| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056150 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Catered Manor Care Center | 4010 N Virginia Rd.<br>Long Beach, CA 90807 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatments and services to prevent decline in range of motion ([ROM], full movement potential of a joint [where two bones meet]) on two of six sampled residents (Resident 13, and Resident 70). The facility failed to:1.Ensure Restorative Nursing Aide ([RNA] an advanced nursing assistant who helps residents maintain their function and mobility) notify licensed nurses of Resident 13's inability to tolerate application of handroll ( soft, cylindrical cushions placed in the palm to jeep joints flexible and stop the hand from curling tightly into a fist) and Resident 13's complained of pain on resident's right hand during application of a handroll.2.Ensure appropriate handroll was used on Resident 13's right hand consistently as ordered.3. Ensure Occupational Therapy (OT- profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) accurately assessed Resident 13's right hand/fingers ROM on 4/2/2026.4.Follow Resident 13's Care Plan titled, Resident needs RNA Splinting (device use to stretch, support joints to prevent contractures [a stiffening/shortening at any joint, that reduces the joint's range of motion]) Program and Resident 13 at risk for decline in ROM. limitation of right hand ROM, deformity/contracture, increased pain and decreased for functional use of extremity, initiated on 4/2/2026 which indicated to monitor Resident 13's response and tolerance to treatment (handroll), notifying the rehab department (medical unit designed to restore lost functions, skills, or independence) if resident shows decline in function, and observe for signs and symptoms of painThese failures resulted in Resident 13 complaining of pain in her right hand, and increased contracture of her right hand's third to fifth ( middle finger, ring finger and pinky) digits (fingers). 5.Ensure bilateral hand splints were consistently applied to Resident 70 as ordered five times per week for two to four hours per day.6.Ensure nursing staff notified OT of Resident 70's functional decline, including increased dependence with eating and worsening loss of hand function.7.Ensure OT monitored, reassessed, and followed up on the resident's ROM and functional status despite multiple ongoing skilled OT orders for orthotic management and self^care training.8.Identify and address the resident's loss of ability to feed herself, as Resident 70 progressed from requiring supervision/touching assistance to becoming fully dependent.9.Follow the facility's policy and procedure (P&P), titled Resident Mobility and Range of Motion, dated 2/2026, which indicated, residents will not experience an avoidable reduction in range of motion (ROM) and will receive treatment, services, equipment and assistance to increase and/or prevent a further decrease in ROM.These failures resulted in Resident 70 experiencing a decline in bilateral hand function, increased dependence with eating, and worsening contractures.<br><br>Findings:<br><br>During a review of Resident 13's Face Sheet , the Face Sheet indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including unspecified dementia (progressive state of decline in mental abilities), primary osteoarthritis (weak and brittle bones due to lack of calcium and Vitamin D)<br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of the right hand, gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach), muscle weakness and hypertension (HTN-high blood pressure).<br><br>During a review of Resident 13's Joint Mobility Screening ( JMA- a clinical evaluation that measures how well a joint moves through its full range of motion) dated 1/16/2026 , the JMA indicated Resident 13's right hand/ fingers had minimal loss ( less than 25 percent [%] ) and right hand stiffness digit three to five ( middle finger, ring finger and pinky). The JMA indicated to continue Occupational Therapy (OT ) services and RNA services.<br><br>During a review of Resident 13's History and Physical (H&P) dated 2/4/2026, the H&P indicated Resident 13 could not make medical decisions.<br><br>During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool) dated 2/11/2026, the MDS indicated Resident 13 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 13 was dependent (helper does all the effort and assistance of two or more helpers was required ) on staff with toileting hygiene, bathing, dressing, and transferring to and from a bed to a chair or wheelchair.<br><br>During a review of Resident 13's JMA dated 4/2/2026, the JMA indicated Resident 13 had a full range of motion on her right hand and fingers.<br><br>During a review of Resident 13 Order Summary Report dated 5/1/2026, the Order Summary Report indicated RNA to apply right hand roll daily five times a week for up to two to four hours as tolerated and to check skin integrity (condition of the skin) before and after handroll application.<br><br>During a review of Resident 13's Care Plan titled, Resident needs RNA Splinting (device use to stretch, support joints to prevent contractures) Program and Resident 13 at risk for decline in ROM. limitation of right hand ROM, deformity/contracture, increased pain and decreased for functional use of extremity, initiated on 4/2/2026 and revised on 5/1/2026. The Care Plan goal indicated Resident 13 will maintain/ prevent decline in ROM through the next review. The Care Plan interventions included application of splint through placement of handroll on the right hand, monitor resident's response and tolerance to treatment, notify the rehab department (medical unit designed to restore lost functions, skills, or independence) if resident shows decline in function, observe for signs and symptoms of pain, discomfort, body posture and inform charge nurse as needed.<br><br>During a review of Resident 13's Medication Administration Record (MAR) dated 5/1/2026 to 5/13/2026, the MAR indicated to monitor level of pain every shift. The MAR indicated Resident 13 had no pain on the dayshift, evening shift and night shift from 5/1/2026 to 5/13/2026.<br><br>During a review of Resident 13's MAR for the month of 5/2026, the MAR indicated a physician order dated 5/7/2026 of Acetaminophen (pain medication) tablet 325 milligrams (mgs. - unit of measurement) two tablets every six hours for pain levels of 1 to 10 (0 out of 10 a numeric pain scale with zero meaning no pain and 10 meaning the worst pain imaginable). The MAR indicated Resident 13 did not receive Acetaminophen from 5/7/2026 to 5/13/2026 for pain.<br><br>During a review of Resident 13's RNA Record for the month of 5/2026, the RNA Record indicated RNA to apply right hand roll daily 5 times per week for up to two to four hours or as tolerated. The RNA Record indicated on 5/13/2026- RNA documented Resident 13 refused the handroll and Resident 13 complained of pain.<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 5/11/2026 at 12:05 p.m. in Resident 13's room, Resident 13's right hand was observed without a hand roll in place. Resident 13 was able to open her right thumb and index finger but her middle, ring, and little fingers remained held closely together in a fistˆlike position when asked to open them. No hand roll was present on the bed or the bedside table.<br><br>During a concurrent interview and record review on 5/13/2026 at 1:15 p.m. with Restorative Nursing Assistant (RNA) 4, Resident 13's RNA Record for the month of 5/2026 was reviewed. RNA 4 stated on 5/11/2026, he applied a towelˆmade hand roll to Resident 13's right hand at 10:00 a.m. for four hours. He stated Resident 13 complained of pain and he noticed tension in her right hand when he applied the hand roll, but he did not notify the licensed nurse. RNA 4 stated he did not check the hand roll after applying it and did not report Resident 13's rightˆhand pain to the licensed nurse. RNA 4 stated Resident 13's pain during the handˆroll application could indicate that her right hand was becoming stiffer.<br><br>During a concurrent observation and interview on 5/13/2026 at 9:45 a.m. with RNA 2 in Resident 13's room, observed a small roll made of gauze (a thin fabric used for wound care) wrapped with paper tape in Resident 13's right hand. RNA 2 stated she made the hand roll using gauze and paper tape. RNA 2 removed the rolled gauze from Resident 13's right hand when asked why the hand roll was made of thin folded gauze.<br><br>During an interview on 5/13/2026 at 1:45 p.m. with RNA 2, RNA 2 stated she used the rolledˆup gauze as a hand roll for Resident 13 because it was thinner and smaller than a hand towel, and Resident 13 could not tolerate the towelˆmade hand roll due to pain. RNA 2 stated this was a change in condition and she should have notified the charge nurse so the charge nurse could notify the physician. RNA 2 stated she believed she could manage Resident 13's righthand contracture and her difficulty tolerating the towel hand roll, which was why she did not notify the charge nurse. RNA 2 stated RNA services were not provided consistently due to staffing issues. She stated if Resident 13's pain and inability to tolerate the appropriate hand roll were not addressed, the resident could experience a decline in mobility and worsening of the rightˆhand contracture.<br><br>During an interview on 5/13/2026 at 9:47 a.m. with RNA 3, RNA 3 stated Resident 13 always complained of pain in her fingers when she performed finger exercises on her right hand. RNA 3 stated she used the rolledˆup gauze as a hand roll on 5/12/2026 for Resident 13's right hand because of Resident 13's complaint of pain.<br><br>During an interview on 5/13/2026 at 11:48 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated she had never seen Resident 13 with a hand roll on her right hand but had seen the resident holding a folded napkin in that hand.<br><br>During a concurrent interview and record review on 5/14/2026 at 10:36 a.m. with the Director of Rehab (DOR)/OT, Resident 13's OT Discharge Note dated 1/29/2026, and JMA Joint Mobility assessment dated [DATE] were reviewed. The DOR/OT stated JMA was conducted upon admission, quarterly and annually and when a resident transitioned from therapy services to RNA Services. The DOR/OT stated Resident 13 was discharged from OT on 1/29/2026. The DOR/OT stated Resident 13 had minimal loss on her right hand (minor reductions in joint flexibility or range of motion) and right-hand stiffness on digits 3 to 5 (middle finger, ring finger, and pinky). The DOR/OT stated placement of a handroll on the right hand was recommended to keep the right palm open. The DOR/OT stated a hand roll can be a carrot splint (a specialized, cone-shaped medical device used to gently open and position tightly clenched hands), rolled up face cloth or towel. The DOR/OT stated Resident<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 13 was using a rolled-up face cloth or towel and aqua foam roll when she was discharged from OT Services on 1/29/2026. The DOR/OT stated Resident 13's palm would not remain open if the appropriate hand roll was not applied consistently to her right hand. The DOR/OT stated she was not aware of the issue, noting that it had not been discussed during their weekly meetings. She stated it represented a change in condition due to the resident's pain and inability to tolerate the hand roll application. The DOR/OT stated Resident 13 may experience a decline in her mobility.