STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056308	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Rehabilitation Center	21414 S. Vermont Avenue Torrance, CA 90502

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the nursing staff failed to: 1.Ensure that the call light device was within easy reach for Resident 42 and Resident 45. 2.Provide a communication board (a visual aid often featuring pictures, symbols, or words to help individuals with aphasia express themselves and understand others when verbal communication is difficult) for Resident 120, who is aphasic. These deficient practices had the potential to result in a delay of care and the residents needs not being met. Findings: a.During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was initially admitted to the facility on [DATE] and last admitted on [DATE] with a diagnosis including ataxic gait (an abnormal walking pattern), repeated falls, and depression , unspecified (a condition of persistent sadness and loss of intertest in activities). During a review of Resident 42's History and Physical (H&P), dated 3/25/2025, the H&P indicated, Resident 42 does not have the capacity (ability) to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool) dated 3/28/2025, it was noted that Resident 42 requires substantial to maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with lying to sitting on the side of the bed, sitting to standing, and toilet transfers. Due to medical conditions, Resident 42 has not attempted walking 10 feet. During a record review of Resident 42's care plan dated 3/25/2025, it was noted that Resident 42 is at risk for falls due to difficulty maintaining sitting/standing balance and a history of multiple falls. The care plan includes an intervention to ensure the call light is within reach and that staff respond in a timely manner. During an observation on 6/9/2025 at 10:45 a.m., Resident 42 was in bed with the call light found on the right side of the bed, hanging on the floor. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview at 11:00 a.m. with Certified Nursing Assistant 7 (CNA 7), CNA 7 stated that Resident 42 is blind and knows how to locate their call light. The CNA emphasized that the call light should always be within the resident's reach to ensure their safety and meet any potential needs. During an interview on 6/9/2025 at 12:20 p.m., with the Registered Nurse 4 (RN 4) , RN 4 stated we make rounds every two hours and while rounding we make sure the call light is in reach. RN 4 stated it is important to make sure call light is in reach to avoid accidents. RN 4 stated especially for a resident who has a visual impairment it should be within reach. b. During a review of Resident 45's admission Record, the admission Record indicated, Resident 45 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnoses including chronic kidney disease stage 2 (mild kidney damage) of pulmonary hypertension (blood pressure in the lungs is abnormally high) , hyperlipidemia (elevated levels of fat in the blood) and a need for assistance with personal care. During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. Resident 45 requires set -up or clean- up assistance (helper sets up or clean up; resident completes activity) with eating, oral hygiene and dependent (resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with upper and lower body dressing and toilet hygiene. During a review of Resident 45's care plan dated 4/14/2025 the care plan indicated Resident 45 requires assistance with ADL's (activities of daily living- basic tasks an individual perform to maintain their personal hygiene, care and independence) self -care and mobility secondary to recent decline in functional ability. The care plan intervention indicated to encourage resident to use call light for assistance. During an observation on 6/9/2025 at 10:23 a.m., Resident 45 requested assistance with retrieving the call light. The call light was located on the left side of the bed, hanging. Licensed Vocational Nurse 12 (LVN 12) arrived, picked up the call light from the side of the bed, and handed it to the resident. LVN 12 mentioned that it is important to ensure the call light is within the resident's reach to prevent falls. c. During a review of Resident 120's admission Record, the admission Record indicated, Resident 120 was initially admitted to the facility on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness affecting one side of the body) following cerebral infarction (when blood flow to part of the brain is blocked leading to tissue damage and death) and aphasia (difficulty speaking). During a review of Resident 120's H&P dated 5/23/2025, the H&P indicated, Resident 120 does not have the capacity to understand and make decisions. During a review of Resident 120's MDS dated [DATE], the MDS indicated Resident 120 requires substantial/maximum assistance with upper and lower body dressing ,oral hygiene. Resident 120 is dependent (resident does none of the effort to complete an activity) with upper and lower body dressing . (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 120's care plan there was no care plan addressing Resident 120's aphasia. During an observation and interview on 6/10/2025 at 3:46 p.m., Resident 120's family member stated that Resident 120 did not have a communication board and has never been provided with one to assist in communicating with the staff. During an interview on at 6/10/2025 at 11:00 a.m., with Certified Nurse Assistant 3 (CNA 3), CNA 3 states Resident 120 does not have a communication board, and she does not know what one looks like. During an interview on 6/10/2025 at 2:23 p.m., with the Licensed Vocational Nurse 8 (LVN 8) , LVN 8 stated he was the one who placed a communication board in resident 120's room on 6/10/2025 because there was none. LVN 1 stated it is important there is a communication board available for Resident 120 so we can help her with her basic needs. During an interview on 6/13/2025 at 10:10 a.m., with Director of Nursing (DON), DON stated call lights should be in reach for easy access so residents can get the help that is needed. DON stated when working with a resident who has trouble communicating, they should have a communication board , DON stated the resident's self-esteem can be lowered, and they can be at risk for injury. During a review of the facility's P&P titled Answering the Call light undated, the P&P indicated the purpose of this procedure is to respond to the resident's requests and needs : 1.When a resident is in bed or confined to a chair be sure the call light is within easy reach of the residents. During a review of the facility's P&P titled Heritage Rehabilitation Center undated, the P&P indicated caring for someone with aphasia requires patience, understanding, and communication strategies that go beyond spoken words. Focusing on a quiet, well- lit environment, utilizing nonverbal cues , and providing clear , simple communication can significantly improve the experience for both the individual with aphasia and their caregivers. Use Alternative Communication Systems: Consider using visual aids like pictures , diagrams, or writing , and explore technology like smart phones or tablets with communication apps.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess and code the Minimum Data Set (MDS, resident assessment tool) assessments for one of six sampled residents (Resident 32) by failing to ensure Section GG 0115A was coded accurately to indicate functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) of Resident 32's both arms. This deficient practice had the potential to result in delayed or missed identification of joint range of motion (ROM, full movement potential of a joint) changes, inaccurate care planning, and inadequate provision of services and treatments for Resident 32. Findings: During a review of Resident 32's admission Record, the admission indicated Resident 32 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including osteoarthritis (loss of protective cartilage that cushions the ends of your bones) of the left shoulder and the left hand and contracture (loss of motion of a joint associated with stiffness and joint deformity) of an unspecified joint (where two bones meet). During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 32 required partial/moderate assistance for eating, oral hygiene, and upper body dressing, substantial/maximal assistance for rolling to both sides and transfers, and was dependent for toilet hygiene, lower body dressing, personal hygiene, and bathing. Section GG 0115A of the MDS for functional limitations in ROM was coded zero which indicated Resident 32 had no ROM limitations in both arms. During a review of Resident 32's Joint Mobility Evaluation (JME, a brief assessment of a resident's ROM in both arms and both legs), dated 6/27/2024, the JME indicated Resident 32 had minimal (26 - 50 percent [%]) ROM limitations in both shoulders and severe (76-100%) ROM limitations in both hands/fingers. During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 was cognitively intact. The MDS indicated Resident 32 required partial/moderate assistance for eating, oral hygiene, and upper body dressing, substantial/maximal assistance for rolling to both sides and transfers, and was dependent for toilet hygiene, lower body dressing, personal hygiene, and bathing. Section GG 0115A of the MDS for functional limitations in ROM was coded zero which indicated Resident 32 had no ROM limitations in both arms. During a review of Resident 32's JME, dated 9/27/2024, the JME indicated Resident 32 had minimal ROM limitations in both shoulders and severe ROM limitations in both hands/fingers. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/10/25 at 9:58 a.m., in Resident 32's room, Resident 32 was lying in bed. Resident 32's both elbows were bent, and both hands were in a fisted position with thin gauze material in the palms of both hands. The fingers of the left hand were hyperextended (the extension of a body part beyond it's normal limits) in the middle joints and bent at the fingertips. The fingers of the right hand were bent into a fisted position with the pointer finger hyperextended at the middle joint and bent at the fingertip. Resident 32 was unable to raise both arms to shoulder height and was unable to open both hands. During a concurrent interview and record review on 6/12/2025 at 3:25 p.m., the Minimum Data Set Nurse 1 (MDSN 1) and Minimum Data Set Nurse 2 (MDS 2) stated the MDS was an assessment tool completed upon admission, quarterly, and upon a significant change of condition to identify the needs of the residents in the facility. MDSN 1 and MDSN 2 stated the facility monitored for changes in joint ROM by the MDS (section GG0115) and JMEs performed by the Rehab Department. MDSN 1 and MDSN 2 stated Section GG 0115A indicated if a resident had functional ROM limitations in both arms. MDSN 1 and MDSN 2 stated they typically had a licensed therapist from Rehab assist in assessing a resident's ROM, observed a resident actively move his or her arms and legs to perform activities of daily living (ADLs, basic activities such as eating, dressing, and toileting) and compared the results to the JME when coding Section GG 0115. MDSN 1 and MDSN 2 reviewed Resident 32's MDS assessments, dated 6/27/2024 and 9/27/2024, and confirmed Section GG 0115A of both MDS assessments were coded a zero which mean Resident 32 had no ROM limitations in both arms. MDSN 1 and MDSN 2 reviewed Resident 32's JMEs, dated 6/27/2024 and 9/27/2024, and confirmed the JMEs indicated Resident 32 had minimal ROM limitations in both shoulders and severe ROM limitations in both hands. MDSN 1 and MDSN 2 confirmed Section GG 0115A on MDS assessments, dated 6/27/2024 and 9/27/2024, were coded incorrectly and should have been coded two since Resident 32 had ROM limitations in both arms. MDSN 1 and MDSN 2 stated it was important the MDS was coded accurately to ensure the facility provided the appropriate care, services, exercises, and equipment the residents needed. During an interview on 6/12/2025 at 5:13 pm, the Director of Nursing (DON), the DON stated it was important the MDS was coded accurately to ensure the facility was able to assess if the care provided was appropriate for the resident's needs. The DON stated incorrect coding of the MDS could potentially result in an inaccurate assessment of the resident which could negatively impact the care and services he or she received. During a review of the facility's Policy and Procedures (P&P) titled, Resident Assessments, revised 10/2023, the P&P indicated The resident assessment coordinator was responsible for ensuring the interdisciplinary team conducted timely and appropriate resident assessments. The P&P indicated all persons who completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the comprehensive care plan for two of four sampled residents (Resident 50 and 61) by failing to: 1.Revise and update Resident 50's care plan after a fall on 4/19/2025. 2.Revise and update Resident 61's care plan after Resident 61 pulled out her nasogastric tube (NG tube- a thin flexible tube inserted through the nose, down the throat, and into the stomach) and conduct an Interdisciplinary Team (IDT) conference. These failures resulted in Resident 50 falling on 5/22/2025 and Resident 61 pulling out her NG tube multiple times. Findings: 1. During a review of Resident 50's admission Record, the admission Record indicated Resident 50 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), osteoporosis (weak and brittle bones due to a lack of calcium and Vitamin D), fractures of left and right humerus (the long bone of the upper arm), repeated falls, and lack of coordination. During a review of Resident 50's Minimum Data Set (MDS-resident assessment tool) dated 5/22/2025, the MDS indicated Resident 50 had moderately impaired cognitive skills (ability to think, understand, learn, and remember) for daily decision making and was dependent (helper does all the effort) with toileting hygiene, showering and bathing. During a review of Resident 50's Change in Condition (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional condition) dated 4/19/2025 and timed at 6:30 a.m., the COC indicated Resident 50 was found sitting on the bathroom floor after getting out of bed unassisted and suddenly feeling weak. During a review of Resident 50's Interdisciplinary Team (IDT team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Note dated 4/28/2025 timed at 10:25 a.m., the IDT note indicated Resident 50 had an incident on 4/19/2025 around 6 a.m., when Resident 50 was observed sitting on the floor outside the bathroom. The IDT note indicated Resident 50 was assessed with no injury. The IDT note indicated Resident 50 was currently on a toileting schedule and has a talking device to remind and redirect Resident 50 to call for assistance. The IDT note indicated Resident 50 was observed by staff that she can manipulate the talking device. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 50's Care Plan titled, At risk for falls, difficulty maintaining sitting/standing balance, history of falls/multiple falls initiated on 12/25/2024, the Care Plan goal for Resident 50 was to have decrease in significant injury as a result from falls and to minimize the risk for falls in the next three months. The Care Plan interventions included call light within reach and respond in a timely manner, care items within reach, check for wetness, keep resident clean and dry at all times, frequent visual checks, bed in low position, schedule toileting every two hours and as needed, and supervise/assist resident with bedside care. During a review of Resident 50's Care Plan titled, At risk for falls, difficulty maintaining sitting/standing balance, history of falls/multiple falls initiated on 12/25/2024, the Care Plan did not indicate any revision on Resident 50's fall risk interventions and safety precautions after Resident 50 had a fall on 4/19/2025. During a review of Resident 50's COC dated 5/22/2025 and timed at 7:25 a.m., the COC indicated Resident 50 had an unwitnessed fall and was found lying on the floor. 2. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and dysphagia (difficulty swallowing). During a review of Resident 61's MDS dated [DATE], the MDS indicated Resident 61's cognition was severely impaired and was dependent for toileting, showering, dressing, personal hygiene, and rolling to either side in bed. During a concurrent interview and record review on 6/12/2025 at 8:55 a.m., with Licensed Vocational Nurse (LVN) 9, LVN 9 stated Resident 61 has pulled out her NG tube several times. LVN 9 validated that the care plan was not updated after each time Resident 61 pulled out her NG tube on 8/12/2024 and 4/24/2025. LVN 9 stated the care plan should be revised after each time Resident 61 pulls out her NG tube being it increases her risk of aspiration (when the feeding formula or stomach contents go into the lungs instead of the digestive system). LVN 9 stated revising the care plan was important to do to possibly lessen the number of times Resident 61 pulls out her NG tube and increase monitoring for Resident 61. During a concurrent interview and record review on 6/12/2025 at 10:10 a.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 validated Resident 61's care plan was not revised after she pulled her NG tube out on 8/12/2024 and 4/24/2025. RNS 2 stated the care plan should be updated after each time Resident 61 pulls out her NG tube so additional interventions could be added to prevent Resident 61 from pulling out her NG tube in the future. During a subsequent concurrent interview and record review on 6/12/2025 at 8:55 a.m., with LVN 9, LVN 9 stated Resident 50 was a high fall risk and that was the reason why Resident 50's room was closer to the nurse's station. LVN 9 stated after a fall, the care plan should be revised to prevent future falls from occurring. LVN 9 validated Resident 50's care plan dated 12/25/2025 was not revised following her fall on 4/19/2025 and it should have been done because additional interventions could have prevented the most recent fall on 5/22/2025 which resulted in fractures (broken bone). LVN 9 stated Resident 50's fall on 5/22/2025 was preventable if she had been monitored more closely and had a bedside commode (portable toilet) at her bedside being she gets up without assistance to use the bathroom. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent concurrent interview and record review on 6/12/2025 at 12:24 p.m., with RNS 2, RNS 2 stated Resident 50 was a high fall risk and recently had a fall on 5/22/2025. RNS 2 stated after Resident 50's fall on 4/19/2025 Resident 50's care plan should be revised to add new interventions to prevent future falls. RNS 2 validated Resident 50's care plan was not revised and should have been. RNS 2 stated its important to revise the care plan after a fall because the interventions in place were not effective, therefore new interventions will be added to prevent future falls. During an interview on 6/13/2025 at 9:24 a.m., with the Director of Nursing (DON), the DON stated a care plan is a guide and outlines the plan of care for the resident. The DON stated the care plan includes goals and interventions and should be revised when not effective. The DON stated Resident 50's care plan should have been revised after each fall so new interventions could be added to prevent future falls as well as for Resident 61 when she pulls out her NG tube. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered undated, the P&P indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and residents' conditions change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that facility staff did not administer Resident 120's benzonatate (a medication used to treat cough) capsules via gastrostomy tube ([G-tube] a soft tube surgically placed directly into the stomach for administration of medication and nutrition), for one of six sampled residents. This deficient practice failed to provide medication in accordance with professional standards of practice and had the potential to result in adverse effects and untreated cough for Resident 120. Findings: During a review of Resident 120's admission Record dated 6/10/2025, the admission Record indicated Resident 120 was admitted to facility on 5/22/2025 with diagnoses including but not limited to dysphagia (difficulty swallowing), aphasia (a disorder that makes it difficult to speak) following cerebral infarction (loss of blood flow to a part of the brain), pneumonia (an infection/inflammation in the lungs) due to methicillin susceptible staphylococcus aureus (a type of bacteria) and pneumonitis (inflammation of the lung tissue) due to inhalation of food and vomit. During a review of Resident 120's History and Physical (H&P), dated 5/23/2025, the H&P indicated, Resident 120 did not have the capacity to understand and make decisions. During a review of Resident 120's Minimum Data Set (MDS - resident assessment tool), dated 5/26/2025, the MDS indicated Resident 120 was unable to complete assessment for cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 120 needed maximal assistance from the facility staff for Activities of Daily Living (ADLs) such as oral hygiene, upper and lower body dressing, putting on/taking off footwear, dependent on staff for toileting, showering and personal hygiene. The MDS indicated there was no assessment for the level of assistance needed for eating due to medical condition or safety concerns. During an observation on 6/10/2025 at 1:48 p.m. in Resident 120's room, Licensed Vocational Nurse (LVN) 3 prepared ipratropium inhalation solution (a medication used to relieve difficulty in breathing) 0.02% for administration via nebulizer as needed for cough. Resident 120, who was non-verbal, indicated refusal of the medication by nodding her head when informed by LVN 3 about the medication and its purpose. During an interview on 6/10/2025 at 1:48 p.m. in Resident 120's room, a family member expressed concern that as needed cough medications were not administered unless Resident 120 specifically requested them. The family member could not recall the names of the medications but believed there was another as needed medication besides the ipratropium inhalation solution that helped with the cough. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/10/2025 at 2:22 p.m. with LVN 3, the medication card for Resident 120's benzonatate 100 mg and the Medication Administration Record (MAR) for June 2025 were reviewed. The medication card indicated, Benzonatate 100 mg, take 1 capsule via G-tube every 12 hours as needed for cough. The MAR indicated, benzonatate 100 mg capsules were administered as needed on 6/1/2025, 6/2/2025 and 6/9/2025. LVN 3 stated Resident 120 wanted the ipratropium inhalation solution for cough, but then she refused to take the medication. LVN 3 stated Resident 120 was on G-tube feedings, and had a physician order for benzonatate capsule 100 mg via G-tube every 12 hours as needed for cough. During a review of Resident 120's Order Summary Report dated 6/11/2025, the order summary report indicated, but not limited to the following physician order: Tessalon [NAME] (generic name - benzonatate) oral capsule 100 milligrams ([mg] a unit of measurement for mass), give 1 capsule via G-tube every 12 hours as needed for cough, order date 5/30/2025, start date 5/30/2025 Geri-Tussin ([generic name - guaifenesin] a medication used to treat cough) oral liquid 100 mg/5 milliliters ([mL] a unit of measurement for volume), give 10 mL by mouth every 12 hours for cough for 1 week, order date 6/4/2025, start date 6/4/2025, end date 6/11/2025 Geri-Tussin oral liquid 100 mg/5 mL, give 10 mL by mouth every 6 hours as needed for cough for 2 weeks, order date 6/4/2025, start date 6/11/2025, end date 6/25/2025 Geri-Tussin oral liquid 100 mg/5 mL, give 10 mL via g-tube every 12 hours for cough until 6/11/2025 20:59 (10:59 p.m.) total 1 week (started on 6/4/2025), order date 6/10/2025, start date 6/10/2025, end date 6/11/2025 Geri-Tussin oral liquid 100 mg/5 mL, give 10 mL via g-tube every 6 hours as needed for cough for 2 weeks, order date 6/10/2025, start date 6/11/2025, end date 6/25/2025 Ipratropium bromide inhalation solution 0.02%, 1 vial inhale orally via nebulizer (a device that converts liquid medication into a mist that can be inhaled into the lungs to treat breathing difficulty) every 6 hours as needed for cough, order date 6/8/2025, start date 6/8/2025 During an interview on 6/10/2025 at 4:03 p.m. with LVN 3, LVN 3 stated the facility was instructed by the pharmacy (PH 1) to puncture benzonatate capsule, remove the medication fluid and pour it in the g-tube with water as instructed per physician order. LVN 3 stated she did not have a reference or literature to indicate this method of use for benzonatate capsule and stated she would ask PH 1 to provide that information. (continued on next page)

