STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056316	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Care Center	1920 N. Fair Oaks Avenue Pasadena, CA 91103

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the low air loss mattresses (LALMs, designed to distribute a resident's body weight over a broad surface area and help prevent skin breakdown) for two (2) of 2 sampled residents (Residents 13 and 81) reviewed for pressure ulcers (injuries to the skin and underlying tissue resulting from prolonged pressure) were set at the correct settings in accordance with the facility's policy and procedure (P&P) and the physician's orders:Resident 13, who weighed 90 pounds (lbs.), had a LALM setting of 50 lbs.Resident 81, who weighed 103 lbs., had a LALM setting of 120 lbs.This deficient practice had the potential for Resident 13 to develop a pressure ulcer and placed Resident 81 at risk for deterioration of the resident's current pressure ulcer.Findings: 1. During a review of Resident 13's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), arthritis (disease characterized by joint inflammation, pain, stiffness, and reduced range of motion, often causing significant damage or disability) and right femur (long bone in leg) fracture (a break in the bone). During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool) dated 3/27/2026, the MDS indicated Resident 1 did not have intact cognitive (ability to think and process information) ability. The MDS indicated Resident 13 was dependent (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear, personal hygiene, rolling left and right, moving from sitting on side of bed to lying flat on bed, lying to sitting on side of bed, getting in and out of shower and transferring from bed to chair. During an observation on 4/20/2026 at 10:08 AM, Resident's LALM was observed set to 50 lbs. During a concurrent observation and interview on 4/20/2026 at 10:15 AM with Licensed Vocational Nurse (LVN) 1, Resident 13's LALM was observed to be set at 50 lbs. LVN 1 stated Resident 13's LALM is set at 50 lbs. but should be set at 87 lbs. since the resident's weight is 90 lbs. LVN 1 stated Resident 13 is bedbound, and it is important to set the LALM at the correct weight setting so that pressure could be redistributed properly to prevent pressure ulcers. During a concurrent interview and record review on 4/20/2026 at 10:18 AM with LVN 1, Resident 13's Order Summary Report dated 2/2/2026 was reviewed. The Order Summary Report indicated Resident 13 may have LALM set to resident's weight for skin management. LVN 1 stated the order indicated Resident 13's LALM is to be set at the resident's weight, but it was not set at the correct setting. During a concurrent interview and record review on 4/20/2026 at 10:20 AM with LVN 1, Resident 13's Weight Summary dated 4/3/2026 was reviewed. The Weight Summary indicated Resident 13 weighed (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	90 lbs. LVN 1 stated Resident 13's most recent weight is 90 lbs. and the LALM should have been set to 90 lbs. During a concurrent interview and record review on 4/23/2026 at 2:13 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Support Surface Guidelines, dated 9/2013 was reviewed. 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 of skin breakdown. Redistributing support surfaces are to promote comfort for all bed bound residents, prevent skin breakdown, promote circulation and provide relief or reduction. The DON stated the LALM is used to prevent pressure ulcers by redistributing the pressure residents put on the bed. The DON stated that if the LALM is not set at the correct setting it may promote skin breakdown instead of preventing it. 2. During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses that included encephalopathy (a disturbance of brain function),end-stage renal disease (ESRD, irreversible decline in a person's own kidney function), pressure ulcer stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) in the coccyx (tailbone) area and diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels). During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 81 was dependent for oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying-to-sitting on the side of the bed, and chair/ bed-to-chair transfer, and toilet transfer. The MDS also indicated Resident 81 was at risk for pressure ulcers, had one unhealed stage 4 pressure ulcer, and was using pressure relieving devices for bed. During a review of Resident 81's Physician's Order (PO) dated 4/13/2026, the PO indicated, low air loss mattress for skin management and set settings per resident's comfort/preference or resident's weight every shift. During a review of Resident 81's Weight and Vital signs dated 4/14/2026, it indicated Resident 81's weight is 103 pounds (lbs.- unit of measurement). During a review of Resident 81's Braden Scale Assessment (BSA, tool used to check a resident's risk for developing pressure sores), dated 4/13/2026, it indicated Resident 81 was at high risk for developing pressure ulcers. During an observation and interview on 4/20/2026 at 9:49 AM in Resident 81's room, Resident 81 was observed sleeping and lying on a LALM which was set at 120 lbs. During a concurrent observation and interview on 4/21/2026 at 2:46 PM with Registered Nurse Supervisor 3 (RNS 3) inside Resident 81's room, Resident 81 was awake and lying on a LALM which was set at 120 lbs. RNS 1 stated Resident 81's LALM was set on 120 millimeters of mercury (mmHg, unit of pressure). RNS 3 stated Resident 81's LALM had incorrect setting, LALM should be set on 103 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lbs. RNS 3 stated if the LALM setting was higher than 103 lbs., the LALM would be too firm for Resident 81. During a concurrent observation and