STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056194	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Gardens Convalescent Hospital	915 S. Crenshaw Blvd. Los Angeles, CA 90019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident had the capacity to sign a consent for anti-psychotropic medications (a medication that changes brain function and results in alterations in perception, mood, consciousness or behavior) for two of five sampled residents (Resident 62 and Resident 3).This failure violated the residents' right to make an informed decision regarding the use of anti-psychotropic medications and had the potential for Resident 62 and Resident 3 to have unnecessary continuation of psychotropic medication. Findings: 1.Resident 62's admission Record, the admission record indicated that Resident 62 was initially admitted to the facility on [DATE], with diagnoses including hepatic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition a disease in which the functioning of the brain is affected by severe liver disease), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and transient ischemic attack (TIA-a temporary blockage of blood flow to the brain). During a review of Resident 62's Minimum Data Set (MDS - a resident assessment tool) dated 01/14/2026, MDS indicated that Resident 62's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 62 required partial to substantial assistance from staffs for activities of daily living (ADLs – toileting hygiene, shower/bathing). During a review of Resident 62's History and Physical (H&P), dated 1/23/2026, H&P indicated that Resident was admitted from General Acute Care Hospital (GACH) from Assisted Living Facility for confusion and agitation. During a review of Resident 62's records titled Order Summary Report dated 04/16/2026, indicated a physician order for; Escitalopram Oxalate (medication to treat depression and general anxiety disorder) oral tablet 10 milligram (mg-unit of measurement) give one tablet by mouth one time a day for depression manifested by verbalization of sadness. Informed consent obtained. Risks and benefits explained. Initiated on 01/09/2026. Seroquel Oral Tablet 50 mg (Quetiapine Fumarate) (medication to treat schizophrenia, bipolar disorder [mania and depression] and major depressive disorder [mood disorder characterized by persistent sadness and low energy]) give one tablet by mouth one time a day for schizoaffective disorder (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manifester by verbal aggression, paranoia others are after him, auditory hallucinations as evidenced by talking to persons not there. Informed consent obtained by physician. Risks and benefits explained. Initiated on 02/20/2026. During a concurrent observation and interview on 4/13/2026 at 10:40 a.m. with Resident 62, Resident 62 was lying in bed, awake, alert and oriented to name but not to place and time. Resident 62 stated, I'm just laying here, and I want to get out. During a review of Resident 62's Psychotropic medication administration informed consent for Seroquel and Escitalopram dated 01/09/2026 indicated that a verbal consent was obtained from Resident 62. The informed consent form, however, did not include the name of the licensed staff that verified the informed consent prior to initiation of the medication. During a concurrent interview and record review on 4/14/2026 at 12:00 p.m. with Assistant Director of Nursing (ADON), Resident 62's Psychotropic medication informed consent and MDS were reviewed. ADON stated residents prescribed with anti-psychotropic medication requires informed consent outlining the risks and benefits. ADON stated that Resident 62's Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score dated 01/14/2026 were two which indicated lack of capacity to make decisions. ADON further stated that it was inappropriate to obtain informed consent for Resident 62's lack of capacity. ADON added that there should be a complete licensed staff name and not only signature for verification of consent. ADON stated that anti psychotropic medication may act as restraints and could compromise the residents' safety. During an interview on 4/16/2026 at 8:43 a.m. with Director of Nursing (DON), DON stated the process in obtaining an informed consent was for the physician to speak with the resident or their representative to provide informed consent. When a resident can sign, the licensed nurse verifies informed consent to ensures residents are aware of risks and benefits and have the right to accept or refuse the treatment. DON added that nurses with licenses must confirm informed consent when residents are prescribed anti psychotropics, since these medications can cause side effects that may be viewed as chemical restraints. DON stated that it is important to respect residents' right to know and decline medications, even those recommended by a doctor. DON added that if residents cannot understand, the resident is not able to give informed consent. During a review of facility's Policy and Procedure (P&P) titled, Informed Consent for Psychotropic Drugs, reviewed on 03/05/2026, the P&P indicated, the procedures for obtaining, verifying, and documenting informed consent to ensure resident rights, safety, and proper medication use for those with behavioral or psychotic symptoms, including dementia. 2.During a review of Resident 3's admission Record (face sheet), dated 4/15/2026, the face sheet indicated Resident 3 was initially admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses including but not limited to Parkinsonism (a general term for brain disorders that cause slowed movements, stiffness, and tremors), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities), bipolar disorder (a chronic mental health condition characterized by intense extreme mood swings that interfere with daily life), and anxiety (feelings of worry or nervousness). No family or resident representative on record. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 is rarely/never understood and is dependent on staff for all functional abilities. Resident 3 can never/rarely make (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decisions. Resident 3 does not have any mood or behavior symptoms. During a review of Resident 3's physician's order, dated 1/6/2026, the order indicated to give Resident 3 buspirone (a medication used to treat anxiety) 15 milligrams tablet twice a day. During a review of Resident 3's physician's order, dated 1/24/2025, the order indicated to give Resident 3 valproic acid (a medication used to treat bipolar disorder manifested by mood swings) 750 milligrams three times a day. During a review of Resident 3's care plan titled The Resident uses Anti-Anxiety Medication: Buspirone, dated 8/29/2024, the care plan indicated the resident/family/caregivers must be educated about the risks and benefits of the medication. The facility must monitor side-effects such as drowsiness, memory loss, and impaired thinking. During a review of Resident 3's care plan titled Black Box Warning for Use of Valproic Acid, dated 8/27/2024, the care plan indicated side effects of valproic acid include dizziness, weakness, and sleepiness. During a review of Resident 3's Interdisciplinary Care Conference (ICC) note, dated 1/26/2025, the ICC note indicated one Licensed Vocational Nurse (LVN) was in attendance to decide Resident 3's psychotropic medication management upon readmission to the facility. The ICC note did not indicate a physician or resident representative was in attendance. Decision was made to continue with psychotropic medication. During an observation on 4/13/2026 at 9:36 AM in Resident 3's room, Resident 3 was lying in bed, awake with eyes open. Resident 3 did not verbally respond to attempts of conversation. During an interview on 4/15/2026 at 9:12 AM with the Social Services Director (SSD), the SSD stated Resident 3 does not have consent for psychotropics because she is not able to consent for herself and she has no designated representative. A representative from the Long-Term Care Representative Program (LTCRP - a state program to represent residents who lack the capacity to make medical decisions and have no other representatives) has not come to participate in the ICC to discuss the necessity of psychotropic medications for Resident 3 throughout stay in facility. It is the facility's responsibility to contact LTCRP when a resident without the capacity to consent needs an informed consent signed for the initiation of psychotropic medication. During an interview on 4/15/2026 at 2:17 PM with the Assistant Director of Nursing (ADON), ADON stated Resident 3 was initially ordered buspirone and valproic acid during a short-term hospitalization. Upon re-admission to the facility on 1/24/2025, the facility's physician ordered for Resident 3 to receive these medications in the facility. The facility did not obtain consent for buspirone and valproic acid because they were medications initiated in the hospital. It is important for the facility to obtain informed consent for psychotropic medications upon initiation in the facility because residents have a right to be informed of the side effects of the medications and have a right to refuse. During an interview on 4/16/2026 at 8:43 AM with the Director of Nursing (DON), DON stated the facility must assess the resident to determine if the resident can consent to psychotropic medications. If a resident cannot consent, their responsible party should be contacted for consent. If the resident does not have a responsible party, the resident must be referred to the LTCRP to obtain informed consent. It is important to obtain informed consent before administering psychotropic (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications because residents have the right to refuse medication. Psychotropic medications can be considered a chemical restraint if used inappropriately because of their side effects. During a concurrent interview and record review on 4/16/2026 at 11:10 AM with ADON, Resident 3's Psychotropic Medication Administration Informed Consent, dated 1/6/2026 was reviewed. The consent indicated Resident 3 gave verbal consent to receive buspirone and was verified by ADON. ADON stated she did not complete the form correctly because Resident 3 does not have the capacity to consent. Consent was not obtained for buspirone or valproic acid. During a review of the facility's policy and procedure (P&P) titled, Informed Consent for Psychotropic Drugs, last reviewed 3/5/2026, the P&P indicated the prescribing practitioner must obtain informed consent for all psychotropic medications prior to initiation or dose increase. The facility is prohibited from using psychotropics as chemical restraints. The facility must have procedures to identify substitutes for residents lacking capacity to give consent. The interdisciplinary team (consisting of the physician, registered nurses, and the resident/representative) must be involved in reviewing the use of psychotropics.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure person centered care plan was implemented for three of six (6) sampled residents:1. When Resident's 16 non-pharmacological (evidence-based, non-chemical, and non-invasive methods used to treat, manage, or prevent health conditions without medication) intervention for pain was not offered prior to pain medication administration.2. Resident's 3 who was receiving nutrition through a gastrostomy tube (Gˆtube, a flexible tube surgically inserted through the abdomen into the stomach for the administration of nutrition, fluids, and medications) head of the bed (HOB)was not elevated to at least 30 degrees during feedings. 3. Resident's 50 indwelling catheter (a tube inserted into the bladder to drain urine) care was done.The deficient practice of not offering non-pharmacological interventions had a potential to cause inadequate pain management and unnecessary medication administration for Resident 16.The deficient practice of not elevating HOB while feeding is on has a potential for risk of aspiration (accidentally inhaling food, liquids, stomach acid, or saliva into lungs) during enteral feedings (a method of delivering liquid nutrition directly into the stomach) for Resident 3. The deficient practice of not providing indwelling catheter care has the potential to increase the risk of urinary tract infection (UTI- an infection in the bladder/urinary tract) for Resident 50.Findings: 1.During a record review of Resident 16 admission record, the admission record indicated Resident 16 was admitted to the facility on [DATE] with diagnoses of end stage renal disease (ESRD, late stage of kidney failure to filter blood and produce urine), difficulty in walking, pathological fracture of left hand (fracture of bones in hand due to weak bone mass), wedge compression fracture of t11-t12 vertebra (fracture of spinal bones), osteoporosis (weak bones, low density of bones), encounter for fitting and adjustment of extracorporeal dialysis catheter (dialysis access, tubing inserted into the blood vessel) dependence on hemodialysis (artificial filtration of blood to remove body wastes, replacing kidney function). During a record review of Resident 16's Minimum Data Set (MDS, resident assessment tool) dated 2/10/2026 the MDS indicated Resident's 16 Brief Interview for Mental Status (BIMS tool to assess cognition, memory, comprehension) score was 6, indicates severe impairment in cognitive function (diminished capacity to answer questions appropriately, to remember and comprehend concepts). The MDS indicated the functional abilities (abilities to perform daily tasks like dressing, walking, toileting) of Resident 16 required partial/moderate assistance - helper does less than half the effort with activities of daily living (dressing, standing, sitting, and walking, transfers from bed to chair, toileting and showering). During an observation on 4/13/2026 at 9:15 a.m. during morning care of Resident 16 by Certified Nurse Assistant 1 (CNA) 1, Resident 16 yelled, I am hurting all over my head, arm, and asking for help. Resident 16 stated to CNA 1 about having pain in his head, repeating help my boo-boo. During an interview on 4/14/2026 at 11:10 a.m. with CNA 2, CNA 2 stated that one of her duties was to observe signs and symptoms of being uncomfortable such as moaning during care, residents (in general) may be moving a lot, trying to get up, or verbalizing pain. CNA 2 stated that she would stop providing care and would notify the LVN about the pain. During interview on 4/14/2026 at 11:31 a.m. with LVN 1, LVN 1 stated part of non-pharmacological interventions were to provide coffee, let resident watch TV, talk to him, call his wife, reposition, take (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	him outside, or activities' room, or to a patio. LVN 1 stated that on 4/13/2026 she administered pain medication to Resident 16 without doing non-pharmacological interventions prior to administering pain medicine. During the 04/15/2026 interview at 8:14 a.m., the Registered Nurse Supervisor (RNS) stated that pain is assessed and managed according to the physician's order and the care plan, with documentation in the MAR under pain monitoring. The RNS explained that nonˆpharmacological interventions should be tried first and their effectiveness documented by the LVN in Progress Notes. The RNS was unable to find documentation showing that nonˆpharmacological measures were attempted before medication was given on 4/13/2026. The RNS added that the care plan must be followed and leastˆinvasive measures attempted first due to the dependency risks associated with narcotics. During a record review of the care plan for Resident 16 with focus area: Potential for Alteration in Comfort/Pain dated 02/28/2024 indicated Non-pharmacological intervention: (Positioning for comfort, Hot Pack, Cold Pack, massage, distraction). During a record review of policies and procedures (P & P) for Pain Management dated 3/5/2026, the P & P indicated Residents receiving interventions for pain will be monitored for the effectiveness non-pharmacological interventions and effectiveness. 