bronchospasm further causing breathing difficulty for Resident 99 requiring immediate treatment and hospitalization. During a review of the facility's policy and procedures (P&P,) titled Storage of Medications, last reviewed 11/25/2025, the P&P indicated: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. M. Outdated, contaminated, or deteriorated medications.are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exist. During a review of the facility's P&P titled Procedures for All Medications, last reviewed 11/25/2025, the P&P indicated: E. When opening a multi-dose container, place the date on the container. During a review of the facility's P&P, titled Guide for Special Handling of Medications, last reviewed 11/25/2025, the P&P indicated: Ophthalmic preparations - discard 28 days after opening. Expiration date may vary per manufacturer's recommendations. Xopenex (brand name for levalbuterol) - discard 2 weeks after opening the foil pouch. During a review of manufacturer's guide Highlights of Prescribing Information for latanoprost dated January 2023, the guide indicated Protect from light. Store unopened bottle(s) under refrigeration at 36 to 46 F. Once a bottle is opened for use, it may be stored at room temperature up to 77 F for 6 weeks. During a review of manufacturer's guide Highlights of Prescribing Information for levalbuterol inhalation dated July 2019, the guide indicated ?Store Levalbuterol Inhalation Solution, USP in the protective foil pouch at 20 - 25 C (68 - 77 F). Once the foil pouch is opened, the vials should be used within 2 weeks.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved appearance, flavor and temperature when: 1.Cold foods were not served cold and capri blend vegetables were squashed and brownish green in color for lunch meal on 4/20/2026.2. Foods not served at palatable temperatures for breakfast time on 4/22/2026.These failures had potential to result in 103 of 125 facility residents including Resident 76, Resident 130, and Resident 169 at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: During a review of Resident 76's Face Sheet, the Face Sheet indicated the facility admitted Resident 76 on 4/18/2025 with diagnosis including, but not limited to, essential hypertension (HTN, high blood pressure), type two diabetes (increased of blood sugar due to insulin resistance), and dysphagia (difficulty swallowing). During a review of Resident 76's Minimum Data Sheet (MDS- a resident assessment tool) dated 10/21/2025, the MDS indicated Resident 76 understood others and make self-understood. The MDS indicated Resident 76 needed supervision or touching assistance (helper provides verbal cues and or touching or steadying and or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently) when eating. During a review of Resident 76's Order Summary Report, dated 4/18/2026, the report indicated Resident 76 was ordered consistent carbohydrate (same amount of carbohydrate each meal), no added salt (NAS, no salt packet on the tray), regular texture, thin consistency (no modification with texture and consistency). During a resident council meeting interview on 4/21/2026 at 11:03 a.m., Resident 76 stated the breakfast sausage was cold and pink inside and the food has been cold lately. Resident 76 stated the breakfast, and lunch has been coming out later lately and they did not receive lunch until 2:00 p.m. today. Resident 76 stated the food quality has been low. During a review of Resident 130's Face Sheet, the Face Sheet indicated the facility admitted Resident 130 on 3/26/2010 with diagnoses including, but not limited to, essential HTN, type 2 diabetes, and hyperlipidemia (high fats in the blood). During a review of Resident 130's MDS dated [DATE], the MDS indicated Resident 130 understood others and make self-understood. The MDS indicated Resident 130 needed set up and clean up assistance (helper sets up and cleans up, resident completes activity. Helper assists only prior to or following the activity) when eating. During a review of Resident 130's Order Summary Report, dated 3/25/2026, the report indicated Resident 130 was ordered CCHO, soft-bite size level 6 (foods that are tender, moist that does not require chewing before swallowing. Foods must be cut into small pieces no larger than 1.5 centimeters x 1.5 centimeters), thin consistency, okay to have regular bread, bread-like products and baked goods. During a resident council meeting interview on 4/21/2026 at 11:03 a.m., Resident 130 stated foods were served cold at different times. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Winter Menus, dated 4/20/2026, the spreadsheet indicated residents on regular and therapeutic diets would include the following foods on the tray: -Baked hamburger three (3) ounces (oz, a unit of measurement) -Brown sauce 1 oz -Diced Fried Potatoes 1/2 cup (c, a household measurement) -Capri blend vegetables 1/2 c -Wheat roll 1 pc -Margarine 1 teaspoon -Spring Fruit crisp 3x2 1/2 inch -Milk 4 oz During an observation on 4/20/2026 at 1:10 a.m., observed fruit cup, pudding and spring fruit were out on trayline (an area where foods were assembled from the steamtable to resident's plate), with no ice. During a concurrent observation and interview on 4/20/2026 at 1:26 p.m., of the trayline with the Dietary Supervisor (DS), observed the following temperature of the cold foods: -Pudding 59.7 F -Fruit cup 54.8 F -Spring fruit crisp 67 F The DS stated, these are not cold items. The DS stated since the cold foods have been out of the refrigerator and not on ice, foods would not be served cold the residents affecting the quality of food. The DS stated cold food must be served cold and it should be 40 F and below. The DS stated residents would not be satisfied and happy and would not eat the food if the cold foods were not served cold. The DS (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the residents could potentially lose weight from not eating the food. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 4/20/2026 at 2:18 p.m., with the DS, observed the DS take the temperature of the following foods with the resulting temperatures: -Milk 48 F -Spring fruit crisp 70 F The DS stated the temperature of cold foods needs to improve as residents would not eat the food if it were not in palatable temperatures. The DS stated the capri blend vegetables looked mushed and brownish green in color because it was overcooked. The DS stated the presentation of the vegetables and the way it was cooked needs improvement as residents could lose weight and would not get the vitamins and nutrients that they need from over cooking the vegetables. The DS stated the vegetables needed to be colorful, green or light green and not overcooked to prevent losing vitamins from cooking. During a review of Resident 169's Face Sheet, the Face Sheet indicated the facility initially admitted Resident 169 on 4/19/2024 and readmitted on [DATE] with diagnoses including, but not limited to, Parkinson's disease (progressive brain disorder that causes nerve cells to breakdown, resulting to loss of dopamine [a chemical needed for smooth, coordinated muscle movement), Vitamin B12 deficiency anemia (a condition where the body lacks enough healthy red blood cells due to storage of vitamin B12 [vitamin necessary to produce red blood cells that carry oxygen]), major depressive disorder (a mental health condition characterized by a persistent feeling of deep sadness, emptiness, or loss of interest in activities for at least two weeks). During a review of Resident 169's MDS dated [DATE], the MDS indicated Resident 169 understood others and make self-understood. The MDS indicated Resident 169 needed set up and clean up assistance when eating. During a review of Resident 169's Order Summary Report, dated 9/5/2025, the report indicated Resident 169 was ordered regular diet, regular texture (diet with no restriction), thin consistency, large portion to increase calorie needs (adding extra food on a standard tray) During a resident council meeting interview on 4/21/2026 at 11:03 a.m., Resident 169 stated most of the time breakfasts were served cold. During a review of the facility's menu spreadsheet titled Winter Menus, dated 4/22/2026, the spreadsheet indicated residents on regular and therapeutic diets would include the following foods on the tray: -Blended juice 4 oz -Oatmeal 3/4 c -Breakfast meat 1 oz -Waffles (4-5 inches), 1 piece -Strawberry topping 1/4 c -Warm syrup and margarine 1 tsp -Parsley sprig -Milk 8 oz During concurrent test tray and interview on 4/22/2026 at 9:14 a.m., of regular diet with the DS and the Registered Dietitian (RD), observed the DS take the temperature of the following foods using the facility thermometer with the following readings: -Sausage 88 F -Waffles 95 F -Oatmeal 130 F -Whole milk 45 F The DS stated the food could be hotter and they have a delayed trayline today because of additional requests from the residents making the food not hot. The RD stated it was important to have the meals on time to prevent resident's dissatisfaction and to keep the temperature in palatable temperatures. During a review of the facility's policies and procedures (P&P) titled, Food Preparation Policy, dated 11/25/2026, the P&P indicated, Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value.All foods will be prepared by methods that preserve nutritive value, flavor, and appearance, and will be attractively served at a proper temperature and in a form to meet individual needs of the resident.11. Hold food for the shortest time possible before service. Do not hold food for more than 2 hours. Hot food must be more than or equal to 140 F and cold food less than or equal to 40 F. During a review of the facility's P&P titled, Food Preparation of Vegetables and Fruits, dated 11/25/2025, the P&P indicated, Fruits and vegetables will be prepared to conserve the nutritive value, enhance flavor, and appearance and to prevent foodborne illnesses.3) [NAME] vegetables in small amount of water and for the shortest time possible. Avoid overcooking and long holding. 4) Prepare vegetables as close to the meal as possible.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs when pureed capri blend vegetables looked flat and spread on the plate and puree spring fruit crip was watery and did not hold its shape. These failures had the potential to result in difficulty in swallowing, difficulty in eating, decrease in food and nutrient intake to 21 of 21 residents on puree diet (foods that are soft, pudding like consistency and hold its shape), resulting in unintended (not planned) weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of the facility's cook spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Winter Menus, dated 1/12/2026, the spreadsheet indicated residents on puree diet/International Dysphagia Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4 would include the following foods on the tray: -Pureed baked hamburger 1/2 cup (c, a household measurement) -Pureed brown sauce 1 ounce (oz, a unit of measurement) -Pureed boiled potatoes 1/2 c -Pureed capri blend vegetables 1/3 c -Pureed wheat roll 1/4 c -Margarine 1 test -Pureed spring fruit crisp 1/4 c -Milk 4 oz During an observation on 4/20/2026 at 1:38 p.m., of puree food plated on the plate of residents, observed the pureed capri vegetables looked flat and spread out on the plate. Observed no spoon tilt test (a test used to assess the cohesiveness and stickiness of foods) or fork pressure test (a test used to assess the firmness and texture of food by applying pressure with the tines of the fork) was performed during trayline (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving]) by the kitchen staff. During an observation on 4/20/2026 at 2:08 p.m., of the trayline, there were no observations of staff performing spoon tilt test or fork pressure test on pureed foods all during the trayline lunch service. During a concurrent observation and interview on 4/20/2026 at 2:36 p.m. of the puree tray with the Dietary Supervisor (DS), the DS stated the pureed capri blend vegetables did not hold its shape on the plate and the puree spring fruit crisp looked watery. The DS stated the pureed food should not look flat on the plate and watery as the residents could choke and aspirate (accidental breathing in of food and liquid into the airway and lungs) as a potential outcome of improper puree texture and consistency. During an interview on 4/22/2026 at 8:17 a.m., with the Registered Dietitian (RD), the RD stated they follow IDDSI standards with the diet and staff should perform spoon tilt test and fork pressure tests when they make the food and during trayline to make sure they serve the right texture for the residents with difficulty swallowing and eating eat safely. During a concurrent review and interview on 4/22/2026 at 8:27 a.m., of the puree tray picture taken at lunch time at 4/21/2026 with the RD, the RD stated based on the picture, the food held its shape on the plate for pureed tray however the pureed capri blend vegetables could have been in better shape because it was possible for the heat in trayline to make the food lose its structure. The RD stated the spring fruit crisp was holding a mount, but it was possible to be a little liquid-y because fruits have a lot of liquid naturally. The RD stated she would have the staff add some thickener and have them remake the puree vegetables and dessert. The RD stated that after reviewing the picture visually, the puree food in trays should not be served to the residents. The RD stated it was important to make sure they serve the residents the right texture so that they could eat safely, especially for residents with difficulty swallowing and chewing. During a review of the facility's Diet Manual titled, IDDSI Level 4L Regular Pureed Diet, dated 11/25/2025, the manual indicated, The pureed diet has been designed for resident who have difficulty chewing and/or swallowing. The texture of the pureed food items included in this diet should be smooth and free of lumps, hold their shape, while not being too firm or sticky, and should not weep. Detailed recipes and procedures for pureeing food may be found in Book 1, under the Food Safety/Miscellaneous section. During a review of the facility's recipe titled, Recipe: Pureed (IDDSI Level #4) Vegetables, dated 11/25/2025, the P&P indicated, 5. Finished puree items should be smooth (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. During a review of the facility's recipe titled, Recipe: Pureed (IDDSI Level 4) Fruit, dated 11/25/2025, the recipe indicated, 3. The finished pureed items should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and fork drip test.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide residents' meals at regular times scheduled in accordance with resident needs, preferences, and requests when lunch was served late on 4/22/2026.This deficient practice had the potential to result in hunger and frustration for 124 to 125 residents receiving meals from the kitchen, including Resident 76 and Resident 88. Findings:1. During a review of Resident 76's Face Sheet, the Face Sheet indicated the facility admitted Resident 76 on 4/18/2025 with diagnoses including, but not limited to, essential hypertension (HTN, high blood pressure), type two diabetes (increased of blood sugar due to insulin resistance), and dysphagia (difficulty swallowing).During a review of Resident 76's Minimum Data Sheet (MDS- a resident assessment tool) dated 10/21/2025, the MDS indicated Resident 76 understood others and make self-understood. The MDS indicated Resident 76 needed supervision or touching assistance (helper provides verbal cues and or touching or steadying and or contact guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently) when eating. During a review of Resident 76's Order Summary Report, dated 4/18/2026, the report indicated Resident 76 was ordered consistent carbohydrate (CCHO, same amount of carbohydrate each meal), no added salt (NAS, no salt packet on the tray), regular texture, thin consistency (no modification with texture and consistency).During a resident council meeting interview on 4/21/2026 at 11:03 a.m., Resident 76 stated the breakfast sausage was cold and pink inside and the food has been cold lately. Resident 76 stated that breakfast and lunch had been arriving late recently and they did not receive lunch until 2:00 p.m. today, and that the quality of food had been poor. During a review of Resident 88's Face Sheet, the Face Sheet indicated the facility admitted Resident 88 on 3/31/2026 with diagnoses including, but not limited to, essential HTN, hyperlipidemia (high fat in the blood), and congestive heart failure (progressive condition where the heart muscle cannot pump blood efficiently enough to meet body's needs).2. During a review of Resident 88's MDS dated [DATE], the MDS indicated Resident 88 understood others and make self-understood. The MDS indicated Resident 88 needed supervision or touching assistance when eating. During a review of Resident 88's Order Summary Report, dated 4/18/2026, the report indicated Resident 88 was ordered CCHO, NAS, regular texture, thin consistency, double protein, double non-starchy vegetables and no starches and grains.During a resident council meeting interview on 4/21/2026 at 11:03 a.m., Resident 88 stated lunch did not arrive until nearly 2:00 p.m. the other day. During an interview on 4/20/2026 at 8:53 a.m., with the Assistant Dietary Supervisor (ADS), the ADS stated the breakfast trayline (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates) duration is one (1) hour During an observation on 4/20/2026 at 8:54 a.m. of the meal schedule posted in the hallway, observed a sign that indicating the following meal schedule: Breakfast 7:30 a.m. Lunch 12:30 p.m. Dinner 5:30 p.m.During an observation on 4/20/2026 at 9:14 a.m., of the breakfast trayline service, staff were observed to have finished the breakfast trayline.During an observation on 4/20/2026 at 12:48 p.m., dietary staff were observed starting the lunch trayline service.During an observation on 4/20/2026 at 12:58 p.m., of the lunch tray line service, staff were observed pushing the first cart containing food trays to the dining room. During an observation on 4/20/2026 at 2:08 p.m., of the trayline lunch service, staff were observed to have finished the lunch trayline.During an observation on 4/20/2026 at 2:10 p.m. staff were observed staff the last tray cart out of the kitchen, which arrived at Station 1 at 2:11 p.m.During an observation on 4/20/2026 at 2:14 p.m., of nursing staff passing food trays, nursing staff were observed serving the first tray to a resident at bedside.During an observation on 4/20/2026 at 2:18 p.m., of nursing staff passing food trays, nursing (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff were observed serving the last tray in the cart to a resident at bedside. During an interview on 4/21/2026 at 2:48 p.m. with the Dietary Supervisor (DS), the DS stated the meal schedule for breakfast is at 7:30 a.m., lunch at 12:30 p.m., and dinner at 5:30 p.m.During an observation on 4/22/2026 at 7:33 a.m., of the breakfast trayline service, staff were observed starting the trayline service.During a concurrent observation and interview on 4/22/2026 at 7:56 a.m., of the breakfast service with [NAME] 2, observed staff pushed the first cart of food out of the kitchen. [NAME] 2 stated the breakfast trayline runs from 7:30 a.m. to 8:30 a.m.During an observation on 4/22/2026 at 9:04 a.m., staff were observed preparing the last breakfast tray.During an observation on 4/22/2026 at 9:06 a.m., observed the tray cart arrived at Station 3.During an observation on 4/22/2026 at 9:07 a.m., of the nursing staff's process for checking meal trays, a nursing staff was observed checking the trays against the diet type report to ensure accuracy of the meals.During an observation on 4/22/2026 at 9:10 a.m., of the nursing staff's process for checking meal trays, nursing staff were observed finishing the tray checks and passing the meal trays to residents in their rooms. During an observation on 4/22/2026 at 9:13 a.m., observed the nursing staff pass the last tray to a resident's room.During an interview on 4/22/2026 at 9:14 a.m., with the DS and Registered Dietitian (RD), the DS stated that the trayline was delayed today because there was a lot of food production for special requests from residents. The DS stated the residents were requesting extra omelet. The DS stated the first cart should come out at 7:30 a.m. but it came out ten (10) minutes late. The DS stated the trayline lasted for an hour and the delay was not reasonable, and the staff could do better. The DS further stated the meals should be served on time because residents expect it at a certain time. The RD stated it was important for meals to come on time to prevent resident dissatisfaction and to keep food temperatures palatable. During a review of the facility's policies and procedures P&P titled Meal Service, dated 11/25/2025, the P&P indicated, Resident meals will be served in a standard manner at regular hours with maximum if fourteen hours between the evening meal and breakfast the following day. Residents may also choose at the discretion of the Dietary Services Supervisor and Administrator individual mealtimes. An unavoidable variance of fifteen minutes will be considered acceptable. This is to facilitate routine and optimum resident nourishment.Time schedule: breakfast: 7:30-8:30 a.m.; lunch 12:30-1:30p.m., and dinner 5:30-6:30 p.m.