STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056228	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Haven Healthcare	1495 West Cameron Ave. West Covina, CA 91790

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain written informed consent for two out of two sampled residents (Residents 30 and 3) for the use of psychotropic (any medication capable of affecting the mind, emotions, and behavior) medication. These deficient practices had a potential for Residents 30 and 3 not receiving adequate or sufficient information regarding psychotropic drugs necessary to make an informed health care decision.Findings: a. During a review of Resident 30's admission Record (AR), the AR indicated the facility admitted Resident 30 on 6/19/2025 with diagnoses including major depressive disorder (a feeling of severe sadness or hopelessness) and schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real). During a review of Resident 30's OSR dated 6/19/2025, the OSR indicated for licensed staff to administer Wellbutrin (a medication that change the way your brain uses certain chemicals to regulate mood and behavior) Extended Release (designed to release slowly into the body) 150 milligrams one tablet by mouth one time a day related to major depressive disorder manifested by persistent verbalization of feeling sad. During a review of Resident 30's History and Physical (H&P) dated 6/22/2025, the H&P indicated Resident 30 did not have the capacity to understand and make decisions. During a review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 12/23/2025, the MDS indicated Resident 30's cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 30 required moderate physical assistance with toileting, shower, lower body dressing and putting on/taking off footwear. During a review of Resident 30's Order Summary Report (OSR) dated 1/14/2026, the OSR indicated for licensed staff to administer Olanzapine (medication to treat serious mental disorder) 5 milligrams (mg, unit of measurement) one tablet by mouth at bedtime for schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems) bipolar type (mental disorder with periods of depression and periods of elevated mood) manifested by episodes of paranoia (irrational distrust and suspicion) hearing voices that are not there. During a concurrent record review and interview on 3/11/2026 at 1:15 pm with Registered Nurse 2 (RN 2), Resident 30's medical record was reviewed. RN 2 stated, Resident 30's Psychotherapeutic Drug Informed Consent for Olanzapine and Wellbutrin were not dated when signed by the physician. RN 2 stated, it was the RN who obtained informed consent from the Responsible Party (RP) or the resident and not the physician. RN 2 stated, informed consent needed to be signed and dated by the (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician to determine when the consent was obtained. During a concurrent record review and interview on 3/12/2026 at 2:30 pm with the Director of Nursing (DON), the DON stated Psychotherapeutic Drug Informed Consent needed to be dated when the physician obtained the informed consent from the resident or RP. The DON stated, licensed nurses needed to verify the informed consent obtained by the physician from the resident or RP. The DON stated it was important to have a valid informed consent for residents receiving psychotropic medications because the risks and benefits needed to be discussed with the resident or resident's RP by the physician. During a review of the facility's policy and procedure (P&P) titled, Informed Consent, dated 1/23/2026, the P&P indicated, The facility will have the Attending Physician/Licensed Healthcare Practitioner (LHP) determine when material circumstances have changed so that an informed consent is required from the resident before providing treatment. The Attending Physician/LHP will then obtain informed consent from the resident or authorized representative before administration of a therapy or procedure that requires an informed consent. The use of an informed consent will be done for but not limited to the following: Psychotherapeutic Drugs. b.During a review of Resident 3's admission Record (AR) dated 3/13/2026, the AR indicated Resident 3, a [AGE] year-old female, admitted on [DATE], with the diagnosis that included but not limit to: senile degeneration of brain (a condition age-related, progressive, and irreversible loss of nerve cell, causing significant cognitive decline beyond normal aging), diabetes (a condition where a person's body has trouble controlling the amount of sugar in their blood), hypertension (high blood pressure) and anxiety disorder (a condition when a person feels constant or overwhelming worry or fear.) During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 2/25/2026, MDS indicated Resident 3 had an anxiety and psychotic disorder (a person has trouble telling what is real because their brain is sending confusing signals, causing hallucinations or false beliefs.) During a review of Resident 3's psychotherapeutic drug informed consent (PTDIC- a document that explains the essential information a patient must understand before starting treatment) for lorazepam (an anti-anxiety medication), dated 2/20/2026, the PTDIC did not indicate the date the physician signed the form to treat Resident 3 with lorazepam. During a review of Resident 3's PTDIC for olanzapine (an anti-psychotic medication that helps with agitation, to calm the brain when someone has serious mood, behavior, or thinking problem), dated 2/20/2026, the PTDIC did not indicate the date the physician signed the form to treat Resident 3 with olanzapine. During a review of Resident 3's PTDIC for quetiapine fumarate (an anti-psychotic medication that helps calm the brain when someone has serious mood, behavior, or thinking problems), dated 2/20/2026, the PTDIC did not indicate the date the physician signed the form to treat Resident 3 with quetiapine fumarate. During an interview on 3/12/2026 at 2:30 PM with Director of Nursing (DON), DON stated that PTDIC must be signed and dated by the physician. The DON explained that without a date, the consent form is incomplete because the facility cannot verify when it was obtained or became effective. A valid, dated PTDIC is essential for residents receiving psychotropic medications so the physician can (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document that risks and benefits were discussed with the resident or representative. During a record review of the facility's policy and procedure (P&P) titled, Informed Consent, dated 1/23/2026, the P&P indicated, The Facility will have the Attending Physician/Licensed Healthcare Practitioner (LHP) determine when material circumstances have changed so that an informed consent is required from the resident before providing treatment. The Attending Physician/LHP will then obtain an informed consent from the resident or authorized representative before administration of a therapy or procedure that requires an informed consent. The use of an informed consent will be done for but not limited to the following: Psychotherapeutic Drugs.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the call light (an alerting device to assist a resident when needed) was within reach and appropriate to the patient's physical ability for two of two sampled residents (Residents 25 and 62). These failures had the potential to delay meeting Resident 25 and 62's needs or result in a fall or accident/injury. Findings: a. During a review of Resident 62's admission Record (AR), the AR indicated the facility re-admitted Resident 62 on 2/11/2026 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), muscle weakness, abnormal gait and mobility (irregular walk and movement). During a review of Resident 62's History & Physical (H&P) dated 2/12/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 62's Minimum Data Set (MDS, a resident assessment tool) dated 2/16/2026, the MDS indicated Resident 62 had moderately impaired cognition (ability to understand) and required partial/moderate assistance (helper does less than half the effort) to roll left and right (ability to roll from lying on back to left and right side, and return to lying on back on bed) and walk 10 feet (once standing, the ability to walk at least 10 feet in a room, corridor, or similar space). During a review of Resident 62's Care Plan (CP), the CP indicated Resident 62 had: 1. An unsteady gait, recent fall in the last 30 days and was risk for further falls and injury related to dementia or Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). The CP was dated 2/12/2026, with an intervention to place most needed personal belongings within the resident's reach, including the call light. 