2.During a review of Resident 3's admission Record (face sheet), dated 4/15/2026, the face sheet indicated Resident 3 was initially admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses including but not limited to Parkinsonism (a general term for brain disorders that cause slowed movements, stiffness, and tremors), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities), dysphagia (medical term for difficulty swallowing), and gastrostomy status (medical condition of having an artificial, surgically created opening in the stomach wall that allows a feeding tube to be inserted directly into the stomach for nutrition, hydration, and medication). During a review of Resident 3's MDS dated [DATE], the MDS indicated the resident is rarely/never understood. The MDS also indicated the resident receives nutrition through a feeding tube and has impairment in range of motion to both sides of the upper and lower extremities. During a review of Resident 3's Nursing Documentation Evaluation, dated 8/23/2024, the evaluation indicated Resident 3 receives nutritional supplements through enteral feeding via G-tube. During a review of Resident 3's physician's order, dated 1/24/2025, the order indicated Resident 3's head of bed should be elevated to at least a 30-degree angle during feeds and for one hour after feeding. During a concurrent observation and interview on 4/13/2026 at 12:59 PM with the Assistant Director of Nursing (ADON) in Resident 3's room, Resident 3 was lying nearly flat in bed with the tube feeding machine on. ADON stated Resident 3 is lying flat and the head of bed is at less than a 30-degree angle. ADON stated the facility does not have a measuring device to measure the angle of the resident's head of bed. ADON stated that Resident 3's head should be raised higher, to at least a 30-degree angle, while the resident is receiving tube feedings to prevent the risk of aspiration. During an interview on 4/15/2026 at 9:49 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated residents could be neglected in their care if the resident's care plan is not followed. It could harm the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident physically, emotionally, and financially. During a concurrent interview and record review on 4/15/2026 at 2:15 PM with the Assistant Director of Nursing (ADON), Resident 3's care plan titled, Resident is at risk for aspiration related to G-tube, created on 1/3/2026, was reviewed. The care plan indicated Resident 3's head of bed should be elevated to at least 30 degrees during feeding and for one hour after feeding. ADON stated that this care plan was not implemented based on the previous observation of Resident 3. During an interview on 4/16/2026 at 9:07 AM with the Director of Nursing (DON), DON stated care plans are created to describe what and how interventions are implemented. Care plans are how nurses know what interventions to perform. It is important for care plans to be followed, and if they are not, we must investigate why. During an interview on 4/16/2026 at 9:19 AM with DON, DON stated that aspiration is a complication of enteral tube feeding. The resident's head of bed should be raised to a 30–45-degree angle during feeds to prevent the risk of aspiration to the resident. During a review of the facility's P&P titled, Care Plan Comprehensive, last reviewed 3/5/2026, the P&P indicated the interdisciplinary team must implement a comprehensive person-centered care plan for each resident. 3.During a review of Resident 50's admission Record, the record indicated that Resident 50 was originally admitted on [DATE] and readmitted on [DATE] for polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), sepsis (a life-threatening blood infection), and a urinary tract infection. During a review of Resident 50's MDS dated [DATE], the MDS indicated that Resident 50's cognitive patterns (thought processes) were fully intact. The MDS indicated that Resident 50 needed supervision for eating, oral hygiene, and upper body dressing; and moderate assistance with toileting, showering, and lower body dressing. The MDS also indicated that Resident 50 is always incontinent and has an indwelling catheter. During a review of the physician's orders for the indwelling catheter on 4/16/2026, the following active orders indicated the following: Indwelling Catheter: Monitor for S/S of possible urinary infection and notify MD. Document 0=none / FP = Flank Pain or SP= Suprapubic pain or T = Tenderness/ CU = change in character of urine (New bloody urine; foul smell of urine or change in urinary sediment)/ MC = mental change or FC = functional change worsening of status) Every shift document 0 for no characteristics or letter of signs/symptoms. Start date 2/11/2026. Indwelling Catheter: Monitor for change in urine character: Document 0 = none/ C = Cloudiness/ S = Sediment FS = Foul Smell/ B = Blood in urine/ DC = deepening or concentrating urine output. Notify MD for potential UTI. Every shift document letter or urine characteristic or 0 for no urine characteristics. Start Date 2/11/2026. Indwelling Foley catheter care: Cleanse the urethral meatus (where the catheter enters) with NS, gently wiping away any debris every day shift for infection prevention. Start Date: 2/12/2026. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/15/2026 at 9:49 a.m. with Licensed Vocational Nurse (LVN2), LVN 2 stated indwelling catheter needs to have a physician's order and care plan. LVN 2 stated the nurses must implement the care plan to prevent complications like UTI and the Treatment Nurse performs indwelling catheter care during the day shift. The Registered Nurse (RN) is the one who initiates and develops care plan for residents. LVN 2 stated that if the care plan is not implemented there is potential for physical and emotional harm to the residents and possible neglect. During a concurrent interview, and record review of the Physician's Order and Treatment Administration Record (TAR) with LVN 5 on 4/15/2026 at 1:45 p.m., LVN 5 stated that proper indwelling catheter care is important to prevent bacteria from entering and causing infection or UTI. LVN 5 stated that catheter care should be documented in the electronic medical record (EMR). While reviewing the orders, care plan, and TAR for Resident 50, LVN 5 stated that the TAR showed blank spaces instead of an X or check mark to indicate the task was completed. LVN 5 stated that documenting each completed task is important, so staff know who performed it, when it was done, and whether it was completed. LVN 5 emphasized that documentation ensures proper monitoring and keeps the residents safe. During concurrent interview and record review of the TAR with the Registered Nurse Supervisor (RN1) on 4/15/2026 at 2:10 p.m., RN1 stated that the TAR was blank on 2/15/2026 evening shift for indwelling catheter care monitoring. RN1 stated she is unsure why it is blank and would need to ask someone what it means. During concurrent interview, and record review of Resident 50's TAR with Director of Nursing (DON) on 4/16/2026 at 9:00am, DON stated the treatment nurse comes during the day shift to complete the indwelling catheter care. The DON stated for evening and night shifts, the charge nurse completes the indwelling catheter care. The DON stated that care plans determine how staff care for the patient; if a care plan is not being followed, we [staff] investigate. The DON stated the importance of following the care plan for indwelling catheter is to prevent infection. The DON stated that the TAR dated 2/15/2026 was blank for indwelling catheter care and monitoring. The DON stated if there is a blank spot on the TAR, that means it was not documented or not completed. The DON stated the charge nurse did not follow the care plan for that shift, and there is no excuse for why it was not completed. During a review of the facility's P & P titled Care Plan Comprehensive dated 8/25/2021, the policy stated, The facility's interdisciplinary Team.must develop and implement a comprehensive person-centered care plan for each resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure proper sanitation and food handling practices were upheld in the kitchen when: 1. Cups of milk and pineapple stored in the refrigerator were not labeled with preparation or use-by date. 2. A kitchen food scoop was stored in the container of food thickener.3. Apples and onions beyond their use-by date were not disposed of.4. Kitchen Dishwasher (KD) 1 and 2 handled washed dishes with dirty gloves.5. Kitchen aide (KA) handled bread with dirty gloves. These failures had the potential to spread pathogens (a germ that causes disease) to the residents, increasing their risk of developing foodborne illnesses that could lead to medical complications and hospitalization. Findings: During an observation on 4/13/2026 at 7:26 AM in the kitchen's walk-in refrigerator, there were three trays of pre-poured milk cups on a shelf. On a separate shelf there was a tray of individually packed pineapple chunks. The cups of milk and pineapple, and the trays they were placed on, did not have labels indicating when they were prepared or the use-by date. During a concurrent observation and interview on 4/13/2026 at 7:36 AM with the Dining Services Manager (DSM) in the kitchen, a food scoop was stored inside a container of white powder. DSM stated this is a container of food thickener that is added to food depending on the recipe. She stated the scoop should not be kept in the container because it is dirty and can increase the risk of contamination of the resident's food. During a concurrent observation and interview on 4/13/2026 at 7:40 AM with the DSM in the kitchen walk-in refrigerator, three trays of milk cups and one tray of pineapple chunks did not have a preparation and use-by date label on them. DSM stated the trays of milk and pineapple chunks must be labeled so staff know when they were prepared and when they expire, because if expired, they can harm the residents. During a concurrent observation and interview on 4/13/2026 at 7:47 AM with the DSM in the kitchen, there was a bucket of onions and a separate bucket of apples. The label on the onion bucket indicated a preparation date of 3/23/2026 and a use-by date of 4/10/2026. The label on the apple bucket indicated a preparation date of 4/1/2026 and a use-by date of 4/10/2026. DSM stated the onions and apples should have been thrown out because they are not good anymore and are expired. She stated it is important to make sure foods are discarded by the label's use-by date because they could be spoiled or have fungi, which could harm the residents when eaten. During a concurrent observation and interview on 4/13/2026 at 7:53 AM with the DSM in the kitchen, KD 1 was rinsing dirty water pitchers in the sink wearing gloves. With the same gloves, he pulled out a tray of freshly sanitized dishes from the dishwasher. He then proceeded to load the dirty water pitchers into the dishwasher still wearing the same gloves. DSM stated KD 1 needs to wash the dishes again because now the dishes are contaminated from his dirty gloves. His gloves could have bacteria that could spread and harm the residents. During a concurrent observation and interview on 4/14/2026 at 8:31 AM with the DSM in the kitchen, KD 2 was rinsing dirty plates in the sink wearing gloves. With the same gloves, he pulled out a tray of freshly sanitized plate covers from the dishwasher. DSM stated KD 2 should not have done this because of his dirty gloves. During an observation on 4/14/2026 at 12:08 PM in the kitchen, KA was wearing gloves serving lunch for the residents. KA used food scoops to scoop vegetables and rice onto the lunch plate. KA then used the same gloves to grab a dinner roll and put it on the plate to serve to the resident. During an interview on 4/14/2026 at 12:18 PM with KA, KA stated she forgot that she should use tongs to handle the bread and should not have used her dirty gloves. She said this is important to keep the food clean. During an interview on 4/14/2026 at 2:27 PM with DSM, DSM stated KA should not have used the same gloves to serve the dinner rolls that she used to touch the various plates and scoops because it could contaminate the food. During an interview on 4/15/2026 at 11:13 AM with the Infection Preventionist (IPN), IPN stated that after kitchen staff are done cleaning dirty plates, they should immediately wash their hands and switch gloves before moving onto another task. It is important to take off dirty gloves before moving onto another task to prevent the (continued on next page)

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Windsor Gardens Convalescent Hospital	915 S. Crenshaw Blvd. Los Angeles, CA 90019

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spread of bacteria and cause contamination of food, which would harm the residents. This hand hygiene practice is for infection control. IPN further stated that expired foods are an infection risk. Foods have a use-by date, which is their expiration date. Once that date is past, the food is not good anymore because it can cause someone to get sick. During an interview on 4/16/2026 at 10:15 AM with KD 2, KD 2 stated that there should be two people doing the dishwashing job. One person handles the dirty dishes and loads them into the dishwasher. The second person takes out the cleaned dishes from the dishwasher. It is important because if there is only one dishwasher and they use their gloves to touch the dirty and clean dishes, it can cause contamination and infection. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating, undated, the P&P indicated all foods should be dated before being stored with a label that includes the food item name, the date of preparation, and the use-by date. During a review of the facility's P&P titled, Food: Preparation, last reviewed 3/5/2026, the P&P indicated all staff will practice proper hand-washing techniques and glove use. It also indicated all foods should be prepared in accordance with the Food and Drug Administration (FDA) Food Code. During a review of the FDA Food Code, last full revision 2022, the FDA Food Code indicated food shall be protected from cross contamination by the separate storage of spoiled foods