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. A personal iced drink with a straw was stored in the pitcher storage area.2. Kitchen staff failed to perform handwashing when:a. Dietary Aide 1 (DA 1) sneezed and touched his hair, then proceeded to work on the trayline (an area where food is assembled from the steamtable [kitchen appliance that keeps food warm at a safe serving temperature] onto resident's plates) without washing his hands.b. DA 1 transitioned from handling dirty items to clean items in the pot sink area without washing his hands.c. [NAME] 2 touched the lid of the trash can and then handled a pan containing pureed sausages without washing her hands. 3. Refrigerator and freezer temperature monitoring was not consistently performed when: a. The refrigerator and freezer temperature log contained no documented temperature records for 4/13/2026 and 4/19/2026.b. The resident's freezer located by Station 1 did not contain a thermometer, and staff did not monitor the freezer temperature. 4. Kitchen equipment and utensils were not maintained free from dirt, dust and food debris when:a. The reach-in refrigerator contained dried food spills, gelatin residue, dust and dirt debris.b. Dry storage shelves contained dirt, dust particles and debris.c. Sugar, rice and cereal containers in the dry storage area contained food residue, dust and dirt debris.d. Mixer contained whipped cream debris and had not been cleaned after use.e. The vent near the preparation area contained accumulated dirt and dust.f. Black condiment containers located by the trayline contained accumulated sugar, pepper, salt and artificial sweeteners debris.g. The residents' refrigerator located at Station 1 contained food spills.5. Seven (7) dented cans (a hallow, dip, or depression on a surface, caused by blow, impact or pressure) were stored together with non-dented cans in the food storage area. 6. Resident's trays were not air-dried during the lunch trayline process and [NAME] 2 reused a paper towel to wipe the towels dry. 7. Soap splashes were observed in the clean drying area where pans were drying, creating the potential for cross-contamination.8. Staff failed to follow the manufacturer's guidelines for the use and testing of quaternary ammonium (QUAT, a common chemical cleaner used to kill germs, bacteria and viruses) sanitizer when:a. Dietary Aide 1 (DA 1) did not immerse the pots and pans in the sanitizer sink for the required 60 seconds b. DA 1 did immerse the QUAT test strips in the testing solution for the required 15 seconds and did not check the temperature of the testing solution. The Testing solution temperature was not maintained between 65 degrees Fahrenheit (F, a scale of temperature) to 75 F, as required.c. [NAME] 2 failed to sanitize the Robo Coupe (a high-performance food processor for chopping, mixing, pureeing, and blending large quantities of food) after each use.These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one surface, object, or substance to another) which could lead to foodborne illness (an illness caused by consuming contaminated food or beverages) for 124 of 125 medically compromised residents who received food and ice from the kitchen. Findings: 1. During an initial kitchen tour observation on 4/20/2026 at 8:19 a.m., of the pitcher storage area near the trayline, an iced brown drink with a straw was observed.During an interview on 4/20/2026 at 9:20 a.m., with the Dietary Supervisor (DS), the DS stated the iced drink with a straw by the pitcher storage area was not acceptable because eating and drinking was not allowed in the kitchen as part of the facility's policy. The DS stated dietary staff could not drink or eat in the kitchen as their saliva could potentially contaminate the food causing cross-contamination. The DS stated residents could develop foodborne illness as a potential outcome of cross-contamination. During a review of the facility's P&P titled Sanitation and Infection Control, dated 11/25/2025, the P&P indicated, Food service employees will follow infection control policies to ensure the department operates under sanitary conditions at all times.12. Employee personal belongings (i.e. clothing, food, cellphone, etc.) should be stored in a separate area away from food or items used in food service.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306.2. a. During an observation of DA 1 on 4/20/2026 at 8:23 a.m., near the trayline, DA 1 sneezed and covered his mouth with his gloved hands, then removed his gloves and put on a new glove, without handwashing prior to going back to serving the breakfast trayline.During an observation on 4/20/2026 at 8:32 a.m., of breakfast trayline, DA 1 touched his hair with bare hands, put on gloves then proceeded to continue serving food in the trayline. During an observation on 4/20/2026 at 12:57 p.m., of the lunch trayline, DA 1 touched his mask with his left hand and returned to working at the trayline without washing his hands. During an interview on 4/21/2026 at 3:26 p.m., with the DS, the DS stated removing dirty gloves with the use of a paper towel after sneezing then putting on gloves without handwashing was not acceptable. The DS stated DA 1 should have removed his dirty gloves after he sneezed, and then he should have washed his hands before changing his gloves and going back to work. The DS stated DA 1 needed to follow this procedure because hands carry germs, and residents could become ill from foodborne illness if germs are spread through cross-contamination. The DS further stated that DA 1 could not touch his hair or mask and continue working without washing his hands, as this could result in cross-contamination of food and potentially lead to foodborne illness among residents. The DS stated that DA 1 had received handwashing training a long time ago but could not recall the exact training date.During a review of the facility's policy and procedure (P & P) titled, Sanitation and Infection Control, dated 11/25/2025, the P&P indicated that handwashing should be performed after using the toilet, sneezing, using a handkerchief or tissue, and after touching the face and hair.b. During an observation on 4/21/2026 at 2:52 p.m., of the dishwashing process in the two (2)-compartment sinks, DA 1 washed the pans in the 2- compartment sink near the preparation area then transferred them to the 2- compartment sink near the DS office. DA 1 was observed placing the pans into the sanitizer and drying area without washing his hands.During an interview on 4/21/2026 at 3:10 p.m. with the DS, the DS stated DA 1 should have completed the dishwashing process at the first two compartment sinks before proceeding to the second two compartment sinks, so he would not need to go back and forth between dirty and clean areas. The DS stated DA 1 failed to change his gloves and wash his hands and should have washed his hands when going to dirty to clean to prevent cross contamination. During an interview on 4/21/2026 at 3:20 p.m. with DA 1 and the DS, DA 1 stated he should have washed his hands and changed his gloves when moving from the 2-compartment sink by the preparation area to the 2-compartment sink by the office. DA 1 stated he had received training in handwashing and was supposed to wash his hands but forgot. DA 1 further stated he needed to wash his hands for infection control purposes. During a review of the facility's policy and procedure (P & P) titled, Sanitation and Infection Control, dated 11/25/2026, the P&P indicated, handwashing should be done after handling the carts, soiled dishes and utensils.During a review of the facility's P&P titled, Manual Dishwashing - 2 or 3 Compartment Sink, dated 11/25/2026, the P&P indicated, To prevent cross-contamination, wash hands and change gloves when handling clean dishes.c. During an observation on 4/22/2026 at 6:37 a.m., of the puree food preparation, [NAME] 2 prepared puree food then went to throw away a plastic wrap and touched the lid of the trash can in the preparation area. [NAME] 2 went back to work and touched the pan containing puree food and placed it on the steamtable. During an interview on 4/22/2026 at 6:48 a.m., with the DS stated garbage is considered dirty and once a kitchen staff touched a garbage container, they should immediately wash their hands then change gloves to prevent cross contamination.During a review of the facility's P&P titled, Safe Food Transfer and Cross-Contamination Prevention Policy dated 11/25/2025, the P&P indicated, Staff must wash their hands with soap and water or use a facility-approved hand sanitizer before handling food or containers.Gloves must be work during the transfer process. Gloves must be changed if they become torn, contaminated, or after handling non-food items.During a review of the facility's P&P titled, Sanitation and Infection Control, dated 11/25/2025, the P&P indicated, handwashing should be done after handling any waste and waste (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	products, and before and after handling of foods. The P&P further indicated, staff should avoid cross-contamination.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); P (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands.3. a. During an observation on 4/20/2026 at 8:53 a.m., of the refrigerator log, the refrigerator 2 log did not indicate refrigerator temperature for 4/13/2026.During an observation on 4/20/2026 at 8:58 a.m., of the refrigerator log, there were no temperatures indicated for 4/13/2026 for PM shift and 4/19/2026 in the PM shift.During an interview on 4/20/2026 at 9:25 a.m., with the DS, the DS stated kitchen staff take the refrigerator and freezer temperatures once in the morning and once in the afternoon to make sure the food is safe. The DS stated if the refrigerator and freezer temperatures were not taken and monitored, it could be out of temperature range causing the food to spoil and go bad for residents. The DS stated when food gets spoiled and consumed by the residents, it could potentially cause foodborne illness. The DS stated he checked the temperature logs everyday, but he did not see that there were no temperatures documented on 4/13/2026 and 4/19/2026.During a review of the facility's P&P titled, Refrigerator/Freezer Storage, dated 11/25/2025, the P&P indicated, Dietary staff will check and record temperatures of all refrigerators and freezers to ensure the equipment is within appropriate temperature for food storage and handling. Dietary staff will record and initial temperature log at the beginning of the shift.Refrigerator and freezer temperatures will be checked, recorded, and initialed by dietary staff on both the AM and PM shift to ensure temperatures remain in acceptable ranges.b. During a concurrent observation and interview on 4/22/2026 at 9:59 a.m., of the residents' refrigerator with the DS and Licensed Vocational Nurse 1 (LVN 1), ice buildup was observed in the freezer and there was no thermometer inside it. LVN 1 stated there was no thermometer inside the freezer, and they do not monitor the temperature of the freezer. The DS stated they need to monitor the freezer temperature so ensure that the food stays frozen, and will not melt and spoil. The DS stated there was ice buildup in the freezer, and it should not be to ensure the freezer works properly and keeps its temperature During a review of the facility's P&P titled, Refrigerator/Freezer Storage dated 11/25/2025, the P&P indicated (1) Dietary staff will check the inside temperature of the refrigerator and freezers. Each refrigerator and freezer must have a clear visible thermometer placed inside the unit, located near the door or warmest area. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 4-204.112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a TEMPERATURE MEASURING DEVICE shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot FOOD storage unit. (B) Except as specified in (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display. 4. a. During an observation on 4/20/2026 at 8:58 a.m., of the refrigerator, there was a sticky Jello like debris spill on the refrigerator wall, dust, dirt and spills were observed at the bottom of the refrigerator shelf.During a concurrent observation and interview (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 4/20/2026 at 9:04 a.m., of the reach-in refrigerator with the DS, the DS stated the last time the reach-in refrigerator was cleaned was yesterday, however, he did not think it was cleaned yesterday because there was food debris, and a dried-up spill from gelatin. The DS stated it was important to maintain the cleanliness of the refrigerator to keep food safe and for infection control purposes, as they do not want food debris mixed with ready-to-eat food or cross-contamination. The DS stated residents could develop foodborne illness as a result of cross-contamination. During a review of the facility's P&P titled, Refrigerator/Freezer Storage, dated 11/25/2026, the P&P indicated, 17. The refrigerator and freezer area will be clean, dry, well-ventilated at all times.During a review of Food Code 2022, dated 1/18/2022, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred.b. During a concurrent observation on 4/20/2026 at 12:17 a.m., of the dry storage shelves with the DS, dust and dirt was observed on the storage shelves where foods are stored. The DS stated there was dust and dirt on the shelf's surfaces, and the expectation was to have a clean storage area for food, free from dust and spills to prevent pest and contamination. The DS stated residents could potentially develop food borne illness from cross-contamination of food.During a review of the facility's P&P titled, Storage of Canned and Dry Good, dated 11/25/2026, the P&P indicated, The storage area will be clean, dry, well ventilated at all times.c. During a concurrent observation and interview on 4/20/2026 at 12:20 p.m., of the sugar, rice and cereal container with the DS, dust particles and sugar crystals were observed on the containers. The DS stated there were sugar particles on the covers of the sugar container and rice container. The DS further stated Raisin Bran and [NAME] Krispies containers had dust particles. The DS stated they should keep the food containers clean to keep food safe to prevent cross-contamination and foodborne illnesses. During a review of the facility's P&P titled, Kitchen Cleanliness and Sanitation Policy, dated 11/25/2026, the P&P indicated, To ensure the safety and well-being of residents, staff, and visitors, this facility is committed to maintaining a clean, sanitary, and complaint kitchen environment.During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At anytime when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold.d. During a concurrent observation and interview on 4/21/2026 at 2:33 p.m., of the mixer with the DS, the mixer was observed with white debris. The DS stated the mixer looked like it had whipped cream debris and it was not clean. The DS stated the mixer was used for whip cream 2-3 days ago and it had to be clean after use so that there would be no food particles or splashes. The DS stated it was important to clean the mixer after every use to keep the food clean avoiding cross-contamination that could lead to foodborne illness as a potential outcome. During a review of the facility's P&P titled, Cleaning Schedule, dated 11/25/2026 the P&P indicated, All areas and equipment in the kitchen should be cleaned daily.During a review of Food Code 2022, the Food Code 2022 indicated, 4-602.12 Cooking and Baking Equipment. (A) The food contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. This section does not apply to hot oil cooking and filtering (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	equipment if it is cleaned as specified subparagraph 4-602.11 (D)(6).e. During a concurrent observation and interview on 4/21/2026 at 2:39 p.m., of the hood vent near the ice machine with the DS, dust buildup on the vent surfaces was observed. The DS stated they clean the vent once a week but there was dust buildup on the vent. The DS stated it was important to maintain the cleanliness of the vent because dust and dirt could fall into the food from the vent causing cross-contamination. During a review of the facility's P&P titled, Sanitizing Equipment and Surfaces, dated 11/25/2025, the P&P indicated, 6. Dietary staff should ensure that all equipment, shelves, serving utensils, utility carts, cutting boards, vents, and surfaces areas are clean and in good condition.During a review of Food Code 2022, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.f. During a concurrent observation and interview on 4/21/2026 at 4:01 p.m., of the salt, sugar, pepper and artificial sweetener containers, salt, sugar, pepper and artificial sweetener debris and particles were observed on each container. The DS stated kitchen staff clean the containers once a day however they did not clean it today because they did not get to it. The DS stated it was important to maintain cleanliness of the condiment containers to prevent pests because pests could spread diseases. The DS stated pests could go to the trash and it carries bacteria making resident sick of diseases and infection.During a review of the facility's P&P titled, Kitchen Cleanliness and Sanitation Policy, dated 11/5/2026, the P&P indicated, Dietary Staff must sanitize all food-contact surfaces, utensils, preparation tables, and equipment after each use or as needed throughout the service. All surfaces must be kept clean, dry, and free of debris or grease.g. During a concurrent observation and interview on 4/22/2026 at 9:59 a.m., of the resident's refrigerator with LVN 1 and the DS, the freezer was observed with ice buildup and the refrigerator had food debris and a red dried spill. LVN 1 stated the refrigerator was not clean because there was dried red spill. The DS stated it was important to maintain the cleanliness of the resident's refrigerator to prevent cross-contamination. During a review of the facility's P&P titled, Refrigerator/Freezer Storage, dated 11/25/2025, the P&P indicated, 17. The refrigerator and freezer area will be clean, dry, well-ventilated at all times.18. Freezer must be maintained free of excessive ice or frost buildup to ensure proper air circulation and temperature control. Dietary staff will report any ice buildup to the Dietary Supervisor and Maintenance.During a review of Food Code 2022, the Food Code 2022 indicated, 4-701.10 Food Contact Surfaces and Utensils shall be sanitized. 4-702.11 Before use After cleaning. Utensils and Food-Contact Surfaces of Equipment shall be sanitized before use after cleaning.5. During an observation on 4/20/2026 at 12:04 p.m., of the dry storage area, a cart was observed and an area by the door labeled dented cans. Three (3) dented cans were stored with non-dented cans.During an interview on 4/20/2026 at 12:07 p.m., with the DS, the DS stated dented cans are separated and labeled because they return it to the vendor and they could not use them. The DS stated dented cans are hazardous to the residents because it could potentially contaminate the can and the food inside is already bad. The DS stated there were 7 dented cans stored with non-dented cans and it was not acceptable.During a review of the facility's P&P titled, Safe Food Transfer and Cross-Contamination Prevention Policy, dated 11/25/2025, the P&P indicated, All cans must be checked for swelling, dents, rust, or signs of contamination.During a review of the facility' P&P titled, Storage of Canned and Dry Goods, dated 11/25/2025, the P&P indicated, 10. Canned items should be inspected for damage such as dented, leaking or bulging cans. These items should be stored separately in the designated area-DENTED CANS for return to the vendor or disposed of properly.