STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056322	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Springs Skilled Nursing & Wellness Center	2635 Honolulu Ave Montrose, CA 91020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect and promote one of two sampled residents' (Resident 1) right to self^determination (refers to a person's ability to make choices and direct their own behavior based on their own interests, values, and goals) and to be free from interference (any action by facility staff that improperly hinders or undermines a resident's ability to make decisions, express preferences, or refuse care). On 5/15/2026, between 2:30 to 3:00 PM, Licensed Vocational Nurse (LVN) 1, Certified Nurse Assistant (CNA) 1, and CNA 2 transferred Resident 1 from his bed using a Hoyer Lift to take him to the Shower Room, despite the resident's repeated verbal objections due to pain and discomfort. This failure violated the resident's right to exercise freedom of choice and refuse treatment, in accordance with the facility's policies titled Refusal of Treatment, Resident's Rights, and the resident's multiple care plans addressing refusal of care. Findings: During a review of Resident 1's admission Record (AR), the AR indicated that the resident was initially admitted on [DATE], and readmitted on [DATE], with diagnoses that included muscle wasting (the thinning, shrinking, or loss of muscle tissue), osteoarthritis (a degenerative condition where the protective cartilage cushioning the ends of bones wears away over time, causing pain, stiffness, and swelling in joints) of both knees, and history of psychological trauma. During a review of Resident)'s History and Physical (H&P), undated, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 1's care plans, the care plan initiated on 10/30/2024 also included a care plan for the resident's pain. The care plan included interventions for staff to monitor for vocal complaints and altered mood. During a review of Resident 1's care plan initiated on 4/22/2025, the care plan indicated the resident has a behavior problem of yelling at staff and refuses to get out of bed. The care plan interventions included for staff to listen to resident's instructions and be slow and gentle. During a review of Resident 1's care plan dated 5/23/2025, the care plan indicated resident's refusal to participate in another activity in the restorative nursing program (a program that helps long-term care residents maintain or regain their highest possible level of physical, mental, and psychosocial independence). The care plan indicated an issue with the resident verbalizing he has arthritis and cannot be touched. The care plan included interventions to assess and administer pain medication if needed, and for staff to respect resident decision and refusal. During a review of Resident 1's care plan dated 6/17/2025, the care plan indicated the resident's refusal of care related to weight monitoring. The care plan goal indicated to respect residents right with autonomy in getting care. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/18/2026, the MDS indicated that the resident has mildly impaired cognition (the ability to process thoughts and emotions). The MDS indicated that the resident is dependent (the helper does all the effort) on activities such as changing position from sitting to lying and lying to sitting on the side of the bed. During a review of Resident 1's Multidisciplinary Care Conference Notes (MCC), dated 4/23/2026, attended by LVN 3, Social Worker (SW) 1, Dietitian (DD) 1, and Activities Aide (AA)the MCC indicated that Resident 1 was in attendance during the MCC. The MCC indicated that Resident 1 was alert and oriented to person, place, time and situation and there were no significant changes in resident's overall condition. The MCC indicated (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that goals for the resident were to be free from pain and discomfort and that the resident will participate in activities of choice. During a review of Resident 1's Progress Notes for May 2026, the Notes indicated that on 5/15/2026 at 10:41 PM, the resident complained of generalized pain with a rate of 8 to 9 out of 10. During a review of Resident 1's Progress Notes for the month of May 2026, the Notes indicated the following entries: A late entry documented on 5/16/2026 timed at 6:47 PM, the Note indicated a Transfer to Hospital Summary. The Summary Note indicated Resident 1 requested to be transferred to the GACH due to severe low back pain and because the pain medication provided by the facility was not effective. The Note indicated Resident 1 left the facility at 6:47 PM via ambulance. Further review of Resident 1's Progress Notes did not include documented evidence that the resident agreed to be showered or given an option to be showered and transferred from bed to the facility's Shower Room on 5/15/2026. During a review of Resident 1's care plan dated 9/29/2025, the care plan indicated the resident's refusal to be cleaned for over 2 days and requesting to be changed once a month. The care plan included interventions to for staff to inform the Director of