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff followed facility's Infection Prevention Control Policy to prevent the spread of infection, when facility failed to ensure:The facility's Water Management Program ([WMP] - a written, step-by-step plan for buildings to ensure their water system was safe, clean, and efficient) was implemented as written.Licensed Vocational Nurse (LVN 2) did not don (put on) a gown prior to applying a lidocaine patch (a medication Patch) to Resident 93, who was on enhanced based precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms {MDROs} in nursing homes).These deficient practices had potential to spread infections and illnesses among residents, staff and visitors.Findings: A. During a concurrent interview and record review on 4/16/2026 at 10:33 a.m. with Maintenance Supervisor (MS) of WMP and maintenance logs on 4/16/2026 at 10:33 a.m., MS stated that he handled water monitoring, while the Infection Preventionist (IPN) ensured implementation of the WMP. MS stated that water temperatures are checked weekly every Friday. MS stated that chlorine residuals and pH (measure of acidity or alkalinity of an aqueous solution) levels were not tested in the facility as it was not required. MS further stated the need for regular water quality testing and documentation to prevent the growth and spread of waterborne pathogens (bacteria, viruses, or parasites found in contaminated water), which could put residents, staff, and visitors at risk for waterborne infections (illnesses caused by bacteria, viruses, or parasites from human or animal waste that contaminate drinking or recreational water) and related complications. During an interview on 4/16/2026 at 11:43 a.m. with IPN, IPN stated that MS is responsible for monitoring the water quality. IPN stated she was unsure whether chlorine residuals and pH were monitored. IPN further stated that following the WMP is crucial for maintaining water quality and preventing bacterial growth that could threaten the safety of residents, staff, and visitors. During a review of the facility's WMP, undated, the WMP indicated that control measures are actions implemented within building water systems to reduce the growth and dissemination of Legionella. These measures include processes such as heating, disinfectant application, and cleaning. Operational monitoring covered the TELS preventative maintenance program and internal facility logs to track control measures. The WMP further stated that the effectiveness of the control plan will be assessed through infection control surveillance. During a review of facility's Policy and Procedures (P&P) titled, Infection Prevention and Control, dated 12/2023, the P&P indicated, that the infection prevention and control policies aim to monitor, prevent, detect, investigate, and manage infections in the facility; ensure a safe, sanitary, and comfortable environment for all staff, residents, visitors, and the public; and offer evidence-based guidelines reflecting current best practices. 2.During a review of the Resident's admission record, the admission record indicated Resident 93 was admitted on [DATE] with a diagnosis of diffuse large B-cell lymphoma (a cancer that affects the lymphatic system), diabetes mellitus (DM- a condition in which blood sugar levels are not adequately controlled), and unspecified fracture of the lower, left leg (injury in the leg with an unknown cause). During a review of Resident's 93 Minimum Data Set (MDS- a resident assessment tool) dated 3/10/26, the MDS indicated Resident 93's cognitive abilities (thought process) were intact. Resident 93 is independent for eating, moderate assistance for personal hygiene and upper body dressing; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requires supervision for oral hygiene; and is dependent (needs complete assistance from a helper or helpers) for management of footwear, toileting, lower body dressing and showering. During a concurrent observation and interview on 04/14/2026 at 8:12 a.m. with LVN 2 while doing medication pass, LVN 2 entered Resident 93's who is on EBP. LVN 2 applied lidocaine patch on Resident 93's left arm without donning a gown before administering the medication. LVN 2 stated that since Resident 93 is on EBP, staff should perform hand hygiene, put on gloves, and a gown. LVN 2 stated he didn't put on a gown before entering Resident 93's room. During a concurrent interview and record review on 04/15/2026 at 7:30 a.m. with Registered Nurse (RN 1), Resident 93's physician's order was reviewed. RN1 stated that Resident 93 had orders for EBP for a wound. RN 1 stated, the nurse (in general) would need to use gown and gloves when applying the lidocaine patch before entering the EBP room. RN 1 stated that applying a lidocaine patch on the skin is considered a close contact activity. During a concurrent interview, record review, with Director of Nursing (DON) on 4/15/2026 7:45 a.m., DON stated that for EBP rooms, nurses (in general), nurses (in general), would need to use gown and gloves for close contact with the residents. The DON stated that it is considered close contact with the resident when a nurse (in general) performs activities that require them to touch the patient, including application of a lidocaine patch. DON stated the nurse (in general) would need to don a gown and gloves for the lidocaine application. During a subsequent interview and record review on 4/15/2026 at 7:45 a.m. with the DON, the DON stated that the policy section indicated .targeted gown and gloves use during high contact resident care activities. The DON stated that LVN should have used gowns while applying the patch. During a review of the facility's policy and procedure titled Enhanced Standard/Barrier Precautions dated 3/5/2026 indicated that .Enhanced Barrier Precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure informed consent was obtained in a timely manner from the resident before administering COVID-19 (highly contagious respiratory illness caused by the SARS-CoV-2 virus) vaccine (a preparation that is used to stimulate the body's immune response against diseases) for two of five sampled residents (Resident 19 and Resident 20) when:The informed consent for the COVIDˆ19 vaccine, including a discussion of the risks, benefits, and potential side effects for Resident 19, was obtained on 01/07/2026, which was 34 days prior to the administration on 02/10/2026.The informed consent for the COVID-19 vaccine, including a discussion of the risks, benefits, and potential side effects for Resident 20 was obtained on 08/27/2025, which was 21 days prior to the administration on 09/17/2025.These deficient practices violated Resident 19 and Resident 20's rights to make an informed decision at the time of administration. A. During a review of Resident 19's admission Record, the admission record indicated that Resident 19 was initially admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), hyperlipidemia (abnormally high levels of fats in the blood) and hypertension (HTN-high blood pressure).During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool) dated 03/21/2026, MDS indicated that Resident 19's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 19 required minimal to moderate assistance from staff for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 19's record titled Order Summary indicated a physician's order initiated on 02/10/2026 of COVID-19 Vaccine Inject 1 syringe intramuscularly one time only for vaccine for 1 Day.B. During a review of Resident 20's admission Record, the admission record indicated that Resident 20 was initially admitted to the facility on [DATE], with diagnoses including dysphagia (difficulty swallowing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and muscle weakness. During a review of Resident 20's MDS dated [DATE], MDS indicated that Resident 20's cognitive skills for daily decisions were intact. The MDS indicated Resident 20 was independent for ADLs.During a review of Resident 20's record titled Order Summary indicated a physician's order initiated on 09/17/2025 of COVID-19 Vaccine Intramuscular Suspension Prefilled Syringe 50 microgram (mcg-unit of measurement)/0.5 milliliter (ml-unit of measurement) Inject 1 syringe intramuscularly one time only for immunization for 1 day.During a concurrent interview and record review on 4/16/2026 at 11:43 a.m. with Infection Preventionist (IPN), Resident 19 and Resident 20 immunization record and vaccine consent form were reviewed. The IPN stated that immunization is vital to prevent severe illness and noted her responsibility for tracking residents' immunizations. The IPN stated that informed consent is crucial for residents to understand the risks, benefits and side effects of getting vaccinated. The IPN stated that informed consent for the covid vaccine for Resident 19 was obtained on 01/07/2026 and it was administered on 02/10/2026. The IPN stated that informed consent for the covid vaccine for Resident 20 was obtained on 08/27/2025 and it was administered on 09/17/2025. The IPN stated the residents could have changed their mind since informed consent for covid vaccine was obtained a month ago for Resident 19 and three weeks ago for Resident 20.During an interview on 4/16/2026 at 8:43 a.m. with Director of Nursing (DON), DON stated obtaining informed consent ensures residents are aware of risks and benefits and have the right to accept or refuse the treatment. DON stated that it is important to respect residents' right to know and decline medications, even those recommended by Medical Doctor.During a review of facility's Policy and Procedure (P&P) titled Coronavirus Disease-Vaccination of Residents, reviewed 3/05/2026, the P&P indicated that, residents or their (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representatives can accept or decline the COVID-19 vaccine and may change their decision at any time. Education, documentation, and reporting are managed by the infection preventionist. Before vaccination, residents receive information about benefits, risks, and potential side effects. Consent forms are provided in an understandable language and format. The medical record must show that education was given, including material samples, the date, and details of risks and benefits including signed consent.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate the resident's preference to go out on pass (a temporary, therapeutic leave allowing residents to go outside the facility) for one of two sampled residents (Resident 13). This failure resulted in Resident 13's feeling that his concerns were not being heard by staff and had the potential to affect Resident 13's sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem.During a review of Resident 13's admission Record, the admission record indicated that Resident 13 was initially admitted to the facility on [DATE], with diagnoses including hepatic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition a disease in which the functioning of the brain is affected by severe liver disease), schizoaffective disorder, bipolar type (a mental illness that can affect thoughts, mood, and behavior) and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool) dated 03/02/2026, MDS indicated that Resident 13's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 13 required mild to moderate assistance from staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 13's history and physical (H&P), H&P indicated that resident 13 had the capacity to make decisions. During a concurrent observation and interview on 4/13/2026 at 11:45 a.m. with Resident 13, Resident 13 was awake, alert and oriented to name, time and place. Resident 13 stated difficulty with independence and wishing to go more frequently if possible but facing obstacles. Resident 13 stated he felt that his concerns were not being heard by staff. Resident 13 stated that being able to go out adds meaning and satisfaction to his life. Resident 13 requested a simpler process to pursue his preferences.During a review of Resident 13's care plan titled behavior problem initiated on 12/12/2024, the care plan indicated an intervention as follows: anticipate and meet the resident's needs and provide a program of activities that is of interest and accommodates residents' status. During a review of Resident 13's records titled Elopement Evaluation dated 10/07/2025, it indicated that resident was not at risk for elopement. During a concurrent interview and record review on 4/15/2026 of Resident 13's order summary and care plan report on 4/15/2026 at 10:22 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 explained that when a resident requests to go out on pass, a physician's order is required. LVN 4 stated there was a care plan for Resident 13 to go out on pass, however, there were no active physician orders for out on pass for Resident 13. LVN 4 stated that there was an order on 07/10/2025 but discontinued on 02/28/2026. LVN 4 stated that failure to implement or follow the care plan can negatively affect residents' rights, health, and safety. LVN 4 further stated that residents shouldn't feel confined to staying in this facility- this is their home, and they should have the freedom to go out as they wish. LVN 4 added supporting them helps reduce stress. During an interview on 4/15/2026 at 11:38 a.m. with Social Service Director (SSD), SSD stated that resident 13 was permitted to go out on pass. SSD also stated that escorts cannot be provided every week or twice a week. SSD stated the facility is home to residents, who are free to leave and not restrained to stay.During an interview on 4/16/2026 at 8:43 a.m. with Director of Nursing (DON), DON stated that residents have rights to live normally, have access to what they need safely, receive proper care and treatment, and be treated with respect and dignity. DON also stated that residents may go out on pass with family or a representative or an escort if safety concerns exist. DON further stated that it is important for residents to exercise their rights as it can affect their well-being. DON added that residents are just like us, providing residents with a safe environment outside. It's important that residents don't feel restricted from leaving this place.During a review of the facility's Policy and Procedure (P&P) titled, (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Rights, dated 4/15/2026, the P&P indicated, that Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include self-determination, support from the facility, freedom from interference or discrimination, and refusal of care.During a review of facility's P&P titled, Out on Pass, undated, the P&P indicated, that the facility is dedicated to enabling residents to participate in family and community life, supporting their well-being. The facility will make reasonable efforts to ensure residents' safety and uphold their rights when they go out on pass.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to:Inform the Primary Care Physician (PCP) as soon as the facility received Resident 96's abnormal laboratory (lab) result of potassium of 5.8 mEq/L (critical electrolyte that helps nerve function, muscle contraction, and maintaining normal blood pressure normal range 3.5-5.5 milliequivalents per liter, mEq/L, a unit of measure) on 3/13/2026 at 8:55 a.m. The PCP was notified at 1:00 p.m. (almost 4 hours after the facility received the abnormal high lab result) for one of one sampled resident.Notify Resident 96's PCP that Kayexalate (emergency kit -EKIT medication used to treat hyperkalemia [having too much potassium in your blood] by binding potassium in the intestines in exchange for sodium, which is then eliminated via stool) was available at the facility when Resident 96 had a high level of potassium of 5.8 mEq/L (milliequivalents per liter ([mEq/L] unit of measure with normal range of 3.5 mEq/L - 5.5 mEq/L).on 3/13/2026, so the physician could determine if treatment was needed.These failures resulted in Resident 96 not being monitored or assessed, and the resident's hyperkalemia state not being treated, following a documented Change of Condition (COC) first identified on 3/13/2026. On 3/16/2026 and collected at 10:25 a.m., a repeat lab test result showed a critical potassium level of 6.0 mEq/L confirming a worsening and untreated hyperkalemia state, a condition associated with fatal cardiac (heart) arrhythmias (abnormal heart rhythm).Findings:During a review of Resident 96 admission record, the admission record indicated the facility admitted Resident 96 on 1/30/2024 with a diagnoses that included anxiety (a mental health condition characterized by excessive, persistent, and unreasonable worry or fear that interferes with daily functioning), hypertension (high blood pressure) dementia (impaired cognitive functioning), anemia (low red blood cells in the blood, dysphagia (difficulty swallowing), presence of a cardia pacemaker (an internally implanted device to support the heart electrical activity), cardiomyopathy (enlarged heart condition) diabetes (high blood sugar level), history of infection of the urinary tract (the body's drainage system for removing waste and extra water, produced as urine), arthritis (joint inflammation) ,and infections of the digestive tract (a tube-like series of organs that runs from the mouth to the anus, acting as the body's food processing center), and acute kidney failure (impairment of the kidneys to rid the body of metabolic [the body's process of turning food and drink into energy to sustain life] waste).During a review of Resident 96's Lab Results Report -Basic Metabolic (BMP), reported on 3/13/2026 at 8:55 a.m., the result indicated a high potassium level of 5.8 mEq/L. During a review of Resident 96's Interact Change of condition (COC) Evaluation, dated 3/13/2026 at 2:52 p.m., the COC indicated Resident 96 had an abnormal lab of potassium level 5.8 mEq/LDuring a review of Resident 96's Nursing Notes, dated 3/13/2026 4:44 p.m. the notes indicated Resident 96's abnormal lab value was relayed to the physician and the physician ordered to repeat the lab test on 3/16/2026.During a review of Resident 96's Nurse's notes from 3/12/206 to 3/14/2026, the notes did indicate care plan interventions were being implemented for Resident 96 as a result of the COC.During an interview on 4/15/2026 at 1:03 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that if there is a change of condition (COC), following assessment, the staff should notify the PCP to check