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard.6. During an observation on 4/20/2026 at 12:59 p.m., of the lunch trayline, residents' food trays had water particles and were stacked wet. [NAME] 2 wiped the wet trays with a napkin and used the same napkin for wiping multiple trays.During a concurrent observation and interview on 4/20/2026 at 1:01 p.m., during the lunch trayline process, the DS stated [NAME] 2 was wiping residents' trays with a paper napkin and that kitchen staff did not allow the trays to air dry before placing them into the trayline. The DS stated the trays still contained water droplets and it was important to allow the trays to air dry to prevent moisture buildup that could promote bacterial growth. The DS stated residents could potentially develop foodborne illnesses due to cross-contamination associated with bacterial growth on the trays.During an interview on 4/20/2026 at 1:05 p.m., with the DS, the DS stated [NAME] 2 used a napkin to dry a tray, then reused the same napkin to wipe other trays. The DS stated the proper drying process is to allow the trays to air dry or to use a paper towel and dispose of it and use a new one. The DS stated it was not appropriate to use the same napkin to wipe multiple trays to prevent cross-contamination.During a review of the facility's P&P titled Manual Dishwashing-2 or 3 Compartment Sink, dated 11/25/2026, the P&P indicated, 6. Pots, pans, dishes and utensils must be completely air dried before storage. Items shall not be stacked or nested together while wet. All equipment must be allowed to air dry, clean, sanitized racks with adequate spacing to allow air circulation.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry.7. During an observation on 4/21/2026 at 2:52 p.m. of the 2-compartment sink located by the preparation area, pans were observed stacked wet drying and the drying area had soap bubbles and residues.During a concurrent observation and interview on 4/21/2026 at 3:10 p.m., DA 1 was observed manually washing dishes with the DS, the DS stated the pans are stacked wet and it should not be stacked wet and must be dried individually. The DS stated the pot washing area is a dirty area and the drying area is a clean area. However, DA 1 did not maintain the cleanliness of the drying area because there were dish soap residues on the edge of the drying area. The DS stated the pans that were currently drying were contaminated because the dirt (dish soap) spills onto the clean pans.During an interview on 4/21/2026 at 3:20 p.m. with DA 1 and DS, DA 1 stated the 2-compartment sink is a clean area because he cleans it every time he starts working and the soap in the drying area was not dirty. The DS stated he did not agree with DA 1 statement.During a review of the facility's P&P titled, Manual Dishwashing- 2 or 3 Compartment Sink, dated 11/25/2025, the P&P indicated to place washed dishes onto a clean surface and allow to air dry.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306.8. a. During an observation on 4/21/2026 at 2:52 p.m., of the DA 1 pot washing process, DA 1 transferred the pans from the 2-compartment sink by the preparation area to the 2-compartment sink near the office then turned on the water and rinse the pans. DA 1 dipped the pans for 30 seconds (surveyor timing using a wristwatch) then placed the pans in the drying area.During an interview on 4/21/2026 at 3:00 p.m., with DA 1, DA 1 stated after transferring the pans to the 2-compartment sink by the office, he placed the pans in the first compartment and rinsed them with 110 F water temperature. DA 1 stated he (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dipped the pans in the sanitizer for 40 seconds and he knows it's 40 seconds by just observing and counting in his head.During an interview on 4/21/2026 at 3:10 p.m., with the DS, the DS stated while looking at the QUAT sanitizer poster in the 2-compartment sink, he was trained to follow the manufacturer guidelines of the QUAT sanitizer, and the pots and pans must be dipped for 60 seconds or no longer than one (1) minute. The DS stated 40 seconds of dipping the pans in the sanitizer was not enough. The DS stated the sanitizer kills bacteria and if the pans were not dipped for 60 seconds, the sanitizer would not kill bacteria. The DS stated residents could develop foodborne illness as a potential outcome.During a review of the facility's P&P titled, Manual Dishwashing-2 or 3 Compartment Sink, dated 11/25/2026, the P&P indicated, Two compartment sink procedures: Fill sink 1 with warm water and soap to proper level to complete wash process. Scrub all surfaces to clean and remove food and other debris Drain Sink 1 and rinse all sink walls with fresh water. Refill sink 1 to proper level to freely rinse all items with fresh water only. Fill sink 2 with fresh water to proper level with water from cold line and add Quaternary sanitizer. Test to ensure proper solution of no less than 200ppm to no more than 400 ppm is available with proper test strips. Place all items in solution for no less than one minute.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device.b. During a concurrent demonstration and interview on 4/21/2026 at 3:32 p.m., of the QUAT sanitizer testing with DA 1, DA 1 demonstrated testing the concentration of QUAT sanitizer by putting on gloves, and taking a test strip from the container and dipping the test strip in the QUAT sanitizer testing solution for 15 seconds (surveyor timing using wristwatch). DA 1 stated he dipped the test strips for 10 seconds and he knew it was 10 seconds by counting 1 then would pause for 1-2 seconds then count again. DA 1 did not test the temperature of the testing solution prior to dipping the test strip.During a concurrent demonstration and interview on 4/21/2026 at 3:44 p.m., of the QUAT sanitizer testing with DA 1 and the DS, the DS stated they do not check the water temperature of the QUAT testing solution. The DS stated the testing solution temperature was at 76.3 F (when temped using a thermometer) and did not follow the manufacturer's instructions because testing solution temperature should be at 65-75 F. The DS stated it was important to follow the manufacturer's instructions to make sure that sanitizer concentrations were at its accurate reading and the sanitizer would work properly to kill germs. The DS stated cross contamination, and foodborne illness would be the potential outcome of not having QUAT sanitizer concentration accurate.During a review of the facility's manufacturer's instruction, titled Hydrion Quat-10 Test Paper, with expiration date of 10/1/2026, the instruction indicated, Instructions: Dip paper in quat solution. Not foam surface for 10 seconds. Do not shake. Compare colors at once. Testing solution should be between 65-75 F Testing solution should have a neutral pH. Follow manufacturer's dilution instructions carefully.During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact

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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 record review, the facility failed to dispose garbage and refuse properly when: 1.A garbage container by the preparation area was not completely closed or covered when not actively in use. 2.The dumpster (a movable waste container designed to be brought and taken away by special collection vehicle, or to a bin that a specially designed garbage truck lifts) surroundings had sticky black spills. These failures had potential to attract birds, flies, insects, pests and possibly spread infection to 125 of 125 facility residents. Findings: During an observation on 4/20/2026 at 8:49 a.m., of the trash can containing food scraps, paper and plastic trash, it was observed that the trash can was not actively being used and it was not covered. During a concurrent observation and interview on 4/20/2026 at 9:10 a.m., with the Dietary Supervisor (DS), the trash can by the preparation area was observed to uncovered. The DS stated that the trash should be kept closed with a lid to prevent cross-contamination. The DS stated none of the staff were using the trash can and that it should be covered because it could attract flies that may contaminate residents' food, potentially causing foodborne illness. During a review of the facility's policies and procedures (P&P) titled Waste Control and Disposal, dated 11/25/2025, the P&P indicated, (2) trash bins should be covered at all times. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment. During an observation on 4/22/2026 at 10:14 a.m., with the DS, dark liquid spills were observed on the ground surrounding the dumpster. The DS stated there were dark liquid spills present but did not know what the substance was and stated it could be anything. The DS stated the maintenance department only used brooms to maintain and clean the area. The DS further stated it was important for the dumpster grounds to remain free from spills because spills could attract pests that could enter the facility and potentially spread infection to residents. During an interview on 4/22/2026 at 10:21 a.m. with the Maintenance Supervisor (MS) and the DS, the MS stated they only use brooms to maintain the cleanliness of the area surrounding the dumpster. However, the DS stated his expectation was for the surrounding dumpster area to remain clean and free of spills and trash. The MS stated the surrounding area should be kept to prevent flies, mice, and rats from entering the facility, as these pests could potentially spread diseases. During a review of the facility's P&P titled Waste Control and Disposal, dated 11/25/2025, the P&P indicated, 6. Outside garbage bin should be kept close at all times and surrounding area must be kept clean. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1). Accurately document on the medical diagnoses and on the Physician Orders for Life-Sustaining Treatment (POLST-a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life) for one of 35 sampled residents (Resident 211).2). Accurately document the form titled Supportive and Safety Device/Restraint - Physical. The form indicated that informed consent (process in which the residents are given important information including possible risks and benefits, about a medical procedure or treatment) had been obtained for the use of lower bedside rails (adjustable metal or rigid plastic bars that attach to the bed) however, the facility was unable to provide the required signed consent form for review for one of two sampled residents (Resident 19).3). Ensure the medication administration record (MAR - a record of all active physician orders and medications administered to a resident) was accurate by documenting that 17 doses of menthol-methyl salicylate cream (a medication used for pain) was administered between 4/9/2026 and 4/20/2026, when it was unavailable in the facility, for one (1) of six (6) residents observed for medications administration (Resident 201.)This failure had the potential to result in the delay in treatment for Resident 211 placing Resident 211's safety at risk and cause confusion about the authorized use of upper and lower side rails for Resident 19, increased the risk that Resident 201 could experience continued and worsening pain resulting in physical and psychosocial harm. Findings: 1). During a review of Resident 211's Face Sheet (FS - front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 211 was admitted on [DATE] with diagnoses that included cerebral Infarction (stroke – loss of blood flow to a part of the brain), nontraumatic subarachnoid hemorrhage (sudden bleeding in the brain that is not caused by head injury), and hypertension (high blood pressure). During a review of Resident 211's History and Physical (H&P), dated 4/10/2026, the H&P indicated Resident 211 has depression. During a review of Resident 211's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 4/21/2026, the MDS indicated Resident 211 has severely impaired cognitive skills for daily decision making. Resident 211 requires a helper to do all of the effort for toileting hygiene, shower/bathe, dressing, sit to lying, and lying to sitting on side of bed. During a concurrent interview and record review on 4/23/2026 at 11:30 am with Social Services Director (SSD), Resident 211's POLST was reviewed. The POLST indicated the advanced directive (a legal document indicating resident preference on end-of-life treatment decisions) was dated 4/9/2026. The SSD stated the POLST was filled out incorrectly as the advanced directive was dated 7/19/2025. During a concurrent interview and record review on 4/23/2026 at 3:39 pm with Assistant Director of Nursing (ADON) 1, Resident 211's current Medical Diagnoses was reviewed. The Medical Diagnoses did not indicate depression as a current medical diagnosis. ADON 1 stated it is a mistake that depression is not listed as a Medical Diagnosis. During a review of the facility`s policy and procedures (P&P) titled Charting and Documentation, last reviewed on 11/25/2025, the P&P indicated documentation in medical record will be objective, complete, and accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2). During a review of Resident 19's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 4/9/2014 and readmitted on [DATE] with diagnoses including hypertension (high blood pressure), diabetes type two (high blood sugar), and Alzheimer's disease (disease that affects memory, thinking and behavior). During a review of Resident 19's History and Physical (H&P) dated 11/10/2025, the H&P indicated Resident 19 was able to make needs known and cannot make medical decisions. During a review of Resident 19's MDS dated [DATE], the MDS indicated the resident's cognitive skills (are the mental abilities a person uses to think, learn, understand, and process information) for daily decision making were moderately impaired. The MDS indicated Resident 19 was dependent (helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for rolling left and right, transferring from bed to chair, and transferring to the tub/ shower. The MDS indicated the resident did not perform sitting to lying, lying to sitting on side of the bed, sit to stand, toilet transfers, or walking 10 feet. During a review of Resident 19's Order Recap Report (ORR), the ORR indicated an order with a start date of1/14/2026, for use of bilateral upper and lower half side rails up and locked when in bed for Activities of Daily Living (ADL- activities such as bathing, dressing and toileting a person performs daily) changes, check every day shift. During a concurrent observation and interview on 4/20/2025 at 1:55 p.m., with Registered Nurse (RN) 1, inside Resident 19`s room, Resident 19 was observed in bed with bilateral upper and lower half side rails up and locked. RN 1 stated Resident 19 is in bed with bilateral upper and lower side rails up. During a concurrent interview and record review on 4/20/2026 at 2:04 p.m., with RN 1, Resident 19's Informed Consent for use of side rails was reviewed. RN 1 stated there was a signed informed consent by the resident's POA agent for the use of upper side rails only, however, she was unable to locate a signed informed consent for the use of the lower side rails. RN 1 stated that, according to facility policy, informed consent must be obtained from the resident or the POA agent prior to the use of side rails. RN 1 stated that Resident 19's rights were not protected as consent had not been obtained for the use of lower side rails. During a concurrent interview and record review on 4/20/2026 at 2:10 p.m., with Assistant Director of Nursing (ADON) 1, Resident 19's Informed Consent for use of side rails, was reviewed. ADON 1 stated she cannot find the informed consent signed by the resident or the POA agent for the use of lower side rails. ADON 1 stated informed consent must be obtained from the resident or the POA agent prior to the use of side rails to ensure the resident's rights were protected. During an interview and record review on 4/21/2026 at 3:20 p.m. with ADON 1, the form for Resident 19 titled Supportive and Safety Devices/Restraint Physical – Initial, dated 1/13/2026, was reviewed. ADON 1 stated the form indicated that the resident's responsible party was notified of the decision and that consent was obtained. ADON 1 stated she could not provide any documentation showing the responsible party was notified or that consent was obtained for the use of the lower side rail locked and up from 1/13/2026 to the present. ADON 1 stated the documentation was not accurate. During a concurrent interview on 4/22/2026 at 4:30 p.m., with the Director of Nursing (DON), the DON stated that licensed nursing staff should have obtained informed consent for the use of lower half side rails, in accordance with facility policy and to protect resident rights. The DON stated she was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unable to provide a signed informed consent for Resident 19's use of lower side rails which resulted in a violation of the resident's or the POA agent's rights. During a review of the facility`s policy and procedures (P&P) titled Side rails, reviewed on 11/25/2025, the P&P indicated before using bed rails for any reason, the staff shall inform the resident or resident representative about the benefits and potential hazards associated with siderails and obtain informed consent. During a review of the facility`s policy and procedures (P&P) titled Charting and Documentation, last reviewed on 11/25/2025, the P&P indicated documentation in medical record will be objective, complete, and accurate. 3). During a review of Resident 201's Face Sheet dated 4/20/2026, the Face sheet indicated Resident 201 was originally admitted to the facility on [DATE] with a diagnosis including low back and right hip pain. During a review of Resident 201's Order Summary Report (a report listing the physician order for the resident) dated 4/19/2026, the report indicated Resident 201 was prescribed menthol-methyl salicylate cream to left hand twice a day for left hand middle and ring finger pain, starting 4/9/2026. During a review of Resident 201's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for April 2026, the MAR indicated Resident 201 was prescribed menthol-methyl salicylate cream to the left hand, twice a day for left hand middle and ring finger pain, to give at 9 a.m. and 5 p.m. The MAR also indicated menthol-methyl salicylate cream was documented as administered as follows: 1. Administered by LVN 5 at 5 p.m. on 4/10, 4/11, 4/13, 4/16, 4/17, 4/18, 4/19/20262. Administered by LVN 7 at 9 a.m. on 4/15, 4/16, 4/17, 4/18/20263. Administered by LVN 8 at 5 p.m. on 4/14, 4/15/20264. Administered by LVN 9 at 9 a.m. on 4/12, 4/19/20265. Administered by LVN 10 at 9 a.m. on 4/14/20266. Administered by RN 2 at 9 a.m. on 4/13/2026 During an observation on 4/20/2026 at 10:10 a.m. in Medication Cart Station 3, Licensed Vocational Nurse (LVN) 2 was observed not administering menthol-methyl salicylate cream (a medication used for pain) to Resident 201. During an interview on 4/20/2026 at 2:25 p.m. with LVN 2, LVN 2 stated LVN 2 did not administer menthol-methyl salicylate that day (4/20/2026) at 10:10 a.m. to Resident 201, as prescribed by Resident 201's physician, since menthol-methyl salicylate was not available in Medication Cart Station 3 or in the facility. LVN 2 stated menthol-methyl salicylate cream was a medication used to relieve pain and not administering can harm Resident 201 by not relieving the pain leading to worsening of the pain. During an interview on 4/21/2026 at 11:57 a.m. with the Director of Nursing (DON), the DON stated that LVN 2 failed to administer menthol-methyl salicylate to Resident 201 on 4/20/2026 at 10:10 a.m. since menthol-methyl salicylate cream was not available in the facility. The DON stated menthol-methyl salicylate cream was prescribed for pain and not administering can potentially harm Resident 201 by not relieving the pain and worsening pain. During a concurrent record review, the DON reviewed the electronic prescription transmission record for menthol-methyl salicylate cream dated 4/9/2026 and April 2026 MAR for Resident 201. The DON stated there were no manifests or record of delivery for menthol-methyl salicylate cream from the pharmacy. The DON acknowledged the facility had not received and pharmacy had not delivered (continued on next page)