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Heritage Rehabilitation Center	21414 S. Vermont Avenue Torrance, CA 90502

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 6/10/2025 at 5:15 p.m. with Registered Pharmacist (RPH 1), RPH 1 stated that they instructed facility staff to squeeze/aspirate the benzonatate capsule to extract the medication from the capsule and then pour and administer via g-tube directly, followed by a water flush as directed by physician order. RPH 1 mentioned that there were no specific references or literature available regarding the use of benzonatate capsules via g-tube but noted that both RPH 1 and other pharmacists had observed this method being used. RPH 1 stated that according to hospital records, pharmacists' experience, and doctor's orders, administering benzonatate capsules via g-tube was deemed acceptable because the benefits of treating cough outweighed the potential risk of mucosal membrane irritation. During a phone interview again on 6/11/2025 at 10:24 a.m. with RPH 1, RPH 1 stated for an example, in cases of drug- drug interactions we still give medications, similarly, although there were no studies regarding the use of benzonatate capsule via g-tube, but it has been used safely in that manner. RPH 1 stated although the mechanism of action indicated a localized effect, benzonatate capsule would still be absorbed via gastrointestinal tract and have peripheral (effects outside of brain and spinal cord), and central (effects within brain and spinal cord) effect. RPH 1 then stated he recommended to the Director of Nursing (DON) and the physician in the morning to try guaifenesin liquid via g-tube for Resident 120 first before trying benzonatate capsule via g-tube. During an interview on 6/12/2025 at 1:03 p.m. with the DON, the DON stated for a resident with g-tube, the staff should have selected a liquid formulation to be administered via g-tube. the DON stated benzonatate capsule could cause burning sensation in the mouth if given by removing the liquid from the capsule. The DON stated there was a risk for benzonatate capsule to not be properly aspirated for the dose needed. The DON stated it would not be possible to ensure its safety and efficacy for Resident 120. The DON stated facility staff should check medication card, drug handbook or call pharmacy to determine if the medication was on the do not crush list. During a review of the facility's Tessalon [NAME] and capsule's package insert, dated 12/2015, the document indicated, Swallow Tessalon capsules and [NAME] whole. Do not break, chew, dissolve, cut, or crush Tessalon capsules and [NAME]. Release of Tessalon from the capsule in the mouth can produce a temporary local anesthesia of the oral mucosa and choking could occur. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, undated, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The individual administering medications must check the label three times to verify the right medication , right time and right method of administration before giving the medication. During a review of the facility's P&P titled, Administering Medications through an Enteral Tube, undated, the P&P indicated, 1. Request liquid forms of medications from the pharmacy, if possible. 2. Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved 'Do not Crush Medication List.' 3. Do not crush the contents of an opened capsule. Do not administer oily medications through an enteral tube.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary care and treatment for four of six sampled residents (Resident 19, 14. 61 and 39). The facility failed to: 1. Ensure Licensed Vocational Nurse (LVN) 8, LVN 9 and Registered Nurse (RNS) 4 assessed and monitored Resident 19 when the resident had a change in condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, and understand] behavioral, or functional status which without immediate intervention, may result in complications or death) manifested by shivering and shaking on 6/8/2025 at 11:10 p.m., and every two hours thereafter. 2. Ensure LVN 8 informed LVN 9 of Resident 19's shivering and shaking on 6/8/2025 at 11:10 p.m. during change of shift handoff. These failures resulted in Resident 19 found unresponsive on 6/9/2025, at 4:14 a.m., pronounced dead on 6/9/2025 at 5:03 a.m. after cardiopulmonary resuscitation (CPR- an emergency procedure used to restart a person's heart and breathing by giving strong, rapid pushes to the chest to keep blood moving through the body) efforts. 3. Ensure Resident 14 was provided with medications for constipation (a condition in which stool becomes hard, dry , difficult to pass, and bowel movements become infrequent) when Resident 14 had no bowel movement (the movement of feces through bowel and out of anus) for three days. This failure had the potential to put Resident 14 at risk for fecal impaction (hardened stool that is stuck in the rectum) that could lead to bowl obstruction (partial or complete blockage of small or large intestine which is life threatening). 4.a.Ensure licensed staff document a change in condition each time Resident 61's nasogastric tube (NG tube- a thin flexible tube inserted through the nose, down the throat, and into the stomach) was pulled out by Resident 61. b. Ensure an order was obtained prior to reinserting Resident 61's NG tube. Document the location of the NG tube placement for Resident 61. These failures had the potential to cause delay in provision of necessary care and treatment to Resident 61 and complications of prolonged used of NG tube. 5. Ensure Resident 39's physician was notified that Resident 39 was taking clopidogrel (a medication used to prevent blood clots with a side effect of bleeding), after the resident sustained a fall. This failure prevented the physician from being able to make informed decisions regarding the care and treatment of Resident 39. Findings: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1. During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), cardiomyopathy (a long term condition that affects the heart muscle making it harder to pump blood), Covid -19 (highly contagious respiratory disease caused by Coronavirus which is transmitted thru coughing, talking , sneezing and touching contaminated surfaces), and end stage renal disease (ESRD- irreversible kidney failure) with dependence on renal hemodialysis (procedure to remove waste products and excess fluids from the blood when kidneys stop working properly). The admission Record indicated the resident was discharged to a funeral home on 6/9/2025 at 10:25 a.m. During a review of Resident 19's Minimum Data Set (MDS-resident assessment tool) dated 5/15/2025, the MDS indicated Resident 19 had moderately impaired cognitive skills (ability to think, understand, learn, and remember) and was dependent on staff (helper does all the effort to complete the activity) with bathing, dressing, toilet transfer (ability to get on and off a toilet or a commode) and toileting hygiene. During a review of Resident 19's Weights and Vital Signs (VS- basic functions of the body such as temperature, blood pressure (a pressure of the blood against the artery walls when the heart beats), pulse and respiratory rate [breathing] rate), the Weights and Vital Signs Summary indicated the following: 1. On 6/8/2025, at 5:57 p.m. Resident 19's blood pressure (bp reading was 130/72 millimeters of mercury (mmHg-unit of blood pressure measure) 2. On 6/8/2025, at 10:59 a.m. Resident 19's heart rate (HR- number of times the heart beats per minute; reference range is between 60 to 100 beats per minute) was 65 beats per minute, respiratory rate (RR-number of breaths a person takes per minute; reference range is between 12 to 18 breaths per minute) was 18 RR per minute, temperature was 97.5 degrees Fahrenheit (°F- unit of measurement; reference range between 97 degrees F to 99 degrees F), and oxygen saturation (O2 Sat- concentration of oxygen in the blood; reference range between 95 percent to 100 percent) was 97 percent (%) on room air (no supplemental oxygen used). During a review of Resident 19's Transfer/Discharge summary, dated [DATE] and timed at 8:09 a.m., the Transfer/Discharge Summary indicated on 6/9/2025, at 4:30 a.m. , the charge nurse was summoned due to Resident 19 not responding and not breathing. The Transfer/Discharge Summary indicated Registered Nurse (RNS) 4 responded to the summon right away. The Transfer/Discharge Summary indicated chest compressions (applying pressure on someone's chest in order to help blood flow through the heart in an emergency situation) were started, oxygen was delivered to Resident 19 via Ambu bag (a portable, hand held device used to provide respiratory support to patients in emergency situation), and 911(number that is called in order to contact the emergency services) was called. The Transfer /Discharge Summary indicated paramedics (highly trained healthcare professionals who provide emergency medical care) arrived on 6/9/2025 at 4:35 a.m. and continued cardiopulmonary resuscitation (CPR- an emergency procedure used to restart a person's heart and breathing by giving strong, rapid pushes to the chest to keep blood moving through the body) on Resident 19. The Transfer/Discharge Summary indicated paramedics' team leader pronounced Resident 19 expired on 6/9/2025 at 5:03 a.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 19's Emergency Medical Services (EMS-a system that respond to emergencies in need of highly skilled prehospital clinicians) Incident Information dated 6/9/2025, at 4:35 a.m., the EMS Incident Form indicated EMS team was notified on 6/9/2025 at 4:35 a.m. of Resident 19's cardiac arrest (heart malfunctions and stops beating on its own caused by an electrical problem in the heart). The EMS Incident Information indicated a team was dispatched to the facility and arrived at 4:40 a.m. The EMS Incident Information indicated facility staff stated to the EMS team that Resident 19 was last seen on 6/9/2025, at 4:15 a.m. sleeping and breathing. The EMS Incident Form indicated Resident 19 was in asystole (when heart's electrical system fails entirely causing the heart to stop pumping and is also known as flat line) upon assessment and throughout the entirety of the resuscitative effort provided to the resident. The EMS Incident Information indicated the time of death of Resident 19 was 5:03 a.m. on 6/9/2025. During a review of Resident 19's Medication Administration (MAR) dated 5/18/2025, the MAR indicated an order for Humulin (Insulin NPH- intermediate acting insulin to treat DM that reaches the blood stream in about 2 to 4 hours) suspension 100 unit/milliliter (ml-unit of measurement) inject 10 unit subcutaneously (applied under the skin) in the evening for DM with food. During a review of Resident 19's Care Plan titled, Potential for hyperglycemia (condition in which the level of sugar in the blood) /hypoglycemia (low blood sugar). related to DM, initiated on 5/31/2024 and revised on 5/20/2025, the Care Plan indicated Resident 19 had an episode of hyperglycemia and hypoglycemia The Care Plan indicated the goal for Resident 19 was to be asymptomatic (not showing symptoms) of hyperglycemia and hypoglycemia daily for three months. The Care Plan indicated the interventions included to notify the physician of the resident's change in condition and to monitor, document, and report to the physician as needed any signs and symptoms of hypoglycemia such as sweating, tremor (shaking movements in one or more parts of the body), increased heart rate, pallor (skin paleness), nervousness, confusion, slurred speech and lack of coordination. During a telephone interview on 6/12/2025 at 10:49 a.m., with Certified Nursing Assistant (CNA) 8, CNA 8 stated on 6/8/2025, at 11:10 p.m. he noticed Resident 19 was shaking and shivering. CNA 8 stated he gave him (Resident 19) a blanket. CNA 8 stated he told Licensed Vocational Nurse (LVN) 8 about Resident 19's shaking and shivering and that Resident 19 did not look good because his upper body was shaking. CNA 8 stated LVN 8 took Resident 19's temperature and told CNA 8 that Resident 19 was okay, and that Resident 19 had been shaking and shivering because had taken a shower. CNA 8 stated on 6/9/2025, from12:00 a.m. to 12:30 a.m. Resident 19 was awake, and was no longer shaking, appeared awake but was staring at the ceiling. CNA 8 stated he asked Resident 19 at that time if he was okay, and the Resident 19 stated he was okay. CNA 8 stated on 6/8/2025, after 12:30 a.m. he got busy with other residents and did not see Resident 19 until 4:14 a.m. on 6/9/2025. CNA 8 stated on 6/9/2025, at 4:14 a.m. he entered Resident 19's room and turned on the lights upon entrance., CNA 8 stated he did not hear Resident 19 talking but he (CNA 8) did not look at Resident 19 as he was to changing Resident 19's roommate. CNA 8 stated after he almost finished changing Resident 19's roommate incontinent pad (diaper), he looked at Resident 19 and saw Resident 19 not moving, his chest did not rise or fall and looked dead. CNA 8 stated he notified LVN 9 immediately. LVN 9 called RNS 4 and called Code Blue (announcement in the facility that someone is experiencing a life-threatening medical emergency). CNA 8 stated LVN 8 and LVN 9 did not tell him to monitor or check on Resident 19 after he had an episode of shaking and shivering on 6/8/2025 at 11:10 p.m. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 6/12/2025, at 7:19 a.m. and subsequent telephone interview on 6/12/2025, at 10:14 a.m. with LVN 9, Resident 19's electronic medical records (EHR) was reviewed. LVN 9 stated he did not see Resident 19 after 11:30 p.m. on 6/8/2025 when Resident 19 had episode of shaking and shivering because he was busy with another resident (unknown) who was restless, confused and was trying to get out of bed. LVN 9 stated most of his time on 6/9/2025 was spent with that resident (unknown) . LVN 9 stated he saw Resident 19 awake, resting comfortably at 11:30 p.m. on 6/8/2025 but did not talk to the resident. LVN 9 stated the last time he saw Resident 19 was on 6/8/2025 at 11:30 p.m. LVN 9 stated LVN, RN, or CNA should conduct rounding (in general) every two hours. LVN 9 stated he received report from LVN 8 from outgoing 7 p.m.- 11 pm shift but LVN 8 did not mention any change in Resident 19's condition such as shaking and shivering and reported Resident 19 was okay. LVN 9 stated he notified RNS 4 that he was busy with another resident (unknown) on 6/9/2025. LVN 9 stated RNS 4 did not come to see him (LVN 9) or see Resident 19. LVN 9 stated on 6/9/2025, at 4:30 a.m., CNA 8 notified him that Resident 19 was not breathing, and code blue was announced. LVN 9 stated they initiated CPR and EMS arrived on 6/9/2025 at 4:35 a.m. and took over the CPR During a telephone interview on 6/12/2025, at 11:39 a.m. with LVN 8, LVN 8 stated on 6/8/2025, at around 11:00 p.m., CNA 8 notified LVN 8 that Resident 19 was shivering and shaking. LVN 8 stated he provided an extra blanket and took Resident 19's temperature. LVN 8 stated he took the temperature, and it was normal but did not remember what the temperature was when Resident 19 was shivering and shaking. LVN 8 stated he did not document the temperature on Resident 19's health record. LVN 8 stated Resident 19's shivering and shaking considered a change in the resident's condition because it probably was indicating the resident had a fever or hypoglycemia (low blood sugar). LVN 8 stated he did not do a change of condition because he had done his intervention already by checking Resident 19's temperature and providing Resident 19 with a blanket. LVN 8 stated he did not inform Resident 19's physician about the shivering and shaking and did not check Resident 19's other vital signs including blood pressure, pulse rate, respiratory rate, oxygen saturation, and blood sugar. LVN 8 stated he should have checked the Resident 19's vital signs, notified the physician to address the change in condition , initiate a COC, monitor Resident 19 frequently (at least every two hours) and checked his blood sugar when Resident 19 was shivering and shaking as Resident 19 had a history of hypoglycemia (low blood sugar) and was receiving insulin (medication to treat DM). LVN 8 stated Resident 19 had a change in condition due to low blood sugar last month (May). LVN 8 stated he administered NPH Insulin (intermediate acting insulin to treat DM that reaches the blood stream in about 2 to 4 hours) on 6/8/2025 at 6:00 p.m., LVN 8 stated NPH insulin could lower the blood sugar within 4 to 5 hours of administration. LVN 8 stated failure to monitor Resident 19 after the resident was having symptoms of shaking and shivering could have contributed to Resident 19's death. LVN 8 stated he should have checked Resident 19's vital signs, notify the physician who could have ordered a transfer to the hospital for further evaluation, monitor the resident by conducting a COC to ensure Resident 19's condition would not worsen. LVN 8 stated he should have informed LVN 9 and RNS 4 regarding Resident 19's shaking and shivering to keep an eye on Resident 19 on 6/8/2025. During an interview on 6/12/2025, at 8:29 a.m., with RNS 4, RNS 4 stated on 6/8/2025, at 10:30 p.m. Resident 19 was asleep. RNS 4 stated she did not go to Resident 19's room until the resident was found pulseless and not breathing on 6/9/2025 at 4:30 a.m. RNS 4 stated on 6/9/2025, at 4:30 a.m. Resident 19 was pulseless and they were unable to check his vital signs. RNS 4 stated they initiated CPR on Resident 19 and another staff called 911. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/12/2025, at 3:19 p.m. with RNS 2, RNS 2 stated when Resident 19 had shaking and shivering on 6/8/2025 at 11:10 p.m., Resident 19 should have been monitored closely as it was considered a COC. RNS 2 stated a COC should be performed when the condition of a resident deviated from his baseline (an initial measurement of a condition that is taken at an early time point and used for comparison over time to look for changes in condition) . RNS 2 stated doing COC was important to ensure monitoring of the change of condition was performed, assessment and evaluation of the resident's condition done, and the physician informed to obtain physician orders for treatment. During an interview on 6/12/2025, at 4:49 p.m. with the Director of Nursing (DON), the DON stated facility staff should checked resident every two hours. The DON stated Resident 19's symptoms of shaking and shivering were considered a change of condition. The DON stated LVN 8 should have done a COC, checked the full set of vital signs, not just the temperature, including blood sugar because Resident 19 received 10 units of NPH insulin on 6/8/2025 at 4:38 p.m., and 2 units of sliding scale Regular insulin at 9:32 p.m. The DON stated LVN 8 should have informed LVN 9 and RNS 4 when Resident 19's had episode of shivering and shaking on 6/8/2025 at 11:10 p.m., during handoff. The DON stated COC was a monitoring tool and not having vital signs documented meant VS were not done. The DON stated the licensed nurse should have done a COC, took a full set of vital signs, rechecked resident's blood sugar, notified the physician, assessed and monitored Resident 19 when he had shivering and shaking. The DON stated Resident 19 should have been monitored and assessed and could have transferred to general acute care hospital (GACH) in a timely manner. The DON stated Resident 19 expired on 6/9/2025, at 5:03 a.m. 3. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including constipation, repeated falls, urinary tract infection (UTI- an infection in the bladder/urinary tract), polyp of the colon (mall clump of cells that forms in the lining of the colon), and major depressive disorder(serious mental illness characterized by persistent sadness, loss of interest in activities, and significant impairment in daily functioning). During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 had an intact cognition and required partial/moderate assistance (helper does less than half the effort) with toilet transfer(ability to get on and off a toilet commode), bed mobility, and bathing. The MDS indicated Resident 14 was always incontinent (having no or insufficient voluntary control) of stool. During a review of Resident 14's Activities of Daily Living (ADL- activities such as bathing, dressing and toileting a person performs daily) Task for bowel and bladder elimination, the ADL Task indicated Resident 14 did not have a bowel movement (BM-process of emptying the bowels of solid or semisolid feces) on 6/1/2025, 6/2/2025, 6/3/2025 and on 6/7/2025, 6/8/2025, 6/9/2025. During a review of Resident 14's Care Plan titled, Potential Alteration in Bowel Elimination related to Constipation, initiated on 4/26/2025. the Care Plan indicated the goal for Resident 14 to have bowel movement regularly for the next three months. The Care Plan indicated the interventions included monitoring for bowel movement, for amount, consistency and frequency, review medication that cause constipation, and administer medication as ordered. During a review of Resident 14's Physician's Order Summary Report , the Physician's Order Summary Report, dated 5/5/2025 indicated an order of Sertraline (medication used to treat depression) 25 milligrams (mg-. unit of measurement) one tablet at bedtime for depression. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 14's Physician's Order Summary Report, the Physician's Order Summary Report dated 5/5/2025 indicated a physician's order to monitor side effects of anti-depressant (medication used to treat depression) medication such as constipation. During a review of Resident 14's Physician's Order Summary Report, the Physician's Order Summary Report dated 5/23/2025 indicated an order of Bisacodyl (used to treat constipation) 10 mg Suppository, to insert one suppository rectally (given via rectum) as needed for constipation if no BM in 24 hours. During a review of Resident 14's Physician's Order Summary Report, the Physician's Order Summary Report indicated an order for 70 percent (%- quantify the amount or concentration of the medicine) Sorbitol solution (used to treat occasional episodes of constipation) 30 milliliter (ml- unit of measurement) every 6 hours as needed for constipation. During an interview on 6/9/2025, at 11:03 a.m. with Resident 14, Resident 14 complained of constipation and stated she did not have a bowel movement for a while. Resident 14 stated she kept telling the staff about her concern (constipation). During an interview on 6/10/2025, at 12:06 p.m. with Certified Nursing Assistant (CNA 5), CNA5 stated if the resident (in general) has no bowel movement for three days, the CNA notifies the charge nurse CNA 5 stated she did not check Resident 14 if the resident had BM for the past few days (6/7/2025, 6/8/2025, 6/9/2025). CNA 5 stated she should have checked if Resident 14 had a bowel movement for the past few days (6/7/2025, 6/8/2025, 6/9/2025). CNA 5 stated Resident 14 would get constipated with the risk to go to the hospital. During a concurrent interview and record review on 6/10/2025 at 3:22 p.m., with LVN 11, Resident 14's MAR and ADL Task for Bowel and Bladder Elimination were reviewed. LVN 11 stated Resident 14 had no bowel movement on 5/28/2025, 5/29/2025, 5/30/2025 and on 6/7/2025, 6/8/2025, 6/9/2025, and 6/10/2025. LVN 11 verified through MAR review that Resident 14 did not receive any as needed (prn) medications for constipation on the days Resident 14 had no BM for 3 days. LVN 11 stated the licensed nurse should have assessed Resident 14 for abdominal pain, asked the resident if she had a bowel movement monitored BM frequency, and administered prn medications for constipation. LVN 11 stated Resident 14 could be at risk for bowel obstruction (occurs when something blocks the normal passage of digested food, and fluids), sepsis (serious condition in which the body responds improperly to an infection) or infection that could lead to death if constipation was not addressed. During an interview on 6/12/2025, at 3:08 p.m. with RN Supervisor (RNS 2), RNS 2 stated Resident 14 could be at risk for fecal impaction (a large lump of dry, hard stool that stays stuck in the rectum), bowel obstruction, abdominal discomfort, nausea, vomiting and could increase Resident 14 risk for hospitalization if constipation was not addressed. RNS 2 stated the licensed nurse should have monitored Resident 14's BM frequency and on if there was no BM on the third day, the licensed nurse should have administered the prn medication for constipation as ordered. During an interview on 6/12/2025, at 4:43 p.m. with the DON, the DON stated the LVN (in general) should have monitored Resident 14's BM frequency, informed the physician and administered prn medication for constipation on the third day if the resident had no bowel movement. The DON stated if Resident 14's constipation was not addressed the resident appetite would be affected by the resident would have an abdominal discomfort and vomiting, and possible bowel obstruction. (continued on next page)