<br><br>During a concurrent observation and interview on 5/14/2026 at 11:00 a.m. with the DOR and Resident 13, observed Resident 13 eating breakfast with an aqua foam roll (a type of hand roll) placed in her right hand. Resident 13 grimaced ( a facial expression usually of disapproval or pain) and stated that she could hardly eat because of the pain in her right hand, saying, masakit, masakit (Tagalog for painful). The DOR removed the hand roll from Resident 13's right hand and stated that the resident was in pain and that she would notify the charge nurse. The DOR/OT did not asked Resident 13 to report her pain level using the pain scale ( pain scale ratine from zero to ten-screening tool using numerical value to assess the level of pain).<br><br>During a concurrent interview and record review on 5/14/2026 at 11:28 a.m. with the DOR/OT, Resident 13's JMA dated 4/2/2026 was reviewed. The DOR/OT stated it was a mistake when she documented Resident 13 had a full range of motion on the right hand and fingers. The DOR/OT stated her documentation did not reflect the actual status of the resident's right hand.<br><br>During an interview on 5/14/2026 at 11:10 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated he had administered acetaminophen (pain medication) to Resident 13 for her leg pain. LVN 3 stated he was not aware that Resident 13 was experiencing pain in her right hand.<br><br>During a subsequent interview on 5/14/2026 at 11:11 a.m. with the DOR, the DOR stated RNA should have communicated to the licensed nurses about Resident 13's right hand pain and inability to apply the appropriate handroll to the licensed nurses so it will be communicated to the physician. The DOR stated the licensed nurses will obtain a physician order for a referral to the rehab department to evaluate Resident 13's right hand. The DOR stated it was definitely a change in condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) because of the presence of pain and inability to tolerate placement of appropriate handroll. The DOR stated presence of pain on the right hand means the fingers were stiff and got more contracted and this can lead to decline in mobility. The DOR stated she did not know Resident 13 was not tolerating the application of handroll on her right hand. The DOR stated Resident 13 was able to use the handroll without pain when the resident was discharged from OT Services on 1/29/2026.<br><br>During an interview on 5/14/2026 at 5:10 p.m. with the Director of Nursing (DON), the DON stated the RNA staff should have reported the change in condition related to Resident 13's rightˆhand pain and contracture to the licensed nurses so licensed nurse could obtain a physician order for a referral to the rehab department for evaluation and treatment. The DON stated failing to address Resident 13's rightˆhand pain and her inability to consistently tolerate the appropriate hand roll would cause her contracted fingers to worsen, negatively affecting her functional mobility (physical ability to move around and do everyday tasks safely and independently).<br><br>During a review of facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, dated 2/2026, the P&P indicated Residents will not experience an avoidable reduction in range of motion and residents who have limited range in motion will receive treatment and services to increase (continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and prevent a further decrease in ROM.<br><br>During a review of facility's Job Description of a Restorative Care Nurse dated 10/2020, the Job Description of a Restorative Care Nurse indicated A restorative care nurse should assist residents with ROM, and recommend modifications or changes in resident's restorative care as needed.<br><br>5.During a review of Resident 70's Face Sheet , the Face Sheet indicated Resident 70 was admitted to the facility on [DATE] with diagnoses including spinal stenosis (narrowing of the open spaces within the spine), paraplegia, (loss of movement and/or sensation, to some degree, of the legs) intervertebral disc degeneration (a condition where the rubbery, shock-absorbing cushions between the vertebrae degenerate or rupture), and contractures to both knees and contractures to both ankles.<br><br>During a review of Resident 70's History and Physical (H&P) dated 7/24/2024, the H&P indicated Resident 70 was alert and oriented to name, place, and time. The H&P indicated Resident 70 was admitted to the facility for physical therapy (PT, licensed professional aimed in the restoration, maintenance, and promotion of optimal physical function) and occupational therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities).<br><br>During a review of Resident 70's MDS dated [DATE], the MDS indicated Resident 70 usually had the ability to express wants and ideas. The MDS indicated Resident 70 usually had the ability to make self understood and the ability to understand others with clear comprehension. The MDS indicated Resident 70 had impairment on both sides of the upper extremities. The MDS indicated Resident 70 needed partial to moderate assistance (helper does less than half the effort) from nursing staff with eating, oral hygiene, sitting, lying down and rolling from left to right.<br><br>During a review of Resident 70's Physician Orders, dated 12/17/2025 to 1/13/2026, the Physician Orders indicated order for skilled physical therapy services with treatment plan to include daily Physical Therapy treatment three times per week for four weeks for.Orthotic Management (the clinical use of externally worn devices-such as braces and splints [a device used to restrict, protect, or immobilize a part of the body to support function and increase ROM] used to align, protect, or improve the function of a body part) and self-care training .one time only for four weeks.<br><br>During a review of Resident 70's Physician Orders, dated 12/19/2025 to 1/13/2026, the Physician Orders indicated order for skilled OT services with treatment plan to include daily OT treatment three times per week for four weeks for. both hands Orthotic Management and self-care training.<br><br>During a review of Resident 70's Physician Orders, dated 1/13/2025 to 2/8/2026, the Physician Orders indicated OT order for skilled occupational therapy services with treatment plan to include daily three times per week for four weeks for. both hands orthotic management and self-care training.<br><br>During a review of Resident 70's Physician Orders, dated 4/3/2025 to 4/30/2026, the Physician Orders indicated OT clarification order for skilled occupational therapy services with treatment plan to include daily three times per week for four weeks for. both hands orthotic management and self-care training.<br><br>During a review of Resident 70's OT Treatment Encounter Note dated 1/21/2026, the note indicated Resident 70 required supervision or touching assistance for eating<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 70's MDS, dated [DATE], the MDS indicated Resident 70 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) on nursing staff with eating, oral hygiene, sitting, lying down and rolling from left to right. The MDS indicated Resident 70 received Restorative Nursing Programs (RNA) of Passive Range of Motion (PROM)<br><br>During a review of Resident 70's Care Plan titled Resident Needs RNA Splinting Program, dated 4/30/2026, the Care Plan goal indicated Resident 70 to maintain and prevent a decline in muscle strength and in functional use of the extremities. Resident 70 to maintain and prevent a decline in ROM. The Care Plan interventions indicated to notify rehabilitation if Resident 70 shows a decline in function<br><br>During a review of Resident 70's Physician Orders, dated 5/1/2026, the Physician Orders indicated RNA([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to apply bilateral resting hand splints (a rigid or semi rigid orthotic device designed to support the wrist, hand, and fingers in a neutral or relaxed position) daily 5 times per week for up two to four hours or as tolerated. Check skin integrity before and after application. every day shift - Document total number of hours tolerated.<br><br>During an observation on 5/11/2026 at 12:47 p.m. in Resident 70's room, Resident 70 was sitting up in bed with no splints on both hands. Resident 70 was being fed lunch by Certified Nursing Assistant (CNA) 9 seated at Resident 70's bedside.<br><br>During a concurrent observation and interview on 5/13/2026 at 9:07 a.m. with Resident 70 in Resident 70's room, Resident 70 was lying in bed with no splints on either hand. Resident 70 showed both hands, and her fingers were contracted with no splints in place. Resident 70 stated when she first came to the facility, she was able to use both hands and could feed herself. She stated she was getting worse rather than better and that she was supposed to have splints for both hands<br><br>During an interview on 5/13/2026 at 10:23 a.m. with CNA 9, CNA 9 stated Resident 70 has tightness and stiffness to the joints in both hands. CNA 9 stated Resident 70 needs 100 percent (%) assistance with eating. CNA 9 stated Resident 70 can hold a piece of bread and a coffee cup.<br><br>During an interview on 5/13/2026 at 1:18 p.m. with RNA 2, RNA 2 stated Resident 70 receives RNA services five times per week. RNA 2 stated two weeks earlier, Resident 70 thanked her for applying the hand splints because they had not been applied regularly. RNA 2 stated the fullˆtime RNA had quit the previous week and stated RNAs must follow the physician's orders to prevent further contractures<br><br>During a concurrent interview and record review on 5/14/2026 at 10:36 a.m. with the Director of Rehabilitation/Occupational Therapist (DOR/OT), the OT Discharge Summary for Resident 70, dated 12/17/2025 to 4/28/2026, was reviewed. The OT Discharge Summary indicated Resident 70 required setup or cleanup assistance from nursing staff for eating. The DOR/OT stated Resident 70 had limitations in both hands and had physician orders for bilateral hand splints to be worn two to four hours per day. The DOR/OT stated she was not aware Resident 70 had become dependent on nursing staff for eating and stated nursing staff should have notified her so she could reassess the resident. She stated Resident 70 had experienced a decline in functional ability in both hands, progressing from needing setup or cleanup assistance to becoming totally dependent for eating. The DOR/OT stated Resident 70's decline could worsen or remain at a dependent level if she was not informed of changes in the resident's condition and if the splints were not applied as ordered.<br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 5/14/2026 at 5:37 p.m. with the Director of Nursing (DON), the DON stated Resident 70 had experienced a decline in the mobility of both hands. The DON stated that this decline would affect Resident 70's overall physical functioning. The DON stated Resident 70 was at risk for developing skin breakdown and further contractures<br><br>During a review of the facility's policy and procedure (P&P), titled Resident Mobility and Range of Motion, dated 2/2026, the P&P indicated, Residents will not experience an avoidable reduction in range of motion (ROM). Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.<br><br>During a review of the facility's P&P, titled Job Description/ Occupational Therapist, dated 1/19/2024, the P&P indicated, Job duties.Ability to observe and evaluate treatment effect, discusses observations with staff, Certified Occupational therapist Assistant, Physician and Rehab Director Responsible for the monitoring and documentation of resident treatment and response. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow appropriate isolation precautions and observe infection control measures for three of 19 sampled residents (Resident 31, Resident 47 and Resident 58) by failing to:1. Ensure Resident 31 with active shingles (a painful viral infection that causes a blistering skin rash) and immunocompromised (the body's defense system is weakened or not working properly) was placed in airborne precaution isolations (used to prevent the spread of germs that can float in the air) to prevent the potential transmission of shingles to other residents and staff. 2. Offer and provide hand hygiene (simple practice of cleaning your hands to remove dirt, grease and germs) to Resident 47 and Resident 58 before mealtime. These failures had the potential to to place residents, staff, and visitors at risk for exposure, transmission, and possible outbreak of shingles within the facility, increase the risk of cross-contamination (the transfer of bacteria, viruses, microorganisms or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and spread infection among the residents, staff and visitors.<br><br>Findings:<br><br>1. During a review of Resident 31's Face Sheet, the Face Sheet indicated Resident 31 was initially admitted to the facility on [DATE] and readmitted on [DATE], with a diagnoses including multiple myeloma ( a rare, blood cancer), cerebrovascular accident ([CVA] damage to the brain from interruption of its blood supply), and hemiplegia (paralysis of one side of the body).<br><br>During a review of Resident 31's Minimum Data Set ([MDS] - a resident assessment tool), dated 4/22/2026, the MDS indicated Resident 31 required substantial/maximal assistance (helper does more than half the effort) with toileting, lower body dressing, and putting on and taking off footwear.<br><br>During a review of Resident 31's Medication Administration Record (MAR), dated 5/5/2026, the MAR indicated, Contact and Droplet Precautions ( infection control measures used to stop the spread of germs transmitted through coughing and sneezing and direct and indirect physical contact) for seven days every shift for suspected shingles for 14 days.<br><br>During a review of Resident 31's Situation, Background, Assessment, and Recommendation ([SBAR] a technique which is used to facilitate prompt and appropriate communication within the care team), dated 5/5/2026, the SBAR indicated, Resident 31 was noted with a rash on the left buttock to left inner thigh noted with clustered, small red and silver patched rashes. The SBAR indicated, DX: Shingles. Contact/droplet isolation initiated.<br><br>During a concurrent observation and interview on 5/11/2026 at 10:22 a.m. with Certified Nurse Assistant (CNA) 1, contact precaution signage was observed posted outside Resident 31's room. The posted PPE instructions included gowns and regular surgical masks. The CNA 1 stated Resident 31 was on contact and droplet precautions for shingles. CNA 1 stated he was not aware Resident 31 required airborne precautions. CNA 1 stated he had provided care to Resident 31 utilizing a gown, gloves, and a surgical mask. CNA 1 stated that he did not use an N95 respirator mask (is a type of tight-fitting mask designed to seal closely to the face) because the resident was not identified as requiring airborne precautions. CNA 1 stated that Resident 31's shingles were not always covered during care. CNA 1 stated he follows the isolation signage posted outside resident's rooms and relies on nursing staff to determine and implement the appropriate isolation precautions. CNA 1 stated<br>(continued on next page) |

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| | 056150 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Catered Manor Care Center | 4010 N Virginia Rd.<br>Long Beach, CA 90807 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | incorrect isolation precautions could potentially expose other residents and staff to infectious diseases.<br><br>During an interview on 5/11/2026 at 2:40 pm with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that she was made aware that Resident 31 had shingles on May 5, 2026, at 3:00 pm, by the Infection Preventionist Nurse (IPN). LVN 2 stated she performed a skin assessment and observed fluid filled lesions on the left buttock and the both inner thighs. LVN 2 stated that Resident 31 was moved to a single occupancy room on 5/5/2026. LVN 2 stated that contact precaution and droplet precaution were initiated by the IPN based on the Nurse Practitioner's order on 5/5/2026. LVN 2 stated that Resident 31's was immunocompromised (your immune system is weakened) due to her history of myeloma (is a type of blood cancer).<br><br>During a concurrent interview and record review on 5/11/2026 at 3:40 pm with the Infection Preventionist Nurse (IPN), Resident 31's Order Summary dated 5/5/2026 was reviewed, the Order Summary indicated to initiate contact and droplet precautions for 7 to 14 days. The IPN stated that she was first made aware that Resident 31 had shingles on 5/5/2026 at 3:00 pm by the TN during rounds. The IPN stated that the facility had been monitoring the rash and had not been confirmed as shingles yet. The IPN stated that contact precautions should be implemented immediately for suspected shingles also droplet precaution. The IPN stated that personal protective equipment ([PPE] equipment used to prevent or minimize exposure to hazards) that the staff should use while providing care for residents in contact or droplet precaution should include for a gown, gloves, and surgical mask. The IPN stated that the residents that are in airborne precaution, the staff should wear an N95 mask. The IPN stated the lesions were located on Resident 31's left buttocks and inner thigh. The IPN stated Resident 31 was immunocompromised due to her medical condition. The IPN stated it was important to ensure proper isolation because other residents, staff and visitors could be exposed. The IPN stated \the shingle lesions were not covered for Resident 31.<br><br>During an interview on 5/12/2026 at 8:50 am with the Nurse Practitioner (NP), the NP stated that he was first notified that Resident 31 had shingles on 5/5/2026 by the Treatment Nurse. The NP stated he was informed Resident 31 had a rash located on the left buttock and left inner thighs. The NP stated upon his assessment Resident 31 had localized red pinpoint fluid filled lesions noted. The NP stated that Resident 31 was immunocompromised due to her diagnosis of myeloma. The NP stated contact precautions, and droplet precautions were initiated. The NP stated Resident 31 lesions were not covered and that the lesions did not have to be covered up because the lesions may become macerated (soften and mushy). The NP acknowledged that placing residents in the wrong isolation precautions and that could have exposed other residents and staff to shingles and spread throughout the facility.<br><br>During a review of the facility's policy and procedure (P&P) titled, Isolation- Categories of Transmission-Based Precautions dated 2026, the P&P indicated .Airborne Precautions; 2. Preventing the spread of airborne pathogens requires a room with special air handling and ventilation called an airborne infection isolation room (AIIR). 3. If an AIIR is not available, a resident suspected of having an airborne infectious disease shall be masked and transported to a facility with an AIIR.<br><br>2. During a dining observation on 5/11/2026 at 12:46 p.m. in Resident 47's room, Certified Nursing Assistant (CNA) 10 brought the lunch tray of Resident 47. CNA 10 did not offer or provide any hand hygiene to Resident 47.<br><br>During a dining observation on 5/11/2026 at 12:48 p.m. CNA 10 brought the lunch tray to Resident 58<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | who was sitting in a wheelchair outside his room. CNA 10 did not offer or provide hand hygiene to Resident 58 before he ate.<br><br>During a review of Resident 47's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 47 was admitted on [DATE] to the facility with diagnoses including legal blindness( severe vision loss that cannot be corrected with glasses or contacts), thoracogenic scoliosis ( unnatural sideways curvature of the spine), history of falling, anxiety disorder ( a person experiences constant, intense, uncontrollable fear or worry about everyday situations) and hypertension (HTN-high blood pressure).<br><br>During a review of Resident 47's History and Physical (H&P- physician's comprehensive and initial assessment of a patient) dated 2/25/2026, the H&P indicated Resident 47 make medical decisions.<br><br>During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool) dated 3/25/2026, the MDS indicated Resident 47 had an intact cognition (thought process) and was independent (resident completes activity by herself) with eating. The MDS indicated Resident 47 had severely impaired vision (no vision or sees only light, colors or shapes and eyes do not appear to follow objects).<br><br>During a review of Resident 58's Face , the Face Sheet indicated Resident 58 was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses including ascites(abnormal buildup of excess fluid in the belly), heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), cirrhosis of the liver(severe, scarring of the liver), and hyperlipidemia (elevated level of fats in the blood).<br><br>During a review of Resident 58's MDS dated [DATE], the MDS indicated Resident 58 had moderately impaired cognitive skills (a person has noticeable difficulties with thinking, memory, language or problem-solving) and required set-up or clean-up assistance (helper sets up or cleans up) with eating.<br><br>During an interview on 5/12/2026 at 4:38 p.m. with CNA 6, CNA 6 stated she would practice hand hygiene before passing out trays to the residents and provide hand hygiene to residents by offering wash cloth with soap and water or hand sanitizer (a liquid or gel used to kill most germs and viruses on the hands) to clean residents' hands before mealtime. CNA 6 stated residents get sick or catch a virus (tiny non-living germs that can only reproduce by sneaking inside a living cell) or germs from their hands which can make them sick if their hands are not clean before eating.<br><br>During an interview on 5/14/2026 at 12:02 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated residents are encouraged to practice hand hygiene using wet towel or ABHR (alcohol-based hand rub-a liquid, gel, or foam sanitizer designed to be rubbed onto the hands to kill germs and prevent the spread of infection). The IPN stated residents could get sick if they are not offered hand hygiene by the staff before and after meals.<br><br>During an interview on 5/14/2026 at 5:10 p.m. with the Director of Nursing (DON), the DON stated the staff was expected to provide wipes, wet towels and alcohol gel to the residents before meals. The DON stated residents could get sick if their hands are not sanitized or cleaned before meal because their hands could be contaminated with germs.