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California Healthcare and Rehabilitation Center	6700 Sepulveda Blvd. Van Nuys, CA 91411

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	menthol-methyl salicylate cream for Resident 201 since 4/9/2026, resulting in Resident 201 missing administration of doses between 4/9/2026 and 4/20/2026. The DON stated that when a medication was unavailable to administer, the licensed nurses must notify the pharmacy, the resident's physician, and let the DON know about the missing medication. The DON stated none of the licensed nurses contacted her about missing medications for Resident 201. The DON added the April 2026 MAR was inaccurately documented that Resident 201 was administered menthol-methyl salicylate cream 17 times by several different licensed nursing staff between 4/9/2026 and 4/20/2026. The DON stated it was unacceptable to sign the MAR that menthol-methyl salicylate cream was administered when it was not available in the facility, resulting in failing to maintain an accurate MAR for Resident 201 for April 2026. During a concurrent document review and interview on 4/21/2026 at 12:17 p.m. with Registered Nurse (2,) RN 2 reviewed Resident 201's April 2026 MAR. RN 2 acknowledged the checkmarks on the MAR between 4/9/2026 and 4/20/2026 indicated that menthol-methyl salicylate cream was administered 17 times to Resident 201. RN 2 stated the checkmark on the MAR with her initials on 4/13/2026 at 9 a.m. indicated menthol-methyl salicylate cream was successfully administered to Resident 201. RN 2 stated Resident 201's menthol-methyl salicylate cream was not available in the facility and that she failed to inform the DON and follow up with pharmacy. RN 2 stated if a medication was unavailable, it should not have a checkmark on the MAR. RN 2 stated if she was unable to complete medication administration, the MAR should indicate it was not given. RN 2 stated that marking the MAR that menthol-methyl salicylate cream was administered when it was not created an inaccurate clinical record for Resident 201. During a review of the facility's Policy and Procedures (P&P,) titled Medication Administration -General Guidelines, last reviewed 11/25/2025, the P&P indicated: Medications are administered as prescribed in accordance with good nursing principles and practices. The Individual who administers the medication dose records the administration on the resident's MAR after the medication is given.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility to offer the updated 2025/2026 influenza (flu, a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs) vaccine (medications used to prevent diseases usually given by injection or by mouth) at the start of the respiratory illness season (typically from October through April in the U.S., peaking between December and February, characterized by increased circulation of respiratory illnesses including the fly and COVID-19 [an infectious respiratory illness caused by the SARS-CoV-2 virus]) when the vaccine became available for four of five sampled residents (Residents 1, 2, 13, and 20) investigated for immunizations (the process where a person is made resistant to a disease). This deficient practice increased the risk for Residents 1, 2, 13, 20 to experience complications from the flu virus including pneumonia (an infection/inflammation in the lungs), respiratory failure (when the lungs cannot release enough oxygen into the blood), and death. Findings: ˆ During a review of Resident 1's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 8/22/2025 and most recently readmitted the resident on 4/6/2026 with diagnoses including, but not limited to, acute (severe, sudden onset) respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) with hypoxia (an insufficient amount of oxygen in your body tissues) and anemia (a condition where the body does not have enough healthy red blood cells). a. During a review of Resident 1's Physician Progress Note dated 4/8/2026, the progress note indicated Resident 1 did not have the capacity to understand or make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/22/2026, the MDS indicated Resident 1 rarely or never understands others and can rarely or never express ideas and wants. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Vaccine Consent Form, dated 3/15/2026, the form indicated the resident's responsible party provided consent for the resident to receive the 2025/2026 flu vaccine on 3/15/2026. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), undated, the MAR indicated the flu vaccine was administered to Resident 1 on 3/30/2026. b. During a review of Resident 2's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 2/19/2018 and most recently readmitted the resident on 2/8/2026 with diagnoses including, but not limited to, traumatic subdural hemorrhage (bleeding between the brain and its outer covering [dura]) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 2's History and Physical (H&P) dated 2/9/2026, the H&P indicated Resident 2 had capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was cognitively intact (able to think, learn, and remember clearly). The MDS indicated Resident 2 was dependent on staff for toileting, showering, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 2 required substantial assistance (helper does more than half of the effort) with upper body dressing and required partial assistance (helper does less than half of the effort) with oral hygiene. During a review of Resident 2's Vaccine Consent Form, dated 3/20/2026, the form indicated the resident provided consent to receive the 2025/2026 flu vaccine on 3/20/2026. During a review of Resident 2's Immunization Details, undated, the Immunization Details indicated the Infection Prevention Nurse (IPN) administered the flu vaccine to Resident 2 on 3/30/2026. c. During a review of Resident 13's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 3/12/2024 and most recently readmitted the resident on 2/12/2026 with diagnoses including, but not limited to, respiratory failure and dependence on a ventilator (a medical device to help support or replace breathing). During a review of Resident 13's SOAP (Subjective, Objective, Assessment, Plan- a (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based onˆobservation,ˆinterview and record review, the facility failed to provide care in a manner that maintained a resident's dignity and respectˆforˆtwo of twoˆsampled residentsˆ(Residentˆ212 and 94)ˆreviewed under theˆdignityˆcare area by: a. Failing to ensureˆthe Infection Preventionist Nurseˆ(IPN) knocked or requestedˆpermission before entering Resident 212's room.ˆ b. Failingˆto ensureˆResidentˆ94'sˆindwelling urinaryˆcatheter (a flexible tube that is inserted into the bladder to help drain urine)ˆcollection bag (designed to collect urine drained from the bladder via catheter)ˆwas coveredˆwith a dignity bag (a bag used to cover and hold the catheterˆdrainage/collection bag, so it is not visible).ˆˆ Theseˆdeficient practicesˆviolated the residents' rights to be treated with respect and dignity andˆhadˆthe potential toˆnegativelyˆaffectˆresident's sense of self-worth and self-esteem.ˆ Findings:ˆ a. During a review of Residentˆ212'sˆFace Sheet, the Face Sheet indicatedˆthe facility admitted Residentˆ212ˆto the facilityˆon 4/15/2026ˆwith diagnoses includingˆdementiaˆ(a progressive state of decline in mental abilities),ˆtracheostomy (a surgical procedure that creates an opening in the neck leading directly into the trachea [windpipe])ˆand dependence on a ventilator (a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own).ˆ During a review of Residentˆ212's Minimum Data Set (MDS - a resident assessment tool) datedˆin progress as ofˆ4/23/2026, the MDS indicated the residentˆnever/rarelyˆmake herself understood andˆnever/rarelyˆunderstood others. The MDS further indicatedˆResidentˆ212ˆwas dependentˆ(helperˆdoes all the effort) with all activities of daily livingˆ(ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆ During a concurrent observation and interview onˆ4/20/26ˆatˆ9:57ˆa.m.,ˆinside Resident 212's room, Resident 212 was lying in bed, asleep.ˆThe IPNˆwasˆobservedˆentering Residentˆ212`s roomˆfrom the hallway, without knocking on the door and asking permission to go inˆand began pulling on a curtain to close it.ˆWhen interviewed,ˆthe IPN statedˆshe forgot to knock before entering the resident's room.ˆThe IPNˆstatedˆthat she should have knocked and askedˆforˆpermission to go inˆbecause residents deserve privacyˆand dignity.ˆ During an interview onˆ4/23/26ˆatˆ1:26ˆP.M.ˆwithˆthe Director ofˆNursing, (DON), the DONˆstatedˆthat anyone entering a resident`s room must knock and ask permission prior to entering the resident`s room. The DONˆstatedˆresident`s privacy should be respectedˆand residents should be treated with respect and dignity.ˆ  During a review of the facility`s policy and procedureˆ(P&P)ˆtitled Resident Rights last reviewed onˆ11/25/2025ˆtheˆP&Pˆindicated thatˆthe facility shall treat each resident with consideration, respect and fullˆrecognition of dignity and individuality, including privacy in treatment and in care of personal needs.ˆThe policy furtherˆindicated thatˆstaff are expected to knock and request permission before entering a resident's room.ˆ ˆ b. Duringˆaˆreview of Residentˆ94'sˆFace Sheet,ˆtheˆFace Sheetˆindicatedˆtheˆfacility admitted (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ˆResidentˆ94ˆto the facilityˆonˆ9/10/2025ˆwithˆdiagnoses that includedˆsevere protein-calorie malnutrition (critical lack of food, specifically protein and calories,ˆcausing the body to waste away, lose muscle due to starvationˆor chronic disease),ˆneuromuscular dysfunction of bladder (condition when a person lacks bladder control due to brain, spinal cord or nerve problems) andˆretention of urine (inability to completely empty the bladder of urine).ˆ DuringˆaˆreviewˆofˆResidentˆ94's MDS, dated [DATE], the MDS indicated Residentˆ94ˆwas able toˆmakeˆself-understoodˆand ableˆto understand others.ˆTheˆMDS indicated Residentˆ94ˆwasˆsubstantial/maximal assistanceˆ(helper doesˆmore than halfˆthe effort)ˆwithˆlower body dressing, partial/moderate (helper doesˆmore than half the effort) with upper body dressing, shower/bath self, toileting hygiene, and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating,ˆoral hygieneˆandˆpersonal hygiene.ˆˆ Duringˆanˆobservationˆonˆ4/20/2026 atˆ11:53ˆa.m.,ˆinside Resident 94's room, Residentˆ94's Foley catheter collection bag wasˆobservedˆanchoredˆto the trash containerˆnext to Resident 94's bed. Theˆcatheterˆcollectionˆbagˆheldˆclear, yellow fluidˆexposed toˆpublic view.ˆˆ During a concurrent observation and interview onˆ4/20/2026 atˆ12:03ˆp.m. withˆRegistered Nurseˆ(RN)ˆ2ˆinsideˆResidentˆ94's room,ˆ RN 2ˆstatedˆthat Resident 94'sˆurine collectionˆbagˆshould be covered with a dignity bagˆto maintain the resident's privacy.ˆ During anˆinterview on 4/23/2026 at 11:54 a.m.ˆAssistant Director of Nursingˆ(DON)ˆ1,ˆADONˆ1ˆstatedˆthatˆplacing the urine collection bag in a dignity bag protects Resident 94's privacy. The DONˆstatedˆthat the dignity bag keeps the urine out of public view, preserving the resident's dignity.ˆ During a review of Residentˆ94's Order Summary Report, datedˆ4/22/2026, the Order Summary Reportˆindicatedˆa physician's order onˆ9/11/2025 forˆFoley (a type of indwelling catheter) catheter size 16x10ˆmillimeters (ml unit of volume)ˆattached to bedside drainage bag due to neurogenic bladder.ˆˆ During a review of the facility's P&P titled, Dignityˆlast reviewed 11/25/2025, the P&P indicated, Each resident shall be cared for and in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Residents are treated with dignity and respect at all times.Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity andˆassistˆresidents for example: a.ˆhelping the resident to keep urinary catheter bags covered.ˆ ˆ ˆ ˆ

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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. Based on interview, and record review, the facility failed to implement its policy and procedure (P&P) titled Side Rails (adjustable metal or rigid plastic bars that attach to the bed) for one of four residents (Resident 19) reviewed under the restraints care area by failing to obtain an informed consent (process in which the residents are given important information including possible risks and benefits, about a medical procedure or treatment) for the use of lower side rails. This deficient practice violated Resident 19's and/or the resident's representative the right to be informed of and to participate in the resident's treatment. Findings:ˆ During a review of Resident 19's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 4/9/2014 and readmitted Resident 19 on 11/08/2025 with diagnoses including hypertension (high blood pressure), diabetes type two (high blood sugar), and Alzheimer's disease (a disease that affects memory, thinking and behavior).ˆThe Face Sheet indicated Resident 19 has a designated Power of Attorney (POA- legal authorization that grants a designated individual the authority to make decisions on behalf of the resident) agent. During a review of Residentˆ19'sˆHistory and Physical (H&P) dated 11/10/2025, the H&PˆindicatedˆResidentˆ19ˆwas able to make needs known and cannot make medical decisions.ˆˆˆ During a review of Resident 19's Minimum Data Set (MDS-a resident assessment tool) dated 01/29/2026, the MDS indicated the resident's cognitive skills (are the mental abilities a person uses to think, learn, understand, and process information) for daily decision making were moderately impaired. The MDS indicated Resident 19 was dependent (helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for rolling left and right, transferring from bed to chair, and transferring to the tub/ shower. The MDS indicated the resident did not perform sitting to lying, lying to sitting on side of the bed, sit to stand, toilet transfers, or walking 10 feet. During a review of Resident 19's Order Recap Report (ORR), the ORR indicated an order with a start date of1/14/2026, for bilateral upper and lower half side rails up and locked when in bed for Activities of Daily Living (ADL- activities such as bathing, dressing and toileting a person performs daily) changes, check every day shift. During a concurrent observation and interview on 4/20/2025 at 1:55 p.m., with Registered Nurse (RN) 1, inside Resident 19`s room, observed Resident 19 in bed with bilateral upper and lower half side rails up and locked. RN 1 stated Resident 19 is in bed with bilateral upper and lower side rails up. During a concurrent interview and record review on 4/20/2026 at 2:04 p.m., with RN 1, Resident 19's Informed Consent for use of siderails was reviewed. RN 1 stated there was a signed informed consent by the resident's POA agent for the use of upper side rails only, however, she was unable to locate a signed informed consent for the use of the lower side rails. RN 1 stated that, according to facility policy, informed consent must be obtained from the resident or the POA agent prior to the use of side rails. RN 1 stated that Resident 19's rights were not protected as consent had not been obtained for the use of lower side rails. During a concurrent interview and record review on 4/20/2026 at 2:10 p.m., with Assistant Director of Nursing (ADON) 1, Resident 19's Informed Consent for use of side rails, was reviewed. ADON 1 stated she cannot find the informed consent signed by resident or the POA agent for the use of lower side rails. ADON 1 stated informed consent must be obtained from the resident or the POA agent prior to the use of side rails to ensure the resident's rights were protected. During a concurrent interview and record review on 4/21/2026 at 3:18 p.m. with ADON 1, Resident 19's Medication Administration Record (MAR) dated 1/14/2026 to 4/20/2026, was reviewed. The MAR indicated that bilateral upper and lower half side rails were up and locked continuously from 1/14/2026 to 4/20/2026 (more than 3 months). ADON 1 stated that Resident 19 had bilateral upper and lower half side rails in place during that period. During a concurrent interview on 4/22/2026 at 4:30 p.m., with the Director of Nursing (DON), the DON stated that licensed nursing staff should have obtained informed consent for the use of lower half side rails, in accordance with facility policy and to protect resident rights. The DON stated she was unable to (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide a signed informed consent for Resident 19's use of lower side rails which resulted in a violation of the resident's or the POA agent's rights. During a review of the facility`s policy and procedures (P&P) titled Side Rails, reviewed on 11/25/2025, the P&P indicated before using bed rails for any reason, the staff shall inform the resident or resident representative about the benefits and potential hazards associated with siderails and obtain informed consent. During a review of the facility`s P&P titled Resident Rights, reviewed on 11/25/2025, the P&P indicated free choice, the resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect resident wellbeing.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to clarify wishes written on Resident 211's advanced directive (a legal document indicating resident preference on end-of-life treatment decisions) with the healthcare agent (a person legally authorized to make decisions on behalf of another individual when that person is unable to communicate r communicate their own decisions when one of four sampled resident's (Resident 211) orders did not match the advance directive. This failure had the potential to result in Resident 211 receiving unnecessary treatment and inappropriate care. Findings: During a review of Resident 211's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted Resident 211 on [DATE] with diagnoses that included cerebral infarction (stroke - loss of blood flow to a part of the brain), nontraumatic subarachnoid hemorrhage (sudden bleeding in the brain that is not caused by head injury), and hypertension (high blood pressure). During a review of Resident 211's Minimum Data Set (MDS-a resident assessment tool) dated [DATE], the MDS indicated Resident 211 has severely impaired cognitive skills for daily decision making. Resident 211 required a helper to do all of the effort for toileting hygiene, shower/bathe, dressing, sit to lying, and lying to sitting on side of bed. During a review of Resident 211's Order Summary Report, dated [DATE], the Order Summary Report indicated an order dated [DATE] to attempt resuscitation (initiate medical interventions to restart a person's heart or breathing when they have stopped). During a review of Resident 211's Baseline Care Plan, dated [DATE], the Baseline Care Plan indicated Resident 211's code status as Attempt Resuscitation (Cardiopulmonary Resuscitation-CPR [is an emergency lifesaving procedure performed when a person's heart has beating or they are not breathing). During a concurrent interview and record review on [DATE] at 11:30 a.m. with the Social Services Director (SSD), Resident 211's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life), dated [DATE] was reviewed. The POLST indicated to attempt resuscitation and provide full treatment (primary goal of prolonging life by all medically effective means). The SSD stated the POLST should have indicated selective treatment (goal of treating medical conditions while avoiding burdensome measures) as indicated on the advanced directive. During a concurrent interview and record review on [DATE] at 11:30 a.m., with Social Services Director (SSD), Resident 211's Advanced Directive, dated [DATE] was reviewed. The advanced directive indicated, Resident 211 does not want to prolong life. The SSD stated the instructions indicated in the advance directive were not reflected in Resident 211's physician orders. The SSD further stated Resident 211's family should have been called to clarify the wishes of Resident 211. The SSD stated the advance directive is used to follow the correct protocol and wishes of the resident for end-of-life decisions. During a review of the facility's policy and procedure (P&P) titled, Advance Directive Acknowledgement, last reviewed [DATE], the P&P indicated to support the resident's rights in making decisions regarding their care and treatment as instructed on the advance directive.

