STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056367	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of North Hills	9655 Sepulveda Boulevard North Hills, CA 91343

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care in a manner that maintained a resident's dignity and respect for one of two sampled residents, reviewed under the care area of dignity by failing to ensure Treatment Nurse 1 (TN1) knock or request permission before entering Resident 82's room. This deficient practice violated the resident`s rights to be treated with respect and dignity and had the potential to affect the residents` sense of self-worth and self-esteem. Findings: During a review of Resident 82's admission Record, the admission Record indicated the facility originally admitted the resident on 09/13/2024 and readmitted on [DATE] with diagnoses including, chronic respiratory failure (can occur when your blood has too much carbon dioxide or not enough oxygen) and sepsis (a life-threatening complication of an infection). During a review of Resident 82's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 3/15/2025, the MDS indicated the resident had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. The MDS indicated that Resident 82 was totally dependent on staff for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During an observation on 6/17/2025 at 8:45 a.m., observed Treatment Nurse 1(TN 1) enter Resident 82`s room without knocking or asking permission from Resident 82.  During an interview on 6/17/2025 at 8:53 a.m., TN 1 that she did not knock and asked permission when she entered Resident 82`s room. TN 1 stated she should have knocked and asked permission before entering Resident 82's room to show respect and promote privacy because the facility is Resident 82's home. During a review of the facility`s policy and procedure titled Dignity and Respect, last reviewed on 1/08/2025, the policy indicated that Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .staff will knock and request permission before entering residents` rooms .staff are expected to speak respectfully to residents, including addressing the resident by his or her name of choice .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 provide the resident and the resident's representative information regarding formulating an advance directive (AD-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 for one of six sampled residents investigated during review of advance directive care area (Resident 82). This deficient practice had the potential for Resident 82 and their representative to not be informed of their right to formulate an advance directive and not honor the resident's wishes regarding end-of-life care. Findings: During a review of Resident 82's admission Record, the admission Record indicated the facility originally admitted the resident on 09/13/2024 and readmitted on [DATE] with diagnoses including, chronic respiratory failure (can occur when your blood has too much carbon dioxide or not enough oxygen) and sepsis (a life-threatening complication of an infection). During a review of Resident 82's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 3/15/2025, the MDS indicated the resident had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. The MDS indicated that Resident 82 is totally dependent on staff for activities of daily living (These activities are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During an interview and record review on 06/18/25 08:34 a.m., with Registered Nurse 1 (RN1), reviewed Resident 82`s medical records. The medical records did not have documented evidence the resident had completed an advance directive, or that the facility had provided the resident and their representative with information on how to create one. RN 1 stated that failing to provide Resident 82 or their representative with information and assistance on how to create an advance directive, if the resident so chooses constitutes a violation of the resident's right. During a review of the facility`s policy and procedure titled Advance Directive [AD] last reviewed on 1/08/2025, the policy and procedure indicated that Residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify the resident's physician for one of 10 sampled residents (Resident 82) when licensed nursing staff failed to put on a left hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) for three to four hours a day, seven days a week as ordered by a physician. This deficient practice had the potential to cause a decline in range of motion (ROM, full movement potential of a joint) and worsening of contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in Resident 82. Findings: During a review of Resident 82's admission Record, the admission Record indicated the facility admitted the resident on 9/13/2024 and readmitted the resident on 3/6/2025 with diagnoses including but not limited to acute and chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) with hypoxia (low oxygen level in tissues), quadriplegia (paralysis from the neck down, including legs, and arms), contracture of muscle, unspecified site, and complete traumatic amputation (surgical removal of a limb) at right shoulder joint. During a review of Resident 82's Minimum Data Set (MDS, resident assessment tool) dated 3/15/2025, the MDS indicated Resident 82 had no speech and was severely impaired in cognitive skills (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) for daily decision making. The MDS indicated Resident 82 required dependent assistance from staff for bed mobility, personal hygiene, dressing, and toileting. The MDS also indicated Resident 82 had functional limitation impairments in ROM on both sides of the upper extremity (UE, shoulder, elbow, wrist, hand) and functional limitation impairments on both sides of the lower extremity (LE, hip, knee, ankle, foot). During a review of Resident 82's Order Summary Report (OSR) dated 6/17/2025, the OSR indicated an order dated 3/7/2025 for licensed nurse to provide left elbow, left hand and bilateral (both sides) knee splints for three to four hours seven times a week as tolerated. The OSR indicated an order dated 3/7/2025 for licensed nurse to passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to left upper extremity (LUE), and both lower extremity (BLE) seven times a week as tolerated. During a review of Resident 82's Care Plan (CP) dated 6/17/2025, the CP indicated Resident 82 was at high risk for decline in ROM, decreased muscle strength and at risk for contracture formation. The CP goal indicated resident will decrease complaints of pain and discomfort and will maintain ROM. The CP interventions included licensed nurse to provide PROM exercises to LUE and BLE seven times a week as tolerated and licensed nurse to provide left elbow, left hand and both knee splints for three to four hours seven times a week as tolerated. During an observation on 6/17/2025 at 12:15 p.m., observed Resident 82 lying in bed. Resident 82's left elbow was bent and had a splint on the left elbow, the left wrist was fully bent, and left fingers were partly bent. There were no splints observed on Resident 82's left wrist or hand. Resident 82's both knees were bent and there were splints on both knees. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/2025 at 3:48 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the charge nurse (LVN) assigned to Resident 82 completed the PROM exercises and put on the splints every day. LVN 2 stated he completed the ROM exercises with Resident 82 today and put on the left elbow splint and both knee splints up to three to four hours a day. LVN 2 stated Resident 82 had orders to put on left elbow splint and both knee splints only. LVN 2 stated Resident 82 did not have any orders to put a left hand splint and LVN 2 had not put any left hand splints on Resident 82. LVN 2 stated if Resident 82 had a change in condition, then LVN 2 would need to notify the Registered Nurse supervisor. During a concurrent observation and interview on 6/18/2025 at 12:30 p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 completed PROM exercises to Resident 82 on the left upper extremity and both lower extremities. After PROM exercises, LVN 3 put on the right knee splint and requested assistance from Registered Nurse Supervisor 3 (RN 3) to assist with putting on the left knee splint. RN 3 reminded LVN 3 to put on the left elbow splint. LVN 3 proceeded to retrieve an elbow splint in the closet and put the left elbow splint on Resident 82. RN 3 reminded LVN 3 to put on the left hand splint. LVN 3 stated the left hand splint was still missing and stated she could not put on the left hand splint. During an interview on 6/18/2025 at 1:11 p.m., with LVN 3, LVN 3 stated she had not put on the left hand splint on Resident 82 for at least two weeks, but could not remember exactly how long Resident 82 did not put on the left hand splint. LVN 3 stated if the left hand splint or any splint was not put on, then it should be documented in Resident 82's medical records. LVN 3 stated if Resident 82 did not put on the left hand splint for any reason, nursing staff should notify the therapy department and inform the physician. During a concurrent interview and record review on 6/18/2025 at 1:18 p.m., with RN 3, reviewed Resident 82's medical records including progress notes, RNA weekly summary, and nursing notes from 3/7/2025 to 6/18/2025. RN 3 stated Resident 82 had an order dated 3/7/2025 for licensed nurse to provide left elbow, left hand and bilateral knee splints for three to four hours seven times a week as tolerated, and an order dated 3/7/2025 for licensed nurse to provide PROM exercises to LUE and BLE times a week as tolerated. RN 3 stated nursing staff should put on the left hand splint every day and stated she was not aware of any nurses reporting to her that Resident 82 did not put on the left hand splint for any reason, including the left hand splint missing. RN 3 reviewed Resident 82's medical records including progress notes, RNA weekly summary, and nursing notes and stated nursing staff did not document Resident 82 did not wear the left hand splint since the order was written on 3/7/2025 or any reports to the physician. RN 3 stated licensed nursing staff should put on the left hand splint every day, because Resident 82 could get more contracted, and it could be harder to put on the splints later. During an interview on 6/18/2025 at 2:17 p.m., with the Director of Nursing (DON), the DON stated if there was an order to put a left hand splint, then this was the intervention to help Resident 82 prevent further contractures and the order must be completed as ordered. The DON stated if the licensed nurses could not put on the splint that day for any reason, staff should document and report this and notify the family and the physician and depending on the reason for not putting on the splint, the physician could indicate to just monitor or it could indicate that Resident 82 needed therapy to intervene or to check the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Notification of Changes, approved 1/8/2025, the P&P indicated, The facility notifies the physician and resident representative of a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure a resident receiving risperidone (used to treat schizophrenia [mental disorder in which people interpret reality abnormally]) was monitored for a specific paranoid (intense anxious or fearful feelings and thoughts) behavior exhibited for one of three residents (Resident 75). This deficient practice had the potential to result in inaccurate evaluation of the efficacy of risperidone and placed the resident at risk of experiencing medication adverse effect (undesired harmful effect resulting from a medication or other intervention) such as hypotension (low blood pressure) which could lead to fall and injury. Findings: During review of Resident 75's admission Record, the admission Record indicated that the facility originally admitted the resident on 3/21/2024 and readmitted the resident on 5/31/2024 with diagnoses that included muscle weakness, schizophrenia, and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 75's Minimum Data Set (MDS - a resident assessment tool), dated 3/30/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired and the resident required setup or clean-up assistance with oral hygiene, toileting hygiene, shower and personal hygiene. During a concurrent interview and record review on 6/19/2205 at 11:27 a.m., with Registered Nurse 1 (RN 1), reviewed Resident 75`s physician`s order for risperidone oral tablet one (1) milligram (mg- unit of measurement) two times a day for schizophrenia manifested by paranoia and monitor episodes of paranoia every shift, dated 6/28/2024. RN 1 stated that the monitoring for episodes of schizophrenia every shift was documented in the Medication Administration Record. RN 1 stated the monitoring of paranoia is vague and is not specific as to the paranoid behavior exhibited by Resident 75. RN 1 stated that monitoring of the behavior should be specific in evaluating the efficacy of the medication and if the medication is appropriate for the resident or if the medication is even necessary. RN 1 stated that resident taking risperidone can experience adverse side effect such as hypotension (low blood pressure) which can result to fall and injury. During a review of the facility`s policy and procedure titled, Unnecessary Drugs, last reviewed on 1/8/2025, the policy indicated, Each resident`s drug regimen shall be free from unnecessary drugs .the intent of these requirements is to ensure each resident`s entire drug/medication regimen is managed and monitored to promote or maintain the resident`s highest practicable mental, physical, and psychosocial well-being . (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policy and procedure titled, Dignity and Respect Psychoactive Medications, last reviewed on 1/8/2025, the policy indicated, The facility`s medication management process focuses on recognition or identification of the resident`s problem, completion of the assessment, diagnosis, attempted root cause identification, management, and treatment through non-pharmacological interventions when possible, monitoring, and revising interventions to improve the resident`s quality of life .