2. Impaired urinary elimination (incontinence)-occasionally incontinent with bladder related to dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), impaired mobility and required ADL assistance for toileting hygiene or toileting transfers. The CP was dated 3/2/2026 with an intervention to place the call light within reach and answer the call light promptly. During a concurrent observation and interview on 3/10/2026 at 9:43 am with Resident 62 in Resident 62's room, Resident 62 was lying in bed that had a large yellow star on the footboard, and the call light was hanging off the resident's left side of the bed and touching the floor. Resident 62 stated Resident 62 was unable to locate the call light and could not call for help. During a concurrent observation and interview on 3/10/2026 at 9:44 am with the Assistant Director of Nursing in Resident 62's room, Resident 62 was lying in bed that had a large yellow star on the footboard and the call light was hanging off the resident's left side of the bed and touching the floor. The ADON stated, Resident 62 was a fall risk and the yellow star indicated Resident 62 was in the fall risk program. The ADON stated Resident 62's call light should be within reach to allow Resident 62 to press it and ask for help, including obtaining assistance to go to the bathroom because Resident 62 was at risk for falling. During a review of the facility's Policy and Procedure (P&P) titled, Communication-Call System, dated (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/9/2024, the P&P indicated the purpose of the call system was providing a mechanism for residents to promptly communicate with nursing staff. The P&P indicated, call cords would be placed within the resident's reach in the resident's room. b. During a review of Resident 25's AR, the AR indicated Resident 25 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (disease that affects the function or structure of the brain), schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear). During a review of Resident 25's MDS dated [DATE], the MDS indicated Resident 25 had intact cognition for daily decision making. The MDS indicated Resident 25 needed setup or clean-up assistance (helper sets up or cleans up) assistance from staff for eating, oral hygiene, and showering/bathing self. During a review of Resident 25's CP dated 1/4/2026, the CP indicated Resident 25 had impaired bowel elimination related to impaired mobility (the ability to move) and required assistance with care. The CP intervention indicated for staff to place Resident 25's call light within reach and answer promptly. During a concurrent observation and interview on 3/11/2026 at 10:02 am, Resident 25 was awake, lying in bed with call light on the floor below Resident 25's bed. Resident 25 stated I do not know where it is (referring to call light). It should be there. During a concurrent observation and interview on 3/11/2026 at 10:08 am, with Registered Nurse 1 (RN 1), RN 1 stated Resident 25's call light was on the floor, below the resident's bed. RN 1 stated the call light should be within resident's reach at all times so they can place a call for assistance or help in the case of an emergency. During an interview on 3/12/2026 at 2:32 pm with the Director of Nursing (DON), the DON stated the call light needed to be within reach of the residents at all times so they can ask for assistance when needed. During a review of the facility's P&P titled, Communication-Call System, dated 2/9/2024, the P&P indicated Call cords will be placed within the resident's reach in the resident's room.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care and services to promote healing for residents with pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) for one of three sampled residents (Resident 65) by failing to:a. Ensure Resident 65's Low Air Loss Mattress (LAL - a specialized medical support surface designed to prevent and treat skin ulcers by combining alternating pressure with a steady low-volume airflow) pressure was set consistent with the resident's weight. b. Ensure to turn and reposition Resident 65 every two hours in accordance with Resident 65's care plan. These failures had the potential to result in worsening of Resident 65's existing pressure ulcer/injury and developing new skin breakdown.Findings: a. During a review of Resident 65's admission Record (AR), the AR indicated the facility admitted Resident 65 on 11/10/2025 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently) and chronic kidney disease (CKD - irreversible, and gradual loss of kidney function). During a review of Resident 65's untitled Care Plan (CP) dated 2/26/2026, the CP indicated Resident 65 had a wound decline. The CP interventions included the use of LAL mattress to reduce or relieve pressure on bony prominences. During a review of Resident 65's Order Summary Report (OSR) dated 2/28/2026, the OSR indicated Resident 65 had an order for LAL mattress and for staff to check the setting of LAL mattress every shift, for wound management. During a review of Resident 65's Minimum Data Set (MDS - a resident assessment tool) dated 3/2/2026, the MDS indicated Resident 65 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 65 was dependent (helper did all the effort) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. The MDS indicated Resident 65 had a stage 3 pressure ulcer (ulcer that extends into the underlying subcutaneous tissue layer, but not all the way to the bone). The MDS indicated Resident 65 was on hospice care (compassionate care for people near the end of life). During a review of Resident 65's Skin Weekly Assessment (SWA) dated 3/5/2026, the SWA indicated Resident 65 had a stage 3 pressure ulcer on the sacrococcyx region (refers to the area at the base of the vertebral column). During a concurrent observation inside Resident 65's room and interview on 3/11/2026 at 1:57 pm with the Treatment Nurse (TN), Resident 65 was lying in bed, on Resident 65's back, on a LAL bed mattress. The TN stated the LAL mattress pressure was set up at 150. The TN stated Resident 65's weight was 131 pounds (lbs.). The TN stated the LAL mattress pressure was too firm for Resident 65. The TN stated the LAL mattress pressure needed to be set based on the resident's weight for equal distribution of pressure to relieve pressure on bony prominences and to prevent worsening of Resident 65's pressure ulcer. During an interview on 3/11/2026 at 2:02 pm with the Assistant Director of Nursing (ADON), the ADON stated the LAL mattress should be set according to the resident's weight for equal pressure distribution on the back of the resident and to aid with pressure ulcer/injury healing. During a review of the undated LAL mattress Operation Manual (OM), the OM indicated, Determine the patient's weight and set the control knob to that weight setting on the control unit. During a review of the facility's Policy and Procedure (P&P) titled, Wound Management, dated February 9, 2024, the P&P indicated, A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. An assessment of care needs for pressure ulcer and wound management will be made with emphasis on but not limited to: mechanical offloading and pressure reducing devices. Reducing skin friction, sheer, and moisture. Evaluating and modifying interventions for a resident with existing pressure ulcers/pressure injuries Pus/PIs). b. During a review of Resident 65's untitled CP dated 2/18/2026, the CP indicated Resident 65 had an impaired skin integrity. The CP interventions included turning and repositioning the resident every 2 hours and as needed while in bed. During an observation inside Resident 65's room on 3/11/2026 at 9:29 am, Resident 65 was lying in bed, on (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 65's back. During an observation inside Resident 65's room on 3/11/2026 at 10:55 am, Resident 65 was lying in bed, on Resident 65's back. During an observation inside Resident 65's room on 3/11/2026 at 11:56 am, Resident 65 was lying in bed, on Resident 65's back. During an observation inside Resident 65's room on 3/11/2026 at 12:36 pm, Resident 65 was lying in bed, on Resident 65's back. During a concurrent observation inside Resident 65's room and interview on 3/11/2026 at 1:57 pm with the TN, Resident 65 was lying in bed, on Resident 65's back. The TN stated the facility had a turning schedule program. The TN stated, at this time (1:57 pm), Resident 65 should have been facing the door. The TN stated Resident 65 had a stage 3 pressure ulcer on the sacrococcyx area. The TN stated Resident 65 should be turned and repositioned every 2 hours to relieve and reduce pressure on bony prominences and prevent worsening of Resident 65's pressure ulcer. During an interview on 3/11/2026 at 2:02 pm with the ADON, the ADON stated residents with pressure ulcers and at risk of developing pressure ulcers should be turned and repositioned every 2 hours to reduce pressure and prevent pressure injuries on vulnerable areas like the sacrum, hips, and heels. During a review of the facility's P&P titled, Support Surface Guidelines, dated February 9, 2024, the P&P indicated, The facility would implement measures to reduce tissue pressure that includes frequent repositioning, protective devices and the use of support surfaces.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure the resident was administered oxygen therapy (treatment that provides supplemental oxygen) at the rate ordered by the physician and the resident's care plan (CP) for the use of oxygen was revised for one of one sampled resident (Resident 2). This deficient practice placed Resident 2 at risk for respiratory distress (difficulty breathing).Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility 12/5/2025 with diagnoses including respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow) and muscle weakness (a reduced ability to exert force). During a review of Resident 2's History and Physical (H&P) dated 12/8/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment and care planning tool) dated 12/10/2025, the MDS indicated Resident 2's cognition was intact and Resident 2 was dependent on toileting hygiene, bowel and bladder incontinence (involuntary loss of urine or stool), shower/bathe self, and lower body dressing. The MDS indicated Resident 2 was receiving oxygen therapy. During an observation in Resident 2's room on 3/10/26 at 9:40 a.m., Resident 2 was receiving 2 liters per minute (LPM) of oxygen via nasal cannula (tube which on one end splits into two prongs which are placed in the nostrils to deliver oxygen) while lying in bed. During a review of Resident 2's Physician's Order (PO) dated 2/28/26, the PO indicated for licensed staff to provide oxygen at 3L/minute (3 LPM) via nasal cannula continuously every shift. During a review of Resident 2's Ineffective Breathing Pattern Care Plan (CP) with last revision date of 12/7/25, the CP indicated for licensed staff to administer supplemental oxygen as prescribed: O2 at 2 LPM via nasal cannula continuously. During a concurrent interview and record review on 3/12/26 at 11:21 a.m., with Licensed Vocational Nurse 4 (LVN 4), Resident 2's PO was reviewed. LVN 4 stated the current PO indicated for Resident 2 to receive oxygen at 3LPM via nasal cannula continuously every shift. LVN 4 stated the oxygen setting was checked once in a shift or usually during medication administration. LVN 4 stated it was important to revise the resident's CP based on the current PO to provide appropriate/necessary care to the resident. LVN 4 stated it was important to follow the PO to provide accurate care to the resident. During a phone interview on 3/13/2026 at 4:55 p.m., with Registered Nurse 3 (RN 3), RN 3 stated it was important that Resident 2's oxygen setting was accurate as ordered because if the treatment was not followed, it could negatively affect the resident. RN 3 stated if Resident 2 was not getting 3 LPM oxygen as ordered, the resident is not getting enough oxygen. During a review of the facility's Policy and Procedure (P&P), titled, Oxygen Administration, dated February 9, 2024, the P&P indicated to check the physician's order and turn on the oxygen at prescribed rate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage for one of two resident refrigerators.This deficient practice had the potential to result in pathogen (germ) exposure to residents and places them at risk for developing foodborne illness. Findings: During an observation of the Nursing Station 3's resident refrigerator in the presence of the Assistant Director of Nursing (ADON) on 3/11/2026 at 9:35 AM, the following were observed:1. Resident 50's opened salad dressing bottle with best-used-by date of 11/13/2025 inside the refrigerator.2. Resident 27's bag of lemons did not have a received date.3. There was a puddle of water at the bottom of Resident 27's bag of lemons. During an interview with the ADON on 3/11/2026 at 9:35 AM, the ADON stated Resident 50's salad dressing that was beyond the best-used-by date should not be inside the resident's refrigerator due to the risk of food poisoning such as stomachache, diarrhea, nausea, and vomiting. The ADON stated the licensed nurse should have checked the resident's refrigerator for any food beyond the best-used-by date and threw it away. The ADON stated the nursing staff did not label the received date for Resident 27's bag of lemons. The ADON stated the nursing staff who received Resident 27's bag of lemons should have labeled the bag of lemons with the resident's name and the date of refrigeration. The ADON stated labeling the food with the resident's name prevented other residents from touching and contaminating the food. The ADON stated there should not be any puddle of water inside the refrigerator because it could cause mold and infection. During an interview with the Dietary Supervisor (DS) on 3/11/2026 at 1:23 PM, the DS stated the dietary department was responsible for the resident's refrigerator by providing the temperature log and labels. The DS stated nursing staff was responsible for ensuring proper food labeling. The DS stated the salad dressing was considered perishable and should not be inside the refrigerator after the best-used-by date because of the risk of infection. The DS stated the food's flavor would not be the best and optimal after the best-used-by date. During a review of the facility's Policy and Procedure (P&P) titled Food: Safe Handling for Foods from Visitor, dated 2/2023, the P&P indicated that staff would properly maintain the refrigerator for storage of foods brought in by visitors. The P&P indicated staff would label food with the resident name and the current date. The P&P indicated staff would daily monitor for refrigerated storage duration and discard of any food items that had been stored for more than 7 days.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to accurately document the nursing interventions and medication indication on the residents' medical record for four of four sampled residents (Residents 2, 3, 33, and 40) when: a. The facility did not complete Adult Daily Living (ADL, the basic self˜care tasks an adult performed each day, such as bathing, dressing, eating, toileting, and mobility) documentation for Resident 2 and completed in a timely manner. b 1. Resident 3 was placed on NPO as ordered by MD, on MAR resident was receiving a regular diet from 3/5/2026 to 3/11/2026. b 2. Resident 33 did not have a history or diagnosis of depression but resident was receiving Trazadone for depression. c. The facility did not complete ADL documentation for Resident 2 and completed in a timely manner. These deficient practices had the potential to result in lack of communication between staff and delay and interruption of care needed to maintain the residents' highest practicable, physical, mental, and psychosocial well-being. Findings: a. During a review of Resident 40's admission Record (AR), the AR indicated the facility admitted Resident 40 on 1/22/2026 with diagnoses including sepsis (a life-threatening blood infection [when germs entered the body and caused illness]) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 40's History and Physical (H&P) dated 1/24/2026, the H&P indicated Resident 40 could make needs known but could not make medical decisions. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool) dated 1/26/2026, the MDS indicated Resident 40 had intact cognition (ability to understand). The MDS indicated Resident 40 required maximal assistance (helper did more than half the effort) from staff with eating and oral hygiene. The MDS indicated Resident 40 was dependent on staff with toileting hygiene, showering/ bathing, personal hygiene, and mobility. During a concurrent record review and interview with Certified Nurse Assistant 1 (CNA 1) on 3/13/2026 at 9:26 AM, Resident 40's Documentation Survey Report (DSR) for February and March 2026 were reviewed. The DSR indicated the CNAs (in general) documented Resident 40's bathing for 81 out of 84 shifts from 2/1/2026 to 2/28/2026. The DSR indicated the CNAs (in general) documented Resident 40's bathing for 34 out of 36 shifts from 3/1/2026 to 3/12/2026. CNA 1 stated the CNAs (in general) should have documented on the resident's medical record after bathing the resident to validate the bathing was done. CNA 1 stated the CNAs needed to document on the resident's medical record if the resident refused bathing. CNA 1 stated it was important to complete the documentation on the resident's medical record before the end of the shift because it was the standard of practice. CNA 1 stated if there was no staff initial on the DSR, it indicated bathing was not done for the residents. CNA 1 stated the CNAs (in general) should provide bathing to the residents to keep the residents clean for infection control. During an interview with the Assistant Director of Nursing (ADON) on 3/13/2026 at 9:54 AM, the ADON stated incomplete medical record documentation would affect the continuity of residents' care. The ADON stated, without accurate documentation, nursing staff would not know what happened previously to the residents. The ADON stated it was important for staff to complete documentation before the end of the shift to demonstrate that care was provided for the residents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled Documentation-Nursing, dated 2/9/2024, the P&P indicated the CNA would sign each entry on the Adult Daily Living (ADL) Flow Sheet in the appropriate area of the record according to the date and shift that services were performed. The P&P further indicates that documentation would be completed by the end of the assigned shift. b1.During a review of Resident 3's admission Record (AR) dated 3/13/2026, the AR indicated Resident 3, a [AGE] year-old female, admitted on [DATE], with the diagnosis that included but not limited to: senile degeneration of brain (a condition age-related, progressive, and irreversible loss of nerve cell, causing significant cognitive decline beyond normal aging), diabetes (a condition where a person's body has trouble controlling the amount of sugar in their blood), and high blood pressure. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 2/25/2026, MDS indicated Resident 3 is on hospice care (a special care for people who are very sick and near the end of their life). During a review of Resident 3's physician's orders dated 2/24/2026, the order indicated Resident 3 is under hospice care. During a review of Resident 3's physician's orders dated 2/28/2026, the order indicated Resident 3 had an active regular diet (a meal with normal foods without dietary restrictions) since 2/28/2026. During a review of Resident 3's physician's orders dated 3/5/2026, the order indicated Resident 3 was placed on nothing by mouth (NPO, a strict medical instruction to consume no food, drinks, liquids, or sometimes medications) since 3/5/2026. During a concurrent interview and record review on 3/12/2026 at 2:00 PM with Licensed Vocational Nurse (LVN) 3, Resident 3's medication administration record (MAR) dated 3/2026 was reviewed. The MAR indicated Resident 3 received a regular diet from 3/5/2026 to 3/11/2026. LVN 3 stated Resident 3's meal was documented given on MAR from 3/5/2026 to 3/11/2026; however, she did not give any meals to Resident 3 because Resident 3 could not swallow, and she knew Resident 3 was on NPO. LVN 3 also stated her documentation for Resident 3's meals on MAR were wrong, it should be documented as not given with a progress note to indicate the reason why the meal was not given. During an interview on 3/12/2026 at 2:20 PM with the Assistant Director of Nursing (ADON), ADON stated Resident 3's MAR for 3/2026 indicated a discrepancy regarding Resident 3's diet and NPO orders. The nurse who received the NPO order should have discontinued Resident 3's regular diet order at the same time. This failure caused miscommunication and incorrect MAR documentation. Resident 3 cannot swallow and giving a meal could lead to aspiration (any food, liquid, saliva accidentally goes into the lungs instead of the stomach). During a review of the facility's policy and procedure (P&P) titled, Documentation – Nursing, dated 2/9/2024, the P&P indicated documentation should be concise, clear, pertinent and accurate. b2.During a review of Resident 33's admission Record (AR) dated 3/13/2to, the AR indicated Resident 33, a [AGE] year-old female, initial admitted on [DATE] and re-admitted on [DATE], with the diagnosis that included but not limited to: fracture of left femur (a condition the left thigh bone is broken), high blood pressure), and epilepsy (a condition that cause a person to have seizures [a sudden uncontrolled involuntary movement, such as shaking, stiffening or jerking]) . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 33's MDS dated [DATE], the MDS did not indicate Resident 33 had a diagnosis of depression. During a review of Resident 33's physician's orders dated 1/6/2026, the order indicated Resident 33 is taking trazodone for depression. During a review of Resident 33's psychotherapeutic drug informed consent (PTDIC- a document that explains the essential information a patient must understand before starting treatment) dated 1/6/2026, the PTDIC indicated trazodone was being used to improve Resident 33's overall sleep quality. During a review of Resident 33's MAR dated 3/2026, the MAR indicated Resident 33 had been taking trazodone every day at bedtime for depression. During a review of Resident 33's psychiatric evaluation (psych eval) dated 1/16/2026, the psych eval did not indicate Resident 33 had depression and recommended Resident 33 to continue taking trazodone for insomnia (the inability to sleep). During an interview on 3/11/2026 at 2:00 PM with Assistant Director of Nursing (ADON), ADON stated Resident 33 did not have a diagnosis of depression. The nurse who got the order should have clarified the correct indication for the use of trazodone with the physician. ADON also stated it is the nurse's responsibility to verify unclear orders. An unclear medication order increases the risk of a medication error and may expose Resident 33 to unnecessary side effects from continued use of an antidepressant. During an interview on 3/12/2026 at 3:53 PM with Registered Nurse (RN) 2, RN 2 stated she entered the trazodone order for Resident 33 exactly as the physician dictated. She said she did not know the resident had no diagnosis of depression and had not reviewed Resident 33's psych eval. RN 2 stated that if she had read the psych eval, she would have clarified the correct indication for use of trazodone order with the physician. During an interview on 3/13/2026 at 8:46 AM with Pharmacy Consultant (PC), PC stated Resident 33's trazodone's order was for depression; however, as he reviewed Resident 33's medical record, he did not find any diagnosis for depression. PC stated the indication of Resident 33's trazodone order should not be for depression, but insomnia. There is a transcription issue for Resident 33's trazodone order, and it should have been clarified with the physician. During a review of the facility's policy and procedure (P&P) titled, Documentation – Nursing, dated 2/9/2024, the P&P indicated documentation should be concise, clear, pertinent and accurate. c. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 12/5/2025 with diagnoses including unspecified fracture of the lower end of the right femur (a broken bone), morbid obesity (excessive body fat that poses a risk of severe health complications), and muscle weakness (a reduced ability to exert force). During a review of Resident 2's H&P dated 12/8/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognition was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact and Resident 2 was dependent on toileting hygiene, bowel and bladder incontinence (involuntary loss of urine or stool), shower/bathe self, and lower body dressing. During an interview on 3/13/26 at 9:45 a.m., with CNA 3, CNA 3 stated oral care was documented in the computer to specify if oral care was provided by staff or if the residents did it themselves. CNA 1 stated the CNAs needed to document on the resident's medical record if the resident refused bathing. CNA 1 stated it was important to complete the documentation on the resident's medical record before the end of the shift because it was the standard of practice. CNA 1 stated if there was no staff initial on the DSR, it indicated bathing was not done for the residents. During a review of the February and March 2026 DSR for Resident 2, there was no oral care documented for the following dates: Night Shift: 2/11/26, 2/12/26, 2/14/26, 2/15/26, 2/20/26-2/25/26 and 2/28/26. Night Shift: 3/1/26, 3/3/26, 3/6/26-3/9/26 and 3/12/26. Evening Shift :3/2/26. During an interview with the Assistant Director of Nursing (ADON) on 3/13/2026 at 9:54 AM, the ADON stated incomplete medical record documentation would affect the continuity of residents' care. The ADON stated, without accurate documentation, nursing staff would not know what happened previously to the residents. The ADON stated it was important for staff to complete documentation before the end of the shift to demonstrate that care was provided for the residents. During a review of the facility's policy and procedure (P&P) titled Documentation-Nursing, dated 2/9/2024, the P&P indicated the CNA would sign each entry on the Adult Daily Living (ADL) Flow Sheet in the appropriate area of the record according to the date and shift that services were performed. The P&P further indicates that documentation would be completed by the end of the assigned shift.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to ensure hospice (compassionate care for people near the end of life) residents received the necessary care and services for one of one sampled resident (Resident 65) by failing to:a. Ensure Resident 65 received two skilled nursing visits every week in accordance with the hospice plan of care order.b. Ensure Resident 65 received two hospice aide visits every week in accordance with the hospice plan of care order. These failures had the potential not to meet Resident 65's hospice needs affecting the resident's quality of life. Findings: a. During a review of Resident 65's admission Record (AR), the AR indicated the facility admitted Resident 65 on 11/10/2025 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently), and chronic kidney disease (CKD - irreversible, and gradual loss of kidney function). During a review of Resident 65's Order Summary Report (OSR) dated 2/28/2026, the OSR indicated the attending physician ordered Resident 65's admission to hospice care. During a review of Resident 65's Hospice Plan of Care Order (HPOC), dated 2/28/2026, the HPOC indicated the facility's contracted hospice would provide two visits every week of skilled nursing services for pain and symptom management. During a review of Resident 65's Minimum Data Set (MDS - a resident assessment tool), dated 3/2/2026, the MDS indicated Resident 65 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 65 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. The MDS indicated Resident 65 was in hospice care. During a concurrent interview and record on 3/11/2026 at 10:59 am