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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 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 provide a safe homelike environment to two of two sampled residents (Resident 50 and Resident 13) investigated under environment task by failing to: a. Ensure Resident 50 had a trash bin to dispose of his trash in his room. This deficient practiceˆcaused Resident 50 to have to dispose his trash in the bin labeled urinal only and hadˆthe potentialˆtoˆaffect the resident`s self-esteem and self- worth. b. Ensure Resident 13's floor mat (a cushioned floor pad designed to help prevent injury should a person fall) was in good condition and there was not trash on the floor and a dark red substance on the bottom of the bed frame. This deficient practice had the potential to violate the resident's right to living in a safe, comfortable, and homelike environment. Findings: a. During a review of Resident 50's Face Sheet, the Face Sheetˆindicatedˆtheˆfacility admitted ˆResident 50 onˆ12/7/2023 and readmitted on [DATE]ˆwith diagnosis including emphysema (long-term lung condition that causes shortness of breath), history of falls and muscle weakness. During a review of Resident 50's History and Physical (H&P) dated 8/15/2025, the H&P indicated Resident 50 had the capacity to understand and make decisions. During a reviewˆofˆResident 50's Minimum Data Set (MDS-a resident assessment tool) dated 2/22/2026, the MDS indicated Resident 50 had the ability to make himself understood and had the ability to understand others. The MDS indicated that Resident 50ˆrequiredˆsupervision (helper provides verbal cues) from staff for oral hygiene,ˆtoileting, upper and personalˆhygiene. During a concurrent observation and interview on 4/20/2026 at 8:22 a.m., with Resident 50 in Residentˆ50`sˆroom, Resident 50 was sitting up in bed. Resident 50 threw a piece of trash in a waste bin marked, URINAL ONLY, which had a urinal hanging inside it. Inside this bin had several items of trash in it already. When asked why he was throwing trash in his urinal only bin, Resident 50 stated he did not have another trash bin for trash but would like one for his room. During a concurrent observation and interview on 4/20/2026 at 8:29 a.m., with the Assistant Director of Staff Development (ADSD), in Residentˆ50`sˆroom, the ADSD looked in the URINAL ONLY bin and stated trash should not be in there because the resident should have his own bin specifically for trash. The ADSD stated this is Resident 50's home and he should have a trash bin in his room. During an interview on 4/23/2026 at 1:17 p.m., with the Assistant Director of Nursing (ADON), the ADON stated to maintain a homelike environment, the resident should have his own trash bin in his room. During a review of the facility`s policy and procedures (P&P) titled, Homelike Environment, last reviewed on 11/25/2025, the P&P indicated that Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.clean, sanitary and orderly environment; clean bed and bath linens that are in good condition.ˆ b. During a review of Resident 13's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 3/12/2024 and most recently readmitted the resident on 2/12/2026 with (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses including, but not limited to, respiratory failure and dependence on a ventilator (a medical device to help support or replace breathing). During a review of Resident 13's SOAP (Subjective, Objective, Assessment, Plan- a structured, four-part documentation method used by healthcare providers to record patient visits consistently) note dated 2/17/2026, the SOAP note indicated Resident 13 was minimally alert, not oriented, and non-communicative. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 rarely or never understands others and can rarely or never express ideas and wants. The MDS indicated Resident 13 was dependent on staff for all ADLs. During an observation on 4/23/2026 at 9:32 a.m. at Resident 13's bedside, Resident 13's floor mat was in poor condition and coming apart at the edges. There was a dried dark red substance on Resident 13's bed frame and there were trash and a towel under Resident 13's bed on the floor. During a follow-up observation on 4/23/2026 at 10:21 a.m. at Resident 13's bedside, there was still a dried dark red substance on the resident's bedframe and trash and a towel on the floor under the bed. The floor mat with the layers coming apart at the edges was still in place. During an interview on 4/23/2026 at 10:27 a.m. with Licensed Vocational Nurse (LVN 13), LVN 13 stated he picked up the trash under the bed and cleaned the substance off of the bed frame. LVN 13 stated the room should be clean for infection control and the resident's dignity. During an interview on 4/23/2026 at 3:24 p.m. with the Director of Nursing (DON), the DON stated Resident 13's floor mat was not maintained in proper condition and posed a potential safety risk. The DON stated residents should be provided with a clean environment and that Resident 13's room condition had the potential to contribute to infection. During a review of the facility's P&P titled, Homelike Environment, last reviewed on 11/25/2025, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment. The P&P indicated the facility staff, and management maximizes the characteristics of the facility that reflect a personalized, homelike setting including a clean, sanitary, and orderly environment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to remove one of five sampled residents' (Residents 8) restraints reviewed under the Restraints care area, in accordance with the physician's order. This failure to remove the restraints as ordered had the potential to increase the risk of harm including decreased circulation, skin breakdown, and decline in mobility. Findings:During a review of Resident 8's Face Sheet, the Face Sheet indicated the facility admitted Resident 8 on 5/4/2024 and readmitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia (a life-threatening, sudden-onset medical emergency where the lungs cannot properly oxygenate the blood), tracheostomy (a surgical procedure that creates an opening in the windpipe to establish a direct airway), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and traumatic subdural hemorrhage (bleeding in the out lining of the brain usually due to severe head injury such as accidents or falls). During a review of Resident 8's Minimum Data Set (MDS-a resident assessment tool) dated 3/20/2026, the MDS indicated Resident 8 has severely impaired cognitive skills (mental abilities used to think, learn, remember, understand, and make decisions) for daily decision making. Resident 8 required a helper to do all of the effort for toileting hygiene, shower/bathe, dressing, sit to lying, and lying to sitting on side of bed. During a review of Resident 8's Order Summary Report dated 4/22/2026, the Order Summary Report indicated an order dated 1/12/2026 for the following: -Apply hand mitten to left hand to prevent pulling out tracheostomy tube and scratching. Release every two (2) hours for 15 minutes for circulation and to check for skin integrity. Hand hygiene will be provided during release. Monitor placement (Holidays off on Wednesdays and Sundays). Check every shift every Monday, Tuesday, Thursday, Fri, and Saturday. During an observation on 4/22/2026 (Wednesday) at 10:21 a.m., in Resident 8's room, Resident 8 was observed sleeping in bed with the left-hand mitten on. During an observation on 4/22/2026 at 11:30 a.m., in Resident 8's room, Resident 8 was observed in bed with left hand mitten on. During an interview on 4/22/2026 at 11:57 a.m., with Assistant Director of Nursing (ADON) 1, ADON 1 stated the order to remove Resident 8's hand mitten on holidays was not followed because Resident 8 is still wearing a hand mitten on the left hand. During a review of the facility's policy and procedures (P&P) titled, Restraints: Holiday, the P&P indicated holidays from restraints is to provide residents who are not appropriate for restraint reduction with a temporary break from restraints.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an admission comprehensive assessment within the required timeframe for when one of three sampled residents (Resident 211). This failure had the potential to result in Resident 211 not receiving the necessary treatment and appropriate care. Findings: During a review of Resident 211's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted Resident 21 admitted on [DATE] with diagnoses that included cerebral infarction (stroke - loss of blood flow to a part of the brain), nontraumatic subarachnoid hemorrhage (sudden bleeding in the brain that is not caused by head injury), and hypertension (high blood pressure). During a review of Resident 211's Minimum Data Set (MDS-a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 211 had severely impaired cognitive skills (mental abilities used to think, learn, remember, understand, and make decisions) for daily decision making. Resident 211 required a helper to do all of the effort for toileting hygiene, shower/bathe, dressing, sit to lying, and lying to sitting on side of bed. During a concurrent interview and record review on 4/23/2026 at 12:50 p.m. with the Assistant MDS Nurse (AMDS), the admission comprehensive assessment, dated 4/21/2026 was reviewed. The admission comprehensive assessment indicated the assessment was still in progress and not completed. The AMDS stated the admission comprehensive assessment should have been completed on 4/22/2026 but could not be closed because of four incomplete areas. The AMDS further stated that sections from Social Services and Dietary need to be completed before the admission comprehensive assessment could be closed. During a review of the Centers for Medicare & Medicaid Services (CMS) Resident Assessment Instrument (RAI), version 2.0, the RAI indicated the completion of the admission comprehensive assessment should be completed no later than the admission date (4/9/2026) plus 13 days (4/22/2026).

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was transmitted timely to the Centers for Medicare and Medicaid Services (CMS, a U.S. federal agency that administers major healthcare programs such as Medicare [a federal health insurance program in the U.S. for people aged 65 or older] and Medicaid [a program in the U.S. that provides low-cost health coverage to millions of Americans with limited income]) for two (Resident 22 and Resident 166) of two sampled residents. This deficient practice had the potential to result in delayed services for Resident 22 and Resident 166. Findings: a. During a review of Resident 22's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 22 to the facility on 5/24/2023 and re-admitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 22 required supervision or touching assistance (helper provides verbal cues and/or touching /steadying assistance as the resident completes activity) with eating. The MDS indicated Resident 22 had a planned discharge. During a review of Resident 22's Census Report (report which indicates a resident's admissions and discharges from the facility), the report indicated Resident 22 was discharged from the facility on 1/28/2026. During a review of Resident 22's Physician's Orders, dated 1/29/2026, the order indicated an order to discharge Resident 22 to a board and care facility (small, licensed residential facilities providing 24-hour staffing, meals, and assistance with daily activities (ADLs) in a home-like setting). The order indicated Resident 22 was discharged to the board and care facility on 1/28/2026. During a review of Resident 22's Nursing Progress Note, dated 1/28/2026, the note indicated Resident 22 was discharged to a board and care on 1/28/2026. During a review of Resident 22's MDS Summary indicated the Assessment Reference Date (ARD, isˆthe specific, final day of the look-back or observation period used to capture a nursing home resident's clinical status) for his discharge was 1/28/2026 and the MDS is to be completed by 2/11/2026. Resident 22's MDS Summary indicated the MDS is still in progress (being processed by the facility and not yet submitted to CMS). During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN) on 4/22/2026 at 10:23 a.m., the MDSN reviewed Resident 22's MDS records. The MDSN stated there was no discharge MDS assessment completed for Resident 22 when he was discharged [DATE]. The MDSN stated the discharge assessment should have been completed within 14 days. The MDSN stated he was not sure why it was not completed and submitted. The MDSN stated it was important to complete the MDS timely so that CMS can know a resident's functioning status and monitor for improvement or decline. During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22 had a planned discharge from the facility on 1/28/2026. The MDS indicated in section Z: Assessment Administration that the MDS was signed as completed on 4/24/2026. b. During a review of Resident 166's Face Sheet, the Face Sheet indicated the resident was admitted to the facility originally on 12/02/2025 and re-admitted on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (a long-term, ongoing condition where the lungs cannot adequately transfer oxygen into the blood, resulting in a low oxygen levels and requiring oxygen for bodily functions). During a review of Resident 166's MDS, dated [DATE], the MDS indicated Resident 166 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 166 was dependent on staff (the helper does all the effort; resident does none of the effort) for dressing, and (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal hygiene. The MDS indicated this assessment was an unplanned discharge. During a review of Resident 166's Census Report, the report indicated Resident 166 was transferred to the hospital on 1/30/2026. During a review of Resident 166's MDS Summary indicated the ARD for his discharge was 1/30/2026 and the completion date was 2/17/2026. During a concurrent interview and record review with the MDSN on 4/22/2026 at 10:23 a.m., the MDSN reviewed Resident 166's MDS Assessment, dated 1/30/2026. The MDSN indicated the discharge assessment should have been completed within 14 days. The MDSN stated the completion date was 2/17/2026 but should have been completed by 2/13/2026. The MDSN stated he was not sure why it was not completed timely. The MDSN stated it is important to complete the MDS timely so that CMS can know a resident's functioning status and monitor for improvement or decline. During an interview with the Director of Nursing (DON) on 4/23/2026 at 12:10 p.m., she stated the MDSN should have completed Resident 22's and Resident 166's MDS according to the MDS guidelines. The DON stated this was important to ensure there are no delays in care and that residents' discharge plans are implemented. During a review of the facility's CMS Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, dated 10/2025, indicated all Medicare and/or Medicaid-certified nursing homes must transmit required MDS data records to the CMS Internet Quality Improvement and Evaluation System (IQIES). The manual indicated the discharge assessment completion date is to be completed within 14 calendar days (consecutive days, not normal business working days).