if the facility can provide the care or if needed to be transfer to General Acute Care Hospital (GACH). The PCP may order laboratory or other interventions. If the laboratory is ordered, the laboratory will call the facility if there are critical results. The staff at facility will call in a few hours for results. In critical results, once the lab calls, the staff will notify the doctor.During a concurrent interview and record review on 4/15/2026 at 1:03 p.m. with LVN 3, Resident 96's laboratory results (reported on 3/13/2026) were reviewed. The laboratory results indicated Resident 96 had a high potassium level of 5.8 mEq/L. LVN 3 stated if a resident has an elevated potassium, the physician can order Kayexalate (a medication that treats hyperkalemia above 5.0 mEq/L), which was available in the emergency- kit (E-kit) because abnormal potassium can have complications in the heart. LVN 3 stated that for change of condition (COC) it (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the responsibility of the charge nurse or the Registered Nurse Supervisor to notify the physician. LVN 3 stated that laboratory results will be available online and it was the responsibility of the LVN or RN to call the physician for any abnormal laboratory result once it was available.During an interview on 4/15/2026 at 1:03 p.m., with LVN 3, LVN 3 stated that lab results were available in the electronic medical records (EMR). LVN 3 stated that Resident 96 should have received appropriate care by ensuring the physician was notified as soon as laboratory results were received, particularly if any abnormalities were identified. LVN 3 stated that this was especially important for residents with a Change of Condition (COC), so that any medical issues can be promptly addressed and complications prevented. LVN 3 stated anyone can help residents by providing and not delaying care.During an interview on 4/15/2026 at 1:29 p.m. with Registered Nurse (RN) 1, RN 1 stated that the EMR will flag and alert staff once staff log in. RN 1 stated that physicians were supposed to be notified of abnormal labs as soon as possible for best care of residents. RN 1 stated, once the physician responds, it should be documented in the progress notes with actions or no actions. RN 1 stated it was important to provide up to date information to the physician and elevated potassium level should be reported to physicians as there could be heart concerns heart attack. During a concurrent interview and record review on 4/15/2026 at 1:29 p.m., Resident 96's care plan titled, Risk for complications related to cardiac status due to history of hyperkalemia and the care plan interventions were reviewed with RN 1. RN 1 stated that assessment involved evaluating patients to ensure their bodies and organ systems were functioning properly. RN 1 stated the purpose of assessment was to identify and monitor for any changes from the patient's baseline condition. RN 1 stated residents with hyperkalemia should be monitored at least every shift but more assessments if there are changes in condition. RN 1 stated a change in baseline warrants an assessment, a note, and immediate physician notification.During the interview and record review with RN 1 on 4/15/2026 at 1:45 p.m., Resident 96's change of condition notes, nursing notes, physician notes, acute progress notes, laboratory results, medication administration record and care plans were reviewed. RN 1 stated Resident 96's potassium level result of 5.8 mEq/L was available on 3/13/2026 at 8:55 a.m. and the physician was notified at 4:44 p.m. RN 1 could not explain why there was a delay in relaying the lab results. RN 1 stated upon identification of Resident 96's abnormal labs, the resident should have been assessed; and a call and a faxed report to the physician should have been made. RN 1 reviewed the care plan interventions and medical records and stated there was no documented evidence that Resident 96's level of consciousness (alertness) or neuromuscular function -- including sensation, strength, and movement-- was assessed or closely monitored for symptoms of hyperkalemia and potential cardiac arrest at least once every shift for three days.During a concurrent interview on 4/16/2026 at 9:31 a.m. with Assistant Director of Nursing and review of Interact COC, dated 3/13/2026 timed 2:52 p.m. and laboratory result dated 3/13/2026 timed 8:55 a.m. were reviewed. The records indicated Resident 96's potassium lab value result was 5.8 mEq/L. The ADON stated that if there is an abnormal lab result, the timeframe to notify the physician (if critical) is right away so physician can give orders or intervention. The ADON stated hyperkalemia is treated with Kayexalate which is available in the E-kit. The ADON stated if the family refused to have Resident 96 receive further treatment, treatment options should be discussed with them (the family), and the risk and benefits documented in the progress notes. The ADON stated there were no documented notes that risks and benefits were discussed with Resident's 96's family, who is so involved with plan of care.During an interview on 4/16/2026 10:38 a.m. with the Director of Nursing (DON), the DON stated the laboratory results are received in EMR and for any abnormal high or critical high, the laboratory will contact the facility and alert the staff. The DON stated that normal or abnormal labs are reported to the physician as soon as it is available in the EMR and any nursing staff has access to EMR. The DON stated the Resident 96's EMR showed blood tests were ordered in response to Resident 96's change in condition on 3/12/2026 and that the lab result of the potassium was 5.8 mEq/L(high). The DON stated that if serum potassium results are on the high side, the facility needs to address it and (continued on next page)

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Windsor Gardens Convalescent Hospital	915 S. Crenshaw Blvd. Los Angeles, CA 90019

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirm if the physician will order Kayexalate. The DON stated that potassium is an important electrolyte for the heart muscle. The DON stated the lab report on 3/13/2026 at 8:55 a.m. did not identify the facility's staff's name who was contacted about the abnormal laboratory result, which is usual laboratory practice. The DON stated the nurses will conduct a COC as soon as they can, an important communication to all nurses. The DON stated that if the nurses are busy during the shift, it may delay in initiating the documentation on the form. During the interview, on 4/16/2026 at 10:38 a.m., the DON stated that Resident 96's EMR is unable to provide documentation of care plan interventions or implementation of assessments being implemented. The DON stated there was no documentation that the risks and benefits of not correcting hyperkalemia were discussed with Resident 96's family members. The DON stated quality of care is when the facility provides what care is needed to residents. The DON stated DNR does not change any care provided to the residents. The DON defined DNR as it means not resuscitating when the heart stops beating unless there is added restriction.During a review of the facility's policy and procedure (P&P) titled, Guidelines for Notifying Physicians of Clinical Problems, dated 2/2014, the P&P indicated to help ensure that medical problems are communicated to the medical staff in a timely, efficient and effective manner and all significant changes in resident status are assessed and documented in the medical record. Immediate notification (acute) problems the following symptoms, signs and laboratory values should prompt immediate notification of the physician after an appropriate nursing evaluation. Immediate implies that the physician should be notified as soon as possible either by phone, pager, text messaging or other means.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to ensure the confidentiality of resident medical records when the medication labels for two of two sampled residents (Residents 1 and 74) were left unattended on a medication cart in the facility hallway. This failure had the potential to violate Resident 1 and 74's right to confidentiality.Findings: During a concurrent observation and interview on 4/16/2026 at 10:46 AM with Licensed Vocational Nurse (LVN) 4 in the facility hallway, two medication labels were left on top of the medication cart. One medication label indicated Resident 1's name, a prescription number, and the name of the medication doxazosin mesylate (a medication to treat high blood pressure) 4 milligram tablet. The second medication label indicated Resident 74's name, a prescription number, and the name of the medication lisinopril (a medication to treat high blood pressure) 10 milligram tablet. LVN 4 stated these labels are from each resident's individual medication package. It is not facility policy to leave these labels on top of the medication cart unattended because the labels contain confidential patient information. Leaving these labels out is a violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA - a federal law that establishes national standards to protect sensitive patient health information). During an interview on 4/16/2026 at 11:17 AM with the Assistant Director of Nursing (ADON), ADON stated medication labels should not be left out on medication carts. It is important not to leave these labels out because they contain confidential information and that would be a violation of HIPAA and patient confidentiality.During a review of the facility's policy and procedure (P&P) titled, Confidentiality of Information and Personal Privacy, last reviewed 3/5/2026, the P&P indicated the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. The facility will strive to protect the resident's privacy regarding his or her medical treatments.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the pressureˆrelieving device of a low air loss (LAL) mattress was set according to the manufacturer's recommended guidelines for Resident 71. This deficient practice had the potential to compromise the resident's right to a safe, clean, comfortable, and homelike environment and to place Resident 71 at risk for pressureˆulcer development and discomfort while in bed.Findings:During a review of Resident 71 admission record, the admission record indicated admitted on [DATE] with a diagnoses of stroke [cerebral vascular accident (reduction of blood flow to the brain resulting in brain injury), hypertension (high blood pressure), hyperlipidemia (abnormally high levels of fats in the blood), hemiparesis (neurological condition characterized by weakness, numbness, and reduced motor function on one side of the body, often affecting the arm, leg, and face).During a record review of Resident 71's Minimum Data Setˆ(MDS- resident assessment tool) dated 3/18/2026, The MDS indicated that Resident 9 is rarely/never understood. The MDS also indicated that Resident 71 is dependent with eating, toileting hygiene and shower. During an observation on 04/13/2026 12:33 p.m., Resident 71's bed has low air loss overlay (LAL) mattress machine on bed with sticker set at wt. 98 was set approximately 150 lbs. During a concurrent interview and observation on 04/15/2026 10:46 a.m. with certified nursing assistant (CNA) 1 while at the bedside of Resident 71 CNA 1 stated that the setting for the LAL at 150 lbs when the machine indicates set at 98Lbs. CNA 1 stated Treatment Licensed Vocational Nurse (LVN) manage settings for LAL.During a concurrent interview on 04/15/2026 10:52 a.m. and observation of the LAL mattress with LVN 3, LVN 3 stated the settings on the LAL mattress was weight based. LVN 3 stated that settings exceeded the recommended settings. LVN 3 stated that if the mattress is too hard it is not good for the resident's skin and that is the reason why the LAL mattress is ordered.During a review of the facility's policy and procedure (P&P) titled, Support Surface Guidelines, dated 03/05/2026, indicated, guides the facility staff to: Redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. The P & P indicated elements of support surfaces that are critical to pressure ulcer prevention and general safety include pressure redistribution, moisture control, shear reduction, heat dissipation/temperature control, friction control, infection control, flammability, and life expectancy.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS- resident assessment tool) pain management section for one of three sampled residents (Resident 23).This deficient practice had potential to cause inaccurate care quality measures and triggered care plan will be inaccurate for Resident 23.During a record review of Resident 23's admission record, the admission record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses of lack of coordination (affecting transfers and mobility, may cause falls), mild protein-calorie malnutrition (nutritional imbalance leading to weight loss), diverticulosis of large intestine (pockets in the large intestine that can cause bleeding or infection), diaphragmatic hernia (protrusion of part of stomach, out of normal position from abdominal cavity into chest cavity, causing difficulty in digestion and breathing).During a review of Resident 23's Minimum Data Set (MDS- resident assessment tool) the MDS dated [DATE] indicated Resident 23's Brief Interview for Mental Status (assessment tool for brain's complex mental processes involved in gaining knowledge and comprehension) was 13, meaning the person was cognitively intact (able verbalize needs and comprehend). MDS indicated functional abilities (person's ability to perform activities of daily living such as dressing, standing, sitting, and walking, transfers from bed to chair, toileting) of Resident 23 required supervision or touching assistance (helper provide verbal cues or touching) with activities of daily living (dressing, standing, sitting, and walking, transfers from bed to chair, toileting) and partial/moderate assistance with showering.During a record review Resident 23's MDS dated [DATE] and medication administration record (MAR), the MDS section J Health Conditions - J0100. Pain management indicated discrepancy between MDS and medication administration record (MAR) for 01/ 2026. The MAR indicated that Acetaminophen (pain relieving medication) was given for pain level 3/10 (numeric rating for pain assessment: 1-4 mild pain, 5-7 moderate pain, 8-10 severe pain) on 1/29/2026, which was within five days look-back period of MDS assessment (Assessment Reference Date 1/28/2026-2/2/2026).During a concurrent interview and record review on 04/16/2026 at 12:01p.m. with MDS coordinator Resident 23's MDS dated [DATE] under Section J Pain Management, the MDS indicated Complete for all residents, regardless of current pain level: At any time in the last five days, has Resident 23 Received PRN (Pro re nata, as needed) pain medications OR was offered and declined? the answer selected was No. The MDS coordinator stated they do ask the residents and nurses regarding the pain when they fill out the MDS report.