STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide one of eight (8) sampled residents (Resident 56) with respect and dignity during mealtime, when Certified Nurse Assistant (CNA) 3 was observed standing over Resident 56 while providing feeding assistance. This failure had the potential to result in negatively affecting Resident 56's self-esteem and self-worth. Findings: During a review of Resident 56's admission Record (AR), the AR indicated the facility admitted Resident 56 on 8/19/2019 and readmitted Resident 56 on 6/29/2021 with diagnoses that included contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of Resident 56's left and right hands, dysphagia (difficulty swallowing), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool), dated 3/25/2025, the MDS indicated Resident 56 had modified independence (some difficulty in new situations only) when making decisions regarding tasks of daily life. The MDS indicated Resident 56 required maximal assistance (helper does more than half the effort) with activities of daily living (ADLS, activities such as bathing, dressing, and toileting a person performs daily) such as eating (the ability to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquid once the meal is placed before the resident). The MDS indicated Resident 56 had a mechanically altered (required change in texture of food or liquids) therapeutic diet (a meal plan ordered by the physician to help manage or treat a specific medical condition). During a review of Resident 56's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 5/27/2025, the H&P indicated Resident 56 did not have the capacity to make their own decision. During a review of Resident 56's Order Summary Report, dated 5/30/2025, the Report indicated that Resident 56 had an order for a pureed (smooth, soft, and creamy) texture, nectar thick (thicken liquid consistency) regular diet. During an observation on 7/1/2025 at 1:08 PM in Resident 56's room, Resident 56 was observed lying in bed with the head of bed elevated, and CNA 3 was observed standing by Resident 56's bedside while feeding and assisting Resident 56 with meals. During an interview on 7/1/2025 at 3:03 PM with CNA 3, CNA 3 stated, Resident 56 was a completely dependent resident. CNA 3 stated, Resident 56 required feeding assistance during meals. During an interview on 7/1/2025 at 3:05 PM with CNA 3, CNA 3 stated a chair was not used while feeding Resident 56 since CNA 3 could not find a chair, therefore assisted feeding Resident 56 while standing up. During an interview on 7/1/2025 at 3:08PM with CNA 3, CNA 3 stated, when assisting with meals with any resident, staff should be seated and at eye level with the resident to ensure a resident did not feel rushed. During an interview on 7/3/2025 at 3:30 PM with Registered Nurse (RN) 1, RN 1 stated, if a resident required assistance with feeding during meals, the CNAs must sit and be at eye level with the resident. RN 1 stated, the staff assisting with feeding must be patient with the resident to allow the resident enough time to swallow. RN 1 stated, the CNA must sit at eye-level with the resident to allow the resident and the CNA to converse with each other. RN 1 stated by having staff sit and be eye level with a resident during meals allowed the resident to feel dignified, respected, and more comfortable with the CNA. During a review of the facility's policies and procedures (P&P) titled Resident Rights - Accommodation of Needs, dated 1/1/2012, the P&P indicated the facility staff interacts with the resident in a way that accommodates the physical or sensory limitations of the residents, promotes communication, and maintains each resident's dignity.

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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 interview, and record review, the facility failed to obtain an informed consent (a process of communication between a person and the health care provider that often leads to agreement or permission for care, treatment, or services) for psychotropic/psychotherapeutic (any drug that affects behavior, mood, thoughts, or perception) drug for one of two sampled resident (Resident 52) who was prescribed Ativan (a psychotropic medication used for anxiety). This deficient practice violated Resident 52's rights to be informed when choosing the type of care or treatment to be received, making decisions on alternative measures that the resident or responsible party preferred, which can negatively affect Resident 52's quality of life. Findings: During a review of Resident 52’s admission Record [AR], the AR indicated Resident 52 was originally admitted to the facility on [DATE], with diagnoses that included dementia (the loss of thinking, remembering and reasoning) and anxiety disorder (feeling of fear as a reaction to stress). During a review of Resident 52’s History and Physical Examination (HPE, a comprehensive physician’s note regarding the assessment of the patient’s health status) signed by the attending physician on 11/17/2023, the HPE indicated Resident 52 had the capacity to understand and make decisions. During a review of Resident 52’s Minimum Data Set (MDS, a resident assessment tool), dated 5/24/2025, the MDS indicated the Resident 52’s cognition (thought process) was moderately impaired. During a review of Resident 52’s “Order Summary Report” dated 6/2/2025, indicated Resident 52 had a physician order for Ativan Oral Tablet 0.5 mg (unit of measurement) to give 0.5 mg by mouth two times a day for anxiety manifested by irritability and easily agitated. During a concurrent interview and record review on 7/2/2025 at 2:15 PM with the Medical Records (MR), Resident 52’s medical chart under the consent section and electronic health record (EHR, an electronic/digital collection of medical information about a person that is stored on a computer) was reviewed. The MR stated the informed consent form for the use of Ativan was not in Resident 52’s hard copy medical record and EHR. During a concurrent interview and record review on 7/2/2025 at 2:15 PM with Registered Nurse Supervisor (RN 1), Resident 52’s medical paper chart under the consent section and EHR were reviewed. RN 1 stated the Resident 52’s EHR and hard copy medical record did not have any documentation that an informed consent for psychotropic medication Ativan was given to Resident 52 in 2025. RN 1 stated there should have been a current consent form obtained for 2025. RN 1 stated that consent for psychotropic medications forms was updated and reviewed quarterly. RN 1 stated it was the responsibility of the RN to follow up and make sure a signed and dated consent form was in Resident 52’s medical record. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/2025 at 1:05 PM with the Director of Nursing (DON), The DON stated he reviewed Resident 52’s medical record (paper chart and EHR) and he was unable to locate the consent form for the use of the psychotropic medication Ativan for 2025. The DON stated, it was important for the informed consent to be completed since the consent form validated that Resident 52 was informed that the physician had explained to Resident 52 and /or the responsible party the risks and benefits while taking the psychotropic medication Ativan and other alternative treatments had been provided. DON stated, not having an informed consent for psychotropic medications violates resident rights. During a review of the facility’s policy and procedure (P&P) titled “Informed Consent,” revised 6/27/2024, the P&P indicated that the licensed nurse will confirm that the Healthcare Practitioner obtained informed consent and will document the verification in the Resident's medical record, before administering the first dose or first increased dose of psychoactive medications, applying physical restraints or medical devices. The P&P indicated the informed consent will be placed in the resident's medical record. During a review of the facility’s P&P titled “Behavior/Psychoactive Medication Management” revised 4/24/2025, the P&P indicated the facility must obtain a resident's written informed consent for treatment using psychoactive drugs and consent renewal every 6 (six) months.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide prompt efforts to resolve grievances for one of two sampled residents (Resident 107) who voiced to the facility during the Resident Council Meetings to provide a follow-up or a resolution for Wi-Fi extenders (a device that helped extend the range of your existing Wi-Fi network) because it was for the resident's phone and television to work correctly. This deficient practice resulted in unresolved grievance for Resident 107 that affects the residents the resident's quality of life. Findings: During a review of Resident 107's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (CHF, a heart disorder which caused the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension (HTN, high blood pressure), and anemia (a condition where the body did not have enough healthy red blood cells). During a review of Resident 107's History and Physical (H&P) dated 10/31/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 107's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/7/2025, the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated that the resident required setup or clean-up assistance from facility staff for eating, oral/personal hygiene and rolling to the left and right. The MDS indicated the resident required supervision or touching assistance from facility staff for toileting hygiene, showering, and transfers. During a review of the Facility's Resident Council Meeting Notes dated 4/8/2025, the Resident Council Meeting Notes indicated Residents are asking to have Wi-Fi extender due to some not being able to connect to personal devices. The Resident