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit a resident's Discharge Minimum Data Set (MDS - a resident assessment tool) timely for one of one sampled resident (Resident 115). This deficient practice had the potential to delay care and services for the resident. Findings: During a review of Resident 115's admission Record, the admission Record indicated the facility admitted the resident on 2/3/2025 with diagnoses including a fracture (broken bone) of the shaft of the right tibia (shin bone). During a review of Resident 115's MDS, dated [DATE], the MDS indicated the resident had intact cognition (thought processes) and required supervision or touching assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a concurrent interview and record review on 6/17/2025 at 4:13 p.m., with Minimum Data Set Nurse 1 (MDSN 1), reviewed Resident 115's Centers for Medicare & Medicaid Services (CMS) Submission Report (a document or set of documents submitted to CMS as part of various reporting requirements across different CMS programs). MDSN 1 stated that, according to the report, Resident 115's Discharge MDS was submitted late. MDSN 1 stated the Assessment Reference Date (ARD - the specific date that marks the end of a lookback period, which is used to determine when the MDS assessment captures a resident's condition or status) for the resident's Discharge MDS was 2/24/2025. MDSN 1 stated that the facility had 14 days from that date to complete the assessment and then another 14 days from the date of completion to submit the assessment. MDSN 1 stated that Resident 115's Discharge MDS was completed on 3/10/2025 and should have been submitted on 3/24/2025. MDSN 1 stated the Discharge MDS was submitted on 6/17/2025. During an interview on 6/18/2025 at 2:41 p.m., with the Director of Nursing (DON), the DON stated it was important for Resident 115's Discharge MDS to submitted timely so that CMS had an accurate record of which residents were still in the facility and who had been discharged . During a review of the Resident Assessment Instrument (RAI) Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary, provided by the facility, the transmission date should be no later than 14 calendar days after the MDS completion date. During a review of the facility's policy and procedure titled, Resident Assessment, last reviewed and revised on 1/8/2025, the policy and procedure indicated that the facility uses the RAI in accordance with specified format and timeframes in conducting comprehensive assessments .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and implement a person-centered care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for three of 27 sampled residents (Resident 75, 94, and 82) by failing to: 1. Develop a care plan addressing Resident 75's use of bed siderails. ? 2. Develop a care plan addressing Resident 94's preferred language for communication. 3. Develop a care plan addressing Resident 82's multiple joint contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) and limited range of motion (ROM, full movement potential of a joint). These deficient practices had the potential to result in failure to deliver the necessary care and services. Findings: a. During review of Resident 75's admission Record, the admission Record indicated that the facility originally admitted the resident on 3/21/2024 and readmitted the resident on 5/31/2024 with diagnoses that included muscle weakness, schizophrenia, and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 75's Minimum Data Set (MDS - a resident assessment tool), dated 3/30/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired and the resident required setup or clean-up assistance with oral hygiene, toileting hygiene, shower and personal hygiene. During a concurrent interview and record review on 6/18/2025 at 1:28 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 75`s physician`s orders. Resident 75's physician`s order dated 5/31/2024 included an order to provide ½ side rails when in bed as an enabler, for self- positioning and bed mobility, every shift for safety. RN 1 stated that the use of side rails had to be assessed for safety and care planned with interventions to monitor the resident for risk of entrapment. RN 1 stated that there is no care plan in place for Resident 75`s use of side rails. RN 1 stated that without a care plan for the risks of entrapment, the staff would not be able to provide intervention to minimize the risks which could result in injury if the resident gets entrapped.  During a review of the facility`s policy and procedure titled, Bedrails, last reviewed on 1/8/2025, the policy indicated, The facility must attempt to use alternatives prior to installing a side or bed rail .the resident is assessed for the use of bed rails, which include a review of the risks including entrapment . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility`s policy and procedure titled, Develop-Implement Comprehensive Care Plans, last reviewed on 1/8/2025, the policy indicated that Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident`s medical, physical, mental and psychosocial needs . c. During a review of Resident 82's admission Record (AR), the AR indicated Resident 82 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to acute and chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) with hypoxia (low oxygen level in tissues), quadriplegia (paralysis from the neck down, including legs, and arms), contracture of muscle, unspecified site, and complete traumatic amputation (surgical removal of a limb) at right shoulder joint. During a review of Resident 82's Minimum Data Set (MDS, resident assessment tool) dated 3/15/2025, the MDS indicated Resident 82 had no speech and was severely impaired in cognitive skills (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) for daily decision making. The MDS indicated Resident 82 required dependent assistance from staff for bed mobility, personal hygiene, dressing, and toileting. The MDS also indicated Resident 82 had functional limitation impairments in ROM on both sides of the upper extremity (UE, shoulder, elbow, wrist, hand) and functional limitation impairments on both sides of the lower extremity (LE, hip, knee, ankle, foot). During a review of Resident 82's Order Summary Report (OSR) dated 6/17/2025, the OSR indicated an order dated 3/7/2025 for licensed nurse to provide left elbow, left hand and bilateral (both sides) knee splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) for three to four hours seven times a week as tolerated. The OSR indicated an order dated 3/7/2025 for licensed nurse to provide passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to left upper extremity (LUE) and both lower extremity (BLE) seven times a week as tolerated. During a review of Resident 82's Care Plans (CP) on 6/16/2025, there was no CP for Resident 82's contractures, impairments in ROM, and order for licensed nurses to perform PROM exercises and to put on left elbow, left hand, and both knee splints three to four hours a day, seven times a week. During an observation on 6/17/2025 at 9:20 a.m., Resident 82 was laying in bed. Resident 82's left elbow was fully bent, left wrist was fully bent, and left fingers were partly bent. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/18/2025 at 1:18 p.m., with Registered Nurse Supervisor (RN 3), reviewed Resident 82's care plans. RN 3 stated Resident 82 required a care plan for contractures and limited ROM and was on a nursing maintenance program. RN 3 reviewed Resident 82's care plans and RN 3 stated Resident 82 had a care plan created on 6/17/2025 that indicated Resident 82 was at high risk for decline in ROM and contracture formation. RN 3 indicated the care plan interventions included licensed nurse to provide PROM exercises to LUE and BLE seven times a week as tolerated and licensed nurse to provide L elbow, L hand, and B knee splints for three to four hours seven times a week as tolerated. RN 3 stated the care plan was not created until yesterday (6/17/2025) and that the care plan should have been created when the maintenance program was ordered on 3/7/2025. RN 3 stated Resident 82 required a care plan so that all staff were aware of Resident 82's conditions and be on the same page in terms of the goals and interventions the facility provided for Resident 82's contractures and limited ROM. RN 3 stated care plans and the goals were reviewed quarterly with family and staff to review if the interventions were effective and the interventions could not be reviewed if there were no care plans. During an interview on 6/18/2025 at 2:17 p.m., with the Director of Nursing (DON), the DON stated the purpose of a care plan was to indicate everything the facility provided for a resident based on a diagnosis or certain condition. The DON stated a resident with a contracture or at risk for contractures required a care plan because there needed to be interventions in place to prevent a contracture or worsening of a contracture. During a review of the facility's policies and procedures (P&P) titled, Develop-Implement Comprehensive Care Plans, approved on 1/8/2025, the P&P indicated, The comprehensive care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. During a review of Resident 94's admission Record, the admission Record indicated the facility admitted the resident on 11/4/2024 with diagnoses including but not limited to cerebral infarction (the death of brain tissue due to a blockage of blood flow to the brain) and right-sided hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 94's Minimum Data Set (MDS - a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 94 had severe cognitive impairment (had trouble with thinking, learning, and remembering) and was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 94 was sometimes able to understand others and could sometimes make himself understood. The MDS indicated Resident 94's preferred language was Spanish. During a concurrent interview and record review on 6/18/2025 at 10:06 a.m. with Minimum Data Set Nurse 1 (MDSN 1), Resident 94's care plan titled The resident has a communication problem r/t Language barrier ., dated 3/19/2025 did not indicate Resident 94's preferred language was Spanish. MDSN 1 stated Resident 94's care plan should indicate Spanish is his preferred language so staff knows how to best communicate with him, and they can get the correct interpreter if needed. During an interview on 6/19/2025 at 4:05 p.m. with the Director of Nursing (DON), the DON stated that Resident 94's preferred language for communication should be indicated in the care plan so they know how to communicate with the resident, and they can use a communication board in the correct language with him if needed. (continued on next page)

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The Rehabilitation Center of North Hills	9655 Sepulveda Boulevard North Hills, CA 91343

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled Develop-Implement Comprehensive Care Plans, last reviewed 1/8/2025, the policy and procedure indicated the facility will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident to address their medical, physical, and psychosocial needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to conduct a quarterly review of a resident's comprehensive care plans (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) for one of one resident (Resident 75). This deficient practice had the potential to result in failure to deliver the necessary care and services. Findings: During review of Resident 75's admission Record, the admission Record indicated that the facility originally admitted the resident on 3/21/2024 and readmitted the resident on 5/31/2024 with diagnoses that included muscle weakness, schizophrenia, and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 75's Minimum Data Set (MDS - a resident assessment tool), dated 3/30/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired and the resident required setup or clean-up assistance with oral hygiene, toileting hygiene, shower and personal hygiene. During a concurrent interview and record review on 6/18/2025 at 1:06 p.m., with Registered Nurse Supervisor 1 (RN 1), reviewed Resident 75`s Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) Care Planning meeting notes dated 3/28/2025. RN 1 stated that there was no IDT Care Plan meeting conducted the previous quarter (December 2024). RN 1 stated that the facility missed the December 2024 quarterly IDT Care Plan meeting review of Resident 75`s comprehensive care plans. RN 1 stated that per policy, there should be a quarterly IDT Care Plan meeting to review the comprehensive care plans and revise if necessary. RN 1 stated that the quarterly review of the comprehensive care plan is necessary to evaluate if the goals of the comprehensive care plan have been met or if the comprehensive care plans need to be revised and include other interventions to ensure the care plan goals are met. RN 1 stated if the comprehensive care plans are not reviewed and revised, if necessary, the resident`s needs may not be provided and identified resulting to unmet goals.  During a review of the facility`s policy and procedure titled, Comprehensive Care Plans-Timing, last reviewed on 1/8/2025, the policy indicated, Each resident has a person-centered, comprehensive care plan, developed, reviewed, and revised by the facility interdisciplinary team including the resident and resident representative, if applicable .the interdisciplinary team reviews and revises the comprehensive car plans after each assessment, including both the comprehensive and quarterly review assessments .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: A. Ensure a resident's low air loss mattress (LALM - designed to distribute a resident's body weight over a broad surface area and help prevent skin breakdown) was set to the resident's weight per manufacturer's guidelines for one (Resident 82) out of five sampled residents investigated for pressure ulcer/injury (PI/PU, injuries to the skin and underlying tissue resulting from prolonged pressure). This deficient practice placed the resident at risk of discomfort and development of new pressure ulcers. B. Ensure residents received care consistent with professional standards of practice to prevent pressure injuries by failing to ensure the LALM had firmness adjustment knob to set and determine the firmness setting as ordered by the physician in one of two residents (Resident 103) reviewed under the pressure ulcer/injury care area. This deficient practice had the potential for the worsening of or the development of PI/Pus in Resident 103. Findings: a. During a review of Resident 82's admission Record, the admission Record indicated the facility originally admitted the resident on 9/13/2024 and readmitted the resident on 3/6/2025 with diagnoses including chronic respiratory failure (can occur when your blood has too much carbon dioxide or not enough oxygen) and sepsis (a life-threatening complication of an infection). During a review of Resident 82's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 3/15/2025, the MDS indicated the resident had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses. The MDS indicated that Resident 82 is totally dependent on staff for activities of daily living (These activities are fundamental to survival and well-being and include things like?eating, bathing, dressing, and toileting). During an observation on 6/17/2025 at 8:32 a.m., observed Resident 82`s LALM setting at #3 and with the weight setting at 180 pounds (lbs.