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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. Based on observation, interview, and record review, the facility failed to provide care and services in accordance with professional standards that will meet each resident's physical, mental and psychosocial needs for one of one sampled residents (Resident 94) when the facility: 1.Failed to notify physician of Resident 60's refusal of dermatologist recommendation for skin biopsy of right temple 2. Failed to obtain treatment orders for ongoing care of right temple skin wound. This deficient practice had the potential for the wound to worsen, resulting in delayed healing and increased risk for infection.Findings: During a review of Resident 94's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted Resident 94 to the facility on 9/10/2025 with diagnosis that included severe protein-calorie malnutrition (critical lack of food, specifically protein and calories, causing the body to waste away, lose muscle due to starvation or chronic disease), neuromuscular dysfunction of bladder (condition when a person lacks bladder control due to brain, spinal cord or nerve problems) and retention of urine (inability to completely empty the bladder of urine). During a review of Resident 94's Minimum Data Set (MDS - a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 94 was able to make self-understood and able to understand others. The MDS indicated Resident 94 required substantial/maximal assistance (helper does more than half the effort) with lower body dressing, partial/moderate (helper does more than half the effort) with upper body dressing, shower/bath self, toileting hygiene, and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral hygiene and personal hygiene. During a concurrent observation and interview on 4/20/2026 at 11:53 a.m., observed Resident 94 with an adhesive bandage on his right temple. Resident 94 stated he had a sore beneath the band aid from picking on it. During a follow-up interview on 4/22/2026 at 12:02 p.m. with Resident 94, Resident 94 stated ointment was applied to the sore on his right temple, and the adhesive bandage was changed by the nurse in the morning. Resident 94 stated he is bothered by the looks of the sore. Resident 94's voice raised as he continued to speak about the sore and stated I don't like that it's (referring to the right temple sore) there. I don't want to talk about it anymore. I just don't like it. During a concurrent interview and record review on 4/23/2026 at 9:53 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 94 has a dry sore, a scab to the right temple. LVN 3 stated the sore is from a skin condition. LVN 3 stated Resident 94 was referred to dermatologist and initially seen by dermatologist on 3/10/2026. Resident 94's Dermatology Progress Notes dated 3/10/2026 was reviewed. The Dermatology Progress Notes indicated a diagnosis of right temple prurigo nodularis (a chronic [persist of a long time] noncontagious skin disease characterized by intense itching and the development of firm, scaly and often painful nodules on the arms, legs and trunk) was under treatment, indicated a treatment of topical steroids and the resident refused biopsy. LVN 3 stated she did not notify Resident 94's primary physician of Resident 94's refusal of dermatologist recommendation for skin biopsy of right temple. Resident 94's Dermatology Progress Notes dated 4/7/2026 was also reviewed. The Dermatology Progress Notes indicated the resident refused biopsy. LVN 3 stated she did not inform Resident 94's primary physician of the resident's second refusal. LVN 3 stated it was her responsibility to communicate to Resident 94's primary physician about Resident 94's refusal to have a biopsy. LVN 3 stated it is important to communicate to the physician that Resident 94 refused biopsy so that the physician is informed and can decide what to do next in providing care to the resident. During an interview on 4/23/2026 at 11:54 am with Assistant Director of Nursing (ADON) 1, ADON 1 stated that the nurse should have notified Resident 94's physician when the resident refused the biopsy recommended by the dermatologist. ADON 1 stated failing to promptly communicate with the physician can lead to delays in care, which may worsen the resident's condition. During a concurrent interview and record review on 4/23/2026 at 9:53 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 94's physician order dated 3/10/2026 was reviewed. The order indicated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clobetasol Propionate External Cream, apply to right temple topically every day shift for prurigo nodularis for 30 days, cleanse with normal saline, pat dry cover with dry dressing. LVN 3 stated the order was prescribed by the dermatologist and last administered on 4/10/2026. LVN 3 stated there are no current treatment orders for Resident 94's right temple sore beginning 4/11/2026. LVN 3 stated she has been leaving Resident 94's sore open to air since the sore is dry, no drainage or will apply adhesive bandage per resident request. LVN 3 stated she should have obtained orders for the appropriate care for Resident 94's right temple sore. LVN 3 stated that she should have communicated to Resident 94's physician how the dermatologist last evaluated Resident 94 on 4/7/2026, did not issue any new treatment orders, and that the current order is set to expire on 4/10/2026. During an interview on 4/23/2026 at 11:54 am with Assistant Director of Nursing (ADON) 1, ADON 1 stated physician orders should have been obtained if there were no longer active treatment orders to follow for Resident 94's right temple wound. ADON 1 stated the delay in obtaining orders delayed the delivery of care to Resident 94 which had the potential to worsen Resident 94's skin condition. During a review of Resident 94's Medication Administration Record (MAR) dated March 2026 and April 2026, the MAR indicated Clobetasol Propionate External Cream, apply to right temple topically every day shift for prurigo nodularis for 30 days, cleanse with normal saline, pat dry cover with dry dressing was administered daily starting on 3/12/2026 and last administered on 4/10/2026. During a review of the facility's policy and procedure (P&P) titled, Non-Pressure Sore Management last reviewed 11/25/2025, the P&P indicated, Procedure: .3. Notification of physician and orders for non-pressure sore treatment. During a review of facility's job description titled Job Description Job Title: Treatment Nurse dated 1/27/2022, the job description indicated, Treatment Nurse Essential Duties and Responsibilities include the following: -Immediately calls physician for appropriate treatment order on skin problems when identified and as needed. -Monitors and treats skin conditions per physician's orders. -Monitors condition changes and properly documents and follows-up as necessary.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to to ensure the low air loss mattress (a specialized mattress that continuously circulates air) was used correctly for two of six sampled residents (Resident 155 and 60) reviewed under pressure ulcer/injury when:1.Resident 155's LALM was set to 499 pounds instead of 160 pounds. 2. Resident 60's LALM was turned off. These failures had the potential to result in development or worsening of pressure ulcers (localized pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), slower healing, and increased skin breakdown. Findings: 1. During a review of Resident 155's Face Sheet (FS - front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 155 was admitted on [DATE] with diagnoses that included cerebral infarction (stroke – loss of blood flow to a part of the brain), tracheostomy (a surgical procedure that creates an opening in the windpipe to establish a direct airway), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 155's Minimum Data Set (MDS-a resident assessment tool) dated 4/12/2026, the MDS indicated Resident 155 has severely impaired cognitive skills for daily decision making. Resident 155 required a helper to do all of the effort for toileting hygiene, shower/bathe, dressing, sit to lying, and lying to sitting on side of bed. During a review of Resident 155's History and Physical (H&P), dated 4/30/2025, the H&P indicated Resident 155 does not have the capacity to understand and make decisions. During a review of Resident 155's physician's order for LALM dated 12/8/2025, the physician's order indicated to use LALM for wound care and management, check everyday. During a concurrent observation and interview on 4/20/2026 at 11:29 am with the Assistant Director of Nursing (ADON) 1 in Resident 155's room, the LALM was set on 499 pounds. ADON 1 stated, Resident 155's LALM was set 499 pounds for a firmer mattress when providing care, it should be set at 160 pounds when done with care. ADON1 further stated keeping a resident on a firm setting can cause skin breakdown redness and increased pressure. During a review of Resident 155's skin assessment dated [DATE], the skin assessment indicated Resident 155 has pressure ulcers on the right hip and sacro-coccyx (base of the spine). During a review of Resident 155's skin assessment dated [DATE], the skin assessment indicated Resident 155 has pressure ulcers on the right ankle, right knee and sacro-coccyx. During a review of Resident 155's care plan for LALM dated 4/2/2025, the care plan indicated to ensure LALM are inflated as recommended. During a review of the facility's LALM operation manual titled, Operation Manual for Protekt Aire 4000DX/5000DX, undated, the operation manual indicated the LALM is intended to reduce the incidence of pressure ulcers. The operation manual also indicated a firm surface will make it easier for the patient to transfer or reposition. Make use of the static mode function for this feature. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Policy: Pressure Sore Management, reviewed 11/25/2025, the P&P indicated to treat pressure sores with all available measures to reduce skin breakdown and pressure sores. During a review of the facility's P&P titled, Policy: Pressure-Reducing Mattresses, reviewed 11/25/2025, the P&P indicated to provide a mattress that will prevent and/or minimize pressure on the skin and ensure proper functioning. 2. During a review of Residentˆ60's Face Sheet (the front page of the chart that contains a summary of basic information about theˆresident),ˆthe Face Sheet indicated Residentˆ60ˆwas admitted on [DATE], and was re-admitted [DATE]ˆwith diagnosis that includedˆdementiaˆ(a progressive, irreversible syndrome characterized by a decline in cognitive function—memory, language, and behavior—beyond normal aging, caused by damaged brain cells),ˆprotein-calorie malnutrition (condition caused by not eating enoughˆor lackingˆkey vitaminsˆleading toˆweakness,ˆweight loss,ˆand weakenedˆbody'sˆdefense system to fight germs).ˆ During a review of Residentˆ60's Minimum Data Set (MDS – a resident assessment tool), datedˆ4/2/2026, the MDS indicated Residentˆ60'sˆcognitive skillsˆ(core mental processes that the brain uses to think, learn, acquire knowledge and solve problems)ˆfor daily decision making is severely impaired (never/rarely made decisions). The MDS indicated Resident 60ˆrarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Residentˆ60ˆwas dependent (helper doesˆall ofˆthe effort)ˆfor all activities of daily living (ADLˆ–ˆactivities including feeding, hygiene, and mobility).ˆThe MDS indicated Resident 60ˆhas a pressure ulcer/injury, a scar over body prominence, or a non-removable dressing/device andˆisˆat risk of developing pressure ulcer.ˆˆ During an observation onˆ4/20/2026 atˆ11:20 a.m.,ˆResident 60ˆwasˆobservedˆlyingˆin bed with eyes closed.ˆLALMˆwas not activated.ˆTheˆOn lightˆwas dim/not lit on theˆpump unit of the LALMˆplaced at the foot of Resident 60's bed.ˆ Duringˆsubsequentˆobservation on 4/20/2026 atˆ12:39 a.m., andˆ2:20ˆp.m.,ˆResidentˆ60ˆwasˆobservedˆin bed withˆLALMˆnot activated.ˆThe On light was dim/not lit on the pump unit of the LALM placed at the foot of Resident 60's bed.ˆ Duringˆanˆinterview onˆ4/20/2026 atˆ3:24.p.m.ˆwithˆLicensed Vocational Nurse (LVN)ˆ3,ˆLVNˆ3ˆstatedˆsheˆobservedˆResident 60'sˆLALM turned offˆatˆapproximatelyˆ2:24ˆduring herˆnursingˆroundsˆ(the regular,ˆroutineˆvisits by the nurseˆtoˆassessˆcare, ensure safety, and address comfort needs).ˆLVN 3ˆstatedˆshe did not know whyˆResident 60'sˆLALM was notˆturned on.ˆLVN 3 stated thatˆthe LALM should always beˆturned onˆwhen Resident 60 is in bed.ˆLVN 3ˆstatedˆthat sheˆturned onˆthe LALM. LVN 3 statedˆthatˆtheˆLALMˆactivated andˆworked properly onceˆshe turned on the LALM by pressing theˆOnˆbutton.ˆ During an interview onˆ4/23/2026 atˆ11:54ˆamˆwith theˆAssistantˆDirector of Nursing (ADON)ˆ1,ˆADONˆ1ˆstatedˆthatˆLALM, when ordered for a resident,ˆshould beˆalways turned onˆforˆresident'sˆcomfort andˆtoˆprevent pressure ulcers from developingˆorˆworsen a pressure ulcerˆthat has already developed.ˆADON 2ˆstatedˆthat when the LALM is not turned on, the resident is not receiving theˆtreatment and care asˆphysicianˆprescribed. ADON stated not havingˆtheˆLALMˆturned onˆincreased Resident 60'sˆrisk for developing (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressureˆulcerˆandˆexperiencing discomfort.ˆ During a review of Resident 60's Braden Scale for Predicating Pressure Sore Risk dated 1/2/2026, the Braden Scale for Predicating Pressure Sore Riskˆindicatedˆ Resident 60's score was 14.ˆResident 60'sˆassessment scoreˆplaced him at moderate risk for developing pressure ulcer/sore. According to the scoring description, score of 15-18 is at risk, 13-14 moderate risk, 10-12 moderate risk, 10-12ˆhigh risk, 9 or belowˆvery highˆrisk.ˆ During a review of Resident 60's physician order dated 10/13/2026, the orderˆindicatedˆlow air loss mattress for wound care and managementˆevery dayˆshift for skin maintenance.ˆ During a review of Resident 60's care plan titled, At risk for falling from low-air-loss mattress due to resident requiring total careˆinitiatedˆ1/21/2026, the care planˆindicatedˆensure LALM are inflated and recommended.ˆ During a review of the facility'sˆpolicy and procedureˆ(P&P)ˆtitled, Pressure-Reducing Mattress last reviewedˆ11/25/2025, the P&Pˆindicated, Toˆprovide mattresses that will prevent and/or minimize pressure on the skinˆ During a review ofˆtheˆoperation manual titled Operational Manual forˆProtektˆAire 4000DX/5000DX, the operation manualˆindicatedˆ.ˆintendedˆto reduce the incidence of pressure ulcers whileˆoptimizingˆpatient comfort.Pump unit activation;ˆSwitch the power on. Once ready, the indicatorˆof the power key will remain on.ˆ

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for two out of five residents (Resident 105 and Resident 202) investigated for accidents by: a. Failing to ensure Resident 105's floor mat (a cushioned floor pad meant to prevent injury if a person falls) was placed next to Residents 105's bed. b. Failing to ensure medical equipment or waste container was not placed on top of Resident 105's floor mat. c. Failing to ensure a floor mat was placed on the right side of Resident 202's bed as ordered.These deficient practices placed the residents at increased risk of injury. Findings: a/b. During a review of Resident 105's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 105 on 3/3/2022, and re-admitted Resident 105 on 9/25/2025 with diagnoses that included epilepsy (a brain disorder that causes seizures), metabolic encephalopathy (general term that describes brain disease, damage, or malfunction usually related to inflammation within the body) and cerebral infarction (stroke - damage to the tissues in the brain due to a loss of oxygen to the area). During a review of Resident 105's Minimum Data Set (MDS – a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 105's cognitive skills (core mental processes that the brain uses to think, learn, acquire knowledge and solve problems) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 105 rarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Resident 105 was dependent (helper does all of the effort) for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).^ During a concurrent observation and interview on 4/20/2026 at 3:20. p.m. with Certified Nursing Assistant (CNA) 2 in Resident 105's bedside, observed Resident 105's floor mat positioned against the left side of the wall in Resident 105's room. This placement resulted in a portion of the floor adjacent to Resident 105 remaining uncovered by the floor mat. Waste container and medical device pole (height adjustable stand used in health care setting to hold fluids and/or safely hold bags, fluids, and medical pumps) observed on top of the floor mat. CNA 2 stated the waste container and medical device pole should not be on top of the floor mat. During an interview on 4/20/2026 at 3:22 p.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated nothing should be resting on top of the floor mats. LVN 6 stated that floor mats purpose is to provide cushion in the event of a resident fall. LVN 6 stated that having items on the floor mat would prevent the mat from providing cushion to the resident who falls. LVN 6 stated that additionally, the items on top of the floor mat may cause resident harm or injury during the fall. During an interview on 4/23/2026 at 11:54 a.m. with Assistant Director of Nursing (ADON) 1, ADON 1 stated that floor mats are used when a resident is at risk for fall to decrease potential injury in the event of a fall. ADON 1 stated the floor mat should be placed on both sides of a resident's bed, on the floor immediately next to the resident's bed. ADON 1 stated there should not be any items on top of the floor mat for the floor mat to serve its function of preventing injury during a fall. ADON 1 stated items on top of the floor mat could cause further injury during a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 105's physician order dated 1/5/2026, the physician order indicated an order for a floor mat to decrease potential injury. During a review of Resident 105's Fall Risk Assessment, dated 9/25/2025, Resident 105 risk assessment score was 24. The Fall Risk Assessment indicated a score of 18 or more indicates the resident is high risk for falls. During a review of Resident 105's care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) on at risk for falls/injury related to general weakness, impaired cognition, poor body balance/control, poor safety awareness/judgment, seizure disorder, last revised 2/28/2026, the care plan indicated to provide the resident with a safe and clutter-free environment. During a review of Resident 105's care plan last revised on 2/28/2026, the care plan indicated the resident is on lower bed and floor mat to decrease potential injury. c. During aˆreview ofˆResident 202'sˆFace Sheet, the Face Sheetˆindicated the facilityˆadmitted the resident onˆ8/18/2022ˆandˆmost recentlyˆreadmitted the resident onˆ2/2/2026ˆˆwith diagnoses including,ˆbut not limited to,ˆacute respiratory failureˆ(a condition where the lungs cannot release enough oxygen into the blood), epilepsy, and a history of falling.