Council Meeting Notes indicated a department response Administrator is working with maintenance supervisor to obtain Wi-Fi extenders appropriate for the facility. The Resident Council Meeting Notes included several e-mail correspondences with the administrator (ADM) and the Senior Information Technology (IT) Support from 4/16/2025 to 4/25/2025 indicating approval of the request and discussing difference access points to place the equipment. During a review of the ADM's e-mail correspondence dated 4/28/2025 to 6/24/2025, the e-mail correspondence indicated equipment had been delivered to the facility and the facility was waiting on a vendor to run lines through the facility before installation. The e-mail correspondence's last note on 6/24/2025 indicated, I have someone coming out tomorrow for the third quote. He should be there in the afternoon. During Resident Council Meeting and concurrent interview on 7/1/2025 at 10:02 AM, Resident 107 stated she had already spoken about the Wi-Fi extenders twice to the facility staffs and today was the third time. Resident 107 stated she spoke with the ADM to provide information on the extenders to boot up what's already in place because It's hard to get my phone and tv to work correctly. During an observation and interview on 7/1/2025 at 11:25 AM, the Registered Nurse (RN) 3 was moving the medication cart around the hallway and was observed getting medications ready in front of a resident's room. The RN 3 stated, Because of the internet, I need to move a little far and stationed the medication cart in front of a different resident's room. The RN 3 stated, I'm having issues, so I was moving to see if there was a better connection. During an interview on 7/3/2025 at 12:35 PM, Resident 107 stated when she informed the ADM of the Wi-Fi extenders and the ADM looked interested. Resident 107 stated, the facility maintenance staff started to measure the building, but no rationale was provided as to why the extenders were not placed yet and there was no follow-up that she could recall. During an interview on 7/3/2025 at 4:41 PM, the ADM stated the facility followed up with the resident regarding the Wi-Fi extender. When asked, the ADM was unable to provide documentation of the interaction with the maintenance supervisor on why the Wi-Fi extender has not been placed. The ADM stated if there was no follow-up with the resident, Resident 107 felt like the request was not being addressed and the facility would not be able to ensure the resident's satisfaction. During a review of the facility's policy and procedure (P&P) titled, Grievances and Complaints dated December 2017, the P&P indicated The facility Administrator is the Grievance Official responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, maintain the confidentiality of information associated with the grievance as necessary and assuring written grievance decisions are provided to the residents upon request. The P&P indicated, If follow-up is required, the Grievance Official is responsible for ensuring that the follow-up action is taken in a timely manner.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Advance Directives Acknowledgement Form (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) and Physician Orders for Life-Sustaining Treatment (POLST, medical order forms that tell medical staff what to do if you have a medical emergency and are unable to speak for yourself) were obtained and readily accessible in the residents' hard copy medical records for one of three sampled residents (Resident 34). These deficient practices had the potential for residents' medical treatment provisions to not be carried out, according to the resident's wishes during emergency situations and/or when a resident was incapacitated (the clinical state in which a patient is unable to participate in a meaningful way in medical decisions). Findings: During a review of Resident 34’s admission Record [AR], the AR indicated Resident 34 was originally admitted to the facility on [DATE], with diagnoses that included a bipolar disorder (mental health condition that causes extreme mood swings) and paranoid schizophrenia (distorted thinking and awareness). During a review of Resident 34’s History and Physical Examination (HPE, a comprehensive physician’s note regarding the assessment of the patient’s health status) signed by the attending physician on 5/17/2025, the HPE indicated Resident 34 had a fluctuating capacity to understand and make decisions. During a review of Resident 34’s Minimum Data Set (MDS, a resident assessment tool) dated 5/23/2025, the MDS indicated the Resident 1’s cognition (thought process) was severely impaired. During a concurrent interview and record review on 7/1/2025 at 1:19 PM with the Social Services Designee (SSD), Resident 34’s hard copy medical record was reviewed. The SSD stated Resident 34’s advance directive acknowledgement form and the POLST was not in the resident’s medical record. The SSD stated the POLST was important for the facility staff to know what Resident 34 wishes were regarding treatment in the event of a medical emergency. During a concurrent interview and record review on 7/1/2025 at 1:40 PM with Registered Nurse Supervisor (RN 1), Resident 34’s hard copy medical record was reviewed. RN 1 stated that Resident 34’s advance directive acknowledgement form and the POLST were not located in Resident 34’s medical record RN 1 stated it was important for the POLST to be placed in the residents’ hard copy medical record so the licensed nursing staff would know what Resident 34's wishes were regarding treatment and care during a medical emergency. During an interview on 7/3/2025 at 1:48 PM with the Director of Nursing (DON), DON stated that the advance directive acknowledgement form and POLST must be readily accessible and placed in the resident’s hard copy medical records in the event of an emergency so the licensed nurses would know how to properly respond and provide the correct treatment in accordance with Resident 34’s medical treatment wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s policy and procedures (P&P) titled “Advance Directive” revised 7/25/24, the P&P indicated “upon admission, the Admissions Staff or Designee will provide written information to the resident concerning his or her right to make decisions concerning medical care; including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.”

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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 interview and record review, the facility failed to develop a comprehensive person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual for two of four sample residents (Resident 43 and 27) by failing to: 1. Develop a care plan to address interventions for Resident 43's abdominal pain on 3/25/2025. 2. Develop a care plan for Resident 27's to address interventions for medication side effects and behavior monitoring for poor impulse control which was prescribed Depakote (an antiepileptic medication used to reduce excessive electrical activity in the brain believed to cause mood fluctuations in bipolar disorder [sometimes called manic-depressive disordered; mood swings that range from the lows of depression to elevated periods of emotional highs]). These deficient practices had the potential to result in Resident 43 not receiving individualized and necessary care and treatment for pain control and had the potential to result in Resident 27 receiving a delay in resident-care services and the inability to monitor the effectiveness or non-effectiveness of the specific care provided. Findings: 1.During a review of Resident 43’s admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included abdominal pain, gastro-esophageal reflux disease (GERD, a condition where stomach acid frequently flows back into the esophagus, causing irritation and discomfort), and Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 43’s Physician’s Order dated 3/25/2025, the Physician’s Order indicated may transfer resident to the general acute care hospital (GACH) for further evaluation and management of abdominal pain. Bed hold for seven days if admitted . Hold medication upon transfer and may discontinue medication if admitted . During a review of Resident 43’s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 6/14/2025, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated Resident 43 required setup or clean-up assistance from facility staff for eating, supervision or touching assistance from facility staff for oral/personal hygiene and required substantial/maximal assistance from facility staff for transfers. During a review of Resident 43’s Change in Condition Evaluation dated 3/25/2025 at 2:06 PM, the Evaluation indicated the resident had abdominal pain that started on 3/24/2025 in the afternoon. The Evaluation indicated the resident verbalized having abdominal pain but refused pain medication. The Evaluation indicated the Physician was notified and ordered Resident 43 to transfer to the GACH (General Acute Care Hospital) for further evaluation and management. During a review of Resident 43’s Vitals and Pain Note dated 3/25/2025 at 2:22 PM, the Vitals and Pain Note indicated the resident had occasionally moderate aching pain over the last five days with a pain score of four (a numerical pain scale from 0 to 10, where 0 meant no pain and 10 meant the worse pain imaginable). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 43’s Comprehensive (complete) Care Plan dated 3/25/2025, the Care Plan did not mention the resident’s abdominal pain. During a concurrent interview and record review of Resident 43’s Comprehensive Care Plan on 7/3/2025 at 8:43 AM, the Licensed Vocational Nurse (LVN) 2 stated if a resident had a change in condition, the facility was supposed to implement a care plan for that change to make sure the facility was informed of what the next plan of care would be. LVN 2 stated if a care plan was not implemented the resident would not be getting the proper care that was designed/catered to the resident and Resident 43 could decline very fast if the care provided was not what the resident was supposed to receive. LVN 2 stated Resident 43 did not have a Care Plan to address intervention for the resident’s abdominal pain on 3/25/2025. During a concurrent interview and record review of Resident 43’s Comprehensive Care Plan on 7/3/2025 at 3:18 PM, the Director of Nursing (DON) stated there was no care plan on 3/25/2025 for Resident 43’s abdominal pain but the facility should have implemented a care plan for that day. The DON stated if a care plan was not implemented there was potential for incomplete records on what the facility did for interventions. During a concurrent interview and record review of the facility’s policy and procedure (P&P) titled, “Comprehensive Person-Centered Care Planning” dated November 2018 on 7/3/2025 at 3:41 PM, the P&P with the DON indicated, “Additional changes or updates to the resident’s comprehensive care plan will be made based on the assessed needs of the resident.” The P&P indicated, “The comprehensive care plan will be periodically reviewed and revised by IDT (interdisciplinary team) after each assessment. In addition, the comprehensive care plan will also be reviewed and revised at the following times: change of condition.” The DON stated the facility was not following the P&P and could potentially be administering care outside of the facility’s established policy and procedure or standard for Resident 43. 2. During a review of Resident 27’s admission Record (AR), the AR indicated the facility admitted Resident 27 on 10/18/2024 with diagnoses that included Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet) and depression (mental health condition characterized by persistent sadness, loss of interest in activities, and difficulty carrying out daily tasks). During a review of Resident 27’s History and Physical (H&P, a comprehensive physician’s note regarding the assessment of the resident’s health status), dated 10/22/2024, the H&P indicated Resident 27 had the ability to follow simple commands and had the capacity to make Resident 27’s own decisions. During a review of Resident 27’s Minimum Data Set (MDS, a resident assessment), dated 3/28/2025, the MDS indicated Resident 27’s cognition (a person’s mental process of thinking, learning, remembering, and using judgement) was moderately impaired. The MDS indicated Resident 27’s active diagnoses included depression and bipolar disorder. The MDS indicated Resident 27 took the following medications: an antidepressant, an anticoagulant (medication to prevent blood clots), an opioid (strong pain reliever), a hypoglycemia (medication to decrease blood sugar) medication, and an anticonvulsant (medication to reduce abnormal electrical brain activity). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 27’s Order Summary Report, the Report indicated an order, with a start date of 6/17/2025, for Depakote ER Oral Tablet Extended Release 24 hours 500 milligrams (mg, unit of measure). The order indicated to “give 500 mg by mouth in the morning for poor impulse control disorder manifested by verbal aggression.” During a review of Resident 27’s Order Summary Report, the Report indicated an order with a start date of 6/11/2025 to monitor side effects of Depakote every shift such as diarrhea, constipation, altered appetite, drowsiness or confusion. During a review of Resident 27’s Order Summary Report, the Report indicated an order with a start date of 6/11/2025 to monitor target behaviors for use of Depakote ER for poor impulse control manifested by verbal aggression. During a concurrent interview and record review on 7/3/2025 at 4:06 PM with Registered Nurse (RN) 1, Resident 27’s care plans were reviewed. There was no care plan initiated for the use of Depakote for Resident 27. RN 1 stated, there was no care plan indicated for Resident 27’s Depakote medication. RN 1 stated, there should be a care plan created for Depakote. During an interview on 7/3/2025 at 4:10 PM with RN 1, RN 1 stated a care plan must be initiated for each medication that affected the resident’s mood and behavior. RN 1 stated, Resident 27 received Depakote for behaviors of poor impulse control, which affected the resident’s mood and behavior. RN 1 stated, a care plan for Depakote was important to identify the purpose of the medication, to monitor the effectiveness of the medication, and to monitor the side effects of the medication. During a review of the facility’s policies and procedures (P&P) titled, Person-Centered Planning, dated 4/24/2025, the P&P indicated “the facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident’s medical, nursing, mental, and psychosocial needs.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide pillows or wedges for body support to help one of four sampled residents (Resident 54) who was quadriplegic (complete immobility due to severe disability from injury to the brain or spinal cord) to achieve the desired comfort and position as indicated in the resident's care plan and the facility's policy and procedures. These deficient practices had the potential for Resident 54 to develop pain, discomfort and contracture (a permanent tightening of muscles, tendons, skin, or other tissues, causing joints to shorten and become stiff, thus limiting normal movement) negatively affect the residents' physical comfort and psychosocial well-being. Findings: During a review of Resident 54's admission Records (AR), the AR indicated that the facility admitted Resident 54 on 6/12/2020, with diagnoses including multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), gastrostomy status (presence of a G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and functional quadriplegia (complete immobility due to severe disability from another medical condition without injury to the brain or spinal cord). During a review of Resident 54's Minimum Data Set (MDS, a resident assessment tool) dated 3/27/2025, the MDS indicated that Resident 54 was severely cognitively impaired (never/rarely made decisions). The MDS indicated that Resident 54 needed substantial/maximal assistance (helper does more than half the effort) on toileting hygiene, personal hygiene, rolling left to right, sit to lying, lying to sitting on side of bed, and toilet transfer. During a review of Resident 54's Care Plan revised 7/3/2025, the care plan indicated that Resident 54 had impaired physical mobility (a limitation in a person's ability to move around independently and freely) related to contractures. The Care Plan intervention included to provide comfort by putting pillows or wedges on desired or comfort position. During a concurrent observation and an interview on 6/30/2025 at 8:40 AM in Resident 54's room, Resident 54 was observed in a position with upper and lower body facing opposite direction, with no supportive devices such as pillows or wedges on for comfort position. CNA 1 stated he just finished providing the morning ADL (activities of daily living- basic self-care tasks that individuals perform on a daily basis) care for Resident 54. CNA 1 was observed exiting the resident room for his next resident without ensuring the resident had pillows and wedges for comfort. During a concurrent observation and an interview on 6/30/2025 at 8:50 am with the Licensed Vocational Nurse (LVN) 1 in Resident 54's room, LVN 1 stated Resident 54 did not look comfortable lying in bed and without support for his position. LVN 1 stated Resident 54 was dependent on staff's assistance with repositioning and it's not acceptable leaving resident like this. During a concurrent record review and an interview on 7/3/2025 at 10:23 AM, Resident 54's Care Plan was reviewed. LVN 1 stated an appropriate supportive device should be used for Resident 54 because he had limited mobility and was unable to stay in a comfortable position by himself. During an interview on 7/3/2025 at 3:50 PM with the Director of Nursing (DON), DON stated it was important for nursing staffs to provide assistance to residents who could not reposition or maintain in the position on their own, and use of supportive device will be necessary for resident's physical comfort. During a review of the facility's Policy and Procedures titled Positioning and Body Alignment revised in 1/1/2012, the P&P indicated that each resident who is partially or totally dependent will be positioned in good body alignment. The P&P indicated to have proper equipment to redistribute pressure and maintain body alignment at bedside, position resident to maintain comfort and redistribute pressure, and ensure sufficient support for the extremities and head.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the facility's policies and procedures (P&P) titled, Fall Management Program and Fall Prevention and Management Program for two of four sampled residents (Resident 106 and Resident 27) by: 1. Failing to provide appropriate and sufficient supervision for Resident 106 by failing to: a. Implement Resident 106's Risk for Falls Care Plan interventions to not leave Resident 106 unattended when toileting. b. Update Resident 106's Fall Risk after falling on 6/24/2025 as indicated in the facility's P&P titled, Fall Prevention and Management Program. c. Document interventions recommended by the Interdisciplinary Team (IDT, a group of healthcare professionals with various areas of expertise who work together toward the goal of the resident) after Resident 106's fall on 6/24/2025. 