- unit of weight)  During a concurrent observation and interview on 6/17/2025 at 8:53 a.m., with Treatment Nurse 1 (TN 1), observed Resident 82`s LALM setting at #3 and weight setting at 180 lbs. TN 1 confirmed and stated the observed setting of the LALM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/17/2025 at 8:57 a.m., with TN 1, reviewed Resident 82`s physician's order dated 3/6/2025. Resident 82's physician`s order included an order to provide a low air loss mattress at setting #2 every day and night shift for wound management. TN 1 stated that the LALM setting is based on the weight of the resident. TN 1 stated that LALM distributes the air in different areas so there will be no excess pressure in one body part. TN 1 stated the LALM is used for pressure ulcer prevention and skin management. TN 1 stated that the higher the setting, the more the LALM becomes firmer and if it's not set correctly, it can cause discomfort and can compromise the skin which can lead to the development of pressure ulcer. TN 1 stated upon verifying the current weight of Resident 82 which is 115 lbs. on 6/6/2025, that the setting of Resident 82's LALM was not appropriate for Resident 82 and may cause skin problem. During a review of the facility`s policy and procedure titled, Low Air Loss Mattresses, last reviewed on 1/8/2025, the policy indicated, The facility has guidelines to provide residents with a low air loss mattress to reduce skin irritation and breakdown; and to allow maximal effectiveness of the low air loss mattress when a physician orders such therapy .low air loss mattresses provide airflow to help skin dry, as well as to relieve pressure. Both features help prevent ulcers. Alternating pressure mattresses help treat pressure sores by providing two sets of air cells that expand and contract on an alternating basis to continually shift pressure . b. During a review of Resident 103's admission Record, the admission Record indicated the facility admitted Resident 103 on 4/21/2025 with diagnoses including tracheostomy status (an opening in the windpipe to allow for breathing, often with the insertion of a tracheostomy tube), gastrostomy status (the surgical creation of an opening into the stomach, typically for the purpose of feeding or administering medications), and pressure ulcer sacral (a large, triangular bone at the base of the spine) region stage 1 (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness. During a review of Resident 103's History and Physical (H&P), dated 4/23/2025, the H&P indicated Resident 103 was non-verbal, unable to follow commands and did not have the capacity to understand and make decisions. During a review of Resident 103's MDS dated [DATE], the MDS indicated Resident 103 was not able to understand others and make himself understood. The MDS further indicated Resident 103 was dependent on facility staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and any mobility such as rolling from side to side. During a review of Resident 103's's Physician's Order, the Physician's Orders indicated an order dated 6/7/2025, for the LALM setting at 80-120 for skin maintenance every day and night shift. During an observation on 6/16/2025 at 9:06 am in Resident 103's room, Resident 103 was lying in bed on a LALM device. The alternating pressure pump at the foot of Resident 103's bed, did not have a pressure adjustable knob to set and determine the LALM pressure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/16/2025 at 9:18 am in Resident 103's room with Registered Nurse 4 (RN 4), RN 4 looked at Resident 103's alternating pressure pump and stated there should be a pressure adjustment knob present and without the knob, staff was unable to accurately adjust the amount of pressure on the LALM. RN 4 stated staff should have reported the missing knob immediately to the unit supervisor or maintenance to prevent further skin breakdown on Resident 103 who currently has a stage 1 PU on his sacrum. During an interview on 6/19/2025 at 3:15 pm with the Director of Nursing (DON), the DON stated there is an order to check the LALM twice a day and staff should have noticed the pressure adjustment knob was missing on Resident 103's LALM and reported it right away to prevent further skin breakdown. The DON stated Resident 103 is unable to move on his own and is very vulnerable to pressure ulcers. During a review of the facility provided Policy and Procedure (P&P) titled, Low Air Loss Mattress last reviewed on 1/8/2025, the P&P indicates the purpose of the policy is to promote interventions that prevent pressure injury development. The P&P further patient assessment, monitoring, and proper maintenance and use of equipment is required. During a review of the facility provided LALM instructions titled Proactive Alternating Pressure Pump & Bubble Pad User Manual, undated, indicated to use pressure adjustment knob to give maximum patient comfort.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 10 sampled residents (Resident 82) received appropriate services to prevent a decline in range of motion (ROM, full movement potential of a joint) by failing to: 1. Provide sufficient physical therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) and occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) services to safely assess and monitor Resident 82's use of a new left elbow splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint), new left hand splint, new right knee splint, new left knee splint, and new left ankle splint on 9/20/2024. 2. Provide Resident 82 with a left-hand splint three to four hours a day, seven times a week as ordered by a physician. These deficient practices had the potential to cause injury and pain for ill-fitting splints and for a decline in ROM in Resident 82. Findings: During a review of Resident 82's admission Record (AR), the AR indicated Resident 82 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to acute and chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) with hypoxia (low oxygen level in tissues), quadriplegia (paralysis from the neck down, including legs, and arms), contracture of muscle, unspecified site, and complete traumatic amputation (surgical removal of a limb) at right shoulder joint. During a review of Resident 82's Rehabilitation Joint Mobility Screening (JMS) dated 9/14/2024, the JMS indicated Resident 82 had moderate ROM limitations in the left shoulder, left elbow, left wrist and fingers. The JMS indicated not applicable for ROM of right shoulder, right elbow, and right wrist and fingers. The JMS indicated Resident 82 had minimal ROM limitations of the left hip, left knee, left ankle, and right ankle. The JMS indicated Resident 82 had severe ROM limitations in the right hip and right knee. The JMS indicated Resident 82's chart review revealed Resident 82 had a diagnosis or condition that puts him/her at risk for contracture development. The JMS indicated recommendations for skilled PT and recommendations for skilled OT. The JMS comments indicated Resident 82 had a right upper extremity amputation at shoulder level and recommended right hand and right elbow splint, both knee splints and left ankle splint. During a review of Resident 82's Order Summary Report (OSR) dated 6/17/2025, the OSR indicated an order dated 3/7/2025 for licensed nurse to provide left elbow, left hand and bilateral (both sides) knee splints for three to four hours seven times a week as tolerated. The OSR indicated an order dated 3/7/2025 for licensed nurses to provide passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to left upper extremity (LUE), and both lower extremity (BLE) seven times a week as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 82's Minimum Data Set (MDS, resident assessment tool) dated 3/15/2025, the MDS indicated Resident 82 had no speech and was severely impaired in cognitive skills (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) for daily decision making. The MDS indicated Resident 82 required dependent assistance from staff for bed mobility, personal hygiene, dressing, and toileting. The MDS also indicated Resident 82 had functional limitation impairments in ROM on both sides of the upper extremity (UE, shoulder, elbow, wrist, hand) and functional limitation impairments on both sides of the lower extremity (LE, hip, knee, ankle, foot). During a review of Resident 82's Care Plan (CP) dated 6/17/2025, the CP indicated Resident 82 was at high risk for decline in ROM, decreased muscle strength and at risk for contracture formation. The CP goal indicated resident will decrease complaints of pain and discomfort and will maintain ROM. The CP interventions included licensed nurse to provide PROM exercises to LUE and BLE seven times a week as tolerated and licensed nurse to provide left elbow, left hand and both knee splints for three to four hours seven times a week as tolerated. During an observation on 6/17/2025 at 12:15 p.m., Resident 82 was lying in bed. Resident 82's left elbow was bent and had a splint on the left elbow, the left wrist was fully bent, and left fingers were partly bent. There were no splints observed on Resident 82's left wrist or hand. Resident 82's both knees were bent and there were splints on both knees. 1. During a review of Resident 82's Physical Therapy Evaluation (PT Eval) and Plan of Treatment dated 9/20/2024, the PT Eval indicated Resident 82 was referred for PT eval to address contracture of bilateral knees and ankles. The PT Eval indicated Resident 82 had impairments in BLE ROM and did not have any strength in BLE. The PT Eval indicated no skilled services recommended at this time, resident will be provided with both knee splints and left ankle splints and will be recommended to participate with exercise program under licensed nurses. The PT Eval indicated splint recommendation for both knees and left ankle for three to four hours. During a review of Resident 82's PT Treatment Encounter Note (PT TEN) dated 9/20/2024, the PT TEN indicated stretching was provided to both knees and both ankles with PROM to improve mobility. The PT TEN indicated no skilled services recommended at this time, resident tolerated wearing both knee and left ankle splints for three hours. During a review of Resident 82's Occupational Therapy Evaluation (OT Eval) dated 9/20/2024, the OT Eval indicated Resident 82 was referred to skilled OT services for contracture management. The OT Eval indicated the reason for skilled services was to provide left elbow splint and left hand splint to prevent further contractures and to establish restorative nursing program for PROM exercises and splint application. The OT Eval indicated Resident 82 was at risk for further contractures and skin breakdown. The OT Eval indicated Resident 82 had impairments in ROM at left shoulder, elbow, wrist, and hand and did not have any strength in UE. During a review of Resident 82's OT Treatment Encounter Note (OT TEN) dated 9/20/2024, the OT TEN indicated Resident 82 tolerated left elbow and left hand splint for four hours, discharge resident at this time and licensed nurses will continue to apply the splints and provide PROM exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 6/18/2025 at 10:56 a.m., the Occupational Therapist (OT 1) stated OTs assessed ROM and determined if a resident would benefit from a splint to manage contractures and prevent ROM from getting worse. OT 1 stated therapy needed to address ROM and contractures, because over time worsening ROM could cause more positioning issues and cause skin integrity problems. OT 1 stated if OT determined a resident required a splint, OT would provide OT treatment to monitor the splint for resident discomfort and skin integrity. OT 1 stated providing a new splint would require a series of treatment sessions to slowly increase the resident's tolerance to wearing a splint to about four to six hours maximum. OT 1 stated this process would take about two to three weeks or more depending on if it was complicated such as a resident having a lot of splints like an elbow splint, hand splint, knee splint, and ankle splint. OT 1 stated it would take extra time to determine a resident's comfort and tolerance to all these new splints. OT 1 stated initially an OT would put on a splint for 30 minutes to one hour and check for any redness and slowly increase another hour and assess for redness and discomfort over multiple sessions. OT 1 stated the purpose of these treatments over multiple sessions was to determine the safety and use of the splints, because an OT would need to adjust and assess to make sure the splint was working and to prevent further decline. OT 1 stated this assessment and treatments were critical, because a splint needed to be adjusted accordingly. During an interview and record review on 6/18/2025 at 11:17 a.m., the Director of Rehabilitation (DOR) stated it was important for therapy to assess and monitor a resident's ROM and to determine if therapy intervention was needed for a resident. DOR stated splints were to prevent worsening of contractures and therapy was the department that determined if a splint was appropriate for a resident. DOR stated therapists would recommend the type of splint, try the splint on the resident as part of the treatment and assess how long a resident could tolerate the splint. DOR stated a splint could cause irritation to the skin and injury to the extremity if the splint was not assessed correctly or fit properly. In the same interview and record review, the DOR reviewed Resident 82's medical records and therapy records and stated Resident 82 was newly admitted to the facility on [DATE] and had orders for PT and OT evaluations. DOR stated PT and OT recommended splints for Resident 82 and provided one PT and OT treatment session and discharged Resident 82 to a nursing maintenance program. DOR stated PT and OT completed an evaluation and one treatment session on 9/20/2024 to assess and fit Resident 82 for five splints in total, a left elbow splint, left hand splint, left and right knee splints, and a left ankle splint. DOR stated during the PT and OT treatment session on 9/20/2024 both PT and OT put on a new left elbow, left hand, left and right knee, and left ankle splints on Resident 82 for three to four hours. DOR stated Resident 82 received only one treatment session to assess and monitor splints because of the resident's insurance. DOR stated Resident 82 was at high risk to develop complications from wearing multiple splints and stated five splints was a lot and Resident 82 required more therapy treatment sessions to monitor Resident 82's tolerance of five new splints. DOR stated generally, PT would not put on a splint for more than two hours the first time wearing a splint, because a therapist needed to monitor and assess if a resident could safely tolerate wearing the splints for a shorter period before increasing the wearing time of splints to three or four hours. DOR stated Resident 82 did require more therapy treatment sessions to assess the fit and safety of the splint before transitioning to nursing because therapy staff had the expertise to determine the safety of a splint and not the nursing staff. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/18/2025 at 2:17 p.m., the Director of Nursing (DON) stated if Resident 82 needed more therapy regardless of insurance and payer source, the facility needed to provide therapy. DON stated any resident under the facility's care, the facility was responsible to provide any service and care that was needed to properly care for the resident. 2. During an interview on 6/17/2025 at 3:48 p.m., the Licensed Vocational Nurse (LVN 2) stated the charge nurse (LVN) assigned to Resident 82 completed the PROM exercises and put on the splints every day. LVN 2 stated he completed the ROM exercises with Resident 82 today and put on the left elbow splint and both knee splints up to three to four hours a day. LVN 2 stated Resident 82 had orders to put on left elbow splint and both knee splints only. LVN 2 stated Resident 82 did not have any orders to put a left hand splint and LVN 2 had not put any left hand splints on Resident 82. During a concurrent observation and interview on 6/18/2025 at 12:30 p.m., Licensed Vocational Nurse (LVN 3) completed PROM exercises to Resident 82 on the left upper extremity and both lower extremities. After PROM exercises, LVN 3 put on the right knee splint and requested assistance from Registered Nurse Supervisor (RN 3) to assist with putting on the left knee splint. RN 3 reminded LVN 3 to put on the left elbow splint. LVN 3 proceeded to retrieve an elbow splint in the closet and put the left elbow splint on Resident 82. RN 3 reminded LVN 3 to put on the left hand splint. LVN 3 stated the left hand splint was still missing and stated she could not put on the left hand splint. During an interview on 6/18/2025 at 1:11 p.m., LVN 3 stated she had not put on the left hand splint on Resident 82 for at least two weeks but could not remember exactly how long Resident 82 did not put on the left hand splint. LVN 3 stated if the left hand splint or any splint was not put on, then it should be documented in Resident 82's medical records. During an interview and record review on 6/18/2025 at 1:18 p.m., RN 3 stated Resident 82 had an order dated 3/7/2025 for licensed nurse to provide left elbow, left hand and bilateral knee splints for three to four hours seven times a week as tolerated, and an order dated 3/7/2025 for licensed nurse to provide PROM exercises to LUE and BLE times a week as tolerated. RN 3 stated nursing staff should put on the left hand splint every day and stated she was not aware of any nurses reporting to her that Resident 82 did not put on the left hand splint for any reason, including the left hand splint missing. RN 3 reviewed Resident 82's medical records including progress notes, RNA weekly summary, nursing notes and stated nursing staff did not document Resident 82 did not wear the left hand splint since the order was written on 3/7/2025. RN 3 stated licensed nursing staff should put on the left hand splint every day, because Resident 82 could get more contracted, and it could be harder to put on the splints later. RN 3 stated if Resident 82 was more contracted, it would be impossible to do anything with Resident 82 because moving Resident 82 would cause more pain, it could cause more pressure between the skin and put Resident 82 at risk for yeast infection and the skin would be harder to clean. During an interview on 6/18/2025 at 2:17 p.m., the DON stated if there was an order to put a left hand splint, then this was the intervention to help Resident 82 prevent further contractures and the order must be completed as ordered. DON stated if the licensed nurses could not put on the splint that day for any reason, staff should document and report this and notify the family and the physician and depending on the reason for not putting on the splint, the physician could indicate to just monitor or it could indicate that Resident 82 needed therapy to intervene or to check the resident. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policies and procedures (P&P) approved 1/8/2025 titled, Joint Mobility Range of Motion, the P&P indicated the facility will maintain or increase the motion of a joint, prevent contractures or reduce current contractures. During a review of the facility's P&P approved 1/8/2025 titled, Specialized Rehabilitative Services, the P&P indicated the facility arranges for the provision of specialized rehabilitative services to all residents that require these services for the appropriate length of time as assessed .Restorative services are not considered Specialized Rehabilitative Services. During a review of the facility's P&P approved 1/8/2025 titled, Splinting, the P&P indicated apply and remove the splint as ordered by the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: a. Ensure that a licensed nurse did not leave 11 medications at a resident`s bedside who was assessed as not safe to self-administer oral medications for one of two residents (Resident 11). This deficient practice had the potential for the resident to choke on the medications upon oral ingestion while unsupervised. b. Provide bed rail padding for a resident with a history of epileptic seizures (a sudden surge of abnormal electrical activity in the brain, leading to a range of symptoms like muscle spasms, loss of consciousness) as ordered by the physician for one of one resident (Resident 54). This deficient practice placed Resident 54 at an increased risk for injuries. c. Provide a resident, who is at high risk for falls, with landing mats (cushioned mats placed on the floor, typically beside a bed or chair, to mitigate injury if a patient falls) as ordered by the physician for one (Resident 107) out of four sampled residents investigated under the care area of accidents. This deficient practice had the potential to place the resident at increased risk of falls with a subsequent injury. Findings: 1. During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 1/24/2005 with diagnoses including hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and glaucoma (a group of eye conditions that can cause blindness). During a review of Resident 11`s Minimum Data Set (a resident assessment tool), dated 4/25/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired. The MDS also indicated that the resident required assistance from staff with performing activities of daily living (ADLs - activities related to personal care). During a review of Resident 11`s physician orders, the physician orders indicated the following orders: - Aricept tablet (used to treat dementia [decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities]) 10 milligrams (mg, unit of measurement), give one tablet by mouth one time a day for dementia, dated 7/17/2021. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Celexa tablet (used to treat depression [mood disorder that causes a persistent feeling of sadness and loss of interest]) 20 mg, give one tablet by mouth one time a day for depression, dated 12/12/2021. - Cetirizine oral (used to treat allergy symptoms) tablet 5 mg, give one tablet by mouth one time a day for allergic rhinitis (group of symptoms affecting the nose), dated 7/19/2023. - Cranberry tablet 450 mg, give one tablet by mouth one time a day for supplement, dated 5/19/2022. - Docusate sodium capsule (stool softener) 250 mg, give one capsule by mouth two times a day for constipation hold for loose stools, dated 5/4/2020. - Hiprex tablet (used to prevent recurrent urinary tract infections [an infection in any part of the urinary system]) one (1) mg, give one tablet by mouth two times a day for urinary tract infection prophylaxis (attempt to prevent a disease), dated 7/9/2024. - Lactase enzyme tablet 9000 unit (unit of measurement), give three tablets by mouth one time a day for lactose intolerance (a common digestive issue where the body has trouble breaking down lactose, a sugar found in milk and dairy products), dated 9/10/2017. - Lactobacillus oral capsule (probiotic [live bacteria and yeasts that have beneficial effects on your body]), give one capsule by mouth two times a day for gastrointestinal prophylaxis, dated 10/25/2023. - Magnesium tablet (supplement) 400 mg, give one tablet by mouth one time a day for supplement, dated 6/28/2018. - Multivitamins with minerals give one tablet by mouth one time a day for supplement give with apple sauce, dated 10/28/2017. - Norvasc (used to treat high blood pressure) tablet 5 mg, give 1.5 tablet by mouth one time a day for hypertension, dated 12/29/2021. - Oscal 500/200 D-3 tablet (used to prevent or treat low blood calcium levels) 500-200 mg-unit, give one tablet three times a day for supplement, give with apple sauce, dated 11/10/2017. - Potassium chloride extended release (ER) tablet 20 milliequivalent (mEq, unit of measurement) give one tablet by mouth one time a day for supplement, give with full glass of water/juice, dated 10/11/2016. During a concurrent observation and interview on 6/17/2025 at 10:42 a.m., observed Resident 11 in an upright position with the overbed table across her with a spread-out napkin containing 11 medications and a cup with apple sauce. Resident 11 stated that these are her morning medications and the cup with apple sauce contains three medications that were crushed and mixed with the apple sauce. Resident 11 identified all the eleven medications which included the Norvasc 1.5 tabs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/17/2025 at 10:42 a.m., in Resident 11's room with the Director of Nursing (DON), observed Resident 11's 11 medications and a cup of apple sauce at Resident 11`s overbed table. The DON stated she will make sure Resident 11 will take all her medications and is not aware if Resident 11 had been assessed for medication self-administration. Upon exiting the room, the DON and this writer approached Licensed Vocational Nurse 5 (LVN 5) and inquired why the medications were left at the bedside. LVN 5 stated she got distracted when a staff told her that another resident was asking for pain medication. LVN 5 verified when shown a photo of the medications with a time stamped of 6/17/25 at 10:42 a.m. and stated that she indeed left the medication and did not witness the resident ingesting the medications. During a concurrent interview and record review on 6/19/2025 at 10:45 a.m., with the Assistant Director of Nursing, reviewed Resident 11`s medication self-administration assessment (MSA-A) dated 3/28/2025. The ADON stated that Resident 11's MSA-A only was assessed as safe with self-administering only inhalers and eyedrops. The ADON stated that since the resident is not safe to administer oral medications, the nurses should not leave the medication at bedside for safety reasons. The ADON stated Resident 11 may miss taking some of the medications and if medications are left with the resident without supervision, Resident 11 can potentially choke while ingesting the medications. During a concurrent interview and record review on 6/19/2025 at 12:56 p.m., with Licensed Vocational Nurse 5 (LVN5), reviewed Resident 11`s 9:00 a.m. medications. LVN 5 stated that one of the eleven medications that were scheduled for 9:00 a.m. was Norvasc. LVN 5 was shown a photo of the 11 medications taken on 6/17/2025 at 10:42 a.m. and pointed out that the one and a half tablet of Norvasc is among those medications in the photo. LVN 5 stated that medications should be administered within 60 minutes of the scheduled administration time which the latest administration time should have been 10 a.m. LVN 5 stated that the if a blood pressure (BP) medication is not administered on time, it could result in the resident`s BP going high which could result in a cerebrovascular accident (CVA -when blood flow to and/or in the brain is disrupted, damaging the effected part of the brain without the blood flow). LVN 5 stated that before she left Resident 11`s room, Resident 11 had taken some of the medications and when LVN 5 left, the medications placed on the napkins were the remaining medications that were ordered. LVN 5 stated LVN 5 should not have left the medication at the bedside because it is unsafe and the resident could potentially choked on the medication which could lead to aspiration. During a review of the facility`s policy and procedure titled, Medication Administration-General Guidelines, last reviewed on 1/8/2025, the policy indicated, Medications are administered within 60 minutes of scheduled time .the resident is always observed after administration to ensure that the dose was completely ingested . During a review of the facility`s policy and procedures titled, Resident Self Administer Medications, last reviewed on 1/8/2025, the policy indicated, A resident may only self-administer medications after the IDT has determined which medications may be self-administered . c. During a review of Resident 107's admission Record, the admission Record indicated the facility admitted the resident on 5/9/2025 with diagnoses including anoxic brain damage (occurs when the brain is completely deprived of oxygen) and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 107's History and Physical (H&P - a comprehensive assessment of a patient's health status, combining a patient's reported medical history with a physical examination conducted by a healthcare professional), dated 5/10/25, the H&P indicated that the resident did not have the capacity to make decisions. During a review of Resident 107's Minimum Data Set (MDS - a resident assessment tool), dated 5/16/25, the MDS indicated that the resident had severely impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). On 6/18/2025 at 9:08 a.m., during a concurrent interview and record review, reviewed Resident 107's Fall Risk Evaluation, dated 5/9/2025, with Registered Nurse 2 (RN 2). RN 2 stated that the resident was assessed as being at high risk for falls due to the resident's diagnosis of seizures. Reviewed the resident's physician's orders with RN 2. RN 2 stated the resident had an order for low bed with landing mats for safety, ordered on 5/9/2025. Reviewed the resident's care plans (a document that outlines the specific healthcare needs and treatment plan for an individual receiving care) with RN 2. RN 2 stated the resident had a care plan for bilateral landing mats, initiated on 5/9/2025. On 6/18/2025 at 9:13 a.m., during a concurrent observation and interview, observed Resident 107 in the presence of RN 2. RN 2 stated that the resident did not currently have any landing mats at the bedside. On 6/18/2025 at 2:41 p.m., during an interview with the Director of Nursing (DON), the DON stated it was important to follow the physician's orders for use of landing mats for a resident assessed as being at high risk for falls to prevent injuries in case a fall could not be prevented. The DON stated that injuries could be prevented or lessened with the use of landing mats. The DON stated that, without landing mats in place, the resident could potentially sustain an injury from a fall. During a review of the facility's policy and procedure titled, Fall Management Program, last reviewed and revised on 1/8/2025, the policy and procedure indicated that the facility strived to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls and to provide an environment which remains as free from accident hazards as possible. b. During a review of Resident 54's admission Record, the admission Record indicated the facility originally admitted Resident 54 on 5/27/2021 and re-admitted on [DATE] with diagnoses including epileptic seizures, aphasia (a disorder that makes it difficult to speak), and acute respiratory failure (a sudden, serious condition that makes it difficult to breathe on your own) with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues). During a review of Resident 54's History and Physical (H&P), dated 5/12/2025, the H&P indicated Resident 54's assessment plan included to continue seizure regimen seizure (a prescribed course of medical treatment). During a review of Resident 54's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/21/2025, the MDS indicated Resident 54 was sometimes able to understand others and make himself understood. The MDS further indicated Resident 54 was dependent on facility staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and any mobility such as rolling from side to side. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 54's Physician's Order, the Physician's Order indicated the following orders: -6/19/2025 - Apply padded siderails for seizure precautions. -5/12/2025 - Padded side rails for seizure precautions every shift. During an observation on 6/19/2025 at 1:26 pm in Resident 54's room, Resident 54 was up in bed watching television. The bed rails on Resident 54's bed was made of metal and were not padded. During a concurrent observation and interview on 6/19/2025 at 1:33 pm in Resident 54's room with the Assistant Director of Nursing (ADON), the ADON stated Resident 54's bed did not have the necessary padding on his bedrails to keep him safe during a seizure. The ADON further stated the facility did not follow doctor's instructions to apply padding to Resident 54's side rails and without them Resident 54 could sustain injuries if he had another seizure. During a review of the facility provided Policy and Procedure (P&P) titled, Care of Resident Having Seizure last reviewed on 1/8/2025, the P&P indicated during preparation for managing resident with seizure history may have padded side rails for protection. During a review of the facility provided P&P titled, Free of Accident Hazards/Supervision/Devices, last reviewed on 1/8/2025, the P&P indicates a guideline for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess and document the location and characteristic of a resident's pain prior to pain medication administration for one of one sampled resident (Resident 110) investigated under the pain care area. This deficient practice had the potential for inadequate management of Resident 110's pain resulting in decreased quality of life. Findings: During a review of Resident 110's admission Record, the admission Record indicated the facility originally admitted the resident on 11/26/2024 and readmitted on [DATE] with diagnoses including aftercare following a joint replacement surgery, intracerebral hemorrhage (bleeding into the brain tissue), and right knee osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 110's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 5/5/2025, the MDS indicated the resident was cognitively intact (can think, learn, and remember clearly) and required supervision or touching assistance from staff for most activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview on 6/17/2025 at 3:59 p.m. with Resident 110, Resident 110 stated he had pain in his mouth due to accidentally biting his tongue and mouth tissue repeatedly over the last several months due to his broken teeth, and in his right knee related to arthritis (inflammation of one or more joints, causing pain, swelling, stiffness, and reduced range of motion) and a recent knee replacement surgery. During a review of Resident 110's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated March 2025, the MAR indicated an order to give one 5 milligram (a medication used for moderate to severe pain) tablet of oxycodone ever six hours as needed for pain. The MAR indicated Licensed Vocational Nurse 4 (LVN 4) administered oxycodone 5 mg to Resident 110 for a 6/10 pain level (0=no pain, 10=worst possible pain) on 3/7/2025 at 9:20 a.m. and it was effective. During a concurrent interview and record review on 6/19/2025 at 1:08 p.m. with LVN 4, Resident 110's Progress Notes dated 3/7/2025 indicated oxycodone was administered at 9:20 a.m. to Resident 110 with no additional notes regarding the pain assessment. LVN 4 stated prior to administering pain medication, she should assess the resident's pain including the site and type of pain they are having but that she does not always do this. LVN 4 indicated this assessment has to be documented in a progress note. LVN 4 stated she did not assess Resident 110's pain location or quality of pain before administering oxycodone to him on 3/7/2025 at 9:20 a.m. LVN 4 stated this assessment should be done to make sure the pain medication is effective. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/2025 at 4:05 p.m. with the Director of Nursing, the Director of Nursing stated prior to administering a pain medication, nurses should assess the resident's pain including pain characteristics, location, intensity, and have them rate their level of pain on a pain scale (a tool that helps measure pain intensity and other features) if they are able. The DON stated this assessment is done to make sure they treat the resident's pain effectively. During a review of the facility's policy and procedure (P&P) titled Pain Assessment and Management, reviewed 1/8/2025, the P&P indicated the facility provides pain management to residents who require it consistent with professional standards of practice. The P&P indicated residents are assessed for pain whenever new or worsening pain is suspected. The P&P indicated verbal descriptions of pain can help a practitioner identify the source, nature, and other characteristics of the pain.