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	056308	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Rehabilitation Center	21414 S. Vermont Avenue Torrance, CA 90502

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F 0684 Level of Harm - Actual harm Residents Affected - Few	4. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and dysphagia (difficulty swallowing). During a review of Resident 61's MDS dated [DATE], the MDS indicated Resident 61's cognition was severely impaired and was dependent for toileting, showering, dressing, personal hygiene, and rolling to either side in bed. During a review of Resident 61's Order Summary Report, the Order Summary Report indicated there were a total of seven orders (5/9/2024, 8/12/2024, 10/27/2024, 11/19/2024, 1/11/2025, 4/24/2025, and 5/25/2025) placed for chest X-rays (pictures of the inside of your body) for NG tube placement. During a review of Resident 61's Order Summary Report, the Order Summary Report indicated an order was placed 1/11/2025 and 4/24/2025 for a chest X-ray for NG tube placement with no order to re-insert the NG tube. During a review of Resident 61's COC dated 1/11/2025, timed 10:30 a.m., the COC indicated Resident 61 pulled out her NG tube. No COC for 4/24/2025 for when Resident 61 pulled out her NG tube. During a review of Resident 61's Care Plan title Potential for injury related to pulling out NG tube, the Care Plan indicated there were no revisions made to the care plan after Resident 61 pulled her NG tube out on 5/9/2024, 8/12/2024, 10/27/2024, 11/19/2024, 1/11/2025, 4/24/2025 and 5/25/2025. During an interview on 6/11/2025 at 9:19 a.m., with Certified Nurse Assistant (CNA) 9, CNA 9 stated Resident 61 has mitten restraints (prevents someone from grabbing something) because she tends to pull out her NG tube. During a concurrent interview and record review on 6/12/2025 at 8:29 a.m., the Licensed Vocational Nurse (LVN) 9, LVN 9 stated Resident 61 pulls her NG tube out at least every three months. LVN 9 stated there should be an order for NG tube re-insertion, a COC documented, and documentation indicating when and which nostril the NG tube was placed. LVN 9 validated there were no orders to re-insert Resident 61's NG tube on 1/11/2025 and 4/24/2025. LVN 9 validated there were no COC documented on 4/24/2025. LVN 9 validated there were no documentation when and where the NG tube was re-inserted on 5/9/2024, 8/12/2024, 10/27/2024, 11/19/2024, 1/11/2025, 4/24/2025, and 5/25/2025. LVN 9 stated there should be a progress note indicating which nostril the NG tube was placed. During an interview on 6/12/2025 at 10:10 a.m., with the Registered Nurse Supervisor (RNS) 2, RNS 2 stated when Resident 61 pulls out her NG tube, there should be an order to re-insert the NG tube, a COC documented, and documentation of which nostril the NG tube was placed. RNS stated it was important to document which nostril the NG tube was placed to better monitor for complications of the affected nostril and to ensure they rotate sites of where the NG tube was placed. During an interview on 6/13/2025 at 9:24 a.m., with the Director of Nursing (DON), the DON stated Resident 61 had removed her NG tube several times and each time there should be an order to re-insert, a COC documented, and documentation of re-insertion and which nostril the NG tube was re-inserted and if not, this was to be considered inaccurate documentation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Nasogastric Tube Insertion and Care, undated, the P&P indicated, Verify that there is a physician's order for insertion of the nasogastric tube. The person performing this procedure should record the following information in the resident's medical records: the date and time the procedure was performed, the size and length of the nasogastric tube, and verification of tube placement. During a review of the facility's P&P titled, Charting and Documentation, undated, the P&P indicated, The following documentation is to be documented in the resident medical record: treatments or services performed, changes in the residents condition, events, incidents, or accidents involving the resident and progress toward or changes in the care plan goals and objectives. 5. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] with the diagnoses including malignant neoplasm of prostate (prostate cancer) and cerebral vascular accident (CVA - a stroke, loss of blood flow to a part of the brain). During a review of Resident 39's Medication Administration Record (MAR) for 11/ 2024, the MAR indicated Resident 39 was receiving clopidogrel 75 milligrams (mg- unit of measurement) daily to prevent a stroke During a review of Resident 39's care plan, titled Resident was at risk for bleeding/bruising/skin tear/hematuria (blood in the urine) /melena (blood in the stool) secondary to clopidogrel, the Care Plan interventions included to monitor Resident 39 for bruises or bleeding episodes. The care plan interventions also indicated the physician should be notified accordingly for unusual observation related to clopidogrel. During a review of Resident's 39's Change of Condition Evaluation (COC- a tool used by health care professionals when communicating about critical changes in residents' status) dated 11/9/2024, the COC indicated Resident 39 fell from the wheelchair to the ground. The COC did not indicate Licensed Vocational Nurse (LVN) 10 reported the resident was on clopidogrel to the on-call physician. During an interview on 6/12/2025 at 2:27 p.m., with LVN 10, LVN 10 stated they should have notified Resident 39's physician that Resident 39 was on clopidogrel because of the potential risk for bleeding. LVN 10 stated the physician would have ordered labs and an x-ray (create images of the inside of the body) immediately to see if Resident 55 was bleeding internally had they been notified. LVN 10 stated it was important to notify the doctor of antiplatelets (medications used to prevent blood clots) when a resident falls because of the risk for internal bleeding. During an interview on 6/12/2025 at 1:59 p.m., with Registered Nurse Supervisor (RNS) 3, RNS 3 stated, If a resident falls and the physician just orders to monitor the resident when they are on antiplatelet therapy, the nurse was responsible to take the initiative and notify the physician to recommend an x-ray and evaluation. This resident (Resident 39) should have at least had an x-ray done for possible internal bleeding. During an interview on 6/12/2025 at 5:13 p.m., with the Director of Nursing (DON), the DON stated that notifying the physician of a resident being on blood thinners or antiplatelets after they fall will determine the physician's course of actions and what they would order; it was part of the facility's protocol to accurately report to the doctor. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P)titled, Change in a Resident's Condition, undated, the P&P indicated the facility will promptly notify resident's attending physician and representatives of changes in the resident's medical/ mental condition. The P&P indicated the Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical condition. During a review of facility's Job Description of a Charge Nurse undated, the Job Description of a Charge Nurse indicated the charge nurse will accurately assess, document, and report the resident's symptoms, reactions, progress to the attending physician ,nursing supervisor , DON, Administrator and other participating in care and treatment of the resident. The Job Description of a Charge Nurse indicated the charge nurse will promptly notify the attending physician and responsible party, family of change in resident's condition and in accordance with the facility's policies and procedures.

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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, interviews and record reviews, the facility failed to provide the necessary treatment and services to minimize the risk of development of pressure injuries (PIs, areas of damaged skin caused by staying in one position for too long) for one of three sampled residents (Resident 115) by failing to: a.Ensure the low air loss mattress (LALM - a pressure relieving mattress filled with air) remains inflated. This deficient practice had the potential for Resident 115 to develop new pressure injury and skin wounds to worsen. Findings: During a review of Resident 115's admission Record, the admission Record indicated the facility admitted Resident 115 on 4/21/2025 with diagnoses of muscle wasting and atrophy (partial or complete wasting away of the body), not elsewhere classified, multiple sites, pressure-induces deep tissue damage of sacral region (pressure ulcer of lower back and spine), pressure-induces deep tissue damage of the left heel, pressure-induces deep tissue damage of the right heel and essential primary hypertension (high blood pressure). During a review of Resident 115's Minimum Data Set (MDS, a care assessment and screening tool), dated 4/24/2025, the MDS indicated Resident 115 cognition was intact and required substantial/maximal assistance (helper does more than half the effort) for showering, supervision or touching assistance (helper provides verbal cues and/ or touching /steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene and personal hygiene. During a review of Resident 115's Order Summary Report (OSR) dated 4/22/2025, the OSR indicated that Resident 115 was prescribed a LALM for wound management. During a review of Resident 115's care plan titled, At Decubitus Risk to Further Develop Pressure Ulcer indicated the nursing intervention for low air loss mattress. During an observation on 6/9/2025, at 10:45 a.m., Resident 115 was observed in bed with the LALM deflated. The resident stated that the bed was hard. During a concurrent observation and interview on 6/9/ 2025, at 3:05 p.m., with the Registered Nurse 4 (RN 4), RN 4 stated that the bed used by Resident 115 is designed to help prevent pressure ulcers. RN 4 explained that it is the Certified Nursing Assistant's (CNA) responsibility to inform the charge nurse if the air mattress is not inflated. It is also the nursing staff's duty, along with the treatment nurse, to ensure that the bed is properly set up and inflated. The Licensed Vocational Nurse (LVN) emphasized the importance of keeping the resident's bed inflated at all times to prevent further deterioration of the wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/9/2025 at 3:15 p.m., Treatment Nurse 1 (TN 1) mentioned he visited resident 115 an hour earlier but did not check the mattress patency. TN 1 noted that Resident 115 has pressure wounds, which could worsen without the mattress. He emphasized that the resident needs the LALM on. During an interview on 6/13/2025 at 10:20 a.m. with the Director of Nursing, it was stated that an LALM is a preventive measure to prevent skin breakdown. The responsibility to ensure it is functioning lies with the TN and the LVN. If it is not working, it can hinder its purpose and potentially worsen the wound. During a review of the facility's policies and procedures (P&P) titled Support Service Guidelines undated, the P&P indicated the purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk for skin breakdown. 1.Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as a foam, gel, static air, alternating air or air- loss or gel when lying in bed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to improve and/or prevent a decline in range of motion (ROM, full movement potential of a joint) for one of six sampled residents (Resident 39) by failing to provide Resident 39 with active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) exercises to the left ankle per Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) physician's orders and in accordance with Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) recommendations. This deficient practice had the potential to cause Resident 39 to have a decline in ROM leading to contracture (loss of motion of a joint) development and have a decline in physical functioning and mobility (ability to move). Findings: During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including malignant neoplasm of the prostate (cancerous tumor of the prostate gland), contracture of an unspeficied joint (where two bones meet), and muscle wasting (thinning or loss of muscle tissue). During a review of Resident 39's PT Evaluation and Plan of Treatment (PT Eval), dated 1/14/2025, the PT Eval indicated Resident 39 had impaired strength in both hips, knees, and ankles. During a review of Resident 39's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated discharge recommendations for a Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) program for PROM exercises and stretching to Resident 39's both legs. During a review of Resident 39's Minimum Data Set (MDS, resident assessment tool), dated 3/18/2025, the MDS indicated Resident 39 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 39 required supervision or touching assistance for eating, substantial/maximal assistance for upper body dressing, and was dependent for oral hygiene, toileting hygiene, bathing, lower body dressing, personal hygiene, rolling, and transfers. The MDS indicated Resident 39 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one leg (hip, ankle, knee, foot). During a review of Resident 39's Order Summary Report, the Order Summary Report indicated a physician's order for RNA to provide AAROM exercises to Resident 39's left leg, three times a week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/10/2025 at 9:27 am, in Resident 39's room, Resident 39 was lying in bed. Resident 39's right leg was straight with a slight bend in the knee and the toes pointing downwards. Resident 39's left leg was bent and outwardly rotated with the knee fully bent and the toes slightly pointing downwards. Resident 39 tried to straighten the left knee and left ankle but could not and stated he needed assistance to move the leg because it was so painful. During an observation of Resident 39's RNA session on 6/11/2025 at 8:56 am, in Resident 39's room, Resident 39 was lying in bed. Restorative Nursing Aide 1 (RNA 1) assisted Resident 39 with ROM exercises to both shoulders, elbows, wrists, and hands. RNA 1 assisted Resident 39 with ROM exercises to the left hip and left knee. RNA 1 did not assist Resident 39 with left ankle ROM exercises. After completing left hip and left knee ROM exercises, RNA 1 applied a splint to Resident 39's left knee and proceeded to assist Resident 39 with ROM exercises to the right hip, knee, and ankle. During an interview on 6/11/2025 at 9:07 am, RNA 1 stated she did not provide ROM exercises to Resident 39's left ankle but should have. RNA 1 confirmed there was an RNA order for RNA to provide AAROM to Resident's left leg which meant assisting with ROM exercises to the entire leg, including the left hip, knee, and ankle. RNA 1 stated Resident 39 required assistance with ROM exercises to both legs due to weakness, particularly the left leg. RNA 1 stated it was important to assist Resident 39 with left ankle ROM because the left ankle was stiff, and he was unable to move the ankle on his own. RNA 1 stated it was important to provide ROM exercises as ordered to prevent joint stiffness. During an interview on 6/12/2025 at 2:49 pm, the Director of Rehabilitation (DOR), the DOR stated the purpose of RNA services was to maintain and improve a resident's functional level and ROM. The DOR stated the Rehab department determined the types of exercises RNAs were to perform when creating an RNA program. The DOR stated if an RNA order was written for ROM exercises to the left leg, it was expected the RNA provide ROM to the entire leg, including the hip, knee, and ankles. The DOR stated if RNA did not provide RNA services as ordered, it could potentially result in Resident 39's decline in ROM, functional mobility, activities of daily living (ADLs, basic activities such as eating, dressing, toileting), and quality of life. During an interview on 6/12/2025 at 5:13 pm, the Director of Nursing (DON), the DON stated the purpose of the RNA program was to ensure the residents in the facility attained and maintained their highest level of function, ADLs, and mobility. The DON stated if residents did not receive RNA services as ordered, it could potentially result in a decline in ROM, mobility, and ADLs. During a review of the facility's Policy and Procedure (P&P), titled Resident Mobility and ROM, revised 7/2017, the P&P indicated residents would not experience an avoidable reduction in ROM and residents with limited ROM would receive treatment and services to increase and/or prevent a further decrease in ROM.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents, who were identified at risk for falls, did not fall and sustain injury for two of three sampled residents (Resident 50 and Resident 89). The facility failed to: 1. Ensure Resident 50's talking device (recordable voice alarm with a personalized message that plays when an alarm is triggered) was turned on as one of the interventions of fall risk prevention program for Resident 50. 2. Ensure the licensed nurses evaluated the effectiveness of interventions of Resident 50's care plan titled, At risk for falls, difficulty maintaining sitting/standing balance, history of falls/multiple falls initiated on 12/25/2024, after the resident's fall on 4/19/2025, to develop new interventions to prevent the resident's fall on 5/22/2025 with injuries. 3. Ensure staff followed the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, undated, which indicated, The care team will target interventions that will reduce individual risks related to hazards in the environment including adequate supervision and assistive devices (equipment that can help you perform tasks and activities). 4. Ensure Resident 89, who required supervision at all times, was supervised while smoking on 2/27/2025 at 1:45 p.m., in accordance with the facility's policy and procedure (P&P) titled, Smoking Policy-Residents (undated). 5. Ensure Restorative Nursing assistant (RNA) 1 did not leave Resident 89 unsupervised on 2/27/2025 at 1:45 p.m., when RNA 1 wheeled Resident 89 to designated smoking area in front of the facility. 6. Ensure staff followed Resident 89's Care Plan, titled Resident 89 is at risk for injury related to smoking, dated 9/11/2023, by not leaving Resident 89 unsupervised while smoking. 7. Ensure the spray bottle containing clear liquid was labeled to identify ingredients inside the bottle, affecting one of four medication carts (Medication Cart B2). These failures resulted in: A. Resident 50 falling from a bed to the floor on 5/22/2025 around 7:25 a.m., sustaining a right inferior (lower) pubic ramus (a bone in the pelvis, specifically a thin, flat part of the pubic bone) fracture (broken bone) right superior (above) pubic ramus (a break in the upper part of the pubic bone on the right side of the pelvis) fracture, right sacral (tail bone) fracture, and bilateral rib fractures which required hospitalization in a general acute care hospital (GACH) for evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	B. Resident 89 falling from a wheelchair and sustaining a nose fracture small cut on a forehead that was bleeding, bruised (skin is not broken but is discolored) and swollen. Resident 89 sustained abrasions (superficial wound caused by scraping away of the skin's outer layer) to the forehead and left knee. Resident 89 was transferred to GACH on 2/27/2025 at 3:42 p.m., for further evaluation and treatment of swelling to both eyes. C. Had the potential to result in accidental exposure to or ingestion of isopropyl alcohol. Findings: A. During a review of Resident 50's admission Record, the admission Record indicated Resident 50 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), osteoporosis (weak and brittle bones due to a lack of calcium [mineral needed for healthy bones] and Vitamin D {nutrients needed to keep bones healthy}), fractures of left and right humerus (the long bone of the upper arm), repeated falls, and lack of coordination. During a review of Resident 50's Change in Condition (COC- a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional condition) Form dated 12/22/2024 and timed at 2:16 p.m., the COC Form indicated Resident 50 informed the charge nurse (unknown) that she fell in the bathroom the day before (12/21/2024) after getting up unassisted. The COC Form indicated Resident 50 stated she lost her footing, fell on the ground, but was able to get up and went back to her bed on her own without calling for assistance. The COC Form indicated Resident 50 had a hematoma (a solid swelling of clotted blood within the tissues) to her right side of the head. The COC Form indicated Resident 50 was on toileting every two hours and as needed, frequent visual checks and talking device in place and working. During a review of Resident 50's Care Plan titled, At risk for falls, difficulty maintaining sitting/standing balance, history of falls/multiple falls initiated on 12/25/2024, the Care Plan goal for Resident 50 was to have decrease in significant injury as a result from falls and to minimize the risk for falls in the next three months. The Care Plan interventions included to apply and check the talking device while in bed and or wheelchair to remind and redirect Resident 50 to call for assistance and to have frequent visual checks. During a review of Resident 50's Interdisciplinary Team (IDT team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Note dated 1/9/2025 timed at 11:14 a.m., the IDT Note indicated on 12/22/2024 around 7:15 a.m., Licensed Vocational Nurse (LVN) 12 observed Resident 50 with a hematoma to the right side of her head. IDT Note indicated Resident 50 stated she fell in the bathroom on 12/21/2024. Resident 50 stated she went to the bathroom unassisted and when she was returning back to bed, she lost her footing, bumped herself (unknown where) and ended up on the floor. Resident 50 stated she got up and went back to bed. The IDT Note indicated Resident 50 was on fall management program which consist of a talking device to remind and redirect Resident 50 to call for assistance, and a perimeter mattress (type of mattress designed with raised edges or bolsters to prevent falls and provide a safer sleep environment) for extra support. The IDT Note indicated Resident 50 was able to silence or turned off her talking device because she wanted to go to the bathroom by herself. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Rehabilitation Center	21414 S. Vermont Avenue Torrance, CA 90502