with the Case Manager (CM), the Hospice and Palliative Care Patient Calendar for March 2026 and In Home Visit and Coordination Care log for March 2026 were reviewed. The CM stated the hospice provider admitted Resident 65 to hospice care on 2/28/2026. The CM stated the patient calendar, and the coordination care log indicated the hospice licensed vocational nurse (LVN) visited Resident 65 one time on 3/2/2026 for Week 1, covering March 1-7, 2026. The CM stated the patient calendar, and the coordination care log indicated the hospice LVN visited Resident 65 one time on 3/10/2026 for Week 2, covering March 8-14, 2026. The CM stated the contracted hospice should provide Resident 65 of the skilled nursing visits specified in the plan of care to promote comfort and supportive care to the resident. b. During a review of Resident 65's HPOC dated 2/28/2026, the HPOC indicated the facility's contracted hospice would provide two visits every week of hospice aide (HA) services for personal care and activity of daily living (ADL) support. During a concurrent interview and record on 3/11/2026 at 10:59 am with the Case Manager (CM), the Hospice and Palliative Care Patient Calendar for March 2026 and In Home Visit and Coordination Care log for March 2026 were reviewed. The CM stated the patient calendar and the coordination care log indicated the HA visited Resident 65 one time on 3/2/2026 for Week 1, covering March 1-7, 2026. The CM stated the patient calendar and the coordination care log indicated the HA did not visit Resident 65 for Week 2, covering March 8-14, 2026. The CM stated the contracted hospice should provide Resident 65 of the HA visits specified in the plan of care. The CM stated any missed visits should be communicated to the nursing staff of the facility to ensure there would be no interruptions and delay in providing and meeting the Resident 65's needs. During an interview on 3/11/2026 at 11:24 am with the Assistant Director of Nursing (ADON), the ADON stated the contracted hospice should provide services and frequency of visits as specified in the plan of care and collaborated with the facility to ensure the hospice residents were provided with comfort and quality of life during the residents' end-of-life process. During an interview on 3/12/2026 at 11:27 am with Hospice Registered Nurse (HRN), the HRN stated the hospice agency should provide the services and frequency of visits as specified in the resident's plan of care to ensure the resident's needs were taken care of and addressed. During a review of the (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's Hospice-Skilled Nursing Facility Agreement with effective date of February 1, 2026, the agreement indicated, Hospice Plan of Care - the hospice interdisciplinary group (IDG) shall prepare an individualized written hospice plan of care for each hospice patient in the nursing home. The hospice plan of care shall specify the hospice care and services necessary to meet the needs of the hospice patient and his/her family as identified in the initial, comprehensive, and updated assessments. During a review of the facility's Policy and Procedure (P&P) titled, End of Life Care, dated February 9, 2024, the P&P indicated, If hospice care is ordered by the attending physician and elected by the resident or his/her representative, the resident's care plan will reflect hospice interventions. Social services and nursing staff will coordinate with the hospice team to ensure that the resident needs were addressed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure oral care was provided to one of one sampled resident (Resident 2). This deficient practice did not maintain the resident's highest practicable physical, mental, and psychosocial well-being. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 12/5/2025 with diagnoses including unspecified fracture of the lower end of the right femur (a broken bone), morbid obesity (excessive body fat that poses a risk of severe health complications), and muscle weakness (a reduced ability to exert force). During a review of Resident 2's History and Physical (H&P) dated 12/8/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment and care planning tool) dated 12/10/2025, the MDS indicated Resident 2's cognition was intact and Resident 2 was dependent on toileting hygiene, bowel and bladder incontinence (involuntary loss of urine or stool), shower/bathe self, and lower body dressing. During a review of the February and March 2026 DSR for Resident 2, there was no oral care documented for the following dates: Night Shift: 2/11/26, 2/12/26, 2/14/26, 2/15/26, 2/20/26-2/25/26 and 2/28/26.Night Shift: 3/1/26, 3/3/26, 3/6/26-3/9/26 and 3/12/26. Evening Shift : 3/2/26. During a concurrent observation and interview on 3/10/26 at 9:40 a.m., with Resident 2, Resident 2 stated Resident 2 was not provided with oral care inside Resident 2's mouth. Resident 2 stated staff did not provide oral care to Resident 2. Resident 2 did not have teeth. During a subsequent interview on 3/12/26 at 1:50 p.m., Resident 2 stated Resident 2 was not assisted with oral care. Resident 2 who was a dependent resident stated, staff had not assisted Resident 2 with gargling or mouth swabbing. During an interview on 3/13/26 at 9:45 a.m., with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated for dependent residents, staff had to do everything with feeding, bathing, all the ADLs including oral care, brushing/combing the resident's hair and trimming nails. CNA 3 stated oral care included rinsing the mouth with mouthwash and brushing the teeth and for residents with no teeth staff use swabs with mouthwash with water. CNA 3 stated oral care needed to be done before and after breakfast and before lunch time daily. CNA 3 stated it was important to provide daily oral care to prevent infection in the gums and for oral hygiene. During an interview on 3/13/26 at 10:01 a.m. with CNA 4, CNA 4 stated oral care was provided in the morning before and after breakfast and then after lunch daily. CNA 4 stated that for a resident with no teeth, staff should swab the inside of the resident's mouth with water. CNA 4 stated all residents should be receiving oral care daily to prevent cavities, tartar, and oral infections. During a review of the facility's Policy and Procedure (P&P), titled, Activities of Daily Living (ADLs), Supporting, dated, revised July 2024, the P&P indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure the resident had a complete and accurate Advance Directive Acknowledgement Form (a signed form provided to acknowledge that information regarding an Advance Directive [AD, a written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the individual is incapacitate]) for one of six sampled residents (Resident 2). This deficient practice had the potential for Residents 2 to receive life-sustaining care and/or treatment not desired.Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 12/5/2025 with diagnoses including unspecified fracture of the lower end of the right femur (a broken bone), morbid obesity (excessive body fat that poses a risk of severe health complications), and muscle weakness (a reduced ability to exert force). The AR indicated Resident 2 was the responsible party (person legally accountable for the patient's medical decisions and/or financial obligations). During a review of Resident 2's History and Physical (H&P) dated 12/8/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment and care planning tool) dated 12/10/2025, the MDS indicated Resident 2's cognition was intact and Resident 2 was dependent on toileting hygiene, bowel and bladder incontinence (involuntary loss of urine or stool), shower/bathe self, and lower body dressing. During a review of Resident 2's clinical record, the AD Acknowledgment Form dated 12/13/24 was not signed by the resident. Resident 2 was self- responsible. During a concurrent interview on 3/12/2026 at 11:28 a.m. and review of Resident 2's AD Acknowledgement Form dated 12/13/2024 with the Social Services Director (SSD), the SSD stated licensed nurses complete the AD Acknowledgement Form upon admission and Social Services follows up. The AD Acknowledgement Form did not have Resident 2's signature. The AD Acknowledgement Form indicated the SSD signed with the SSD's initials in the representative portion of the AD Acknowledgement Form. The SSD stated the AD Acknowledgement Form should have a signature from the self-responsible resident or a representative. The SSD stated it was the facility's policy to have the signature on the AD Acknowledgement Form. The SSD stated it was important to obtain a signature because it was proof that staff provided information for an AD if residents did not have AD and that the staff had collected the necessary information. During a review of the facility's Policy and Procedure (P&P), titled, Advance Directives, dated February 2024, the P&P indicated upon admission, the Admissions Staff or designee will provide written information to the resident concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. The Interdisciplinary Team will annually review the advance directive with the resident or responsible party, to ensure that the directive still reflects the wishes of the resident.