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to provide the necessary care and treatment for one of one sampled resident (Resident 96) by failing to: a. Reassess Resident 96's ongoing use of Bactrim (a prescription antibiotic combination used to treat bacterial infections) and sacubitril-valsartan (medication for congestive heart failure [CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling]), and notify the physician that the electronic medical records (EMR) system triggered a drug-drug interaction (DDI) alert (an alerts that appear on the screen by flagging potential adverse reactions or duplicate therapies during the prescribing process. These alerts appear during medication search or processing allowing clinicians to cancel or override them) due to concurrent use of Bactrim and sacubitril-valsartan. This combination of medications can significantly increase the risk of hyperkalemia, a condition caused by dangerously high elevated levels of potassium (an essential mineral and electrolyte that helps the body maintain fluid balance, sends nerve signals, and regulates muscle contractions, including the heart). Resident 96 continued to take these medications from 3/12/2026 through 3/16/2026. b. Assess and monitor Resident 96 including the resident's level of consciousness and neuromuscular (nerves and muscles) status - including sensation, strength and movement- as required by the resident's care plan, Risk for complications related to cardiac status due to history of hyperkalemia, when the resident had a high level of potassium of 5.8 mEq/L on 3/13/2026. These failures resulted in Resident 96 not being monitored or assessed, and the resident's hyperkalemia state not being treated, following a documented Change of Condition (COC) first identified on 3/13/2026. On 3/16/2026 and collected at 10:25 a.m., a repeat lab test result showed a critical potassium level of 6.0 mEq/L confirming a worsening and untreated hyperkalemia state, a condition associated with fatal cardiac (heart) arrhythmias (abnormal heart rhythm). Resident 96, who had a Do Not Resuscitate (DNR) status, expired on 3/16/2026 at 11:25 p.m. Findings: During a review of Resident 96 admission record, the admission record indicated the facility admitted Resident 96 on 1/30/2024 with a diagnoses that included anxiety (a mental health condition characterized by excessive, persistent, and unreasonable worry or fear that interferes with daily functioning), hypertension (high blood pressure) dementia (impaired cognitive functioning), anemia (low red blood cells in the blood, dysphagia (difficulty swallowing), presence of a cardia pacemaker (an internally implanted device to support the heart electrical activity), cardiomyopathy (enlarged heart condition) diabetes (high blood sugar level), history of infection of the urinary tract (the body's drainage system for removing waste and extra water, produced as urine), arthritis (joint inflammation) ,and infections of the digestive tract (a tube-like series of organs that runs from the mouth to the anus, acting as the body's food processing center), and acute kidney failure (impairment of the kidneys to rid the body of metabolic [the body's process of turning food and drink into energy to sustain life] waste). During a review of Resident 96's care plan titled Risk for complications related to cardiac status due to history of hyperkalemia initiated 4/10/2024, the care plan goal indicated the resident will display lab results within normal limits and absence of signs and symptoms related to hyperkalemia. The care plan included the following interventions: a) Assess and document the resident's level of consciousness (alertness) and neuromuscular function, including sensation, strength, and movement. b) Monitor serum potassium levels. c) Be aware that cardiac arrest can occur. During a review of Resident 96's care plan titled, Resident is on multiple medications. At risk for ill effects of multiple drug use, initiated 1/31/2026, the care plan interventions included the following interventions: a) Inform and explain to family members/significant others and residents of the risks and benefits of multiple meds. b) Monitor for any signs and symptoms (s/s) of adverse reaction. c) Report to MD (the physician) and family members/significant others for any change of condition. d) Pharmacist review as per policy. During a review of Resident 96's History and Physical (H&P), dated 2/14/2026, the H&P indicated Resident 96 was able to make needs known but had a fluctuating capacity to understand and make (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical decisions. During a review of Resident 96's quarterly Minimum Data Set (MDS- a resident assessment tool), dated 3/23/2026, the MDS indicated Resident 96' s cognition (mental process of acquiring, storing, retrieving, and using information) was severely impaired-never/rarely made decisions. The MDS indicated Resident 96 was dependent on staff for all activities of daily living [(ADL) activities such as bathing, dressing, toileting, and hygiene a person performs daily]. The MDS indicated Resident 98 is dependent on staff for mobility such as moving from lying to sitting up in bed and transferring from bed to chair. During a record review of physician's orders for Resident 96, the physician order dated 3/12/2026 indicated an order for sacubitril-valsartan oral tablet 24-26 milligrams (mg, a unit of measurement), to give one (1) tablet by mouth two times a day for congestive heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently), hypertension (high blood pressure) and to hold for systolic blood pressure (SBP, the top number in the blood pressure reading, representing the maximum pressure in the arteries when the heart beats and pushes blood) less than (<) 110 or heart rate (HR)<60. During a review of Resident 96's Interact Change of condition (COC) Evaluation, dated 3/12/2026 at 11 a.m., the COC indicated Resident 96 had vaginal discharge and Nurse Practitioner (NP) 1 ordered Bactrim double strength and laboratory draw orders which included basic metabolic panel ([BMP], a blood test measuring electrolytes and certain metabolites that can help assess kidney problems or dehydration), a urinalysis ([UA], a test that examines the appearance, concentration, and content of urine) and urine culture (a test to identify germ causing infection). During a review of Resident 96's Medication Administration Record (MAR) for March 2026, the MAR showed Resident 96 received twice daily doses of sacubitril/valsartan and Bactrim DS, which was initiated on 3/12/2026 at 5 p.m., and subsequent doses twice daily through 3/16/2026. During a review of Resident 96's Lab Results Report -Basic Metabolic (BMP), reported on 3/13/2026 at 8:55 a.m., the result indicated a high potassium level of 5.8 mEq/L. During a review of Resident 96's Interact Change of condition (COC) Evaluation, dated 3/13/2026 at 2:52 p.m , the COC indicated Resident 96 noted with abnormal lab of potassium level 5.8 mEq/L (milliequivalents per liter ([mEq/L] unit of measure with normal range of 3.5 mEq/L - 5.5 mEq/L). During a review of Resident 96's Nursing Notes, dated 3/13/2026 4:44 p.m. the notes indicated abnormal labs were relayed to the physician and the physician ordered to repeat the lab on 3/16/2026. During a review of Resident 96's Nurse's notes from 3/12/206 to 3/14/2026, the notes indicated no documentation of care plan interventions being implemented. During a review of Resident 96's MAR, the MAR indicated the resident had an advanced directive - not Attempt Resuscitation/CPR Comfort Focused Treatment - primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. DO NOT HOSPITALIZE, NO IV THERAPY NO ARTIFICIAL MEANS OFNUTRITION, INCLUDING FEEDING TUBES. During a review of Resident 96's 3/16/2026 SBAR (Situation, Background, Assessment, Recommendation) nursing notes, dated 3/16/2026, the SBAR indicated that at 11:25 p.m., Unable to obtain vitals (no rise and fall of chest observed). Daughter notified of patient's expiration. The SBAR indicated the physician was made aware and the physician made an order to release the resident. During an interview on 4/15/2026 at 1:29 p.m. with Registered Nurse (RN) 1, RN 1 stated that the EMR will flag and alert staff once staff log in. RN 1 stated it was important to provide up to date information to the physician and elevated potassium level should be reported to physicians as there could be heart concerns heart attack. During a concurrent interview and record review on 4/15/2026 at 1:29 p.m., Resident 96's care plan titled, Risk for complications related to cardiac status due to history of hyperkalemia and the care plan interventions were reviewed with RN 1. RN 1 stated that assessment involved evaluating patients to ensure their bodies and organ systems were functioning properly. RN 1 stated the purpose of assessment was to identify and monitor for any changes from the patient's baseline condition. RN 1 stated residents with hyperkalemia should be monitored at least every shift but more assessments if there are changes in (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition. RN 1 stated a change in baseline warrants an assessment, a note, and immediate physician notification. During the interview and record review with RN 1 on 4/15/2026 at 1:45 p.m., RN 1 reviewed the care plan interventions and medical records and stated there was no documented evidence that Resident 96's level of consciousness (alertness) or neuromuscular function -- including sensation, strength, and movement-- was assessed or closely monitored for symptoms of hyperkalemia and potential cardiac arrest at least once every shift for three days. During the interview and record review with RN 1 on 4/15/2026 at 1:45 p.m., Resident 96's change of condition notes, nursing notes, physician notes, acute progress notes, laboratory results, medication administration record and care plans were reviewed. Resident 96's physician orders indicated medication orders of Bactrim DS tablet 800-160 milligrams (a unit of measure), by mouth, one tablet twice a day and sacubitril-valsartan (trade name of Entresto) oral tablet 24-26 milligrams, one tablet by mouth, two times a day. RN 1 stated when Bactrim DS was inputted in the EMR, a DDI alert warning licensed staff of Resident 96's drug-drug interaction for the sacubitril-valsartan and Bactrim DS was noted and the triggered alert was due to a significant risk for hyperkalemia, especially with renal impairment. RN 1 stated it was important not to ignore pop-upˆwarnings for monitoring and to be aware. RN 1 stated the Bactrim DS started on 3/12/2026. During the interview and record review with RN 1 on 4/15/2026 at 1:45 p.m., RN 1 stated upon physician notification on 3/13/2026 (at 4:44 p.m.), the physician ordered repeat labs on 3/16/2026. RN 1 stated there was no documented evidence that the physician was notified of the drug-drug interaction alert generated in the EMR indicating a potential risk of hyperkalemia to Resident 96. RN 1 stated Resident 96 would probably have benefited from cardiac monitoring. RN 1 stated that Do not Resuscitate (DNR) does not stop the facility from providing care and necessary services needed to achieve good quality of care to any residents. RN 1 stated nurses still need to assess and monitor any residents that have COC that are DNR otherwise that can be a neglect. During an interview on 4/16/2026 at 8:59 a.m., with LVN 5, LVN 5 stated when the electronic order for Bactrim was entered a DDI alert appeared on the screen, warning the prescriber of increased risk for hyperkalemia. LVN 5 stated Resident 96's diagnosis of heart problems and renal problems also contributed to the alert to be triggered. LVN 5 stated she did not notify the physician about the DDI alert warning for increased hyperkalemia risk; she just clicked the alert and continued the order. LVN 5 stated the DDI alerts should have been reviewed and discussed with the physician, so the physician can decide to continue or cancel the prescription. LVN 5 stated DDI alert is important as medication can have effect with other drugs. LVN 5 stated if there was an abnormal lab result, the staff should notify the physician of the result, assess the resident, and document in the nursing progress notes. During the interview on 4/16/2026 at 9:31 a.m., the DDI alert in the physician's order and care plan, Risk for complications related to cardiac status due to history of hyperkalemia, was reviewed with the ADON. The ADON stated that LVN's or RN's need to pay attention to Resident 96's history. The ADON stated that the nursing staff did not provide any documentation that will support the assessment and monitoring of Resident 96's level of consciousness and neuromuscular status - including sensation, strength and movement- as required per care plan. The ADON stated that the Interact COC started at 2:52 p.m. (on 3/13/2026), 6 hours from the time the potassium lab result received (at 8:55 a.m. on 3/13/2026). During the interview on 4/16/2026 at 9:31 a.m., the ADON stated that during medication pass, DDI will also prompt nurses to check lab. The ADON stated that it is important to collaborate, address the problem and provide interventions to impact good quality of care. The ADON stated the residents with DNR status still need to get same care, DNR is for resuscitation not changing care. During a telephone interview on 4/16/2026 at 10:27 a.m. with Pharmacy (Pharm) 1, Pharm 1 stated abnormal potassium levels can cause cardiac (heart) arrythmia (irregular heart beat) if not being addressed timely. During an interview on 4/16/2026 10:38 a.m. with the Director of Nursing (DON), the DON stated that potassium is an important electrolyte for heart muscle. During the interview, on 4/16/2026 at 10:38 a.m., The DON stated the medication system has a warning pop-up embedded in the EMR for DDI. The DON (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the nurses, who will see the alert, should let the doctor know of the potential reaction. The DON stated that the nurse should not over-ride the warning without informing the physician and this needs to be documented in EMR. The DON stated Resident 96's EMR assessments were not documented as more frequent than routine vital signs (VS). The DON verbalized that not every intervention is on the medication record. During the interview, on 4/16/2026 at 10:38 a.m., the DON stated that Resident 96's EMR is unable to provide documentation of care plan interventions or implementation of assessments being implemented. The DON stated there was no documentation that the risks and benefits of not correcting hyperkalemia were discussed with Resident 96's family member. The DON stated quality of care is when the facility provides what care is needed to residents. The DON stated DNR does not change any care provided to the residents. The DON defined DNR as it means not resuscitating when the heart stops beating unless there is added restriction. During a telephone interview on 4/16/2026 at 2:27 p.m. with Nurse Practitioner (NP)1 regarding the Bactrim order. NP1 stated she was not working (not present) in the facility at the time and date the order was made, which was 3/12/2026 at 11 a.m. for Bactrim and blood tests. NP 1 stated that it was never brought to her attention about the DDI nor the potassium result. NP 1 stated if she knew about the warning about the medication interaction, she would either change the order or collaborate with the facility staff. NP 1 defined hyperkalemia is something that should be addressed as soon as possible to prevent any complications. During a review of the facility's policy and procedure (P&P) titled, Guidelines for Notifying Physicians of Clinical Problems dated 2/2014, the P&P indicated to help ensure that medical problems are communicated to the medical staff in a timely, efficient and effective manner and all significant changes in resident status are assessed and documented in the medical record. Immediate notification (acute) problems the following symptoms, signs and laboratory values should prompt immediate notification of the physician after an appropriate nursing evaluation. Immediate implies that the physician should be notified as soon as possible either by phone, pager, text messaging or other means.