interview on 4/21/2026 at 2:48 PM with Resident 81 inside Resident 81's room, Resident 81 was awake and lying on a LALM which was set at 120 mmHg. Resident 81 stated it hurts my buttocks when the mattress was too hard. During an interview on 4/23/2026 at 2:13 PM with the Director of Nursing (DON), the DON stated LALM setting should be set based on the Resident's weight. The LALM purpose was to prevent formation of PU. If LALM was not set up correctly and the resident does not have a wound, it can form a skin breakdown. But if the Resident had a PU, the wound could get worse. During review of the facility's undated user's manual titled, Brand 1 Alternating Pressure Mattress Replacement System with Low Air Loss, the manual indicated in the product function section, adjust the dial to correspond to the patients' appropriate weight setting. During a review of the facility's policy and procedure (P&P) titled Support Surface Guidelines revised 9/2013, the P&P indicated redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the kitchen staff (Cook 3) failed to follow the facility's food preparation policy by not using serving utensils and not changing gloves during the lunch tray line assembly (organized process in a healthcare or foodˆservice setting where staff assemble meal trays for residents) on 4/22/2026. This deficient practice had the potential to expose residents to pathogens (germs), placing them at risk for developing foodborne illness, which may cause symptoms such as upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever, and could lead to serious medical complications or hospitalization. Findings: During an observation in the kitchen on 4/22/2026 at 12:12 PM, [NAME] 3 touched and picked up a cooked fish fillet from a baking tray with her gloved hand and placed it on a resident's serving plate. Using the same gloves, [NAME] 3 then proceeded to scoop the vegetable entree from the serving tray on the tray line assembly. During an observation in the kitchen on 4/22/2026 at 12:15 PM, [NAME] 3, with the same gloves, picked up a beef patty and half a slice of baked potato from the serving trays on the tray line assembly and placed both items on a resident's serving plate. [NAME] 3 then continued scooping food at the serving table without changing her gloves. During an observation in the kitchen on 4/22/2026 at 12:19 PM, [NAME] 3 picked up half a slice of baked potato and one beef patty with the same gloved hand, placed them on the serving plate, and continued scooping food at the serving table without changing her gloves. During a concurrent observation and interview on 4/22/2026 at 12:19 PM with the Dietary Supervisor (DTS), DTS stated that [NAME] 3 should not handle food directly with gloved hands and should use tongs to pick up items such as beef patties, as this can cause crossˆcontamination and result in residents becoming ill. During an interview on 4/22/2026 at 12:30 PM, [NAME] 3 stated she should not have touched the beef patty with her gloved hand because it could contaminate the food. [NAME] 3 added that food contamination can cause illness for residents. During a concurrent interview and record review on 4/22/2026 at 12:40 PM with the DTS, the facility's policy and procedure (P&P) titled, Food: Preparation, revised September 2017, was reviewed. The P&P indicated that all staff must practice proper handwashing techniques and glove use and must use serving utensils appropriately to prevent crossˆcontamination. The DTS stated that kitchen staff did not follow the policy during today's tray line assembly.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two (2) of five (5) sampled residents (Resident 12 and 57) reviewed for unnecessary (any drug when used without adequate monitoring, and without adequate indication for use) medications were free from unnecessary psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) as indicated in the facility's policy and procedure by failing to ensure: 1.a. Resident 12's behavior of being easily irritable for the use of Depakote (also used to treat acute manic or mixed episodes associated with bipolar disorder with or without psychotic features) was monitored.b. Resident 12 was monitored for a specific manifestation of restlessness for the use of Clonazepam (Klonopin, is a prescription medicine used to calm the nervous system. It is primarily used to treat seizure disorders [epilepsy] and panic disorders/attacks by reducing abnormal brain activity and inducing relaxation). 2. Resident 57's was monitored for the specific behavior for the use of Fluoxetine (Prozac, is a medication that helps regulate the mood and treats depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (emotion characterized by feelings of tension, worried thoughts and physical changes), obsessive-compulsive disorder [OCD, is a chronic mental health condition characterized by uncontrollable, recurring thoughts {obsessions} and/or repetitive behaviors {compulsion}] that a person feels driven to perform to reduce anxiety and eating disorders). These deficient practices have the potential to increase the risk of Residents 12 and 57 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medication (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), which may lead to an overall negative impact on the residents' physical, mental, and psychosocial well-being. Findings:1. During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 12's diagnoses included metabolic encephalopathy (ME, occurs when problems with your metabolism cause brain dysfunction), major depressive disorder, generalized anxiety disorder, epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]) and dementia (a progressive state of decline in mental abilities). During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool) dated 4/3/2026, the MDS