Nursing (DON) for assistance to negotiate care when refusing to be changed and has BM. The care plan interventions further included for staff to return a few minutes later when still refusing care and to medicate with pain at least one hour before treatment or care. During a review of Resident 1's Medication Administration Record (MAR) for the month of May 2026, the MAR indicated that Hydrocodone-acetaminophen 10-325 MG was administered on 5/15/2026 at 8:41 AM for a pain level of 8 out of 10 (severe pain), and again on 5/16/2026 at 6:41 PM for a pain level of 10 out of 10 (severe pain). During a review of Resident 1's Change in Condition Evaluation (CIC), dated 5/16/2026, timed at 7:09 PM, and signed by Registered Nurse (RN) 1, the CIC indicated Resident 1's uncontrolled pain of the lower back. The CIC further indicated that Resident 1 complained of severe lower back pain and Norco 10-325 mg was administered. However, the pain medication was not effective as reported by Resident 1. The CIC indicated that the resident requested to be transferred to the GACH. During a record review of Resident 1's physician's order, dated 5/16/2026, the order indicated to transfer the resident to the [GACH] due to severe lower back pain. During a review of Resident 1's GACH Emergency Department (ED) Notes, dated 5/16/2026, timed at 9:31 PM, the ED Notes indicated that Resident 1 complained of severe low back pain after he was being lifted by facility staff and he felt a crack. During a review of Resident 1's GACH Magnetic Resonance Imaging (MRI, a medical imaging test that uses strong magnets and radio waves to generate highly detailed cross-sectional pictures of the body's internal structures) dated 5/18/2026, the MRI indicated that Resident 1 was found to have acute (new) L1, L3, and L4 compression fractures with 20-25% height loss. During a review of Resident 1's Discharge Summaries Notes from the GACH, dated 5/26/2026, the GACH Note indicated that Resident 1 was diagnosed with acute fractures of the lower back. The Notes also indicated that Resident 1 underwent Kyphoplasty (a surgical procedure used to treat painful spinal compression fractures). During a phone interview on 6/22/2026 at 1:29 PM with Resident 1's Family Member (FM) 1, FM 1 stated that on 5/15/2026, Resident 1 was forced by the facility's staff to take a shower in the facility's Shower Room. FM 1 stated that Resident 1 screamed and pleaded for staff to not move him from his bed, but the staff did not listen to [Resident 1's] pleas . FM 1 further stated that Resident 1 was begging facility staff to stop and not take him to the Shower Room to shower. FM 1 further stated that even when Resident 1 pleaded with the facility staff to stop, the facility staff insisted on continuing with the procedure and showered the resident inside the Shower Room. During an interview on 6/23/2026 at 2:10 PM with Resident 2 (Resident 1's roommate), Resident 2 stated that on the day before Resident 1 was taken by the ambulance, he heard Resident 1 shouting at the facility staff to stop moving him. Resident 2 stated that Resident 1 was shouting very loud at facility staff to put him back on his bed. During a phone interview on 6/23/2026 at 2:21 PM with CNA 1, CNA 1 stated that on 5/15/2026, Resident 1 was taken from his room to the shower room during the change of shift from day shift to evening shift (between 2:30 to 3:00 PM). CNA 1 stated that Resident 1 kept refusing to go to the Shower Room to be cleaned because of discomfort coming from the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's back. CNA 1 stated that he and other staff, CNA 2 and LVN 1, helped in transferring the resident from the bed to a shower chair using a Hoyer lift. CNA 1 stated that while Resident 1 was being showered in the Shower Room, the resident requested warm water to be showered on his back for the discomfort he felt. CNA 1 stated that LVN 1 insisted on continuing with the shower even when Resident 1 complained of the discomfort. During an interview on 6/23/2026 at 2:42 PM with LVN 1, LVN 1 stated that on 5/15/2026, LVN 1 recalled that Resident 1 did not want to be moved from his bed. LVN 1 stated the staff decided to go through with the shower even when the resident was refusing because the resident was not okay with anything. During an interview on 6/23/2026 at 3:14 PM with CNA 2, CNA 2 stated that on 5/15/2026, while staff was lifting Resident 1 using the Hoyer lift, Resident 1 was yelling No! No! Son of a bitch! Don't do that! because he did not want to be moved. CNA 2 stated that while the resident was being showered, the resident requested for warm water to run through his lower back because the resident verbalized pain in his lower back. During an interview on 6/23/2026 at 3:22 PM with Registered Nurse (RN) 1, RN 1 stated that on 5/15/2026, she was not informed that Resident 1 refused to be brought to the Shower Room. RN 1 also stated that on 5/16/2026, Resident 1 requested to be transferred to the hospital because of severe lower back pain. RN 1 recalled that Resident 1 stated that the pain was bad, and that the pain medication Norco was not helping with the pain. RN 1 also