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 50's COC dated 4/19/2025 and timed at 6:30 a.m., the COC indicated Resident 50 was found sitting on the bathroom floor after getting out of bed unassisted and suddenly feeling weak. During a review of Resident 50's IDT Note dated 4/28/2025 timed at 10:25 a.m., the IDT note indicated Resident 50 had an incident on 4/19/2025 around 6 a.m., when Resident 50 was observed sitting on the floor outside the bathroom. The IDT note indicated Resident 50 was assessed with no injury. The IDT note indicated Resident 50 was currently on a toileting schedule and has a talking device to remind and redirect Resident 50 to call for assistance. The IDT note indicated Resident 50 was observed by staff that she can manipulate the talking device. During a review of Resident 50's Minimum Data Set (MDS-resident assessment tool) dated 5/22/2025, the MDS indicated Resident 50 had moderately impaired cognitive skills (ability to think, understand, learn, and remember) for daily decision making and was dependent (helper does all the effort) with toileting hygiene, showering and bathing. During a review of Resident 50's Physician's Order Summary Report, the Physician's Order Summary Report indicated an order to apply and check talking device while in bed and or wheelchair to remind and redirect the resident to call for assistance. During a review of Resident 50's COC dated 5/22/2025 and timed at 7:25 a.m., the COC indicated Resident 50 had an unwitnessed fall and was found lying on the floor. During a review of the facility's Investigation Report, (undated), the Investigation report indicated at the time of the incident (on 5/22/2025), Resident 50's talking device was noted to be disconnected. During a review of Resident 50's COC dated 5/22/2025 and timed at 2:58 p.m., the COC indicated Resident 50 had an open area to her right eyebrow. Registered Nurse Supervisor (RNS) called 911 and Resident 50 was transferred to GACH on 5/22/2025 (unknown time). During a review of Resident 50's GACH's Consultation Notes report dated 5/23/2025, the Consultation Note report indicated Per the facility, Resident 50's bed alarm (talking device) did not alarm, and she got out of bed by herself and fell. The Consultation Note report indicated Resident 50 had a computed tomography scan (CT- a medical imaging procedure that uses x-rays to create detailed, cross-sectional images of the body's internal structures) of the abdomen and pelvis on 5/22/2025. The CT scan indicated Resident 50 had a right inferior pubic ramus fracture, a right superior pubic ramus fracture, a right sacral fracture, and multiple bilateral rib fractures. During a concurrent observation and interview on 6/10/2025 at 8:22 a.m., Resident 50 was observed with a right eye bruise. Resident 50 stated she fell the other day (unable to state exact date). During an interview on 6/11/2025 at 1:46 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 50 had a fall on 5/22/2025 and sustained a fracture. CNA 1 stated Resident 50 was confused and forgot to use her call light. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 6/12/2025 at 8:55 a.m., with Licensed Vocational Nurse (LVN) 9, LVN 9 stated Resident 50 was a high fall risk. LVN 9 stated Resident 50's room was close to the nurse's station. LVN 9 stated after each fall, the care plan should be revised to evaluate the effectiveness of interventions to prevent future falls from occurring. Reviewed Resident 50's Care Plan, LVN 9 stated Resident 50's care plan was not revised following her fall on 4/19/2025 and it should have been done because additional interventions could have prevented the resident's fall on 5/22/2025 which resulted in multiple fractures. LVN 9 stated Resident 50's fall was preventable if she had been monitored more closely and had a bedside commode (portable toilet) at her bedside as she gets up without assistance to use the bathroom. During a concurrent interview and record review on 6/12/2025 at 10:10 a.m., with Registered Nurse Supervisor (RNS) 2, Resident 50's Care plan was reviewed. RNS 2 stated Resident 50 was a high risk for fall and recently had a fall on 5/22/2025. RNS 2 stated after a resident falls, the care plan should be revised to add new interventions. RNS 2 stated after Resident 50's fall on 4/19/2025, the care plan was not reviewed and revised. RNS 2 stated it was important to revise the care plan after a fall because the interventions in place were not effective, therefore, a new intervention could be added to prevent future falls. During an interview on 6/13/2025 at 9:24 a.m., with the Director of Nursing (DON), the DON stated a care plan was a guide that outlines the plan of care for the resident. The DON stated the care plan includes goals and interventions and should be revised when interventions were not effective. The DON stated Resident 50's care plan should have been revised after each fall so new interventions could be added to prevent future falls. During an interview on 6/13/2025 at 10:16 a.m., with the Quality Assurance Licensed Vocational Nurse (QA LVN), the QA LVN stated Resident 50 tends to disconnect the talking device. During a review of the facility's P&P titled, Safety and Supervision of Residents undated, the P&P indicated, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Implementing interventions to reduce accident risks and hazards shall include the following: ensuring that interventions are implemented and documenting interventions. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered undated, the P&P indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and residents' conditions change. C.During a concurrent observation and interview on 6/10/2025 at 9:20 a.m. during medication pass with the Licensed Vocational Nurse (LVN) 1, LVN 1 used a few sprays from an unlabeled spray bottle containing clear liquid to sanitize his hands. LVN 1 stated the spray bottle contained hand sanitizer and they transferred the liquid from the original large container into the smaller spray bottle that was in use at medication cart. LVN 1 showed a large bottle labeled with 70 percent (%) isopropyl alcohol stating that the contents of the unlabeled spray bottle were the same as the large container. During an interview on 6/12/2025 at 12:51 p.m. with the Director of Nursing (DON), the DON stated it was important that the unlabeled spray bottle with clear liquid was labeled to identify its ingredients inside, which was isopropyl alcohol, to prevent any accidental ingestion by facility residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 6/12/2025 at 12:13 p.m. with the Quality Assurance Licensed Vocational Nurse (QA LVN), observed Medication Cart B2 contained an unlabeled spray bottle. QA LVN stated the facility started receiving the large isopropyl alcohol containers recently and so they had to transfer the liquid into a smaller spray bottle to be stored on medication carts. QA LVN stated it was important to label the small spray bottle to identify that it contained 70% isopropyl alcohol, to maintain safety of facility's staff and residents. QA LVN stated it would be a risk for residents if they just grabbed it and ingested by accident. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, undated, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated, Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. B. During a review of Resident 89's admission Record, the admission Record indicated, Resident 89 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including repeated falls, nicotine (the additive drug found in tobacco products) dependency, bone density disorder (the bones are weak and more likely to break than normal), osteoarthritis (a degenerative joint disease, in which the tissues in the joint breakdown over time), and muscle wasting (the weakening, shrinking, and loss of muscle tissue). During a review of Resident 89's Care Plan, titled Resident 89 is at risk for injury related to smoking, dated 9/11/2023, the Care Plan indicated the interventions included not to leave Resident 89 alone while smoking, and provide supervision when resident is smoking. During a review of Resident 89's Physician's Order Summary, dated 11/28/2024, the Physician's Order Summary indicated Resident 89 had an order for fall precautions (measures taken to reduce the risk of falling and the likelihood of serious injury if a fall does occur). During a review of Resident 89's Smoking Safety Evaluation, dated 2/13/2025, the Smoking Safety Evaluation indicated, Resident 89 required supervision to smoke safely. During a review of Resident 89's Fall Risk Evaluation, dated 2/13/2025, the Fall Risk Evaluation indicated Resident 89 was at risk for fall. The Fall Risk Evaluation indicated Resident 89 was chairbound (confined to a chair, typically due to illness, injury, or disability) and had a balance problem while standing and walking. During a review of Resident 89's COC Evaluation dated 2/27/2025 timed at 2:27 p.m., the COC indicated that on 2/27/2025 around 2:05 p.m., Resident 89 was found on the ground in front of the facility (designated smoking area). The COC indicated Resident 89 sustained a bump on the forehead with open area. The COC indicated Resident 89 stated that she dropped her cigarettes and wanted to pick it up. The COC indicated Resident 89's physician was informed and ordered to transfer Resident 89 to GACH. During a review of Resident 89's Physician's Order Summary, dated 2/27/2025, the Physician's Order Summary indicated an order to transfer Resident 89 to GACH for further evaluation of the bump on the head after falling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 89's GACH's Emergency Department (ED) Notes, dated 2/27/2025, the ED Notes indicated Resident 89 had a bilateral nasal (nose) bone fracture with, moderate soft tissue swelling over the left periorbital (around the eye) and nasal region. The ED Noted indicated a Computerized Topography (CT -medical imaging that create detailed images of the body) of the head was done and CT scan result was bilateral (both) nasal bone fracture with moderate soft tissue swelling over the left periorbital and nasal region. The ED Notes indicated Resident 89 had an abrasion (superficial wound caused by scraping the skin) to the left forehead and mild laceration (a wound where the skin and underlying tissues are torn or cut) which was repaired with Steri-Strips (thin sticky adhesive bandages used to close small, shallow wounds or surgical incisions, often as an alternative to stiches or staples) During a review of Resident 89's Physician's Order Summary, dated 2/27/2025, the Physician's Order Summary indicated to apply Betadine (solution used to treat or prevent skin infection in minor cuts, or scrapes) to the left forehead abrasion topically (to the skin) in the morning. The Physician's Order Summary indicated the following order: 1. Monitor Resident 89's forehead bump with Steri-Strips for increase discoloration, bleeding, drainage, increase swelling, discharges, pain, and signs and symptoms of infection. 2. Cleanse forehead bump with Normal Saline (salt solution used for cleansing wounds), pat dry, apply Steri-Strips, and cover with gauze dressing. 3. Monitor Resident 89's right periorbital purplish discoloration for presence of increase discoloration, open area, bleeding, drainage, increase swelling, discharges, pain, signs and symptoms of infection every shift. 4. Apply Vitamin A&D external ointment (skin protectant and can aid in the healing of minor cuts, cuts, scrapes) to Resident 89's left knee abrasion daily. During a review of Resident 89's Physician's Order Summary, dated 2/28/2025, the Physician's Order Summary indicated an order to monitor Resident 89 nose discoloration and left periorbital area for increase of purplish discoloration, open area, bleeding, drainage, increase swelling, discharges, pain, signs and symptoms of infection every shift. The Physician's Order Summary indicated an order for ice compress to the forehead and facial affected area for 10 to 20 minutes to reduce swelling three times a day. During a review of Resident 89's Minimum Data Set (MDS-resident assessment tool), dated 5/15/2025, the MDS indicated, Resident 89 was dependent on nursing staff for toileting, dressing, and transferring. The MDS indicated Resident 89 needed partial to moderate assistance from nursing staff with walking, standing and sitting. During a review of Resident 89's Physician's Progress Note dated 6/4/2025, the Physician's Progress Note indicated, Resident 89 was able to express needs and make healthcare decisions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/11/2025 at 2:52 p.m., with Restorative Nursing Assistant (RNA) 1, RNA 1 stated on 2/27/2025 at 1:45 p.m., RNA 1 wheeled Resident 89 to the designated smoking area in front of the facility. RNA 1 stated she stayed for 10 minutes and supervised Resident 89 while the resident was smoking. RNA 1 stated Resident 89 wanted to stay longer in the designated smoking area to get some fresh air. RNA 1 stated she left Resident 89 alone at the designated smoking area and went back inside the facility to assist another resident with RNA services. RNA 1 stated she asked the Receptionist (RCPT) to call her when Resident 89 was ready to come back inside the facility. RNA 1 stated she heard RCPT responded okay. RNA 1 stated she heard from another staff that Resident 89 fell from his wheelchair while trying to pick up a cigarette from the ground. RNA 1 stated Resident 89 was on the ground and was bleeding from the forehead. RNA 1 stated other staff helped her (RNA 1) to put Resident 89 back on the wheelchair and wheeled Resident 89 back to the facility. RNA 1 stated that she should have not left Resident 89 unsupervised while smoking in the designated smoking area for safety and prevent Resident 89 from falling. RNA 1 stated facility did not have an assigned staff to supervise the smoking area. RNA 1 stated a certified nursing assistant (CNA) assigned to the resident was responsible for supervising the resident while the resident smokes. During an interview on 6/12/2025 at 1:52 p.m., with RCPT, RCPT stated there have been instances when facility staff were supervising residents' while smoking in the designated smoking area and will step out for few minutes and return right away. RCPT stated she does not recall RNA 1 telling her to call her when Resident 89 was ready to come back inside the facility. RCPT stated she saw Resident 89 at the designated smoking area before the fall. RCPT stated she stepped away from the receptionist desk and heard about Resident 89 fall. RCPT stated she no longer supervised residents outside the designated smoking area because she was not at the receptionist's desk continuously. During an interview on 6/12/2025 at 4:04 p.m., with the Director of Nursing (DON), the DON stated if a resident requires supervision during scheduled smoking time, the facility staff should always be at the designated smoking area to supervise residents for safety and prevent fall. The DON stated Resident 89 needed supervision for safety when smoking in the designated smoking area. During a review of the facility's P&P titled, Safety and Supervision of Residents, undated, the P&P indicated the facility strives to make the environment as free from hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility's P&P titled, Smoking Policy-Residents, undated, the P&P indicated any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two sampled residents (Resident 78 and Resident 95) were provided with a bowel and bladder retraining and/or toileting program (aims to help individuals regain control over their bowel and bladder functions through a structured approach), to regain normal bowel and bladder function as much as possible and received appropriate treatment and services to restore continence. This failure had a potential risk for Resident 78 and Resident 95 to lose their ability to regain control of bowel and bladder function, which could result in loss of dignity. Findings: 1. During a record review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including mild protein-calorie malnutrition (a mild deficiency in the intake of both protein and calories, resulting in adequate nutrition), nausea with vomiting, and muscle wasting. During a review of Resident 78's History and Physical (H&P), the H&P indicated, Resident 78 was able to express needs, communicate, follow commands and talk in full sentences. During a review of Resident 78's Minimum Data Set (MDS-a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 78 was dependent on nursing staff with transferring. The MDS indicated Resident 78 needed substantial to maximal assistance with toileting, showering, dressing, sitting and standing. The MDS indicated Resident 78 needed setup or clean-up assistance from nursing staff with eating and oral hygiene. 2. During a record review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses including chronic cystitis (repeat occurrence of bladder inflammation, often caused by bacterial infections), urinary tract infection (a bacterial infection of the urinary system) and diverticulosis (a condition where small, bulging pouches (diverticula) develop in the lining of the digestive tract). During a review of Resident 95's Care Plan, titled, Resident is incontinent in bowel and bladder functions, dated 1/6/2025, the Care Plan indicated to provide incontinent care as needed. During a review of Resident 95 Order Summary, dated 1/25/2025, the Order Summary indicated Resident 95 had an order for cranberry extract 250 milligram (mg) give two tablets by mouth once a day to prevent urinary tract infections. During a review of Resident 95's MDS dated [DATE], the MDS indicated, Resident 95 had the ability to express ideas, wants and understand others. The MDS indicated Resident 95 was dependent on nursing staff with toileting, showering and dressing. The MDS indicated Resident 95 was not in a toileting program for urinary incontinence. The MDS indicated Resident 95 was always incontinent with urine and bowel. The MDS indicated Resident 95 was not currently in a toileting program to manage the resident's bowel incontinence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 95's Weekly Summary Nurse Progress Note, dated 6/3/2025, the Weekly Summary Nurse Progress Note indicated Resident 95 was always incontinent of urine. The Weekly Summary Nurse Progress Note indicated Resident 95 was always incontinent with the bowel. The Weekly Summary Nurse Progress Note indicated Resident 95 was not in a bowel and bladder management program. During an interview on 6/9/2025 at 11:41 a.m., with Resident 95, Resident 95 stated she was not incontinent and was embarrassed when she was admitted to the facility and was told she had to wear diapers. During an interview on 6/10/2025 at 10:53 a.m., with Certified Nursing Assistant (CNA) 12, CNA 12 stated Resident 95 was incontinent to urine and bowel. CNA 12 stated Resident 95 wears diapers. CNA 12 stated Resident 95 requires minimal assistance and has never assisted Resident 95 to the bathroom. During a concurrent interview and record review on 6/10/2025 at 12:06 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 95's Bowel and Bladder Evaluation, dated 3/25/2025 was reviewed. The Bowel and Bladder Evaluation indicated Resident 95 was incontinent with bowel and bladder. The Bowel and Bladder Evaluation indicated Resident 95 was able to call for assistance when she needed toileting and or changing. The Bowel and Bladder Evaluation indicated will continue to check and change Resident 95's diaper. LVN 2 stated Resident 95 was continent because she was aware of when she must use the bathroom. LVN 2 stated Resident 95 will have feeling of embarrassment if told she was incontinent and use a diaper. During a concurrent interview and record review 6/10/2025 at 11:51 a.m., with LVN 2, Resident 78's Bowel and Bladder Evaluation, dated 4/15/2025 was reviewed. The Bowel and Bladder Evaluation indicated Resident 78 had frequent incontinence of both bowel and bladder functions. The Bowel and Bladder Evaluation indicated Resident 78 was able to use a urinal and say if he needs to go to the bathroom or needs to be changed. LVN 2 stated Resident 78 was not incontinent and was able to use the urinal. During an interview on 06/12/2025 at 8:24 a.m., with Registered Nurse Supervisor (RNS), RNS 2 stated Resident 78 was admitted to the facility for management of left knee prosthesis (an artificial body part, such as a leg) . RNS 2 stated Resident 78 needed assistance with toileting and uses a urinal. RNS 2 stated Resident 78 loses control of his bowel and bladder function because he was unable to get assistance to the bathroom. RNS 2 stated Resident 78 was able to feel the urge to urinate and defecate. RNS 2 stated Resident 78 should be on a bowel and bladder training program. RNS 2 stated she does not know why Resident was not on a bowel bladder program. RNS 2 stated Resident 78 could have a decline in bladder and bowel function, skin break down if left in adult diapers too long. RNS 2 stated Resident 78's dignity will be affected. During an interview on 6/12/2025 at 8:52 a.m., with Registered Nurse Supervisor, (RNS) 2, RNS 2 stated Resident 95 was not in a bowel or bladder program. RNS 2 stated facility needs a better bowel and bladder management program with accurate documentation. RNS 2 stated facility need to have proper assessments to provide care and management when a problem with bowel and bladder was identified. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2025 at 2:35 p.m., with the Minimum Data Set Nurse (MDSN), the MDSN 1 stated on the MDS she coded Resident 78 as incontinent because he cannot hold his urine or stool long enough to be assisted to bathroom by the certified nursing assistants. MDSN 1 stated the certified nursing assistants told MDSN that Resident 78 cannot hold his urine. MDSN 1 stated Resident 78 was not in any bladder or bowel program. MDSN 1 stated Resident 78 dignity can be affected. During an interview on 6/12/2025 at 3:37 p.m., with the Director of Nursing (DON), the DON stated Resident 78 and Resident 95 will not be able to have the correct care provided and dignity will be affected if they were told to use diapers when they are able to feel the urge and call for assistance to go to the bathroom. During a review of the facility's policy and procedure (P&P), titled Urinary Continence and Incontinence-Assessment and Management, undated, the P&P indicated, .The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. During a review of the facility's P&P, titled Bowel Elimination, the P&P indicated, Purpose: Ensure resident bowel function will be restored as much as possible and provide toileting program.