indicated Resident 12 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 12 was substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, sit to stand, chair/ bed-to-chair transfer toilet transfer, tub/ shower transfer, and walk 10 feet. During a concurrent interview and record review on 4/22/2026 at 11:06 AM with MDS Nurse (MDS 1), Resident 12 's Physician's order (PO) dated 3/20/2026 and medical records were reviewed. The PO indicated Depakote 125 milligrams (MG, unit of volume). Give one (1) tablet by mouth three (3) times a day for mood disorder manifested by (M/B) easily irritable. MDS 1 stated there was no order to monitor Resident 12's behavior of being easily irritable for the use of Depakote. MDS 1 also stated that Resident 12's medical records did not reflect that the resident's behavior of being easily irritable was monitored. MDS 1 further stated that if there was no documentation of monitoring for Resident 12's behavior of being easily irritable, it meant the licensed staff did not monitor Resident 12's specific behavior for which Depakote was prescribed. During a concurrent interview and record review on 4/22/2026 at 11:07 AM with MDS 1, Resident 12's PO orders were reviewed. The PO indicated:> (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clonazepam 0.5 MG. Give 0.25 MG by mouth at bedtime for anxiety M/B restlessness for 14 days, ordered 4/17/2026.> Monitor episodes of anxiety M/B restlessness and tally by hashmarks every shift starting on the last day of month and ending on the last day of month every month, ordered 3/30/2026. MDS 1 stated the PO did not include, but should have included, a specific manifestation for restlessness because every resident may exhibit restlessness differently. MDS 1 further stated this would ensure that staff are monitoring the same behavior in order to evaluate whether the medication is effective. During a concurrent interview and record review on 4/22/2026 at 11:09 AM with MDS 1, Resident 12's care plan, dated 4/17/2026, the care plan interventions indicated were to:Administer medication as ordered and monitor for adverse side effects.Dose reduction if appropriateTry to determine the reason for behavioral disturbancesMDS 1 stated the CP interventions for the use of clonazepam for Resident 12 were not adequate and resident specific. 2. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. The admission record indicated Resident 's diagnoses included Lewy body dementia (LBD, is a brain disorder that can lead to problems with thinking, movement, behavior, and mood, major depressive disorder, anxiety disorder, and epilepsy. During a review of Resident 57's MDS dated [DATE], the MDS indicated Resident 57 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 57 was partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) for toileting hygiene, shower/ bathe self, putting on/ taking off footwear, roll left and right, sit to lying, lying-to-sitting on the side of the bed, and chair/ bed-to-chair transfer. During a concurrent interview and record review on 4/22/2026 at 10:29 AM with MDS 1, Resident 12's PO order dated 2/5/2026 was reviewed. The PO indicated Fluoxetine 20 MG one time a day for depression. MDS 1 stated the PO did not include, but should have included, a specific manifestation for the use of Fluoxetine. MDS 1 stated it should have included manifestation of behavior such as Resident 12 verbalizations of missing his spouse. MDS 1 further stated this would ensure that staff are monitoring the specific behavior in order to evaluate whether Fluoxetine is effective. During a concurrent interview and record review on 4/23/2026 at 11:37 AM with the Director of Nursing (DON), Resident 12's PO order dated 2/5/2026 was reviewed. The DON stated the fluoxetine order was incomplete. The PO did not include Resident 12's manifested behavior for depression. During a review of the facility's Policy and Procedure (P&P) titled, Antipsychotic Medication Use, revised 12/2016, the P&P indicated antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The P&P also indicated: 6. Diagnosis of a specific condition for which anti-psychotic medications are necessary to treat will be based on a comprehensive assessment of the resident.16. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including anti-psychotic medications.17. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician. During a review of the facility's P&P titled, Behavioral Assessment, Intervention and Monitoring, revised 3/2019, The P&P Management indicated,7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.8. interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, as a minimum:a. a description of the behavioral symptoms, including:(1) frequency;(2) intensity;(3) duration;(4) outcomes;(5) location;(6) environment; and(7) precipitating factors or situations.b. targeted and individualized interventions for behavioral and/or psychosocial symptoms;c. the rationale for the interventions and approaches;d. specific and measurable goals for targeted behaviors; ande. how the staff will monitor the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effectiveness of the interventions.10. 