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's eyeglasses were kept in working condition for one of three sampled residents (Resident 11). This failure resulted in Resident 11 not being able to see adequately and expressing feeling of frustration from not being able to enjoy his preferred activity.During a review of Resident 11's admission Record, the admission record indicated that Resident 11 was initially admitted to the facility on [DATE], with diagnoses including cerebrovascular disease (loss of blood flow to a part of the brain), alcoholic cirrhosis (permanent scarring that damages the liver and interferes with its functioning), and atrial fibrillation (afib- an irregular and very rapid heart rhythm that and can lead blood clots in the heart).During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool) dated 03/12/2026, MDS indicated that Resident 11's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 11 was fully dependent from staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing). The MDS also indicated that Resident 11 has impaired vision with the use of corrective glasses.During a concurrent observation and interview on 4/13/2026 at 10:00 a.m. with Resident 11, Resident 11 was awake, alert, and responsive while watching television up close. Resident 11 stated that his eyeglasses broke two or three months ago and informed the staff , Resident 11 expressed frustration at being unable to see clearly as he enjoys watching television.During a concurrent interview and record review of Resident 11's progress notes record on 4/15/2026 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that nurses are responsible for ensuring assistive devices are always available to residents and must address any problems as they arise. LVN 4 added that there was no documentation or communication about Resident 11's broken eyeglasses. LVN 4 further stated that eyeglasses are crucial for residents' vision, allowing them to read, watch television, and engage in daily activities without difficulty. LVN 4 added that if Resident 11's vision needs are unmet, the resident could feel sad, neglected, and unheard.During an interview on 4/15/2026 at 11:38 a.m. with the Social Services Director (SSD), the SSD stated that residents should always have access to their assistive devices to support their quality of life and care, ensuring they feel safe and comfortable. The SSD further stated that limited vision poses a safety risk for residents. During an interview on 4/16/2026 at 8:43 a.m. with Director of Nursing (DON), DON stated that the entire team was responsible in ensuring that assistive devices were available to residents and report any issues to the social worker as needed. DON stated that vision is crucial for residents' quality of life and safety, as impaired sight can hinder their needs and communication.During a review of Resident 11's care plan report titled impaired visual function initiated on 7/10/2025, the care plan indicated a goal that resident will maintain optimal quality of life within limitation imposed by visual function. The care plan interventions include arranging eye care consultations as needed and providing suitable visual aids for activity participation.During a review of facility's Policy and Procedures (P&P) titled Resident Rights, dated 4/15/2026, the P&P indicated that the residents have the right to communicate with and access people and services inside and outside the facility; exercise their rights as facility or U.S. residents; receive facility support in exercising these rights; do so without interference, coercion, discrimination, or reprisal; refuse care; and be informed about their rights and responsibilities.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure re- assessment was done each time Resident 6 has a fall and implementation of fall prevention interventions, including timely post-fall reassessment and revision of the care plan, for 1 of 1 sampled resident (Resident 6) who was identified as high risk for falls.This deficient practice has a potential for Resident 6 to have recurrent falls , sustaining injury from fall compromising residents safety.During a review of Resident 6's admission Record (Face Sheet), the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertension (a condition characterized by persistently elevated blood pressure, which can increase the risk of cardiovascular complications), atherosclerotic heart disease (a condition where plaque builds up in the arteries, reducing blood flow to the heart), benign prostatic hyperplasia (BPH - a non-cancerous enlargement of the prostate that can cause urinary difficulty), history of falls, muscle weakness, and gait instability. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 02/11/2026, the assessment indicated the resident required extensive assistance with mobility and activities of daily living (ADL's routine task such as dressing, toileting, and transferring) and was identified as being at risk for falls.During a record review of Resident 6's Care Plan Report Focus Resident is at high risk for falls/injury related to history of repeated falls, poor safety awareness initiated on 6/6/2026, Another care plan initiated on 09/10/2025 with a Focus on resident is at risk for falls due to unsteady gait and poor safety awareness, resident requires assistance with ambulation to ensure safety. Provide physical assistance with ambulation per care plan. During a record review of the Resident's 6 Interdisciplinary Care Conference (IDT-involves professionals to collaborate patient centered-care) dated 7/28/2025 at 1:00 p.m., the IDT indicated that the resident slipped out a wheelchair onto the floor in the hallway while attempting to ambulate without assistance, and Resident's 6 IDT dated 09/04/2025 at 1:00 p.m. , the IDT indicated Resident 6 was observed sitting on a floor mat by an unknown CNA after attempting to ambulate independently without staff assistance. During a review of Resident 6's fall risk assessment dated [DATE], Resident 6 was identified as having a high risk for falls. No other documented fall risk assessment.During an interview on 04/15/2026 at 11:10 a.m. with Minimum Data Set Nurse (MDSN), the MDSN stated that there is no re-assessment done each fall, it is only done on admission. MDSN stated it is important to do re-assessment to check effectiveness of interventions and if there is decline.During an interview on 04/16/2026 at 10:10 a.m., Certified Nursing Assistant (CNA 5), CNA 5 stated that Resident 6 attempted to stand independently from the wheelchair, leaned forward, and subsequently fell.During an interview on 04/16/2026 at 11:30 a.m. with Licensed Vocational Nurse (LVN 2) , LVN 2 stated that Resident 6 was agitated prior to fall and attempted to stand without assistance. LVN 2 stated that post-fall interventions were initiated, including a head-to-toe assessment, neurological check, and monitoring of vital signs. During an interview on 04/15/2026 at 11:27 a.m. with Registered Nurse (RN 1), RN 1 reported that high-risk residents should have interventions such as floor mats, care plans, and assistance with ambulation, and confirmed the residents had a history of falls.During a concurrent interview and record review on 04/15/2026 at 11:17 a.m. with RN 1, RN 1 stated the record indicated Resident 6 had a history of falls and was identified as high risk; however, there was no updated care plan reflecting recent falls or documented reassessment following the most recent fall. RN 1 stated that expected interventions for high-risk residents but were unable to provide evidence that these interventions were updated in the care plan following the fall.During a record review of the facility's policy and procedure (P&P) titled Fall risk assessment dated 03/2018, the P & P indicated the nursing staff, in conjunction with attending physician, consultant pharmacist, therapy staff and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on relevant assessment information. The P & P indicated the staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are modifiable

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure adequate documentation of intake and output for one (Resident 8) out of one sampled residents who are on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).This deficient practice had the potential to cause fluid overload (excess water in the body) or dehydration (insufficient water in the body) for Resident 8.Findings:During a review of Resident 8's admission record, the admission record indicated Resident 8 was originally admitted on [DATE] with diagnoses including, but not limited to polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet); end stage renal disease (ESRD- irreversible kidney failure); chronic (systolic) congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling); and adult failure to thrive (decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity).During a review of the Minimum Date Set, (MDS- a resident assessment tool) dated 3/24/2026, MDS indicated that Resident 8's cognitive status (thought process) was not fully intact. MDS indicated that Resident 8 was independent with eating, moderate assistance with oral hygiene and upper body dressing, and maximal assistance with toileting, bathing, and lower body dressing. During a concurrent interview and record review on 4/14/2025 at 11:30 a.m., Licensed Vocational Nurse (LVN 2) stated that residents receiving dialysis obtain hemodialysis at an outpatient dialysis clinic. LVN 2 reported that Resident 8's most recent dialysis session occurred on 4/11/2026. Documentation for each dialysis treatment is recorded on the Hemodialysis Communication Record, which contains three sections: the top and bottom sections completed by facility staff, and the middle section completed by the dialysis center. LVN 2 stated the facility uploads the completed form into the resident's medical record.During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 4/14/2026 at 12:10 p.m., the ADON stated that management of care for dialysis residents includes completing assessments, following physician orders, and developing care plans. The ADON stated the dialysis center documents the resident's preˆ and postˆdialysis weight and records this information on the Hemodialysis Communication Record. The ADON stated that when a resident has physicianˆordered fluid restrictions, dietary staff and nursing staff coordinate the implementation of those restrictions. The ADON stated Resident 8 has physician orders for fluid restrictions as follows: Fluid restriction 1200ml/24 hours. With a breakdown of:Dietary total 600mL: Breakfast: 240ml, Lunch: 240ml, Dinner: 120ml. Nursing Total: 600ml 7 - 3: 200ml, 3 - 11: 200ml, 11 - 7: 200ml every shift. Start date 3/20/2026 2300. During a continued interview and record review with ADON on 4/14/2026 at 12:10 p.m., ADON reviewed Resident 8's Medication Administration Record (MAR) and stated MAR is marked as completed or not completed each shift. ADON stated there is no place where the specific amount of fluid given to the resident is documented. During a concurrent interview and record review on 4/16/2026 at 9:40 a.m. with the Director of Nursing (DON), the DON stated the dialysis clinic typically obtains the resident's preˆdialysis and postˆdialysis weights. The DON stated the purpose of obtaining the weights for dialysis residents is to determine the resident's fluid status and ensure the resident is not fluid overloaded. The DON stated most dialysis residents have physicianˆordered fluid restrictions. The DON stated the facility follows the physician's orders for fluid restrictions and that the total daily fluid allowance is divided among the three nursing shifts (7:00 a.m.-3:00 p.m., 3:00 p.m.-11:00 p.m., and 11:00 p.m.-7:00 a.m.). The DON stated there is no specific time and no designated location in the residents' documentation where intake and/or output amounts are consistently recorded for dialysis residents.During a record review of the facility's policy and procedure (P & P) titled Dialysis Care dated on 8/25/2021, the section titled Fluid Restrictions stated Nursing and Dietary Staff will carefully organize the division and distribution of fluid. The P & P indicated, All (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record. During a record review of the facility's policy and procedure titled, Hydration- Clinical Protocol dated March 2026, the policy indicated physician and staff will monitor fluid and electrolyte imbalances, including assessment of voiding patterns and clinical status.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's head of the bed was elevated to at least 30 degrees during feedings as ordered for one of three sampled residents (Resident 3), who was receiving nutrition through a gastrostomy tube (Gˆtube, a flexible tube surgically inserted through the abdomen into the stomach for the administration of nutrition, fluids, and medications). This failure had the potential to increase the risk of aspiration (accidentally inhaling food, liquids, stomach acid, or saliva into lungs) in the resident.Findings: During a review of Resident 3's admission Record (face sheet), dated 4/15/2026, the face sheet indicated Resident 3 was initially admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses including but not limited to Parkinsonism (a general term for brain disorders that cause slowed movements, stiffness, and tremors), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities), dysphagia (medical term for difficulty swallowing), and gastrostomy status (medical condition of having an artificial, surgically created opening in the stomach wall that allows a feeding tube to be inserted directly into the stomach for nutrition, hydration, and medication).During a review of Resident 3's Minimum Data Set (MDS - a standardized clinical tool used in nursing homes to evaluate every resident), dated 1/8/2026, the MDS indicated the resident is rarely/never understood. The MDS also indicated Resident 3 receives nutrition through a feeding tube and has impairment in range of motion to both sides of the upper and lower extremities. During a review of Resident 3's Nursing Documentation Evaluation, dated 8/23/2024, the evaluation indicated Resident 3 receives nutritional supplements through enteral feeding (a method of delivering liquid nutrition directly into the stomach) via G-tube. During a review of Resident 3's physician's order, dated 1/24/2025, the order indicated Resident 3's head of bed should be elevated to at least a 30-degree angle during enteral feeding and for one hour after feeding. During a review of Resident 3's care plan titled, Resident is at risk for aspiration related to G-tube, created on 1/3/2026, the care plan indicated Resident 3's head of bed should be elevated at least 30 degrees during feeding and for one hour after feeding.During a concurrent observation and interview on 4/13/2026 at 12:59 PM with Assistant Director of Nursing (ADON) in Resident 3's room, Resident 3 was lying nearly flat in bed with the tube feeding machine on. ADON stated Resident 3 is lying flat and the head of bed is at less than a 30-degree angle. ADON stated the facility does not have a measuring device to measure the angle of the resident's head of bed. ADON stated Resident 3's head should be raised higher, to at least a 30-degree angle, while the resident is receiving enteral feedings to prevent the risk of aspiration. During an interview on 4/16/2026 at 9:19 AM with the Director of Nursing (DON), DON stated that aspiration is a complication of enteral tube feeding. The resident's head of bed should be raised to a 30-45-degree angle during feeding to prevent the risk of aspiration to the resident. During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding, last revised 3/5/2026, the P&P indicated the resident's head of bed should be elevated at a 30-degree angle during feedings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure bed rails zoning was measured for Resident 12 annually or ongoing for bed safety assessments was completed for one of one sampled resident reviewed (Resident 12). This deficient practice had the potential to result in an inability to verify that the bed system remained safe for residents' use and placed the resident at risk for entrapment, injury, and harm.During a record review of Resident 12's admission Record (Face Sheet), the admission record indicated the resident was admitted to the facility on [DATE] with a diagnoses including type 2 diabetes mellitus (high blood sugar due to the body not using insulin properly) , diabetic neuropathy (nerve damage causing numbness or pain, usually in the hands and feet), essential hypertension (chronic high blood pressure without a specific cause), and muscle weakness with abnormalities of gait and mobility (reduced strength and difficulty walking or moving safely). During a record review of the physician's order for Resident 12 dated 01/23/2026 at 2:55 p.m., the order indicated 1/4 side rail X 2 up in bed as enabler to assist with mobility - nonrestraint.During an observation on 04/15/2026 at 8:30 a.m., Resident 12 was observed in bed with bed rails in use. During a record review of the Bed System Measurement Device Test Results Worksheet dated 02/10/2025, it indicated the bed system measurements were completed for Bed ID 24A. During a concurrent interview on 04/15/2026 at 8:45 a.m. and record review of the bedrail measurements with the Maintenance Supervisor (MS), MS stated that the bed rail zone measurements were completed on the time of admission but no follow up. Regarding annual measurements and ongoing reassessment, MS was unable to provide evidence that the annual bed rail zone measurements were completed or reassessment if needed. MS stated Residents that has siderails are at risk for entrapment, or limbs can be caught if not properly assessed.During a concurrent interview and record review on 04/15/2026 at 10:10 a.m., MS stated that while initial measurements are performed at admission, there is no documented evidence of annual measurements or periodic reassessment to ensure continued bed system safety. During a record review of the facility's P & P titled Bedrails dated 2/21/2025, the facility will assure the correct installation and maintenance of bed rails prior to use, the facility will follow the manufacturer's recommendation/instructions regarding bed rail use, the facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices, the assessment must assess the resident's risk from using bed rails, the assessment should assess the resident's risk of entrapment between the mattress and the bed rail or the in the bed rail itself.During a record review of the facility's P & P titled Siderails dated 12/28/2023, the policy stated that the space between the mattress and the side rails will be assessed to reduce the risk of entrapment (the amount of space may vary depending on the type of bed and mattress being used) upon admission when the side rails are required or after admission if side rails are required.