recalled that Resident 1 verbalized to her that the back pain was killing [him]. RN 1 also stated that the resident has never asked to be transferred because that would mean moving him from his bed, therefore, there must have been something that was actually wrong with the resident. During another interview on 6/23/2026 at 3:26 PM with RN 1, RN 1 further stated that if a resident complains of pain or discomfort during care, the nurses must stop the procedure because they might aggravate the pain or make it worse. During a concurrent interview and record review on 6/23/2026 at 4:33 PM with RN 2, Resident 1's medical record was reviewed, including all care plans, progress notes for May 2026, and the MCC Notes dated 4/23/2026. RN 2 stated that the care plans did not indicate any history of lower back pain and that the resident's lower back pain appeared to be a new problem. RN 2 further stated that the progress notes for May 2026 did not contain evidence that staff explained the care being provided or the reason for showering the resident in the Shower Room. RN 2 also stated that the MCC dated 4/23/2026 did not include a plan for the resident to receive showers in the Shower Room, and that the MCC documented the resident's refusal to get out of bed. RN 2 added that the MCC and care plans included goals for the resident to be free from pain and discomfort and to participate in activities of choice. Further review of the progress notes from 5/15/2026 to 5/16/2026 with RN 2 showed no documented evidence that Resident 1 agreed to be showered or was given the option to refuse being showered and transferred from his bed to the facility's Shower Room on 5/15/2026. During an interview on 7/1/2026 at 10:54 AM with CNA 1, CNA 1 stated that Resident 1 was cursing at staff while he was being lifted from his bed using the Hoyer lift. CNA 1 further stated that Resident 1 told staff to not move him from the bed and to not lift him up. During a review of a Statement of Declaration (SOD) signed by Certified Nursing Assistant (CNA) 1 to the dated 7/1/2026, the SOD indicated that on 5/15/2026, CNA 1, along with LVN 1 and other CNAs, were assisting Resident 1 to be showered. The SOD indicated that Resident 1 stated Fuck you! and Piece of Shit! toward the staff. The SOD indicated that Resident 1 was refusing the care being provided by the staff because of resident's discomfort. During an interview on 7/1/2026 at 11:51 AM with the DON, the DON stated that he did not recall being contacted by staff on 5/15/2026 when Resident 1 was refusing to be showered. The DON stated that Resident 1 has a care plan for his refusal of care in which staff are to call him if the resident refuses care. The DON added that if a resident refuses care, he expects staff to step away and approach again, notify the charge nurse and supervisor. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 1/1/2012, the P&P indicated that residents have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care. The P&P indicated that employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights. The P&P (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that the facility does not hamper, compel by force, treat indifferently, or retaliate against a resident for exercising his or her rights. The P&P also indicated that each resident is allowed to choose health care that is consistent with his or her interests, assessments and plan of care, including bathing schedules and personal care needs, such as bathing methods. During a review of the facility's P&P titled, Refusal of Treatment, revised 1/1/2012, the P&P indicated that residents are able to exercise their right to refuse treatment. The P&P indicated that the facility will honor a resident's request not to receive medical treatment as prescribed by their Attending Physician, as well as care services outlined on the resident's assessment and Care Plan. The P&P indicated that the resident is not forced to accept any medical treatment and may refuse specific treatment even though it is prescribed by their Attending Physician. The P&P also indicated that when a resident refuses care, the Charge Nurse or Director of Nursing Services (DNS [or DON]) interviews the resident to determine what and why the resident is refusing. The P&P also indicated that the Charge Nurse or DON will document information relating to the refusal in the resident's medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to implement Resident 1's careˆplan interventions to notify the Director of Nursing (DON) to assist with negotiating care when one of two sampled residents (Resident 1) refused incontinence care, get out of bed, and to be cleaned in the Shower Room. LVN 1, CNA 1, and CNA 2 transferred Resident 1 with a Hoyer lift from the bed to a shower chair and transported the resident to the Shower Room without a physician's order or careˆplan direction, despite the resident's repeated verbal objections due to pain and discomfort on 5/15/2026. As a result of the deficient practice, on 5/16/2026 at 6:47 PM (27 hours 47 minutes from the time Resident 1 complained of discomfort during the Hoyer Lift transfer) Resident 1 requested