0. When medications are prescribed for behavioral symptoms, documentation will include:a. rationale for use;b. potential underlying causes of the behavior;c. other approaches and interventions tried prior to the use of anti-psychotic medications;d. potential risks and benefits of medications as discussed with the resident and/or family;e. specific target behaviors and expected outcomes;f. dosage;g. duration;h. monitoring for efficacy and adverse consequencesThe P&P Monitoring also indicated,2. The IDT will monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported.3. Interventions will be adjusted based on the impact on behavior and other symptoms, including any adverse consequences related to treatment.4. If antipsychotic medications are used to treat behavioral symptoms, the IDT will monitor their indication and implement a gradual dose reduction, or document why this cannot or should not be done (for example, recurrence of psychotic symptoms after several previous attempts to taper medications).a. The IDT will monitor for side effects and complications related to psychoactive medications; for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling.b. ff such symptoms are identified, and some medication is still needed, the IDT will adjust the current regimen to try to minimize side effects while maintaining therapeutic effectiveness.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff did not develop a care plan (a dynamic, written document outlining a patient's health needs, goals, and customized interventions, formulated through assessment) to address the use of indwelling catheter (a flexible, sterile tube inserted into the bladder to continuously drain urine into a collection bag) for one (1) of 18 sampled residents (Resident 8) as indicated on the facility policy. This deficient practice had the potential for Resident 8 to have catheter-associated urinary tract infections (infection in the urinary tract due to the medical device such as indwelling catheter). Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. with diagnoses that included hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, type 2 diabetes mellitus (high blood sugar levels in blood stream) without complications, and other seizures (a sudden, uncontrolled burst of electrical activity in the brain). During a review of Resident 8's Minimum Data Set (MDS, resident assessment tool), dated 2/6/2026, the MDS indicated Resident 8 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 8 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right. During a review of Resident 8's Physician's Order (PO) dated 1/30/2026, the PO indicated, to monitor indwelling catheter urinary drainage bag and document the following the color, output, odor, hematuria (blood in urine), every dayshift. During a concurrent interview and record review on 4/22/2026 at 3:55 PM with Medical Record (MR), Resident 8's Care Plan Report was reviewed dated from 1/30/2026 to 4/22/2026, MR stated she could not find any Care Plan to address the use of indwelling catheter in Resident 8's Care Plan Report. MR stated it is important for the nurses to develop the use of Foley Catheter plan of care for Resident 8, it is essential for providing individualized, safe, and consistent patient care while promoting efficient communication among healthcare teams. During a concurrent interview and record review on 4/22/2026 at 3:59 PM with the Director of Nurses (DON), the DON stated nurses are supposed to develop a resident centered care plan for Resident 8's use of indwelling catheter in order to prevent, reduce, or manage catheter-associated urinary tract infections and to providing individualized, safe, and consistent patient care while promoting efficient communication among healthcare teams. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, was reviewed. The P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan will:Include measurable objectives and time frames. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial (dynamic interaction between an individual's thoughts/ emotions/ behavior with their social environment) well-being.

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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 observation, interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 72) reviewed for indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) were accurately monitored on 4/20/2026 and 4/22/2026, in accordance with the physician's (MD, medical doctor) order and facility's policy and procedure (P&P) by failing to ensure:Resident 72's indwelling catheter was monitored and documented for sedimentation (particles in liquid) in the urine (common causes include dehydration, kidney stone or urinary tract infection [UTI; an infection in the urinary system, which includes the kidneys, ureters, bladder, and urethra]) on 4/20/2026 and 4/22/2026.MD was notified of Resident 72's sedimentation in urine noted on 4/20/2026.These deficient practices have the potential for Residents 72 to develop urosepsis (a life-threatening UTI) and worsening conditions.Findings:During a review of Resident 72's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), cerebral infraction (damage to tissues in the brain due to a loss of oxygen to the area) and acute pyelonephritis (a serious UTI). During a review of Resident 72's Minimum Data Set (MDS- a resident assessment tool) dated 2/11/2026, the MDS indicated Resident 1 had intact cognitive (ability to think and process information) ability. The MDS indicated Resident 72 required maximal assistance (helper does more than half the effort) for eating. The MDS indicated Resident 72 was dependent (helper does all the effort) for oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear, personal hygiene, rolling left and right, getting in and out of shower and transferring from bed to chair. During an observation on 4/20/2026 at 2:22 PM, Resident 72's indwelling catheter tubing was observed with cloudy urine with sedimentation. During a concurrent observation and interview on 4/22/2026 at 12:26 PM with Registered Nurse (RN) 2, Resident 72's indwelling catheter tubing was observed to have cloudy urine and sediment. RN 2 stated that there is sedimentation in Resident 72's urine which can be harmful because it may cause the resident to get an infection. RN 2 stated that the MD should have been notified if there is sediment in urine and a change in condition (CoC) would be