<br><br>During a review of facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 2/2026, the P&P indicated the facility considers hand hygiene is the primary means to prevent the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | spread of healthcare associated infections (infections that residents get while the receiving health care). |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess the mental capacity (the ability to understand information and make decisions) of one of four sampled residents (Resident 6) before obtaining informed consent (a voluntary agreement to accept treatment or procedures after receiving information about the risks, benefits, and alternatives) for a psychotropic medication (a drug that affects brain activity related to mental processes and behavior). Resident 6 had fluctuating capacity to make medical decisions.This failure had the potential to violate Resident 6's right to receive adequate information about the risks and benefits of taking psychotropic. Findings:During a review of Resident 6's Face Sheet, the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (a mental health condition characterized by excessive worry or fear), unspecified dementia( a progressive state of decline in mental abilities), unspecified psychosis, (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), depression(common, serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 6's History and Physical (H&P) dated 4/202/2026, the H&P indicated Resident 2 was having memory loss and had fluctuating capacity to make medical decisions.During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 6 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 6 was dependent (helper does all the effort) on staff with toileting hygiene, bathing, and transfer to and from a bed to a chair.During a review of Resident 6's Order Summary Report dated 4/20/2026, the Order Summary Report indicated Buspirone Hydrochloride (medication that treats anxiety) 5 milligrams (mg- unit of measurement) give 0.5 mg. by mouth two times a day for anxiety manifested by verbalization of feeling anxious.During a review of Resident 6's Order Summary Report dated 5/6/2026, the Order Summary Report indicated Escitalopram Oxalate ( medication to treat depression) 5 mg one tablet by mouth in the morning for depression manifested by verbalization of sadness.During a review of Resident 6's Order Summary Report dated 5/6/2026, the Order Summary Report indicated Quetiapine Fumarate (antipsychotic [a type of medication prescribed to treat mental health problem] that treats schizophrenia [a mental illness that is characterized by disturbances in thought]and bipolar disorder[sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated] 100 mg every 12 hours for schizophrenia manifested by recurrent outburst of anger.During a concurrent interview and record review on 5/14/2026 at 2:43 p.m. with Registered Nurse (RN) 1, Resident 6's Informed Consents for Buspirone, Escitalopram Oxalate, Quetiapine Fumarate and H&P dated 4/20/2026 were reviewed. RN 1 stated Resident 6 signed the informed consents for Buspirone, Escitalopram and Quetiapine Fumarate. RN 1 stated Resident 6 should not be signing informed consents for the psychotropic medications because the resident lacked the capacity to make medical decisions. RN 1 stated the purpose of informed consents was to inform the family representative or resident about the risks and benefits of the psychotropic medications and possible side effects that these medications can cause. RN 1 stated not informing the resident or family representative has the potential to violate Resident 6' right to be informed.During an interview on 5/14/2026 at 5:10 p.m. with the Director of Nursing (DON), the DON stated legal documents such as informed consent should be signed by a family representative because Resident 6 will not understand the risks or benefits of the psychotropic medication or he would not be able to recognize or identify side effects that could be related to the psychotropic medicines.During a review of facility's policy and procedure (P&P) titled, Verification of Informed Consent for Psychotherapeutic medications, revised 6/2024, the P&P indicated each resident has the right to be free from psychotherapeutic drugs (medications that affect the mind, emotions, and<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | behavior) and the facility should provide informed consent before treatment with psychotherapeutic drugs. The P&P indicated the physician must personally examine the resident and obtain informed written consent signed by the resident or resident representative before prescribing a psychotherapeutic drug. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were provided accurate information necessary to make informed choices regarding their smoking preferences.The facility failed to:1.Provide consistent and accurate information during the admission process regarding whether the facility was a smoking or nonˆsmoking facility.2. Ensure staff, including the Administrator and admission Coordinator, understood and communicated the facility's smoking policy correctly.3. Ensure the admission Packet and written policies aligned with the information provided verbally to residents.4.Follow the facility's policy and procedure (P&P) titled Resident Self Determination and Participation, dated 2/2026, which indicated if the facility policy changes to one that prohibits smoking (including electronic cigarettes), residents who are currently allowed to smoke will be provided an area to smoke which maintains the quality of life and safety for smoking residents., and residents admitted after the No Smoking policy was adopted are informed of the policy on admission.These failures resulted in residents being incorrectly informed that the facility was nonˆsmoking, despite facility policies indicating otherwise. This inconsistent and inaccurate communication compromised residents' ability to make informed choices, thereby infringing upon their right to selfˆdetermination. This deficient practice has the potential to affect all residents by limiting their ability to exercise personal preferences and rights related to smoking. Based on observation, interview, and record review, the facility failed to honor resident choice and preference for one of six sampled residents (Resident 47) by failing to accommodate Resident 47's request to receive a bed bath on Sundays. This failure resulted in Resident 47 not having their expressed preference for personal care honored.<br><br>Findings:<br><br>During an interview on 5/11/2026 at 2:09 p.m. with the Administrator (ADM), the ADM stated the facility had been a nonˆsmoking facility since 2010 and residents and their families were informed of the nonˆsmoking status prior to admission.<br><br>During a concurrent interview and record review on 5/14/2026 at 8:57 a.m. with the admission Coordinator (AC), the facility's admission Packet was reviewed. The packet included a Smoking Policy and Guidelines section which indicated that the facility recognized residents' right to smoke and complied with local and state smoking regulations. The AC stated he was responsible for informing residents during the admission process that the facility was nonˆsmoking; however, based on the admission Packet and policy, the facility was a smoking facility, and residents who wished to smoke were given incorrect information.<br><br>During an interview on 5/14/2026 at 5:04 p.m. with the Director of Nursing (DON), the DON stated based on the facility's smoking policy, the facility was not providing accurate information to residents regarding smoking and was not following its own policy. The DON stated there was no documentation indicating that the facility was a nonˆsmoking facility. The DON stated residents have the right to smoke and that their rights were being violated.<br><br>During an interview on 5/14/2026 at 5:45 p.m. with the ADM, the ADM stated the facility needed to make adjustments to the smoking policy and the admission Packet. The ADM stated residents were being told the facility was nonˆsmoking but that there was no documentation indicating when the facility became nonˆsmoking. The ADM stated he was new to the facility and had been told that the<br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility was nonˆsmoking<br><br>During a review of the facility's policy and procedure (P&P), titled Smoking Policy – Residents, undated, the P&P indicated, This facility has established and maintains safe resident smoking practices. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences.<br><br>During a review of the facility's P&P, titled Resident Self Determination and Participation, dated 2/2026, the P&P indicated, .If the facility policy changes to one that prohibits smoking (including electronic cigarettes), residents who are currently allowed to smoke will be provided an area to smoke which maintains the quality of life and safety for smoking residents, while considering the health and well-being of non-smoking residents. Residents admitted after the No Smoking policy is adopted are informed of the policy on admission.<br><br>2.During a concurrent observation and interview on 5/11/2026 at 11:19 a.m. with Resident 47, at Resident 47's bedside, there was a sign posted above the bed that indicated Resident 47 must have a bed bath every Sunday morning. Resident 47 stated she did not get a bed bath from Certified Nursing Assistant (CNA) 4 yesterday (5/10/2026) instead she was brought to the bathroom sink by CNA 4. Resident 47 stated CNA 4 gave her towels to clean herself instead of providing a bed bath. Resident 47 stated she felt like she was going to fall and had pain when she stood up in the bathroom sink to clean herself. Resident 47 stated she was blind and need help cleaning herself. Resident 47 stated she felt disappointed and sad with her care.<br><br>During a review of Resident 47's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 47 was admitted on [DATE] to the facility with diagnoses including legal blindness( severe vision loss that cannot be corrected with glasses or contacts), thoracogenic scoliosis ( unnatural sideways curvature of the spine), history of falling, anxiety disorder( a person experiences constant, intense, uncontrollable fear or worry about everyday situations) and hypertension (HTN-high blood pressure).<br><br>During a review of Resident 47's History and Physical (H&P- physician's comprehensive and initial assessment of a patient) dated 2/25/2026, the H&P indicated Resident 47 could make medical decisions.<br><br>During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool) dated 3/25/2026, the MDS indicated Resident 47 cognition was intact (thought process) and required set-up or clean up assistance (helper sets up or cleans up) with toileting hygiene, bathing and transferring to and from a bed to a chair or wheelchair. The MDS indicated Resident 47 had severely impaired vision (no vision or sees only light, colors or shapes and eyes do not appear to follow objects),<br><br>During a review of Resident 47's Care Plan titled, Resident's Preferences, initiated 3/31/2025 and revised 4/2/2026, the Care Plan's goal indicated Resident 47 would express satisfaction with her daily routine. The Care Plan interventions indicated Certified Nursing Assistants (CNA) would provide resident's care in accordance with Resident 47's wishes.<br><br>During an interview on 5/14/2026 at 7:59 a.m. with CNA 4, CNA 4 stated she did not provide Resident 47 a bed bath and brought Resident 47 to the bathroom. CNA 4 stated she gave Resident 47 towels to clean herself in the bathroom. CNA 4 stated she saw the signage posted in the wall of Resident 47's<br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | room indicating provision of bed bath every Sunday. CNA 4 stated Resident 47 wanted to use the bathroom and did not know what kind of level of assistance the resident required because she was not familiar with the resident. CNA 4 stated it was important to follow the preference and choice of residents to ensure Resident 47 residents would feel satisfied and happy with their care.<br><br>During an interview on 5/14/2026 at 8:53 a.m. with Resident 47, Resident 47 stated she asked CNA 4 to take her to the bathroom because she needed to move her bowels (to pass stool or excrete solid waste from the body) then CNA 4 gave her towels to clean herself instead of providing a bed bath.<br><br>During an interview on 5/14/2026 at 10:26 a.m. with CNA 5, CNA 5 stated Resident 47 could not see and required assistance in taking her to the bathroom or to the shower. CNA 5 stated it was important to follow what Resident 47 choice and preference because it was a resident right.