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse 8 (LVN 8) possessed the necessary knowledge and skills to properly assess and evaluate one of one sampled resident (Resident 630's) food allergy (when your body's immune system mistakenly identifies a food as harmful and triggers a reaction). This deficient practice placed Resident 630 at risk of being exposed to an allergen (substance that can cause an allergic reaction), which could have led to a serious allergic reaction (a condition that causes illness when someone eats certain foods or touches or breathes in certain substances). Findings: During a review of Resident 630's admission Record, the admission Record indicated the facility admitted Resident 630 on 6/6/2025 with diagnoses that included multiple sclerosis (a disease that causes breakdown of the protective covering of nerves in the brain and spinal cord), essential hypertension (high blood pressure), and diabetes mellitus (DM, a disease of inadequate control of blood sugar levels). During a review of the Allergy Report dated 6/17/2025, the Allergy Report did not indicate that Resident 630 had food allergies. During a review of the Diet Type Report dated 6/17/2025, the Diet Type Report indicated Resident 630 had no known food allergies. During a review of Resident 630's Care Plan related to Nutrition, dated 6/6/2025, the Care Plan indicated Resident 630 was on a no added salt (NAS, no salt packet on the tray) regular diet but there was no food allergy indicated. During an interview on 6/16/2025 at 12:58 p.m., with Resident 630, inside Resident 630's room, Resident 630 stated he was allergic to pepper, but they still give him peppers. Resident 630 stated he is allergic to all peppers except black peppers from the shaker, but his meal ticket indicated he is only allergic to bell peppers. During a concurrent interview and record review on 6/16/2025 at 1:43 p.m., with the Dietary Supervisor (DS), Resident 630's medical record related to nutrition, diet and allergies were reviewed. The DS stated she interviewed Resident 630 yesterday (6/15/2025). The DS stated Resident 630 informed her that he (Resident 630) was allergic to all kinds of pepper except black pepper. The DS stated that she (DS) entered bell pepper in the menu system because they only serve that kind of pepper in the menu. The DS stated pepper allergy for Resident 630 was not entered in the allergy section of the medical record. The DS stated the nurses were aware of entering peppers in the electronic medical records (EMR) as she did not have any capacity of entering the allergy in the EMR. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/2025 at 3:40 p.m., with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated Resident 630 told him that he was allergic to peppers, and he was served food containing with bell peppers on his breakfast tray on 6/15/2025. LVN 8 stated Resident 630 got scrambled eggs with finely chopped bell peppers. LVN 8 stated he notified the Registered Dietitian (RD) and the DS, but he (LVN 8) did not enter the food allergies in the chart as he (LVN 8) thought Resident 630 was joking with him. LVN 8 further stated he did not follow up and did not endorse it to other health care team members. LVN 8 stated they only based allergies on the history and physical records for Resident 630. LVN 8 stated, they assumed that Resident 630 has no known food allergy because the H&P indicated that. LVN 8 stated he should have contacted Resident 630's physician so they could check the labs to confirm the food allergy. LVN 8 stated it was important to communicate and notify Resident 630's food allergies because they would not know what kind of allergic reaction Resident 630 would have. LVN 8 stated the DS told him that Resident 630 is allergic to peppers and heard that DS entered it in the system, but he was not sure. LVN 8 stated he should have notified the physician, updated the Medication Administration Record (MAR - a report detailing the medications and treatments administered to a resident by a healthcare professional), and Resident 630's medical records. LVN 8 stated that medication that would interact with Resident 630's food allergies should have been on hold. LVN 8 stated he should have notified the kitchen staff and should have endorsed to the nursing staff Resident 630's food allergies. LVN 8 stated they did not have any specific training about food allergies, but they had training for the medical records data entry. During an interview on 6/17/2025 at 4:10 p.m., with the Director of Staff Development (DSD), the DSD stated that the facility does not provide specific training on food allergies; however, staff received training on how to enter food allergies and medications into the medical record system. During an interview on 6/18/2025 at 3:40 p.m. with the Director of Nursing (DON), the DON stated the process of handling food allergies was to ask the resident what food allergies they have, notify the resident's physician, update the medical record, MAR and face sheets (admission records), notify the kitchen, update the care plan and communicate to staff. The DON stated it was important to know resident's food allergies to prevent giving food the residents are allergic to. The DON stated if residents eat the food that they are allergic to, they might have allergic reactions like hives (a skin reaction that causes itchy welts [raised red or pink bumps]), rash (an area of skin that has a noticeable change in color, texture, or appearance, often accompanied by irritation, swelling, or itching), respiratory issues such as shortness of breath that could lead to complications. The DON stated the facility staff have to document the allergy the same day they were made aware of as it could affect resident's care and quality of life. The DON stated LVN 8 should have obtained more detailed information to verify the accuracy of Resident 630's reported food allergy and to prevent Resident 630 from being served an allergen. During a review of the facility's Policies and Procedures (P&P) titled Food and Drink- Allergies and Preferences dated 1/8/2025, the P&P indicated Each resident shall receive food that accommodates residents' allergies, intolerances, and preferences. Guidelines: (1) The interdisciplinary team is aware of each resident's allergies, intolerances, and preferences, and provide appropriate alternatives. (4) Ask residents how the food meets their preferences, allergies and/or intolerances. (6) Resident's allergies, intolerances, preferences, or need for a therapeutic diet are comprehensively assessed and documented in the resident medical record. (7) The interdisciplinary team develop and revises each resident's comprehensive care plan including but not limited to the resident's food allergies, intolerances, preferences, or need for a therapeutic diet. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's training records titled Active Assignment for LVN 8 dated 2/2024 to 12/2024, the training records did not indicate allergy trainings. During a review of facility's job description (JD) titled Licensed Vocational Nurse (LVN) dated and signed by LVN 8 on 10/18/2023, the JD indicated, The Licensed Vocational Nurse (LVN) is responsible for managing resident's care plans and supervising resident care activities. Both care management and supervisory responsibilities must be executed in accordance with state and federal regulations and facility policies and procedures. Notify attending physician, family, and members of interdisciplinary team when resident is involved in an accident and/or accident or if here is a change in condition.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to: 1. Account for two (2) doses of Controlled Medication (also known as Controlled Drug and Controlled Substance [CM, CD, CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for Resident 13 and 110 in one (1) of four (4) inspected medication carts (Medication Cart 1 Station 3.) 2. Identify and report CM discrepancy for June 2025 in one (1) of four (4) inspected medication carts (Medication Cart 2 Subacute.) 3. Reconcile (the process of comparing transactions and activity to supporting documentation) and account for one (1) medication emergency kit (eKIT) containing CMs for June 2025, in one (1) of two (2) inspected Medication Rooms (Medication Room Station 2.) These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and the risk that residents in the facility could experience adverse drug reactions [unwanted, uncomfortable, or dangerous effects that a medication may have, such as coma (a state of deep unconsciousness) from exposure to harmful medications, and delayed medication treatment from shortage of medication, possibly leading to physical and psychosocial harm, and hospitalization. Findings: During an observation on 6/16/2025 at 11:57 a.m., with Licensed Vocational Nurse 5 (LVN 5), in Medication Cart 1 Station 3, there was a discrepancy in the count between the Drug Control Receipt Record accountability log (an inventory and accountability form for CMs) and the amount of medication remaining in the medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following residents: 1. One (1) dose of oxycodone (a CM used for pain) 5 milligram ([mg] - a unit of measure of mass) immediate release (IR) tablet was missing from the medication bubble pack compared to the count indicated on the Drug Control Receipt Record accountability log for Resident 110. The Drug Control Receipt Record accountability log for oxycodone IR indicated the medication bubble pack should have contained a total of 24 oxycodone IR 5 mg tablets, after the last administration of oxycodone IR 5 mg tablet documented/signed off on 6/16/2025 at 7 a.m., however the medication bubble pack contained 22 oxycodone IR 5 mg tablets and no other documentation of subsequent administrations on the log. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. One (1) dose of oxycodone with acetaminophen (a combination CM used for pain) 10-325 mg tablet was missing from the medication bubble pack compared to the count indicated on the Drug Control Receipt Record accountability log for Resident 13. The Drug Control Receipt Record accountability log for oxycodone with acetaminophen indicated the medication bubble pack should have contained a total of 25 oxycodone with acetaminophen 10-325 mg tablets, after the last administration of oxycodone with acetaminophen 10-325 mg tablet documented/signed-off on 6/16/2025 at 01:30 a.m., however the medication bubble pack contained 24 oxycodone with acetaminophen 10-325 mg tablets and no other documentation of subsequent administrations on the log. During a concurrent interview, LVN 5 stated LVN 5 administered two (2) oxycodone 5 mg tablets to Resident 110 that morning at 11:27 a.m. and one (1) oxycodone with acetaminophen 10-325 mg tablet to Resident 13 that morning at 8 a.m. and forgot to sign the Drug Control Receipt Record accountability logs. LVN 5 stated LVN 5 failed to follow the facility's policy of signing each CM dose on the Drug Control Receipt Record accountability log after preparing the dose for the residents. LVN 5 stated LVN 5 understood it was important to sign each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 5 stated if documentation was not accurate then it can lead to medication error if overdosed (administering more than the prescribed dose) leading to stoppage of breathing, hospitalization and possibly death for Resident 13 and 110. During an observation, on 6/16/2025 at 1:44 p.m., in the presence of LVN 6, there was a discrepancy in the count between the Liquid Controlled Drug Receipt accountability log (inventory and accountability form for CMs) form and the amount of medication remaining in the medication bottle in Medication Cart 2 Subacute for the following resident: 1. 18 milliliters ([ml] - unit of measure of volume) of clobazam (a CM used for seizures [sudden, uncontrolled body movements caused by abnormal electrical activity in the brain leading to loss of muscle control and shaking]) was short in the medication bottle compared to the count indicated on the Liquid Controlled Drug Receipt log for Resident 30. The Liquid Controlled Drug Receipt log indicated the bottle should have contained a total of 48 ml clobazam, after the last administration documented/signed off on 6/16/2025 at 9 a. m., however the bottle contained 30 ml clobazam and contained no other documentation of subsequent administrations on the log. During a concurrent record review on 6/16/2025 at 1:44 p.m., in the presence of LVN 6, in Medication Cart 2 Subacute, the Narcotic (CM) check list log used for CM reconciliation (review of inventory by 2 people to identify discrepancies) indicated no discrepancies were identified in Medication Cart 2 Subacute on 6/16/2025 at 7 a.m. between LVN 6 and an unknown LVN. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 6/16/2025 at 1:44 p.m., LVN 6 stated based on the Liquid Controlled Drug Receipt log he expected the medication bottle to contain 48 ml clobazam for Resident 30, however he confirmed the bottle contained 30 ml clobazam and does not match the amount indicated on the Liquid Controlled Drug Receipt log. LVN 6 stated the last documented administration on the log was on 6/16/2025 at 9 a.m. by LVN 6 and that there were no subsequent administrations documented on the log. LVN 6 stated that the Narcotic check list log indicated no discrepancies were found in Medication Cart 2 Subacute for the CMs reconciled on 6/16/2025 at 7:00 a.m. LVN 6 stated that he initialed the Narcotic check list log on 6/16/25 at 7:00 a.m., and marked the Discrepancy column with a symbol (the number zero with a line across) indicating there was no CM discrepancies identified in Medication Cart 2 Subacute at that time. LVN 6 stated that even though he marked and signed the log indicating no discrepancy, he confirmed the clobazam liquid count for Resident 30 did not match the Liquid Controlled Drug Receipt log count. LVN 6 stated that he failed to accurately verify the clobazam medication bottle count for Resident 30 during the CM reconciliation on 6/16/2025 at 7 a.m. and identify and report the discrepancy to the Director of Nursing (DON). LVN 6 stated that accurate CM reconciliation was important to have the correct amount of medications available and to administer the correct dose to residents, and if not done properly it can lead to delayed medication treatment and possible medication underdose (giving less than the intended dose,) overdose and harm Resident 30 by causing respiratory (relating to the organs involved in breathing) depression (stoppage), shortness of breath, seizure, and possibly death. During an interview on 6/16/2025 at 2:07 p.m., with the DON, the DON stated during CM reconciliations the outgoing and oncoming nursing staff need to reconcile the CMs in the medication carts and sign off on the Narcotic check list log that the count of medications matches the count on the log. The DON stated that this was basic nursing expectation. The DON stated the DON was not aware of any discrepancies for CMs in Medication Cart 2 Subacute for 6/16/2025 at 7 a.m. until now. The DON stated the DON understood the importance of identifying and investigating CM discrepancies immediately, to prevent CM diversions, and harm due to potential error in CM dose, such as overdose resulting in respiratory depression. The DON stated LVN 6 and outgoing LVN (unknown) failed to identify a discrepancy for clobazam for Resident 30 in Medication Cart 2 Subacute and failed to notify her. The DON stated the DON will notify Resident 30's physician and complete a change of condition (COC) report for Resident 30. During an observation on 6/17/2025 at 9:35 a.m., with Registered Nurse 5 (RN 5), in Medication Room Station 2 there was: 1. One (1) medication eKIT stored in the refrigerator and labeled 60, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for June 2025. During a concurrent interview, RN 5 stated that all CMs, including medication eKITs containing CMs should be reconciled at every shift. RN 5 stated eKIT labeled 60 containing CMs in Medication Room Station 2 was not reconciled at every shift in June 2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/17/2025 at 1:28 p.m., with the DON, the DON stated that medication eKITs containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated one (1) eKit labeled 60 containing CMs in Medication Rooms Station 2 did not have accountability and reconciliation log at each shift change for June 2025. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKits containing CMs in all Medication Room Station 2. During the same interview, the DON stated that facility policy was documenting the preparation of CM immediately on the Drug Control Receipt Record accountability log for residents. The DON stated not documenting the Drug Control Receipt Record timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. The DON acknowledged that LVN 5 failed to follow facility policy and process of documenting the accountability log for oxycodone 5 mg dose prepared for Resident 110 and oxycodone with acetaminophen 10-325 mg dose prepared for Resident 13 on 6/16/2025 placing the residents at risk of harm. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including chronic (lasting for a long time) pain. During a review of Resident 13's Order Summary Report (a report listing the physician order for the resident) dated 6/16/2025, the report indicated Resident 13 was prescribed oxycodone with acetaminophen 10-325 mg tablet to give one (1) tablet orally every four (4) times a day for chronic pain, starting 3/28/2025. During a review of Resident 13's Medication Administration Record ([MAR] - a record of mediations administered to residents) for June 2025, the MAR indicated Resident 13 was prescribed oxycodone with acetaminophen 10-325 mg tablet to give one (1) tablet orally every four (4) times a day for chronic pain, at 2 a.m., 8 a.m., 2 p.m. and 8 p.m., and Resident 13 was administered oxycodone with acetaminophen 10-325 mg on 6/16/2025 at 8 a.m. During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including seizures. During a review of Resident 30's Order Summary Report dated 6/16/2025, the report indicated Resident 30 was prescribed clobazam 2.5 mg per ml to give four (4) ml via gastrostomy tube ([G-tube] - a tube inserted through the belly that brings nutrition directly to the stomach) two (2) times a day for seizure, starting 4/22/2025. During a review of Resident 30's MAR for June 2025, the MAR indicated Resident 30 was prescribed clobazam 2.5 mg per ml to give four (4) ml via G-tube two (2) times a day for seizure, at 9 a.m. and 5 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 110's admission Record dated 6/16/2025 the admission Record indicated Resident 110 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including fracture (breakage) of left ilium (a bone in the upper part of the hip,) osteoarthritis (a condition where the cushion between joints breaks down over time, causing pain, stiffness, and reduced movement) of right knee, and aftercare for joint (the part where two or more bones meet) replacement surgery. During a review of Resident 110's Order Summary Report dated 6/16/2025, the report indicated Resident 110 was prescribed oxycodone 5 mg tablet to give two (2) tablets orally every four (4) hours as needed for severe pain, starting 6/12/2025. During a review of Resident 110's MAR for June 2025, the MAR indicated Resident 110 was prescribed oxycodone 5 mg tablet to give two (2) tablets orally every four (4) hours as needed for severe pain, and Resident 110 was administered oxycodone 5 mg on 6/17/2025 at 11:27 a.m. During a review of the facility's Policy and Procedures (P&P) titled, Safeguarding Controlled Substances, last reviewed 1/8/2025, the P&P indicated: The facility has established guidelines for safe handling receiving, storing, administering, reconciling, and safeguarding controlled substances. Purpose: To minimize the time between identification and actual loss or diversion of medications or suspected controlled substance diversion involving any employee, determination of the extent of loss or diversion and to safeguard patients and their property. Definitions: Controlled Medications are substances that have an accepted medical use (medications which fall under US Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. Administration of Controlled Substances The Licensed Nurse will enter the following information immediately upon removing dose(s) from the controlled storage on the resident's individual controlled substance accountability reconciliation log. a. Date of medication removal. b. Time of medication removal. c. Amount of medication removed. d. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Amount of medication remaining. e. Signature of nurse removing the medication. Discontinued/Unused Controlled Substances 13. Controlled substances will be counted at the onset and completion of each shift by two nurses and verified accurately through each nurses' signature on the reconciliation log. Controlled Drug Count/Change of Shift Reconciliation 1. Each individual controlled substance must be counted when there is a change in shift nurse. 2. The on-coming licensed nurse will view and verify each medication supply and amount[s] remaining, while the off-going nurse calls out the resident name, medication, and amounts remaining on controlled logs. 3. The count should be completed in a diligent manner and the oncoming nurse should examine tablets and medications carefully during the count. 4. Narcotic e-kits should be checked & verified as present/sealed or reconciled as indicated. 5. Both on-coming, and off-going licensed nurses will sign the controlled drug count verification form when deemed accurate. Following this procedure and confirmation of controlled substance accuracy, the on-coming nurse may take accountability of the medication cart and keys.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to: 1. Ensure a resident was free from significant medication error by failing to administer antihypertensive medication (used to treat high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) timely for one of one resident (Resident 11) investigated under medication administration. This deficient practice had the potential to cause complications such as high blood pressure that could require hospitalization. 2. Ensure licensed nurses administered and/or held midodrine (medication used to treat low blood pressure [BP]) in accordance with the physician's prescribed parameters for one of two sampled residents (Resident 97) investigated under the care area of significant medications. This deficient practice had the potential for placing the resident at increased risk of experiencing adverse side effects. 3. Ensure residents were free of any significant medication errors by failing to not administer 31 doses of expired insulin (a medication used to control high blood sugar levels) Humulin N (an intermediate acting insulin) Kwikpen (an injection device containing insulin) by seven (7) different licensed nursing staff to Resident 101 in one (1) of four (4) inspected medication carts (Medication Cart 1 Subacute). Resident 101 received a total of 31 doses of expired insulin from 6/1/2025 to 6/16/2025, not in accordance with manufacturer guidelines, standards of practice and facility policy and procedures. These deficient practices had the potential to cause Resident 101 to experience adverse effects (unwanted, unintended results) and serious health complications due to improper management of blood sugar, resulting in a possible coma (a state of deep unconsciousness caused by injury or illness,) hospitalization and/or death. Findings: 1. During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 1/24/2005 with diagnoses including hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and glaucoma (a group of eye conditions that can cause blindness). During a review of Resident 11`s Minimum Data Set (a resident assessment tool), dated 4/25/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired. The MDS also indicated that the resident required assistance from staff with performing activities of daily living (ADLs - activities related to personal care). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11`s physician`s orders, the physician's order included an order for Norvasc (used to treat high blood pressure) tablet five (5) milligrams (mg- unit of measurement), give 1.5 tablet by mouth one time a day for hypertension, dated 12/29/2021. During a concurrent observation and interview on 6/17/2025 at 10:42 a.m., observed Resident 11 in an upright position with the overbed table across her with a spread-out napkin containing 11 medications and a cup with apple sauce. Resident 11 stated that these are her morning medications and the cup with apple sauce contains three medications that were crushed and mixed with the apple sauce. Resident 11 identified all the eleven medications which included the Norvasc 1.5 tabs. During a concurrent observation and interview on 6/17/2025 at 10:42 a.m., in Resident 11's room with the Director of Nursing (DON), observed Resident 11's 11 medications and a cup of apple sauce at Resident 11`s overbed table. The DON stated she will make sure Resident 11 will take all her medications and is not aware if Resident 11 had been assessed for medication self-administration. Upon exiting the room, the DON and this writer approached Licensed Vocational Nurse 5 (LVN 5) and inquired why the medications were left at the bedside. LVN 5 stated she got distracted when a staff told her that another resident was asking for pain medication. LVN 5 verified when shown a photo of the medications with a time stamped of 6/17/25 at 10:42 a.m. and stated that she indeed left the medication and did not witness the resident ingesting the medications. During a review of the facility`s Medication Administration Schedule, it indicated that for an order of once a day, the administration time is at 9:00 a.m.  During a concurrent interview and record review on 6/19/2025 at 10:45 a.m., with the Assistant Director of Nursing, reviewed Resident 11`s medication self-administration assessment (MSA-A) dated 3/28/2025. The ADON stated that Resident 11's MSA-A only was assessed as safe with self-administering only inhalers and eyedrops. The ADON stated that since the resident is not safe to administer oral medications, the nurses should not leave the medication at bedside for safety reasons. During a concurrent interview and record review on 6/19/2025 at 12:56 p.m., with Licensed Vocational Nurse 5 (LVN5), reviewed Resident 11`s 9:00 a.m. medications. LVN 5 stated that one of the eleven medications that were scheduled for 9:00 a.m. was Norvasc. LVN 5 was shown a photo of the 11 medications taken on 6/17/2025 at 10:42 a.m. and pointed out that the one and a half tablet of Norvasc is among those medications in the photo. LVN 5 stated that medications should be administered within 60 minutes of the scheduled administration time which the latest administration time should have been 10 a.m. LVN 5 stated that the if a blood pressure (BP) medication is not administered on time, it could result in the resident`s BP going high which could result in a cerebrovascular accident (CVA -when blood flow to and/or in the brain is disrupted, damaging the effected part of the brain without the blood flow). During a review of the facility's policy and procedure titled, Medication Administration-General Guidelines, last reviewed on 1/8/2025, the policy indicated, Medications are administered within 60 minutes of scheduled time .the resident is always observed after administration to ensure that the dose was completely ingested . 2. During a review of Resident 97's admission Record, the admission Record indicated the facility originally admitted the resident on 7/18/2024 and readmitted the resident on 8/27/2024 with diagnoses including hypotension (low blood pressure). (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 97's History and Physical (H&P - a comprehensive assessment of a patient's health status, combining a patient's reported medical history with a physical examination conducted by a healthcare professional), dated 4/16/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 97's Minimum Data Set (MDS - a resident assessment tool), dated 3/30/2025, the MDS indicated that the resident had moderately impaired cognition (thought processes) and was dependent on staff for all activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). On 6/18/2025 at 8:07 a.m., during a concurrent interview and record review, reviewed Resident 97's physician's orders with Registered Nurse 2 (RN 2). RN 2 stated that the resident had an order for midodrine 10 milligrams (mg - unit of measurement) by mouth (PO) every 8 hours for hypotension and hold if the systolic blood pressure (SBP - the top number in a blood pressure reading, representing the pressure in your arteries when your heart contracts and pumps blood) is greater than 120 millimeters of mercury (mmHg - unit of measurement), ordered on 2/25/2025. Reviewed the resident's 6/2025 Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and midodrine bubble packs (a pre-formed plastic sheet with individual pockets, each designed to hold a single dose of medication) with RN 2. RN 2 confirmed the following: 1. On 6/3/2025 at 6 a.m., the resident's BP was 132/72 mmHg, and the MAR and bubble pack indicated that the medication was given. RN 2 stated the medication should have been held. 2. On 6/4/2025 at 6 a.m., the resident's BP was 110/67 mmHg, and the MAR and bubble pack indicated that the medication was held. RN 2 stated the medication should have been given. 3. On 6/6/2025 at 6 a.m., the resident's BP was 82/57 mmHg. The MAR indicated that the medication was given but review of the bubble pack indicated the medication was not given. RN 2 stated the medication should have been given. 4. On 6/6/2025 at 10 p.m., the resident's BP was 106/64 mmHg. The MAR indicated that the medication was given but review of the bubble pack indicated the medication was not given. RN 2 stated the medication should have been given. 5. On 6/7/2025 at 6 a.m., the resident's BP was 110/70 mmHg. The MAR indicated that the medication was given but review of the bubble pack indicated that the medication was not given. RN 2 stated the medication should have been given. 6. On 6/7/2025 at 10 p.m., the resident's BP was 114/82 mmHg. The MAR indicated that the medication was given but review of the bubble pack indicated that the medication was not given. RN 2 stated the medication should have been given. 7. On 6/9/2025 at 10 p.m., the resident's BP was 112/68 mmHg, and the MAR and bubble pack indicated that the medication was not given. RN 2 stated the medication should have been given. 8. On 6/10/2025 at 6 a.m., the resident's BP was 100/75 mmHg, and the MAR and bubble pack indicated that the medication was not given. RN 2 stated the medication should have been given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 6/14/2025 at 6 a.m., the resident's BP was 124/70 mmHg. The MAR indicated the medication was given but review of the bubble pack indicated the medication was held. RN 2 stated the medication should have been given. 10. On 6/17/2025 at 6 a.m., the resident's BP was 115/70 mmHg. The MAR and bubble pack indicated the medication was held. RN 2 stated the medication should have been given. 11. On 6/18/2025 at 6 a.m., the resident's BP was 112/72 mmHg. The MAR and bubble pack indicated the medication was held. RN 2 stated the medication should have been given. On 6/18/2025 at 2:41 p.m., during an interview, with the Director of Nursing (DON), the DON stated it was important to hold or administer blood pressure medication in accordance with the physician's prescribed parameters to prevent any complications or adverse side effects, such as having the resident's blood pressure go too high or too low. The DON stated that midodrine was used to treat hypotension, so it should be given if the resident's BP is low. The DON stated that, if not given when needed, the resident's blood pressure can drop even further, and they may experience clamminess, lethargy, change in blood pressure, and change in level of consciousness. During a review of the facility's policy and procedure titled, Medication Administration - General Guidelines), last reviewed and revised on 1/8/2025, the policy and procedure indicated that medications are administered as prescribed in accordance with good nursing principles and practices .Medications are administered in accordance with written orders of the prescriber. 3. During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was originally admitted to the facility on [DATE] with diagnosis including Type 2 Diabetes Mellitus 2 ([DM2] - a condition where there is high blood sugar levels.) During a review of Resident 101's Order Summary Report (a report listing the physician order for the resident), dated 6/16/2025, the report indicated Resident 101 was prescribed Humulin N Kwikpen to inject 5 units ([un] - a measure of dosage for insulin) subcutaneous ([SQ] - under the skin) two (2) times a day for DM 2, starting 4/8/2025. During a concurrent observation and interview on 6/16/2025 at 1:08 p.m., with Licensed Vocational Nurse 7 (LVN 7), observed in Medication Cart 1 Subacute, the following medications were found either expired and not discarded, or stored contrary to their respective manufacturer's specifications and facility policies and procedures: 1. One (1) open insulin Humulin N Kwikpen for Resident 101 was found stored at room temperature with a handwritten label indicating that use at room temperature began on 5/15/2025, and to discard on 6/12/2025. According to the manufacturer's product labeling, open Humulin N Kwikpen should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 14 days of opening pen. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 7 stated according to the handwritten date, Resident 101's Humulin N Kwikpen was opened on 5/15/2025 and considered expired on 6/12/2025. LVN 7 stated the pen continued to be stored and used in Medication Cart 1 Subacute for Resident 101. LVN 7 stated expired medications needed to be removed from the cart and placed in the expired medication bin to be disposed of and not accidentally used for residents. LVN 7 stated that expired insulin has lost its potency (strength) and administering expired insulin Humulin N after 6/12/2025 will not be effective in controlling blood sugar levels and can harm Resident 101 by causing hyperglycemia and coma, leading to hospitalization and death. LVN 7 stated the pen needed to be discarded and replace with a new one from pharmacy on 6/12/2025. LVN 7 stated that several licensed nurses administered several doses of expired Humulin N Kwikpen to Resident 101 until 6/16/2025, and this was considered a significant medication error. During a review of Resident 101's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for June 2025, the MAR indicated Resident 101 was prescribed Humulin N Kwikpen 5 unit two (2) times a day for DM 2, at 9 a.m. and 7 p.m., and that Resident 101 received 31 doses of expired insulin Humulin N Kwikpen from the following nurses on the following dates and times: · LVN 7 - 1 dose at 9 a.m. on 6/1/2025, 6/4/2025, 6/8/2025, 6/9/2025, 6/11/2025, 6/15/2025, 6/16/2025 and 1 dose at 5 p.m. on 6/1/2025, 6/4/2025, 6/8/2025, 6/9/2025, 6/11/2025, 6/15/2025, · LVN 2 - 1 dose at 9 a.m. on 6/2/2025 and 1 dose at 5 p.m. on 6/2/2025 · LVN 9 - 1 dose at 9 a.m. on 6/3/2025, 6/7/2025, 6/14/2025, and 1 dose at 5 p.m. on 6/3/2025, 6/7/2025, 6/14/2025 · Registered Nurse 6 (RN 6) - 1 dose at 9 a.m. on 6/5/2025, 6/10/2025 and 1 dose at 5 p.m. on 6/6/2025 · LVN 3 - 1 dose at 9 a.m. on 6/6/2025 and 1 dose at 5 p.m. on 6/6/2025 · RN 3 - 1 dose at 5 p.m. on 6/10/2025 · LVN 10 - 1 dose at 9 a.m. on 6/12/2025, 6/13/2025 and 1 dose at 5 p.m. on 6/12/2025, 6/13/2025 During an interview on 6/17/2025 at 1:28 p.m., with the Director of Nursing (DON), the DON acknowledged several LVN's failed to remove an expired Humulin N Kwikpen from the medication cart leading to the administration of expired insulin to Resident 101 resulting in significant medication error. The DON stated that expired insulins have lost potency and effectiveness and when administered expired insulin will not be effective in controlling blood sugar levels leading to hyperglycemia and adverse effects (unwanted, unintended results) for Resident 101, potentially resulting in coma, hospitalization and/or death. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed 1/8/2025, the P&P indicated, The expiration/beyond use date on the medication label must be checked prior to administering. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication Destruction, last reviewed 1/8/2025, the P&P indicated, Discontinued, expired or outdated medications should be placed in a designated, secure location which, marked to identify the medications, are discontinued indicating they are subject to destruction. During a review of the facility's P&P titled, Medications with Shortened Expiration Dates, last reviewed 1/8/2025, the P&P indicated, Insulin - Discard 28 days after opening except for the following Insulins. The following Insulins shall be discarded after opening as follows: Humulin N KwikPen (14 days.) During a review of the facility-provided document titled, Instructions for Use for Humulin N Kwikpen, last revised June 2022, the document indicated, Store the pen you are currently using at room temperature (up to 86 degrees Fahrenheit [30 degrees Celsius]). Throw away the Humulin N pen you are using after 14 days, even if it still has insulin left in it.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to: 1. Label one Timolol (a brand name medication used to treat glaucoma [a condition of increased pressure in the eyeball]) eye drop bottle for Resident 89, with an open date in accordance with facility requirements and manufacturer's requirements in one (1) of four (4) inspected medication carts (Medication Cart 2 Station 3.) 2. Remove and discard from use one (1) open, expired insulin (medication used to regulate blood sugar levels) Humulin N (an intermediate acting insulin) Kwikpen (an injection device containing insulin) stored at room temperature for Resident 101, in accordance with manufacturer's requirements and facility policy and procedures in one (1) of four (4) inspected medication carts (Medication Cart 1 Subacute.) 3. Label one (1) open insulin Humulin R (short-acting insulin) vial stored at room temperature for Resident 120, in accordance with manufacturer's requirements in one (1) of four (4) inspected medication carts (Medication Cart 1 Station 3.) These deficient practices increased the risk that Residents 89, 101 and 120 could receive medication that had become ineffective or toxic due to inadequate storage and labeling, possibly leading to health complications such as worsening glaucoma, coma (a state of deep unconsciousness caused by injury or illness,) hyperglycemia (high blood sugar levels,) and infections potentially resulting in hospitalization and/or death. Findings: During a concurrent observation and interview on 6/16/2025 at 11:57 a.m., with Licensed Vocational Nurse 5 (LVN 5), in Medication Cart 1 Station 3, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: - One (1) open insulin Humulin R vial for Resident 120 was found stored at room temperature without a date indicating when storage or use at room temperature began. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the manufacturer's product labeling, opened Humulin R vials should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 31 days of opening or once storage at room temperature began. LVN 5 stated the insulin Humulin R multi-dose (containing more than one dose) vial for Resident 120 was open, used, stored at room temperature, and not labeled with a date when use at room temperature began. LVN 5 stated LVN 5 was unaware when the insulin Humulin R vial for Resident 120 was stored at room temperature and unaware when it would expire and needed to be discarded. LVN 5 stated that most insulin vials expire within 28 days of opening the vial, and that the Humulin R vials for Resident 120 needed to be removed from the medication cart to ensure expired insulin was not administered in error to Resident 120. LVN 5 stated administering expired insulin in error will not be effective in keeping the blood sugar stable and can harm Resident 120 by causing high or low blood sugar levels, leading to coma and hospitalization. LVN 5 stated the insulin Humulin R vial needed to be immediately replaced with new ones from pharmacy for Resident 120. During a concurrent observation and interview on 6/16/2025 at 1:08 p.m., with LVN 7, observed in Medication Cart 1 Subacute the following medications were found either expired and not discarded, or stored contrary to their respective manufacturer's specifications and facility policies and procedures: - One (1) open insulin Humulin N Kwikpen for Resident 101 was found stored at room temperature with a handwritten label indicating that use at room temperature began on 5/15/2025, and to discard on 6/12/2025. According to the manufacturer's product labeling, open Humulin N Kwikpen should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 14 days of opening pen. LVN 7 stated according to the handwritten date Resident 101's Humulin N Kwikpen was opened on 5/15/2025 and considered expired on 6/12/2025. LVN 7 stated the pen continued to be stored and used in Medication Cart 1 Subacute for Resident 101. LVN 7 stated expired medications needed to be removed from the cart and placed in the expired medication bin to be disposed of and not accidentally used for residents. LVN 7 stated that expired insulin has lost its potency (strength) and administering expired insulin Humulin N after 6/12/2025 will not be effective in controlling blood sugar levels and can harm Resident 101 by causing hyperglycemia and coma, leading to hospitalization and death. LVN 7 stated the pen needed to be discarded and replace with a new one from pharmacy on 6/12/2025. LVN 7 stated that several licensed nurses administered several doses of expired Humulin N Kwikpen to Resident 101 until 6/16/2025, and this was considered a significant medication error. During a concurrent observation and interview on 6/17/2025 at 12:35 p.m., with LVN 8, observed in Medication Cart 2 Station 3 the following medication was found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, expired and not discarded, or stored and labeled contrary to facility policies: - One open Timolol eye drop bottle for Resident 89 was found stored at room temperature and not labeled with a date on which storage at room temperature began. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the manufacturer's product storage and labeling, opened Timolol bottles may be stored at room temperature between 15 and 30 degrees Celsius for one (1) month. LVN 8 stated that the Timolol eye drop bottle for Resident 89 was not labeled with a date when use at room temperature began. LVN 8 stated eye drop medications were usually good for 28 days after opening the bottle. LVN 8 stated LVN 8 was unable to identify the expiration date without knowing the date when use the bottle was opened, potentially increasing the risk of administering expired Timolol for Resident 89. LVN 8 stated using expired eye drop medication will not be effective in treating Resident 89's glaucoma and potentially cause eye infections since the dropper of the bottle was no longer sterile (free from bacteria) beyond the 28-day expiration date. LVN 8 stated the Timolol bottle for Resident 89 needed to be immediately removed from the medication cart and replaced with a new one from pharmacy. During an interview on 6/17/2025 at 1:28 p.m., with the Director of Nursing (DON), the DON stated that the facility failed to label the Timolol eye drop bottle for Resident 89 with a date indicating when use began. The DON stated that opened multi-dose (containing more than one dose) medications, such as eye drops, should be labeled with a date indicating when use began to know when they should be disposed of, otherwise these medications are considered expired and should be removed from the medication cart. The DON stated this failure can potentially lead to the administration of expired Timolol to Resident 89, which will not be effective in treating the resident's Glaucoma and causing eye infections due to the compromised sterility of the medication. The DON stated insulin Humulin N Kwikpen for Resident 101 expired on 6/12/2025 and insulin Humulin R vial for Resident 120 was not labeled with a date indicating when use began. The DON acknowledged several LVN's failed to remove an expired Humulin N Kwikpen from the medication cart leading to the administration of expired insulin to Resident 101 resulting in significant medication error. The DON acknowledged, in addition, several LVN's failed to label an open vial of Humulin R increasing the potential for administration of expired insulin to Resident 120. The DON stated that expired insulins have lost potency and effectiveness and when administered expired insulin will not be effective in controlling blood sugar levels leading to hyperglycemia and adverse effects (unwanted, unintended results) for Resident 101 and 120, potentially resulting in coma, hospitalization and/or death. During a review of the facility's policy and procedure (P&P) titled, Labeling of Biologicals and Storage of Biologicals, last reviewed 1/8/2025, the P&P indicated, The facility, in coordination with the licensed pharmacist, provides accurate labeling to facilitate precautions and safe administration of medications, and safe and secure storage. Drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. If a multi-dose vial has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. During a review of the facility's P&P titled, Administering Medications, last reviewed 1/8/2025, the P&P indicated, Multi-dose units of medications shall reflect the date the medication was opened on the container. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication Destruction, last reviewed 1/8/2025, the P&P indicated, Discontinued, expired or outdated medications should be placed in a designated, secure location which, marked to identify the medications, are discontinued indicating they are subject to destruction. During a review of the facility's P&P titled, Medications with Shortened Expiration Dates, last reviewed 1/8/2025, the P&P indicated, Insulin - Discard 28 days after opening except for the following Insulins. The following Insulins shall be discarded after opening as follows: Humulin N KwikPen (14 days). During a review of manufacturer's guide Patient Medication Information for Timolol eye drops, dated 1/19/2017, the guide indicated, Store at room temperature (15 degrees Celsius - 30 degrees Celsius). Write the date on the bottle when you open the eye drops and throw out any remaining solution one month after opening the bottle. During a review of the facility-provided Highlights of Prescribing Information for Humulin R, last revised June 2023, the document indicated, When stored at room temperature, Humulin R can only be used for a total of 31 days including both not in-use (unopened) and in-use (opened) storage time. During a review of the facility-provided Instructions for Use for Humulin N Kwikpen, last revised June 2022, the document indicated, Store the pen you are currently using at room temperature (up to 86 degrees Fahrenheit [30 degrees Celsius]). Throw away the Humulin N pen you are using after 14 days, even if it still has insulin left in it.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to ensure a resident obtained needed dental services when one of two residents (Resident 13) did not have their dental services coordinated to provide dental extractions as recommended by the dentist. This deficient practice had the potential for Resident 13 to experience pain, infection, chewing problems, and weight loss. Findings: During a review of Resident 13's admission Record, the admission Record indicated the facility originally admitted the resident on 6/27/2024 and readmitted the resident on 10/9/2024 with diagnoses including but not limited to congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and end stage renal disease (ESRD-irreversible kidney failure). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 13 was cognitively intact (can think, learn, and remember clearly) and was dependent on staff for toileting, bathing, dressing the lower body, and putting on footwear. The MDS indicated Resident 13 required setup or clean-up assistance with eating, oral hygiene, and personal hygiene. The MDS further indicated Resident 13 was on a mechanically altered diet (a texture-modified diet designed for individuals who have difficulty chewing or swallowing). During a concurrent observation and interview on 6/16/2025 at 9:32 a.m., with Resident 13, Resident 13 stated all of his teeth are small nubs and they are all supposed to get pulled out. Resident 13 stated he doesn't know why they haven't been pulled yet. Resident 13 opened his mouth and showed small, broken teeth in his mouth. Resident 13 stated he needs his food to be cut up very small in order for him to eat. During a concurrent interview and record review on 6/18/2025 at 3:58 p.m., with the Social Services Director (SSD), reviewed Resident 13's dental assessment, dated 10/11/2024, and Medical Order Request Form for Tooth Extraction, undated. The SSD stated the dental assessment indicated treatment recommendation to get several teeth extracted. The SSD stated Resident 13's most recent dental visit was on 5/26/2025 but the extractions had still not been completed. The SSD stated since Resident 13 takes anticoagulants (medicines that reduce the ability of the blood to clot), he would need to discontinue them temporarily to be able to safely get the extractions. The SSD stated a physician needs to be informed about the needed dental extractions to determine if the resident can safely discontinue the anticoagulants. The SSD stated their process is to have social services notify nursing of the needed extraction and nursing would contact the physician. The SSD stated the Medical Order Request Form for Tooth Extraction is undated and not signed by the physician so nursing may not be aware of it. The SSD could not provide documentation that nursing or the physician was notified of Resident 13's needed extractions. During an interview on 6/19/2025 at 11:23 a.m., with the Assistant Director of Nursing (ADON), the ADON stated she was not aware that any notification had been made to a physician about Resident 13's anticoagulants needing to be held. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/2025 at 1:08 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated it was endorsed to her today that Resident 13 needed tooth extractions. LVN 4 stated she was not aware of this issue until the morning of 6/19/2025. During a concurrent interview and record review on 6/19/2025 at 2:16 p.m., with the SSD, the SSD stated the physician was not informed of Resident 13's needed extractions before 6/19/2025 so Resident 13 could not get the extractions. The SSD stated the resident is at risk for infection, abscesses (buildup of pus that can affect any part of your body), weight loss, or may not be able to chew food adequately. During an interview on 6/19/2025 at 4:05 p.m., with the Director of Nursing (DON), the DON stated if a resident on anticoagulants needs tooth extractions, a physician would need to be notified to determine if the residents can stop taking the anticoagulants. The DON stated if a resident needs tooth extractions and doesn't get them they can experience complications like infection and pain. During a review of the facility's policy and procedure (P&P) titled, Dental Services, reviewed 1/8/2025, the P&P indicated the facility assists residents in obtaining needed dental services including routine and emergency services to meet the needs of each resident.