transfer to a General Acute Care Hospital (GACH) due to severe lower back pain. At the hospital, he was diagnosed with acute compression fractures in three lumbar vertebrae and underwent kyphoplasty (a minimally invasive procedure used to treat painful vertebral compression fractures that are not improving with basic treatments like rest or pain medication, by creating space in the broken bone and filling it with cement to stabilize the bone and reduce pain). Resident 1 was discharged from the GACH to another facility on 5/23/2026. Findings: During a review of Resident 1's admission Record (AR), the AR indicated that the resident was initially admitted on [DATE], and readmitted on [DATE], with diagnoses that included muscle wasting (the thinning, shrinking, or loss of muscle tissue), osteoarthritis (a degenerative condition where the protective cartilage cushioning the ends of bones wears away over time, causing pain, stiffness, and swelling in joints) of both knees, and history of psychological trauma. During a review of Resident)'s History and Physical (H&P), undated, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 1's care plan initiated on 4/22/2025, the care plan indicated the resident has a behavior problem of yelling at staff and refuses to get out of bed. The care plan interventions included for staff to listen to resident's instructions and be slow and gentle. During a review of Resident 1's care plan dated 9/29/2025, the care plan indicated the resident's refusal to be cleaned for over 2 days and requesting to be changed once a month. The care plan included interventions to for staff to inform the Director of Nursing (DON) for assistance to negotiate care when refusing to be changed and has BM. The care plan interventions further included for staff to return a few minutes later when still refusing care and to medicate with pain at least one hour before treatment or care. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/18/2026, the MDS indicated that the resident has mildly impaired cognition (the ability to process thoughts and emotions). The MDS indicated that the resident is dependent (the helper does all the effort) on activities such as changing position from sitting to lying and lying to sitting on the side of the bed. The MDS also indicated that the resident was not assessed for the ability to transfer from bed to chair and transferring to a toilet because it was Not Applicable- not attempted and the resident did not perform [the] activity prior to the current illness, exacerbation, or injury. Resident 1's MDS further indicated that the resident was assessed to have moderate pain occasionally. During a review of Resident 1's Multidisciplinary Care Conference Notes (MCC), dated 4/23/2026, attended by LVN 3, Social Worker (SW) 1, Dietitian (DD) 1, and Activities Aide (AA)the MCC indicated that Resident 1 was in attendance during the MCC. The MCC indicated that Resident 1 was alert and oriented to person, place, time and situation and there were no significant changes in resident's overall condition. The MCC indicated that goals for the resident were to be free from pain and discomfort and that the resident will participate in activities of choice. However, the MCC indicated Resident 1 declines care and hygiene, refuses to get out of bed and was not compliant with services. The MCC indicated that facility staff would continue to support Resident 1 through explanation of risks and benefits, redirection, and encouragement. During a review of Resident 1's Progress Notes for May 2026, the Notes indicated that on 5/15/2026 at 10:41 PM, the resident complained of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	generalized pain with a rate of 8 to 9 out of 10. During a review of Resident 1's Progress Notes for the month of May 2026, the Notes indicated the following entries: A late entry documented on 5/16/2026 timed at 6:47 PM, the Note indicated a Transfer to Hospital Summary. The Summary Note indicated Resident 1 requested to be transferred to the GACH due to severe low back pain and because the pain medication provided by the facility was not effective. The Note indicated Resident 1 left the facility at 6:47 PM via ambulance. Further review of Resident 1's Progress Notes did not include documented evidence that the resident agreed to be showered or given an option to be showered and transferred from bed to the facility's Shower Room on 5/15/2026. During a review of Resident 1's Physical Therapy (PT) Discharge Summary Note, dated 9/26/2025, the Note indicated, under the section titled, Functional Skills Assessment, that the resident was not assessed for the ability to transfer due to medical conditions or safety concerns. The PT Note did not document an evaluation of Resident 1 for the use of a Hoyer lift, nor did it include any recommendation for a Hoyer lift during transfers or bed mobility. During a review of Resident 1's Occupational Therapy (OT) Discharge Summary Note, dated 9/24/2025, the OT Note indicated, under the section titled Functional Skills Assessment that the resident was assessed as dependent on toilet transfers. The OT Note did not document an evaluation of