completed. During a concurrent interview and record review on 4/22/2026 at 12:36 PM with Licensed Vocational Nurse (LVN) 3, Resident 72's Order Summary Report dated 2/23/2026 was reviewed. The Order Summary Report indicated that Resident 72's indwelling catheter is to be monitored for sedimentation every shift and MD is to be notified of sedimentation. LVN 1 stated the order indicated Resident 72's indwelling catheter is to be monitored for sedimentation and urine consistency every shift. During a concurrent interview and record review on 4/23/2026 at 2:18 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Urinary Catheter Care, dated 9/2014 was reviewed. The P&P indicated:The purpose of this procedure is to prevent catheter associated urinary tract infections.Observe the resident for complications associated with urinary cathetersCheck the urine for unusual appearance.Observe for other signs and symptoms of UTI or urinary retention.Report findings to the physician or supervisor immediately.The DON stated staff must notify the MD and do a CoC if they see sediment in a resident's indwelling catheter urine. The DON stated that the resident may get urosepsis or a UTI if sedimentation is not addressed. During a concurrent interview and record review on 4/23/2026 at 2:32 PM with the DON, Resident 72's Treatment Administration Record (TAR) dated 4/1/2026 to 4/30/2026 was reviewed. The TAR indicated that Resident 72's indwelling catheter did not have any sedimentation from dayshift (7:00 AM to 3:00 PM) on 4/20/2026 and dayshift to afternoon shift (3 PM to 11 PM) on 4/22/2026. The DON stated that staff have been documenting that Resident 72 has not had sediment in urine from 4/20/2026 to 4/22/2026. The DON stated that there is no documented evidence that the MD was called regarding sediments noted in the resident's urine on 4/20/2026. (continued on next page)

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	056316	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Camellia Gardens Care Center	1920 N. Fair Oaks Avenue Pasadena, CA 91103

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/23/2026 at 2:37 PM with the DON, Resident 72's CoC dated 4/22/2026 entered at 5:39 PM was reviewed. The CoC indicated Resident 72's indwelling catheter had sediments. The DON stated that staff did a CoC for Resident 72's sediment in urine on the afternoon shift of 4/22/2026 yet they still documented normal urine appearance in the TAR for the afternoon shift. The DON stated this is inconsistent documentation and staff have been inaccurately documenting the appearance of Resident 72's urine.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) for one (1) of five (5) sampled residents (Resident 57) reviewed for unnecessary medications, in accordance with the facility's policy. This deficient practice had the potential for Resident 57 to receive unnecessary medications and experience adverse drug reactions.Findings:During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. The admission record indicated Resident 's diagnoses included Lewy body dementia (LBD, is a brain disorder that can lead to problems with thinking, movement, behavior, and mood) , major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems), anxiety disorder (mental health condition marked by persistent excessive worry, fear, or nervousness that interferes with daily life), and epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]). During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool) dated 2/10/2026, the MDS indicated Resident 57 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 57 was partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) for toileting hygiene, shower/ bathe self, putting on/ taking off footwear, roll left and right, sit to lying, lying-to-sitting on the side of the bed, and chair/ bed-to-chair transfer. During a review of Resident 57 's Physician's order (PO) dated 2/5/2026 to 2/13/2026, the PO indicated the following:Apixaban (Eliquis, a prescription medicine used to treat blood clots in the veins of the legs or lungs) 2.5 milligrams (MG, unit of volume) two times a day for DVT prophylaxis (PPX prevention).Fluoxetine (Prozac, is a medication that helps regulate mood and treats depression, anxiety, obsessive-compulsive disorder [OCD, is a chronic mental health condition characterized by uncontrollable, recurring thoughts {obsessions} and/or repetitive behaviors {compulsion}]that a person feels driven to perform to reduce anxiety and eating disorders) 20 MG one time a day for depression manifested by (M/B) withdrawal of activities.Lorazepam (Ativan, is used to treat anxiety disorders) 0.5 MG three times a day for anxiety M/B agitation and physical aggression related to preference to smokeQuetiapine (Seroquel, is an atypical antipsychotic used to treat schizophrenia, bipolar disorder [manic-depressive illness / manic depression, is a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration] and depression) 25 MG two times a day for psychosis (a mental health condition where a person loses touch with reality) M/B paranoia (an intense, unfounded fear or suspicion that others are trying to harm, trick, or deceive the person, despite having no real evidence) and false belief he is on emergency with repetitive saying need to use the phone to callOxcarbazepine (an anticonvulsant drug that reduces the incidence of seizures in epilepsy by inhibiting abnormal electrical activity in the brain) 300 MG three times a day for seizures. During a review of the facility's Medication /Drug Regimen Review (MRR) Binder from 2/2026 to 4/2026, the MRR Binder did not include an MRR report for Resident 57. During a concurrent interview and record review on 4/23/2026 at 11:39 AM with the Director of Nursing (DON), the MRR Binder for 2/2026 to 3/2026 was