<br><br>During an interview on 5/14/2026 at 12:13 p.m. with the Director of Staff Development (DSD), the DSD stated CNAs get report from CNAs from outgoing shift on how to take care of a resident. The DSD stated CNA 4 should have followed Resident 47's preferences to get a bed bath instead of providing towels to the resident to clean herself. The DSD stated Resident 47 would not feel comfortable and could violate Resident 47 right to have a bed bath on Sundays.<br><br>During an interview on 5/14/2026 at 5:10 p.m. with the Director of Nursing (DON), the DON stated the staff must follow resident's preferences because it was a resident right and this would help create a home-like environment for Resident 47.<br><br>During a review of facility's policy and procedure titled, Resident Self-Determination and Participation, dated 2/2026, the P&P indicated each resident is allowed to choose that are consistent with his or her interests, values, assessments and plans of care. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 6) was free of chemical restraints (use of medication to control a patient's behavior or restrict patient's movement and not required to treat the medical symptom). The facility failed to:1.Assess appropriateness of Resident 6's psychotropic medicines (drugs that affect the mind, emotions and behavior) who has a diagnosis of dementia (a progressive state of decline in mental abilities) after being admitted to the facility on [DATE]. Resident was receiving Buspirone (medication that treats anxiety) 0.5 milligram (mg.- unit of measurement) by mouth two times a day for anxiety, Quetiapine Fumarate (generic name of Seroquel- antipsychotic [a type of medication prescribed to treat mental health problem])100 mgs. by mouth every 12 hours for Schizophrenia (a mental illness that is characterized by disturbances in thought) manifested by recurrent outburst of anger and Escitalopram (Lexapro - medication that treats depression) 5 mgs. 1 tablet in the morning for depression manifested by verbalization of sadness. Resident 6 had no documented diagnosis of Schizophrenia.This failure had the potential to put Resident 6 at risk for unnecessary medication and adverse reactions (an unintended, harmful, or unpleasant physical response to a medical treatment) affecting resident's quality of life.Findings:During a review of Resident 6's Face Sheet, the Face Sheet indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (a mental health condition characterized by excessive worry or fear), unspecified dementia( a progressive state of decline in mental abilities), unspecified psychosis, (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), depression(common, serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 6's History and Physical (H&P) dated 4/202/2026, the H&P indicated Resident 2 was having memory loss and had fluctuating capacity to make medical decisions.During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 6 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 6 was dependent (helper does all the effort) on staff with toileting hygiene, bathing, and transfer to and from a bed to a chair. The MDS indicated Resident 6 had diagnoses of anxiety disorder, depression and psychotic disorder (a mental health condition that causes people to lose touch with reality). The MDS indicated Resident 6 was on antipsychotic, antianxiety and antidepressant.During a review of Resident 6's Order Summary Report dated 4/20/2026, the Order Summary Report indicated Buspirone Hydrochloride (medication that treats anxiety) 5 milligrams (mg- unit of measurement) give 0.5 mg. by mouth two times a day for anxiety manifested by verbalization of feeling anxious.During a review of Resident 6's Order Summary Report dated 5/6/2026, the Order Summary Report indicated Escitalopram Oxalate ( medication to treat depression) 5 mg one tablet by mouth in the morning for depression manifested by verbalization of sadness.During a review of Resident 6's Order Summary Report dated 5/6/2026, the Order Summary Report indicated Quetiapine Fumarate (antipsychotic [a type of medication prescribed to treat mental health problem] that treats schizophrenia [a mental illness that is characterized by disturbances in thought]and bipolar disorder[sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated] 100 mg every 12 hours for schizophrenia manifested by recurrent outburst of anger.During a review of Resident 6's Care Plan titled, Resident 6 has a behavior problem, anger outbursts related to diagnosis of schizophrenia, initiated on 5/6/2026, the Care Plan goal indicated Resident 6 will have no evidence of behavior problem by review date. The Care Plan interventions included providing the medications as appropriate.During an interview on 5/13/2026 at 12:09 p.m. with Certified Nursing Assistant (CNA)7, CNA 7 stated Resident 6 was<br>(continued on next page) |

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| | 056150 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Catered Manor Care Center | 4010 N Virginia Rd.<br>Long Beach, CA 90807 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | always sleepy in the morning and had to wake him up to eat breakfast. CNA 7 stated Resident 6 does not refuse care and had no behavioral problem when she was taking care of the resident.During a concurrent interview and record review on 5/14/2026 at 2:43 p.m., with Registered Nurse (RN) 1, reviewed Resident 6's electronic medical record (EMR - digital version of a resident's paper chart which contains medical and treatment history). RN 1 stated Resident 6 did not have a psychiatric evaluation addressing Resident 6's behaviors and use of psychotropic medications. RN 1 stated the Interdisciplinary Team (IDT team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) met on 4/20/2026, but the team did not discuss Resident 6's behaviors or psychotropic medication use. RN 1 stated that a psychiatric evaluation was necessary to determine whether Resident 6 still needs psychotropic medications. RN 1 stated Resident 6 was receiving Escitalopram, Buspirone, and Quetiapine fumarate, which could be unnecessary medications. She stated these medications pose risks of adverse side effects such as hypotension (low blood pressure), sleepiness, and dizziness, which can negatively affect the resident's mobility, activities of daily living (ADLs), and overall quality of life.During an interview on 5/14/2026 at 5:10 p.m. with the Director of Nursing (DON), the DON stated the facility conducts a medication review from the psychiatrist (a medical doctor who specializes in mental health) when a resident was admitted or readmitted to the facility and was on psychotropic medications. The DON stated there was no psychiatric evaluation or assessment conducted for Resident 6 and the facility should have done psychiatric referral. The DON stated Resident 6 taking psychotropic medications can be an unnecessary medication because the staff will not know if the psychotropic medications were still indicated for Resident 6. The DON stated Resident 6 can be at risk for adverse effects of the medications.During a review of facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, dated 2/2026, the P&P indicated residents will only receive antipsychotic medications when indicated and necessary to treat specific conditions. The P&P indicated diagnosis of a specific condition for which the antipsychotic medications are necessary to treat is based on the comprehensive assessment of the resident.During a review of facility's P&P titled, Psychotropic Medication Use, dated 7/2022, the P&P indicated admission or re-admission, new medications or renewal of orders are situations that will prompt an evaluation or reevaluation of the resident. The P&P indicated IDT conducts an evaluation when determining to initiate, modify or discontinue medication therapy. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During an interview and record review the facility failed to ensure two of three sampled residents (Resident 3 and Resident 6) had a PASRR level II (a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) completed to reflect Resident 3 and Resident 6's medical conditions.This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 3 and Resident 6.Findings:A. During a review of Resident 3's Face Sheet (admission record) dated 5/14/2026, the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE]. The face sheet indicated Resident 3 had diagnosis including schizophrenia (a mental illness that is characterized by disturbances in thought), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN-high blood pressure).During a review of Resident 3's History and Physical (H&P) dated 4/20/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS -resident assessment tool) dated 5/2/2026, the MDS indicated, Resident 3 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 3 needed substantial/maximal assistance (helper does more than half the work) in activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 3 was on an antipsychotic (a type of medication prescribed to treat mental health illness).During a review of Resident 3's Order Summary Report dated 5/14/2026, the Order Summary Report indicated, Resident 3 was prescribed aripiprazole (antipsychotic medication) 30 milligrams (mg- unit of measure) give at bedtime for schizophrenia manifested by (m/b) angry outbursts, haloperidol (antipsychotic medication) 2 mg's give one at bedtime for schizophrenia m/b auditory (hearing) hallucinations (false perceptions of things that are not actually there yet feel completely real) and ziprasidone (antipsychotic medication) 80 mg's two times (bid) a day for schizophrenia m/b disordered thinking (disruption in a person's ability to process, organize and communicate thoughts).During a review of Resident 3's care plan titled The resident uses psychotropic medications dated 5/11/2026, the care plan indicated, Resident 3 was taking ziprasidone for schizophrenia m/b disorganized thinking.During a review of Resident 3's care plan titled The resident uses psychotropic medications dated 5/11/2026, the care plan indicated, Resident 3 was taking haloperidol for schizophrenia m/b auditory hallucinations.During a review of Resident 3's care plan titled The resident uses psychotropic medications dated 5/11/2026, the care plan indicated, Resident 3 was taking aripiprazole for schizophrenia m/b angry outbursts.During a review of Resident 3's PASRR level 1 screening notice dated 4/20/2026, the PASRR level 1 indicated, Resident 3 was positive for serious mental illness and a PASRR level II mental health evaluation was required. The PASRR level 1 screening indicated the facility would be contacted in two to four days to set up an appointment for a level II mental health evaluation.B. During a review of Resident 6's Face Sheet dated 5/14/2026, the Face Sheet indicated, Resident 3 was admitted to the facility on [DATE], the face sheet indicated, Resident 6 had diagnosis including anxiety (emotion characterized by feelings of tension, worried thoughts ), diabetes mellitus and depression (a mood disorder causing persistent feelings of sadness).During a review of Resident 6's H&P dated 4/20/2026, the H&P indicated, Resident 6 had fluctuating (changes continually) capacity to make medical decisions.During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had moderate cognitive impairment. The MDS indicated Resident 6 was totally dependent (helper does all the work) with ADLs. The MDS indicated Resident 6 had diagnosis of anxiety, depression and had a psychotic (severe mental