Resident 1 for the use of a Hoyer lift, nor did it include any recommendation for a Hoyer lift during transfers or bed mobility. During a review of Resident 1's Medication Administration Record (MAR) for the month of May 2026, the MAR indicated that Hydrocodone-acetaminophen 10-325 MG was administered on 5/15/2026 at 8:41 AM for a pain level of 8 out of 10 (severe pain), and again on 5/16/2026 at 6:41 PM for a pain level of 10 out of 10 (severe pain). During a review of Resident 1's Change in Condition Evaluation (CIC), dated 5/16/2026, timed at 7:09 PM, and signed by Registered Nurse (RN) 1, the CIC indicated Resident 1's uncontrolled pain of the lower back. The CIC further indicated that Resident 1 complained of severe lower back pain and Norco 10-325 mg was administered. However, the pain medication was not effective as reported by Resident 1. The CIC indicated that the resident requested to be transferred to the GACH. During a record review of Resident 1's physician's order, dated 5/16/2026, the order indicated to transfer the resident to the [GACH] due to severe lower back pain. During a review of Resident 1's GACH Emergency Department (ED) Notes, dated 5/16/2026, timed at 9:31 PM, the ED Notes indicated that Resident 1 complained of severe low back pain after he was being lifted by facility staff and he felt a crack. During a review of Resident 1's GACH Magnetic Resonance Imaging (MRI, a medical imaging test that uses strong magnets and radio waves to generate highly detailed cross-sectional pictures of the body's internal structures) dated 5/18/2026, the MRI indicated that Resident 1 was found to have acute (new) L1, L3, and L4 compression fractures with 20-25% height loss. During a review of Resident 1's Discharge Summaries Notes from the GACH, dated 5/26/2026, the GACH Note indicated that Resident 1 was diagnosed with acute fractures of the lower back. The Notes also indicated that Resident 1 underwent Kyphoplasty (a surgical procedure used to treat painful spinal compression fractures). During a phone interview on 6/22/2026 at 1:29 PM with Resident 1's Family Member (FM) 1, FM 1 stated that on 5/15/2026, Resident 1 was forced by the facility's staff to take a shower in the facility's Shower Room. FM 1 stated that Resident 1 screamed and pleaded for staff to not move him from his bed, but the staff did not listen to [Resident 1's] pleas. FM 1 stated that Resident 1 was put on a Hoyer sling by the facility staff and when Resident 1 was lifted using the Hoyer sling, Resident 1 felt three pops on his lower back, which was then followed by excruciating pain. FM 1 further stated that Resident 1 was begging facility staff to stop and not take him to the Shower Room to shower. FM 1 further stated that even when Resident 1 pleaded with the facility staff to stop, the facility staff insisted on continuing with the procedure and showered the resident inside the Shower Room. During the same phone interview on 6/22/2026 at 1:29 PM with FM 1, FM 1 stated that on the day (5/15/2026) after Resident 1 was forced to take a shower. Resident 1 requested to be transferred to the [GACH] because of his severe back pain. FM 1 stated that at the [GACH], the resident was found to have fractures of the lower back. FM 1 added that because of the fracture, Resident 1 required to undergo (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a surgical procedure to relieve severe back pain. During an interview on 6/23/2026 at 2:10 PM with Resident 2 (Resident 1's roommate), Resident 2 stated that on the day before Resident 1 was taken by the ambulance, he heard Resident 1 shouting at the facility staff to stop moving him. Resident 2 stated that Resident 1 was shouting very loud at facility staff to put him back on his bed. During a phone interview on 6/23/2026 at 2:21 PM with CNA 1, CNA 1 stated that on 5/15/2026, Resident 1 was taken from his room to the shower room during the change of shift from day shift to evening shift (between 2:30 to 3:00 PM). CNA 1 stated that Resident 1 kept refusing to go to the Shower Room to be cleaned because of discomfort coming from the resident's back. CNA 1 stated that he and other staff, CNA 2 and LVN 1, helped in transferring the resident from the bed to a shower chair using a Hoyer lift. CNA 1 stated that while Resident 1 was being showered in the Shower Room, the resident requested warm water to be showered on his back for the discomfort he felt. CNA 1 stated that LVN 1 insisted on continuing with the shower even when Resident 1 complained of the discomfort. During an interview on 6/23/2026 at 2:42 PM with LVN 1, LVN 1 stated that on 5/15/2026, Resident 1 felt uncomfortable while he was being lifted using the Hoyer lift. LVN 1 stated that because of the discomfort, the staff placed a pillow under the resident's lower back while he was on the Hoyer lift to help with the discomfort. LVN 1 further stated that the resident did not want to be moved because of pain in his knees. LVN 1 further stated that Resident 1 was cursing at staff because he did not want to go to the Shower Room. LVN 1 recalled that Resident 1 did not want to be moved from his bed. LVN 1 stated the staff decided