ˆ During a review ofˆResident 202'sˆHistory and Physical (H&P), datedˆ2/5/2026, theˆH&PˆindicatedˆResident 202ˆwasˆatˆa high riskˆfor falls.ˆˆ During a review ofˆResident 202's MDS, dated [DATE], the MDS indicatedˆResident 202ˆwasˆin a persistent vegetativeˆstate (a disorder of consciousness following severe brain injury where the person is awake but completely unaware of themselves or their environment)ˆandˆwas dependentˆwithˆallˆADLs. During a review of Resident 202'sˆOrder Summary Report, the Order Summary Reportˆindicatedˆan active order dated 2/2/2026 for floor mat to decrease potential injury. During a review of Resident 202's care plan for at risk for falls/injury.,ˆlast revised 2/26/2026, the care plan indicatedˆaˆgoal to reduce the risk of falls and injury.ˆThe care planˆindicatedˆto provide theˆresidentˆwith a safe and clutter-free environment.ˆ During an observation on 4/20/2026 at 10:37 a.m. at Residentˆ202's bedside, Resident 202 was in bed and there was a floor mat on the left side of the resident's bed but not on the right side of the resident's bed.ˆ During a concurrent observation and interview on 4/20/2026 at 1:19 p.m. with the ADON 2, ADON 2ˆverified there was no floor mat on the right side of the resident's bed. ADON 2ˆstatedˆthe floor mat should be there. ADON 2 stated Resident 202 is at risk forˆfalls,ˆand the floor mat should be there for her safety in case of a fall.ˆ During an interview onˆ4/23/2026ˆatˆ3:24ˆp.m. with the Director of Nursing (DON),ˆtheˆDONˆstatedˆResident 202 should have floor mats as a part of her safety precautions.ˆThe DONˆstatedˆif there is no floor mat the resident is at risk of injury.ˆˆˆ (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled Initial Fall Risk Assessment last reviewed 11/25/2025, the P&P indicated, Purpose – To identifyˆresidents who are at risk of falling and begin interventions to prevent injury.Each resident will be given a score, if the core is 18 or above, the resident will be considered as high risk for fall and a plan of care will be established immediately for implementation of interventions to attempt prevention.Recommend the interventions as needed: . floor mat/landing mat.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure the indwelling urinary catheter tubing (a hollow tube inserted into the bladder to drain or collect urine) did not have a dependent loop and urine did not backflow for one of two residents (Resident 212) investigated under urinary catheter. This deficient practice had the potential to negatively affect Resident 212 from receiving the proper care necessary to prevent urinary tract infection (UTI - an infection in the bladder/urinary tract). Findings: During a review of Residentˆ212'sˆFace Sheet, the Face Sheetˆ the facilityˆadmitted ˆ Residentˆ212 to the facilityˆonˆ4/15/2026ˆwith diagnoses includingˆdementiaˆ(a progressive state of decline in mental abilities), tracheostomy (a surgical procedure that creates an opening in the neck leading directly into the tracheaˆ[windpipe])ˆand dependence on a ventilator (a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own).ˆ During a review of Residentˆ212's Minimum Data Set (MDS-a resident assessment tool) which wasˆ in progress as ofˆ4/23/2026, the MDS indicated the residentˆnever/rarelyˆmake herself understood andˆnever/rarelyˆunderstood others. The MDS furtherˆindicatedˆResidentˆ212ˆwas dependentˆ(helperˆdoes all the effort) withˆall activities of daily livingˆ(ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆ ˆˆ During an observation and interview onˆ4/20/26ˆatˆ9:55ˆa.m ,ˆinside Resident 212's room, Resident 212 was lying in bed, asleep with a urinary catheter bag hanging in the middle of the left side of the resident's bed frame. The urinary catheter tubing hung below the left side of the bed and had a large, dependent loop. The looped portion of the urinary catheter tubing contained yellow liquid with a small amount of sediment that back flowed towards the urine drainage port. ˆ During a concurrent observation and interview on 4/20/26ˆatˆ9:59ˆa.m., inside Resident 212's room with the Infection Preventionist Nurse (IPN), the IPN stated Resident 212's urinary catheter tubing was looped and contained yellow liquid with white sediment that back flowed toward the urine drainage port. The IPN stated the urinary catheter tubing should be straight to drain the urine into the urinary catheter bag. The IPN further stated if the urine is not draining properly, the resident could possibly get an infection because the urine might backflow into his body.ˆˆ During an interview onˆ4/23/26ˆatˆ1:32ˆP.M.ˆwith Assistant Director ofˆNursing 1 (ADON 1), ADON 1ˆstated nursing staff should always ensure urinary catheter tubing remain straight and not coiled or looped to prevent UTI's. During a review of the facility`s policy and procedureˆ(P&P)ˆtitled Catheter Care, Urinary last reviewed onˆ11/25/2025ˆtheˆP&PˆindicatedˆthepurposeˆofˆtheˆpolicyˆwasˆtoˆpreventˆurinaryˆcatheterˆassociatedˆcomplicationsˆsuchˆasˆUTIs.ˆTheˆP&Pˆfurtherˆindicatesˆunobstructedˆflowˆmustˆbeˆmaintainedˆandˆfreeˆofˆkinks.ˆˆˆ

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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 flush the gastrostomy tube ([GT] - a tube inserted through the belly that delivers nutrition and medications directly to the stomach) with water prior to medication administration, for one (1) of six (6) residents observed for medication administration (Resident 87.) This deficient practice had the potential to cause Resident 87 to receive suboptimal (less than the highest standard or quality) care and have complications of the GT, including aspiration (when food or liquid comes back up from the stomach and enters the lungs [pair of organs situated within the rib cage responsible for breathing,]) and clogging requiring replacement of the GT. Findings: During an observation on 4/21/2026 at 9:45 a.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed not flushing the GT with water, and LVN 4 grabbing the medication cup containing crushed (pressed very hard so that the shape is destroyed and turned into soft powder) medication for administration into the GT for Resident 87. LVN 4 was stopped by the surveyor before any medication was administered to Resident 87 and was asked to discuss the GT technique with the surveyor. During a concurrent interview, LVN 4 stated that LVN 4 failed to flush the GT with water prior to administration of medications. LVN 4 stated that without flushing the GT with water before administering mediations could clog the tube preventing medication delivery and increase the risk of aspirations and tube replacement for Resident 87. During an interview, on 4/21/2026 at 3:48 p.m., with the Director of Nursing (DON,) the DON stated that LVN 4 failed to flush Resident 87's GT with water prior to medication administration. The DON stated this technique was important to ensure Resident 87's GT was not clogged, that the resident dido not aspirate and did not need to have the GT replaced. During a review of Resident 87's admission Record (a document containing demographic and diagnostic information,) dated 4/21/2026, the record indicated the facility originally admitted Resident 87 to the facility on 1/22/2018 and re-admitted on [DATE] with a diagnosis including encounter for attention to gastrostomy (artificial entrance to the stomach.) During a review of Resident 87's Order Summary Report (a report listing the physician order for the resident,) dated 4/20/2026, the report indicated may give 30 cubic centimeter ([cc] - a unit of measure of volume) of fluids via GT pre (before) and post (after) medication administration. Review of the facility's Policy & Procedures (P&P), titled Medication Administration via Gastrostomy of Nasogastric Tube, last reviewed 11/25/2025, the P&P indicated: 5. All medications will be administered appropriately. 8a. The enteral feeding tube should be flushed with at least 30 cc of water before and after medications are administered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the hemodialysis (also known as dialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) center completed a pre and post-dialysis assessment (evaluation done after hemodialysis by the hemodialysis licensed nurses) by not ensuring the dialysis center recorded a resident's pre- and post-dialysis weights (the weight before and after fluid is removed during the dialysis treatment) on the Dialysis Communication Record (a record of a resident's vital signs and assessments the days he goes to a dialysis treatment) for one (Resident 18) of two residents in the facility investigated for dialysis. This deficient practice had the potential for Resident 18 to have unidentified complications after dialysis treatment such as abnormal vital signs (pulse rate, temperature,ˆrespiratory rate, and blood pressure). Findings: During a review of Resident 18's Face Sheet, the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the document indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included end stage renal disease (ESRD, irreversible kidney failure) and dependence on dialysis. During a review of Resident 18' s Minimum Data Set (MDS, a resident assessment tool), dated 4/06/2026, the MDS indicated Resident 18 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 18 required supervision (helper provides verbal cues) with eating. The MDS indicated Resident 18 receives dialysis treatments. During a review of Resident 18's Physician's Orders, dated 4/14/2026, the orders indicated Resident 18 is to receive dialysis treatments Tuesdays, Thursdays, and Saturdays at a dialysis facility. During a review of Resident 18's Dialysis Communication Record, dated 4/21/2026, the document indicated there were blank spaces for the pre-dialysis and post-dialysis weights. During a review of Resident 18's Care Plan for Weight Variance, initiated 6/20/2021, the care plan indicated a goal that the resident will not have unrecognized signs and symptoms of fluid overload or dehydration. The care plan indicated an intervention that post dialysis dry weights will be utilized that are identified on the Pre/Post Dialysis Form. During a concurrent interview and record review with Licensed Vocational Nurse 11 (LVN 11) on 4/22/2026 at 4:03 p.m., LVN 11 reviewed Resident 18's Dialysis Communication Record. LVN 11 confirmed that there was not a pre- or post-dialysis weight on Resident 18's Dialysis Communication Record. LVN 11 stated he would call the dialysis center to obtain the missing dialysis weights. During a concurrent interview and record review with Registered Nurse 3 (RN 3) on 4/22/2026 at 4:10 p.m., RN 3 reviewed Resident 18's Dialysis Communication Record. RN 3 confirmed that there was not a pre- or post-dialysis weight on Resident 18's Dialysis Communication Record. Reviewed Resident 18's Nursing Progress Notes which did not indicate any licensed nurse contact the dialysis facility for the pre-and post-dialysis weights. LVN 11 stated the licensed nurse should call the dialysis center that day to obtain the missing dialysis weights. RN 3 stated this is important to have baseline weights, to ensure there is no fluid overload occurring for Resident 18. During an interview with the Assistant Director of Nursing 1 (ADON 1) on 4/23/2026 at 8:12 a.m., ADON 1 reviewed Resident 18's Dialysis Communication Record. The ADON 1 stated if a resident returns from the dialysis facility without pre or post weights, the licensed nurses will call the dialysis facility to obtain them. The ADON 1 stated that it is important to ensure the fluid removed is not excessive and is important indicator of a resident's fluid status. During an interview with the Director of Nursing (DON) on 4/23/2026 at 12:10 p.m., stated the licensed nurses need to contact the dialysis center to obtain the pre- and post-weight. The DON stated knowing the weights are important which can indicate fluid overload, which could lead to edema (swelling in the arms and legs), high blood pressure, and possible congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of the facility's (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy and Procedure (P&P) titled, Care of Resident Receiving Renal Dialysis, last reviewed 11/25/2025, the P&P indicated the Dialysis Communication Record should be complete during dialysis days by the dialysis facility nurse. The policy indicated the completed Dialysis Communication Record will be sent back with the resident and facility will complete the post dialysis assessment. ^ ^ ^

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain consent and a physician's order for the use of four side rails for one of two sampled residents (Resident 116).This deficient practice had the potential to place the resident at risk for inappropriate use of bed rails and bed rail-related accidents, including the risk of a body part being caught between the rails which could lead to injury.Findings: During a review of Resident 116's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 116 was admitted on [DATE] with diagnosis that included nontraumatic intracranial hemorrhage (spontaneous brain bleed), respiratory failure (when the lungs cannot get enough oxygen in the blood making it difficult to breath), and hypertensive emergency (blood pressure rises to extreme levels that cause damage to vital organs).During a review of Resident 116's MD Progress Notes, dated 7/9/2025, the progress notes indicated Resident 116 does not have the capacity to understand and make decisions.During a review of physician's order dated 1/8/2026, the order indicated (Support and Safety Device) bilateral upper half siderails up and locked when in bed for ADL changesDuring a review of Resident 116's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2026, the MDS indicated Resident 116 makes self usually understood (difficulty communicating some words or finishing thoughts but is able if prompted or given time) and usually understands others (misses some parts/intent of message but comprehends most conversation). The MDS indicated Resident 116 was dependent (helper does all of the effort) in all activities of daily living (ADL - activities including feeding, hygiene, and mobility).During an observation on 4/20/2026 at 3:35 p.m., Resident 116 was observed lying in bed with upper and lower bed side rails raised up on both sides of the bed. During a concurrent observation and interview on 4/20/2026 at 3:43 p.m. with Certified Nursing Assistant (CNA) 3, Resident 116 was lying in bed with the left and right upper side rails raised up and right-side lower side rail raised up. CNA 3 stated she had the lower left side rail down since she was preparing to provide care to Resident 116. CNA 3 stated she will raise all four side rails up once done with providing care to Resident 116. CNA 3 stated Resident 116 is supposed to have all four side rails raised up. During a concurrent observation and interview on 4/20/2026 at 3:55 p.m. with Director of Staff Development (DSD), Resident 116 was lying in bed with all four bed side rails up. DSD stated Resident 116 should only have upper side rails up per the physician's orders. During a concurrent interview and record review on 4/20/2026 at 4:25 p.m. with Assistant Director of Nursing (ADON) 1, Resident 116's Informed Consent dated 7/9/2025 was reviewed. The Informed Consent indicated bilateral upper half side rails up when in bed secondary to involuntary movement by gravity due to elevated head of bed for management and provision of enteral feeding. ADON 1 stated the physician's order is for bilateral upper side rails. ADON 1 stated there was no informed consent or physician's order for Resident 116 to have all four side rails. ADON 1 stated that an informed consent and physician's order specific for four side rails was required for Resident 116 to have all four bed side rails applied.During a review of the facility's policy and procedure (P&P titled), Bed Safety and Bed Rails last reviewed date 11/25/2025, the P&P indicated, The use of bed rails is prohibited unless the criteria for use of bed rails have been met.If attempted alternatives do not adequately meet the resident's needs, the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: .consultation with the attending physician.Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:a. The assessed medical needs that will be addressed with the use of bed rails;b. The residents risk from the use of bed rails and how these will be mitigated; c. The alternatives that were (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempted but failed to meet the resident's needs; andd. The alternatives that were considered but not attempted and the reasons.