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide behavioral health treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of two sampled residents (Resident 13) by failing to provide an ongoing assessment, monitoring and implementing a person-centered care plan when Resident 13 stated persistent negative feelings related to trauma experience.This deficient practice had the potential to negatively affect the delivery of behavioral health care and services to Resident 13.During a review of Resident 13's admission Record, the admission record indicated that Resident 13 was initially admitted to the facility on [DATE], with diagnoses including hepatic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition a disease in which the functioning of the brain is affected by severe liver disease), schizoaffective disorder, bipolar type (a mental illness that can affect thoughts, mood, and behavior-known as mania and depression) and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool) dated 03/02/2026, MDS indicated that Resident 13's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 13 required mild to moderate assistance from staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 13's history and physical (H&P), H&P indicated that resident 13 had the capacity to make decisions. During a concurrent observation and interview on 4/13/2026 at 11:45 a.m. with Resident 13, Resident 13 was awake, alert and sitting in the wheelchair. Resident 13 reported having history of bipolar disorder, schizoaffective disorder, and PTSD. Resident 13 stated that being independent made him feel satisfied, but he had difficulty getting the staff to listen.During a review of Resident 13's Trauma assessment dated [DATE] and 04/02/2025, it indicated that Resident 13 noted that he was still affected by a combat event and expressed the need for support with his needs and medications.During a review of Resident 13's care plan report, titled past experience of trauma as evidenced by resident reported still be bothered by combat events, initiated on 12/12/2024, indicated the goal for the resident to feel safe in the center, identify stressors, and report them to staff. Interventions included encouraging the resident to recognize personal trauma and triggers and minimize their impact; respecting concerns; involving the resident in decisions; listening without judgment or guilt; and evaluating the need for psychological or behavioral health consultation and referrals as needed.During a concurrent interview and record reviews of Resident 13's order summary report on 4/15/2026 at 08:25 a.m. with Registered Nurse Supervisor (RN 1), RN 1 stated the nursing care for residents with PTSD included engaging resident in alternative activities, providing reorientation, using non-pharmacological interventions, and eliminating triggers. RN 1 stated there was no physician or nursing documentation of behavioral monitoring or assessment of Resident 13's triggers. RN 1 stated a physician order was needed for tally or behavior monitoring of Resident 13 to implement the care plan. RN 1 further stated the importance for ongoing assessment of behavioral health in residents with PTSD to ensure effective treatment and adjust as necessary.During an interview on 4/15/2026 at 11:38 a.m. with Social Service Director (SSD), SSD stated that Trauma Assessments involve questions about residents past experiences, particularly for veterans, including triggers, trauma and abuse. SSD stated that it is important to monitor the resident's behavioral health to minimize behavioral risks, reduce triggers, prevent aggression, and ensure safety and comfort. SSD added that without it may result in residents not receiving necessary care during crucial times, potentially compromising their safety. SSD further stated that the whole team shares responsibility for safeguarding the well-being and ensuring appropriate care of every resident.During an interview on (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/16/2026 at 8:43 a.m. with the Director of Nursing (DON), DON stated that taking care of resident with PTSD included individualized nursing intervention, medication management, redirection and activity engagement are provided. DON stated that social worker conducts trauma assessments with questionnaires for residents with history of behavioral health. DON stated that when there is PTSD diagnosis, adding the resident's monitoring of triggers and side effects of medications are included in the plan of care. DON stated it is to ensure that behavior is monitored for everyone's safety and to ensure residents feel secure.During a review of facility's Policy and Procedure (P&P), titled, Behavior Management, reviewed on 03/05/2026, the P&P indicated that staff must ensure residents with mental disorders or psychosocial difficulties receive appropriate treatment to improve their well-being. Non-pharmacological interventions are the primary approach and included in care plans. The facility monitors identified residents who show behavioral symptoms, implements non-drug interventions first, obtains informed consent, and refers to mental health services when needed.During a review of facility's P&P titled, Trauma Informed Care, dated 3/05/2026, the P&P indicated, that the facility will identify trauma triggers for residents and add trigger-specific interventions to their care plans to reduce exposure and mitigate effects. Common triggers include lack of privacy, loud noises or bright lights, certain sights or objects, sounds, smells, physical touch, and caregivers of the opposite sex. The effectiveness of interventions will be regularly evaluated, involving the resident and their family or representative to ensure open communication and adjustments as needed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) rotation of injection sites for three out of three sampled residents (Resident 61, Resident 9 and Resident 57). This deficient practice had the potential to result in lipodystrophy (partial or complete loss of fat) which affects insulin absorption, potential hyperglycemia (high blood glucose) for Resident 61, 9 and 57. Findings: During a review of Resident 61's admission Record, the admission record indicated Resident 61 was admitted on [DATE] with left-sided hemiparesis/hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), cerebral infarction (a type of brain damage due to a blockage in blood flow), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of the Minimum Data Set (MDS – a resident assessment tool) dated 1/9/2026 for Resident 61, MDS indicated that Resident 61's cognitive status (thought process) was fully intact. The MDS indicated that Resident 61 was independent for eating; moderate assistance for lower body dressing, and oral hygiene; and maximal assistance for toileting and showering. The MDS indicated that Resident 61 was receiving insulin injections for DM. During an interview on 4/15/2026 at 9:35 a.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated that insulin injections can be administered in subcutaneous sites (SQ- a fatty layer in between the skin and the muscle), such as the upper arm and abdomen. LVN 2 stated that sites are supposed to be rotated when injecting insulin to prevent lipodystrophy. LVN 2 also stated that the residents who received insulin injections are educated about the need to rotate sites with each injection given. LVN 2 stated the Medication Administration Record (MAR) would indicate where the last administration site was, and that the nurse should choose an alternative site before administering the next injection. During a record review of the physician's orders for Resident 61 dated 7/31/2025, the orders indicated an active Insulin Regular Human Injection Solution, inject as per sliding scale before each meal and bedtime. Rotate Injection Sites. During a record review on 04/15/2026 12:20 p.m. of Resident 61's Location of Administration for Insulin Injections, the following was documented: 3/12/2026 6:30 a.m. and 3/12/2026 at 4:30 p.m. insulin was administered in the left lower quadrant (LLQ) During a record review of the facility's policy and procedure (P & P) titled, Insulin Administration Purpose under, Steps in the Procedure (Insulin Injections via Syringe), dated 3/5/2026, the P & P indicated, Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a record review of Resident's 9 admission record, the admission record indicated admitted on [DATE] with a medical diagnosis of diabetes mellitus [DM, a disease characterized by high blood sugar (glucose) levels, hyperlipidemia, (abnormally high levels of fats (lipids), such as cholesterol and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	triglycerides, in the blood) During a record review of Resident 9's MDS dated [DATE], The MDS indicated that Resident 9 has a Brief Interview for Mental Status (BIMS a standardized screening tool used in long-term care and post-acute settings to assess cognitive function, specifically memory and orientation) score of 12 cognitively intact. The MDS also indicated that supervision on eating, partial to moderate assistance in toileting hygiene and substantial to maximal assistance with shower. Record review on 04/13/2026 at 11:08 a.m. of Resident 9's medication administration record (MAR) the MAR indicated that during the date and time of 04/12/2026 5:37 p.m.and 04/13/2026 9:30 a.m. insulin was not rotated and administered on Resident 9's right arm on 2 consecutive administrations. During a record review Resident 9 of physician orders for regular insulin as below states to rotate injection sites: Insulin Regular Human Injection Solution Inject subcutaneously before meals and at bedtime . Rotate injection sites. Give no more than 30 mins before meals or give at the beginning of meals (up to 15 mins after the start of meals) and hold the dose if a meal is skipped. b. During a record review of the Resident's 57 admission record, the admission record indicated admitted [DATE] with a diagnosis of anemia (low number of red blood cells), hypertension (high blood pressure), DM. During a record review of Resident 57's MDS dated [DATE], The MDS indicated that Resident 57 has a score of 15 - cognitively intact. The MDS also indicated Resident 57 is independent with eating but requires assistance as setup for oral hygiene, substantial/maximal assistance in toileting hygiene and substantial to maximal assistance with shower. During a review of Resident 57 physician orders identified insulin order Insulin Regular Human Injection Solution, inject subcutaneously before meals and at bedtime. Rotate injection sites. Give no more than 30 mins before meals or give at the beginning of meals (up to 15 mins after the start of meals) and hold the dose if a meal is skipped. During an interview on 04/15/2026 9:35 a.m. with LVN 2, LVN 2 stated that insulin can be administered in subcutaneous sites of the upper arm and abdomen. LVN 2 stated that sites are rotated to prevent lipohypertrophy (fatty lumps). Additionally, the residents are educated about the need to rotate sites. LVN 2 stated the administration site is selected by the medication LVN by reviewing the MAR for last administration site and the staff should choose an alternative site. During a record review, the facility's policy and procedure (P&P) on Insulin Administration Purpose, Revision date March 2025 under the heading Steps in the Procedure (Insulin Injections via Syringe) step #20 directs nursing staff 20. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility's pharmacist consultant's recommendation in the Medication Regimen Review (MRR), which advised adding a pain medication order for mild or severe pain, was reviewed and acted upon for one of five sampled residents (Resident 3)This failure resulted in Resident 3 not receiving recommended adjustments to her pain medication regimen, increasing the risk for Resident 3 to suffer from unmanaged pain. Findings: During a review of Resident 3's admission Record (face sheet), dated 4/15/2026, the face sheet indicated Resident 3 was initially admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses including but not limited to Parkinsonism (a general term for brain disorders that cause slowed movements, stiffness, and tremors), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities), bipolar disorder (a chronic mental health condition characterized by intense extreme mood swings that interfere with daily life), and schizoaffective disorder (a chronic mental health condition with symptoms such as hallucinations, delusions, and severe mood swings). During a review of Resident 3's latest Minimum Data Set (MDS - a standardized clinical tool used in nursing homes to evaluate every resident), dated 1/8/2026, the MDS indicated the resident is rarely/never understood and is dependent on staff for all functional abilities. The MDS also indicated the resident has impairment in range of motion to both sides of the upper and lower extremities. During a review of Resident 3's physician's order, dated 1/24/2025, the physician's order indicated to give two tablets of acetaminophen (a medication to treat pain) 325 milligrams every four hours as needed for moderate pain. During a concurrent interview and record review on 4/15/2026 at 1:35 PM with Registered Nurse (RN) 1, the MRR, dated 3/18/2026, was reviewed. The MRR indicated the pharmacist consultant recommended the addition of an acetaminophen order for mild and severe pain for Resident 3. RN 1 stated that based on her review of Resident 3's medical records, there was no physician documentation of acknowledgement or action taken based on this recommendation. RN 1 further stated it is important to keep medications up to date to make sure residents are receiving appropriate medications.During an interview on 4/16/2026 at 7:16 AM with the Director of Nursing (DON), DON stated he looked in Resident 3's medical records and could not find documentation the MRR recommendation was reviewed or executed. DON further stated the physician should have documented whether the acetaminophen orders should be added or not. During an interview on 4/16/2026 at 9:00 AM with DON, DON stated the facility is responsible to ensure the physician reviews the monthly MRR from the pharmacist to ensure the residents receive the care that they need. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review, last reviewed 3/5/2026, the P&P indicated upon receiving the MRR report from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a medication was not left at the bedside without a physician's order for one of two sampled residents (Resident 15). This deficient practice has the potential risk for medication errors and adverse drug events. During a review of Resident 15's admission Record, the admission record indicated that Resident 15 was initially admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF-(a condition in which the heart does not pump blood as well as it should) and muscle weakness. During a review of Resident 15's Minimum Data Set (MDS -ˆa resident assessmentˆtool) datedˆ4/01/2026, MDS indicated that Resident 15's cognitive (mental action or process ofˆacquiringˆknowledge and understanding) skills for daily decisionsˆwereˆmoderately impaired. The MDS indicated Residentˆ15ˆrequired moderate to maximum assistanceˆfrom staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing).ˆˆ During a concurrent observation and interview on 4/13/2026 at 09:00 a.m. with Resident 15, Resident 15 was awake, alert and watching television. There was an opened bottle of pink liquid medication observed on Resident 15 bedside table. Resident 15 stated it was Pepto-Bismol (a medication to treat heartburn, nausea, indigestion and upset stomach) that she takes for gas and bloating. During a concurrent interview and record of Resident 15 on 4/13/2026 at 9:32 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 15's physician order summary report and self-administration evaluation was reviewed. LVN 6 stated there should be a physician's order for all medications, including medication at residents' bedside. LVN 6 stated that Resident 15 had no active order for Pepto-Bismol and was not able to self-administer medication safely per the Medication Self-Administration Evaluation dated 11/24/2025. LVN 6 stated she needed to remove Resident 15's bedside medication due to possible medication interactions, safety concerns, and inability to monitor usage or prevent access by other residents. During an interview on 4/16/2026 at 8:43 a.m. with Director of Nursing (DON), DON stated that staff should routinely check on residents and assess their needs and environment. DON stated that residents may self-administer medication if deemed capable. DON further stated that leaving medication at the bedside is prohibited, as it poses risks to others due to potential interactions and side effects. During a review of facility's Policy and Procedures (P&P) titled Administering Medications, reviewed 3/5/2026, the P&P indicated that residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure the Dining Services Manager (DSM) had the appropriate competencies and skills to carry out duties in the kitchen when she incorrectly tested the chorine levels of the dishwasher.This failure had the potential to affect chlorine concentration. Excess chlorine on dishes could lead to chlorine poisoning, while insufficient chlorine could leave germs on the dishes, both increasing the residents' risk of serious illness or death. Findings: During a concurrent observation and interview on 4/14/2026 at 8:38 AM in the kitchen, DSM began performing a test to check the dishwasher's chlorine sanitizer levels. DSM removed a test strip from the bottle and dipped it into the liquid draining from the outlet outside the dishwasher. DSM held the strip in the liquid for 5 seconds and then removed it. DSM compared the test strip to the color guide on the bottle and interpreted the chlorine concentration as 200 parts per million (ppm). DSM stated this is the method normally used to check the dishwasher's chlorine levels. She explained that both she and the Kitchen Dishwashers (KD) test the chlorine levels at the start of the morning and afternoon shifts and record the results in their sanitizer logs. She typically tests at the outside drain but sometimes also checks inside the dishwasher.During a concurrent interview and record review on 4/14/2026 at 8:40 AM with DSM, the Dish Machine Log-Low Temperature (Chemical Sanitizer) Log for April 2026 was reviewed. The log indicated the dishwasher chlorine ppm levels have been at least 200 ppm all month. DSM stated she was told during her training that this is an acceptable level of chlorine sanitizer in the dishwasher.During an interview on 4/14/2026 at 8:50 AM with the District Manager (DM) , DM stated he comes once a week to audit the facility and provide kitchen staff with in-services and training. DM stated the chlorine test strips should not be dipped in the drainage outlet outside of the dishwasher because this is not an accurate assessment of chlorine levels of the dishes. He further stated that the strips should be swabbed on the actual kitchenware.During an interview on 4/14/2026 at 8:55 AM with DSM, DSM stated the facility does not have a policy or written training outlining the steps of how to perform chlorine level testing of the dishwasher. The only form of training she has received has come from the company that provides maintenance on the dishwasher. During an interview on 4/15/2026 at 11:13 AM with the Infection Preventionist (IPN), IPN stated residents can get infections if dishes are not washed properly in the dishwasher. During a concurrent interview and record review on 4/15/2026 at 1:08 PM with DSM, Daily Chlorine Testing Station fact sheet, undated, was reviewed. The fact sheet indicated that after the dish cycle has finished, pass the chlorine test strip over the top of a dish. Then immediately compare the test strip color to the color on the chart. The fact sheet also indicated the acceptable range of chlorine levels is 50-100 ppm. DSM stated she was never aware of this sheet before this day. DSM acknowledged that the sheet instructs the user to test the dishes, not the drainage outlet of the dishwasher, for chlorine levels. DSM further stated she now knows the acceptable range of chlorine should be 50-100 ppm, and this process is important to ensure dishes are clean and safe for the residents. During an interview on 4/16/2026 at 10:15 AM with KD 2, KD 2 stated one of his duties as kitchen dishwasher is to test the chlorine levels of the dishwasher at the start of his shift. He further stated that his usual practice is to dip the test strip on the drainage outlet outside the dishwasher where the water is. During a review of the facility's policy and procedure (P&P) titled, Warewashing, last revised December 2024, the P&P indicated all dishware will be cleaned and sanitized after each use. It also indicated the dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dishwasher and proper handling of sanitized dishware.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 3 accurately documented medication administration for one of one sampled resident (Resident 44). This failure had the potential to result in inaccurate medical records, medication documentation errors, and inappropriate clinical decision-making related to medication management.Findings:During a review of Resident 44's admission Record (Face Sheet) indicated Resident 44 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including hypertensive heart disease and chronic kidney disease with heart failure, atrioventricular block (a slowed heart that occurs because of a malfunction with the heart's electrical system) and cardiomyopathies (problems with your heart muscles that can make it harder for your heart to pump blood).During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool) dated 01/2/2026 indicated Resident 44 had no cognitive impairment with Brief Interview for Mental Status (assessment tool for brain's complex mental processes involved in gaining knowledge and comprehension) was 15 .During a review of Resident 44's Medication Administration Record (MAR) dated 4/15/2026, the MAR indicated that Finasteride (a medication used to treat benign prostatic hyperplasia) Benign Prostatic Hyperplasia BPH- a non-cancerous enlargement of the prostate that can cause urinary difficulty)} oral tablet 5 mg 1 tablet by mouth once daily for reducing the size of the prostate and improving urinary flow, was documented as administered at 9:00 a.m.During a review of the physician's order dated 1/15/2026, Finasteride Oral Tablet 5 mg give one tablet by mouth one time a day for BPH use gloves if you suspect you may be pregnant or anticipate a potential pregnancy.During an observation on 4/16/2026 at 9:59 a.m., medication Finasteride not available in medication cart.During a telephone interview on 4/16/2026 at 10:18 a.m. with Pharmacy 1 (Pharm), Pharm 1 stated that there was no Finasteride medication delivered to the facility on 4/15/2026 and no record of dispensing this medication to the facility.During a concurrent interview and record review on 4/16/2026 at 11:20 a.m. with LVN 3 and the MAR was reviewed, the MAR indicated that Finasteride 5 mg was documented as administered on 4/15/2026 however LVN 3 stated that the medication was not received from the pharmacy.During a review of the facility's policy and procedure titled Administering Medications (revised 03/2026), the policy indicated that medications are to be administered safely, timely, and in accordance with prescriber orders. The policy indicated that the individual administering medications responsible for ensuring the right resident, right medication, right dosage, right time, and right route, and must document medications administered in the Medication Administration Record (MAR). The policy indicated that documentation must include that date and time the medication was administered, and that Medication Administration Records must accurately reflect medications actually given to the resident.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure informed consent was obtained in a timely manner from the resident before administering influenza (an infection of the nose, throat and lungs, which are a part of the respiratory system) vaccine (a preparation that is used to stimulate the body's immune response against diseases) for two of five sampled residents (Resident 19 and Resident 20) when: 1.The informed consent for the influenza vaccine, including a discussion of the risks, benefits, and potential side effects for Resident 19, was obtained on 08/27/2025, which was 6 days prior to the administration on 09/02/2025. 2.The informed consent for the influenza vaccine, including a discussion of the risks, benefits, and potential side effects for Resident 20 was obtained on 08/27/2025, which was 21 days prior to the administration on 09/17/2025. This deficient practice violated Resident 19 and Resident 20's rights to make an informed decision by the time of administration. A. During a review of Resident 19's admission Record, the admission record indicated that Resident 19 was initially admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), hyperlipidemia (abnormally high levels of fats in the blood) and hypertension (HTN-high blood pressure).During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool) dated 03/21/2026, MDS indicated that Resident 19's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 19 required minimal to moderate assistance from staff for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 19's record titled Order Summary indicated a physician's order initiated on 09/02/2025 of influenza vaccine 0.5 milliliters (ml- a unit of volume) intramuscular (IM- into a muscle) during flu season in the afternoon for 1 administration. B. During a review of Resident 20's admission Record, the admission record indicated that Resident 20 was initially admitted to the facility on [DATE], with diagnoses including dysphagia (difficulty swallowing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and muscle weakness. During a review of Resident 20's MDS dated [DATE], MDS indicated that Resident 20's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 20 was independent for ADLs. During a review of Resident 20's record titled Order Summary indicated a physician's order initiated on 09/17/2025 of influenza vaccine 0.5 ml Inject 1 syringe intramuscularly one time only for immunization for 1 day.During a concurrent interview and record review on 4/16/2026 at 11:43 a.m. with Infection Preventionist (IPN), Resident 19 and Resident 20 immunization record and vaccine consent form were reviewed. The IPN stated that immunization is vital to prevent severe illness and noted her responsibility for tracking residents' immunizations. The IPN stated that informed consent is crucial for residents to understand the risks, benefits and side effects of getting vaccinated. The IPN stated that informed consent for the influenza vaccine for Resident 19 was obtained on 08/27/2025 and it was administered on 09/02/2025. The IPN stated that informed consent for the influenza vaccine for Resident 20 was obtained on 08/27/2025 and it was administered on 09/17/2025. The IPN stated the residents could have changed their mind since informed consent was obtained 6 days ago for Resident 19 and three weeks ago for Resident 20.During an interview on 4/16/2026 at 8:43 a.m. with Director of Nursing (DON), DON stated obtaining informed consent ensures residents are aware of risks and benefits and have the right to accept or refuse the treatment. DON stated that it is important to respect residents' right to know and decline medications, even those recommended by a doctor.During a review of facility's Policy and Procedure (P&P) titled, Influenza, Prevention and Control of Seasonal, reviewed 3/05/2026, the P&P indicated that, the infection preventionist is responsible for organizing and managing the annual influenza vaccine campaign within the facility. Both residents and staff are strongly encouraged to receive the influenza (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vaccine to promote the health and safety of everyone in the facility. However, individuals with medical contraindications are exempt from receiving the vaccine to ensure their well-being.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 30) has call light (a device to press, to call and ask for help) within reach.This deficient practice had the potential for Resident 30 unable to ask for help if needed.During a record review of the admission record, the admission record indicated Resident 30 was admitted to the facility on [DATE] with diagnoses of chronic systolic (congestive) heart failure and atrial fibrillation (diminished ability of heart to pump blood with irregular heartbeat), presence of prosthetic heart valve (device to replace malfunctioning heart valve to promote one way blood flow), essential hypertension (chronic high blood pressure), benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate gland causing urgency, frequency and incomplete bladder emptying), cerebral infarction due to embolism of cerebral artery (damage to brain cells due to lack of blood supply affecting bodily functions, including mobility).During a review of the Minimum Data Set (MDS, resident assessment tool) dated 4/8/2026 the MDS indicated the Resident's 30 Brief Interview for Mental Status (BIMS, an assessment tool for brain's complex mental processes involved in gaining knowledge and comprehension) score was 13, meaning the person was cognitively intact (person is able to verbalize needs and comprehend). MDS indicated Functional Abilities (ability to move body and perform acts like dressing, walking) of Resident 30 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (dressing, standing, sitting, and walking, transfers from bed to chair, toileting) and dependent on help with showering.During a concurrent observation and interview on 4/13/2026 12:46 p.m. with Resident 30, Resident 30 was awake and sitting in bed in his room and the call light was not within reach, it was tied up on the wall at the head of the bed,During concurrent observation and interview 4/13/2026 12:54 p.m. with Licensed Vocational Nurse 3 (LVN), LVN 3 stated the call light was on the wall and not within reach, it was important to have call light to call help if needed and everybody was responsible for ensuring call lights are within reach.During a record review of care plan for Resident 30 with Focus area The resident is at high risk for falls, dated 4/4/2026, the care plan indicated Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.During record review the facility's policy and procedure (P & P) titled Answering the Call Light dated 3/5/2026, the P & P indicated the purpose to ensure timely responses to the residents' requests and needs and to ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.