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview, and record review the facility failed to ensure one of one sampled resident (Resident 62) was provided with water at the bedside. This failure had the potential to put Resident 62 at risk for dehydration (occurs when your body loses more fluids than it takes in, leading to an insufficient amount of water for normal function.) Findings: During a review of Resident 62's admission Record, the admission Record indicated Resident 62 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including to constipation (digestive issue where bowel movements become less frequent, and stools become difficult to pass) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), nausea with vomiting gastro-esophageal reflux (a condition in which acidic gastric fluid flows backward into the esophagus, resulting in heartburn.) During a review of Resident 62's Minimum Data Set (MDS - a resident assessment tool), dated 5/28/2025, the MDS indicated, Resident 62 had the ability to express ideas and wants. The MDS indicated Resident 65 needed set up or clean-up assistance from nursing staff with eating. The MDS indicated Resident 62 needed partial to moderate assistance with oral hygiene, personal hygiene and dressing. During a review of Resident 62's Care Plan, titled, Potential alteration in bowel elimination related to constipation, dated 2/19/2022, the Care Plan interventions indicated to offer and give resident adequate fluids. During a review of Resident 62's Nutritional Review/Progress Notes, dated 5/28/2025, the Nutritional Review/Progress Notes indicated, .Resident 62 remains at risk to weight changes and dehydration . During a concurrent observation and interview on 6/09/2025 at 12:01 p.m., with Resident 62 in Resident 62's room, observed Resident 62's dry mouth and lips and no pitcher of water at bedside. Resident 62 stated he did not have water since yesterday evening. During an interview on 6/09/2025 at 12:04 p.m., with Certified Nursing Assistant (CNA) 6, CNA 6, stated a hydration nurse and certified nursing assistants go to each resident rooms and refills each residents' pitcher with water starting at 7 a.m. CNA 6 stated resident with no fluid restrictions should always have water at the bedside. During an interview on 6/10/25 at 3:42 p.m., with Certified Nursing Assistant (CNA) 10, CNA 10 stated the hydration nurse passes water and snacks to the residents at 9 a.m., 2 p.m., 7 p.m., and as needed. CNA 10 stated the hydration nurses were responsible for refilling the residents' pitchers with water if they notice the resident was without water. CNA 10 stated Resident 62 will become dehydrated, thirsty, skin and lips will be dry if the resident was not given water. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2025 at 9:16 a.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated a designated person goes to every resident's room and changes their water and offers ice or to refill the residents' pitcher of water. LVN 4 stated this was done, once a day in the morning around 9 a.m. LVN 4 stated the facility has multiple hydration nurses and they are expected to provide residents with water at the bedside. LVN 4 stated residents need to be given water to prevent the resident from experiencing constipation, dry lips, dry skin, and poor skin elasticity. During an interview on 6/12/2025 at 9:59 a.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated the hydration nurse do rounds and offer residents snacks, water and juice and refill the resident's pitcher of water. RNS 2 stated Resident 62 does not have any water restriction. RNS 2 stated Resident 62 resident should always have water at the bedside if not on a water restriction. RNS 2 stated Resident 62 will have dehydration, dry skin, and poor skin turgor and can become thirsty, weak, and sunken eyes if not provided with water at all times. During an interview on 6/12/2025 at 4:13 p.m., with the Director of Nursing (DON), the DON stated the nurses are to provide residents with drinking water for adequate hydration. The DON stated the residents can be dehydrated, have dry skin and dry mouth if adequate hydration id not maintained. During a review of the facility's policy and procedures (P&P), titled Resident Hydration and Prevention of Dehydration, undated, the P&P indicated, This facility will strive to provide adequate hydration and to prevent and treat dehydration. During a review of the facility's policy and procedures (P&P), titled Hydration Nurse, undated, the P&P indicated, The primary purpose of your job position is to provide each of your assigned residents with routine daily hydration care and services in accordance with the resident's assessment and care plan, and as may be directed by your supervisors.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident, who had unrelieved pain on his shoulder, neck, and legs, was provided with effective pain management (the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goal) for one of one sampled resident (Resident 55). The facility failed to: 1. Ensure Lidocaine patch (topical [applied to the surface of the body] pain relievers that work by numbing the skin) and Aspercrem (topical pain relief designed to relieve minor aches and pains associated with conditions like arthritis and backaches) were offered and given to Resident 55 in 4/2025, 5/2025 and 6/2025, as ordered by the physician. 2. Ensure Resident 55's pain level rated 8 out of 10 on a pain rating scale (pain screening tool using numerical value to assess the level of pain ranging from 0 to 10 where (0) No Pain, (1-3) Mild Pain, (4-6) Moderate Pain, and (7-10) Severe Pain) on 6/9/2025 at 12:11 p.m., to his left shoulder and left leg pain was managed and the resident's physician informed. 3. Ensure facility held an Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) meeting with Resident 55 and family member to discuss Resident 55's refusal of pain medication and addressed pain management. 4. Ensure facility staff notified the facility's Medical Director when Resident 55's physician refused to order stronger pain medication than Tylenol (pain medication) 325 milligram (mg-unit of measurement) two tablets by mouth every four hours as needed for moderate pain. These deficient practices had the potential for Resident 55 to experience unrelieved pain to his shoulder, neck and legs, continue to refuse activities of daily living, and Restorative Nursing Assistant (RNA- nursing aide program that helps residents to maintain their function and joint mobility) services. Findings: During a review of Resident 55's admission Record, the admission Record indicated Resident 55 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gout (a type of inflammatory arthritis that causes pain and swelling in the joints), back pain, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), history of falls, and transient ischemic attack (a brief episode of neurological dysfunction caused by a temporary interruption of blood flow to the brain). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 55's Care Plan titled Resident 55 with episodes of refusal of pain medication, dated 9/29/2021, the Care Plan indicated the goal for Resident 55 was to take his medications on time and as ordered daily for three months. The Care Plan interventions indicated to explain the importance of taking the medication and the negative consequences of not taking the medications to Resident 55, explain the medication ordered, frequency, dosage, and indications. Inform Resident 55's of resident's continued refusal of taking medication. During a review of Resident 55's Physician's Orders, dated 3/23/2023, the Physician's Orders indicated Resident 55 had an order for Lidocaine patch 4.0 percent (%) apply to right neck and right shoulder topically as needed for pain management. During a review of Resident 55's Physicians' Order dated 6/9/2024, the Physicians' Order indicated and order to monitor for pain intensity using pain rating scale every shift. During a review of Resident 55's Physician's Orders, dated 10/27/2024, the Physician's Orders indicated Resident 55 had an order for Aspercreme heat gel 10% apply to left arm, hand, and leg topically as needed for pain daily. During a review of Resident 55's Medication Administration Record (MAR) for the months of 4/2025, 5/2025 and 6/2025, the MAR indicated Lidocaine patch and Aspercreme was not given to Resident 55. During a review of Resident 55's Physician's Order dated 5/19/2025, the Physician's Order indicated an order to monitor Resident 55's frequency of pain every shift. During a review of Resident 55's Minimum Data Set (MDS- a resident assessment tool), dated 5/23/2025, the MDS indicated, Resident 55 was able to express ideas and wants and had the ability to understand others. The MDS indicated, Resident 55 was dependent (helper does all the effort) on nursing staff with toileting, showering, dressing, and transferring. The MDS indicated, Resident 55 needed partial to moderate assistance (helper does less than half of the effort) from nursing staff with oral hygiene, personal hygiene, lying down, sitting and rolling from left to right. The MDS indicated for one to three days, Resident 55 rejected care that was necessary to achieve the resident's goals for health and well-being. The MDS indicated Resident 55 had no pain in the last five days. During a review of Resident 55's IDT Note, dated 5/27/2025, the IDT Conference Note indicated, Resident 55 continues to refuse participation in group activities despite encouragement. The IDT Conference Note indicated Resident 55 had episodes of refusal of the RNA program. During an interview on 6/9/2025 at 12:11 p.m., with Resident 55, Resident 55 stated he had a pain on his left shoulder and left leg which he rated 8 of 10 pain on a pain rating scale and was getting worse. Resident 55 stated he had been offered Tylenol for pain. Resident 55 stated he refused to take the Tylenol because it was not relieving his pain. Resident 55 stated he does not ask for pain medication anymore he lays in bed grinding his teeth to not deal with his left shoulder and left leg pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/11/2025 at 9:00 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 55's Nurses Progress Notes, dated 5/28/2025 were reviewed. The Nurses Progress Notes indicated, Resident 55 was asking for Tylenol with Codeine (pain medication that belongs to narcotics) instead of regular Tylenol. The Nurses Progress Notes indicated Resident 55's family member asked for Tramadol (also known as a narcotic pain medication) for Resident 55. The Nurses Progress Notes indicated, Resident 55 refused nursing care and often refused activities of daily living due to pain. The Nurses Progress Notes indicated, Resident 55 request for Tylenol with Codeine and Tramadol was denied by the doctor. LVN 4 stated Resident 55 had an order for Tylenol, Lidocaine patch, and Aspercreme for left arm pain. LVN 4 stated there was no documentation of why the request for Tylenol with Codeine and Tramadol was denied. The LVN 4 stated she forgot to document Resident 55's pain level on 5/28/2025. LVN 4 stated Resident 55 becomes agitated and does not want to participate in activities and personal care because the pain was not managed. LVN 4 stated she heard Resident 55 stated to licensed staff to get him out of the facility and that he wants to go home whenever he had pain to the shoulder, neck and legs. During an interview on 6/12/2025 at 11:39 a.m., with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 55 does not like to participate to any activities and personal care like bed baths. CNA 6 stated Resident 55 expressed to CNA 6, he does not want to be touched due to pain on Resident 55's neck, shoulder, arms and legs on 5/28/2025. CNA 6 stated she reported to the charge nurse Resident 55 did not want a bed bath, and the charge nurse talked to him and offered pain medication. During a concurrent interview and record review on 6/12/2025 at 12:08 p.m., with Restorative Nurse Assistant (specialized CNAs who focus on rehabilitative care to help residents regain or maintain their functional abilities) (RNA) 1, Resident 55's Documentation Survey Report dated 5/2025 and 6/2025, were reviewed. The Documentation Survey Report indicated documentation of Resident Refused (Rr) and Not Applicable (Na) Resident 55's RNA services for the following days: 5/5/2025-resident refused 5/8/2025-resident refused 5/12/2025-resident refused 5/13/2025-resident refused 5/14/2025-resident refused 5/16/2025-resident refused 5/28/2025-resident refused 6/3/2025-not applicable 6/6/2025-not applicable 6/9/2025-not applicable (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RNA 1 stated Resident 55 refuses RNA and only gets out of bed to go to the bathroom. RNA 1 stated Rr means the resident refused and Na means the resident was not able to tolerate RNA due to pain or weakness. RNA 1 stated she reported to the charge nurse (unknown) Resident 55 refusal to participate in RNA services due to pain. During a concurrent interview and record review on 6/12/2025 at 12:40 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 55's Care Plans dated 9/29/2021, 5/19/2023 and 6/13/2024 were reviewed. The Care Plans indicated on 9/29/2021 Resident 55 refused to take pain medication. The Care Plan indicated on 5/19/2023 Resident 55 refused to shower, refused to be cleaned and refused to be changed. The Care Plan indicated on 6/13/2024 Resident 55 had episodes of refusing RNA program. LVN 2 stated on 6/12/2025 Resident 55 had pain and was refusing to bathe and refusing acetaminophen for pain. LVN 2 stated there was no documentation of Resident 55's pain level on 6/12/2025. Reviewed Progress Notes on 6/11/2025 and there was a documentation Resident 55's pain level was 8/10 to the shoulders, legs and neck. During a concurrent interview and record review on 6/12/2025 at 2:16 p.m., with Registered Nurse Supervisor (RNS) 2, Resident 55 Nurses Progress Notes, dated 5/28/2025 were reviewed. The Nurses Progress Notes indicated, Resident 55 was requesting Tylenol with Codeine, Resident 55 doctor made aware, and request denied. RNS 2 Resident 55 has gout, right shoulder pain and neck pain. RNS 2 stated Resident 55's pain should have been reassessed when Resident 55 complained of pain level 8/10 to his shoulders, legs and neck. RNS 2 stated Resident 55 should have had a diagnostic test to rule out the cause of his pain and a referral for pain consultation. RNS 2 stated Resident 55's pain affects his participation with activities of daily living, unable to participate in RNA services, refused to get out of bed, and refuse to participate in facility's activities. During an interview on 6/12/2025 at 3:42 p.m., with the Director of Nursing (DON), the DON stated it was not acceptable for Resident 55 to have constant pain and was not managed accordingly. The DON stated Resident 55 continues to refuse Tylenol. The DON stated Resident 55 does not want to get out of bed and refuses activities of daily living. During a review of the facility's policy and procedure (P&P), titled Pain Assessment and Management, undated, the P&P indicated, The purposes of this procedure are to help staff identify pain in the resident and develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The pain management program is based on a facility-wide commitment to resident comfort. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goal. During a review of the facility's P&P, titled Care Plans, Comprehensive Person-Centered, undated, the P&P indicated, A comprehensive, person-centered care plan that includes objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Administer metformin (a medication for treating high blood glucose), within one hour of its scheduled administration time according to the facility's undated policy and procedure titled Administering Medications. This affects one of the six sampled residents during medication administration (Resident 30). 2a. Ensure Resident 47's aspirin [a medication used to prevent heart attack (flow of blood and oxygen is blocked) and stroke (loss of blood flow to a part of the brain)] chewable tablet was administered as a chewable according to manufacturer formulation specifications instead of being swallowed without chewing, on 6/10/2025, affecting one of six sampled residents during medication administration (Resident 47). 2b. Wear gloves during the administration and handling of Letrozole (a hazardous medication used to treat cancer) for Resident 47 as per facility's P&P titled, Handling of Hazardous Drugs in Healthcare Setting, undated, affecting one of six sampled residents during medication administration (Resident 47). 3. Ensure disposal of discarded medications in an irretrievable, safe and secure manner, as per facility's P&P titled, Discarding and Destroying Medications, undated and Discontinued Medications, undated, affecting three of four inspected medication carts (Station B1 Medication Cart, Station B2 Medication Cart and Station A Medication Cart). These deficient practices failed to provide medications in accordance with the physician's orders or professional standards of practice and had the potential to result in adverse events such as stroke and hyperglycemia (high blood glucose) for Residents 30 and 47, pose an occupational health hazard for facility staff and residents, and increased risk for misuse, drug loss, accidental exposure and/or potential diversion of prescription medications. Findings: 1. During a review of Resident 30's admission Record (a document containing demographic and diagnostic information), dated 6/11/2025, the admission record indicated, Resident 30 was admitted to facility on 1/21/2021 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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 30's Minimum Data Set ([MDS], a resident assessment tool) dated 5/2/2025, the MDS indicated, Resident 30's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses). The MDS indicated Resident 30 needed setup or clean-up assistance from the 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 and oral hygiene, supervision assistance for personal hygiene, moderate assistance for toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and dependent on facility staff for showering. During an observation on 6/10/2025 at 10:02 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared nine medications to be administered to Resident 30. During a medication reconciliation review on 6/10/2025 at 12:21 p.m., Resident 30's Order Summary Report (a document containing a summary of all active physician orders), dated 6/11/2025, metformin's order details were reviewed. The order summary report indicated, but not limited to the following physician order scheduled to be administered daily at 8:00 a.m.: Metformin hydrochloride (HCl) tablet 500 milligrams ([mg] - a unit of measurement for mass), give 1 tablet by mouth two times a day for DM with meals, order date 12/6/2023, start date 12/6/2023. During an interview and record review on 6/11/2025 at 11:59 a.m. with Registered Nurse Supervisor (RNS) 2, it was noted that Resident 30's metformin 500 mg was administered more than an hour late. RNS 1 explained that LVN 2 should have given the medication by 9:00 a.m. on 6/10/2025, but it was administered at 10:00 a.m. This delay could pose a risk for abnormal blood glucose levels for Resident 30. During a review of Resident 30's administration history for metformin 500 mg, dated 5/31/2025 to 6/10/2025, the document indicated metformin 500 mg was not administered within one hour of scheduled time of 8:00 am for five times. During an interview on 6/12/2025 at 1:03 p.m. with the Director of Nursing (DON), DON stated the facility staff was allowed to give a medication one hour before or one hour after the scheduled time of administration. DON stated it was important to follow the 'specific time code' because that would be the physician's required scheduled time of administration. DON stated if the specific time for administration was 8 a.m. then facility staff should have given the medication by 9 a.m. DON stated if the medication was given after 10 a.m. or at 10:22 a.m., it would be considered late administration. DON stated the medication if given late and not given with meals, there was a risk for gastric irritation and hyperglycemia. 2a and 2b. During a review of Resident 47's admission record, dated 6/10/2025, the admission record indicated, Resident 47 was originally admitted to the facility on [DATE] with diagnoses including, but not limited to, atherosclerosis of aorta (a build-up of fat and cholesterol in the largest artery in the body increasing the risk for blood clots, heart attack [blockage of blood flow to the heart] and stroke) and malignant neoplasm (cancer) of unspecified site of left female breast. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 47's MDS, dated [DATE], the MDS indicated, Resident 47's cognition was intact. The MDS indicated Resident 47 needed setup or clean-up assistance from the facility staff for eating, oral hygiene and personal hygiene, maximal assistance for upper body dressing and dependent for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a medication pass observation on 6/10/2025 from 8:39 a.m. to 9:01 a.m. with LVN 1, LVN 1 prepared and administered Resident 47's medications that included one tablet of aspirin 81 mg chewable tablet and one tablet of letrozole 2.5 mg. LVN 1 did not wear gloves while handling letrozole tablet that belonged to a hazardous category of medications. LVN 1 did not instruct Resident 47 to chew aspirin before swallowing and the resident was observed swallowing all medications including aspirin chewable tablet. During a review of Resident 47's Order Summary Report, dated 05/30/2025, the document indicated following physician orders: Aspirin Tablet Chewable 81 mg, give 1 tablet by mouth one time a day for anti-platelet agent to prevent stroke and heart attack with breakfast, order date: 5/30/2024, start date: 5/31/2024. Letrozole tablet 2.5 mg, give 1 tablet by mouth one time a day for breast cancer, order date 11/10/2021, start date 11/11/2021. During a review of Resident 47's order summary report, dated 6/11/2025, the document indicated the aspirin order was changed as following: Aspirin enteric coated (EC) adult low dose oral tablet delayed release 81 mg, give 1 tablet by mouth in the morning for anti-platelet agent to prevent stroke and heart attack with breakfast, order date 6/10/2025, start date 6/11/2025. During an interview on 6/10/2025 at 9:01 a.m. with LVN 1, LVN 1 stated he did not instruct Resident 47 to chew aspirin and resident swallowed it along with her other medications. LVN 1 stated aspirin chewable tablet would have a faster onset of action to prevent stroke if it was chewed before swallowing. During an interview on 6/11/2025 at 11:31 a.m., LVN 5 mentioned that she typically wore gloves before administering Resident 47's letrozole, as the medication card indicated it was hazardous. LVN 5 explained that letrozole could be toxic upon direct contact with bare hands. During an interview on 6/11/2025 at 12:17 p.m. with RNS 2, RNS 2 stated Resident 47 should have been instructed to take aspirin chewable tablet as a chew and swallow based on manufacturer requirements. RNS 2 stated if aspirin was not taken per manufacturer requirements, there would be a risk of poor absorption and may not be effective to prevent blood clots or stroke. During an interview on 6/12/2025 at 12:55 p.m. with the DON, DON stated the resident should have chewed the chewable aspirin tablet before swallowing. DON stated the medication effect might be slower than intended which would delay the effect of blood clotting and to prevent stroke. DON stated facility staff should have verified the order with physician if the chewable aspirin order did not indicate chew and swallow the tablet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2025 at 1:30 p.m. with the DON, DON stated letrozole belonged to hazardous category which was a cancer medication. DON stated the facility nurse should have worn gloves throughout the process of preparing and administering letrozole or any other hazardous medication to residents because of their risk of skin irritation and reproductive risk for females. DON stated the facility staff should provide gloves to the resident if they were going to make any contact with letrozole tablet. During a review of manufacturer labeling of the facility administered aspirin chewable tablet, the document indicated, Chew or crush tablets completely before swallowing, do not swallow tablets whole. During a review of the facility's P&P, titled Administering Medications, undated, the P&P indicated, Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The individual administering medications must check the label three times to verify the right medication , right time and right method of administration before giving the medication. During a review of the facility's P&P titled, Handling of Hazardous Drugs in Healthcare Setting, undated, the P&P indicated, When handling hazardous drugs during medication administration, healthcare workers should prioritize safety and follow established protocols. This includes: 1. Personal Protective Equipment (PPE) - a. Wear gloves when handling the drug, b. Dispose of PPE properly after each use, following facility protocols. The facility's active list of hazardous medications included letrozole. 3a. During a concurrent observation and interview on 6/11/2025 at 1:24 p.m. with LVN 5 of Station B2 Medication Cart, the medication cart contained two red containers filled with a lot of medications, with open lids in the bottom drawer. The two red containers indicated, 'biohazard', along with handwritten word 'pills' on one container and 'liquid meds' on another container. LVN 5 stated the tablets, capsules or pills in the red containers could be loose pills and medications refused by facility residents. LVN 5 stated when the resident refused a medication, LVN would discard it in the red bin, and made a note in resident's chart that medication was refused. LVN 5 stated, if she needed to dispose of narcotic (a term used for controlled medications [medications that the use and possession of are controlled by the federal government]) medications, she would call another licensed nurse as a cosigner, sign in the book, crush the medication, throw in the red bin, would put water in the crushed powder and then discarded and destroyed. LVN 5 stated, she did not see any problem with this method of destruction of medications. LVN 5 stated the red bin contained a lot of medications but could not say for sure if it had controlled medications. LVN 5 stated, you probably can retrieve the medications from the red bin if you have long fingers. LVN 5 stated the medications in the red bin were accessible and were not discarded in an irretrievable manner. LVN 5 stated, it is hard for me to say that there is a risk for diversion because it has not happened, because only licensed nurses have access to the cart. (continued on next page)