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure adequate monitoring and documentation of potential side effects for apixaban, an anticoagulant (blood thinner) used to prevent blood clots, for one of five sample residents (Resident 191) during review of unnecessary medications.This deficient practice had the potential to result in Resident 191 experiencing adverse effects, including signs and symptoms of bleeding. Without proper monitoring, staff may fail to recognize bruising or internal bleeding, resulting in delayed care, significant blood loss, and potentially life-threatening outcomes.Findings: Duringˆaˆreview of Residentˆ191'sˆFace Sheet(admission record), theˆFace Sheetˆindicated the facility originally admitted Resident 191 on 10/23/2016 and re-admitted the resident on 2/20/2026, with diagnoses including hypertension(high blood pressure), chronic respiratory failure (long-term condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen, and functional quadriplegia (complete loss of ability to move all four limbs-arms and legs).During a review of Resident 191's Minimum Data Set (MDS - a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 191's cognition (are the mental abilities a person uses to think, learn, understand, and process information) was severely impaired for daily decision-making. During a review of Resident 191's Physician Order Summary Report, active orders as of 4/21/2026, the Physician Order Summary Report indicated the following order to administer apixaban 2.5 mg tablet, two times a day for deep vein thrombosis (DVT) a serious condition where a blood clot forms in a deep vein, prophylaxis(prevention) with the start date of 2/21/2026.During an interview and record review on 4/22/2026 at 11:06 a.m. with Assisted Director of Nursing (ADON)1, Resident 191's Medication Administration Record (MAR) dated 4/1/2026 to 4/30/2026 was reviewed. ADON 1 stated Resident 191's MAR indicated Resident 19 received apixaban 2.5 mg every day two times a day from 4/1/2026 to 4/20/2026. ADON 1 stated Apixaban is an anticoagulant and can cause major and serious bleeding. ADON 1 stated staff should monitor and document the side effects of apixaban in the Electric Medical Records (EMAR). During the same interview ADON 1 reviewed Resident's 191 EMAR dated 4/1/2026 to 4/20/2026. ADON 1 stated there was no record to indicate that Resident 191's was monitored for side effects of anticoagulant use such as bleeding. ADON 1 stated regular monitoring of the residents allows staff to identify early signs and symptoms of bleeding and report to physicians immediately to prevent harm to residents. During an interview on 4/22/2026 at 12:02 p.m. with Director of Nursing (DON), the DON stated Resident 191 received apixaban 2.5 mg every day two times a day per physician order. The DON stated apixaban is an anticoagulant medication and that side effects of high alert medications should be monitored and documented in the electronic medical administration record (EMAR). The DON stated that apixaban carries risks such as severe bleeding, and lack of monitoring or documentation could result in delayed care. Staff may miss signs of bruising or internal bleeding, which could delay care. The DON stated she could not find documented evidence that staff monitored and assess for side effects of apixaban. The DON stated it is standard of practice for facility staff to monitor the side effects of anticoagulants such as apixaban. A review of the facility's policy and procedure titled Anticoagulation - Clinical Protocol, reviewed on 11/25/2025 indicated to assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. The staff will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Binding Arbitration Agreement (a binding agreement in which parties agree to submit certain disputes to arbitration rather than court litigation) was explained in a manner understandable to the resident for one of three sampled residents (Resident 183), despite the resident having the capacity to make his own decisions. This deficient practice had the potential to result in the residents signing an agreement without fully understanding its terms and could compromise the resident's rights. Findings: During a review of Resident 183's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility from a General Acute Care Hospital (GACH, or simply hospital on 4/21/2026 with diagnoses that included osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D).During a review of Resident 183's Minimum Data Set (MDS, a resident assessment tool), dated 2/04/2026 (Please clarify the date. This date, 2/04/2026 is prior to the admission date of 4/21/2026. Please add an initial admission date) the MDS indicated Resident 183 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 183 was originally admitted to the facility on [DATE]. The MDS indicated Resident 183 required supervision or touching assistance (helper provides verbal cues and/or touching /steadying assistance as the resident completes activity) with eating.During a review of Resident 183's Arbitration Agreement, the document indicated Resident 183 signed the agreement on 4/22/2026.During a review of Resident 183's History and Physical (H & P, a medical document where a resident's physician interviews a patient to gather subjective health history and conducts an objective physical examination), dated 4/23/2026, the H & P indicated Resident 183 has the capacity to understand and make decisions.During an observation and interview with Resident 183 in his room on 4/23/2026 at 1:15 p.m. when asked if he remembers signing an arbitration agreement, he did not say anything. When asked about the arbitration process, he stated who is going to be his arbiter. (actual word is arbitrator, a professional who is involved in the arbitration process) Resident 183 was notified that the facility and he would decide. Resident 183 stated it did not matter; I don't have an arbiter.During an interview with Resident 183 in the presence of the Social Services Director (SSD) on 4/23/2026 at 1:31 p.m., the SSD asked Resident 183 if he felt okay mentally and he nodded his head No. Resident 183 stated, My brain is slowly growing back. Resident 183 then stated the night nurses had taken his phone charger, his phone, and his computer. The SSD told him she would conduct an investigation into these missing items and that in the meantime he could use the portable phone from the nurse's station. Resident 183 stated they refused to give him the phone because they thought he was going to sue the hospital. After leaving Resident 183's room, the SSD stated that maybe Resident 183 was confused in the hospital. Resident 183 stated she heard him say his brain is slowly growing back.During an interview with Registered Nurse 1 (RN 1) on 4/23/2026 at 1:45 p.m., RN 1 stated Resident 183 has periods of confusion and that he had returned from the General Acute Care Hospital (GACH, or simply hospital) on 4/21/2026. During an interview with the Admissions Assistant (AA) on 4/23/2026 at 2:12 p.m., she stated she explains the arbitration process in person if a resident is alert. The AA showed a question/answer paper regarding the arbitration process. During an interview with Resident 183 in the presence of the AA on 4/23/2026 at 2:19 p.m., AA asked Resident 183 if he understood what the arbitration agreement was. Resident 183 stated, Vaguely. My brain is slowing growing back.During an interview with the AA immediately after leaving Resident 183's room, when asked what her assessment was, she stated, He's a little confused, he's there but gets off track. The AA stated it is important for residents to understand what the arbitration agreement is because it is their right and they have the right to know (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what the arbitration agreement is. During an interview with Resident 183 in the presence of the Director of Nursing (DON), Assistant Director of Nursing 1 (ADON 1) and the AA, when the DON asked if he understood the arbitration agreement Resident 183 stated, No. I just signed it because they wanted me to.Upon leaving Resident 183's room, when asked why the AA did not decide to wait a few days until Resident 183 was more alert, the DON, ADON, and AA did not provide an answer to the question.During a review of the facility's Question/Answer Arbitration Agreement document, last reviewed 11/25/2025, the document indicated arbitration is a way for parties to privately resolve disputes and lawsuits rather than going to court. The document indicated both sides and their attorneys must agree to the arbitrator before the arbitrator is selected.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based onˆobservation,ˆinterview, and record review, the facilityˆfailed to maintain infection control measuresˆbyˆfailing to: 1. Ensure trash was not placed with a resident's urinal in the URINAL ONLY bin belonging to one of one sampled resident (Resident 50). This deficient practice placed residents and staff at risk of exposure andˆpossibly contractingˆinfectious microorganisms.ˆ 2. Ensureˆa visitor wore an isolation gown (type of personal protective equipment [PPE- specialized clothing or equipment worn by an employee for protection against infectious materials] used in healthcare settings to protect healthcare personnel from the spread of infection or illness, particularly from contact with blood and body fluids) and gloves when inside a shared resident's room who was on enhanced barrier precautions (EBP -a set of infection control practices that use PPE to reduce exposure to reduce the spread of multidrug-resistant organisms [MDROs -microorganisms that are resistant to multiple classes of antibiotics and antifungals] in nursing homes) for three ofˆfive residents (Residentˆ12, Resident 21, Resident 172). This deficient practice had the potential to cause cross contamination (transfer of bacteria or other microorganisms from oneˆsurface,ˆfood, or personˆtoˆanother) and the spread of infection for residents,ˆstaffˆand visitors.ˆ Findings:ˆ 1. During a review of Residentˆ50'sˆFace Sheet, theˆFace Sheet indicated the facility admitted ˆResidentˆ50ˆonˆ12/7/2023ˆand readmitted the resident on 5/9/2024ˆwith diagnosis includingˆemphysemaˆ(long-term lung condition that causes shortness of breath), history of falls, and muscle weakness.ˆˆˆ ˆˆˆ During a review of Resident 50's History and Physical (H&P)ˆdated 8/15/2025, theˆH&PˆindicatedˆResidentˆ50 had the capacity to understand and make decisions.ˆˆ During a reviewˆofˆResidentˆ50's Minimum Data Set (MDS - a resident assessment tool) datedˆ2/22/2026, the MDS indicated Residentˆ50ˆhad the ability to makeˆhimselfˆunderstood andˆhadˆthe ability to understand others. The MDS indicated that Residentˆ50 required supervision (helperˆprovides verbal cues) from staff for oral hygiene,ˆtoileting, upper andˆpersonalˆhygiene.ˆ During a concurrent observation and interview on 4/20/2026 at 8:22ˆa.m.,ˆwith Resident 50ˆin Residentˆ50'sˆroom, observed Resident 50 sitting up in bed. Resident 50 threw a piece of trash in a waste bin marked, URINAL ONLY, which had a urinal hanging inside it. Observed several items of trash inside the bin already. When asked why Resident 50 was throwing trash in his urinal only bin, Resident 50ˆstatedˆhe did notˆhave another trash bin for trash but would like one for his room.ˆ ˆ During a concurrent observation and interview on 4/20/2026 at 8:29 a.m., with the Assistant Director of Staff Development (ADSD), in Residentˆ50'sˆroom,ˆthe ADSD observed inside the URINAL ONLY bin and stated trash should not be in there because the resident should have his own bin specifically for trash. The ADSD statedˆthis is Resident 50's home and he should have a trash bin in his room.ˆ During anˆinterview on 4/23/2026 at 1:17ˆp.m., with the Assistant Director of Nursing 1 (ADON 1), ADONˆ1 stated Resident 50 should have had a separate trash bin for trash only to prevent the spread of germs because it could lead to infection and cross-contamination. ADON 1 stated trash should have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	never touched the urinal. ^^ During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed on 11/25/2025, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment andˆencouraged to use their personal belongings to the extent possible.clean, sanitary and orderly environment; clean bed and bath linens that are in good condition.ˆ During a review of the facility's P&P titled, Infection Prevention and Control Program, last reviewed on 11/25/2025, the P&P indicated an infection prevention and control program was established and maintained to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. During a review of Resident 12's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 10/15/2023 and re-admitted the resident on 1/18/2026 with diagnosis that included acute respiratory failureˆ(aˆsudden, life-threatening emergencyˆwhere the lungs cannot get enough oxygen into the blood), encephalopathy (where a disease,ˆdamage, or malfunction alters brain function),ˆandˆprotein-calorie malnutrition (condition caused by not eating enough or lacking key vitamins leading to weakness, weight loss, and weakened body's defense system to fight germs).ˆ During a review of Resident 12's Minimum Data Set (MDS – a resident assessment tool) dated 1/28/2026, the MDS indicated Resident 12's cognitive skills (core mental processes that the brain uses to think, learn, acquire knowledge and solve problems) for daily decision making wasˆseverely impaired (never/rarely made decisions).ˆThe MDS indicated Resident 12 rarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Residentˆ12 was dependent (helper doesˆall ofˆthe effort) for all activities of daily living (ADL – activities including feeding, hygiene, and mobility).^^^ During a review of Residentˆ12's Order Summary Report,ˆthe Order Summary reportˆindicatedˆan order, dated 1/30/2026, for contact precautions due toˆCarbapenem-ResistantˆPseudomonasˆaeruginosaˆ(CRPA –ˆan infection from a highly resistant type of bacteria) of sputum (thick fluid coughed up from the lung).ˆ During a review of Resident 12's care plan titled, On isolation CRPA sputum,ˆinitiatedˆ11/22/2023, the care planˆindicatedˆwill observe contact isolation precaution.ˆ During a review of Resident 21's Face Sheet, the Face Sheetˆindicatedˆthe facility originally admitted Resident 21 onˆ10/26/2022 andˆre-admitted the resident on 8/15/2025 with diagnosis that included acute respiratory failure, encephalopathy, and severe sepsis (a life-threatening blood infection).ˆ During a review of Resident 21's MDS dated [DATE], the MDS indicated Resident 21's cognitive skills for daily decision making wasˆseverely impaired.^^The MDS indicatedˆResident 21 rarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Resident 21ˆwas dependent for all activities of daily living.ˆ During a review of Residentˆ21's Order Summary Report, the Order Summary Reportˆindicatedˆan order, dated 1/30/2026, for contact precautions due to MDROˆ- CRPA of sputum.ˆ (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 21's care plan titled, Contact isolation related to MDRO, CRPA of sputum,ˆinitiatedˆ6/13/2023, the care planˆindicatedˆwill observe contact isolation precaution.ˆ ˆ During a review of Resident 172's Face Sheet, the Face Sheetˆindicatedˆthe facility admitted the resident on 4/10/2025 with diagnosis that included acute respiratory failure,ˆencephalopathyˆand cerebral infarction (stroke – when blood flow to part of the brain is blocked).ˆ During a review of Resident 172's MDS dated [DATE], the MDS indicated Resident 172's cognitive skills for daily decision making wasˆseverely impaired.ˆˆThe MDS indicated Resident 12 rarely/never able to make self-understood and rarely/never able to understand others. The MDS indicated Resident 21ˆwas dependent for all activities of daily living.ˆˆ During a review of Residentˆ172's Order Summary Report, the Order Summary Reportˆindicatedˆan order,ˆdatedˆ1/30/2026,ˆfor contact precautions due to CRPA of sputum.ˆ During a review of Resident 172's care plan titled, Contact isolation related to MDRO, CRPA of sputum,ˆinitiatedˆ5/12/2025, the care planˆindicatedˆwill observe contact isolation precaution.ˆ During an observationˆon 4/22/2026 at 12:22 p.m.,ˆobserved a signˆindicating,ˆStop – Contact Precaution,ˆon the entrance to Resident 12, Resident 21, and Residentˆ172's shared room. Observed a visitorˆin the room standing by the foot of Residentˆ172's bedˆandˆobservedˆnot wearing an isolation gown and gloves.ˆObserved aˆfacilityˆstaff memberˆpassing by the roomˆand brieflyˆspeaking with the visitorˆstanding inside Resident 172's roomˆwhile standingˆoutside the room.ˆˆ Duringˆanˆinterview on 4/20/2026 at 12:30ˆp.m., withˆCertified Nursing Assistant 3 (CNA 3),ˆthe staff memberˆwho spoke with the visitor standing in Resident 172's room,ˆCNA 3ˆstated that Resident 172ˆisˆon contact isolation, asˆwell as Resident 12 and Resident 21 who share the room with Resident 172.ˆCNAˆ3ˆstated that contact isolation meant that staff and visitors should be wearing an isolation gown and glovesˆbefore entering theˆresident's room.ˆCNA 3ˆstatedˆthe family member visiting Resident 172ˆwas not wearingˆan isolation gown and gloves while in the room.ˆCNA 3ˆstatedˆshe did not inform the family member to wearˆan isolation gown and gloves whenˆshe spoke withˆtheˆfamily member from outsideˆResident 172'sˆroom.ˆCNA 3ˆstatedˆshe should haveˆspoken to the family member about wearing an isolation gown and gloves asˆit was her responsibilityˆsince sheˆsaw the family memberˆwasˆnot wearing themˆwhile in Resident 172's room.ˆCNA 3ˆstatedˆit is important that staff and visitorsˆwearˆappropriate PPEˆand followˆisolation precautions to prevent spread of infection.ˆ During an interview onˆ4/23/2026 at 11:54ˆa.m.,ˆwithˆAssistant Director of Nursingˆ1 (ADON 1),ˆADON 1ˆstatedˆthe purpose ofˆisolation precautionsˆis to preventˆthe spread of infection.ˆADON 1ˆstatedˆthe precautions are to be followed by both staff and visitors.ˆADONˆ1ˆstatedˆthat when visitorsˆdo not comply, staff mustˆexplain to the visitor the purposeˆofˆisolation precautions and its importance, and/or re-educate as needed.ˆˆ During a review of the facility's policy and procedure (P&P) titled, Isolation – Categories of Transmission-Based Precautions, last reviewed date 11/25/2025, the P&P indicated, Contact precautions are implemented for residents known or suspected to be infected with microorganisms (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056149	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Healthcare and Rehabilitation Center	6700 Sepulveda Blvd. Van Nuys, CA 91411

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.Staff and visitors wear gloves (clean, non-sterile) when entering the room.Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.ˆ During a review of the facility's P&P titled, Infection Prevention and Control Program, last reviewed date 11/25/2025, the P&P indicated, An infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases andˆinfection.Prevention of infection:. (2) instituting measures to avoid complications or dissemination.