

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Grand Park Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2312 West 8th Street Los Angeles, CA 90057	
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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview record review, the facility failed to ensure their Payroll Based Journal (PBJ - information of the provider's daily staffing hours for the appropriate care of the residents) data had been submitted to the Center for Medicare and Medicaid Services (CMS) for one of four required quarters (third quarter from 4/1/25 to 6/30/25) in 2025. This deficient practice had the potential to cause delays in care, treatment, and services necessary to maintain physical and emotional wellbeing for all facility residents. Findings: During a review of PBJ Staffing Data Report dated 7/21/26, the PBJ Staffing Data Report indicated the facility failed to submit data for the third quarter covering 4/1/25 to 6/30/25. During an interview on 7/23/26 at 9:23 a.m. with the Director of Nursing (DON), the DON stated the PBJ had to be submitted quarterly, which was every three months. The DON stated that the Accounting and Payroll Department were responsible for gathering payroll and staffing information. The DON stated that the compiled payroll and staffing information were then sent to the Clinical Consultant (CC) for PBJ data submission. The DON stated the facility missed the deadline to submit the PBJ data for the third quarter of 2025. The DON stated the PBJ had to be submitted prior to the deadline because CMS used that information to monitor if the facility had enough staff to provide care for residents. The DON stated that if there were not enough staff, it could cause delays in care and failure to meet residents' needs. During a phone interview on 7/23/26 at 9:59 a.m. with the Accounting and Payroll Manager (APM), the APM stated the facility had 45 days from the last day of the quarter to submit the PBJ data. The APM stated that there were technical difficulties and by the time the facility was able to resolve those issues, it was past the deadline to submit the PBJ data for the third quarter of 2025. During an interview on 7/23/26 at 11:04 a.m. with the DON, the DON stated the facility did not have any policy or procedures for PBJ submission. The DON stated the facility followed CMS guidelines for guidance in PBJ submission. During an interview on 7/23/26 at 11:08 a.m. with the CC, the CC stated she (CC) was responsible for submitting the quarterly PBJ data. The CC stated that there was confusion between Eastern Standard Time (EST) and Pacific Standard Time (PST), which caused her (CC) to miss the deadline. The CC stated it was important to submit the PBJ data in a timely manner because CMS did not allow for late submissions. During a review of an email exchange between the DON and CMS PBJ Staffing Team, dated 8/15/25 at 10:07 a.m., the email indicated the facility was unable to meet the official PBJ submission deadline of 8/14/25 for the quarter covering 4/1/25 to 6/30/25. During a review of an email exchange between the DON and CMS PBJ Staffing Team, dated 8/15/25 at 10:17 a.m., the email indicated it was not possible to submit or correct PBJ data once a submission deadline had passed. The email indicated that providers were given 45 days from the end of the quarter to submit their PBJ data. During a review of CMS's Electronic Staffing Submission - Payroll Based Journal Public Use File Released dated September 2017, the document indicated all long-term care facilities were required to electronically submit staffing data that was auditable back to payrolls and other verifiable sources.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 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 interview and record review the facility failed to ensure to provide the necessary care for two of five sampled residents (Resident 1 and Resident 10) reviewed for unnecessary medications such as psychotropic (any drug that affects the mental function, behavior, and mood) by failing to:-Ensure Resident 1 was not prescribed and administered (given) Seroquel (generic name quetiapine - a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]) without an appropriate clinical indication (the reason the doctor recommended a specific test, medicine or treatment) and diagnosis.-Ensure to provide non-pharmacological interventions (health treatments and strategies that do not use medications) before Resident 1 was administered Seroquel.-Ensure as needed (PRN) order for Xanax (a prescription medication that slows down brain activity to quickly calm severe anxiety and panic attacks) for Resident 10 had a stop date (the exact calendar day the medication is supposed to be stopped). These failures had the potential to expose Resident 1 and Resident 10 to unnecessary medications and to significant adverse consequences (unwanted, uncomfortable, or dangerous drug side effects) resulting from the prolonged use of Seroquel or Xanax that could lead to impairment or a decline in functional (the gradual or sudden loss of a person's ability to do every day physical and mental tasks on their own) or psychosocial status (a person's mental, emotional, and social wellbeing, reflecting how they think, feel, and interact with the world around them). Findings: a.During a review of Resident 1's admission Record (a document containing demographic and diagnostic information), the admission Record indicated the facility originally admitted Resident 1 on 8/10/2024 and readmitted Resident 1 on 4/16/2026 with diagnoses including but not limited to unspecified psychosis not due to a substance or known physiological condition, unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, major depressive disorder (sadness, low mood), single episode, unspecified, and unspecified Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1's History and Physical (H&P) dated 9/8/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Care Plan Report dated 4/21/2026, the Care Plan Report indicated Resident 1 was taking antipsychotics medication (Seroquel) related to psychosis manifested by recurrent outbursts of anger without apparent reason. The Care Plan Report indicated nursing interventions to observe the side effects of the anti-psychotic meds such as acute dystonia (a sudden, painful, involuntary muscle spasm, most often affecting the head, neck, and face), anticholinergic symptom (dry mouth, blurry vision and constipation), hypotension (low blood pressure), sedation/drowsiness. The Care Plan Report indicated to report to the Medical Doctor (MD) for any acute onset reaction. The Care Plan Report indicated to monitor orthostatic hypotension (a (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sudden drop in blood pressure that happens when you stand up) every shift, every Tuesday for Seroquel. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 5/1/2026 to 5/31/2026, the MAR indicated Quetiapine 25 mg was administered 31 times to Resident 1. During a review of Resident 1's Psychiatric Follow-Up (f/u) Notes dated 6/1/2026, 1/14/2026 and 12/7/2025, the Psychiatric Follow-Up (f/u) Notes indicated Resident 1 was interactive and had episodes of aggression/angry outbursts/anxiousness. The Psychiatric Follow-Up (f/u) Notes indicated Resident 1's current medication was Seroquel 25 mg daily at bedtime (QHS). The Psychiatric Follow-Up (f/u) Notes indicated Resident 1 had a diagnosis of dementia with behavioral disturbance/psychosis. The Psychiatric Follow-Up (f/u) Notes indicated there were no gradual dose reduction (GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued), the benefits outweigh the risks. During a review of Resident 1's MAR dated 6/1/2026 to 6/30/2026, the MAR indicated Quetiapine 25 mg, 0.5 mg (12.5 mg) was administered 29 times to Resident 1. During a review of Resident 1's Order Summary Report dated 6/25/2026, the Order Summary Report indicated but not limited to the following physician orders: - (Seroquel) & ndash; Monitor episode of psychosis manifested by (m/b) recurrent outbursts of anger without apparent reason every shift for Seroquel, record number of behavior observed, order date 1/27/2025, start date 1/27/2025. - Quetiapine Fumarate tablet 25 mg, give 0.5 tablet by mouth at bedtime for psychosis m/b recurrent outbursts of anger without apparent reason, 0.5 tab = 12.5 mg, order date 6/2/2026, start date 6/2/2026. During a review of Resident 1's MAR dated 7/1/2026 to 7/22/2026, the MAR indicated Quetiapine 25 mg, 0.5 tablet (12.5 mg) was administered 22 times to Resident 1. During a review of Resident 1's Minimum Data Set (MDS & ndash; a resident assessment tool), dated 7/19/2026, the MDS did not indicate a cognition (mental action or process of acquiring knowledge and understanding through thought and senses) score. The MDS indicated that Resident 1 was dependent on facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated diagnoses for Resident 1 were Alzheimer's Disease, Non-Alzheimer's Dementia, depression and psychotic disorder (other than schizophrenia). During a review of Resident 1's Order Summary Report (a document containing a summary of all (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	active physician orders) dated 7/22/2026, the order summary report indicated but not limited to the following physician orders: -(Seroquel) &ndash; Monitor episode of psychosis manifested by (m/b) recurrent outbursts of anger without apparent reason every shift for Seroquel, record number of behavior observed, order date 1/27/2025, start date 1/27/2025. -Quetiapine Fumarate tablet 25 milligram ([mg] metric unit of measurement, used for medication dosage and/or amount), give 0.5 tablet via gastrostomy tube ([g-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) at bedtime for psychosis m/b recurrent outbursts of anger without apparent reason 0.5 tab = 12.5 mg, order date 7/17/2026, start date 7/17/2026. During a concurrent interview and record review on 7/23/2026 at 10:53 AM with Licensed Vocational Nurse (LVN) 3, Resident 1's electronic medical records and physical chart notes were reviewed. LVN 3 stated Resident 1 would be calm but sometimes would scream for no reason. LVN 3 stated Resident 1 was on Seroquel at bedtime for psychosis manifested by anger outbursts. LVN 3 stated Resident 1 did not look like a risk of harm to herself, or others and behaviors were not interfering with ADLs. LVN 3 stated Resident 1 was experienced distress constantly, around one to two hours of distress, irritated and angered. During a concurrent interview and record review on 7/23/2026 at 11:04 AM with Registered Nurse Supervisor (RN Supervisor), Resident 1's electronic medical records and physical chart notes were reviewed. The RN Supervisor stated Resident 1 had psychotic behavior then transferred to the hospital (unidentified date) then came back (unidentified date) in declining condition, got g-tube inserted, and was totally dependent on staff and needed assistance for transfer and hygiene. The RN Supervisor stated, Resident 1 had visitors from the community, and they (visitors) would let her (Resident 1) watch the iPad. The RN Supervisor stated that Resident 1's friends (unidentified visitors) would tell Resident 1 not to watch the news otherwise she (Resident 1) would get agitated. The RN Supervisor stated Resident 1 was not combative and was not at risk of harming herself or others. The RN Supervisor stated the psychiatrist note indicated Resident 1 was diagnosed with dementia with behavioral disturbance/psychosis. The RN Supervisor stated it was up to the psychiatrist to evaluate and prescribe the medication and do a GDR. The RN supervisor stated there were no non-pharmacological interventions to manage Resident 1's behaviors before administering psychotropics. The RN Supervisor stated it was important to implement nonpharmacological interventions such as redirection and other measures for Resident 1 before administering antipsychotics. During a concurrent interview and record review on 7/23/2026 at 11:25 AM with the Assistant Director of Nursing (ADON), Resident 1's electronic medical records and physical chart notes were reviewed. The ADON stated when Resident 1 returned from hospital, Seroquel was continued and then the dose was reduced but Seroquel was continued. The ADON stated some patients have this medication and started citing diagnoses such as Alzheimer's Disease and non-Alzheimer's dementia. The ADON stated it was important to review psychotropic medications because unnecessary use would cause side effects. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/23/2026 at 12:50 PM with the psychiatry Physician Assistant (PA) 1, PA 1 stated PA stated Seroquel was being used to assist in Resident 1's behavioral management, and helped Resident 1 with ADLs and family was well aware and understood the risks and benefits of the medication. PA 1 stated that Seroquel was allowed to be used for dementia related psychosis and psychotic disorder. PA 1 stated that for the diagnosis of psychosis, Seroquel was the right medication, and it was continued from hospital's list of medications. PA 1 stated Resident 1 had psychosis due to underlying dementia with behavioral disturbances presence. PA 1 stated that Ativan (generic name &ndash; lorazepam, a medication used to treat anxiety) like anti-anxiety medication was an option but the family was aware of the potential side effects and did not want her (Resident 1) to hurt her or other residents (unidentified). PA 1 stated the other medications (unidentified) likely failed and were not allowing her (Resident 1) to continue with ADLs and was further declining. PA 1 stated the facility continued the medication because it was given to Resident 1 at the hospital or she (Resident 1) was on it at home. PA 1 stated, since this was a small dose of Seroquel 12.5 mg, it would be ok to administer and seemed to be working for Resident 1. PA 1 stated, I would continue this medication, and family was saying that Seroquel was beneficial, and in my opinion, the Seroquel is beneficial and appropriate for this resident. During an interview on 7/23/2026 at 1:39 PM with the Director of Nursing (DON), the DON stated Seroquel could be used for bipolar disorder, schizophrenia and maybe major depressive disorder (MDD). The DON stated some of the side effects from an antipsychotic could be sleepiness and drowsiness. The DON stated maybe sudden death as a black box warning (is a warning that death or serious injury may result from the use of a particular drug) for antipsychotics. The DON stated it was important to review the psychotropic drugs for their appropriateness of treatment, side effects and risks associated with the medications. The DON stated the facility staff needed to first attempt non-pharmacological interventions (NPI) for three days before starting a psychotropic medication. The DON stated that if the medication was routine, then the facility would not do NPI. The DON stated that NPI was only for as needed medications. The DON could not clearly state if Seroquel was an unnecessary psychotropic medication for Resident 1's diagnosis. According to Seroquel's manufacturer's labeling, Seroquel is indicated for the treatment of Schizophrenia, Bipolar 1 disorder manic episodes, Bipolar disorder, depressive episodes. The package insert indicated boxed warning, Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for elderly patients with dementia-related psychosis. During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, dated 3/1/2024, the P&P indicated, Antipsychotic medications may be considered for residents with dementia only after medical, physical, functional.identified and addressed. The P&P indicated, Residents will receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The Attending Physician and other staff will gather and document.and others. The P&P indicated, Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The P&P indicated, Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented.: a. Schizophrenia; b. Schizoaffective disorder; c. Schizophreniform disorder; d. Delusional disorder . f. psychosis in the (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	absence of dementia.k. Nausea and vomiting associated with cancer or chemotherapy. The P&P indicated, Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications.also met: a. the behavioral symptoms present a danger to the resident or others; AND 1. The symptoms are identified as being due to mania or psychosis (such as auditory, visual.grandiosity); or 2. Behavioral interventions have been attempted .except in an emergency. b. During a review of Resident 10's admission Record, the admission Record indicated the facility originally admitted Resident 10 on 6/16/2026 and readmitted Resident 16 on 6/23/2026 with diagnoses that included need for assistance with personal care (requiring hands-on help with basic daily routines like bathing, dressing, and eating because of age, illness, or disability), anxiety disorder (a mental health condition involving excessive fear, persistent worry, and intense nervousness that does not go away and disrupts daily life), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), pain in right wrist, rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), muscle weakness, and neuralgia and neuritis unspecified (unexplained nerve pain or unspecified nerve inflammation somewhere in the body). During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 had the ability to make herself (Resident 10) understood and had the ability to understand others. During a review of Resident 10's Psychiatric Progress Note (a healthcare written record of a patient's mental health visit, covering symptoms, observations, and future plans), dated 7/1/2026, the Psychiatric Progress Note indicated Resident 10 had fair (reasonable) insight (self-awareness and ability to recognize problems) and judgement (decision-making and ability to choose safe, sensible actions). The Psychiatric Progress Note indicated Nurse Practitioner 1 (NP 1 - a registered nurse with extra college training who can examine patients, diagnose illnesses, and write prescriptions) ordered a decrease in Xanax to 0.5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) by mouth every 12 hours PRN for severe anxiety for 30 days. During a review of Resident 10's Order Summary Report, (an active master list of all current medical instructions for a patient, detailing medications, treatments, and therapies ordered by healthcare provider) dated 7/22/2026, the Order Summary Report indicated a physician order for Resident 10 to receive Xanax 0.5 mg one tablet by mouth every 12 hours as PRN for anxiety manifested by the inability to relax. The Xanax order indicated a start date of 7/1/2026. The Xanax order did not indicate the order had an end date. During a concurrent interview and record review on 7/22/2026 at 8:30 AM with the facility's Quality Assurance Nurse (QA &ndash; healthcare professional who plays an essential role in ensuring that quality standards and patient safety are upheld) and Licensed Vocational Nurse 6 (LVN 6), Resident 10's order for Xanax was reviewed. The order indicated for Resident 10 to receive Xanax 0.5 mg one tablet by mouth every 12 hours PRN for anxiety manifested by the inability to relax. The QA and LVN 6 stated the Xanax 0.5 mg order had a start date of 7/1/2026 and the order did not have a stop date. During a concurrent interview and record review on 7/22/2026 at 11:36 PM with the Assistant (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Nursing (ADON) Resident 10's Xanax 0.5 mg order was reviewed. The ADON stated the Xanax 0.5 mg order did not have an end date. During a concurrent interview and record review on 7/22/2026 at 9:20 AM with the Director of Nursing (DON) and NP 1, the facility's policy and procedure (P&P) titled, Antipsychotic Medication (prescription drugs used to calm the brain) Use, last reviewed 1/23/2026, was reviewed. The P&P indicated the need to continue PRN orders for psychotropic medications (prescription drugs that change how your brain works to affect your mood, thoughts, feelings, and behavior) beyond 14 days requires that the practitioner document the rationale (reason) for the extended order. The P&P indicated the duration (length of time) the PRN order will be indicated in the order. The NP stated orders for psychotropic medications are typically written for 14 days if the medication is prescribed as needed. The NP stated Resident 10's order for Xanax 0.5 mg, give one tablet by mouth every 12 hours PRN for anxiety m/b inability to relax needed to have a stop date. The DON stated the facility did not follow their Antipsychotic Medication Use policy when the facility failed to place a stop date on the Xanax 0.5 mg order.