reviewed. There was no documentation that MRR was done for Resident 57 from 2/2026 to 3/2026. The DON stated MRR Binder did include an MRR report for Resident 57 for 2/2026 and 3/2026. During an interview on 4/21/2026 at 11:44 AM, the DON stated the MMR should be completed monthly for all residents. The DON stated Resident's 57 medications (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be reviewed to determine any recommendation for the doctor to adjust the resident's medications because these could affect his cognitive status and could also contribute to his fall risk. During a concurrent interview and record review on 4/23/2026 at 1:37 PM with the Pharmacy Consultant (PHC), the MRR Summary, dated 2/1/2026 to 3/30/2026 was reviewed. PHC stated the MRR Summary did not reflect Resident 57's name on the list of all residents who were reviewed. Resident 57's name was not included on the list, which meant Resident 57's medications were not reviewed. During a review of the facility's Policy and Procedure (P&P) titled, Support Surface Guidelines, revised 9/2013, the P&P indicated upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen, to identify whether:a. there is a clear indication for treating that individual with the medication;b. the dosage is appropriate;c. the frequency of administration and duration of use are appropriate andd. potential or suspected side effects are present.6. The consultant pharmacist shall review each resident's medication regimen monthly, as requested by the staff or practitioner, or when a clinically significant adverse consequence is confirmed or suspected.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor the use of antiseizure medications (ASM, used to treat and prevent seizures [brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior) for one (1) of five (5) sampled residents (Resident 57) reviewed for unnecessary medications by failing to monitor for side effects and seizure episodes in accordance with the care plan and facility policy. This deficient practice had the potential for Resident 57 to experience episodes of seizures without proper monitoring and to develop adverse drug reactions (any unwanted or harmful effect that happens when a person takes a medication at the normal dose) which may result in harm, hospitalization, and death. Findings: During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. The admission record indicated Resident 's diagnoses included Lewy body dementia (LBD, is a brain disorder that can lead to problems with thinking, movement, behavior, and mood) , major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems), anxiety disorder (mental health condition marked by persistent excessive worry, fear, or nervousness that interferes with daily life), and epilepsy (a chronic brain disorder characterized by recurrent unprovoked seizures) During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool) dated 2/10/2026, the MDS indicated Resident 57 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 57 was partial/ moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) for toileting hygiene, shower/ bathe self, putting on/ taking off footwear, roll left and right, sit to lying, lying-to-sitting on the side of the bed, and chair/ bed-to-chair transfer. During a concurrent interview and record review on 4/22/2026 at 10:33 AM with MDS Nurse (MDS 1), Resident 57 's Physician's order (PO) dated 2/15/2026 and medical records were reviewed. The PO indicated Oxcarbazepine (an anticonvulsant drug that reduces the incidence of seizures in epilepsy by inhibiting abnormal electrical activity in the brain) 300 Milligrams (MG, unit of volume) three times a day for seizures. MDS 1 stated they did not have PO for monitoring the side effects (S/E) of antiseizure medications. MDS 1 stated Resident 57's medical records did not indicate that the resident was being monitored for the S/E of oxcarbazepine and seizure episode. MDS 1 stated the licensed nurses should be monitoring Resident 57 for the S/E of ASM such as dizziness, blurred vision, nausea, fatigue, and mood changes. If they did not have a monitoring for ASM use, the staff would not be aware if Resident 57 was experiencing the S/E of ASM, which could delay a treatment evaluation of Resident 57's ASM use. During a concurrent interview and record review on 4/22/2026 at 10:37 AM with MDS 1), Resident 57 's Care Plan (CP) for seizure disorder/ epilepsy dated 2/9/2026 was reviewed. Resident 57's CP interventions indicated: Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness.MDS 1 stated the CP interventions were not followed because the staff did not monitor Resident 57 for the side effects of ASM. During a review of the facility's Policy and Procedure (P&P) titled Seizures and Epilepsy -Clinical Protocol revised 11/2018, the P&P indicated the nurse shall assess and document/report the following under monitoring:a. They should document periodically and objectively the presence or absence of seizure activity.3. The staff and physician will monitor for complications related to antiepileptic medications; for example, dizziness, ataxia (neurological condition characterized by a lack of muscle coordination, resulting in unsteady or clumsy movements-such as difficulty walking, poor balance, and trouble handling object), somnolence (state of drowsiness or strong urge to sleep, where the person feels very sleepy-especially during times when the person is supposed to be awake), headache, diplopia (double vision; when a person sees two images of the same object instead (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of one), blurred vision, nausea, vomiting, and rash.a. The staff, consultant pharmacist, and physician will also monitor for drug interactions between antiepileptic medications and other categories of medications.