to go through with the shower even when the resident was refusing because the resident was not okay with anything. During an interview on 6/23/2026 at 3:14 PM with CNA 2, CNA 2 stated that on 5/15/2026, while staff was lifting Resident 1 using the Hoyer lift, Resident 1 was yelling No! No! Son of a bitch! Don't do that! because he did not want to be moved. CNA 2 stated that while the resident was being showered, the resident requested for warm water to run through his lower back because the resident verbalized pain in his lower back. During an interview on 6/23/2026 at 3:22 PM with Registered Nurse (RN) 1, RN 1 stated that on 5/15/2026, she was not informed that Resident 1 refused to be brought to the Shower Room. RN 1 also stated that on 5/16/2026, Resident 1 requested to be transferred to the hospital because of severe lower back pain. RN 1 recalled that Resident 1 stated that the pain was bad, and that the pain medication Norco was not helping with the pain. RN 1 also recalled that Resident 1 verbalized to her that the back pain was killing [him]. RN 1 also stated that the resident has never asked to be transferred because that would mean moving him from his bed, therefore, there must have been something that was actually wrong with the resident. During a concurrent interview and record review on 6/23/2026 at 4:33 PM with RN 2, Resident 1's medical record was reviewed, including all care plans, progress notes for May 2026, and the MCC Notes dated 4/23/2026. RN 2 stated that the care plans did not indicate any history of lower back pain and that the resident's lower back pain appeared to be a new problem. RN 2 further stated that the progress notes for May 2026 did not contain evidence that staff explained the care being provided or the reason for showering the resident in the Shower Room. RN 2 also stated that the MCC dated 4/23/2026 did not include a plan for the resident to receive showers in the Shower Room, and that the MCC documented the resident's refusal to get out of bed. RN 2 added that the MCC and care plans included goals for the resident to be free from pain and discomfort and to participate in activities of choice. Further review of the progress notes from 5/15/2026 to 5/16/2026 with RN 2 showed no documented evidence that Resident 1 agreed to be showered or was given the option to refuse being showered and transferred from his bed to the facility's Shower Room on 5/15/2026. During a concurrent interview and record review on 6/23/2026 at 4:33 PM with RN 2, Resident 1's medical records were reviewed, including Resident 1's PT Discharge summary, dated [DATE], and OT Discharge summary, dated [DATE]. RN 2 stated that both the PT Discharge Summary and OT Discharge Summary do not indicate that the resident was assessed for the appropriateness to the use of a Hoyer lift. RN 2 stated that if Resident 1 experience pain while a Hoyer lift was being used, then a Hoyer lift might not be an appropriate equipment to use on the resident. RN 2 further stated that if (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff continue to use the Hoyer lift when the resident is already complaining of pain or discomfort, there is a possibility that the resident could become restless and experience more pain and for the resident to get injured. During an interview on 7/1/2026 at 10:54 AM with CNA 1, CNA 1 stated that Resident 1 was cursing at staff while he was being lifted from his bed using the Hoyer lift. CNA 1 further stated that Resident 1 told staff to not move him from the bed and to not lift him up. During a review of a Statement of Declaration (SOD) signed by Certified Nursing Assistant (CNA) 1 to the dated 7/1/2026, the SOD indicated that on 5/15/2026, CNA 1, along with LVN 1 and other CNAs, were assisting Resident 1 to be showered. The SOD indicated that Resident 1 stated Fuck you! and Piece of Shit! toward the staff. The SOD indicated that Resident 1 was refusing the care being provided by the staff because of resident's discomfort. During an interview on 7/1/2026 at 11:51 AM with the DON, the DON stated that he did not recall being contacted by staff on 5/15/2026 when Resident 1 was refusing to be showered. The DON stated that Resident 1 has a care plan for his refusal of care in which staff are to call him if the resident refuses care. The DON added that if a resident refuses care, he expects staff to step away and approach again, notify the charge nurse and supervisor. During a review of the facility's P&P titled, Refusal of Treatment, revised 1/1/2012, the P&P indicated that residents are able to exercise their right to refuse treatment. The P&P indicated that the facility will honor a resident's request not to receive medical treatment as prescribed by their Attending Physician, as well as care services outlined on the resident's assessment and Care Plan. The P&P indicated that the resident is not forced to accept any medical treatment and may refuse specific treatment even though it is prescribed by their Attending Physician. The P&P also indicated that when a resident refuses care, the Charge Nurse or Director of Nursing Services (DNS [or DON]) interviews the resident to determine what and why the resident is refusing. The P&P also indicated that the Charge Nurse or DON will document information relating to the refusal in the resident's medical record. During a review of the facility's P&P titled Pain Management dated 5/26/2023, the P&P indicated a pain assessment would be completed for each resident upon exacerbation of pain. The P&P indicated the goal for pain management would be resident centered and determined by the resident's acceptable level of pain.