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure staff followed the standardized recipes and food serving guide according to the menu and cook's spreadsheet (food portioning and serving guide) instructions on 7/20/2026 lunch service when: 1.Nine fortified diet trays did not receive fortified foods (diet enhanced to increase caloric content of food) and the Dietary Aide (DA2) did not read out the orders for cooks to serve, and 16 regular menu and consistent Carbohydrate diet (CCHO diet) trays received 1/2 cup of the potato and corn instead of 1/4 cup. 2. Kitchen staff failed to ensure minced and moist texture rice was prepared according to the IDDSI-Level Five minced and moist foods-(All foods prepared for this diet must be soft, moist with all excess fluid drained, and minced to size no larger than 4mm fits through the gaps of fork prongs) when 2 lunch trays received steamed rice that was sticky and not moist. These deficient practices had the potential to result in meal dissatisfaction, affecting nutritional status for 9 residents who were on fortified diet and 16 residents who were on CCHO diet and increased choking risk for the 2 out of 128 residents who were on the minced and moist diet.Findings:1. During an observation of the kitchen tray line service for lunch (tray line- a system of food preparation, in which trays move along an assembly line) on 7/20/2026 at 12:00PM, trays requiring a fortified diet received the same food as residents who did not have fortified diet orders. Dietary Aide (DA2) was not heard communicating the fortified diet orders written on the resident tray cards (a printed sheet that includes resident diet order, preferences for food and dislikes) during tray line for lunch service. A review of tray cards on the meal carts indicated orders for fortified diet. However, DA2 did not read out loud the fortified diet and cook 2 and cook 3 did not add any additional food items. During a review of the facility lunch menu for regular and CCHO diets dated 7/20/2026, the menu indicated the following items were to be served: Salisbury Steak and gravy 4 ounces (oz); Grilled onions; Diced fried potatoes 1/2 cup; corn with green peppers 1/2 cup; fresh green salad and dressing, ice cream and milk 1/2 cup. During an observation of the lunch service on 7/20/2026, at 12:00PM, observed both regular and CCHO diets received 1/2 cup of diced fried potatoes and 1/2 cup of corn with peppers. During a review of the facility's Cooks spreadsheet for 7/20/2026 (food portioning and serving guide), the spreadsheet indicated CCHO were to receive scoop size #16 (1/4 cup) and 1/4 cup of corn with green peppers instead of 1/2 cup. During the same observation of the tray line service for lunch on 7/20/2026, at 12:00PM, DA2 was not heard communicating CCHO diets to the cooks (cook 1 and cook 3). During a concurrent interview with DS, DA2 and cooks (cook 1 and cook 3) on 7/20/2026, at 1:00PM, DA2 stated the fortified and CCHO diets were not communicated to the cooks. Cook3 stated trays requiring CCHO diet received more potato and corn than indicated on the menu. Cook3 stated that fortified diets were for residents who were losing weight. Cook3 stated no melted margarine was added to the food during lunch tray preparation on 7/20/2026 because Cook3 did not receive the communication from DA2. During an interview with DS on 7/20/2026 at 1:30PM, DS stated at least two food items needed to be fortified, such as melted margarine on starch or vegetables and gravy on meats. DS said it was important for residents on fortified diets to receive extra calories to prevent weight loss. DS stated residents on the CCHO diet received more starches and that could affect blood sugar levels. During a review of facility policy titled, Fortified Diet (dated 2025) the policy indicated, the fortified diet is designed for residents who cannot consume adequate amounts of calories and or protein to maintain their weight or nutritional status. The goal is to increase the calorie density of foods commonly consumed by the residents. Examples of adding calories may include Extra margarine or butter to (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food items such as vegetables, potatoes etc. During a review of facility policy titled Controlled Carbohydrate Diet (CCHO) (dated 2025) the policy indicated, A controlled carbohydrate diet, (CCHO) is a meal plan without specific, calorie levels typically used for diabetic residents and those with other metabolic concerns. Instead of counting calories, the carbohydrates are evenly systematically and consistently distributed through three meals and snacks in an effort to maintain a stable blood sugar levels throughout the day. 2.During an observation in the kitchen on 7/20/2026 at 12:00PM, cook1 served steamed white rice and soft tofu cut into small pieces. The rice looked sticky and not moist. During a concurrent observation and interview with cook1 and cook2 and dietary supervisor (DS) on 7/20/2026 at 1:00PM, cook2 stated they did not prepare minced and moist rice. Cook2 stated the cooks should have added gravy to the rice to make it moist for the minced and moist diet. Cook3 stated the rice was not moist and needed broth or gravy to make the rice moist. DS agreed that the rice was not moist and not appropriate for the minced and moist diet. Cook1 and cook2 stated it was bad to serve steamed sticky rice because it could cause choking in residents who needed moist food. During an interview with Registered Dietitian RD on 7/21/2026 at 12:15PM, RD stated minced and moist rice needed to be soft and moist with gravy and not sticky. RD stated it was important to make sure textures were prepared correctly to prevent choking in resident. During a review of the facility's recipe titled Classic Rice (dated 2025) the recipe indicated, IDDSI #5 Minced and Moist: soft, measure desired number of servings into a food processor. Mince until food is in pieces =4mm by 15mm. Moisten with gravy/sauce at appropriate thickness. During a review of facility policy and procedures (P&P) titled, Menu Planning (dated 2023), the p & p indicated, The menus are planned to meet nutritional needs of residents in accordance with established national guidelines.Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 5 Minced and Moist was usually eaten with a spoon or fork, for people who could not bite off pieces of food safely but had some basic chewing ability. The guidelines indicated it was important that food was not sticky and could be scooped with a fork, with no liquid dripping and no crumbs falling off the fork. The guidelines indicated the size of the food was to be 4mm, which was about the gap between the prongs of a standard dinner fork. The guidelines indicated the food testing method: Spoon tilt test and Fork drip test.		

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NAME OF PROVIDER OR SUPPLIER Grand Park Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2312 West 8th Street Los Angeles, CA 90057	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when: 1.One Dishwasher (DW) working in the dish machine area did not wash hands and change gloves when removing the clean and sanitized dishes from the dish machine and after touching soiled dishes and trash. 2.The ice machine was not maintained in a sanitary manner; the inner plastic board inside the ice storage bin had yellow stains and residue. 3.Food brought to residents from outside of the facility, including leftovers, were stored in the resident food refrigerator with no date and not monitored for the expiration date. There was no monitoring system for the refrigerator temperatures. There were two cups of ice cream that were melted and stored in the resident refrigerator. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness (infectious organisms or their toxins are the most common cause of food poisoning symptoms may include cramping, nausea, vomiting, or diarrhea) for 128 out of 138 residents who received food from the facility and including residents who had food stored in the resident refrigerator. Findings:During an observation in the kitchen on 7/20/2026 at 9:30AM, the Dishwasher (DW) was observed rinsing soiled dishes and loading the dirty dishes in the dish machine. The DW had gloves on hands, and when the dish machine stopped, the DW replaced gloves (donned new gloves) and removed the clean and sanitized dishes without washing hands. During the same observation in the dishwashing area on 7/20/2026 at 9:30AM, the DW was observed with gloves on hands removing the garbage bag then leaving through the kitchen back door to the main trash dumpster area. The DW then opened the lid of the dumpster bin and threw away the trash bag. The DW then returned to the kitchen, replaced gloves without washing hands and proceeded to remove the clean and sanitized dishes from the dish machine. During a concurrent observation and interview with the DW and Dietary Supervisor (DS) on 7/20/2026 at 9:35AM, the DW stated kitchen staff only changed the gloves and did not wash hands in the handwashing sink after touching soiled dishes and after returning from the trash outside of the kitchen. The DW stated facility staff should wash hands before replacing gloves to prevent bacteria from touching clean areas, sanitized dishes and clean gloves. The DS stated gloves should not replace hand washing and staff should always wash hands before and after different tasks in the kitchen. During a review of the facility's policy and procedures (P&P) titled Hand Washing Procedure (dated 2023) the P&P indicated handwashing is important to prevent the spread of infection. When hands need to be washed: After handling soiled dishes and utensils; Before and after doing housekeeping procedures, touching trash can or lid. A review of the 2022 U.S. Food and Drug Administration Food Code, Code 2-301.14 When to Wash. Indicated, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and E) After handling soiled EQUIPMENT or UTENSILS. (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.(G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD.(H) Before donning gloves to initiate a task that involves working with FOOD. 2. During an observation of the facility ice machine located in the small dining room on 7/20/2026 at 10:00AM, a clean paper towel was used to swipe the ice storage bin ceiling and plastic board inside the bin. Small amounts of yellow residue were transferred on to the paper towel. The residue was located under the plastic (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	baffle (an ice machine baffle or ice deflector is an internal panel or partition that directs the flow of ice as it falls from the evaporator into the storage bin or dispenser. It prevents ice from jamming the machine, guides it evenly into the bin, and stops cubes from spilling out of the front panel.) During a concurrent observation and interview with the DS on 7/20/2026 at 10:30AM, the DS stated an outside vendor cleaned the ice machine once a month and it was due for cleaning for that month (July). The DS verified there was yellow residue produced on the paper towel when the under the plastic board was swiped. The DS stated the ice machine was not clean and the residue could contaminate the ice. The DS stated the ice inside the machine would not be used for residents or staff consumption. The DS was observed putting a sign on the ice machine indicating the machine was out of order. During an interview with the Maintenance Supervisor (MS) on 7/20/2026 at 10:45AM, the MS stated the ice machine cleaning was due for the month of July and the vendor had been contacted to come in that day (7/20/2026). The MS stated ice machines should always be clean to not contaminate the ice and make people sick. During a review of facility's policy and procedure (P&P) titled Ice Machine Cleaning Procedures (Dated 2023) the P&P indicated, The ice machine needs to be cleaned and sanitized monthly. Be sure special attention is paid to cleaning the door molding and the lid of the machine. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Equipment Food-Contact Surfaces and Utensils code 4-602.11, the code indicated, (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of UTENSILS and EQUIPMENT contacting FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cleaned: (4) In EQUIPMENT such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. 3. During a concurrent observation and interview in the nurses' station 1, with LVN2 on 7/20/2026 at 9:45AM, LVN 2 stated resident food brought in from outside was checked by nursing staff for accuracy of diet, then the leftovers were dated, labeled, and stored in the refrigerator located in the dining room. During a concurrent interview with the Assistant DON (ADON) on 7/20/2026 at 9:50AM, the ADON stated the refrigerator for resident food brought in from outside was in the dining room. The ADON stated food had to be labeled, dated, and stored for 48 hours then discarded. The ADON stated it was important for staff to label and date to know when to discard. During an observation in the resident refrigerator located in the small dining room on 7/20/2026 at 9:55AM, four plastic bags with resident leftover food with only resident room number on the bag were observed with no date. Two ice cream containers labeled with resident room numbers were observed melted and stored in the refrigerator. There was no refrigerator temperature log. The refrigerator had no lock and could be accessed by anyone who was in the dining room. During a concurrent observation and interview with CNA 7 on 7/20/2026 at 9:55AM, CNA 7 who was removing food from the resident refrigerator located in the dining room. CNA 7 stated staff also store food in this refrigerator; this refrigerator is not only for residents' food from outside. During an interview with the DON on 7/21/2026 at 9:30AM, the DON stated that resident food brought in from outside was stored in the refrigerator in the dining room. The DON stated the facility did not have a dedicated refrigerator only for residents. The DON stated the dining room was used as a conference room and lounge for staff. The DON stated residents' food was stored in the refrigerator in the dining room for only 48 hours. The DON stated it was important to label and date the food to be discarded by the use by date and prevent food borne illness in residents who had food stored in the refrigerator. The DON stated nurses were expected to monitor the temperature of the refrigerator and monitor for (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired food to discard. The DON did not know where the temperature monitoring log was and was not able to locate the log. The DON agreed that the resident refrigerator needed to be in a secure area where it was only accessible to nursing staff to prevent contamination of food and risk taking the wrong food and diet for residents. During a review of facilities' policy and procedures (P&P) titled, Food for Residents from outside sources (dated 2018) the P&P indicated, Food brought in from outside the facility kitchen for resident's consumption will be monitored. If opened the food must be sealed, dated to the date opened and disposed of in 2 days after opening.