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Heritage Rehabilitation Center	21414 S. Vermont Avenue Torrance, CA 90502

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3b. During a concurrent observation and interview on 6/11/2025 at 2:04 p.m. with LVN 6 of Station B1 Medication Cart, the medication cart contained one red container filled with a lot of medications, with an open lid in the bottom drawer. The red container indicated, 'biohazard', along with handwritten word 'crushed pills.' LVN 6 stated the red bin contained medications that were refused or if dropped on the floor. LVN 6 stated the medications in the red bin were noncontrolled prescription medications and supplements. LVN 6 stated she thought there were probably three months of more medications. LVN 6 first stated if it was a controlled medication to be wasted, they would need two nurses to sign in the book, and controlled medication would be crushed and wasted in the red bin for controlled and noncontrolled medications. LVN 6 then corrected herself and stated the red bin would get controlled and noncontrolled medications, but controlled were medications were very rare, less than once a month. LVN 6 stated it was not good to have those medications sitting there in the medication cart, waiting to be discarded because that could have increased the risk for misuse and diversion. 3c. During a concurrent observation and interview on 6/11/2025 at 4:58 p.m. with LVN 7 of Station A Medication Cart, the medication cart contained three red containers, one of which was filled with lot of loose tablets and capsules, another one was filled with tablets and capsules mixed with some type of liquid, and one more container that was empty, all with open lids in the bottom drawer. The red containers indicated, 'biohazard' along with handwritten word 'pills' on one of the containers. LVN 7 stated the red bin contained refused medications and those that were to treat high blood pressure (BP), where the medication would need to be discarded in the red bin if resident's BP was outside of the prescribed parameters. LVN 7 stated she would pour water in the red bin so that the medications when discarded into the red bin would be irretrievable and could not be misused or abused. LVN 7 stated there were no controlled medications in the red bin, because controlled medications were handed over to the DON for disposal. LVN 7 stated there was a risk of spilling the medications and liquid in the medication cart, which could make unsafe and unsanitary conditions for medication storage in the medication cart. During an interview on 6/12/2025 at 12:26 p.m. with the DON, DON stated facility staff should not be destroying controlled medications on the floor. DON stated the facility staff should maintain a pill packet for controlled medication that needed disposal, document and sign in the book with two nurses' signatures and then should be brought to the DON for its destruction later with a pharmacist. DON stated the medication carts should not have the red biohazard bins or loose tablets discarded in red bins stored in medication carts. DON stated there was a risk that someone could retrieve the loose tablets or capsules from the red container and cause an accidental exposure or misuse. DON stated it was not sanitary to look at the red containers with liquid along with capsules and tablets. During a review of the facility's P&P titled, Discarding and Destroying Medications, undated, the P&P indicated, Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. The P&P indicated, all unused controlled substances shall be retained in a securely locked area with restricted access until disposed of. Non-controlled and Schedule V (non-hazardous) controlled substances will be disposed of in accordance with state . non-hazardous medications. The P&P indicated, Destruction of a controlled substance must render it non-retrievable, meaning that cannot be illegally diverted. During a review of the facility's P&P titled, Discontinued Medications, undated, the P&P indicated, Discontinued medications must be destroyed in accordance with established policies.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for two of six sampled residents (Residents 30 and 47) by failing to: 1. Ensure administration of metformin (a medication used to treat high blood glucose) within one hour of its scheduled time of administration as per facility's policy and procedure (P&P) titled, Administering Medications, undated, affecting one of six sampled residents during medication administration (Resident 30). 2. Ensure Resident 47's aspirin [a medication used to prevent heart attack (flow of blood and oxygen is blocked) and stroke (loss of blood flow to a part of the brain)] chewable tablet was administered as a chewable according to manufacturer formulation specifications instead of being swallowed without chewing, on 6/10/2025, affecting one of six sampled residents during medication administration (Resident 47). These deficient practices of medication administration error rate of 8% exceeded the five (5) percent threshold. Findings: 1. During a review of Resident 30's admission Record (a document containing demographic and diagnostic information), dated 6/11/2025, the admission record indicated, Resident 30 was admitted to facility on 1/21/2021 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 review of Resident 30's Minimum Data Set ([MDS], a resident assessment tool) dated 5/2/2025, the MDS indicated, Resident 30's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses). The MDS indicated Resident 30 needed setup or clean-up assistance from the 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 and oral hygiene, supervision assistance for personal hygiene, moderate assistance for toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and dependent on facility staff for showering. During an observation on 6/10/2025 at 10:02 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared the following nine medications to be administered to Resident 30. 1. One tablet of aspirin enteric coated 81 milligrams ([mg] a unit of measurement for mass) 2. One tablet of metformin 500 mg 3. One tablet of vitamin C (ascorbic acid - a vitamin used to treat low level of vitamin C) 4. One capsule of docusate sodium (a medication used to treat constipation) 250 mg (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. One tablet of famotidine (a medication used to treat acid reflux) 20 mg 6. One tablet of Januvia [(generic name - sitagliptin) a medication used to treat high blood glucose) 50 mg 7. One tablet of lisinopril (a medication used to treat high blood pressure) 5 mg 8. One tablet of metoprolol succinate (a medication used to treat high blood pressure) extended release (ER) 25 mg 9. One tablet of sodium chloride (a supplement used to balance sodium levels) 1 gram ([gm] a unit of measurement for mass) During a medication reconciliation review on 6/10/2025 at 12:21 p.m., Resident 30's Order Summary Report, dated 6/11/2025, was reviewed for metformin's order details. The order summary report included the following physician order scheduled to be administered daily at 8:00 a.m.: Metformin hydrochloride (HCl) tablet 500 mg, give 1 tablet by mouth two times a day for DM with meals, order date 12/6/2023, start date 12/6/2023. During a concurrent interview and record review on 6/11/2025 at 11:59 a.m. with Registered Nurse Supervisor (RNS) 2, the order details and medication administration details for Resident 30's metformin 500 mg in the electronic health record (EHR) were reviewed. RNS 2 noted that Resident 30's metformin 500 mg was administered more than one hour after its scheduled time, categorizing it as late administration. RNS 2 explained that LVN 2 was supposed to administer the medication on 6/10/2025 by 9:00 a.m., with the original scheduled time being 8:00 a.m., but it was administered at 10:00 a.m. RNS 2 mentioned there could be a risk for abnormal blood glucose levels for Resident 30 due to this delay. During a review of Resident 30's administration history for metformin 500 mg, dated 5/31/2025 to 6/10/2025, the document indicated metformin 500 mg was not administered within one hour of scheduled time of 8:00 am for five times. During an interview on June 12, 2025, at 1:03 p.m. with the Director of Nursing (DON), it was stated that facility staff are permitted to administer medication within one hour before or after the scheduled time. The DON emphasized the importance of adhering to the 'specific time code' as it reflects the physician's required schedule for administration. For instance, if the specific administration time is 8 a.m., the medication should be given by 9 a.m. Medications administered after 10 a.m. or at 10:22 a.m. would be considered late. The DON explained that late administration and not giving the medication with meals could lead to risks such as gastric irritation and hyperglycemia. 2. During a review of Resident 47's admission record, dated 6/10/2025, the admission record indicated, Resident 47 was originally admitted to the facility on [DATE] with diagnoses including, but not limited to, atherosclerosis of aorta (a build-up of fat and cholesterol in the largest artery in the body increasing the risk for blood clots, heart attack [blockage of blood flow to the heart] and stroke) and malignant neoplasm (cancer) of unspecified site of left female breast. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 47's MDS, dated [DATE], the MDS indicated, Resident 47's cognition was intact. The MDS indicated Resident 47 needed setup or clean-up assistance from the facility staff for eating, oral hygiene and personal hygiene, maximal assistance for upper body dressing and dependent for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a medication pass observation on 6/10/2025 from 8:39 a.m. to 9:01 a.m. with LVN 1, LVN 1 prepared and administered the following five medications to Resident 47, one of which included one tablet of aspirin 81 mg chewable tablet. LVN 1 did not instruct Resident 47 to chew aspirin before swallowing and the resident was observed swallowing all medications including aspirin chewable tablet. 1. One tablet of aspirin 81 mg chewable tablet 2. One tablet of docusate sodium 100 mg 3. One tablet of letrozole (a hazardous medication used to treat cancer) 2.5 mg 4. One tablet of losartan-hydrochlorothiazide (a combination of two medications used to treat high blood pressure) 100-25 mg 5. One capsule of fish oil (a supplement used to lower cholesterol) 1000 mg During a review of Resident 47's Order Summary Report, dated 05/30/2025, the document indicated following physician orders: Aspirin Tablet Chewable 81 mg, give 1 tablet by mouth one time a day for anti-platelet agent to prevent stroke and heart attack with breakfast, order date: 5/30/2024, start date: 5/31/2024. During a review of Resident 47's order summary report, dated 6/11/2025, the document indicated the aspirin order was changed as following: Aspirin enteric coated (EC) adult low dose oral tablet delayed release 81 mg, give 1 tablet by mouth in the morning for anti-platelet agent to prevent stroke and heart attack with breakfast, order date 6/10/2025, start date 6/11/2025. During an interview on 6/10/25, at 9:01 a.m., LVN 1 stated that they did not instruct Resident 47 to chew aspirin, and the resident swallowed it along with her other medications. LVN 1 noted that chewing an aspirin chewable tablet could result in a faster onset of action to prevent stroke if chewed before swallowing. During an interview on 6/11/2025 at 12:17 p.m. with Registered Nurse 2 (RNS 2), RNS 2 stated that Resident 47 should have been instructed to take the chewable aspirin tablet by chewing and swallowing it, in accordance with the manufacturer's guidelines. RNS 2 explained that if the aspirin is not taken as specified by the manufacturer, there could be a risk of poor absorption, rendering it less effective in preventing blood clots or stroke. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2025 at 12:55 p.m. with the DON, DON stated the resident should have chewed the chewable aspirin tablet before swallowing. DON stated the medication effect might be slower than intended which would delay the effect of blood clotting and prevent stroke. DON stated facility staff should have verified the order with physician if the chewable aspirin order did not indicate chew and swallow the tablet. During a review of manufacturer labeling of the facility administered aspirin chewable tablet, the document indicated, Chew or crush tablets completely before swallowing, do not swallow tablets whole. During a review of the facility's P&P, titled Administering Medications, undated, the P&P indicated, Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The individual administering medications must check the label three times to verify the right medication , right time and right method of administration before giving the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for one (Resident 30) of six sampled residents during medication administration, by failing to administer Resident 30's metformin (a medication used to treat high blood glucose) within one hour of its scheduled time of administration as per facility's policy and procedure (P&P) titled, Administering Medications, undated. This deficient practice failed to provide medication in accordance with the physician's orders or professional standards of practice and had the potential to result in hyperglycemia (high blood glucose) for Resident 30. Findings: During a review of Resident 30's admission Record (a document containing demographic and diagnostic information), dated 6/11/2025, the admission record indicated, Resident 30 was admitted to facility on 1/21/2021 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 review of Resident 30's Minimum Data Set ([MDS], a resident assessment tool) dated 5/2/2025, the MDS indicated, Resident 30's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses). The MDS indicated Resident 30 needed setup or clean-up assistance from the 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 and oral hygiene, supervision assistance for personal hygiene, moderate assistance for toileting hygiene, upper and lower body dressing, putting on/taking off footwear, and dependent on facility staff for showering. During an observation on 6/10/2025 at 10:02 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared nine medications to be administered to Resident 30. During a medication reconciliation review on 6/10/2025 at 12:21 p.m., Resident 30's Order Summary Report (a document containing a summary of all active physician orders), dated 6/11/2025, metformin's order details were reviewed. The order summary report indicated, but not limited to the following physician order scheduled to be administered daily at 8:00 a.m.: Metformin hydrochloride (HCl) tablet 500 milligrams ([mg] - a unit of measurement for mass), give 1 tablet by mouth two times a day for DM with meals, order date 12/6/2023, start date 12/6/2023. During a concurrent interview and record review on 6/11/2025 at 11:59 a.m. with Registered Nurse Supervisor (RNS) 2, Resident 30's order details and medication administration details in electronic health record (EHR) for metformin 500 mg were reviewed. RNS 1 stated Resident 30's metformin 500 mg was administered more than one hour after its scheduled administration time, so it would be considered a late administration. RNS 1 stated LVN 2 should have administered the medication on 6/10/2025 by 9:00 a.m. because it was scheduled to be administered on 6/10/2025 at 8:00 a.m., but it was administered by LVN 2 at 10:00 a.m. RNS 1 stated there would be a risk for abnormal blood glucose levels for Resident 30. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 30's administration history for metformin 500 mg, dated 5/31/2025 to 6/10/2025, the document indicated metformin 500 mg was not administered within one hour of scheduled time of 8:00 am for five times, listed as below. 6/10/2025: administered at 10:22 a.m. during medication pass observation 6/9/2025: documented as administered at 9:42 a.m. 6/5/2025: documented as administered at 4:12 p.m. 6/3/2025: documented as administered at 11:14 p.m. 6/2/2025: documented as administered at 12:05 p.m. During an interview on 6/12/2025 at 1:03 p.m. with the Director of Nursing (DON), DON stated the facility staff was allowed to give a medication one hour before or one hour after the scheduled time of administration. DON stated it was important to follow the 'specific time code' because that would be the physician's required scheduled time of administration. DON stated if the specific time for administration was 8 a.m. then facility staff should have given the medication by 9 a.m. DON stated if the medication was given after 10 a.m. or at 10:22 a.m., it would be considered late administration. DON stated the medication if given late and not given with meals, there was a risk for gastric irritation and hyperglycemia. During a review of the facility's P&P, titled Administering Medications, undated, the P&P indicated, Medications may not be prepared in advance and must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. The individual administering medications must check the label three times to verify the right medication , right time and right method of administration before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Maintain a clean and safe environment for medication storage by removing unsealed red biohazard containers filled with discarded medications in tablets, capsules and liquid form from three of the four inspected carts (Station B1, Station B2, and Station A). 2.Ensure that Resident 30 does not self-administer medications without facility supervision by safeguarding his medications during the medication pass, affecting one of six residents (Resident 30). 3. Ensure Resident 40's Humulin N ([generic name - insulin human isophane NPH] 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) was labeled with an open date and Resident 76's Breyna ([generic name - budesonide with formoterol] a medication delivered in the form of inhalation spray through a device used to treat breathing problems) were labeled in accordance with the manufacturer specifications and per facility's policy and procedure (P&P) titled, Labeling of Medication Containers, undated and Storage of Medications, undated, affecting two of four medication cards inspected (Station C Medication Cart and Station A Medication Cart). These deficient practices resulted in an unclean, unsecure and unsanitary environment for medication storage in medication carts and resident rooms, self-administration of medications without supervision, and had the potential to result in medication errors and/or choking, administering medications that had become expired, ineffective, or toxic due to improper labeling and/or storage, possibly leading to adverse health consequences such as shortness of breath, abnormal blood glucose levels and hospitalization for Residents 30, 40 and 76. Findings: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1a. During a concurrent observation and interview on [DATE] at 1:24 p.m. with Licensed Vocational Nurse (LVN) 5 of Station B2 Medication Cart, the medication cart contained two red containers filled with a lot of medications, with open lids in the bottom drawer. The two red containers indicated, biohazard, along with handwritten word 'pills' on one container and 'liquid meds' on another container. LVN 5 stated the tablets, capsules or pills in the red containers could be loose pills and medications refused by facility residents. LVN 5 stated that when the resident refused medication, LVN would discard it in the red bin, and made a note in resident's chart that medication was refused. LVN 5 stated, if she needed to dispose of narcotic (a term used for controlled medications [medications that the use and possession of are controlled by the federal government]) medications, she would call another licensed nurse as a cosigner, sign in the book, crush the medication, throw in the red bin, would put water in the crushed powder and then discarded or destroyed. LVN 5 stated, she did not see any problem with this method of destruction of medications. LVN 5 stated the red bin contained a lot of medications but could not be sure if it had controlled medications. LVN 5 stated, you probably can retrieve the medications from the red bin if you have long fingers. LVN 5 stated the medications in the red bin were accessible and were not discarded in an irretrievable manner. LVN 5 stated, it is hard for me to say that there is a risk for diversion because it has not happened, because only licensed nurses have access to the cart. 1b. During a concurrent observation and interview on [DATE] at 2:04 p.m. with LVN 6 of Station B1 Medication Cart, the medication cart contained one red container filled with a lot of medications, with an open lid in the bottom drawer. The red container indicated, biohazard', along with handwritten word 'crushed pills.' LVN 6 stated the red bin contained medications that were refused or if they dropped on the floor. LVN 6 stated the medications in the red bin were noncontrolled prescription medications and supplements. LVN 6 stated the red biohazard bin might contain three months' worth of medications. LVN 6 first stated if it was a controlled medication that needed to be wasted, they would need two nurses to sign in the book, and controlled medication would be crushed and wasted in the red bin for controlled and noncontrolled medications. LVN 6 then corrected herself and stated the red bin would get controlled and noncontrolled medications, but controlled were medications were very rare, less than once a month. LVN 6 stated it was not good to have those medications sitting there in the medication cart, waiting to be discarded because that increased the risk for medication misuse and diversion. 