illness) disorder. The MDS indicated that Resident 6 was prescribed an antipsychotic, antidepressant (treats depression) and an anti- anxiety medication.During a review of Resident 6's<br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Order Summary Report dated 5/14/2026, the order summary report indicated, Resident 6 was prescribed buspirone (anxiety medication) 0.5 mg's BID for anxiety m/b verbalization of feeling anxious (response to stress), escitalopram (depression medication) 5 mg's daily for depression m/b verbalization of feeling sadness and quetiapine (antipsychotic medication) 100 mg's every 12 hours for schizophrenia m/b recurrent outburst of anger.During a review of Resident 6's care plan titled Resident 6 has a behavior problem of angry outbursts related to (r/t) schizophrenia dated 5/8/2026. The care plan indicated, Resident 6 was taking medication for schizophrenia. During a review of Resident 6's care plan titled Resident 6 uses anti-anxiety medication r/t an anxiety disorder m/b verbalization of feeling anxious dated 4/20/2026. The care plan indicated, Resident 6 was taking an anti-anxiety medication.During a review of Resident 6's PASRR Notice of Attempted Evaluation dated 4/20/2026, the PASRR indicated, the PASRR office was unable to complete a PASRR level II evaluation for serious mental illness because Resident 6 had no serious mental illness and no functional limitations in the last six months.During an interview on 5/14/2026 at 3:41 p.m. with the Minimum Data Set Assistant (MDSA), the MDSA stated she was responsible for following up on the PASRR level I and PASRR level II. The MDSA stated Resident 3 PASRR level 1 and Resident 6's PASRR level II should have been reviewed by staff to ensure they were followed up on correctly because Resident 3 and Resident 6 both had mental illness. The MDSA stated that PASRR's are done to ensure the residents are receiving the appropriate services.During an interview on 5/14/2026 at 5:10 p.m. with the Director of Nurses (DON), the DON stated the staff need to review the PASRR level I and PASRR level II to ensure they are coded correctly on the PASRR screening form. The DON stated treatment and services for the residents can be affected if not coded correctly.During a review of the facility's policy and procedure (P&P) titled Pre-admission Screening Level II Resident Review (PASRR Level II) dated10/2014, the P&P indicated, the facility staff will coordinate the recommendations from the level II PASRR determination and the PASRR evaluation report with the resident's assessment, care planning and transitions of care. The facility will refer all level II residents and all residents with a newly evident possible serious mental disorder, intellectual disability or a related condition for level II resident review upon a significant change in status assessment. The P&P indicated, the state is responsible for providing specialized services to residents with mental illness or intellectual disabilities residing in a skilled nursing facility. The P&P indicated, the IDT will review the level II evaluation report to develop a care plan and arrange for specialized services recommended for the residents. Specialized services are add on to the facility services- they are of higher intensity and frequency than the services provided by the facility. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility staff failed to ensure one of one sampled resident (Resident 65) received proper assistive devices to maintain hearing abilities by not assisting Resident 65 in arranging for an audiologist (a licensed healthcare professional who diagnoses, treats, and manages hearing loss) referral consult. This deficient practice resulted in Resident 65 not being able to hear adequately during a conversation, not being able to effectively communicate with staff and understand care and services being given.Findings:During a review of Resident 65's Face Sheet, (front page of the chart that contains a summary of basic information about the resident) the Face sheet indicated Resident 65 was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with diagnoses of but not limited to ataxia, spinal stenosis, dementia (a progressive state of decline in mental abilities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 65's History and Physical (H&P), dated 7/29/2025, the H&P indicated Resident 65 was not able to make her own medical decisions at this time.During a review of Resident 65's Minimum Data Set (MDS - a resident assessment tool) dated 3/9/2026, the MDS indicated Resident 65's ability to hear was adequate with no difficulty in in normal conversation. The MDS indicated Resident 65 did not have hearing an aid (a device worn in or behind the ear designed to amplify sound for individuals who have difficulty hearing) or other hearing appliances. The MDS indicated Resident 65 needed substantial to maximal assistance (help does more than half the effort) with oral hygiene, toileting, showering, personal hygiene, transferring and walking.During a review of resident 65's Order Summary, dated 1/28/2026, the Order Summary indicated Resident 65 had an order to have an ENT consultation with follow up treatment as indicated.During a review of Resident 65's ENT (ear, nose and throat) Notes, dated 1/8/2025, the ENT Notes indicated resident 65 had diminished hearing and a recommendation for an order for an audiogram.During a review of Resident 65's ENT Notes, dated 2/3/2026, the ENT Notes indicated Resident 65 had decreased hearing and wax was removed from both ears.During a review of resident 65's Audiogram dated 1/31/2025, the Audiogram indicated Resident 65 had hearing loss significant enough to qualify for hearing aids and is eligible for them under Medi-Cal and will start the process of obtaining the hearing aids.During an interview on 5/13/2026 at 8:22 a.m. with Resident 65, in Resident 65's room Resident 65 stated I am not able to hear. Resident 65 stated she would like to have hearing aids. Resident 65 stated no one has come to check her hearing. During an interview on 5/13/2026 at 11:32 a.m. with Certified Nursing Assistant (CNA) 11, CNA 11 stated Resident 65 had a problem with hearing and does not have hearing aids. CNA 11 stated you have to get close to Resident 65 when speaking to her.During an interview on 5/14/2026 at 12:01 p.m. with the Social Services Director (SSD), the SSD stated she was responsible for referrals, assessments and for hearing and hearing aids. The SSD stated when speaking to Resident 65 you must be directly in front of her when speaking because Resident 65 has difficulty hearing. The SSD stated Resident 65 was last seen by ENT on 2/3/2026 for ear wax removal. SSD stated she should have made a referral to the audiologist because Resident 65 still had hearing loss after the ear wax removal. The SSD stated Resident 65's hearing loss affects communication with staff and Resident 65 was unable to communicate needs effectively.During an interview on 5/14/2026 at 5:34 p.m. with the Director of Nursing (DON), the DON stated ancillary services are a part of the residents care to ensure they see a specialist. The DON stated if the hearing loss is not addressed the resident's wellbeing would be affected. The DON stated the facility needs to identify residents with hearing loss or communication would be affected and the understanding of others would so be affected. During a review of the facility's policy and procedure (P&P) titled Referrals, Social Services, dated 2/2026, the P&P indicated, .Referrals for medical services must be based on physician evaluation of resident need and a related physician order. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services<br>(continued on next page) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that have been ordered by the physician. Social services will document the referral in the resident's medical record.During a review of the facility's policy and procedure (P&P) titled, Social Services, dated 2/2026, the P&P indicated, Our facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 7) received necessary care and services to prevent the development and progression of avoidable pressure injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence). The facility failed to:1. Provide consistent, accurate, and timely skin assessments and wound management for Resident 7. Inconsistent documentation in Shower Day Skin Inspections between 3/5/2026 and 3/18/2026 showing skin intact/clear despite the resident's known Stage III pressure ulcers (a severe, full-thickness skin loss extending down to the subcutaneous fat).2.Perform and document weekly skin assessments for Resident 7 as required by the facility's policy3. Follow Resident 7's Care Plan titled Potential for further pressure ulcer development.,initiated on 2/21/2017, which indicated interventions to evaluate the skin weekly, monitor skin during care, notify medical doctor promptly of any skin breakdown.and request a wound consult as needed.These deficient practices had the potential to result in delayed identification of skin breakdown, worsening of existing wounds, and inadequate wound management.Findings:During review of Resident 7's Face Sheet , the Face Sheet indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 7's diagnoses including encephalopathy (damage or disease that affects the brain), sepsis (a life-threatening blood infection) protein calorie malnutrition ( a lack of dietary protein, calories, or both), malignant neoplasm of the endometrium (type of cancer that begins in the inner lining of the uterus), and dysphagia (difficulty swallowing).During a review Order Summary Report dated 2/9/2026 to 3/2/2026, the Order Summary Report indicated Resident 7 had an order for bilateral buttocks moisture associated skin damage (MASD- skin damage caused by prolonged exposure to moisture) cleanse with normal saline (a saltwater solution) pat dry, apply collagen powder ( treatment used to manage a wound) then cover with dry dressing everyday and as needed for 30 days.During a record review of Resident 7's Order Summary Report dated 2/17/2026, the Order Summary Report indicated to transfer Resident 7 to the general acute care hospital ( GACH) for dehydration (when the body loses or uses more fluid than it takes in, leaving the body without enough water to function normally) and failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity).During a review of resident 7's Care Plan titled Potential for further pressure ulcer development.,initiated on 2/21/2017, the Care Plan indicated a goal for Resident 7 to not develop pressure ulcers. The Care Plan indicated interventions to evaluate the skin weekly, monitor skin during care, notify medical doctor promptly of any skin breakdown., and request a wound consult as needed.During a review of Resident 7's , the GACH records dated 2/26/2026, the GACH records indicated Resident 7 had Stage III pressure ulcers present on admission [DATE]). The records indicated Resident 7 skin was not intact with area showing pink hypopigmented (skin that was lighter than the surrounding normal tissue) scarring, attached edges, and no drainage. The GACH records indicated Stage III pressure ulcer to the bilateral buttocks with skin not intact and pink and yellow moist tissue, attached edges, and no drainage.During a record review of Resident 7's GACH Pre-admission Report Sheet dated 3/2/2026 at 4:00 p.m., the Pre-admission Report Sheet indicated Resident 7 had a Stage III pressure ulcer to the coccyx, and to the left and right buttocks.During a review of Resident 7's Nursing Progress Notes dated 3/2/2026, at 8:49 p.m., the notes indicated Resident 7 returned from the GACH on 3/2/2026 at 6:15 p.m. The Nursing