2. Failing to ensure that the IDT team met after Resident 27 sustained a fall on 5/2/2025 as indicated in the facility's P&P titled, Fall Management Program. As a result of these deficient practices, Resident 106, who had an unwitnessed fall that resulted in an injury and was transferred to the general acute care hospital (GACH) on 6/24/2025 at 11:09 AM for further treatment of three-centimeter (cm, a measure of length) laceration (a deep cut or tear in skin) with skin discoloration to right cheek and received seven sutures (surgical threads used to close wounds from injuries) on the resident's right eyebrow and these deficient practices had the potential to place Resident 27 at risk for further falls. Findings: 1. During a review of Resident 106’s admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), palliative care (specialized medical care focused on improving the quality of life for people with serious illnesses), and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 106’s Risk for Falls Care Plan dated 2/19/2025, the Care Plan indicated a goal for the resident to have reduced risk of falls/injuries daily for 90 days. The Care Plan interventions included frequent safety monitoring, to ensure the room was free of clutter, and to not leave resident unattended when toileting and in shower room. During a review of Resident 106’s History and Physical (H&P) dated 3/5/2025, the H&P indicated the resident could make needs known but could not make medical decisions. During a review of Resident 106’s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 6/8/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person’s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident did not have any falls since admission and required substantial maximal assistance (helper does more than half the effort) with sit to stand and toilet transfer. The MDS indicated the resident did not have any alarms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 106’s Fall Risk Evaluation dated 6/8/2025 at 1:33 AM, the Fall Risk Evaluation indicated the resident was disoriented times three at all times and was chairbound/incontinent (someone who “goes to the bathroom” without actually being able to make it to the bathroom). The Fall Risk Evaluation indicated the resident required use of assistive devices. During a review of Resident 106’s Vitals and Pain Only Evaluation dated 6/24/2025 at 8:43 AM, the Evaluation indicated the resident’s pain level was 3/10 on the pain scale (a pain scale of 1-10 was a common method for gauging pain intensity, with 0 representing no pain and 10 representing the worse possible pain). During a review of Resident 106’s Medication Administration Record (MAR) dated 6/24/2025 at 8:43 AM, the MAR indicated the resident received Acetaminophen oral tablet 500 milligram (mg, unit of mass or weight), 1,000 mg by mouth every eight hours as needed (PRN) mild pain (one to four) for the pain level of 3. During a review of Resident 106’s Change in Condition Evaluation dated 6/24/2025 at 8:52 AM, the Evaluation indicated Resident 106 had an unwitnessed fall in the bathroom with a laceration to right brow bone and an abrasion (the surface layers of the skin (epidermis) had been broken) with skin discoloration to right cheek. The Evaluation indicated Resident 106 received pain medication and treatment was provided. The Evaluation indicated the Resident’s Representative (RR) and physician were notified with orders to transfer the resident to the GACH for further evaluation and treatment. During a review of Resident 106’s Post Fall Evaluation dated 6/24/2025 at 10:13 AM, the Post Fall Evaluation indicated the resident’s pre-fall: fall risk score was a nine and the post-fall: fall risk score was also a nine. During a review of Resident 106’s Fall Risk Evaluation dated 6/24/2025 at 11:15 AM, the Fall Risk Evaluation indicated the resident had no falls in the past three months, had intermittent confusion, and was chairbound/incontinent. The Fall Risk Evaluation indicated the resident required use of assistive devices. During a review of Resident 106’s Skin Check dated 6/24/2025 at 4:31 PM, the Skin Check indicated the resident had a right brow bone laceration acquired in house measuring four cm by 0.3 cm with steri-strips (thin, adhesive strips used to close small cuts or wounds) applied for closure. The Skin Check indicated the resident had a right front knee abrasion, a right cheek abrasion with discoloration, and a right upper orbital region (the bony cavity, or socket in your skull that housed your eyeball and related structures) discoloration, all acquired in house. During a review of Resident 106’s Physician’s Order dated 6/24/2025, the Physician’s Order indicated treatment: right brow bone laceration. Cleanse with normal saline (NS), pat dry, apply steri-strips PRN. During a review of Resident 106’s Physician’s Order dated 6/24/2025, the Physician’s Order indicated treatment: right cheek abrasion with discoloration. Apply triple antibiotic (medication used to treat infection) ointment daily everyday shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 106’s Physician’s Order dated 6/24/2025, the Physician’s Order indicated treatment: right eyebrow skin tear. Cleanse with NS, pat dry, apply steri-strips and monitor daily PRN. During a review of Resident 106’s Physician’s Order dated 6/24/2025, the Physician’s Order indicated treatment: right eyebrow skin tear. Cleanse with NS, pat dry, apply steri-strips and monitor daily everyday shift. During a review of Resident 106’s Physician’s Order dated 6/24/2025, the Physician’s Order indicated treatment: right knee abrasion. Cleanse with NS, pat dry, apply triple antibiotic ointment daily everyday shift for 21 days. During a review of Resident 106’s GACH Emergency Department (ED) Physician Notes dated 6/24/2025 at 11:24 AM, the ER Report indicated the resident fell at the nursing facility with an abrasion or bruising to the right side of the face with no loss of consciousness. The ER Report’s physical exam indicated Resident 106 had an abrasion/laceration to right eyebrow with steri-strips in place and an abrasion to right cheek. During a review of Resident 106’s GACH ED Physician Notes dated 6/24/2025 at 1:59 PM, the ED Physician Notes indicated the Physician performed a laceration repair for Resident 106’s right eyebrow with a local anesthetic (a drug or other substance that caused a loss of feeling or awareness) and placed seven sutures. The ED Physician Notes indicated the sutures were dressed in antibiotic ointment and a four-by-four gauze (a loosely woven, almost translucent fabric that was used to bandage a wound. During a review of Resident 106’s GACH Discharge Instructions dated 6/24/2025 at 3:21 PM, the Discharge Instructions indicated for the resident to follow up with the primary care doctor within three to five days after ED visit for suture removal. During a review of Resident 106’s Physician’s Order dated 6/24/2025, the Physician’s Order indicated to follow up with the primary care physician within three to five days after the emergency room visit for suture removal. During a review of Resident 106’s IDT Progress Notes – Falls dated 6/27/2025 at 7:42 AM, the IDT Progress Notes indicated the resident was assisted to the rest room and the Certified Nursing Assistant (CNA) was making the bed with privacy provided for the resident. The IDT Progress Note indicated the resident seemed to have “gotten up” and sustained a fall and transferred to the GACH to rule out a head injury. The IDT Progress Note indicated recommendations to continue with toileting regimen program, frequent safety checks, nigh shift staff to station by resident’s room, and continue to proactively anticipate needs and help as needed. During an observation in Resident 106’s room on 7/1/2025 at 9:08 AM, the resident’s bed was low to the ground with the call light system in reach. Resident 106 was sitting in a wheelchair smiling and making eye contact but was unable to speak but was mumbling words. Resident 106 had sutures to the right lower eyebrow. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/2/2025 at 3:59 PM, CNA 7 stated on 6/24/2025 he placed Resident 106 in the restroom, left the resident in the restroom alone and closed the door for privacy. CNA 7 stated he would usually leave Resident 106 in the restroom to give the residents privacy. CNA 7 stated he checked on the resident every one minute to ensure the resident was safe but then after closing the door the resident fell. During an interview on 7/2/2025 at 4:28 PM, the Director of Nursing (DON) stated Resident 106 was able to be left in the restroom by himself to provide dignity and give privacy. During a concurrent interview and record review of Resident 106’s IDT Progress Note - Falls on 7/2/2025 at 4:45 PM, The DON stated he did not require the facility staff to document every intervention or every action . The DON stated, “Registered nurses has integrity and for me to say that I said I saw it, it’s enough.” The DON was unable to provide documentation of the night shift staff stationed by the residents’ room as recommended by IDT. During a concurrent interview and record review of Resident 106’s Post Fall Evaluation on 7/3/2025 at 2 PM, the DON stated the document was not correct because the resident’s post fall score should have been higher because of the fall. During a concurrent interview and record review of Resident 106’s Risk for Falls Care Plan on 7/3/2025 at 2:05 PM, the DON stated the facility was not following the Care Plan interventions. The DON stated if the facility was not following the interventions there was potential to pose the resident at risk for falls because the plan of care would not be accurate to reflect the resident’s current status. During an interview on 7/3/2025 at 3:15 PM, the DON stated CNA 7 should have left the door open. The DON stated when the door was closed, there was no direct line of sight or adequate supervision so if the door was kept open, CNA 7 could have potentially intervened and could have been timelier to get to the resident. 