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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 standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for four (4) of 18 sampled residents (Resident 3, 8, 10 and 44) in accordance with the facility's policy and procedure when: 1. Licensed Vocational Nurse 4 (LVN 4) failed to put on a gown while providing care for Resident 3, who was on contact precautions (an infectionˆcontrol measure used in healthcare settings to prevent the spread of infections transmitted through direct or indirect contact with a resident or their environment). 2. Registered Nurse Supervisor 1 (RNS 1) failed to put on a gown while in an enhanced barrier precaution room (EBP, infectionˆcontrol measures used for residents who have wounds, medical devices such as catheters, or certain germs. In an EBP room, staff must wear gloves and a gown when touching the resident or anything in their care area to help prevent the spread of infection) while flushing Resident 8's foley catheter (a thin, flexible tube that is inserted into the bladder to drain urine. It stays in place with a small balloon at the tip that is inflated once the catheter is inside the bladder). 3. RNS 1 and RNS 2 failed to wear a gown while doing a dressing change for Resident 10. RNS 1 failed to ensure trash with bodily fluids was not placed on top of Resident 10's bed while doing a dressing change. 4. Licensed Vocational Nurse 2 (LVN 2) failed to change gloves after touching the privacy curtain and before checking Resident 44's gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) placement and administering the resident's medications. These deficient practices have the potential to result in transmission of infectious organisms, leading to serious illness or harm for Residents 3, 8, 10, and 44, and other residents in the facility. Findings 1.During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 3's diagnoses included chronic respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide, and a deficiency in the amount of oxygen reaching body tissues), spastic quadriplegic cerebral palsy (the most severe form involving high muscle tone and stiffness in all four limbs, the trunk, and the face), and other seizure (a sudden, uncontrolled burst of electrical activity in the brain). During a review of Resident 3's Minimum Data Set (MDS, resident assessment tool), dated 1/3/2026, the MDS indicated Resident 3 was severely impaired (never/rarely made decisions) with cognitive skills (mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right. During an observation on 4/20/2026 at 7:53 a.m. in front of Resident 3's room, Licensed Vocational Nurse 4 (LVN 4) was observed having just provided care to Resident 3 without wearing the personal protective equipment (PPE, items worn to protect staff and residents from the spread of infection such as gloves, gown, and masks) required to prevent the spread of infection. The sign on Resident 3's door indicated that the room was under contact precaution. During an interview on 4/20/2026 at 7:54 AM with LVN 4, LVN 4 stated it is very important to wear proper PPE as indicated on the contact precaution sign when providing care to the residents, as this helps prevent the spread of infections from Resident 3 to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 8's admission Record, the admission Record indicated Resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 8's diagnoses included hemiplegia (a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (a mild loss of strength in a leg, arm, or face) following cerebral infarction (a damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, type 2 diabetes mellitus (high blood sugar levels in blood stream) without complications, and other seizures. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 8 was dependent on oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting off footwear, personal hygiene and roll left and right. During an observation on 4/22/2026 at 3:53 p.m. in Resident 8's room, Registered Nurse Supervisor 1 (RNS 1) was observed flushing Resident 8's foley catheter without a gown. The sign on Resident 8's door indicated that the resident was under EBP. During an interview on 4/22/2026 at 3:55 p.m. with RNS 1, RNS 1 stated that it is very important to wear PPE as indicated on the EBP sign when providing care to a resident, as this helps prevent the spread of infection from Resident 8 to other residents. During an interview on 4/23/2026 at 10:54 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated that it is very important for LVN 4 and RNS 1 to wear their PPE when caring for residents in rooms under contact isolation or enhanced barrier precautions. The IPN stated that this prevents the spread of pathogens and ensures that contamination is contained within the resident's immediate environment. During a record review of facility's Policy and Procedure (P&P) titled, Standard Precautions revised on 10/2018, the P&P indicated Standard precautions are used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Gowns (clean, non-sterile) are worn to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing. 3. During a review of Resident 10's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness, and Stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) to sacrum (lower end of the spinal area at the base of the spine). During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had intact cognitive skills for daily decision making. The MDS indicated Resident 10 was dependent for oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear, personal hygiene, rolling left and right, sitting to lying in bed, lying to sitting on side of bed, sitting to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	standing, toilet transfer, getting in and out of