Progress Notes indicated upon readmission, Resident 7's skin was dry and warm to the touch, with pressure injury on the bilateral buttocks and coccyx.During a review of Resident 7's Order Summary Report dated 3/2/2026, the report indicated a physician order for the coccyx pressure ulcer to be cleansed with normal saline (wound cleanser ), followed by the application of collagen powder (type of treatment used to manage wound) , and cover with a dry dressing every day shift for wound healing for 30 days.During a review<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | of Resident 7's Order Summary Report dated 3/2/2026, the report indicated a physician order for the left buttocks pressure injury to be cleanse with normal saline followed by application of collagen powder and cover with a dry dressing every day shift for wound healing for 30 days.During a review of Resident 7's Care Plan titled Potential for further pressure ulcer development., initiated on 3/3/2026, the Care Plan indicated interventions for daily skin inspections, including observing for redness, open areas, scratches, cuts, and bruises, and reporting any changes to the charge nurse.During a review of Shower Day Skin Inspection, the note indicatedOn 3/5/2026 Resident 7 with ulcer (sacrococcyx was circled on the diagram).On 3/7/2026 Resident 7 skin intact/clear.On 3/11/2026 Resident 7 skin intact/clear.On 3/18/2026 Resident 7 skin intact/clear.During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated 4/3/2026, the MDS indicated Resident 7 was usually able to express wants and ideas. The MDS indicated Resident 7 had the ability to usually understand others. The MDS indicated Resident 7 was dependent (helper does all the effort) on nursing staff with oral hygiene, toileting, bathing, dressing, sitting, lying down and rolling from left to right. The MDS indicated Resident 7 had three Stage III pressure ulcers and no other skin problems.During a review of Resident 7's Weekly and Monthly Pressure Ulcer Management Report for the month of 4/2026, the report indicated:On 4/7/2026 Resident 7 with Stage III sacrococcyx measures 1.0 centimeter (cm-unit of measurement) in length by 1.6 cm in width by 0.2 cm in depth.Stage III left buttock measures 1.0 cm by 1.0 cm by 0.4 cm.Stage III right buttock measures 1.0 cm by 1.0 cm by 0.4 cm.Deep tissue injury (DTI- severe form of pressure injury characterized by a localized area of discolored, intact skin [purple or maroon]) right heel measures 1.0 cm by 1.0 cm.On 4/14/2026 Resident 7 with Stage III sacrococcyx measures 1.0 cm by 1.1 cm by 0.2 cm.Stage III left buttock was resolved.Stage III right buttock was resolved.DTI right heel measures 1.0 cm by 1.0 cm.On 4/21/2026 Resident 7 with Stage III sacrococcyx measures 1.0 cm by 1.4 cm by 0.2 cm.DTI right heel measures 1.0 cm by 1.0 cm.On 4/28/2026 Resident 7 with unstageable full thickness (UTD- pressure injuries in which damage cannot be determined because wound bed was obscured by slough (yellow tissue) or eschar (dead tissue) sacrococcyx measures 5.0 cm by 7.0 cm.DTI right heel measures 1.0 cm by 1.0 cm.During an interview on 5/13/2026 at 10:11 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated Resident 7 had pressure ulcers and was informed during huddle ( meeting held my medical team at the start of a workday) two to three weeks earlier. During a concurrent interview and record review on 5/14/2026 at 2:20 p.m. with Treatment Nurse (TN) 1, Resident 7's Shower Day Skin Inspection dated 3/5/2026 was reviewed. The Shower Day Skin Inspection indicated Resident 7 had an ulcer or blister and moisture associated dermatitis (MASD- moisture associated skin damage caused from prolonged exposure to moisture) on the sacrococcyx (tailbone) and buttocks. TN 1 stated she did not see or document any skin assessments for Resident 7 in 2/2026.During an interview on 5/14/2026 at 3:10 p.m., the Director of Nursing (DON), the DON stated Resident 7 was admitted to the facility in 2017 with no pressure ulcers. The DON stated Resident 7 developed a Stage IV pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the sacrum in 2/2023 while at the facility. She stated the pressure ulcer reopened in 6/2024 and resolved in 11/2024. The DON stated the facility was not completing weekly skin assessments for Resident 7. She stated licensed nursing staff must perform weekly skin assessments, or the facility will not be able to manage the resident's skin issues or changes. The DON stated there was no documented skin assessment upon the resident's readmission from the GACH on 3/2/2026. The DON stated licensed nursing staff are responsible for assessing and documenting any changes in the resident's skin condition.During a review of the facility's policy and procedure (P&P) titled Pressure Injury/Ulcer Risk Assessment, dated 2/2026, the P&P indicated The purpose of a pressure injury risk assessment is to identify all risk factors and then to determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. The risk assessment/Braden scale assessment tool should be conducted as soon as possible after admission, but no later than eight hours after admission is completed. Repeat the risk assessment/Braden scale assessment weekly<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 056150 | A. Building<br>B. Wing | 05/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Catered Manor Care Center | 4010 N Virginia Rd.<br>Long Beach, CA 90807 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition. The following information should be recorded in the resident's medical record utilizing facility forms are the type of assessment(s) conducted. The date and time and type of skin care provided, if appropriate. The name and title (or initials) of the individual who conducted the assessment. Any change in the resident's condition, if identified. The condition of the resident's skin (i.e., the size and location of any red or tender areas), if identified. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>Based on interview and record review, the facility failed to ensure employees' personnel files contained documentation of completed performance evaluations for four of eight employees (Certified Nurse Assistant [CNA] 1, CNA 3, Treatment Nurse [TN] 1, and Registered Nurse [RN] 1 ).This failure had the potential to result in unassessed staff performance, competency and training needs which may result in unsafe and ineffective care for residents.During concurrent interview and record review on 5/12/2026 at 10:20 a.m., with the Director of Staff Development (DSD), employee files were reviewed. The DSD stated CNA 1, CNA 3, TN 1, and RN 1 did not have documentation of their employee performance evaluations. The DSD stated that annual performance evaluations were important to assess whether employees can fulfill their roles and responsibilities for residents in their care. The DSD stated residents can be harmed if employees' strengths and weaknesses were not assessed in performance evaluations.During an interview on 5/12/2026 at 3:00 p.m. with the Director of Nursing (DON), the DON stated that annual performance evaluations were important to assess employees' ability to deliver safe resident care in accordance with facility's policies and procedures. The DON stated residents were at risk for harm if employees' performance were not evaluated in a timely manner.During a review of facility's Policy and Procedure (P&P) titled Performance Evaluation dated February 2026, the P&P indicated The job performance of each employee shall be reviewed and evaluated at least annually.to improve the quality of the employee's work performance. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview and record review the facility failed to ensure proper documentation of the destruction of controlled substances (Schedules II, III, or IV drug, chemical where possession, and use are strictly regulated by the government) as required for six medications in the month of 4/2026 when the pharmacist's signature was not co-signed by a registered nurse.This failure had the potential to result in mismanagement or diversion of controlled substances.Findings:During a concurrent interview and record review on 5/11/2026 at 3:48 p.m. with the Director of Nursing (DON), the controlled substance binder was reviewed. Six controlled substance medication documents for the month of 4/2026 were noted with a pharmacist signature but were not cosigned by a registered nurse. The medications noted without a registered nurse's signature were:1.Tramadol HCL (pain medication) 50 milligram (mg, unit of weight) tablet date disposed on 4/15/20262.Zolpidem Tartrate (used for short-term treatment for difficulty sleeping at night) 10 mg tablet date disposed on 4/15/20263.Temazepam (used for short-term treatment for difficulty sleeping at night) 15 mg capsule date disposed on 4/15/20264.Zolpidem Tartrate 10 mg tablet date disposed on 4/15/20265.Lorazepam (used for treatment of anxiety disorders) 0.5 mg tablet date disposed on 4/15/20266.Hydrocodone-acetaminophen (pain medication) 5-325 mg date disposed on 4/15/2026The DON stated she counts the medication with the pharmacist for destruction and will then sign the controlled substance document. The DON stated, the DON and the pharmacist must both sign the controlled substance documents but she forgot to sign the documents. The DON stated her signature was important to ensure the controlled medications that have been dispensed were the correct amount and validates that the medication were destroyed. During a review of the facility's Policy and Procedure (P&P) titled, Discarding and Destroying Medications, dated February 2026, the P&P indicated Schedule II, III, and IV (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous controlled medications.The medication disposition record contains.signature of witnesses. |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>Based on observation, interview and record review, the facility failed to ensure food service staff was competent in testing the chlorine (deep cleaning and sanitizing agent) of the dishwashing machine for one of two dietary aides (DA)1.This failure had the potential to put residents at risk for food borne illness (any illness resulting from eating contaminated/spoiled foods) due to inability to read and know what the proper range of sanitizer solution for the dishwashing machine.Findings:During a concurrent observation and interview on 5/11/2026 at 8:20 a.m. with Dietary Aide (AD)1, DA 1 used a test strip and dipped it in the water of the dishwashing machine during the final rinse. DA 1 compared the dipped test strip on the color chart found on the canister of the test strip bottle. The test strip read 200 parts per million (PPM- unit of measurement). DA1 stated they used chlorine to disinfect the dishes and follow 200 ppm. DA 1 stated the test strip read 200 PPM.During an interview on 5/13/2026 at 10:43 a.m. with DA1, DA 1 stated she would check the chlorine in the dishwashing machine before using and it should read 50-100 PPM not 200 PPM. DA 1 stated it was important to have the right amount of chlorine in the dishwashing machine to keep the dishes clean. DA 1 stated residents could get sick of food-borne illness if the kitchen staff was incorrectly testing the amount of chlorine of the dishwashing machine.During an interview on 5/14/2026 at 11:46 a.m. with the Dietary Supervisor (DS), the DS stated she provided an in-service to the kitchen staff on how to properly test the chlorine in the dishwashing machine. DS stated it was important that the kitchen staff was competent on how to test the chlorine of the dishwashing machine because too high or too low in the amount chlorine could affect the cleaning of the dishes by not sanitizing properly. The DS stated this could put the residents at risk for food-borne illness.During a review of facility's policy and procedure(P&P) titled, Sanitation, dated 12/2008, the P&P indicated for low temperature dishwasher with chemical sanitation should have a wash temperature of 120 degrees (unit of measurement) and 50 ppm of chlorine in the final rinse.During a review of facility's P&P titled, Dishwashing, undated, the P&P indicated the dishwasher ?s chlorine should read between 50-100 ppm on dish surface on the final rinse and proper chlorine level is crucial in sanitizing the dishes. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to identify and honor cultural food preferences for one of one sampled resident (Resident 76).This failure had the potential to result in weight loss for Resident 76.Findings:During a review of Resident 76's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 76 was admitted to the facility on [DATE] with diagnoses of but not limited to hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left side, muscle weakness, hypertension (HTN-high blood pressure) and hyperlipidemia (high levels of fat circulating in the blood).During a review of Resident 76's Minimum Data Set (MDS-a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 76 needed partial to moderate assistance (helper does less than half the effort) from nursing staff with toileting, showering, dressing, and transferring.During a review of Resident 76's History and Physical (H&P), dated 4/21/2026, the H&P indicated Resident 76 had the capacity to understand and make medical decisions.During a review of Resident 76's Order Summary, dated 3/5/2026, the Order Summary indicated Resident 76 had an order for a No Added Salt (NAS) diet with regular texture and thin liquid consistency.During an interview on 5/12/2026 with Resident 76, Resident 76 stated the food is horrible and he does not get food that honor his culture of being African American. Resident 76 stated he would like to have Soul Food (the traditional ethnic cuisine of African Americans)During an interview on 05/13/2026 at 11:43 a.m. with Certified Nursing Assistant (CNA) 11, CNA 11 stated she does not know what cultural foods Resident 76 likes. CNA 11 stated she does not know if the facility honors cultural food preferences.During a concurrent interview and record review on 5/14/2026 at 4:35 p.m. with the Director of Nursing (DON) Resident 76's Nutritional Screen, dated 3/12/2026, was reviewed. The Nutritional Screen indicated there was no documentation of what Resident 76's cultural preferences for meals were. The DON stated that the facility honors cultural preferences for residents upon admission. The DON stated the cultural food preferences should have been documented in Resident 76's chart and honored to provide the food wishes and nutritional needs of the resident.During a review of the facility's policy and procedure (P&P), titled Resident Self Determination and Participation, dated 2/2026, the P&P indicated, . In order to facilitate resident choices, the administration and staff. include information gathered about the resident's preferences in the care planning process.During a review of the facility's policy and procedure (P&P), titled Resident Food Preferences, dated 2/2026, the P&P indicated, .Upon the resident's admission (or within twenty-four (24) hours after his/her admission) the dietitian or nursing staff will identify a resident's food preferences. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Nursing staff will document the resident's food and eating preferences in the care plan. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review, the facility failed to ensure the quaternary sanitizer solution (disinfectant) in the red bucket used to clean kitchen surfaces was at the 200 parts per million (PPM- unit of measurement) to ensure kitchen surfaces were sanitized properly.This failure had the potential to expose all residents to foodˆborne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites).Findings:During an observation on 5/11/2026 at 8:14 a.m. in the kitchen, a red bucket filled with a quaternary solution was observed to be in a kitchen sink with a dish towel submerged in the solution.During a concurrent observation and interview on 5/11/2026 at 8:25 a.m. with Dietary Aide 3 (DA 3) in the kitchen, DA 3 was observed to take a quaternary solution test strip and dip it into the red bucket quaternary solution. DA 3 then compared the color of the test strip to the color chart provided with test strip. The test strip color was observed to be teal. DA 3 stated the color should be green. DA 3 stated the quaternary solution needs to have the correct amount of solution to ensure the surfaces in the kitchen are sanitized. DA 3 stated that when kitchen surfaces are not sanitized properly there is a risk for food borne illness from cross contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products).Durning an interview on 5/14/2026 at 11:46 a.m. with the Dietary Supervisor (DS), the DS stated she was made aware the quaternary solution in the red bucket did not have the correct amount of quaternary solution. The DS stated that when the solution in the red bucket does not have the correct amount of the quaternary solution there is a possibility the residents could develop a food borne illness because the surfaces in the kitchen would not be properly sanitized.During a review of the policy and procedure (P&P) titled Quaternary Ammonium Log Policy dated 2023, the P&P indicated the quaternary solution is used for sanitizing clean work surfaces in the kitchen. The P&P indicated the concentration will be tested at least every shift or when solution is cloudy. The solution will be replaced when the reading is below 200 ppm. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain complete and accurate clinical records for one of three sampled residents (Resident 11) by not documenting restorative nursing services ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) as ordered.The facility failed to:1 Accurately document restorative nursing services, including passive range of motion ([PROM] movement at a given joint with full assistance from another person) to the bilateral lower extremities and active assistive range of motion ([AAROM]-movement at a given joint with a person's own effort and assistance from an external force or another person) to the bilateral upper extremities, as ordered five times per week.2. Ensure nursing staff recorded the number of minutes of restorative services provided each day, as required by physician orders.3. Follow facility's policy and procedure (P&P) titled, Charting and Documentation, dated 2026, which indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.This deficient practice had the potential to result in inconsistent implementation of services, inability to monitor the resident's progress toward maintaining or improving functional abilities, and potential decline in the resident's physical functioning. Findings:During a review of Resident 11's Face Sheet, the Face Sheet indicated Resident 11 was initially admitted to the facility on [DATE], with a diagnosis of diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and depression (feeling sad).During a review of Resident 11's Care Plan, titled Resident is at risk for Self-Care/ADL Potential for decline in daily activity to complete self-care activities of daily living, related to: generalized muscle weakness. dated 6/17/2025, the Care Plan indicated a goal to prevent decline in function. The Care Plan indicated interventions including RNA five time a week as tolerated, active assistive range of motion to bilateral upper extremities ([BUE] both arms)/ PROM to bilateral lower extremities ([BLE] both legs).During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 2/24/2026, the MDS indicated Resident 11 was dependent (helper does all of the effort) with toileting, showering, lower body dressing and putting on and taking off shoes.During a concurrent observation and interview on 5/11/2026 at 12:48 p.m. with Resident 11, Resident 11 was sitting in her wheelchair inside her room with edema noted to both upper extremities. Resident 11 stated staff do not come every day to provide her exercises. She stated she becomes stiff and weak when she does not receive her exercises.During a review of Resident 11's Order Summary, dated 3/2/2026, the Order Summary indicated, RNA to perform PROM to BLE daily 5 times per week as tolerated. Document number of minutes.During a review of Resident 11's Order Summary, dated 3/2/2026, the Order Summary indicated, RNA to do AAROM to bilateral upper extremities ([BUE] both arms) daily 5 times per week as tolerated. Document number of minutes.During an observation on 5/13/2026 at 9:10 a.m., Resident 11 lying in bed, no RNA services were observed being provided at the time of observation. During an observation on 5/13/2026 11:21 a.m., Resident 11 lying in bed, no RNA services were observed being provided at the time of observation. During a concurrent interview and record review on 5/13/2026 at 1:00 p.m., with Restorative Nurse Assistant (RNA) 2, reviewed Resident 11's Restorative Nursing Documentation dated 5/11/2026, 5/12/2026, and 5/13/2026. The documentation showed no evidence RNA provided RNA services on those dates. RNA 2 acknowledged the lack of documentation and stated staff should document all RNA services on the RNA form. RNA 2 stated Resident 11's restorative nursing program includes PROM exercises to both lower extremities and AAROM to both upper extremities. She stated PROM requires stretching and guiding the resident's extremities to help maintain independence and prevent contractures (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | RNA 2 stated that Resident 11 had not received restorative services as of the time of the interview and she last personally provided services to Resident 11 the previous week. She stated staffing shortages sometimes prevent her from providing RNA services as ordered. RNA 2 stated that if the resident does not receive the ordered restorative nursing services, the resident could experience functional decline, increased stiffness, and pain.During a concurrent interview and record review on 5/14/2026 at 11:27 a.m., with the Director of Nursing (DON), Resident 11 Order Summary dated 3/2/2026. The DON stated Resident 11 with physician's orders for PROM to both upper extremities and AAROM to both lower extremities. The DON stated failure to provide the ordered services could cause a decline in mobility, decreased range of motion (ROM), contractures, and loss of independence with activities of daily living (ADLs). The DON stated the Director of Staff Development (DSD) was responsible for overseeing restorative nursing services and ensuring staff provide and document these services in accordance with physician orders, the resident's care plan, and facility policy. The DON stated failure to document restorative services appropriately prevents verification that the resident received the ordered care and treatment. The DON added that inaccurate or incomplete documentation can lead to missed services, lack of followˆup, and impaired continuity of care.During a review of facility's policy and procedure (P&P) titled Charting and Documentation, dated 2026, the P&P indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitated communication between the interdisciplinary team regarding the resident's condition and response to care. During a review of the facility's P&P titled, Restorative Care Nurse Job Description, dated 2020, the P&P indicated, Maintain treatment records, resident files and progress notes as required. |