2. During a review of Resident 27’s admission Record (AR), the AR indicated the facility admitted Resident 27 on 10/18/2024 with diagnoses that included sepsis (a life-threatening blood infection), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and muscle weakness. During a review of Resident 27’s Fall Risk Evaluation, dated 10/18/2025, the evaluation indicated Resident 27 was assessed as a high risk for falls and included interventions to assist Resident 27 with ambulation(walking) and transfers, and to initiate fall risk precautions. During a review of Resident 27’s Risk for Falls Care Plan (CP), dated 10/18/2024, the CP indicated a goal to reduce the risk for falls. The CP’s interventions indicated frequent safety monitoring, anticipating needs, and keeping all personal and frequently used items within easy reach. During a review of Resident 27’s History and Physical (H&P, a comprehensive physician’s note regarding the assessment of the resident’s health status), dated 10/22/2024, the H&P indicated Resident 27 could follow simple commands and had the capacity to make their own decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 27’s Minimal Data Set (MDS, a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 27’s cognition (a person’s mental process of thinking, learning, remembering, and using judgement) was moderately impaired. The MDS indicated Resident 27 required moderated assistance (helper does less than half the effort) transferring from a sitting to a standing position and when transferring from chair to bed or wheelchair. The MDS indicated Resident 27 used a manual wheelchair or scooter with supervision (helper provides verbal or touch cues to assist the resident) to ambulate within the Resident 27’s room or the facility. The MDS indicated Resident 27 did not have any falls since admission. During a review of Resident 27’s Change in Condition Evaluation (CIC), dated 5/2/2025 at 3:25 AM, the CIC indicated Resident 27 had a fall. The CIC indicated Primary Care Provider (PCP) 1 was notified and recommended an x-ray (diagnostic imaging) of Resident 27’s right hip. During a review of Resident’s 27 Fall Risk Evaluation Progress Note, dated 5/2/2025 timed at 3:46 AM, the Note indicated Resident 27 was assessed as high risk for falls. During a review of Resident 27’s Post Fall Evaluation Progress Nott dated 5/2/2025 timed at 4:02 AM, the Note indicated Resident 27 had an unwitnessed fall in Resident 27’s room. The Note indicated there was no recent change to Resident 27’s environment. During a review of Resident 27’s Transfer to Hospital Summary Progress Note, dated 5/2/2025 at 9:01 AM, the Note indicated Resident 27 fell from Resident 27’s bed around 3:25 AM and initially denied pain. The Note indicated at 7:30 AM Resident 27 complained of right hip pain; PCP 1 was notified and recommended resident to be transferred to the General Acute Hospital (GACH) 1 for further evaluation and treatment. During a review of Resident 27’s Transition of Care/Post Hospitalization Progress Note dated 5/5/2025 at 8:30 AM and written by Nurse Practitioner (NP) 1, the Note indicated Resident 27 was admitted to the GACH 1 on 5/2/2025 after a fall from Resident 27’s bed and complained of right hip pain. The Note indicated Resident 27 was diagnosed with a urinary tract infection (UTI, an infection in the bladder/urinary tract) at GACH 1, and readmitted to the facility on [DATE] with an order for antibiotics (medications that fight bacterial infections by either killing bacteria or preventing their growth for the treatment of UTI. During a review of Resident 27’s Actual Fall Care Plan on 5/2/2025 and dated 5/5/2025, the CP indicated Resident had an actual fall with no injury or minor injury related to poor balance. The CP’s interventions included assessing Resident 27 for pain and providing pain medication as needed, and to determine and address the cause of the fall. During a review of Resident 27’s Progress Note for the month of May 2025, Resident 27’s Progress Notes were reviewed. There was no documentation indicating that an IDT meeting was conducted following Resident 27’s fall on 5/2/2025 and readmission to the facility on 5/3/2025. During an interview on 7/3/2025 at 3:15 PM with Registered Nurse (RN) 1, RN 1 stated, post-fall interventions included pain and neurological assessments, post-fall evaluation, creating and revising a resident’s fall care plan, and the head of the departments conduct an IDT meeting to evaluate the resident’s hazards and risks and to monitor for the effectiveness of the care plan’s interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/2025 at 4:57 PM with the Director of Nursing (DON), the DON stated, an IDT meeting must be conducted 3-5 days after as resident falls so the IDT could review and identify the cause of the fall. During a concurrent interview and record review on 7/3/2025 at 5 PM with the DON, Resident 27’s Progress Notes for the month of May 2025, were reviewed. The DON stated, there was “no note specifically titled IDT Meeting” when Resident 27’s fell on 5/2/2025. During a review of the facility’s P&P titled, “Fall Management Program” dated 3/13/2021, the P&P indicated “The IDT will initiate, review and update the Resident’s fall risk status and care plan at the following intervals: on admission, quarterly, annually, upon identification of a significant change of condition, post fall and as needed.” During a review of the facility’s P&P titled, “Fall Prevention and Management Program” dated 8/1/2014, the P&P indicated “The IDT will initiate, review, and update resident fall risks and Plan of Care at the following intervals: admission, quarterly, annually, upon significant change of condition identification, and post fall.” The P&P indicated “Following each resident fall, the Licensed Nurse will perform a Post-Fall Assessment and update, initiate, or revise a Plan of Care. Following each resident fall, the IDT Falls Committee will review, revise, and update the Plan of Care to meet resident needs. ” During a review of the facility’s P&P titled, “Fall Management Program,” dated 3/13/2021, the P&P indicated “the IDT will investigate the fall including a review of the Resident’s medical record, post-fall huddle, and review of the Incident and Accident Report.” During a review of the facility’s policies and procedures (P&P) titled, “Fall Management Program,” dated 3/13/2021, the P&P indicated “IDT will review the circumstances surrounding the fall then summarize their conclusions on an IDT note.”

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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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and services to prevent urinary tract infections (UTI- an infection in the bladder [a hollow, stretchy organ in the lower part of your abdomen that stores urine before it leaves your body]/urinary tract) by assessing the urine for cloudiness, color, sediments (the matter that settles to the bottom of a liquid), blood, odor, and amount of urine output for one of three sampled residents (Resident 2) with foley catheter (an indwelling device that drains urine from urinary bladder into a collection bag outside of body). This deficient practice had the potential for Resident 2 to develop UTI and receive delayed or no treatment for could lead to a decline in the resident's well-being. Findings: During a review of Resident 2's admission Record (AR), the AR indicated that the facility originally admitted Resident 2 on 8/21/2024 and readmitted on [DATE], with diagnoses including encephalopathy (term that refers to a generalized dysfunction of the brain), end stage renal disease (ESRD, irreversible kidney failure), benign prostatic hyperplasia (BPH, a condition in which the prostate gland grows larger than normal, but the growth is not caused by cancer), and neuromuscular dysfunction of bladder (known as neurogenic bladder, when a person lacks bladder control due to brain, spinal cord or nerve problems.). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 5/24/2025, the MDS indicated that Resident 2 was severely cognitively impaired (never/rarely made decisions). The MDS indicated that Resident 2 needed partial/moderate assistance (helper does less than half the effort) on toileting hygiene, shower/bathe self, and sit to stand. During a review of Resident 2's Physician Orders dated 6/3/2025 indicated the following: 1. Provide foley catheter care every shift. 2. Assess urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediments, blood, odor, and amount of urine output. 3. Change foley catheter per schedule and as needed for leaking, occlusion (blockage), dislodgement (something moving or being removed from a fixed position, for example inside the body), excessive sediment. 