shower and transferring from bed to chair. The MDS indicated that Resident 10 had one stage 4 pressure ulcer present on admission. During a review of Resident 10's Order Summary Report dated 4/16/2026, the Order Summary Report indicated Resident 10 will have Stage 3 pressure ulcer (Full-thickness loss of skin. Dead and black tissue may be visible) cleaned and treated every day. During a review of Resident 10's Care Plan titled, Left Buttock Stage 3 Pressure injury, dated 4/14/2026, the Care Plan indicated an intervention was to keep the site clean and dry. During an observation on 4/22/2026 at 9:46 AM, RNS 1 was observed placing a trash bag on Resident 10's bed next to the resident's left leg. During an observation on 4/22/2026 at 9:51 AM, RNS 1 was observed cleaning Resident 10's sacral pressure ulcer with gauze and throwing the dirty gauze into the trash bag next to Resident 10's left leg. During an observation on 4/22/2026 at 10 AM, RNS 1 was observed rolling Resident 10 to a supine position, causing Resident 10's left leg to land on top of a trash bag full of soiled dressing materials. During a concurrent observation and interview on 4/22/2026 at 10:02 a.m. with RNS 1, Resident 10's left leg was observed resting on top of a trash bag placed on his bed, next to Resident 10's right leg. RNS 1 stated that Resident 10's left leg was on top of the trash bag. RNS 1stated that the trash bag should not be there. RNS 1 stated that Resident 10's leg should not be touching a bag containing dirty gauze from a dressing change. During a concurrent observation and interview on 4/22/2026 at 10:05 a.m. with RNS 1, RNS 2 was observed placing a trash bag next to Resident 10's right leg on his bed and throwing trash into the bag. RNS 1 stated that a trash bag should not be placed next to a resident's leg on their bed. RNS 1 explained that RNS 2 placed the trash bag there so it would not be near the resident's face. RNS 1 stated that a resident could develop an infection if their skin comes into contact with germs from dirty gauze used during a dressing change. During a concurrent observation and interview on 4/22/2026 at 10:15 a.m. with RNS 1, RNS 1 and RNS 2 were observed not wearing gowns while performing a dressing change to Resident 10's sacral pressure ulcer. RNS 1 was observed using gauze to clean the inside of Resident 10's wound and then disposing of the gauze, which was stained with bodily fluids from the wound, into a trash bag. RNS 1 stated that she did not wear a gown because Resident 10 was not on isolation precaution. During a concurrent interview and record review on 4/23/2026 at 1:50 p.m. with the Infection Prevention Nurse (IPN), the facility's policy and procedure (P&P) titled, Infection Control, dated 10/2018, was reviewed. The P&P indicated that infection control policies and practices are intended to maintain a safe, sanitary environment and to help prevent and manage the transmission of diseases and infections among personnel, residents, visitors, and the general public. The IPN stated that it was not acceptable to place a trash bag containing soiled dressingˆchange materials on top of a resident's bed. The IPN stated that if a resident's leg touches soiled gauze from a dressing change, it creates a transmission risk for infection and could cause the resident to become infected. During an interview on 4/23/2026 at 2:29 p.m. with the Director of Nursing (DON), the DON stated that (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RNs should wear gowns while performing dressing changes to prevent the spread of infections. The DON stated that it is not acceptable to place a trash bag on top of a resident's bed during a dressing change because it can cause the resident to develop an infection. During a review of the facility's P&P titled, Wound Care, dated 10/2010, the P&P indicated that gowns will be necessary if there is a likelihood of soiling skin or clothing with blood or other body fluids. 4. During a review of Resident 44's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 44's diagnoses included chronic respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide), traumatic brain injury (results from a violent blow or jolt to the head), and seizure. During a review of Resident 44's MDS dated [DATE], the MDS indicated the resident had severely impaired cognitive skills for daily decision-making. The MDS also indicated the resident was dependent for oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and rolling left and right. During an observation on 4/22/2026 at 8:31 AM in Resident 44's room, LVN 2, while wearing gloves, touched and pulled the curtain to provide privacy and touched the resident's linens. Using the same gloves, LVN 2 then checked Resident 44's Gˆtube residual (the amount of formula and stomach contents remaining between feedings) and administered medications via the Gˆtube without changing gloves. During an interview on 4/22/2026 at 8:40 AM, LVN 2 stated she did not change her gloves after touching Resident 44's curtain and acknowledged she should have changed gloves prior to administering medications via the Gˆtube due to infection control requirements. During an interview on 4/26/2026 at 12:01 PM with the Infection Prevention Nurse (IPN), the IPN stated licensed staff must change their gloves when performing different tasks during medication administration. The IPN stated licensed staff must always use clean gloves to prevent crossˆcontamination and avoid introducing microorganisms into the resident's Gˆtube. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated that medications are to be administered in a safe and timely manner as prescribed, and staff must follow facility infection control procedures (e.g., handwashing, aseptic technique, glove use, isolation precautions) when administering medications.