1c. During a concurrent observation and interview on [DATE] at 4:58 p.m. with LVN 7 of Station A Medication Cart, the medication cart contained three red containers, one of which was filled with loose tablets and capsules, another one was filled with tablets and capsules mixed with some type of liquid, and another container was empty. All three containers were stored with their lids open in the bottom drawer. The red containers indicated, biohazard' along with handwritten word 'pills' on one of the containers. LVN 7 stated the red bin contained refused medications and those that were to treat high blood pressure (BP), where the medication would need to be discarded in the red bin if resident's BP was outside of the prescribed parameters. LVN 7 stated she would pour water in the red bin so that the medications when discarded into the red bin would be irretrievable and could not be misused or abused. LVN 7 stated there were no controlled medications in the red bin, because controlled medications were handed over to the DON for disposal. LVN 7 stated there was a risk of spilling the medications and liquid in the medication cart, which could cause unsafe and unsanitary conditions for medication storage in the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:26 p.m. with the Director of Nursing (DON), DON stated the medication carts should not have the red biohazard bins or loose tablets discarded in red bins stored in medication carts. DON stated there was a risk that someone could retrieve the loose tablets or capsules from the red container and cause accidental exposure or drug misuse. DON stated it was not sanitary to look at the red containers with liquid along with capsules and tablets. During a review of the facility's P&P titled, Storage of Medications, undated, the P&P indicated, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The nursing staff shall be responsible for maintaining medication store AND preparation areas in a clean, safe, and sanitary manner. 2. During a concurrent observation and interview on [DATE] at 10:02 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared the following nine medications to be administered to Resident 30. 1. One tablet of aspirin [a medication used to prevent heart attack (flow of blood and oxygen is blocked) and stroke (loss of blood flow to a part of the brain)] enteric coated 81 milligrams ([mg] a unit of measurement for mass) 2. One tablet of metformin (a medication used to treat high blood glucose) 500 mg 3. One tablet of vitamin C (ascorbic acid - a vitamin used to treat low level of vitamin C) 4. One capsule of docusate sodium (a medication used to treat constipation) 250 mg 5. One tablet of famotidine (a medication used to treat acid reflux) 20 mg 6. One tablet of Januvia [(generic name - sitagliptin) a medication used to treat high blood glucose) 50 mg 7. One tablet of lisinopril (a medication used to treat high blood pressure) 5 mg 8. One tablet of metoprolol succinate (a medication used to treat high blood pressure) extended release (ER) 25 mg 9. One tablet of sodium chloride (a supplement used to balance sodium levels) 1 gram ([gm] a unit of measurement for mass) LVN 2 placed a tray with two medicine cups on Resident 30's bedside table, one containing lisinopril and metoprolol succinate, and another cup with all the other medications. LVN 2 turned away to retrieve gloves, during which time Resident 30 ingested all the medications except for the lisinopril and metoprolol succinate. Upon returning, LVN 2 observed that Resident 30 had taken some of the medications unsupervised. LVN 2 remarked, No, no, no, let me take your blood pressure before you continue with your medications. When Resident 30 was about to take the lisinopril and metoprolol succinate, LVN 2 stated, It is okay; you did not take the blood pressure medications yet. Let me take your blood pressure first. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:59 a.m. with the Registered Nurse Supervisor (RNS) 2, RNS 2 stated that facility staff should not leave medications unattended with the resident. RNS 2 mentioned that facility staff should watch the residents take their medications to ensure they do not fail to take them or hide them. Additionally, it is important for facility staff to observe residents while they are swallowing medications to monitor for any side effects or difficulty swallowing, thus preventing the risk of choking. During an interview on [DATE] at 1:25 p.m., the Director of Nursing (DON) emphasized that staff should follow the pour, pass, sign method. Staff must ensure residents take their medications and do not hide them. The nurse should check the resident's blood pressure before preparing the medication. Additionally, staff must observe residents taking their medications to verify proper administration. During a review of the facility's P&P titled, Administering Medications, undated, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. 3a. During a concurrent inspection and interview on [DATE] at 12:47 p.m. with LVN 4 of the Station C Medication Cart, the following medication was not labeled with an open date as required by manufacturer's specifications and per P&P titled, Labeling of Medications and Storage of Medications: One opened Humulin N 100 units / 10 milliliters ([mL] a unit of measurement for volume) vial for Resident 40 with no open date. According to the manufacturer's product labeling, unopened vial(s) should be stored under refrigeration at 2-degree Celsius ([°C] a unit of temperature) to 8°C (36-degree Fahrenheit [(°F) is a unit of temperature] to 46°F) and open or in-use bottle may be stored at room temperature below 30°C (86°F) for 31 days and must be discarded thereafter. LVN 4 stated the Humulin N should have had an open date because it was important and a requirement for the facility to be able to determine the 28-day expiration date for insulin. LVN 4 stated Resident 40 might not get the full benefit of the insulin, could cause hyperglycemia or abnormal blood glucose levels, possibly leading to hypoglycemic shock and altered consciousness, hospitalization and coma. During an interview on [DATE] at 1:40 p.m., the Director of Nursing (DON) indicated that facility staff should label the insulin vial with an open date upon opening. This practice ensures that staff are aware of the 28-day usage period for insulin. Without labeling, the expiration date would be unclear, potentially impacting the efficacy and safety of the insulin for controlling blood sugar in residents. 3b. During a concurrent inspection and interview on [DATE] at 4:58 p.m. with LVN 7 of the Station A Medication Cart, the following medication was not labeled with an open date as required by manufacturer's specifications and per P&P titled, Labeling of Medications and Storage of Medications: One package of Breyna 160 microgram ([mcg] a unit of measure for mass) - 4.5 mcg (a combination of budesonide and formoterol) inhalation aerosol for Resident 76 with no open date. According to the manufacturer's product labeling, Breyna inhaler should be discarded when the labeled number of inhalations have been used or within 3 months after removal from the foil pouch. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 7 stated she should have discarded the medication within 30 days based on facility's policy. LVN 7 stated that medication might not be safe or effective for Resident 76 and might not help with breathing difficulty. LVN 7 stated resident could have shortness of breath lead to hospitalization. During an interview on [DATE] at 1:45 p.m. with DON, DON stated the facility nurse should have placed an open date on the Breyna inhaler, because if it was continued to be used after 3 months, there was a potential risk for ineffectiveness and safety. DON stated the facility policy addressed this as part of the labeling the containers with an open date for single-use and multiple-use containers. DON stated the medication might not be effective for its intended use to manage asthma or Chronic Obstructive Pulmonary Disease ([COPD] a condition that causes difficulty breathing). During a review of the facility's P&P titled, Labeling of Medication Containers, undated, the P&P indicated, All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. The P&P indicated, Labels for individual drug containers shall include all necessary information, such as: a. The resident's name , h. The expiration date when applicable use.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide necessary dental services for four of four sampled residents (Resident 78,105, 6 and 10). This failure had the potential to lead to weight loss, inability to chew effectively, or infection of the mouth. Findings: During a record review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including mild protein-calorie malnutrition (a mild deficiency in the intake of both protein and calories, resulting in adequate nutrition), nausea with vomiting, and muscle wasting. During a review of Resident 78's History and Physical (H&P), the H&P indicated, Resident 78 he was able to express needs, communicate, follow commands and talk in full sentences. During a review of Resident 78's Minimum Data Set (MDS-a resident assessment tool), the MDS indicated, Resident 78 was dependent on nursing staff with transferring. The MDS indicated Resident 78 needed substantial to maximal assistance with toileting, showering, dressing, sitting and standing. The MDS indicated Resident 78 needed setup or clean-up assistance from nursing staff with eating and oral hygiene. During a review of Resident 78's Order Summary, dated 8/26/2024, the Order Summary indicated, Resident 78 had an order for a dental consultation for a pulled tooth. During a review of Resident 78's Change of Condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) Evaluation, dated 11/4/2024, the Change of Condition Evaluation indicated, Resident 78 had right upper and right lower teeth pain. The Change of Condition Evaluation indicated Resident 78 received a written order from the doctor to have a dental follow-up due to teeth pain. The Change of Condition Evaluation indicated the order was noted and carried out. During a review of Resident 78's Social Services Director Note, dated 3/25/2025, the Social Services Director Note indicated, Resident 78 asked about the next dental visit. The Social Services Director Note indicated Resident 78 stated, I think I'm supposed to be getting dentures. The Social Services Director Note indicated Resident 78 was informed of a dental clearance for teeth extractions, signed by the doctor and the clearance was sent to the dentist. During a review of Resident 78's Onsite Mobile Dental report, dated 4/29/2025, the Onsite Mobile Dental report indicated Resident 78 was recommended new dentures. The Onsite Mobile Dental report indicated dental impressions (a model or cast for dentures) in three weeks. During a review of Resident 78's Onsite Mobile Dental report, dated 5/14/2025, the Onsite Mobile Dental report indicated Resident 78 needs dental impressions the last week of May 2025. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/9/2025 at 11:00 a.m., with Resident 78, Resident 78 stated, he had his teeth removed six weeks ago and needs dentures. Resident 78 stated he has problems with chewing. During an interview on 6/10/25 at 2:42 p.m., with Social Service Director (SSD), the SSD stated, Resident 78 had teeth extractions done on 4/29/2025 and needed dental impressions within three weeks. SSD stated Resident 78 had been wanting new dentures. The SSD stated she did not follow up on the Onsite Mobile Dental for Resident 78 to have dental impressions for new dentures. During an interview on 6/12/2025 at 3:41 p.m., with the Director of Nursing, the DON stated the Onsite Mobile Dental report for Resident 78 to have dental impressions should have been followed up by the SSD. The DON stated not having dentures affects eating and chewing and Resident 78 has a potential for weight loss. During a review of the facility's policy and procedure (P&P), titled Social Service Policy & Procedure Ancillary Services, undated, the P&P indicated .Social Services will coordinate efforts with the ancillary service provides on recommended follow up, such as ordering glasses, hearing aids, or dentures until the need is met . During a record review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnosis including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing)), dementia (a progressive state of decline in mental abilities), schizoaffective disorder(a mental illness that can affect thoughts, mood, and behavior) and candidal stomatitis (infection in the mouth caused by a fungus leading to inflammation and redness). During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 3/26/2025, the MDS indicated Resident 6 had moderately impaired cognitive skills (person had problems remembering things, concentrating, making and solving decisions) and required partial/ moderate assistance (helper does less than the effort) with oral hygiene, bed mobility, and upper body dressing(ability to dress and undress below the waist). During a review of Resident 6's Onsite Mobile Dental Note dated 1/15/2025 , the Onsite Mobile Dental Note indicated Resident 6's upper and lower dentures were okay. During a concurrent observation and interview on 6/9/2025, at 4:33 p.m. with Resident 6 , Resident 6 was edentulous (complete loss of natural teeth). Resident 6 stated her upper and lower dentures do not fit her and told several unnamed staff about her dentures. During a concurrent interview and record review on 6/10/2025, at 2:12 p.m. and subsequent interview on 6/11/2025, at 9:22 a.m. with Social Services Director (SSD), Resident 6's Dental Notes dated 1/15/2025 was reviewed. SSD stated the last dental evaluation or check up was dated 1/15/ 2025 which indicated Resident 6's dentures were okay. SSD stated the facility does not follow up for any concerns regarding dental needs of a resident. SSD stated social services perform their assessments every 3 months to know if a resident had a concern with their vision or dental. SSD stated she will add Resident 6 to the list of residents that will be seen by a dentist to evaluate her dentures. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including DM, bilateral sensorineural hearing loss (trouble hearing in both ears due to the damage in the inner ear or auditory nerve), repeated falls, spinal stenosis (happens when the space inside the backbone is too small causing pressure on the spinal cord and nerves that travel through the spine) and need for assistance with personal care. During a review of Resident 10's MDS dated [DATE],the MDS indicated Resident 10 had moderately impaired cognitive skills and was dependent (helper does all the effort) on the staff with bathing, dressing, toileting hygiene, transfer in and out of a tub or shower. During a review of Resident 10's Onsite Mobile Dental Note dated 5/10/2025, the Onsite Mobile Dental Note indicated Resident 10 had periodontal x-rays (dental imaging that focuses on the bone supporting the teeth) and resident's dentures were adjusted. During a concurrent observation and interview on 6/10/2025, at 9:49 a.m. with Resident 10, Resident 10 stated her dentures would not hold and cannot use them when she eats. Observed Resident 10 not wearing dentures and meal tray ticket indicated Resident 10's diet was Fortified (certain nutrients were added to the food to improve nutritional value) no added salt(NAS) CCHO (controlled carbohydrate - designed to manage blood sugar levels by providing consistent amount of carbohydrate throughout the day) diet in regular texture (normal or expected feel of a food item when eaten), thin /regular liquid consistency with meals. During an interview on 6/12/2025, at 1:50 p.m. with Certified Nursing Assistant (CNA11), CNA 11 stated Resident 10 had dentures, but she would still cut the food into small pieces to help Resident 10. CNA 11 stated Resident 10 will have difficulty in chewing her food, cause her to choke on her food if her dentures did not fit well. During an interview on 6/11/2025, at 8:59 a.m. with SSD , SSD stated Resident 10 received new dentures and was delivered on 2/11/2025. SSD stated the family member (FM) requested to get Resident 10's dentures adjusted and none of the staff notified her about the upper and lower dentures not fitting on the resident. SSD stated Resident 10 would not be able to chew her food well and might not be able to get proper nutrition due to ill-fitting dentures. During an interview on 6/12/2025, at 4:41 p.m. with the Director of Nursing (DON) , the DON stated residents whose dentures were not fitting well would not be able to eat properly which could affect their chewing leading to weight loss. During a review of facility's policy and procedure (P&P), titled Social Service Department Role and Function, undated, the P&P indicated The facility will provide medically related social services to all residents in an effort to help them achieve and maintain their highest practicable level of physical, mental and psychosocial functioning. During a review of Resident 105's admission Record, the admission Record indicated Resident 105 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and schizophrenia (a mental illness that is characterized by disturbances in thought). (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 105's Minimum Data Set (MDS- a resident assessment tool) dated 5/6/2025, the MDS indicated Resident 105's cognition (ability to think, understand, learn, and remember) was intact and required moderate assistance (helper does less than half the effort) with toileting, showering, and dressing. During a concurrent observation and interview on 6/9/2025 at 11:09 a.m., with Resident 105, Resident 105 was observed to have chipped and discolored teeth. Resident 105 stated he has not seen a dentist since he was admitted to the facility (11/4/2024) but would like to. Resident 105 stated he was aware his teeth look bad which affects his appearance, and he was concerned he will lose his teeth if he does not see a dentist. During a concurrent interview and record review on 6/10/2025 at 12:11 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there are no orders for Resident 105 to be seen by a dentist and there was no orders that he was seen by a dentist here at the facility in the past. LVN 1 stated Resident 105 should be seen by a dentist because his teeth does not look good, and it could lead to infection. LVN 1 stated its important to maintain good oral hygiene because Resident 105 could potentially cause the resident to not feel good if his teeth do not look good and he could potentially lose his teeth. During an interview on 6/10/2025 at 2:46 p.m., with the Social Services Director (SSD) 1, the SSD 1 stated Resident 105 was not seen by a dentist, he was missed and was unsure as to why. SSD 1 stated Resident 105 should have been seen because not seeing the dentist could cause his teeth to fall out, affect his dignity, cause pain, or lead to an infection. During an interview on 6/13/2025 at 9:24 a.m., with the Director of Nursing (DON), the DON stated the nursing staff were responsible for assessing the residents teeth and if there were any concerns, the nursing staff will inform the SSD to make dental appointments. The DON stated good oral hygiene was important to maintain, because it can prevent bacteria from building up which can lead to an infection and can also affect their eating abilities. The DON stated Resident 105 not having dental services could potentially cause Resident 105 to have low self-esteem. During a review of the facility's policy and procedure (P&P) titled, Social Service Department Role and Function undated, the P&P indicated, It is the policy of this facility to provide medically related social services to all residents, in an effort to help them achieve and maintain their highest practicable level of physical, mental, and psychological functioning. During a review of the facility's P&P titled, Ancillary Services undated, the P&P indicated, It is the policy of this facility to obtain dental, optometry, ophthalmology, podiatry, audiology, and psychological/psychiatric services for residents who present with or request a need for these ancillary services. All residents will be assessed for ancillary needs upon admission and reassessed quarterly and as needed. All residents will have access to ancillary services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store, handle and maintain food/food supplies with professional standard for food service safety for 125 residents who eat in the kitchen when : 1.Staff failed to wear a hair net while in the kitchen. 2. Food stored in the refrigerator had no label and open date. 3.The counter mounted can opener had a black tarry substance present. 4.One large dented can of jack pot brand 6 pounds 11 ounce of pineapple on the shelf. 5.Floor underneath the triple sink with small white particle and thick black tarry film. These failures had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization. During a concurrent observation and interview on 6/9/2025 at 8:19 a.m., with Dietary Staff Supervisor (DSS) in the kitchen, Dietary Aide (DA) 2 walked into the kitchen without wearing a hair net. DSS told the DA 2 to put on a hairnet. DA 2 put on a hairnet and stated DA 2 forgot to put one on. During an observation of the reach in refrigerator the DSS removed a container of prunes from the refrigerator and stated she will throw them away because the prunes had no open date label. During an interview at 6/12/2025 at 4:11 p.m., with the Director of Nursing (DON), the DON stated anybody who enters the kitchen needs to wear a hairnet to prevent food from falling into the food. The DON stated if the food was not labeled and dated we can not determine when the food was opened or prepared and we must dispose it. The DON stated this is an infection control issue. During a review of the facility's policy and procedures (P&P), titled Dress Code, dated 2023, the P&P indicated, Proper Dress: .Hat for hair, if hair is short, which completely cover hair. Hair net for hair, if hair is long (over the ears or longer) . During a review of the facility's policy and procedures (P&P), titled Labeling and Dating of Food, dated 2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. During an initial observation and interview on 6/9/2025 at 8:16 a.m., with the Dietary Supervisor (DS), there was one large can of pineapple on a shelf with the canned foods. DS stated she did not know there was a dent on the can. DS then removed the can and placed it where it can be returned. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 6/9/2025 at 8:10 a.m.with the Dietary Aide (DA), observed countertop can opener with thick black tarry substance on the base of the can opener. The DA stated she did not know what the tarry substance was, and the staff usually clean the can opener after use. DA stated the can opener was used last night 6/8/2025. DA stated this can be harmful to the residents if the dirty can opener was used as this can contaminate the food . During a record review of the assignment for cleaning of the floors a signature was missing for the date of 6/9/2025, DSD stated if it was not signed it was not done. During an observation and interview on 6/9/2025 at 8:34 a.m., with the DS, DS stated she did not know what the black tarry substance was on the can opener. DS stated the can opener had to have been used last night 6/9/2025. In the corner underneath the 3 basins sink there were little white particles and black hard substance stuck to the floor and the plastic mat was sticky. DS stated the staff cannot get under the sink to clean the floors. DS stated it was important to get rid of the dented cans because the quality of the product of the cans and the product can have a chemical reaction and harm the resident , she stated it was best not to use the dented can, to be on the safe side. During a review of the facility's Policy and Procedure (P&P) titled, Food Storage-Dented Cans: dated 2023, the P&P indicated Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents , rim dents, or swell shall not be retained or used by the facility. All dented cans (defined as side seam or rim dents) and rusty cans are to be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund. All leaking cans are to be disposed of immediately. During a review of the facility's Policy and Procedure (P&P) titled, Can Opener and Base : dated 2023, the P&P indicated Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredded can result from a dull cutting blade or worn-out cogwheel .The can opener must be thoroughly cleaned each work shift and, when necessary , more frequently.