4. Physician Order dated 6/17/2025 indicated to change foley catheter and drainage bag if clogged, or dislodged, and as needed. During a review of Resident 2's Treatment Administration Record (TAR) dated from 6/1/2025 to 7/3/2025, indicated no documented evidence indicating that Resident 2's foley catheter and/or drainage bag were changed. During a review of Resident 2's Progress Notes dated from 6/3/2025 to 7/1/2025, there was also no documented evidence describing Resident 2's urinary output amount, cloudiness, color, sediments, blood, odor, and amount of urine output that was assessed every shift. During a concurrent observation and an interview on 7/1/2025 at 9:20 AM in Resident 2's room, Resident 2 was observed with a foley catheter connected to drainage bag hanging at bedside, the drainage tubing was observed with cloudy yellow urine output with sediments. Resident 2 stated he had to keep the catheter because he could not pee (urinate). Resident 2 stated he had a history of UTI, which he could not recall how long ago but he has not been told about any issue with his urine so far. During a concurrent record review and an interview on 7/3/2025 at 9:40 AM with Registered Nurse (RN) 1, Resident 2's Physician Orders and TAR dated from 6/1/2025 to 7/3/2025, were reviewed. RN 1 stated she could not find documentation mentioning the date Resident 2's foley catheter was changed. RN 1 stated she assumed it was done outside the facility before readmitted on [DATE]. RN 1 stated there was no regular schedule to change the residents foley catheter. RN 1 stated it was very important to monitor when resident's foley was changed and the urine output for any signs and symptoms of infection because prolonged foley catheter use increases risks of infection. During a concurrent record review and an interview on 7/3/2025 at 9:50 AM with the Treatment Nurse (TXN) 1, Resident 2's Physician Orders and TAR dated from 6/1/2025 to 6/30/2025 were reviewed. TXN 1 stated according to the order dated 6/17/2025 foley catheter did not have to be changed unless it's soiled or clogged. TXN 1 stated she could not find documentation mentioning the date that Resident 2's foley catheter was changed. TXN 1 also stated she documented that Resident 2's foley catheter output was assessed but did not indicate the presence of cloudy yellow urine output with sediments. During a concurrent observation and an interview on 7/3/2025 at 10:15 AM with RN 1 and TXN 1 in Resident 2's room. RN 1 and TXN 1 were observed inspecting Resident 2's foley catheter and urinary output. RN 1 and TXN 1 stated that neither of them noticed Resident 2's urine output was cloudy until now. RN 1 stated she had to supervise all floors including 130 beds so she could not check drainage output of every resident. During a concurrent record review and an interview on 7/3/2025 at 1:15 PM with the Director of Nursing (DON), Resident 2's Physician Orders were reviewed. DON stated that the date (6/17/2025) of the order

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to provide adequate nutritional care and services to one of five (5) sampled residents (Resident 117) based on the comprehensive assessment when Certified Nurse Assistant (CNA) 5 failed to assist Resident 117, who required moderate assistance (helper less than half the effort) during mealtime. This failure had the potential to result in Resident 117 not being provided the proper nutritional care and services consistent with the resident's comprehensive assessment which may lead to decreased appetite and sensation for thirst and could result in unplanned weight loss, dehydration, and the inability to maintain the highest practicable level of well-being. Findings: During a review of Resident 117's admission Records (AR), the AR indicated the facility admitted Resident 117 on 6/9/2025 with diagnoses that included dysphagia (difficulty swallowing), severe protein-calorie malnutrition, and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 117's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 6/12/2025, the H&P indicated Resident 117 did not have the capacity to understand and make decisions. During a review of Resident 117's Order Summary Report, the Report indicated an order with a start date of 6/9/2025, for a therapeutic diet (a physician order diet tailored to help manage or treat a specific medical condition or illness) of no added salt, mechanical soft texture diet. During a review of Resident 117's care plan (CP), dated 6/9/2025, the CP indicated Resident 117 was at risk for further decline in activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) assistance for eating, dressing, and personal hygiene. The CP's interventions included monitoring resident frequently, anticipating resident's needs, and meeting resident's needs promptly. During a review of Resident 117's Minimum Data Set (MDS, a resident assessment tool) dated 6/16/2025, the MDS indicated Resident 117's cognition (a person's mental process of thinking, learning, remembering, and using judgement) was severely impaired. The MDS indicated Resident 117's required moderate assistance for ADL such as eating (the ability to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquid once the meal is placed before the resident. The MDS indicated Resident 117 required a mechanically altered therapeutic diet upon admission. During an observation on 7/2/2025 at 8:00 AM in Resident 117's room, Resident 117's breakfast tray was placed in front of Resident 117 on an overbed table (an adjustable table with lockable wheels designed to roll over a bed or chair and provide a flat and stable surface). Resident 117 was observed placing a napkin on top of her upper chest and attempting to cut a piece of bread in half with a fork and spoon. Resident 117 then requested assistance to cut the piece of bread into smaller pieces. During an observation on 7/2/2025 at 10:33 AM in Resident 117's room, Resident 117's snack container was observed next to Resident 117's bed placed the overbed table with a spoon on top of the snack container. Resident 117 grabbed the snack container but was unable to reach for the spoon and water cup. During an interview on 7/3/2025 at 2:00 PM with CNA 4, CNA 4 stated, providing assistance while feeding meant to assist with tray set up and cutting up the resident's food into smaller pieces. During an interview on 7/3/2025 at 2:45 PM with CNA 5, CNA 5 stated, providing assistance while feeding a resident included tray set up and feeding assistance. CNA 5 stated, Resident 117's breakfast tray was set up, but CNA 5 did not cut Resident 117's bread into smaller pieces. During an interview on 7/3/2025 at 3:55 PM with Registered Nurse (RN)1, RN 1 stated, Resident 117's diet ordered was mechanical soft diet and Resident 117 required moderate assistance with feeding. RN 1 stated, the CNA should have set up Resident 117's tray by opening all the lids, cutting the food into smaller pieces, and placing everything within Resident 117's reach before leaving Resident 117's room. During a review of the facility's policies and procedures (P&P) titled Dining Program, dated 1/30/2025, the P&P indicated the nursing staff will provide assistance as needed to those residents who have difficulty or are unable to feed themselves.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medically related social service to assist one of four sampled resident (Resident 91), who had no teeth and loose-fitting dentures, by failing to follow up and make an appointment with the dentist. This deficient practice resulted in Resident 91 not utilizing the facility provided dentures and leaving Resident 91 unable to eat well that could lead to weight loss and negatively impacting the resident's quality of life and well-being. Findings: During a review of Resident 91's admission Records (AR), the AR indicated the facility originally admitted Resident 91 on 5/3/2023 and readmitted on [DATE] with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and asthma (a chronic [long term] condition that causes airways to swell, narrow and fill with mucus). During a review of Resident 91's Minimum Data Set (MDS - a resident assessment tool) dated 5/8/2025, the MDS indicated Resident 91 was moderately cognitively impaired. The MDS also indicated Resident 91 required setup or clean-up assistance (helper sets up or cleans up) on eating and oral hygiene. During a review of Resident 91's Physician's Orders, dated 2/23/2025, the orders indicated to provide mechanical soft texture NAS (no added salt) diet. During a review of Resident 91's History and Physical (H&P), dated 2/24/2025, the H&P indicated Resident 91 had fluctuating capacity to understand and make decisions. During a review of Resident 91's Dental Progress Notes (DPN), dated 4/14/2025, the DPN indicated Resident 91 was upper and lower edentulous (with no teeth). During a review of Resident 91's DPN, dated 4/24/2025, the DPN indicated Resident 91's denture assessment with FUD (full lower denture) loose. During a review of Resident 91's Care Plan Report, indicated Resident 91 refused to wear dentures due to dentures were loose with the denture adjustment was done on 8/2/2024 and the reline was done on 4/21/2025. The interventions included to arrange services as desired/requested/needed. During a review of Resident 91's Social Service Progress Notes (SSPN), dated from 7/29/2024 to 6/30/2025, the SSPN indicated the following: a. SSPN dated 7/29/2024 indicated Resident 91 received the new FUD/ FLD (full upper denture/ full lower denture) and the resident was happy with the results. b. SSPN dated 7/30/2024 indicated Resident 91 requested to return the denture and complained that the dentures he received were not comfortable, and that he could not eat or speak with the new dentures. c. SSPN dated 8/2/2024 indicated that Resident 91's FUD/ FLD adjustment was done with the dentist's recommendation for reline (reshaping the base to ensure optimal fit and functionality). d. SSPN dated from 4/21/2025 and 4/24/2025 indicated that Resident 91's FLD was relined and delivered to Resident 91. e. There was no documented evidence indicating in the SSPN, dated from 4/25/2025 to 6/30/2025, that follow-up visits with Resident 91 and evaluation of denture use were done. During the same observation and a concurrent interview on 7/1/2025 at 12:45 PM, Resident 91 was observed dipping a piece of sandwich in coffee cup. Resident 91 stated, he had not used his dentures for months. Resident 91 stated they (the facility and the dentist) tried to adjust his denture sometime this year (2025), but they knew it still didn't fit. Resident 91 stated he wished they (the social service) could send him out to another dentistry because the dentures were not comfortable from the beginning. Resident 91 stated, I'm a little disappointed, they just asked me to try and repeat. They don't understand my feeling. During a concurrent record review and interview on 7/3/2025 at 9:00 AM with the Social Service Director (SSD) and Social Service Assistant (SSA), Resident 91's SSPN dated from 7/29/2024 to 6/30/2025 were reviewed. The SSA stated she could not find any followed up documents with Resident 91 on how the relined denture fit or if the resident was using it since the last dental service. SSA stated Resident 91 was able to communicate his needs so if he was unhappy with the dentures he could tell us any time. SSD stated she did not follow up with Resident 91 if the dentures were adjusted and fit well because the dentist said it would take a while to get used to it. SSD stated that she did not make any appointment with the dentist to request for another adjustment of the dentures. The SSD also stated it was the responsibility of social service to identify physical and psychosocial needs of the resident, to communicate with the resident and ensure Resident 91 has the proper device when he eats. During a review of the facility's Policy and Procedures (P&P) titled Social Service Program revised 12/1/2013, the P&P indicated the following: 1. Medically-related social services are provided to residents to maintain and improve the resident's well-being. 