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident 3's physician order for a skin scraping and specimen collection was communicated to the laboratory on 6/18/2026, for one of two sampled residents (Resident 3), who was suspected of scabies and required confirmation of diagnosis, in accordance with the facility's policy and procedure titled Laboratory Services. This deficient practice had the potential to result in delayed or inaccurate diagnosis and treatment of Resident 3's skin condition, increased risk of medicationˆrelated adverse effects, and increased risk of transmission of scabies within the facility. Findings: During a review of Resident 3's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included muscle weakness, difficulty in walking, and hepatitis (an inflammation of the liver). During a review of Resident 3's History and Physical (H&P), dated 6/2/2026, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 6/8/2026, the MDS indicated that the resident has moderately impaired cognition (the ability to process thoughts and emotions). During a review of Residentˆ3's Physician Order Sheet (POS) dated 6/18/2026 and signed by Dermatologist Medical Doctor (MD)ˆ1, the POS indicated that Residentˆ3 had a diagnosis of Dermatitis. The POS included medication orders for betamethasone, ivermectin, permethrin, and prednisone. The POS also included an instruction for staff that wrote, please do skin scraping. During a review of Resident 3's Interdisciplinary (IDT) Progress Notes entry, dated 6/18/2026, timed at 2:06 PM, the entry indicated that the resident was assessed by the dermatologist with confirmed [diagnosis of] advanced scabies and that the resident continues to exhibit skin involvement consisting of widespread, scaling, erythematous (exhibiting redness) lesions, and pruritus (itchiness). The entry also indicated that Resident 3 is high risk for transmission due to advanced scabies. During a review of Resident 3's medication and treatment order with start date 6/19/2026, the order indicated give 5 tablets of Ivermectin Oral Tablet 3 mg, by mouth one time a day every Friday for scabies for 4 weeks. During a review of Resident 3's medication and treatment order with start date 6/19/2026, the order indicated to give 2 tablets of Prednisone Oral Tablet 10 mg, by mouth two times a day for scabies for 5 days. During a review of Resident 3's medication and treatment order with start date 6/19/2026, the order indicated to apply Permethrin External Cream 5% to general body topically once a day every Friday for scabies for 4 weeks; apply 2 tubes from neck to toes, leave for 12 hours, then rinse; repeat once weekly x 4 weeks. During a review of Resident 3's medication and treatment order with start date 6/19/2026, the order indicated to apply Betamethasone Dipropionate External Cream 0.05% to general body topically every day and evening shift for scabies for 4 weeks. The resident's records did not indicate documented evidence that a skin scraping specimen was sent out to the laboratory on 6/18/2026 as ordered by MD 1. During a review of Residentˆ3's Medication Administration Record (MAR) for Juneˆ2026, the MAR indicated that ivermectin was administered to Resident 3 on 6/19/2026. The MAR also indicated that prednisone was administered two times a day from 6/19/2026 through 6/22/2026, and one time on 6/23/2026. During a review of Resident 3's Treatment Administration Record (TAR) for Juneˆ2026, the TAR indicated that Permethrin was administered to Resident 3 on 6/19/2026. The TAR also indicated that betamethasone was administered two times per day from 6/19/2026 to 6/22/2026 and one time on 6/23/2026. During a review of Resident 3's care plan for scabies, initiated on 6/2/2026, and revised on 6/19/2026, the care plan included goals for itching and skin irritation will gradually decrease by review date. The care plan also included interventions for staff to administer medications as ordered. The care plan included medications Ivermectin, prednisone, permethrin, and betamethasone. During a review of Resident 3's Change in Condition (CIC) Evaluation, dated 6/18/2026, the CIC indicated that Resident 3 had a change in condition related to scabies. The CIC further indicated that Resident 3 was noted with advanced (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scabies to generalized body- hands and feet. During a review of Resident 3's Order Audit Report, dated 6/23/2026, the Report indicated that an order was created on 6/23/2026, timed at 10:03 AM, for Skin scrape for scabies one time only until 6/19/2026. The order was created by Treatment Nurse (TN) 1. During a review of Resident 3's entire medical records, the