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure trash stored in two of five garbage dumpsters areas was maintained in sanitary manner, the dumpsters were, clean, completely closed, and not overfilled with trash. This failure had the potential to result in pests (organisms that cause harm to humans such as flies, cockroaches, and rodents) entering the facility and spreading diseases to residents. Findings: During a concurrent observation and interview with the Dietary Supervisor (DS) on 7/20/2026 at 8:35 AM, one large dumpster for food and organics was located outside of kitchen back door and was not covered. The dumpster was overfilled with food trash and not covered. There were flies on the trash bags inside the dumpster and around the bin. There was trash on the grounds around the dumpster including disposable gloves and paper. During the same observation in the trash area another trash bin was overfilled and not covered. During a concurrent interview with the DS on 7/20/2026 at 8:35AM, the DS stated the dumpster lids should have been covered and there should not have been trash on the floor. The DS stated the area didn't look clean and there were flies everywhere. The DS was observed using a stick to flip the large dumpsters bins lids shut. The DS stated a dietary staff was assigned to clean the trash area every day to prevent flies from getting in the area and the kitchen. During a review of facility policy and procedures (P&P) titled Sanitation and Infection Control the P&P indicated, Keep lids of outside trash dumpsters closed. A review of Food and Drug Administration (FDA) Food Code 2022 dated 1/18/2023, code number 5-501.113 titled Covering receptacles, indicated: receptacles and waste handling units for refuse, recyclables, and returnable were to be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable indicated refuse, recyclables, and returnable were to be stored in receptacles or waste handling units so that they were inaccessible to insects and rodents.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to respect the residents' rights to dignity (the right to be valued and treated as a worthwhile human being) and privacy (is the right to keep your physical body covered and protected from unwanted viewing) for two of six sampled residents (Resident 4 and Residents 11) by failing to ensure to: - Provide Resident 4's privacy curtain and drape during a G-Tube (gastrostomy tube-is a soft, flexible feeding tube inserted directly through the skin of the belly into the stomach) bolus administration (feeding procedure of giving a measured meal of liquid formula into a stomach feeding tube all at once, usually using a large syringe driven by gravity or a gentle push) procedure. - Provide Resident 11 with a foley catheter (a hollow tube inserted into the bladder to drain or collect urine) privacy bag cover (a fabric pouch or sleeve that hides a medical urine collection bag). These failures have the potential to cause Resident 4 and Resident 11 embarrassment (a painful, self-conscious feeling that happens when private information, actions, or body parts are accidentally exposed to other people), emotional distress (a state of deep mental suffering, intense stress, or emotional pain), low self-esteem (how much a person values, respects and likes themselves), and loss of dignity and psychosocial wellbeing (how a person feels inside their mind and how well they interact with the people and world around them). Findings: a. During a review of Resident 4's admission Record, the admission record indicated the facility originally admitted Resident 4 on 10/12/2022 and was readmitted on [DATE] with diagnoses including but not limited to schizophrenia (a mental illness that is characterized by disturbances in thought), adult failure to thrive (a state of gradual physical, cognitive, and social decline in older adults.) and essential hypertension (HTN-high blood pressure). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 6/11/2026, the MDS indicated Resident 4 rarely understood others with severely impaired cognitive (not able to independently make decisions regarding tasks of daily life) functioning. During a review of Resident 4's History and Physical (H&P) dated 6/23/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Progress Report dated 7/22/2026 at 14:55 PM, the Progress Report indicated that Resident 4's bolus tube feed order was changed to five times a day. During a concurrent observation and interview on 7/22/2026 at 3:58 PM with Licensed Vocational Nurse 8 (LVN 8), the administration of a G-tube bolus feeding of Glucerna 1.5 (a premeasured, high calorie nutritional formula administered directly through a feeding tube) was observed. Observed LVN 8 wearing a gown, mask and gloves, holding a carton of Glucerna 1.5 and an enteral syringe (a large, needless medical device used to deliver liquid, formula, water, or medication through a feeding tube). During the procedure, the privacy curtain was open from Resident 4's foot of the bed exposing Resident 4's abdomen and incontinence (is the involuntary loss or leakage of urine or feces) brief (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(adult disposable underwear) when LVN 8 accessed the residence G-tube and administered the G-tube bolus. Observed, the Assistant Director of Nursing (ADON) entered Resident 4's room and closed the privacy curtain all the way. LVN 8 stated that privacy curtain was not provided before the procedure to ensure Resident 4's privacy. During an interview on 7/23/2026 at 8:24 AM with Registered Nurse (RN 1), RN 1 stated privacy needed to be provided before starting any procedure. RN 1 stated that privacy was important to maintain residents' (in general) dignity and respect for their bodies. During a concurrent interview and record review on 7/23/2026 at 10:10 AM with the ADON, the facility's policy & procedure (P&P) titled Resident Dignity and Personal Privacy was reviewed. The ADON stated that providing privacy to Resident 4 for any procedure was treating residents with respect. The ADON stated LVN 8 should have closed the privacy curtain all the way to prevent embarrassment to Resident 4. The ADON stated LVN 8 did not follow the P&P on dignity and privacy for Resident 4's G-tube bolus procedure. During a concurrent interview and record review on 7/23/2026 at 10:42 AM with the Director of Nursing (DON), the facility's P&P titled Resident Dignity and Personal Privacy was reviewed. The DON stated that the policy requires the use of privacy curtain during treatments or procedures. The DON stated that the administration of G-tube bolus was considered a procedure. The DON stated maintaining privacy was not exposing areas of the resident's body more than necessary during care. The DON stated the facility failed to provide privacy to Resident 4 and had the potential to cause Resident 4 to feel embarrassed and violated. During a review of the facility's Resident Dignity and Personal Privacy policy and procedure (P&P) dated 1/23/2026, the P&P indicated the use of a closed door, a drawn curtain, or both, to shield the resident during all personal care and treatment procedures. The P&P indicated to drape and dress residents appropriately to avoid exposure and embarrassment. The P&P indicated the facility provides care for residents in a manner that respects and enhances each resident's dignity, individuality, and right to personal privacy. During a review of the facility's Resident Rights policy and procedure (P&P) dated 1/23/2026, the P&P indicated employees should treat all residents with kindness respect and dignity. The P&P indicated Federal and State laws guarantee certain basic rights to all residents of the facility the rights included the right to dignified existence and the right for privacy and confidentiality. b. During a review of Resident 11's admission Record (a single-page summary document containing a resident's personal, medical, and insurance information), the admission Record indicated the facility originally admitted Resident 11 on 3/9/2026 and readmitted Resident 11 on 6/21/2026 with diagnoses that included type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), functional quadriplegia (a complete inability to move all four limbs and care for oneself, not because of a broken neck or spinal cord injury, but due to severe physical frailty, advanced illness, or the slow loss of brain power, affecting memory, focus, and problem-solving), muscle weakness, urinary tract infection (UTI- an infection in the bladder/urinary tract), acute pyelonephritis (a sudden and severe bacterial infection of one or both kidneys), cystitis, (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unspecified without hematuria (a standard bladder infection or irritation causing pain and the need to go often, but with no blood in the urine (pee) and no specific exact cause named), end stage renal disease (ESRD - irreversible kidney failure) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 11's H&P dated 6/22/2026, the H&P indicated Resident 11 had a foley catheter (a flexible plastic tube placed inside the bladder to drain urine) in place and was currently receiving hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). The H&P indicated Resident 11 could not make his (Resident 11) needs known and could not make medical decisions. During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 had the ability to make himself (Resident 11) understood and usually had the ability to understand others. The MDS indicated Resident 11 was dependent (helper does all of the effort) for toileting hygiene (ability to clean private parts and bottom) and for showering/bathing. During a review of Resident 11's Health Status Note, dated 7/6/2026 at 10:30 PM, the Health Status Note indicated Resident 11 was able to make his needs known. During a review of Resident 11's Physician Progress Note (medical documents that update a patient's health status and response to treatment during a clinical encounter), dated 7/19/2026 at 11:28 PM, the Physician Progress Note indicated Resident 11 was still producing light yellow color urine. During a review of Resident 11's Health Status Note (a simple written record from a nurse that explains how you feel or what they found), dated 7/21/2026 at 12:50 PM, the Health Status Note indicated Resident 11 was alert and oriented x3 (a person is awake, clear-headed, and aware of three basic facts: who they are, where they are, and what time it is). During a review of Resident 11's Order Summary Report (an active master list of all current medical instructions for a patient, detailing medications, treatments, and therapies ordered by healthcare provider), dated 7/23/2026, the Order Summary Report indicated a physician order for a foley catheter 16 fr. (16 French &ndash; a standard size catheter) for urinary retention (you cannot fully empty your bladder) for BPH (benign prostatic hyperplasia, which is a non-cancerous enlarged prostate [a walnut-sized gland found only in people assigned male at birth that sits right below the bladder and surrounds the tube that carries pee out of the body] that happens to most men as they grow older). During a concurrent observation and interview on 7/20/2026 11:22 AM with in Resident 11's room Licensed Vocational Nurse 1 (LVN 1) who was assigned as the treatment nurse, Resident 11's foley catheter bag was observed to not have a privacy cover (a fabric pouch or sleeve that hides a medical urine collection bag). LVN 1 was observed bringing a privacy bag cover to Resident 11's room. LVN 1 stated the facility needed to provide Resident 11 with a foley catheter bag privacy cover to protect Resident 11's privacy. During an interview on 7/20/2026 at 12:02 PM with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated he did not check if Resident 11 had a privacy cover for Resident 11's foley catheter bag when (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 7 came back to the facility after having a procedure (unknown) done outside of the facility on the morning of 7/20/2026. During an interview on 7/20/2026 at 12:09 PM with Registered Nurse 3 (RN 3), RN 3 stated Resident 11 needed to have a privacy cover on Resident 11's foley catheter bag to protect resident 11's dignity (basic right of a person to be valued, treated with respect, and feel a deep sense of self-worth). RN 3 stated Resident 11's dignity could be affected since Resident 3 was awake and oriented. During a concurrent interview and record review on 7/23/2026 at 12:25 PM with the Director of Nursing, the facility's policy and procedure (P&P), titled Resident Dignity & Personal Privacy, dated 4/2025, the P&P indicated the facility would provide care for residents (in general) in a manner (way) that respects and enhances each resident's dignity, individuality, and right to personal privacy. The DON stated the facility did not follow their P&P when the facility failed to use a privacy cover for Resident 11's foley catheter bag.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 lights (devices that alert healthcare providers that residents need assistance) were within reach for two of 27 sampled residents (Residents 65 and Resident149) by failing to:-Ensure Resident 65 call light was not hanging over the head of the bed and Resident 149's call light was not on the floor.This failure placed Resident 65 and Resident 149 at risk for delayed assistance.Findings:During a review of Resident 65's admission Record, the admission Record indicated the facility originally admitted Resident 65 on 1/19/2018 and re-admitted the resident on 6/26/2026 with diagnoses including heart failure (heart is not pumping blood as well as it should), diabetes mellitus 2 (DM 2-a medical condition characterized by the body's inability to regulate blood sugar levels), respiratory failure (lungs can't get enough oxygen into your blood or remove enough carbon dioxide), hypertension (HTN-the force of blood flowing through the blood vessels is consistently too high), dementia (loss of memory and other mental abilities severe enough to interfere with daily life), and the need for assistance with personal care. During a review of Resident 65's History & Physical (H&P) dated 6/30/2026, H&P indicated Resident 65 did not have the capacity to understand and make decisions. During a review of Resident 65's Minimum Data Sheet (MDS-a resident assessment tool) dated 6/30/2026, the MDS indicated Resident 65 was frequently incontinent (is the involuntary loss or leakage of urine or feces) of bladder and bowel, used a wheelchair (W/C) and needed assistance/dependent with activities of daily living (ADLs, are the basic tasks that individuals perform every day to care for themselves and maintain their well-being). During an observation on 7/20/2026 at 1:03 PM in Resident 65's room, Resident 65's call light was hanging over the head of bed. During an interview on 7/20/2026 at 1:07 PM with Certified Nurse Assistant 4 (CNA 4), CNA 4 stated the call light was hanging over the head of the bed and was not within Resident 65's reach. CNA 4 stated the call light must be on the side of the resident so the resident could reach it. During an interview on 7/23/2026 at 8:54 AM with CNA 4, CNA 4 stated when she (CNA4) saw the call light hanging over the head of the bed, she (CNA4) put the call light back in a position so Resident 65 could access it. CNA 4 stated if Resident 65 could not ask for help because the call light was not within her reach, it would be difficult for Resident 65 to call for help especially in an emergency. During a review of Resident 65's Care Plan Report dated 7/23/2026, the Care Plan Report indicated Resident 65 was at risk for falls and the nursing intervention was to maintain the call light within reach and answer promptly. During an interview on 07/20/2026 at 1:13 PM with Resident 65, Resident 65 stated she (Resident 65) knew what a call light was and that if she (Resident) needed help, she (Resident 65) would press it (call light). Resident 65 stated the call light must be near her (Resident 65) left hand within reach. Resident 65 stated that it was hard to reach the call light when it was over the head of the bed. During a review of Resident 149's admission Record, the admission Record indicated the facility admitted Resident 149 was admitted on [DATE] and readmitted Resident 149 on 7/19/2026 with diagnoses including hypo-osmolality (blood is too diluted) and hyponatremia (blood sodium level is too low), pain in right hip, atrial fibrillation (heart beats fast and irregularly), hyperlipidemia (too much fat in the blood), HTN, DM 2, overactive bladder, abnormalities of gait and mobility, muscle weakness, and the need for assistance with personal care. During a review of Resident 149's H&P dated 5/10/2026, the H&P indicated Resident 149 had the capacity to understand and make decisions. During a review of Resident 149's MDS dated [DATE], the MDS indicated Resident 149 needed assistance/dependent on staff with ADLs. During an observation on 7/20/2026 at 10:51 AM inside Resident 149's room, Resident 149 was sitting on the (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed and her call light was on the floor. During concurrent observation and interview on 7/20/2026 at 10:59 AM with CNA 2, CNA 2 picked up Resident 149's call light from the floor and placed the call light on Resident 149's bed within Resident 149's reach. CNA 2 stated Resident 149's call light was not supposed to be on the floor. During an interview on 7/20/2026 at 11:03 AM with CNA 3, CNA 3 stated Resident 149 would not be able to reach the call light and would not be able to call for help because the call light was on the floor. During an interview on 7/23/29026 at 8:40 AM with Resident 149, Resident 149 stated she (Resident 149) knew what a call light was, and she (Resident 149) would use the call light to when she (Resident 149) needed something from the nurses. Resident 149 stated the nurses (in general) would come to see what she (Resident 149) needed. Resident 149 stated she (Resident 149) would get upset if the call light was not within her reach. Resident 149 stated she (Resident 149) could not reach the call light if it was on the floor. Resident 149 stated the call light needed to be with her reach. During an interview on 7/23/2026 8 AM with the Social Services Director (SSD), the SSD stated some residents (unidentified) were not able to lift their arms to reach the call light or pick up the call light from the floor. The SSD stated when a call light was not within reach, it would affect the residents' (in general) ability to call for help. The SSD stated the call lights needed to be within the resident's reach. During an interview on 7/23/2026 at 8:18 AM with the Director of Nursing (DON), the DON stated the purpose of call lights was to notify the staff (in general) if the residents (in general) needed assistance and that staff (in general) were aware to respond to call lights timely. During a review of the facility's Policy & Procedure (P&P) titled Call Light, revised 5/2023, the P&P indicated when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. The P&P indicated to answer the resident's call as soon as possible.		