2. Responsibilities of the Social Service Department include but not limited to identifying individual and social needs and making supportive visits to the residents. During

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to follow the facility's policy and procedure on Dry Goods Storage Guidelines to ensure safe and sanitary food storage in the kitchen where several food items were stored in the dry storage area with no opened date. In addition, one bag of dried cheese powder, dated 3/28/2025, exceeded storage period and was stored in the dry storage area. This deficient practice had the potential to result in harmful bacteria growth that could lead to foodborne illness (any illness resulting from the consumption of contaminated food or beverages) in 113 out of 117 residents who receive food from the kitchen. Findings: During a concurrent observation and interview on 7/1/2025 at 10:15 AM with the Registered Dietitian (RD) in the dry storage area, there was one medium plastic storage bin labeled with powder cheese dated 4/1/2025. Inside the storage bin, there was one open bag of powdered cheese dated 3/28/2025. The RD stated, 4/1/2025 was the delivery/received date for the cheese with opened bag and was old and should already be discarded. During a concurrent observation and interview with the RD on 7/1/2025 at 10:20 AM in the dry storage area, there was one opened bag of gelatin mix, one opened bag of chocolate cake mix, one opened bag of breadcrumbs and one opened bag of coconut flakes with no label indicating the opened date. The RD stated, once opened, food in the bags should be dated to know when to discard the food. During a concurrent observation and interview with the RD on 7/1/2025 at 10:25 AM in the dry storage area, there was one storage bin labeled with pasta dated 6/11/2025 and inside the bin, there was one individual bag of pasta dated 6/26/2025. The RD stated the delivery/received dates on the storage bins did not match the delivery/received dates on the individual food packages inside the bin. The RD stated facility follows the USDA (United States Department of Agriculture, a government agency that supports American agriculture, rural communities, and food safety food storage guidelines to store products. The RD stated the correct dates are important to know when to discard and to maintain quality of food. During a review of facility's policy and procedures (P&P) titled Food Storage and handling, revised 2/29/2024, the P&P indicated, Dry Storage Area: place opened products in storage containers with tight fitting lids, label and date all storage products, rotate stock. During a review of facility's policy and procedure titles Dry Goods Storage Guidelines dated 2018, indicated, for breadcrumbs, cocoa mixes, and coconut when opened keep for 6 months, for gelatin when opened keep for 3 months.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to enforce the facility's policy and procedure on infection control related to a safe, sanitary environment by failing to: 1. Ensure that Certified Nurse Assistant (CNA) 1 performed hand hygiene between contacts with Resident 2 and Resident 79. 2. Ensure that CNA 1 and Registered Nurse (RN) 1 followed Resident 2 and Resident 54's Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of resistant organisms) to prevent spread of infections. This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection for the residents. Findings: 1. During a review of Resident 54's admission Records (AR), the AR indicated that the facility admitted Resident 54 on 6/12/2020, with diagnoses including multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), gastrostomy status (presence of a G-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and functional quadriplegia (complete immobility due to severe disability from another medical condition without injury to the brain or spinal cord). During a review of Resident 54's History and Physical (H&P) dated 8/5/2024, the H&P indicated that Resident 54 did not have the capacity to understand and make decisions. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool) dated 3/27/2025, the MDS indicated that Resident 54 was severely cognitively impaired (never/rarely made decisions). The MDS indicated that Resident 54 needed substantial/maximal assistance (helper does more than half the effort) on toileting hygiene, personal hygiene, rolling left to right, sit to lying, lying to sitting on side of bed, and toilet transfer. During a review of Resident 54's Care Plan dated 5/26/2025, the care plan indicated that Resident 54 requires G-tube feeding related to dysphagia (difficulty swallowing), and the intervention included to use EBP PPE (personal protective equipment - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environment) for successful infection prevention practices. During a concurrent observation and interview on 7/1/2025 at 8:39 AM in Resident 54's room, CNA 1 was observed picking up dirty linens and the call light from the floor without wearing PPE or gloves. CNA 1 was then observed without performing hand hygiene straightly walking to next bed and picking up Resident 79's finished meal tray with bare hands. Then CNA 1 grabbed Resident 54's call light with bare hands and tried to explain reason of how Resident 54's call light dropped. CNA 1 stated he forgot to perform hand hygiene between contact of the residents and their items, which he should have never forgotten. CNA 1 also stated he should have observed EBP for Resident 54 as indicated on the sign by the room entrance and should have worn an isolation gown and gloves. During an interview on 7/1/2025 at 8:50 AM with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated CNA 1 was supposed to follow the infection control practices all the time. 2. During a review of Resident 2's admission Record (AR), the AR indicated that the facility originally admitted Resident 2 on 8/21/2024 and readmitted on [DATE], with diagnoses including encephalopathy (term that refers to a generalized dysfunction of the brain), end stage renal disease (ESRD -irreversible kidney failure), and benign prostatic hyperplasia (BPH- a condition in which the prostate gland grows larger than normal, but the growth is not caused by cancer.) During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 5/24/2025, the MDS indicated that Resident 2 was severely cognitively impaired (never/rarely made decisions). The MDS indicated that Resident 2 needed partial/moderate assistance (helper does less than half the effort) on toileting hygiene, shower/bathe self, and sit to stand. During a review of Resident 2's Physician Orders indicated the following: i. Physician Orders dated 6/3/2025 indicated Finasteride (a medication used to treat BPH) 5mg (milligrams- metric unit of measurement, used for medication dosage and/or amount) by mouth in the morning for BPH. ii. Physician Order with the same date indicated to provide foley catheter (a tube drains urine from the bladder into a bag outside the body) care every shift. iii. Physician Orders dated 6/24/2025 indicated to hold Resident 2's scheduled medications on dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) days. During an observation on 7/3/2025 at 10AM, Registered Nurse (RN) 1 was observed performing hand hygiene with ABHR (Alcohol-based hand rub- a hand hygiene measure to mitigate and prevent infectious disease transmission), putting on gloves, and entering Resident 2's bedside to check foley catheter. The Infection Preventionist Nurse (IPN) was observed shortly calling RN 1 from the entrance, giving RN 1 an isolation gown and reminding her to put on PPE as indicated marked on the