records do not indicate documented evidence of the result of Resident 3's skin scrape. During a review of Resident 3's Discharge Planning Review Form, dated 6/26/2026, the Form indicated that Resident 3 was to be discharged home as requested by the resident and family. During a review of Resident 3's Progress Note entry, dated 6/26/2026, timed at 11:23 PM, signed by Infection Preventionist Nurse (IPN), the entry indicated that Resident 3 was discharged on 6/26/2026 to the resident's home. During a concurrent observation and interview on 6/23/2026 at 9:58 AM inside Resident 1's room, Resident 1's hands were observed covered with dry flaky skin that had white and yellowish crusting in between the fingers. The resident stated that his hands still feel itchy. The resident also stated that he remembers one of the nurses scraped and was able to take off a chunk of the crust and put it in a container. During an interview on 6/23/2026 at 11:54 AM with TN 1, TN 1 stated that on 6/19/2026, she performed the skin scraping of Resident 3's skin and placed the skin scraping specimens in the treatment cart. TN 1 stated she is not sure if the laboratory staff collected the skin scraping specimens. During a concurrent interview and record review on 6/23/2026 at 11:54 AM with TN 1, Resident 3's Order Audit Report, dated 6/23/2026, was reviewed. TN 1 stated that she inputted the order for Resident 3's skin scraping on 6/23/2026, and backdated it to 6/19/2026. During a follow-up interview on 6/23/2026 at 1:27 PM with TN 1, TN 1 stated that on 6/19/2026, when she performed the skin scraping on Resident 3, she forgot to input the order in Resident 3's medical records. TN 1 stated that when a laboratory order is placed in the resident's medical records, the facility's computer system automatically notifies the laboratory that a specimen needs to be collected at the facility. TN 1 stated that if an order is not inputted, the laboratory would not be notified, unless staff call the laboratory. During another concurrent interview and record review on 6/23/2026 at 1:27 PM with TN 1, Resident 3's entire medical records were reviewed, including the resident's progress notes and laboratory results. TN 1 stated that there are no results of Resident 3's skin scraping. TN 1 also stated that there is no documented evidence that the laboratory was informed of the skin scraping. TN 1 further stated that she called the laboratory, and the laboratory informed her that there were no orders for a skin scraping specimen to be collected on 6/19/2026. TN 1 stated that because the order was not inputted on 6/19/2026, she should have informed the laboratory by phone on 6/19/2026 that there was an order for skin scraping and that the skin specimen was ready to be collected. During an interview on 6/23/2026 at 1:36 PM Infection Preventionist Nurse (IPN), the IPN stated that it is important that Resident 3's skin scraping be conducted to verify the correct diagnosis for Resident 3's skin condition. IPN stated that if Resident 3's skin condition was not actually scabies, then the resident's medications for scabies would not be necessary. IPN stated that the medications for scabies could have side effects that could affect the resident. IPN further states that it is the treatment nurse's responsibility to inform and follow up with the laboratory of any laboratory-related orders such as for Resident 3's skin scraping. The IPN also stated that correctly identifying diseases is important in the prevention of the disease from spreading to other residents and staff. During a review of the facility's policy and procedure (P&P) titled, Prevention and Management of Scabies, revised 1/31/2020, the P&P indicated that the facility works to prevent the spread of scabies in the facility. The P&P indicated that individual cases of scabies will be treated according to the physician orders and the individual treatment protocol. The P&P also indicated that the definition of a scabies outbreak includes one confirmed case (positive skin scraping) and at least two clinically probably cases identified in residents, healthcare personnel, volunteers and/or visitors during a two-week period. The P&P further indicated that on suspect cases of scabies, a dermatologist (or attending physician or other designee) will perform skin scrapings to confirm the presence of scabies. During a review of the facility's P&P titled, Laboratory Services, revised 1/1/2012, the P&P indicated that the (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility will provide laboratory services in an accurate and timely manner to meet the needs of residents per Attending Physician orders. The P&P indicated that upon receiving the order, the licensed nurse will write out the order to the laboratory that includes the date the order was obtained, the resident's room number, the resident's name, the ordering physician's full name, and the name of the test to be done. The P&P also indicated that upon receiving the order, the licensed nurse will notify the laboratory of the laboratory orders. The P&P further indicated that nursing staff will monitor to make sure that lab results are received promptly.