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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 ensure one of one sampled resident's (Resident 50), Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment was accurately coded regarding the use of insulin (a hormone that removes excess sugar from the blood). This failure had the potential to result in delays of necessary care and services and inaccurate plan of care and interventions for Resident 50. Findings: During a review of Resident 50's admission Record (AR), the AR indicated the facility re-admitted Resident 50 on 8/18/2024 with diagnoses including cellulitis (a skin infection that causes swelling and redness) of the abdominal wall, severe sepsis (a life-threatening blood infection), and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control) with other specified complication. During a review of Resident 50's History & Physical (H&P) dated 8/6/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 50's MDS dated [DATE], the MDS indicated Resident 50 was cognitively intact (ability to understand) and received an insulin injection during the last seven days.During a review of Resident 50's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/1/2025 to 12/31/2025 and 1/1/2026 to 1/31/2026, the MARs did not indicate insulin was administered to Resident 50. During an interview on 3/10/2026 at 10:10 am with Resident 50, Resident 50 stated Resident 50 was not on insulin. During an interview on 3/12/2026 at 2:58 pm with the Assistant Director of Nursing (ADON), the ADON stated Resident 50 was initially admitted on [DATE] and had never received insulin. During an interview on 3/13/2026 at 10:45 am with the MDS Nurse (MDSN), the MDSN stated Resident 50 did not have an order for insulin but had an order for Ozempic (medication used to improve blood sugar), which was not classified as an insulin. The MDSN stated insulin use should not have been documented in the MDS dated [DATE]. The MDSN stated it was important to accurately document Resident 50's assessment to provide the Centers for Medicare and Medicaid Services (CMS) the correct resident data, including the medications the resident was taking. During an interview on 3/13/2026 at 11:06 am with the Assistant Director of Nursing (ADON), the ADON stated the MDS was a complete assessment of a resident. The ADON stated MDS assessments needed to be accurate for billing purposes and to reflect all the care provided for the residents. During a review of the facility's Policy and Procedure (P&P) titled, RAI Process, revised 5/19/2024, the P&P indicated each resident's assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment he or she completed. The P&P indicated, all information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD). During a review of the CMS Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1, dated October 2025, the manual indicated the RAI process had multiple regulatory requirements. The manual indicated, federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) required that the assessment accurately reflect the resident's status.

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West Haven Healthcare	1495 West Cameron Ave. West Covina, CA 91790

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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 interview and record review, the facility failed to provide care and services to prevent a fall (unintentional coming to the ground) for one of four sampled residents (Resident 2) by failing to ensure Certified Nursing Assistant 5 (CNA 5) provided two-person physical assistance (help from two persons) when turning Resident 2 in bed while changing Resident 2's adult brief. This deficient practice resulted in Resident 2's fall on 11/24/2025 and Resident 2 sustained a right femur fracture (broken thigh bone).Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 2/13/2024 and readmitted on [DATE] with diagnoses including unspecified fracture of the lower end of the right femur, morbid (severe) obesity (excessive body fat that poses a risk of severe health complications), and muscle weakness (a reduced ability to exert force). During a review of Resident 2's Care Plan (CP) for at risk for falls related to bowel/bladder incontinence (loss of ability to control bowel/bladder) dated 7/30/2025, the CP indicated a goal to minimize falls and injury. The CP interventions included staff to provide assistance with Resident 2's activities of daily living (ADL- basic self-care activities). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment and care planning tool) dated 9/14/2025, the MDS indicated Resident 2's cognition was intact. The MDS indicated Resident 2 was dependent (helper does all effort) to staff on toileting hygiene, lower body dressing, lying to sitting on side of bed and chair to bed transfer. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) to roll left and right. During a review of Resident 2's Situation Background Assessment Request (SBAR) Communication Form dated 11/24/2025, the SBAR indicated on 11/24/2025 at 9:20 pm, CNA 5 attended Resident 2 for adult brief change. The SBAR indicated, upon turning Resident 2 to the left side, Resident 2 slid off the bed. During a review of Resident 2's Post Fall Assessment (PFA) dated 11/24/2025, the PFA indicated upon turning Resident 2 to the left side by CNA 5 during adult brief change, Resident 2 slowly slid off the bed. The PFA indicated CNA 5 held onto Resident 2, with Resident 2 half kneeling on the floor. During a review of Resident 2's General Acute Care Hospital 1(GACH 1) record dated 11/25/2025, GACH 1 record indicated Resident 2 was diagnosed at the emergency room (ER) with a right femur fracture. During a review of Resident 2's GACH 1 femur and knee X-ray report dated 11/25/2025, the report indicated Resident 2 had a nondisplaced distal femoral fracture with moderate suprapatellar (a stable break near the knee). During a review of Resident 2's Nursing admission Assessment (NAA) dated 12/5/2025 at 11:00 p.m., the NAA indicated Resident 2 was readmitted back to the facility from GACH 1. During a review of Resident 2's History and Physical (H&P) dated 12/8/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During an interview on 3/10/2026 at 9:40 a.m. with Resident 2, Resident 2 stated Resident 2 had a history of fall on 11/24/2025. During an interview on 3/12/2026, at 1:52 p.m. with Resident 2, Resident 2 stated Resident 2 remembered Resident 2 slipped from the bed while being changed. Resident 2 stated there was one female CNA who assisted Resident 2 with changing Resident 2's adult brief. Resident 2 stated Resident 2 fell to the right side of Resident 2's bed and Resident 2 fell face down. Resident 2 stated Resident 2 felt pain (not rated) in Resident 2's right leg and injured Resident 2's right knee on the same right leg from the fall. During an interview on 3/13/2026 at 9:45 a.m., with CNA 3, CNA 3 stated when changing a dependent resident (total assistance with activities of daily living), the resident would require two people assisting the resident regardless of the resident's weight. CNA 3 stated that when the resident was morbidly obese, two staff were required to assist the resident to prevent the resident from rolling out of bed while being turned for changing the adult brief. CNA 3 stated for Resident 2, two people were required while changing Resident 2's adult brief. CNA 3 stated Resident 2 needed two people working with Resident 2 because Resident 2 was dependent and morbidly obese. CNA 3 stated Resident 2 could not (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	control Resident 2's weight while being turned by staff and Resident 