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview and record review, the facility failed to conduct a background check during the pre-employment screening for one of one sampled staff (the Administrator [ADM]). This failure had the potential to place residents (in general) at risk for abuse. Findings: During a concurrent interview and record review on 7/22/2026 at 2:01 PM with the Director of Nursing (DON), the ADM's employee file was reviewed. The DON stated the ADM's date of hire was 4/2/2012. The DON stated there was no evidence of a background check before the ADM began working in the facility. The DON stated all staff (in general) were required to complete a background check-up on hire. During an interview on 7/23/2026 at 9:30 PM with the DON, the DON stated the Director of Staff Development (DSD) was responsible for initiating background checks for all employees during the pre-employment screening. The DON stated the DSD was not available for interview due to a family emergency. The DON stated a background check was completed for the ADM in December 2017, after the facility discovered the discrepancy. The DON stated the importance of background checks upon hire for the safety of residents and staff. The DON stated background checks screen for violent history, substance abuse, and record of abuse to others; all of which could exclude staff from safely providing care to residents. During a review of the ADM's Background Report, completed 12/14/2017, the Background Report indicated no red flags or disqualifying records. During a review of the facility's policy and procedure (P&P) titled, Background Screening Investigations, last reviewed January 2026, the P&P indicated background and criminal checks are initiated within two days of an offer of employment and completed prior to employment. During a review of the facility's P&P titled, Abuse Prevention Program, last reviewed January 2026, the P&P indicated as part of resident abuse prevention, the facility will conduct employee background checks.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was transmitted to the Centers for Medicare and Medicaid Services (CMS, a federal health insurance program) for one of three sampled residents (Resident 109) when Resident 109 was discharged from the facility on 2/9/2026. This failure had the potential to result in delayed discharge care for Resident 109. Findings: During a review of Resident 109's admission Record, the admission Record indicated the facility admitted the resident on 9/12/2025 with diagnoses that included metabolic encephalopathy (a brain malfunction caused by a systemic medical problem, chemical imbalance, or organ failure in the body), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), dementia (a progressive state of decline in mental ability), chronic kidney disease (a long-term condition where the kidneys are damaged and cannot filter blood well), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality). During a review of Resident 109's Discharge Return Not Anticipated MDS dated [DATE], the Discharge Return Not Anticipated MDS indicated Resident 109 had severe cognitive impairment (a major loss of intellectual and mental capacity that makes it impossible to live independently, requiring constant supervision and help with daily tasks). The Discharge Return Not Anticipated MDS indicated Resident 109 was discharged home from the facility on 2/9/2026. During a concurrent interview and record review on 7/23/2026 at 11:37 AM with the MDS Coordinator (MDSC), Resident 109's Discharge Return Not Anticipated MDS dated [DATE] was reviewed. The MDSC stated Resident 109 was discharged home from the facility on 2/9/2026. The MDSC stated Resident 109's Discharge Return Not Anticipated MDS was completed on 2/13/2026. The MDSC stated Resident 109's Discharge Return Not Anticipated MDS was submitted to CMS on 7/23/2026. The MDSC stated Resident 109's Discharge Return Not Anticipated MDS should have been submitted to CMS earlier (within 14 days after the discharge). The MDSC stated Resident 109's Discharge Return Not Anticipated MDS assessment should have been submitted according to the guidelines of the RAI Manual (an official guide provided by CMS that details how to assess nursing home residents, use the MDS, and plan care). During a concurrent interview and record review on 7/23/2026 at 12:31 PM with the Director of Nursing (DON), Resident 109's Discharge Return Not Anticipated MDS dated [DATE] was reviewed. The DON stated Resident 109's Discharge Return Not Anticipated MDS dated [DATE] was submitted to CMS on 7/23/2026. The DON stated Resident 109's Discharge Return Not Anticipated MDS should have been submitted to CMS within 14 days of the completion date. The DON stated submission of Resident 109's Discharge Return Not Anticipated MDS on 7/23/2026 was too late. The DON stated it was important to submit MDS assessments timely to ensure that the facility was meeting required guidelines. During a review of CMS's Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2025, the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual indicated 09. Discharge Assessment-Return Not Anticipated (A0310F = 10) Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). During a review of the facility's Policy and Procedure (P&P) titled MDS Completion and Submission (continued on next page)		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timeframes reviewed 1/23/2026, the P&P indicated Our facility will conduct and submit resident assessments in accordance with current federal and states submission timeframes. The assessment coordinator or designee is responsible for ensuring resident assessments are submitted to CMS' Internet Quality Improvement Evaluation System (IQIES) in accordance with federal and state guidelines. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person- centered baseline care plan for one of five sampled residents (Resident 15) reviewed for smoking upon admission by failing to: -Ensure to address Resident 15's smoking status, smoking related needs and individualized interventions to ensure Resident 15's safety. This failure had the potential for Resident 15 not to receive the necessary smoking -related safety care and needs. Findings: During a review of Resident 15's admission Record, the admission record indicated the facility originally admitted Resident 15 on 8/18/2023 and was readmitted on [DATE] with diagnoses including but not limited to schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) unspecified, and essential hypertension (HTN-high blood pressure). During a review of Resident 15's Nursing Risk Evaluation dated 6/24/2026, the Nursing Risk Evaluation indicated that Resident 15 was a smoker. During a review of Resident 15's Minimum Data Sheet (MDS-a resident assessment tool) dated 6/28/2026, the MDS indicated Resident 15 had the ability to understand others and was cognitively intact (able to independently make decisions regarding tasks of daily life). The MDS indicated Resident 15 was a tobacco user. During a review of Resident 15's Activities Initial Interview dated 6/29/2026, the Activities Initial Interview indicated Resident 15 enjoyed smoking out in the facility's patio. During a review of Resident 15's History and Physical (H&P) dated 6/30/2026, the H&P indicated Resident 15 had fluctuating capacity to understand and make decisions. During a concurrent interview and record review on 7/21/2026 at 8:44 AM with Assistant Director of Nursing (ADON), Resident 15's medical record was reviewed. The ADON Stated that resident's (general) care plan was created by the licensed nurses (in general) within 48 hours of admission. The ADON stated that the care plan needed to be specific for each resident. The ADON stated Resident 15 did not have a care plan for smoking. The ADON stated Resident 15 needed to have a person-centered care plan on smoking that included interventions on safety and supervision. The ADON stated the facility did not develop and implement Resident 15's care plan specific to Resident' 15 active smoking status. During an interview on 7/22/2026 8:01AM with Resident 15 at the facility's smoking patio, Resident 15 stated smoking was part of his daily routine. During an interview and a record review on 7/22/2026 at 8:11 AM with the Activities Director (AD), Resident 15's medical record was reviewed. The AD stated that Resident 15 did not have a person-centered care plan addressed to smoking. The AD stated it was important for a care plan to be developed to address the risk of burn, ensure compliance with facility regulations, and prevention of smoking- related injuries. The AD stated that a care plan needed to be in place specific to Resident 15's smoking because smoking was a part of Resident 15's daily life and routine. During an interview and a record review on 7/22/2026 at 12:05 PM with the Director of Nursing (DON), Resident 15's medical record was reviewed. The DON stated a care plan (in general) was developed upon admission for residents (general) at the facility. The DON stated Resident 15's medical record did not include a care plan specific to Resident 15's smoking upon readmission on [DATE]. The DON stated smoking care plan interventions were developed based on residents' (general) Smoking Safety Evaluation. The DON stated that the facility did not develop a care plan addressing Resident 15's smoking upon admission. During a review of the facility's Care Plan Comprehensive policy and procedure (P&P) dated 1/23/2026, the P&P indicated an individualized Comprehensive Care Plan that includes measurable (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The P&P indicated each resident's Comprehensive Care Plan has been designed to incorporate risk factors associated with identified problems and identify the professional services that are responsible for each element of care. The P&P indicated resident's Comprehensive Care Plan is developed within seven days of the completion of the resident's comprehensive assessment (MDS). During a review of the facility's Activity Programs P&P dated 1/23/2026, the P&P indicated activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. The P&P indicated activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a resident specific comprehensive care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) for two of 27 sampled residents (Resident 10 and Resident 14) reviewed for care plans by failing to: -Ensure to implement and revise Resident 10's smoking care plan to prevent smoking accidents. -Ensure to develop a specific individualized care plan for Resident 14 who had a diagnosis of dementia (a progressive state of decline in mental abilities) and was at a high risk of falling. These failures resulted for Resident 10 to sustain a cigarette burn to her right hand and had the potential for Resident 14 to fall and sustain an injury and/or fracture (broken bones). Findings: a. During a review of Resident 10's admission Record (a single-page summary document containing a resident's personal, medical, and insurance information), the admission Record indicated the facility originally admitted Resident 10 on 6/16/2026 and readmitted Resident 16 on 6/23/2026 with diagnoses that included need for assistance with personal care (requiring hands-on help with basic daily routines like bathing, dressing, and eating because of age, illness, or disability), anxiety disorder (a mental health condition involving excessive fear, persistent worry, and intense nervousness that does not go away and disrupts daily life), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), pain in right wrist, rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), muscle weakness, and neuralgia and neuritis unspecified (unexplained nerve pain or unspecified nerve inflammation somewhere in the body). During a review of Resident 10's Assessment Scoring Report dated 6/16/2026, the Assessment Scoring Report indicated Resident 10 required supervised (monitored) smoking. During a review of Resident 10's History and Physical (H&P - complete written record of a patient's medical background, current symptoms, and physical exam finding written by a healthcare provider such as a doctor, physician assistant, or nurse practitioner), dated 6/25/2026, the H&P indicated Resident 10 had a history of tobacco use (consuming products made from the dried leaves of the tobacco plant such as cigarettes, cigars, pipes or chewable products). During a review of Resident 10's Minimum Data Set (MDS &ndash; a resident assessment tool) dated 6/27/2026, the MDS indicated Resident 10 had the ability to make herself (Resident 10) understood and had the ability to understand others. During a review of Resident 10's Psychiatric Progress Note (a healthcare written record of a patient's mental health visit, covering symptoms, observations, and future plans), dated 7/1/2026, the Psychiatric Progress Note indicated Resident 10 had fair (reasonable) insight (self-awareness and ability to recognize problems) and judgement (decision-making and ability to choose safe, sensible actions). (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 10's SBAR (Situation, Background, Assessment, and Recommendation used to share important information clearly and quickly) Communication and progress note, dated 7/14/2026 at 1 PM, the SBAR indicated Resident 10 had capacity (a patient's ability to understand, think through, and make a specific healthcare choice) and was on the facility's list of smokers. The SBAR indicated Resident 10 had a change in skin condition (any noticeable shift in how your skin looks or feels). The SBAR indicated Resident 10 had a burn on the right first knuckle (Resident 10's knuckle on her right index finger). The SBAR indicated Resident 10 accidentally burned her right first knuckle while smoking a cigarette at night. The SBAR indicated the facility's Director of Nursing (DON) and Administrator (ADM) were notified of Resident 10's cigarette burn. The SBAR indicated Resident 10 was self-responsible (a resident who is legally, mentally, and physically independent enough to make their own personal, medical, and financial decisions). During a review of Resident 10's Order Summary Report (an active master list of all current medical instructions for a patient, detailing medications, treatments, and therapies ordered by healthcare provider) dated 7/22/2026, the Order Summary Report indicated a physician order to apply Betadine Swabsticks External Swab 10% (Povidone-Iodine - single-use sticks with a cotton tip soaked in a brown liquid medicine used to clean the skin and kill germs) to right first knuckle topically (directly on the outside of your body such as on the skin) every day for accidental burn caused by smoking for 30 days cleans with normal saline (a safe mix of water and salt that matches the natural salt levels in human blood and tears), pat dry, paint with betadine, and cover with dry dressing (placing a clean, unmoistened piece of material like a gauze pad or bandage/ Band-Aid directly on a wound). During a review of Resident 10's Care Plan Report dated 6/16/2026, the Care Plan Report indicated a goal for Resident 10 to be free from smoking related injury and would comply (obey, follow, or do what is asked) with the facility's smoking policy. The Care Plan Report indicated an intervention (any direct action a nurse takes to help a patient get better, stay comfortable, or avoid future health problems) for the facility to store Resident 10's smoking materials. The Care Plan Report indicated Resident 10 had a care plan focus, dated 7/14/2026, for impaired skin integrity (skin breakdown, a cut or wound, or damage to the outer layers of the skin). During a concurrent observation and interview on 7/20/2026 at 12:19 PM with Resident 10, in facility's designated smoking patio, Resident 10 peeled back the Band-Aid covering the first knuckle on her right index finger and Resident 10's wound was observed. Resident 10 stated she (Resident 10) burned her (Resident 10) right hand a few nights ago. Resident 10 stated she (Resident 10) could not specify the exact date. Resident 10 stated on the night she (Resident 10) burned her hand, there were no lights in the designated smoking patio. Resident 10 stated she (Resident 10) had previously told the DON (unidentified date) it was too dark in the smoking patio at night. During an interview on 7/20/2026 at 12:35 PM with the Activities Director (AD) and the Assistant Director of Nursing (ADON), the AD stated she (AD) had tried to offer Resident 10 a smoking apron (a fire-resistant cover worn over the chest and lap) in the past. The AD stated she (AD) created a care plan for Resident 10's noncompliance (breaking a rule or failing to follow instructions) with using a smoking apron. The AD stated she (AD) did not document each time Resident 10 refused to use a smoking apron. The ADON verified and stated the facility did not document each time Resident 10 refused to use a smoking apron. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/20/2026 at 12:35 PM, with the AD and ADON, the facility's smoking log dated 7/20/2026 was reviewed. The log indicated the names of the residents (in general) who were allowed to smoke in the facility. The log did not indicate who was monitoring the residents (in general) who were smoking in the smoking patio. The AD stated she (AD) could not provide information on which facility staff were currently monitoring the residents (in general) who were currently smoking in the smoking patio. The AD stated she (AD) could not provide documentation on who was monitoring Resident 10 on the night Resident 10 burned her (Resident 10) hand. The AD and ADON stated the facility did not keep a log of which facility staff (in general) would monitor the residents (in general) who smoked in the smoking patio. During an interview on 7/20/2026 at 1:30 PM with Resident 10 in Resident 10's room, Resident 10 stated she (Resident 10) lit her own cigarette and stated there was no facility staff monitoring her (Resident 10) outside the night she (Resident 10) burned her hand. Resident 10 stated she (Resident 10) had her own lighter on the night she burned her hand. Resident 10 stated the facility just confiscated (took away) her (Resident 10) lighter on 7/20/2026. Resident 10 stated she (Resident 10) was mad that she (Resident 10) burned her hand and stated there was not enough light in the smoking patio. Resident 10 stated that even if there was staff monitoring her (Resident 10), Resident 10 stated she (Resident 10) felt the facility staff would not have done anything to help referring to when Resident 10 burned her hand. During an interview on 7/20/2026 at 3:16 PM with Resident 10 in Resident 10's room, Resident stated she (Resident 10) saved a cigarette that staff (unidentified) gave her during the day (on the night Resident 10 burned her hand). Resident 10 stated she (Resident 10) had her (Resident 10) own lighter and went by the nursing station to go to smoke in the smoking patio. Resident 10 stated she did not go through the door in her room that exits into the smoking area. Resident 10 stated it was past midnight when she (Resident 10) went out to smoke. Resident 10 stated she (Resident 10) burned her hand because the smoking patio was very dark. Resident 10 stated the facility needed to protect them (the residents in general) referring to the burn on Resident 10's hand. Resident 10 stated it hurt a lot when Resident 10 burned her hand. Resident 10 stated the facility staff did not monitor her (Resident 10) when Resident 10 burned her hand. During an observation and record review on 7/21/2026 at 2:05 PM, the DON was observed signing a declaration that the facility's camera in the smoking area was not working to the best of the DON's knowledge. During an interview on 7/22/2026 at 1:20 PM with the AD, the AD stated she (AD) would need to document when Resident 10 declined to use a smoking apron. The AD stated moving forward she (AD) would document any issues with Resident 10's smoking. During a concurrent interview and record review on 7/23/2026 at 12:16 PM with the DON, Resident 10's Care Plan Report was reviewed, the Care Plan Report indicated an intervention dated 6/16/2026 for the facility to observe (monitor) resident 10 for unsafe smoking material from outside source and would immediately inform the facility's management. The Care Plan Report indicated an intervention dated 6/16/2026 for the facility to re-evaluate Resident 10's smoking privileges per the facility's policy. The DON stated the facility failed to observe Resident 10 for smoking material from an outside (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	source. The DON stated the facility did not document the re-evaluation of Resident 10's smoking privileges. The DON stated the facility staff would have needed to document their (facility staff) observations of Resident 10's smoking/smoking materials. The DON stated the facility did not follow Resident 10's care plan. During a concurrent interview and record review on 7/23/2026 at 12:16 PM with the DON Resident 10's smoking contract titled Policy and Procedures dated 6/16/2026 at 7:30 PM was reviewed. The smoking contract indicated Resident 10 refused to sign the smoking contract. The smoking contract indicated residents may not carry ignition material (something that helps to start a fire or create a spark). The DON stated even if Resident 10 refused to sign the smoking contract, the facility needed to ensure to check Resident 10 did not have a lighter. The DON stated the facility confiscated Resident 10's lighter after Resident 10 had burned herself (Resident 10). During a concurrent interview and record review on 7/23/2026 at 12:16 PM with the DON, the facility's policy and procedure (P&P), titled Smoking Policy & Procedures, last reviewed 1/23/2026, was reviewed. The P&P indicated all residents (in general) who need supervision (monitoring) and assistance during smoking must be accompanied (going with someone) by a staff member. The P&P indicated residents (in general) without independent (ability to do something without assistance) smoking privileges may not have or keep any smoking material including cigarettes except under direct supervision. The DON stated the facility could not provide documented proof the facility's staff was monitoring Resident 10 when Resident 10 burned her (Resident 10) hand. The DON stated the facility did not follow their policy by allowing Resident 10 to keep a lighter and by not providing proof Resident 10 had been monitored when Resident 10 burned her (Resident 10) hand. During a review of the facility's Policy and Procedure (P&P) titled Care Plan & Comprehensive reviewed 1/23/2026, the P&P indicated the comprehensive care plan would aid in preventing the resident's functional status and or functional levels. The P&P indicated the resident has the right to refuse to participate in his/her care plan and medical and nursing treatments. The P&P indicated when the resident refused, the facility would document in the resident's records in accordance with the facility's established policies. b. During a review of Resident 14's admission Record, the admission Record indicated the facility admitted the resident on 12/23/2022 with diagnoses that included dementia, osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), abnormalities of gait and mobility (disruption in a person's ability to walk and move), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and a fracture of the right pubis (fractured right pubic bone). During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool) dated 4/2/2026, the MDS indicated the resident had severe cognitive impairment (a major loss of mental capacity marked by an inability to live independently, a need for constant supervision, and severe memory or orientation loss). The MDS indicated Resident 14 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) from facility staff with eating and oral hygiene. The MDS indicated Resident 14 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from facility staff with toileting hygiene and personal hygiene. The MDS indicated Resident (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14 required partial/moderate assistance (helper does less than half the effort) from facility staff with showering/bathing herself, upper body dressing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 14 did not have any falls since admission or reentry to the facility. During a review of Resident 14's Fall Risk Evaluation dated 4/2/2026 at 7:58 AM, the Fall Risk Evaluation indicated the resident was at a high risk for potential falls with a score of 19 (a total score of above 10 represented a high risk for potential falls). The Fall Risk Evaluation indicated Resident 14 had intermittent confusion (when a person's thinking, focus, and awareness changes back and forth). The Fall Risk Evaluation indicated Resident 14 had a balance problem while walking. The Fall Risk Evaluation indicated Resident 14 required the use of assistive devices (tools designed to improve a person's stability). During a review of Resident 14's Care Plan Report dated 4/14/2026, the Care Plan Report indicated the resident was at high risk for falls related to gait and balance problems. The Care Plan Report indicated Resident 14 was unaware of her (Resident 14) safety needs. The Care Plan Report indicated goals for Resident 14 to be free of falls and minor injury through the review date. The Care Plan Report indicated interventions that included ensuring Resident 14's call light was within reach and encouraging the resident to use it for assistance as needed; and to educate the resident, family, and caregivers about safety reminders and what to do if a fall occurs. The Care Plan Report indicated Resident 14 needed prompt response to all requests for assistance. During a telephone interview on 7/22/2026 at 10:20 AM with Family Member 1 (FM 1), FM 1 stated that even if Resident 14 was given the information to call for help before getting out of bed, the resident would not know to call for help because she was forgetful. During a concurrent observation and interview on 7/22/2026 at 10:51 AM, with Resident 14, the resident was observed sitting in a wheelchair in front of nursing station 1. Resident 14's wheelchair was observed with a wheelchair alarm (a safety device used to prevent falls, alert caregivers, and monitor movement). Resident 14 stated she doesn't remember anything about falling. During a concurrent interview and Record Review on 7/23/2026 at 10:00 AM with Registered Nurse 2 (RN 2), Resident 14's Care Plan Report dated 4/14/2026 was reviewed. RN 2 stated Resident 14 had a diagnosis of dementia. RN 2 stated Resident 14 was alert and could take instruction but was forgetful. RN 2 stated that Resident 14 was at risk of falling. RN 2 stated Resident 14 needed assistance when getting out of bed. RN 2 stated Resident 14 would attempt to get out of bed unassisted. RN 2 stated Resident 14 would forget to use the call light to call for assistance. RN 2 stated Resident 14 had a care plan for being at risk of falls. RN 2 stated Resident 14's risk of falls care plan had interventions that included encouraging the resident to use the call light for assistance as needed and educating the resident, family, and caregivers about safety reminders and what to do if a fall occurs. RN 2 stated Resident 14 needed a risk of falls care plan that was more tailored to the resident's needs. RN 2 stated that because Resident 14 had dementia, the resident would have difficulty remembering information they (Resident 14) were taught. RN 2 stated Resident 14's at risk of falls care plan needed interventions that were appropriate for dementia. RN 2 stated Resident 14's at risk of falls care plan should have included an intervention for supervision to ensure the resident did not get out of (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed unassisted and have a fall. During a concurrent interview and record review on 7/23/2026 at 10:27 PM with the Assistant Director of Nursing (ADON), Resident 14's Care Plan Report dated 4/14/2026 was reviewed. The ADON stated Resident 14 was alert but forgetful. The ADON stated Resident 14 had dementia. The ADON stated Resident 14 could not take and remember instruction. The ADON stated Resident 14 would acknowledge information in the moment but would then later forget. The ADON stated Resident 14 was at risk of falling. The ADON stated Resident 14 had a risk of falls care plan. The ADON stated Resident 14's risk of falls care plan included interventions to encourage the resident to use the call light for assistance as needed and to educate the resident, family, and caregivers about safety reminders and what to do if a fall occurs. The ADON stated education would not be an appropriate intervention for Resident 14. The ADON stated Resident 14 needed more interventions that were tailored to dementia and the resident's needs. The ADON stated dementia made it difficult for Resident 14 to remember education on the call light. The ADON stated Resident 14's risk of falls care plan should have included interventions such as supervising and monitoring the resident, always having someone with the resident to assist the resident, scheduled bathroom breaks, and reorientation. The ADON stated that the risk of falls care plan should be tailored to Resident 14's needs. The ADON stated the care plan acted as a guide to inform the nursing staff (in general) of how to care for Resident 14. The ADON stated that if the risk for falls care plan was not tailored to Resident 14's needs the nursing staff (in general) might not provide the right care for the resident. The ADON stated there was potential for Resident 14 to not receive the necessary care to prevent falls if the resident's care plan was not tailored to the resident's needs. During a concurrent interview and record review on 7/23/2026 at 12:28 PM with the Director of Nursing (DON), Resident 14's Care Plan Report dated 4/14/2026 was reviewed. The DON stated Resident 14 had dementia and was at risk of falls. The DON stated Resident 14's risk for falls care plan had interventions that included encouraging the resident to use the call light for assistance as needed and educating the resident, family, and caregivers about safety reminders and what to do if a fall occurs. The DON stated that Resident 14 may not be able to recall education about call lights due to having a cognitive impairment. The DON stated Resident 14 may have understood the information in the moment, but due to dementia the resident may later forget. The DON stated that because Resident 14 had dementia and was at high risk for falls, the resident should have had interventions that focused on reminding the resident, re-orienting the resident, and supervising the resident. The DON stated Resident 14's risk of falls care plan should be specific to the resident's needs. The DON stated that education may not be appropriate if the resident cannot recall or remember what they are being educated on. The DON stated that it was important that the care plan was specific to ensure the resident received care specific to their needs. The DON stated there was potential for Resident 14 to fall and injure themselves if the risk for falls care plan was not tailored to the resident's needs. During a review of the facility's Policy and Procedure (P&P) titled Care Plan &ndash; Comprehensive reviewed 1/23/2026, the P&P indicated An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.Each resident's Comprehensive Care Plan has been designed to incorporate identified problem areas; incorporate risk factors associated with identified problems; build on the resident's strengths; reflect treatment goals and objectives in (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	measurable outcomes; identify the professional services that are responsible for each element of care; aid in preventing or reducing declines in resident's functional status and/or functional levels; and enhance the optimal functioning of the resident by focusing on a rehabilitative program.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide necessary treatment and services to minimize risk of development and worsening of pressure injuries/ulcers (PI/PU-localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) for one of two sampled residents (Resident 111) reviewed for PI/PU by failing to: -Ensure to have the correct weight setting of a low air loss mattress (LALM-operates using a blower-based pump that was designed to circulate a constant flow of air) when the machine setting did not match Resident 111's weight. This failure had the potential for placing Resident 111 at risk for skin breakdown and PI/PU. Findings: During a review of Resident 111's admission Record, the admission Record indicated the facility admitted Resident 111 on 2/26/2026 and readmitted the resident on 5/5/2026 with diagnoses including pneumonia (lung infection), sepsis (medical emergency when the body overreacts to an infection), hypertension (HTN-high blood pressure), and dementia ((a decline in mental ability severe enough to interfere with daily life), and the need for assistance with personal care. During a review of Resident 111's Care Plan Report dated 2/26/2026, the Care Plan Report indicated Resident 111 was at risk for PI and the nursing interventions were to apply and monitor the LALM in bed for skin management, function, and effectiveness every shift. During a review of Resident 111's Progress Notes-History & Physical dated 5/8/2026, the Progress Notes-History & Physical indicated Resident 111 could make needs known and could not make medical decisions. During a review of Resident 111's Minimum Data Sheet (a resident assessment tool) dated 5/31/2026, the MDS indicated Resident 111 made herself understood and usually understood others. The MDS indicated Resident 111 was at risk for developing PI/PU and had a pressure reducing device for bed. During a review of Resident 111's Order Summary Report dated 5/31/2026, the Order Summary Report indicated to monitor Resident 111's LALM in bed for function and effectiveness every shift. During a review of Resident 111's Weight Record, the Weight record indicated dated 11/7/22/2026, Resident's weight was 99 pounds (lbs.) on 6/3/2026 and 101 lbs. on 7/02/2026. During an observation on 7/20/2026 at 1:20 PM in resident's room, Resident 111 had a LALM machine at the foot of her (Resident 111) bed with a weight setting of 80 Lbs., and on the right side of the LALM machine there was a sticker label that indicated the setting must be at 89-109 Lbs. for a resident who weighed 99 Lbs. During concurrent observation and interview on 7/20/2026 at 1:22 PM with Licensed Vocational Nurse 1 (LVN1), LVN 1 stated the LALM setting was currently set at 80 Lbs. LVN1 stated the LALM was not at the correct setting and that the setting must be between 89-109 Lbs. LVN1 stated that the wrong LALM setting could cause Resident 111 to be at risk to develop PI/PU. During an interview on 7/20/2026 at 1:37 PM with LVN 1, LVN 1 stated it was primarily her (LVN1) role as a Treatment Nurse to check the LALM machine and the responsibility of the licensed nurses (in general) to also check the LALM. During an interview on 7/23/2026 at 8:45 AM with CNA 4, CNA 4 stated he (CNA4) would check the machine randomly every shift and reported to the licensed nurses (in general) if the machine would not function properly. CNA 4 stated if the settings were incorrect, the settings needed to be corrected right away especially for bed-bound residents. During an interview on 7/23/2026 at 8:24 AM with the Director of Nursing (DON), the DON stated the LALM setting sometimes fluctuated. The DON stated if the LALM setting was incorrect, the CNAs (in general) would only inform the licensed nurses (in general), as CNAs were not supposed to touch and adjust the settings. The DON stated it was the responsibility of the licensed nurses (in general) to make sure the LALM machine was monitored daily and adjusted to the right settings. During an interview on 7/23/2026 at 8:24 AM with the DON, the DON stated the licensed nurses (in (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	general) needed to ensure the correct LALM settings were in place so that the LALM could properly perform its therapeutic purpose by matching the resident's current weight and especially protect the bony prominences. During a review of the facility's P&P titled Prevention of Pressure Injuries, revised 7/12/2023, the P&P indicated to select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. During a review of the facility's undated P&P titled Air Mattress, the P&P indicated the purpose of air mattress is to decrease pressure from the resident's weight in bed and to promote the healing of or the prevention of pressure ulcers. P&P indicated, monitor the mattress to assure that it is functioning properly, and that air level assures that the resident's body doesn't touch the bed. During a review of the Drive LALM operator's manual for Item #14026-A, undated, the manual indicated the resident's weight settings are available along the knob of the perimeter as a guide.		