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Heritage Rehabilitation Center	21414 S. Vermont Avenue Torrance, CA 90502

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), cardiomyopathy (a long term condition that affects the heart muscle making it harder to pump blood), Covid -19 (highly contagious respiratory disease caused by Coronavirus which is transmitted thru coughing, talking , sneezing and touching contaminated surfaces), and end stage renal disease (ESRD- irreversible kidney failure) with dependence on renal hemodialysis (procedure to remove waste products and excess fluids from the blood when kidneys stop working properly). The admission Record indicated the resident was discharged to a funeral home on 6/9/2025 at 10:25 a.m. During a review of Resident 19's Minimum Data Set (MDS-resident assessment tool) dated 5/15/2025, the MDS indicated Resident 19 had moderately impaired cognitive skills (ability to think, understand, learn, and remember) and was dependent on staff (helper does all the effort to complete the activity) with bathing, dressing, toilet transfer (ability to get on and off a toilet or a commode) and toileting hygiene. During a review of Resident 19's Emergency Medical Services (EMS-a system that respond to emergencies in need of highly skilled prehospital clinicians) Incident Information dated 6/9/2025, at 4:35 a.m., the EMS Incident Form indicated EMS team was notified on 6/9/2025 at 4:35 a.m. of Resident 19's cardiac arrest (heart malfunctions and stops beating on its own caused by an electrical problem in the heart). The EMS Incident Information indicated a team was dispatched to the facility and arrived at 4:40 a.m. The EMS Incident Information indicated facility staff stated to the EMS team that Resident 19 was last seen on 6/9/2025, at 4:15 a.m. sleeping and breathing. The EMS Incident Form indicated Resident 19 was in asystole (when heart's electrical system fails entirely causing the heart to stop pumping and is also known as flat line) upon assessment and throughout the entirety of the resuscitative effort provided to the resident. The EMS Incident Information indicated the time of death of Resident 19 was 5:03 a.m. on 6/9/2025. During a record review of Resident 19's Medication Administration Record (MAR) dated 6/9/2025 indicated resident 19 received the following medications. 1.Aspirin (blood thinning medicine)81 milligrams (mgs.- unit of measurement) signed and administered at 9:00 a.m. 2.Docusate Sodium (medicine used as a stool softener)oral capsule 100 mgs. 1 capsule by mouth signed and administered at 9:00 a.m. 3.Nephro (a specialized nutritional shake designed specifically for people on dialysis)4 ounces (oz- unit of measurement) signed and administered at 9:00 a.m. 4.Calcium Acetate (medicine to lower high phosphorus level in the blood in people with kidney disease)oral 667 mgs. 2 tablets signed by mouth and administered at 9:00 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5.Diet percentage (the amount of food the resident had eaten) was 100 percent for breakfast signed by Licensed Vocational Nurse (LVN 6). 6.Prostat (concentrated liquid protein)sugar free liquid 30 milliliters (ml- unit of measurement) signed and administered at 9:00 a.m. 7.Capsaicin (medication used to relieve minor muscle or joint pain) external cream 0.025 percent (% - unit of strength or concentration) apply to neck topically (apply to the skin) signed and administered at 9:00 a.m. 8.Insulin NPH (an intermediate -acting insulin providing a longer duration of action)28 units (u- unit of measurement) subcutaneously (injection given in the layer of fat just below the skin) in the morning for diabetes with food and blood sugar taken was 220 mgs/dl (milligrams per deciliter - unit of measurement) signed and administered at 7:30 a.m. During a concurrent interview and record review on 6/12/2025, at 7:19 a.m. with LVN 9, Resident 19's MAR dated 6/9/2025 were reviewed. LVN 9 confirmed Resident 19's medications were documented on 6/9/2025 at 7:30 a.m., 9:00 a.m. and blood sugar was taken on 6/9/2025 at 7:30 a.m. LVN 9 stated documenting inaccurately could have a potential for medication error. During an interview and record review on 6/12/2025, at 9:08 a.m. with LVN 6, reviewed Resident 19's MAR dated 6/9/2025. LVN 6 stated she signed the medications for 9:00 a.m. and blood sugar reading on 6/9/2025 at 7:30 a.m. on 6/9/2025. LVN 6 stated when a licensed nurse was administering medicines and obtaining blood sugar, the licensed nurse should check the resident's armband (wristband that will ensure positive patient identification and time saving communication of sensitive data in a healthcare environment) for the name, date of birth and picture of the resident in the electronic health record to ensure it was the correct resident. LVN 6 stated she did not administer the medication to Resident 19 and admitted she made a mistake in documenting. LVN 6 stated she should not have signed the MAR of Resident 19 because if the medications were signed in the MAR, it indicated that she had administered them to the resident which could lead to medication error. LVN 6 stated she was overwhelmed on 6/9/2025 and was aware Resident 19 expired in the early morning. During an interview on 6/12/2025 ,at 8:29 a.m. with Registered Nurse Supervisor (RNS 4), RNS 4 stated LVN 6 should have practiced and performed right patient, right dose, right time and right frequency before administering medications to all the residents to prevent committing medication error. During an interview on 6/12/2025, at 4:46 p.m. with the Director of Nursing (DON), the DON stated LVN 6 not documenting accurately in Resident 19's MAR had the potential for committing medication error during medication administration. During a review of facility's policy and procedure (P&P) titled, Administering Medications, undated, the P&P indicated the licensed nurse administering the medication must check the label 3 times to verify the right medication, right dosage, right time and right method of administration before giving medications. Based on observation, interview, and record review, the facility failed to ensure two of six sampled residents (Resident 115 and 19) had accurate documentation on the physician's orders and Medication Administration Record (MAR) by failing to: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.Ensure Resident 115's physician orders indicated the specific type of splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) Resident 115 had to wear on the right leg at all times. 2.Ensure Resident 115's physician's order for a CAM boot splint (othopedic device used to immobilize or protect the foot and ankle after an injury or surgery) to the right leg was discontinued when the splint was discontinued by the physician. These deficient practices resulted in staff confusion and had the potential to negatively impact the provision of necessary care and services, cause miscommunication among staff, and cause a decline in range of motion (ROM, full movement potential of a joint), mobility, and overall function. 3. Ensure Licensed Vocational Nurse (LVN 6) did not document on Resident 19's Medication Administration Record that medications were given on 6/9/2025 at 9 a.m. Resident 19 had expired on 6/9/2025 at 5:03 a.m. This deficient practice had the potential to put other residents at risk for medication error. Findings: During a review of Resident 115's admission Record, the admission Record indicated Resident 115 was admitted to the facility on [DATE] with diagnoses including a fracture (broken bone) of the lateral malleolus (bony prominence on the outer side of the ankle) of the right fibula (one of the two bones of the lower part of the leg) and ataxic gait (uncoordinated walking pattern). During a review of Resident 115's Minimum Data Set (MDS, a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 115 was cognitively (ability to think, understand, learn, and remember) intact. The MDS indicated Resident 115 required supervision/touching assistance for eating and oral hygiene, partial/moderate assistance for upper body dressing, substantial/maximal assistance for bathing, and was dependent in toilet hygiene, lower body dressing, rolling, and transfers. The MDS indicated Resident 115 had functional ROM limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one leg. During a review of Resident 115's Order Summary Report, the Order Summary Report indicated a physician's order, dated 4/21/2025, for keep leg immobilizer (device used to reduce or eliminate movement of a body part) at right leg in place at all times. During a review of Resident 115's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation, dated 5/14/2025, the PT Evaluation indicated Resident 115 was able to put as much weight as tolerated through the right leg while wearing a CAM boot which was to be worn at all times. During a review of Resident 115's Nursing Progress Note, dated 5/27/2025, the Nursing Progress Note indicated Resident 115 returned from an orthopedic (refers to the medical specialty focused on the musculoskeletal system) appointment with a new physician's order to discontinue the (right leg) boot. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/10/2025 at 10:23 pm, in Resident 115's room, Resident 115 was sitting in wheelchair with no splints on the right leg. Resident 115 stated she used to have a boot on the right leg because she broke her ankle. Resident 115 stated she no longer wore the boot because it was heavy and hard to move around when wearing it. During an observation of Resident 115's Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) session on 6/11/2025 at 11:01 am, in Resident 115's room, Resident 115 was sitting in a wheelchair with a platform walker (type of walking assistive device with forearm supports to provide extra support during walking) positioned in front of her body and no splint on the right leg. Resident 115's family member was at the bedside. Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 2 (RNA 2) assisted Resident 115 into a standing position three times using the platform walker. Resident 115 stated she had pain in both legs when standing and refused to participate in further sit to stand transfers. During an interview on 6/11/2025 at 11:21 pm, RNA 2 stated Resident 115 used to have a boot on the right foot at all times but did not know if, why, or when it was discontinued. RNA 2 stated she did not know if Resident 115 had any other splints or immobilizers for the right leg other than the boot. RNA 2 stated she assumed Resident 115's boot was discontinued since she stopped wearing it. During a concurrent interview and record review on 6/11/2025 at 11:43 am, Licensed Vocational Nurse 8 (LVN 8) stated the charge nurse was responsible for updating the physician's order when a resident returned from a consultation appointment. LVN 8 reviewed Resident 115's physician's order, dated 4/21/2025, and confirmed Resident 115 had a physician's order for Resident 115 to wear an immobilizer on the right leg at all times. LVN 8 reviewed Resident 115's Nursing Progress Notes, dated 5/27/2025, and confirmed Resident 115 returned from an orthopedic appointment with a new physician's order to discontinue the boot. LVN 8 stated he was unsure if the boot mentioned in the Nursing Progress Note was different from the immobilizer on the physician's order. LVN 8 stated he did not know what type of splint and/or which joint (where two bones meet) of the leg Resident 115 was supposed to wear the boot and/or immobilizer on since the physician's order did not specify the type of immobilizer or splint to be worn. LVN 8 stated he was confused and had to investigate if Resident 115 had any other immobilizers other than the boot on the right foot. During a follow up interview on 6/11/2025 at 3:33 pm, LVN 8 stated he spoke with the Director of Rehabilitation (DOR) who confirmed Resident 115 previously wore a CAM boot, which was a type of splint, at all times but no longer needed it since it was discontinued by the physician after her follow up orthopedic appointment. LVN 8 stated the nurse who received the physician's order to discontinue the boot should have discontinued the physician's order but did not. LVN 8 stated the physician's order should have specified the type of splint Resident 115 should have been wearing at all times to avoid confusion and ensure staff were implementing the appropriate precautions. LVN 8 stated it was important documentation, including physician's orders were clear and accurate to prevent confusion and to ensure staff provided the appropriate care for the residents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2025 at 5:13 pm, the Director of Nursing (DON) stated it was important documentation, including physician's orders related to splints were current, specific, and accurate to ensure staff provided the appropriate care for residents in the facility. The DON stated splint orders must include the specific type of splint a resident has to wear to avoid confusion and inaccurate provision of services. The DON stated if a splint was discontinued by the physician, the splint order must also be discontinued in the electronic health record. The DON stated if staff immobilized a resident by splinting a body part when the resident did not require immobilization, it could have a negative impact of the resident's care, limit his or her ability to move, and limit his or her abilities to participate and improve in functional activities such as mobility and activities of daily living (basic activities such as eating, dressing, toileting). During a review of the facility's undated job description titled Charge Nurse, the job description indicated one of the specific responsibilities of the charge nurse included accurately interpreting and implementing physician orders. During a review of the facility's undated policy and procedure (P&P) titled Orthotic Devices, the P&P indicated an orthotic or splint was used to promote healing, prevent complications and to maintain function and comfort. The P&P indicated the details about the specific orthotic device, date ordered, and any modification made should be documented. During a review of the facility's undated P&P titled Charting and Documentation, the P&P indicated all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to implement corrective action from the last re-certification survey in regard to the facility repeated deficient practices. Findings: During a review of the facility's Statement of Deficiencies for the 2024 Recertification survey indicated the following repeat deficiencies: Nutrition/Hydration, pain management, food procurement, store/prepare/serve-sanitary, QAPI QAA improvement, reasonable accommodation of needs /preferences, development/ implement comprehensive care plan, Infection prevention & control, quality of care, pharmaceutical services, drug regimen review, labeling and storage of drugs. During a concurrent interview and record review on 06/13/25 at 10:41 a.m., with the Director of Nursing (DON), Administrator (ADM) and Quality Assurance (QA) nurse, reviewed QAPI reports on falls. QA nurse confirmed that these deficiencies were identified and went up and down, but facility was working on them. Per reports goals of QAPI reports as follows: 1.To decrease the number of repeated falls by 10 percent (%) for three months, and no major injury for 3 months. 2. Decrease number of falls events occurring in the evening by 5 % for 3 months. The evaluation reports were as follows: January fall rate 13% Goal not met February fall rate 16% Goal not met March fall rate 9% Goal met April fall rate 10% Goal not met May all rate 14% Goal not met The ADM stated the facility will work on identified repeated deficiencies. The ADM also reports that they were finding different way to improve , by having extra staff , talk with family members , having their Quarterly meeting and as needed if there was any emergency so that they would be able to meet their goals. During a review of the facility's undated policy and procedure (P&P) titled, Quality Assurance and Performance Improvement, (QAPI) indicated that the responsibilities of the QAPI committee are to: a. Collects and analyze performance indicator data and other information: (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Identify, evaluate, monitor and improve facility system processes that support the delivery of care and services c. Identify and help resolve negative outcomes and/ or care quality problems identified during the QAPI process. d. Utilizes the root cause analysis to help identify where identified problems points to underlying systematic problems e. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant (CNA 5) wear proper personal protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) and practice hand hygiene for one of two sampled resident (Resident 119) who had Covid 19 (highly contagious respiratory disease) before entering the room. This failure had the potential to transmit and spread infection among residents ,visitors and staff. Findings: During a review of Resident 119's admission Record, the admission Record indicated Resident 119 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) affecting the left non-dominant side following a stroke[occurs when a blood vessel that carries oxygen and nutrients to the brain is blocked by a clot or bursts]), Covid 19 ,bradycardia (heart rate is very slow and heart cannot pump enough to the body) and presence of cardiac pacemaker (a small, electronic device that helps regulate a slow or irregular heartbeat). During a review of Resident 119's Minimum Data Set (MDS-a resident assessment tool) dated 5/27/2025, the MDS indicated Resident 119 had severely impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 119 was dependent(helper does all the effort) on staff with eating, bathing, dressing, oral hygiene, toileting hygiene and bed mobility. During an observation in Resident 119's room, CNA 5 who was wearing a N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) entered Resident 119's room without hand hygiene and not wearing a protective gown and face shield. Observed CNA5 provided and covered Resident 119 who was lying in bed and carried a transparent plastic bag outside the room. During an interview on 6/9/2025, at10:56 a.m. and subsequent interview on 6/10/2025, at 11:51 a.m. with CNA 5, CNA 5 stated she wore only N 95 mask and did not practice hand hygiene when she entered Resident 119's room. CNA 5 stated she should have practiced hand hygiene, worn gloves, gown, N95 mask and face shield before entering Resident 119's room because it could spread the disease to other residents, staff and visitors. During an interview on 6/9/2025, at 10:38 a.m. with Infection Preventionist Nurse (IPN), IPN stated all staff should practice hand hygiene and wear a gown, N95 mask, gloves and face shield before entering a resident who had Covid 19 to prevent spread of infection. IPN stated that CNA 5 should have worn the proper PPE used for residents who had Covid 19 and practiced hand hygiene before entering Resident 119's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/2025, at 2:13 p.m. with RN Supervisor (RNS 2) , RNS 2 stated, the staff should practice hand hygiene, wear PPE consisting of gown, gloves, mask and face shield every time the staff enter the room of residents who had Covid 19 to prevent spread of Covid 19 to residents and staff. RNS 2 stated residents who had Covid 19 were on droplet (a set of infection control measures used to prevent the spread of diseases that are transmitted through respiratory droplets produced by an infected person when they cough, sneeze, talk or sing) and contact precautions(infection control measures used in healthcare settings to prevent the spread of infection transmitted by direct or indirect contact with a patient or their environment). During a review of facility's policy and procedure (P&P) titled, Isolation-Categories of Transmission-Based Precautions, revised 9/2023, the P&P indicated Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident-care items in the resident's environment. The P & P indicated staff and visitors should wear gloves and a disposable gown before entering the resident's room. The P&P indicated droplet precautions are implemented for an individual documented or suspected to have an infection transmitted by droplets and masks, gloves, gown and face shields are worn when entering the room.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation and interview the facility failed to provide an effective pest control by: a. Preventing an infestation of tiny flies (Drain Flies) in the kitchen. This deficient practice had the potential to affect the residents by causing disease for the 127 residents who eat food in the kitchen. Findings: During an initial observation in the kitchen on 6/9/2025 at 8:16 a.m. with the Dietary Supervisor (DS), two small flies were seen flying over a mat placed in front of the triple sink. Additionally, there were small white particles and a black tarry substance observed on the floor under the sink. The mat was noted to be sticky. DS mentioned that staff are unable to clean under the sink. During a second kitchen inspection on 6/10/2025 at 9:15 a.m., multiple tiny flies flew from the mat in front of the three sinks. The area around the drain under the mat was moist. During a record review of the Orkin Service Report (OSR) dated 5/21/2025 at 8:09 a.m., a technician checked the kitchen for any pest activity and treated as needed. During a review of the records for the floor cleaning assignment, a signature was missing for the date of 6/9/2025. The DS stated that if it is not signed, it is considered not done. During an interview on 6/10/2025 at 12:34 p.m., DS mentioned that the floors and underneath the sink should be cleaned daily. DS noted that water accumulation and dirt on the floor can harbor microorganisms. Additionally, DS stated that flies in the kitchen carry germs, which can potentially cause illness among residents. During a review of the facility's Policy and Procedure (P&P) titled, Sanitation: dated 2023, the P&P indicates, on a monthly basis, a pest control company will inspect and service the Food & Nutrition Services Department. If at any time additional servicing is needed, the pest control is notified.