2 could fall over the bed and get hurt. CNA 3 stated Resident 2 required two people assisting Resident 2 at all times. CNA 3 stated having only one staff working with Resident 2 was against the facility policy. During an interview on 3/13/2026 at 10:01 a.m., with CNA 4, CNA 4 stated Resident 2 was a dependent and bed bound (confined to bed). CNA 4 stated dependent residents could not do anything for themselves. CNA 4 stated two staff were required to change and turn a dependent resident. CNA 4 stated it was important to change Resident 2 with two people assistance for safety. During an interview on 3/13/2026 at 10:40 a.m., with the Director of Nursing (DON), the DON stated on 11/24/25, Resident 2 fell and sustained a fracture. The DON stated when changing Resident 2, Resident 2 would need 2-4 staff, depending on Resident 2's strength. The DON stated when changing or turning Resident 2, it would not be beneficial for less than two staff present. The DON stated having at least two staff when turning or changing Resident 2 was important to prevent the staff from hurting themselves and for Resident 2's safety. During an interview on 3/13/2026 at 11:22 a.m. with the DON, the DON stated it was the DON's understanding that CNA 5 was the only staff present while changing Resident 2 on 11/24/2025 that resulted in Resident 2's fall. During an interview on 3/13/2026 at 11:32 a.m., with the DON, the DON stated CNA 5 made a bad judgement and CNA 5 should have asked for help for additional staff. The DON stated CNA 5 was by herself while changing Resident 2 on 11/24/2025 that resulted in Resident 2's fall. During an interview on 3/13/26 at 12:01 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 2 was a dependent resident who had bladder and bowel incontinence. The ADON stated Resident 2 wore an adult brief and had to be changed by staff. The ADON stated there had to be one staff on each side of the bed for repositioning, changing, and transferring Resident 2. The ADON stated Resident 2 needed two staff assistants for safety because of Resident 2's weight and Resident 2 was dependent on staff. The ADON stated it was ADON's understanding that CNA 5 was changing Resident 2's adult brief and Resident 2's fall and fracture could have been avoided if there were two staff changing Resident 2. During a review of the facility's Policy and Procedure (P&P), titled, Fall Management Program, revised November 21, 2024, the P&P indicated it was the policy of the facility to provide the highest quality care in the safest environment for the residents residing in the facility.

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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 staff failed to elevate the resident's head of the bed (HOB) while receiving formula through the gastrostomy tube (GT - a tube inserted through the abdomen that delivers nutrition directly to the stomach) in accordance with the resident's care plan and physician's order for one of two sampled residents (Resident 11). This deficient practice had the potential to result in aspiration (inhalation of foreign materials) and pneumonia (a lung infection) for Resident 11. Findings: During a review of Resident 11's admission Record, the AR indicated the facility initially admitted Resident 11 on 10/3/2023 and readmitted on [DATE] with diagnoses including gastroesophageal reflux disease (GERD- the stomach acid or contents leak back into the esophagus) without esophagitis (irritation or inflammation of the esophagus [tube that carries food from throat to the stomach]) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 11's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 1/3/2026, the MDS indicated Resident 11 cognition (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 11 was dependent (full staff performance) with oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene.During a review of Resident 11's Order Summary Report (OSR) dated 1/10/2026, the OSR indicated for staff to elevate Resident 11's head of bed at 30 to 45 degrees at all times during feeding and at least one hour after feeding every shift. During a review of Resident 11's OSR dated 1/10/2026, the OSR indicated Resident 11 was on continuous GT feeding of Glucerna 1.5 (formula) at 50 millimeter (ml, unit of measurement) per hour (hr.) via enteral feeding pump for 20 hours in 24 hours, on at 11 am and off at 7 am or until the dose was completed. During a review of Resident 11's untitled Care Plan (CP) dated 1/13/2026, the CP indicated Resident 11 required tube feeding related to dysphagia (difficulty swallowing). The care plan interventions indicated for nursing staff to administer enteral feeding as prescribed and keep Resident 11's head of bed elevated at 30 to 45 degrees at all times during feeding and at least one hour after feeding. During a concurrent observation and interview on 3/11/2026 at 2:04 pm, together with Licensed Vocational Nurse 2 (LVN 2), Resident 11 was awake, lying in bed, in supine position with the head of the bed not elevated to 30 to 45 degrees and was connected to a GT feeding formula. LVN 2 turned on the GT feeding and started leaving Resident 11. LVN 2 stated Resident 11 was lying almost flat in bed and the CNA forgot to elevate the HOB to 30 to 45 degrees after assisting Resident 11 with activities of daily living (ADL). LVN 2 stated Resident 11's HOB should have been elevated to 30 to 45 degrees while the feeding is ongoing for aspiration precaution. During a concurrent interview and record review on 3/11/2026, at 2:18 pm, with the Assistant Director of Nursing (ADON) of Resident 11's medical records (PointClickCare - PCC, a cloud-based software) the ADON stated Resident 11's head of bed needed to be elevated to 30 to 45 degrees while receiving GT feeding and at least one hour after feeding to prevent aspiration. During a review of the facility's Policy and Procedure titled, Gastrostomy Placement, revised 2/9/2024, the P&P indicated To limit the risk for aspiration and reflux, raise the head of the bed 30-45 degrees prior to checking placement of the gastrostomy tube.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to implement its Policy and Procedure (P&P) titled, Foods Brought in by Visitors, by failing to label outside food for Resident 88 and ensure outside food adhered to Resident 88's prescribed diet. This deficient practice had the potential to result in food-borne illnesses (food poisoning) for Resident 88 that could lead to serious medical complications and hospitalization. Findings: During a review of Resident 88's admission Record (AR), the AR indicated the facility admitted Resident 88 on 3/3/2026 with diagnoses including pneumonia (an infection in the lungs) and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 88's Care Plan (CP) dated 3/3/2026, the CP indicated Resident 88 was at risk for aspiration. The CP intervention indicated for the staff to educate the resident and family about the importance of adhering to the prescribed diet and the risks of eating food outside of the prescribed diet. During a review of Resident 88's Minimum Data Set (MDS - a resident assessment tool) dated 3/8/2026, the MDS indicated Resident 88 had intact cognition (ability to understand). The MDS indicated it was very important for Resident 88 to have snacks available between meals. The MDS indicated Resident 88 required setup assistance from staff with eating and oral hygiene. The MDS indicated Resident 88 required supervision from staff with personal hygiene. The MDS indicated Resident 88 required moderate assistance (helper did less than half the effort) from staff with showering/ bathing and bed-to-chair transferring. The MDS indicated Resident 88 required maximal assistance (helper did more than half the effort) from staff with toileting hygiene. During a review of Resident 88's Order Summary Report (OSR) as of 3/12/2026, the OSR indicated an active physician order for Level 6 soft and bite sized texture diet (food was soft and cut into small pieces that were easy to chew) for Resident 88, ordered on 3/11/2026. During an observation on 3/10/2026 at 9:41 AM in Resident 88's room, the following were observed at Resident 88's bedside:1. Two sealed containers of food with no label.2. One jar of roasted cashew nuts halves with no label. 