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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 provide care, assistance, and supervision to ensure an environment free of risks and hazards for three out of six residents (Resident 10, Resident 14, Resident 15) by failing to: 1. Provide direct supervision to Resident 10 when smoking in the facility's smoking patio as indicated in the facility's policy and procedure (P&P) titled Smoking Policy & Procedures, last reviewed by the facility on 1/23/2026. 2. Ensure Resident's 14 who was identified as at risk for falls had floor mats (thick, cushioned pads placed on the floor next to a bed to soften the impact if a person falls) placed on both sides of the bed as per physician's orders dated 4/13/2026. 3. Ensure Resident 15 had a smoking safety evaluation (a check to see if a resident can smoke or vape without hurting themselves or others, covering mental clarity, physical coordination, and safety rules) assessed and documented as indicated in the facility's policy and procedure (P&P) titled Smoking Policy & Procedures, last reviewed by the facility on 1/23/2026. These failures resulted in Resident 10 experiencing a cigarette burn above the right index finger (pointer finger located between the thumb and middle finger) knuckle and had the potential for Resident 14 and Resident 15 to experience avoidable injuries from fire, burns, bruising, head injuries, or broken bones. Findings: During a review of Resident 10's admission Record, the admission Record indicated the facility originally admitted Resident 10 on 6/16/2026 and readmitted Resident 16 on 6/23/2026 with diagnoses that included a need for assistance with personal care (requiring hands-on help with basic daily routines like bathing, dressing, and eating because of age, illness, or disability), anxiety disorder (a mental health condition involving excessive fear, persistent worry, and intense nervousness that does not go away and disrupts daily life), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), pain in right wrist, rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), muscle weakness, and neuralgia and neuritis unspecified (unexplained nerve pain or unspecified nerve inflammation somewhere in the body). During a review of Resident 10's Assessment Scoring Report dated 6/16/2026, Resident 10's Smoking Assessment score was 4, indicating Resident 10 required supervised (monitored) smoking. During a review of Resident 10's History and Physical (H&P - complete written record of a patient's medical background, current symptoms, and physical exam finding written by a healthcare provider such as a doctor, physician assistant, or nurse practitioner) dated 6/25/2026, the H&P indicated Resident 10 had a history of tobacco use (consuming products made from the dried leaves of the tobacco plant such as cigarettes, cigars, pipes or chewable products). During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool) dated 6/27/2026, the MDS indicated Resident 10 had the ability to make herself (Resident 10) understood and had the ability to understand others. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 10's Psychiatric Progress Note (a healthcare written record of a patient's mental health visit, covering symptoms, observations, and future plans) dated 7/1/2026, the Psychiatric Progress Note indicated Resident 10 had fair (reasonable) insight (self-awareness and ability to recognize problems) and judgement (decision-making and ability to choose safe, sensible actions). During a review of Resident 10's Situation, Background, Assessment, and Recommendation (SBAR: used to share important information clearly and quickly) Communication and progress note dated 7/14/2026 at 1PM, the SBAR indicated Resident 10 had capacity (a patient's ability to understand, think through, and make a specific healthcare choice) and was on the facility's list of smokers. The SBAR indicated Resident 10 had a change in skin condition (any noticeable shift in how your skin looks or feels). The SBAR indicated Resident 10 had a burn on the right first knuckle. The SBAR indicated Resident 10 accidentally burned the right first knuckle while smoking a cigarette at night. The SBAR indicated the facility's Director of Nursing (DON) and Administrator (ADM) were notified of Resident 10's cigarette burn. The SBAR indicated Resident 10 was self-responsible (a resident who is legally, mentally, and physically independent enough to make their own personal, medical, and financial decisions). During a review of Resident 10's Order Summary Report (an active master list of all current medical instructions for a patient, detailing medications, treatments, and therapies ordered by healthcare provider) dated 7/22/2026, the Order Summary Report indicated a physician order to apply Betadine Swab sticks External Swab 10% (Povidone-Iodine - single-use sticks with a cotton tip soaked in a brown liquid medicine used to clean the skin and kill germs) to right first knuckle topically (directly on the outside of your body such as on the skin) every day for accidental burn caused by smoking for 30 days, cleanse with normal saline (a safe mix of water and salt that matches the natural salt levels in human blood and tears), pat dry, paint with betadine, and cover with dry dressing (placing a clean, unmoistened piece of material like a gauze pad or bandage/ Band-Aid directly on a wound). During a review of Resident 10's Care Plan (a personalized, written roadmap created by a medical team detailing a patient's health goals, specific daily treatments, and assigned responsibilities for the staff) Report, the Care Plan Report indicated a goal dated 6/16/2026 for Resident 10 to be free from smoking related injury and would comply (obey, follow, or do what is asked) with the facility's smoking policy. The Care Plan Report indicated an intervention (any direct action a nurse takes to help a patient get better, stay comfortable, or avoid future health problems) dated 6/16/2026, for the facility to store Resident 10's smoking materials. The Care Plan Report indicated Resident 10 had a care plan focus dated 7/14/2026, for impaired skin integrity (skin breakdown, a cut or wound, or damage to the outer layers of the skin). During a concurrent observation and interview on 7/20/2026 at 12:10 PM with Resident 10 in facility's designated smoking patio, Resident 10 peeled back the Band-Aid covering the first knuckle on her right index finger and Resident 10's wound was observed. Resident 10 stated she burned her (Resident 10) her hands a few nights ago. Resident 10 stated she could not specify the exact date. Resident 10 stated on the night she (Resident 10) burned her hand, there were no lights in the designated smoking patio. Resident 10 stated she had previously told the DON it was too dark in the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoking patio at night. During an interview on 7/20/2026 at 12:35 PM with the Activities Director (AD) and the Assistant Director of Nursing (ADON), the AD stated she (AD) had tried to offer Resident 10 a smoking apron (a fire-resistant cover worn over the chest and lap) in the past. The AD stated she (AD) created a care plan for Resident 10's noncompliance (breaking a rule or failing to follow instructions) with using a smoking apron. The AD stated she (AD) did not document each time Resident 10 refused to use a smoking apron. The ADON verified the facility did not document each time Resident 10 refused to use a smoking apron. During a concurrent interview and record review on 7/20/2026 at 12:35 PM, with the AD and ADON, the facility's smoking log dated July 20, 2026, was reviewed. The log indicated the names of the residents (in general) that were allowed to smoke in the facility. The log did not indicate who was responsible for monitoring the residents (in general) who were smoking in the smoking patio. The AD could not provide information on which facility staff were monitoring the residents (in general) who were smoking in the smoking patio at the time of observation. The AD could not provide documentation on who was monitoring Resident 10 on the night Resident 10 burned her (Resident 10) hand. The AD and ADON stated the facility did not keep a log of which facility staff (in general) were responsible for monitoring residents (in general) smoking in the smoking patio. During an interview on 7/20/2026 at 12:50 PM, the ADON stated cameras in the smoking patio were working and would verify with the DON if the cameras in the smoking patio were working. During an interview on 7/20/2026 at 1:05 PM the DON stated the camera in the smoking patio was not working. During an interview on 7/20/2026 at 1:10 PM with the Maintenance Supervisor (MS), the MS stated he thought the camera in the smoking patio was working. During a concurrent observation and interview on 7/20/2026 at 1:14 PM with the DON, the facility's cameras were reviewed. The DON showed cameras that were not functioning but could not verify if the non-functional cameras were the ones connected to the smoking patio. The DON stated the cameras inside the facility were available to view in the business office. During an interview on 7/20/2026 at 1:20 PM with the Business Office Manager (BOM), the BOM stated she thought the camera in the smoking patio was working. During an interview on 7/20/2026 at 1:30 PM with Resident 10 in Resident 10's room, Resident 10 stated she (Resident 10) lit her own cigarette and stated there was no facility staff monitoring her (Resident 10) outside. Resident 10 stated she had her own lighter on the night she burned her hand. Resident 10 stated the facility had just confiscated (took away) the lighter that day (7/20/2026). Resident 10 stated she was mad that she burned her hand and stated there was not enough light in the smoking patio. Resident 10 stated that even if there was staff monitoring her (Resident 10), Resident 10 stated she (Resident 10) felt the facility staff would not have done anything to help referring to when Resident 10 burned her hand. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview on 7/20/2026 at 3:16 PM with Resident 10 in Resident 10's room, Resident stated on the day she burned her hand she (Resident 10) had saved a cigarette that staff (in general) had given her earlier during the day. Resident 10 stated she had her (Resident 10) own lighter and went by the nursing station to go to smoke in the smoking patio. Resident 10 stated it was past midnight when she (Resident 10) went out to smoke. Resident 10 stated she burned her hand because the smoking patio was very dark. Resident 10 stated she felt the facility should be protecting us (the residents in general) referring to the burn on Resident 10's hand. Resident 10 stated it hurt a lot when Resident 10 burned her hand. Resident 10 stated facility staff were not monitoring her (Resident 10) when Resident 10 was smoking and burned her hand. During an interview on 7/22/2026 at 1:20 PM, with the AD, the AD stated she (AD) failed to document when Resident 10 declined to use a smoking apron. During a concurrent interview and record review on 7/23/2026 at 12:16 PM, Resident 10's Care Plan Report was reviewed with the DON. The Care Plan Report indicated an intervention dated 6/16/2026, for the facility to observe (monitor) Resident 10 for unsafe smoking material from an outside source for facility staff to immediately inform the facility's management. The Care Plan Report indicated an intervention dated 6/16/2026, for the facility to re-evaluate Resident 10's smoking privileges per the facility's policy. The DON stated the facility failed to observe Resident 10 for smoking material from an outside source. The DON stated the facility did not document the re-evaluation of Resident 10's smoking privileges. The DON stated the facility staff were expected to document their (facility staff) observations of Resident 10's smoking/smoking materials. The DON stated the facility did not follow Resident 10's care plan. During a concurrent interview and record review on 7/23/2026 at 12:16 PM with the DON, the DON reviewed Resident 10's smoking contract titled Policy and Procedures, dated 6/16/2026 at 7:30 PM. The smoking contract indicated Resident 10 had refused to sign the smoking contract. The smoking contract indicated residents may not carry ignition material (something that helps to start a fire or create a spark). The DON stated that even if Resident 10 had refused to sign the smoking contract, facility staff had to make sure to check Resident 10 did not have a lighter. The DON stated the facility had confiscated Resident 10's lighter. During a concurrent interview and record review on 7/23/2026 at 12:16 PM, the DON reviewed the facility's policy and procedures (P&P), titled Smoking Policy & Procedures, last reviewed 1/23/2026. The P&P indicated all residents (in general) who need supervision (monitoring) and assistance during smoking had to be accompanied (going with someone) by a staff member. The P&P indicated residents (in general) without independent (ability to do something without assistance) smoking privileges may not have or keep any smoking material including cigarettes except under direct supervision. The DON stated the facility could not provide documented proof the facility's staff was monitoring Resident 10 when Resident 10 burned her (Resident 10) hand. The DON stated the facility did not follow their policy by allowing Resident 10 to keep a lighter and by not providing proof Resident 10 had been monitored when Resident 10 burned her (Resident 10) hand. During a review of Resident 14's admission Record, the admission Record indicated the facility admitted the resident on 12/23/2022 with diagnoses that included dementia (a progressive state of (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decline in mental abilities), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), abnormalities of gait and mobility (disruption in a person's ability to walk and move), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and a fracture of the right pubis (fractured right pubic bone). During a review of Resident 14's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (a major loss of mental capacity marked by an inability to live independently, a need for constant supervision, and severe memory orientation loss). The MDS indicated Resident 14 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) from facility staff with eating and oral hygiene. The MDS indicated Resident 14 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from facility staff with toileting hygiene and personal hygiene. The MDS indicated Resident 14 required partial/moderate assistance (helper does less than half the effort) from facility staff with showering/bathing herself, upper body dressing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 14 did not have any falls since admission or reentry to the facility. During a review of Resident 14's Fall Risk Evaluation dated 4/2/2026 at 7:58 AM, the Fall Risk Evaluation indicated the resident was at a high risk for falls with a score of 19 (a total score of above 10 represented a high risk for potential falls). The Fall Risk Evaluation indicated Resident 14 had intermittent confusion (when a person's thinking, focus, and awareness changes back and forth). The Fall Risk Evaluation indicated Resident 14 had a balance problem while walking. The Fall Risk Evaluation indicated Resident 14 required the use of assistive devices (tools designed to improve a person's stability). During a review of Resident 14's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 4/13/2026 for floor mats on both sides while on bed to decrease the risk of injury if the resident tried to get up unassisted. The physician order indicated Resident 14 was at high risk for a fall related to confusion, unsteady gait (unstable walking pattern), and a history of a fall secondary to dementia. The physician order indicated to monitor placement of the floor mats every shift. During a review of Resident 14's Care Plan Report dated 4/14/2026, the Care Plan Report indicated Resident 14 was at high risk for falls related to gait and balance problems. The Care Plan Report indicated Resident 14 was unaware of her (Resident 14) safety needs. The Care Plan Report indicated goals for Resident 14 to be free of falls and minor injury through the review date. The Care Plan Report indicated an intervention that included floor mats on both sides while on bed to decrease the risk of injury if the resident tried to get up unassisted. The Care Plan Report indicated Resident 14 was high risk for a fall related to confusion, unsteady gait, and a history of a fall secondary to dementia. During a concurrent observation and interview on 7/22/2026 at 10:57 AM with Certified Nursing Assistant (CNA 6), in Resident 14's room, the resident's bed was observed without floor mats on either side of the bed. CNA 6 stated Resident 14 did not have floor mats. CNA 6 stated Resident 14 should have floor mat on each side of the resident's bed to help lessen injury if the resident fell. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/22/2026 at 11:06 AM with the Assistant Director of Nursing (ADON), in Resident 14's room, the resident's bed was observed without floor mats to either side of the bed. The ADON stated Resident 14 should have a floor mat on both sides of the bed because the resident had physician orders for floor mats. The ADON stated the purpose of the floor mats was to act as a cushion and prevent injury if Resident 14 fell. The ADON stated there was potential for Resident 14 to sustain an injury and fracture if the resident fell and there were no floor mats on either side of the resident's bed. During a concurrent interview and record review on 7/23/2026 at 12:28 PM with the Director of Nursing (DON), Resident 14's physician order dated 4/13/2026 was reviewed. The DON stated Resident 14's physician order dated 4/13/2026 indicated the resident was to have floor mats on both sides of the bed to decrease the risk of injury if the resident tried to get up unassisted. The DON stated Resident 14's physician order indicated the resident was at a high risk for falls related to the resident's confusion, unsteady gait, and history of a fall. The DON stated that if Resident 14 had a physician order for floor mats on both sides of the resident's bed, then the floor mats should have been present. The DON stated that floor mats were supposed to help prevent Resident 14 from getting a fracture if the resident fell. The DON stated that if Resident 14 did not have any floor mats as ordered by the resident's physician, there was potential the resident could have fractured bones if the resident fell. During a review of the facility's Policy and Procedure (P&P) titled Falls and Fall Risk Managing reviewed 1/23/2026, the P&P indicated Purpose: To identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. In conjunction with the Attending Physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. During a review of Resident 15's admission Record, the admission record indicated the facility originally admitted Resident 15 on 8/18/2023 and readmitted the resident on 6/24/2026 with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) unspecified, and essential hypertension (HTN-high blood pressure). During a review of Resident 15's Nursing Risk Evaluation dated 6/24/2026, the admission nursing risk evaluation indicated that Resident 15 was a smoker. During a review of Resident 15's MDS dated [DATE], the MDS indicated Resident 15 had the ability to understand others and was cognitively intact (able to independently make decisions regarding tasks of daily life). The MDS indicated Resident 15 was a tobacco user. During a review of Resident 15's H&P dated 6/30/2026, the H&P indicated Resident 15 had fluctuating (on and off) capacity to understand and make decisions. During a concurrent interview and record review on 7/20/2026 at 3:34 PM with the Assistant Director of Nursing (ADON), Resident 15's medical record was reviewed. The ADON stated that there was no (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Smoking Safety Evaluation on Resident 15's Medical Record. The ADON Stated it was important to complete a Smoking Safety Evaluation for Resident 15 to identify smoking-related hazards to prevent injuries such as burn and potentially cause a fire. The ADON stated Resident 15 should have been assessed for smoking upon admission on [DATE], in accordance with facility's policy. The ADON stated that the Smoking Safety Evaluation included assessment of residents' (general) mental capacity, potential smoking-related hazards and a scoring system that informs staff of the level of supervision required for safe smoking. During an observation and interview on 7/22/2026 8:01AM with Resident 15 at the smoking patio, Resident 15 was observed seated on a patio chair with a lighted cigarette on the right hand. Resident 15 stated that smoking was a part of his daily routine. During an interview and a record review on 7/22/2026 at 8:11 AM with the Activities Director (AD), Resident 15's medical records were reviewed. The AD confirmed there was no Smoking Safety Evaluation on Resident 15's medical record. The AD stated that nurses were supposed to complete the smoking safety evaluation upon Resident 15' admission to the facility on 6/24/2026. The AD stated that smoking safety evaluation was important to identify residents' (in general) safety, cognitive skills and mental condition. The AD stated there was no smoking safety evaluation completed for Resident 15 on 6/24/2026. During an interview and a record review on 7/22/2026 at 11:52 AM with the Director of Nursing (DON), Resident 15's medical record was reviewed. The DON stated that upon admission, a Smoking Safety Evaluation was completed to identify smoking -related and assess the resident's cognitive status to determine whether a resident can smoke safely. The DON stated a score of two indicated supervised smoking with staff to help the residents in holding cigarettes. The DON stated that Resident 15's medical record indicated no Smoking Safety Evaluation was completed for Resident 15 on 6/24/2026 (readmission date). The DON stated the facility failed to complete a Smoking Safety Evaluation for Resident 15 on 6/24/2026. The DON stated the potential harm to Resident 15 included smoking related injuries, burns to the residents, staff or other residents, and the risk of fire especially if a resident using oxygen were to smoke. The DON stated that the facility failed to follow its smoking policy and procedures. During a review of the facility's Smoking policy and procedure (P&P) dated 1/23/2026, the P&P indicated the resident's safety and that of others was of utmost importance. The P&P indicated each resident who expressed a desire to smoke would undergo an evaluation of their physical and cognitive abilities to safely handle smoking materials and evaluation would be conducted upon admission, quarterly, annually, and at significant changes in their condition. The P&P indicated the evaluation would determine whether the resident could smoke and the level of assistance required. During a review of the facility's Safety and Supervision of Residents P&P dated 1/23/2026, the P&P indicated the facility strived to make the environment as free from accident hazards as possible and residents' safety, supervision and assistance to prevent accidents are facilities wide priorities.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to update and post daily staffing information for three of six sample days (7/18/2026, 7/19/2026, and 7/20/2026).This failure had the potential to cause inadequate staffing and for the residents (in general) needs to go unmet.Findings:During a concurrent observation and interview on 7/20/2026 at 9:02 AM with the Assistant Director of Nursing (ADON) in front of Nursing Station 1, the Direct Care Services Hours Per Patient Hours (DHPPD, the actual hours of work performed per patient day by a direct caregiver) for 7/15/2026, 7/16/2026, and 7/17/2026 were posted on the announcement board. The ADON stated the posted DHPPD needed to be updated daily to reflect any changes with the census and staffing.During an interview on 7/22/2026 at 3:41 PM with the Director of Nursing (DON), the DON stated the Director of Staff Development (DSD) was responsible for posting the projected (beginning of shift) and actual (end of day) DHPPD. The DON stated the DSD was not available for interview due to a family emergency. The DON stated the importance of updating and posting the DHPPD was to ensure the facility was adequately staffed. The DON stated inadequate staffing could cause delays in care such as long call light (a device with a button or touch pad a resident uses to set off an alarm that flashes/rings to alert facility staff the resident needs assistance) wait times. The DON stated the DHPPD must be updated daily, even on the weekends. The DON stated the facility did not update nor post the DHPPD for 7/18/2026, 7/19/2026, and 7/20/2026 in a timely manner.During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, last reviewed January 2026, the P&P indicated within two hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed nursing personnel directly responsible for resident care are posted in a location accessible to residents and visitors.		

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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 observation, interview, and record review, the facility failed to ensure medications were administered in accordance with physician orders and professional standards of practice for two of eight sampled residents (Residents 100 and Resident 131) reviewed for medication administration by failing to: -Ensure Licensed Vocational Nurse 4 (LVN4) followed Resident 100's physician's order instructions to flush Resident 100's gastrostomy tube (g-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) with 50 milliliters (mL- a unit of measurement for volume) of water before and after medication administration. -Ensure Resident 131's lidocaine patch (a medication in the form of a patch used to treat inflammation and pain) was removed from application site (right knee) as per physician's orders. -Ensure Resident 131's lidocaine patch was only applied to the right knee and the right thigh in accordance with physician's orders, and not to the left knee. These failures had the potential to result in g-tube clogging and complications and discomfort for Resident 100 and had the potential for medication overdose (you take more than the recommended amount of a medicine or drug and may result in serious, harmful symptoms or death), skin irritation, redness, and hospitalization for Resident 131. Findings: a. During a review of Resident 100's admission Record (a document containing demographic and diagnostic information), the admission Record indicated the facility originally admitted Resident 100 on 10/3/2023 and readmitted Resident 100 on 2/13/2026 with diagnoses that included but not limited to gastrostomy status, gastrostomy malfunction and dysphagia (trouble swallowing). During a review of Resident 100's History and Physical (H&P) dated 2/13/2026, the H&P indicated Resident 100 did not have the capacity to understand and make decisions. During a review of Resident 100's Order Summary Report (a document containing a summary of all active physician orders) dated 2/13/2026, the Order Summary Report indicated to flush Resident 100's G-tube with 50 mL of H2O (water) pre (before) and post (after) medication administration. During a review of Resident 100's Minimum Data Set (MDS, a resident assessment tool) dated 7/18/2026, the MDS indicated Resident 100's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was severely impaired. The MDS indicated Resident 100 needed maximal assistance from the facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as upper body dressing, and was dependent on facility's staff for eating, oral hygiene, toileting hygiene, showering, lower body dressing, putting on or taking off footwear and personal hygiene. During a concurrent medication administration observation and interview on 7/21/2026 between 8:57 AM and 9:36 AM, Licensed Vocational Nurse 4 (LVN 4) prepared six medications: Amlodipine (lowers blood pressure), Ferrous sulfate (iron supplement), Memantine (treat dementia-a decline in mental ability severe enough to interfere with daily life) Metoprolol (treats high blood pressure), multivitamin (supplement), raloxifene (for osteoporosis (bone disease characterized by weak and fragile bones) to be administered to Resident 100 via g-tube. LVN 4 stated she (LVN4) would be flushing the g-tube with 30 mL of water before and after medications were administered and with 5 mL of water in between medications. During medication administration, LVN 4 stated the medications were not passing through the g-tube smoothly via gravity, so she (LVN 4) needed to push on the syringe plunger and then medications were passing through. During a review of Resident 100's Order Summary dated 7/22/2026, the Order Summary indicated to flush the g-tube with 10-15 mL of (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water in between each medication administered. During a concurrent interview and record review on 7/22/2026 at 1:38 PM with Registered Nurse (RN) 1, Resident 100's Order Summary was reviewed. The Order Summary dated 2/13/2026 indicated to flush Resident 100's g-tube with 50 mL of H₂O pre and post medication administration. RN 1 stated g-tube medications needed to be flushed with 50ml of water before and after medication administration. RN 1 stated she (RN1) was looking for an order for water volume to use for in between medications and to dissolve medications. RN 1 stated nursing staff (in general) needed to use a little amount of water to dissolve the powder of crushed medications. RN 1 stated it was important to flush g-tube with the right amount of water in between medication administration and before and after medications were administered to ensure medications moved smoothly through g-tube. During an interview on 7/22/2026 at 2:20 PM with RN 1 and Assistant Director of Nursing (ADON), RN 1 and ADON stated some of the g-tube orders were not renewed when Resident 100 was readmitted. The ADON stated she (ADON) renewed the order for 10-15 mL of water to be used to flush g-tube in between each medication administered. RN 1 and ADON stated the previous order was to flush g-tube with 30-50 mL water before and after medication administration as opposed to current active order to use 50 mL water to flush g-tube before and after medications were administered. RN 1 and the ADON stated this could have caused confusion for LVN 4 during medication administration for Resident 100. During an interview on 7/22/2026 at 4:02 PM with the Director of Nursing (DON), the DON stated the nursing staff (in general) needed to follow the physician orders for g-tube medication administration even if it could be different than facility's policy because physician's orders were based on medication and resident's health factors. The DON stated it was important to administer the correct volume of water throughout medication administration to prevent clogging of the g-tube. During a review of facility's policy and procedure (P&P) titled, Administering Medications through an Enteral Tube, undated, the P&P indicated, The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. The P&P indicated, b. Dilute crushed (powdered) medication with at least 30 mL of water (or prescribed amount). c. Dilute liquid medication with 30 mL or more (depending on viscosity) of water). The P&P indicated, If administering more than one medication, flush with 15 mL of water (or prescribed amount) between medications. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of water (or prescribed amount). b. During a review of Resident's 131's admission Record, the admission Record indicated the facility originally admitted Resident 131 on 8/31/2025 and readmitted Resident 131 on 3/19/2026 with diagnoses that included but not limited to pain in the right thigh, unspecified osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), unspecified site, and osteophyte (a smooth bony lump or bone spur that grows on the edges of bones or joints due to joint damage from arthritis and aging) in right the knee. During a review of Resident 131's Order Summary Report dated 3/19/2026, the Order Summary Report indicated to apply the Lidoderm Patch 5% (Lidocaine) to the right knee topically (means applying a medication directly to a specific surface area of the body) every 12 hours for pain management. The Order Summary Report indicated to apply the Lidoderm at 9 AM and remove at 9 PM. During a review of Resident 131's Order Summary Report dated 3/19/2026, the Order Summary Report indicated to apply the Lidoderm Patch 5% to the right thigh topically at 9 AM and off at 9 PM for pain management and remove per schedule. During a review of Resident 131's H&P dated 3/22/2026, the H&P indicated Resident 131 had capacity to make medical decisions. During a review of Resident 131's MDS dated [DATE], the MDS indicated Resident 131's cognition was intact. The MDS indicated Resident 131 needed setup or clean-up assistance from the facility's staff for ADLs such as eating, supervision level assistance for oral hygiene, moderate assistance for personal hygiene, maximal assistance for (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upper body dressing, and dependent on facility's staff for toileting hygiene, showering, lower body dressing, putting on or taking off footwear. During a concurrent observation and interview on 7/21/2026 at 9:43 AM with LVN 4, LVN 4 was observed preparing two patches of lidocaine 5 percent ([%] a measurement of strength or potency of medication) (removed from package) with instructions to, apply to right thigh/right knee (2 patches), topically on 9 AM, off 9 PM for pain management and remove per schedule. LVN 4 stated Resident 131 wanted to be cleaned up first so she (LVN 4) would return later after administering other medications, to apply lidocaine patch on Resident 131. During a concurrent observation and interview on 7/21/2026 at 9:57 AM with LVN 4, Resident 131 was observed to have one patch with no nurse initials and no date on the right knee, and one patch on the left knee with no nurse initials and no date. There was no patch on Resident 131's right thigh. During a concurrent interview and record review on 7/21/2026 at 10:01 AM with LVN 4, LVN 4 stated LVN 8 applied the lidocaine patch for Resident 131 on 7/20/2026 at 9 PM. LVN 4 stated the nursing staff (in general) would usually write the date on patch when it was applied and the patch that was on Resident 131 did not have a date. LVN 4 stated there was a risk that Resident 131 could receive more lidocaine than necessary, potential for medication overdose and could have side effects because the patch was not removed as per instructions. LVN 4 stated Resident 131 was only supposed to receive the lidocaine patch on the right knee, but it was on both knees which was against physician orders. LVN 4 stated she (LVN4) would need to inform the supervisor (unidentified) and the DON so that they (the DON and the supervisor) could inform the physician and receive instructions. During an interview on 7/21/2026 at 10:38 AM with LVN 4, LVN 4 stated it would be a medication error for the lidocaine patch for Resident 131 because it was incorrectly applied on the wrong site and not according to Resident 131's doctor's instructions. During an interview on 7/21/2026 at 12:46 PM with LVN 4, LVN 4 stated that the physician instructed to hold off on the application of lidocaine patch for Resident 131 on 7/21/2026 and resume administration of lidocaine patch on 7/22/2026 with instructions to only apply on the right knee and the right thigh according to physician's orders. LVN 4 stated that the physician instructed the nursing staff (in general) to monitor Resident 131 for vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions) and drowsiness. According to manufacturer's labeling for lidocaine patch 5%, the prescribed number of lidocaine patches (a maximum of 3) should be applied to intact skin to cover the most painful area only once for up to 12 hours within a 24-hour period. During an interview on 7/22/2026 at 2:58 PM with LVN 8, LVN 8 stated Resident 131 wanted to keep the patch on longer on the right knee on 7/20/2026 at 9 PM, and LVN 8 forgot to remove the patch later. LVN 8 stated Resident 131 removed the right thigh's patch and relocated the patch to the left knee. LVN 8 stated she (LVN8) wanted to clarify that she (LVN 8) did not apply a new patch, and that she (LVN8) just did not remove the old patch. LVN 8 stated there was a risk for side effects such as headache, nausea, stomachache, upset stomach or a rash. LVN 8 stated it would be a good idea to write the date and location when the lidocaine patch was applied to prevent removal and relocation by the resident. During an interview on 7/22/2026 at 4:07 PM with the DON, the DON stated there was a risk for the lidocaine patch to be absorbed for a longer period of time than intended per physician orders. The DON stated this placed Resident 131 at risk of side effects. The DON stated it was important to indicate a date on the lidocaine patch to ensure that the nursing staff (in general) were aware when the patch was applied and when it needed to be removed. The DON stated the nursing staff (in general) could probably write the location where patch was being applied, but it was not a part of the facility's policy. During a review of facility's P&P titled, Specific Medication Administration Procedures - Transdermal Drug Delivery System (Patch) Application, dated 04/2008, the P&P (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Grand Park Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2312 West 8th Street Los Angeles, CA 90057	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, To administer medication through the skin for continuous absorption while the patch is in place, through proper placement of the patch and care of the application sites. The P&P indicated, A. Identify the location on the body for patch placement. B. Remove old patch from body and cleanse site if necessary. C. Remove new patch from package and envelope. D. Label patch with date and nurse's initials. During a review of facility's P&P titled, Administering Medications, dated 7/1/2023, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed.		

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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: 1. Ensure medications in one of two medication rooms' refrigerator (Station 1 Medication Room Refrigerator) requiring refrigeration were stored at temperatures between 2 Celsius [(C) is a unit of temperature] (36-degree Fahrenheit [F] is a unit of temperature) and 8 C (46 F) in accordance with manufacturer specifications and as per facility's policy and procedure (P&P) titled Medication Storage in the Facility - Storage of Medications, dated 01/2025. 2a. Ensure Resident 155's unopened prefilled syringe of Lantus Solostar ([generic name - insulin glargine] a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication] used to treat high blood sugar) in one of two inspected medication carts (Station 1 Medication Cart 1B) was stored in a refrigerator and/or labeled with an open date.2b. Ensure Resident 54's opened foil pack of budesonide (a medication used to treat asthma [a chronic lung disease causing inflammation and muscle tightness around airways] inhalation suspension in Station 1 Medication Cart 1B was labeled with an open date and/or discarded in accordance with the manufacturer specifications and as per facility's P&P titled, Medication Storage in the Facility - Storage of Medications, dated 01/2025, affecting one of two inspected medication carts (Station 1 Medication Cart 1B). These failures had a potential risk of administering expired, ineffective, or toxic medications, leading to adverse health consequences such as abnormal blood glucose levels, breathing difficulties, and hospitalization for Residents 54, 155 and other facility residents.Findings:1. During a concurrent inspection of the medication refrigerator in Station 1 Medication Room and interview on [DATE] at 2:19 PM with the Registered Nurse (RN) 2, the following medications were found stored at temperature of 32.9 F, which was outside of manufacturer's required specifications: a. One unopened emergency medication kit (Ekit, a secured, organized container holding essential, often pre-packaged, drugs and supplies designed for rapid access to treat specific health conditions, emergencies, or, in hospice settings, to provide immediate comfort care) containing one prefilled pen of Novolin R (a type of insulin used to treat high blood sugar) 100 units/milliliters ([mL] a unit of measurement for volume, four pen needles, one pen of Humalog (generic name - insulin lispro) Kwik Pen (a type of insulin used to treat high blood sugar) 100 units/mL and two vials of lorazepam (a medication used to treat anxiety and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] 2 mg/mL. 2. 24 (two boxes of 12 count) suppositories (a small, solid medicine form designed to be inserted into the rectum) of acetaminophen (a medication used to treat fever and pain) 650 milligram ([mg] metric unit of measurement, used for medication dosage and/or amount). 3. Five vials of 10 mL Humulin R 100 units/mL. 4. Two vials of 10 mL Novolin R 100 units/mL. 5. One vial of Rhopressa ([generic name - netarsudil] a medication in form of eye drops used to lower high eye pressure) 0.02% ophthalmic solution. 6. One bottle of Latanoprost (a medication used to lower high eye pressure) 0.005% eye drops. 7. One vial of Vyzulta ([generic name: latanoprostene bunod ophthalmic solution] a medication used to lower high eye pressure) 0.024% ophthalmic solution. 8. Three prefilled pens of Lantus Solostar 100 units/mL. 9. One prefilled pen of insulin lispro 100 units/mL. 10. One prefilled pen of Trulicity ([generic name - dulaglutide] a medication used to treat high blood sugar) 0.75 mg/0.5 mL. According to the manufacturer's product labeling, medications requiring refrigeration were stored in a refrigerator between 36 F and 46 F. RN 2 (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the medication refrigerator temperature should have been maintained between 36 F and 46 F and the temperature of 32.9 F was not an appropriate temperature to store medications. RN 2 stated a temperature out of range could affect the stability of medications and the medications might not be effective to administer to facility's residents. During a concurrent interview and record review on [DATE] at 2:19 PM with RN 2, the medication refrigerator temperature log was reviewed. The temperature log did not indicate medication refrigerator temperature documented for [DATE] at 12:00 PM. RN 2 stated the medication refrigerator temperature was last documented on [DATE] at 12:00 AM and it was not documented on [DATE] at 12:00 PM. During an interview on [DATE] at 3:58 PM with the Director of Nursing (DON), the DON stated the facility replaced the medication refrigerator medications that were outside of the required temperature requirements and ordered from the pharmacy. The DON stated, the effectiveness of medications would be affected if they were not at the optimal temperature. 2a. During a review of Resident 155's admission Record (a document containing demographic and diagnostic information), the admission record indicated Resident 155 was admitted to the facility on [DATE] with diagnosis including but not limited to Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications. During a concurrent observation and interview on [DATE] at 1:10 PM with Licensed Vocational Nurse (LVN) 5, of Station 1 Medication Cart 1B, the following medication was stored in medication cart without an open date instead of refrigerator, which was not in accordance with manufacturer's specifications: a. One prefilled Lantus Solostar 100 units/mL for Resident 155 with no open date. According to the manufacturer's product labeling for the Lantus Solostar, unopened / not in-use Lantus Solostar pen if stored at room temperature (below 86 F) [30 C] and opened / in-use Lantus Solostar pen had to be used within 28 days. LVN 5 stated Resident 155's Lantus Solostar must have been delivered yesterday and someone did not put a date on it and did not place it in the refrigerator. LVN 5 stated Lantus Solostar would not be effective or safe if it was not properly stored. During a review of Resident 155's Order Summary Report (a document containing a summary of all active physician orders) dated [DATE], the order summary report indicated but not limited to the following physician order: Lantus Solostar subcutaneous (under the skin) solution pen-injector 100 units/mL (insulin glargine), inject 30 units subcutaneously at bedtime for diabetes mellitus (DM), hold if blood sugar (BS) less than 100 mg/deciliter ([dL] a unit of measurement for volume), order date [DATE], start date [DATE]. During an interview on [DATE] at 3:56 PM with the Director of Nursing (DON), the DON stated the Lantus Solostar should be labeled with an open date if it was removed from the refrigerator and stored in the medication cart. The DON stated that if the insulin was less effective due to improper storage and labeling it could negatively affect how the resident's blood glucose would be lowered. 2b. During a review of Resident 54's admission Record, the admission record indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breathe) with (acute) exacerbation (sudden worsening of the disease), acute respiratory failure with hypercapnia (lungs cannot get rid of carbon dioxide fast enough leading to high levels of carbon dioxide levels), chronic obstructive pulmonary disease, unspecified, and unspecified asthma (a long-term lung disease causing airway inflammation, wheezing and shortness of breath) with (acute) exacerbation. During a concurrent observation and interview on [DATE] at 1:10 PM with LVN 5 of Station 1 Medication Cart 1B, the following medication was stored against manufacturer's specifications: a. One opened foil pack with one ampule inside of budesonide inhalation suspension 1 mg/2 mL for Resident 54 with no open date. The outside box indicated a date of [DATE]. According to the manufacturer's product labeling, budesonide inhalation (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspension needed to be stored at room temperature 20 C to 25 C (68 F to 77 F) and unopened ampules needed to be stored in foil envelope and protected from light. The manufacturer's product labeling indicated once the foil envelope was opened, the ampules needed to be used within 2 weeks. LVN 5 stated she was not sure why there was no open date on the foil pack, and there was a risk that budesonide would be ineffective and unsafe to administer to treat breathing problems for Resident 54 since it was not stored and labeled properly. During a review of Resident 54's Order Summary Report dated [DATE], the order summary report indicated but not limited to the following physician order: Budesonide inhalation suspension 1 mg/2 mL, inhale 1 vial orally every 12 hours for asthma via nebulizer, rinse mouth after use, order date [DATE], start date [DATE].During an interview on [DATE] at 3:52 PM with the DON, the DON stated it was important to follow manufacturer requirements for budesonide inhalation suspension ampules because there was a risk that the medication could have been administered beyond the manufacturer recommendations. The DON stated the medication would lose potency (strength) and effects which could cause breathing problems for the residents if the medication did not work. During a review of the facility's P&P titled Medication Storage in the Facility - Storage of Medications dated 01/2025, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The P&P indicated, Medications requiring 'refrigeration' or 'temperatures between 2 C (36 F) and 8 C (46 F)' are kept in a refrigerator with a thermometer to allow temperature monitoring. The P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of .and reordered from the pharmacy if a current order exists. The P&P indicated, Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified.		