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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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident bedrooms accommodated no more than four residents for eight of 41 rooms (Rooms 2, 19, 23, 26, 39 with five beds in the room, and rooms [ROOM NUMBER] with six beds in the room) in the facility. This deficient practice had the potential to negatively affect the residents' privacy, safety, and quality of care due to inadequate space for quality nursing and emergency care services. Findings: During a review of the Client Accommodation Analysis document submitted by the facility on 6/30/2025, the document indicated the following rooms did not meet the federal requirement of no more than four beds per resident room in a multiple-resident room: From 6/30/2025 to 7/3/2025, during the recertification survey, the following were observed: 1. room [ROOM NUMBER] has five (5) beds with four (4) beds occupied 2. room [ROOM NUMBER] has six (6) beds with six (6) beds occupied 3. room [ROOM NUMBER] has six (6) beds with five (5) beds occupied 4. room [ROOM NUMBER] has five (5) beds with four (4) beds occupied 5. room [ROOM NUMBER] has six (6) beds with six (6) beds occupied 6. room [ROOM NUMBER] has five (5) beds with four (4) beds occupied 7. room [ROOM NUMBER] has five (5) beds with five (5) beds occupied 8. room [ROOM NUMBER] has five (5) beds with five (5) beds occupied During the survey, multiple observations on 6/30/2025, 7/1/2025, 7/2/2025, and 7/3/2025, were conducted at random times from 7:30 AM to 5:00 PM. The residents in rooms 2, 4, 17, 19, 22, 23, 26, and 39 had enough space for individualized beds, bedside tables, overbed tables (an adjustable tablet with lockable wheels designed to roll over a bed or a chair and provide a flat and stable surface), and individualized resident care equipment. During the resident council meeting on 7/1/2025 at 10:02 AM in the facility's activity room, the resident council was interviewed. The residents did not report any concerns related to the room sizes and space for the residents. During a review of the facility's room waivers letter submitted by the Administrator (ADM) on 6/30/2025 indicated Rooms 2, 4, 17, 19, 23, 22, 26, and 39 had adequate space for nursing caring and for wheelchairs, Geri-Chair (a specialized, wheeled recliner chair designed for individuals with limited mobility, particularly seniors) access, and multiple beds per room and do not adversely affect the health an safety of the residents. During a review of the facility's policies and procedures (P&P) titled Room Waivers, dated 12/01/2015, the P&P indicated the management team consisting of Administrator, Director of Nurses, and Social Services Director will observe the rooms to ensure they are in accordance with the special needs of the resident, and will not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practical well-being.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the room space was at a minimum of 80 square feet (sq.ft.- a unit of measurement) for 18 of 41 resident rooms (room [ROOM NUMBER], 17, 19, 22, 23, 26, 27, 28, 30, 31, 32, 33, 34, 35, 36, 37, 38, and 39). This deficient practice had the potential to negatively affect the quality-of-care delivery and the ability of the nursing care to safely provide care and privacy to the residents. Findings: During the Recertification Survey Entrance Conference on 6/30/2025 at 8:56 AM, in the presence of the Director of Nursing (DON), the Administrator (ADM) stated the facility has 18 rooms (mentioned above) that do not have the required 80 sq. ft. per resident. ADM stated the facility would like to continue to apply for a room waiver for those 18 rooms. During a review of the Client Accommodation Analysis (CAA) dated 6/30/2025, the CAA indicated the following rooms did not meet the required square foot per resident in a multiple resident bedroom: Room #/ # of beds/ # of residents/ Sq. Ft./ Sq. Ft. per resident room [ROOM NUMBER]/ 6 beds/ 6 residents/ 307/ 51.1 room [ROOM NUMBER]/ 6 beds/ 6 residents/ 427.31/ 71.2 room [ROOM NUMBER]/ 5 beds/ 5 residents/ 364.30/ 72.86 room [ROOM NUMBER]/ 6 beds/ 6 residents/ 440.50/ 73.4 room [ROOM NUMBER]/ 5 beds/ 5 residents/ 375.31/ 75 room [ROOM NUMBER]/ 5 beds/ 5 residents/ 340.83/ 68.1 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 231.31/ 77.1 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 229.74/ 76.5 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 233.04/ 77.6 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 233.04/ 77.6 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 231.39/ 77.1 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 231.08/ 77 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 231.08/ 77 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 229.44/ 76.4 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 229.44/ 77.4 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 228.77/ 77.2 room [ROOM NUMBER]/ 3 beds/ 3 residents/ 224.78/ 76.9 room [ROOM NUMBER]/ 5 beds/ 5 residents/ 361.53/ 72.3 During the recertification survey from 6/30/2025 to 7/3/2025, the rooms were observed, and no issues were identified due to the room size. During a review of the facility's Room Waiver Request Letter (RWR), dated 6/30/2025, the RWR letter listed 18 rooms in the facility that are below the required 80 sq. ft per resident in a multiple resident room. The letter also indicated these rooms do not adversely affect the residents health and safety. During a Resident Council/group interview on 7/1/2025 at 10:15 AM in the facility's activity room with the resident council, no concerns were brought up regarding the room sizes for the residents. The California Department of Public Health (CDPH) recommends continuation of the facility's room waiver.

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	07/03/2025

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

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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	07/03/2025

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a call light system (a communication device attached to the bed or on the wall that allows residents to call for assistance from staff when needed) according to the need of two of six residents (Resident 3 and Resident 59) with limited range of motion (ROM) to upper extremities in accordance with the facility's policy and procedure (P&P) titled, P-NP29 Communication - Call System. These deficient practices had the potential to result in a delay in the provision of assistance for all care needs that could lead to accidents for Resident 3 and Resident 59. Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities), arthritis (a condition that caused inflammation and pain in the joints), and osteochondrodysplasias (a group of genetic disorders that affect bone and cartilage development). During a review of Resident 3's History and Physical (H&P) dated 3/1/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 3/26/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident required substantial/maximal assistance from facility staff for upper body dressing, rolling to the left and to the right, sitting to lying, lying to sitting on the side of the bed, and transfers. The MDS indicated Resident 3 had limited range of motion on upper and lower extremities. During an observation on 7/1/2025 at 9:34 AM, Resident 3 was unable to press or reach for the call light system and the resident was unable to extend the arms. During an interview on 7/3/2025 at 8:27 AM, Certified Nursing Assistant (CNA) 6 stated Resident 3 was unable to press the call light system so the facility staff would not be able to help the resident. CNA 6 stated if Resident 3 was unable to press the call light system, the facility staff would not know what the resident needed, and no one would go to help the resident's needs. During an interview on 7/3/2025 at 8:53 AM, Licensed Vocational Nurse (LVN) 2 stated Resident 3 was unable to use the call light system but should have been able to do so, to let the facility staff know when the resident needed something. LVN 2 stated if the resident was unable to press the call light system, the facility staff would not know if the resident needed something and the resident could have felt forgotten and not felt heard. During an interview on 7/3/2025 at 11:20 AM, Registered Nurse (RN) 2 stated if a resident was unable to press the call light system, the call light would have been switched out to a sensitivity call light (referred to a call light that is easily activated by the resident to request for help), or the resident would have been moved closer to the nursing station, and the facility staff would have done frequent rounds. RN 2 stated the residents should have been able to have a call light system they were able to use without difficulty, otherwise the residents could be at risk for falls. RN 2 stated on an emotional level, if the residents were unable to press the call light system, the residents could lose their trust in the nurses and not felt heard. RN 2 stated if the residents were unable to press the call light system the residents might start to do things they were not supposed to and possibly get out of bed and injure themselves. b. During a review of Resident 59's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), weakness, and failure to thrive (a decline caused by chronic diseases and functional impairments which could cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 59's H&P dated 10/14/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 59's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on facility staff for eating, oral/toileting/personal hygiene, showering, and transfers. The MDS indicated the resident was dependent on facility staff for upper and lower body dressing, putting on/taking off footwear, rolling to the left and to the right, sit to lying, and lying to sitting on the side of the bed. The MDS indicated Resident 3 had limited range of motion on upper and lower extremities. During an observation on 7/1/2025 at 9:32 AM, Resident 59 stated It's a little hard sometimes to call them and the resident was unable to press or reach for the call light due to contractures. During an interview on 7/3/2025 at 8:37 AM, CNA 6 stated Resident 59 was unable to press the call light system and should have been able to so that somebody could help the resident. CNA 6 stated if Resident 59 was unable to press the call light system, the resident would not get the help needed and would not receive