3. One jar of peanuts halves with no label. During an observation on 3/10/2026 at 11:45 AM, in Resident 88's room, the following were observed at Resident 88's bedside: 1. One jar of roasted cashew nuts halves with no label. 2. One jar of peanuts halves with no label. During a concurrent observation and interview with Resident 88 on 3/11/2026 at 12:52 PM in Resident 88's room, the following were observed at Resident 88's bedside:1. One jar of roasted cashew nuts halves with no label. 2. One jar of peanuts halves with no label.Resident 88 stated Resident 88's family brought the food yesterday (3/10/26) and Resident 88 ate it. During an interview with Certified Nurse Assistant 2 (CNA 2) on 3/11/2026 at 12:52 PM, CNA 2 stated CNA 2 did not have time to label the food brought in by family on 3/10/2026 for Resident 88. CNA 2 stated nursing staff should label Resident 88's food with room number and name, so the nursing staff would know who the food belonged to and not give it to other residents. During a concurrent pictures review and interview with Licensed Vocational Nurse 3 (LVN 3) on 3/12/2026 at 10:22 AM, the pictures dated 3/10/2026 at 9:42 AM and 11:45 AM, and 3/11/2026 at 12:52 PM, were reviewed. LVN 3 stated the pictures indicated Resident 88's outside food did not have labels of resident's name or date. LVN 3 stated it was the standard of practice and for infection control to label outside food. LVN 3 stated the receiving nurse should label the food with the resident's name and the date received and place it in the refrigerator. LVN 3 stated it was important to label the outside food to prevent foodborne illness. LVN 3 stated the licensed nurse should check the resident's diet order to ensure food brought in from the outside was in accordance with the ordered diet texture for the resident. LVN 3 stated the licensed nurse should document the resident's nonˆcompliance with prescribed diet in the resident's progress notes. LVN 3 stated Level 6 soft and biteˆsized foods were soft like mashed potatoes, while peanuts and cashews were dry and hard and did not meet Level 6 diet requirements. During a concurrent pictures review and interview with the Dietary Supervisor (DS) on 3/12/2026 at 1:42 PM, the picture dated 3/11/2026 at 12:52 PM was reviewed. The DS stated the cashew nuts halves and peanuts halves were not (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate for Level 6 soft bite diet texture for Resident 88. The DS stated outside food should be in accordance with the resident's prescribed diet. The DS stated speech therapy should evaluate the resident to avoid choking for safety. The DS stated the purpose of Level 6 soft and bite size diet for Resident 88 was to avoid difficulty swallowing. During a concurrent record review and interview with the Assistant Director of Nursing (ADON) on 3/12/2026 at 1:54 PM, Resident 88's Nursing Progress Notes (NPN) for 3/2026 were reviewed. The ADON stated the NPN did not indicate documentation that Resident 88's physician was notified regarding Resident 88's outside food that did not adhere to the prescribed/ordered diet. The ADON stated the licensed nurse should have notified Resident 88's physician if Resident 88 insisted on wanting the cashew nuts and peanuts. The ADON stated following the prescribed diet was for the safety of Resident 88. During a review of the facility's P&P titled, Foods Brought in by Visitors, dated 2/9/2024, the P&P indicated the dietary staff would review the resident's diet with the visitor, and provide education regarding the resident's diet orders and safe food handling practices when the resident desired to have food brought in by visitors. The P&P indicated outside food should be stored in a sealable container with the resident's name and date it was bought to the facility. The P&P indicated residents who were not compliant with prescribed diets would receive education from the registered dietician, attending physician or licensed nurse regarding risks and benefits. The P&P further indicated that such education would be documented.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure staffing information on the Nurse Staffing Information Sheet (posted information that contains the facility's current resident census and total number and actual hours worked by licensed and unlicensed nursing staff) was posted in a prominent place readily accessible to residents and visitors. This failure resulted in nursing staffing information not accessible to residents and visitors and had the potential to negatively affect the quality of care for the residents. Findings: During a review of the facility's map, the map indicated there were two nursing stations, Station 1 and Station 2. During observations on 3/10/2026 at 10:44 am, 3/11/2026 at 10:53 am, and 3/12/2026 9:10 am the Nurse Staffing Information Sheet was only posted on the wall across from Nursing Station 1. During a concurrent observation and interview on 3/12/2026 at 2:29 pm with the Assistant Director of Nursing (ADON), the Nurse Staffing Information Sheet was posted across from Nursing Station 1. The ADON stated, the ADON was responsible for staffing postings and the nursing staffing information was only posted across from Station 1. The ADON stated the Nurse Staffing Information was not readily accessible to residents and visitors. The ADON stated, the residents in part of Nursing Station 2 and residents in Station 3 (Station 2 on the facility map) who resided behind the closed double doors were unable to easily access the Nurse Staffing Information posting. The ADON stated visitors needed to go to Nursing Station 1 and 2 (Station 1) to be able to view the Nurse Staffing Information. The ADON stated the Nurse Staffing Information was important for transparency and to allow residents or visitors to determine if the facility staff was adequate. During an interview on 3/13/2026 at 10:17 am with the Director of Nursing (DON), the DON stated the Nurse Staffing Information Sheet was posted in front of Nursing Station 1 and 2 (Station 1) and for residents and visitors to review it, they would need to go to Nursing Stations 1 and 2. During an interview on 3/16/2026 at 11:32 am with the Administrator (ADM), the ADM stated the Nurse Staffing Information Sheet had always been posted at Nursing Station 1 and 2 (Station 1) and should be posted somewhere where it was accessible. The ADM stated accessible means an area that residents or visitors would go to without restrictions. The ADM stated the purpose of posting the Nurse Staffing Information was for residents and visitors to be able to see the current staffing of the facility with the current census. The ADM stated residents and visitors had the right to view the Nurse Staffing Information, know what the staffing was, and if there were enough staff to provide resident care. During a review of the facility's Policy and Procedure (P&P) titled, Nursing Department-Staffing, Scheduling & Postings, dated 2/9/2024, the P&P indicated as a posting requirement that data must be posted in a prominent place readily accessible to residents and visitors.