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs of residents when: 1. [NAME] 1 did not follow the recipe for garlic buttered rice 2. [NAME] 1 did not follow portion sizes for small and large portions by serving three (3) ounces (oz, a unit of measurement) instead of two (2) oz and four (4) oz respectively. This deficient practice had the potential to result in bland (lacking strong flavor or taste) food item resulting to decreased nutrient intake due to poor food intake of 78 of 120 resident who received garlic buttered rice and ineffective therapeutic diet (a meal plan that controls the intake of certain food and nutrients in the treatment or management of certain medical condition or illness) provisions of four (4) of six (6) residents on small portion diets and two (2) of three (3) residents on large portion diets getting food from the kitchen. Findings: 1. During a review of the facility's daily spreadsheet (a list of food, amount of food that each diet would receive) titled Menus, dated 6/16/2025, the spreadsheet indicated residents on regular diet would include the following foods on the tray: - Braised pork shoulder three (3) oz - Garlic buttered rice ½ cup (c., a household measurement) - Zucchini and yellow squash ½ c - Bread or roll with butter and margarine one each. - Choice of beverage one c - Pound cake with fresh strawberries one slice During a concurrent observation of the test tray (a process of tasting, temping [measuring the temperature of food to ensure it is safe to eat] and evaluating the quality of food) of a regular diet (diet with no restriction) and interview on 6/16/2025 at 1:24 p.m., with the Dietary Supervisor (DS), tasted the garlic buttered rice and it did not have a garlic flavor. The DS stated the garlic buttered rice did not have a garlic flavor and that the cooks needed to follow the recipe to achieve flavorful food as this could cause dissatisfaction for the residents resulting to poor food intake. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policies and procedures (P&P) titled Menus dated 1/8/2025, the P&P indicated, The facility assures menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines. During a review of the facility's P&P titled Standardized Recipes dated 1/8/2025, the P&P indicated To provide the dietary department guidelines for the use of standardized recipes. Food products prepared and served by the dietary department will utilize standardized recipes. Standardized recipes will have adjustments or separate recipes for therapeutic and consistency modifications. During a review of the facility's standardized recipe titled Garlic Buttered Rice undated, the recipe indicated ingredients: whole garlic clove, fresh, minced 1 ¼ oz. 2. During a review of the facility's daily spreadsheet titled Menus, dated 6/16/2025, the spreadsheet indicated residents on small portion diet would get braised pork shoulder two oz and large portion diet would get braised pork shoulder four oz. During an observation on 6/16/2025 at 12:09 p.m., observed one (1) pan of braised pork in trayline (an area where foods were assembled from the steamtable to resident's plate). During an interview on 6/16/2025 at 12:11 p.m. with [NAME] 1, [NAME] 1 stated he prepared three oz of braised pork shoulder and there were no other portions he prepared. During an interview on 6/16/2025 at 1:44 p.m., with the DS, the DS stated small portion diet was changing the scoop portion size of food depending on what was indicated in the spreadsheet. The DS stated small portion sizes are requested by residents and for the residents who were trying to lose weight. The DS stated if portions sizes were not followed, the diet was not followed and would not be accurate. The DS stated the residents could get upset because their request was not catered, and they will continue to gain weight unintentionally as the diet would not be effective. During an interview on 6/16/2025 at 1:46 p.m., with the DS, the DS stated the large portion diets are for residents who were losing weight and needed to gain weight or when residents request larger portions. The DS stated if the residents on large portion diet received smaller portions, the diet would not be effective, and residents could get upset and will continue to lose weight as a potential outcome. During a review of the facility's P&P titled Menus dated 1/8/2025, the P&P indicated, (5) Residents receive food in the amount, type, consistency, and frequency to maintain normal body weight and acceptable nutritional values. During a review of the facility's diet manual (a manual containing different diets descriptions, foods allowed and avoided and sample menus the facility have) titled Small Portions dated 1/8/2025, the diet manual indicated General information: Some individuals need or request small portions due to small appetites or are overwhelmed by regular portions. Small portions are to be served only with a physician/prescribing healthcare provider's order. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's diet manual titled Large or Double Portions dated 1/8/2025, the diet manual indicated General Information: Large portions are available for residents whose calorie or preference needs require larger quantities of food. Large portions are to be served only with a physician/prescribing healthcare provider's order.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved temperature, flavor and appearance when: 1. The temperature of the foods were as follows: a. Pound cake with strawberries and whip cream was at 56.5 degrees Fahrenheit (°F, a scale of temperature) b. Zucchini 115°F, c. Puree (a texture modified diet that consists of smooth, moist foods that are easy to swallow, food with soft pudding like consistency) pound cake with strawberries and whip cream was at 60°F 2. Zucchini was soggy and overcooked. 3. Gravy drippings were on the side of the plate. This deficient practice placed 78 of 120 facility residents on regular, therapeutic diets (a meal plan that controls the intake of certain food and nutrients in the treatment or management of certain medical conditions or illness) and puree diets at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: 1. During a review of the facility's menu spreadsheet (a list of food, amount of food that each diet would receive) titled Menus, dated 6/16/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray: - Puree braised pork shoulder ½ cup (c., a household measurement) - Puree garlic buttered rice ½ c - Puree zucchini and yellow squash 3/8 c. - Puree zesty spinach 1/3 c. - Puree bread and margarine ¼ c/ one (1) each - Choice of beverage - Puree pound cake with fresh strawberries ½ c/ one tablespoon (tbsp - a unit of measure used in cooking) (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/16/2025 at 11:34 p.m., in the trayline (an area where foods were assembled from the steamtable to resident's plate), observed staff plated the pound cake with strawberries and whip cream on all the trays assembled in each cart. During a concurrent test tray (a process of tasting, temping [measuring the temperature of food to ensure it is safe to eat] and evaluating the quality of food) observation and interview on 6/16/2025 at 1:14 p.m., with the Dietary Supervisor (DS), observed the regular and puree test trays and took the following food temperatures using the facility thermometer (used to accurately measure the temperature of food during cooking and cooling, ensuring food safety). The DS stated the following: - Pound cake with strawberries and whip cream 56.5°F - Zucchini 115°F - Puree pound cake with strawberries and whip cream 60°F. During an interview on 6/16/2025 at 1:24 p.m., with the DS, the DS stated the residents (unable to recall) previously expressed concerns about food temperatures. The DS stated that in response, random room rounds were conducted, which identified the root cause as delays by staff in distributing meals from the nursing station. The DS stated she was not aware that staff had pre-plated the pound cake with strawberries and whip cream ahead of time. The DS stated it should be plated as close to the serving time. The DS further stated residents could have stomachache (discomfort or pain in the stomach area) and illnesses especially when consuming dairy products that were not in good temperature of below 41°F. During a review of the facility's policies and procedures (P&P) titled Food and Drink dated 1/8/2025, the P&P indicated (2) The facility prepares food that is palatable, attractive, and at appetizing temperature as determined by the type of food to ensure resident's satisfaction, while minimizing the risk for scalding and burns. 2. During a review of the facility's daily spreadsheet titled Menus, dated 6/25/2025, the spreadsheet indicated residents on Regular and therapeutic diet would include the following foods on the tray: - Braised pork shoulder three (3) ounces (oz, a unit of measurement) - Garlic buttered rice ½ cup - Zucchini and yellow squash ½ c - Bread or roll with butter and margarine one each. - Choice of beverage one c - Pound cake with fresh strawberries one slice During an observation on 6/16/2025 at 12:04 p.m., observed a pan of zucchini in trayline that was overcooked. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent test tray observation and interview on 6/16/2025 at 1:24 p.m., with the DS, observed the regular test tray. The DS stated the zucchinis were soggy and overcooked, which affected the food presentation and could result in a loss of flavor. The DS further stated that overcooking zucchini can lead to a loss of nutrients. The DS stated residents may refuse to eat the food if it is not appetizing, which could result in inadequate nutrient intake. During a review of the facility's P&P titled Food and Drink dated 1/8/2025, the P&P indicated The facility assures the nutritive value of food is not compromised. Guidelines: (1) Food shall be prepared in a manner which assures nutritive value of food is not compromised or destroyed related to but not limited to: - Food storage, light, and air exposure; or - Cooking of foods in a large volume of water; or - Holding on steam table. 3. During an observation on 6/16/2025 at 12:11 p.m., observed gravy dripping on the side of the resident's plates. During a concurrent test tray observation and interview on 6/16/2025 at 1:14 p.m., with the DS, observed the regular and puree test trays with gravy dripping on the side of the plate. The DS stated there was gravy dripping on the side of the plate and the plate needed to be dry so that the presentation would be appealing. The DS stated residents would not eat the food if the presentation was not good. During a review of the facility's P&P titled Food and Drink dated 1/8/2025, the P&P indicated (3) The facility provides palatable, attractive, and appetizing food and drink to residents and can help to encourage residents to increase the amount they eat and drink.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to prepare foods in a form designed to meet individual needs when the pureed (a texture-modified diet composed of foods that have been ground, pressed, or strained to a soft, smooth consistency, similar to pudding) roast pork was runny and did not hold its shape on the plate and pureed bread lacked a smooth pudding like consistency, containing visible bread particles. These failures had the potential to result in difficulty in swallowing, chewing, decreased in food intake and nutrient intake to 10 of 10 residents on pureed diet, resulting in unintended (not planned) weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Menus, dated 6/16/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray: - Puree braised pork shoulder ½ cup (c., household measurement) - Puree garlic buttered rice ½ c - Puree zucchini and yellow squash 3/8 c. - Puree zesty spinach 1/3 c. - Puree bread and margarine ¼ c/ one (1) each - Choice of beverage - Puree pound cake with fresh strawberries ½ c/ one tablespoon (tbsp - a unit of measure used in cooking) During an observation on 6/16/2025 at 12:04 p.m., observed the pureed pork did not hold its shape when plated on the plate. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent test tray (a process of tasting, temping [measuring the temperature of food to ensure it is safe to eat] and evaluating the quality of food observation and interview on 6/16/2025 at 1:35 p.m., with the Dietary Supervisor (DS), observed the pureed pork was flat on the tray and the pureed bread had bread particles. The DS stated the pureed pork was too runny on the plate and the pureed bread still has little bread particles and was not pudding like consistency. The DS stated the puree diet is for the residents who could not chew, or swallow and it needed to be blended with pudding like consistency. The DS stated the puree foods should hold it shape, and it should have the same flavor profile as regular diet. The DS stated if the puree food items are not in their proper consistency, food would not be appetizing, and residents would not eat it leading to weight loss as a potential outcome. The DS stated residents may require chewing more and they will have difficulty eating the food as the puree bread had small bread particles in it resulting to weight loss because residents would not eat the food. During a review of the facility's diet manual (a manual containing different diets descriptions, foods allowed and avoided and sample menus the facility have) titled Pureed (PU4) dated 1/8/2025, the diet manual indicated This modification is designed for people who have severe chewing and or swallowing problems. Properly pureed foods eliminate the chewing phase. Puree diet menus follow foods on the regular menu as closely as possible and differ primarily in consistency. Puree all foods to a smooth, lump-free, extremely thick consistency (not firm or sticky). Use appropriate recipes. Food on this level must pass the IDDSI appearance test, fork drip test and spoon tilt test. Food is smooth, with no lumps. During a review of the facility's standardized recipe titled Recipe: Pureed Fish/Meat/Poultry 3 oz revised 10/6/2021, the recipe indicated Process until meat is smooth in consistency. During a review of the facility's standardized recipe titled Recipe Name: Pureed Bread Products revised 10/6/2021, the recipe indicated Ensure mixture achieves smooth, lump free and extremely thick consistency. During a review of the International Dysphagia Diet Initiative (IDDSI - a framework made up of levels and describes food textures and drink thickness) guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated, Level Four (pureed foods and extremely thick drinks) is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and fork drip test.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on interview, and record review, the facility failed to ensure one of one sampled resident (Resident 630's) food allergy (when your body's immune system mistakenly identifies a food as harmful and triggers a reaction) was honored when the food allergy was not entered in Resident 630's medical records in a timely manner, and staff did not accurately enter the food allergy into the meal order system. The diet ticket (a slip of paper or digital record that specifies which meal a resident is supposed to have and when and used by the kitchen staff to ensure each resident receives the correct food at the correct time) indicated an allergy to bell peppers instead of all peppers. This deficient practice resulted in Resident 630 being served peppers which had the potential to result in an allergic reaction (a condition that causes illness when someone eats certain foods or touches or breathes in certain substances). Findings: During a review of Resident 630's admission Record, the admission Record indicated the facility admitted Resident 630 on 6/6/2025 with diagnoses that included multiple sclerosis (a disease that causes breakdown of the protective covering of nerves in the brain and spinal cord), essential hypertension (high blood pressure), and diabetes mellitus (DM, a disease of inadequate control of blood sugar levels). During a review of the Allergy Report dated 6/17/2025, the Allergy Report did not indicate that Resident 630 had food allergies. During a review of the Diet Type Report dated 6/17/2025, the Diet Type Report indicated Resident 630 had no known food allergies. During a review of Resident 630's Care Plan related to Nutrition, dated 6/6/2025, the Care Plan indicated Resident 630 was on a no added salt (NAS, no salt packet on the tray) regular diet but there was no food allergy indicated. During an interview on 6/16/2025 at 12:58 p.m., with Resident 630, inside Resident 630's room, Resident 630 stated he was allergic to pepper, but they still give him peppers. Resident 630 stated he is allergic to all peppers except black peppers from the shaker, but his meal ticket indicated he is only allergic to bell peppers. During a concurrent interview and record review on 6/16/2025 at 1:43 p.m., with the Dietary Supervisor (DS), Resident 630's medical record related to nutrition, diet and allergies were reviewed. The DS stated she interviewed Resident 630 yesterday (6/15/2025). The DS stated Resident 630 informed her that he (Resident 630) was allergic to all kinds of pepper except black pepper. The DS stated that she (DS) entered bell pepper in the menu system because they only serve that kind of pepper in the menu. The DS stated pepper allergy for Resident 630 was not entered in the allergy section of the medical record. The DS stated the nurses were aware of entering peppers in the electronic medical records (EMR) as she did not have any capacity of entering the allergy in the EMR. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/2025 at 3:40 p.m., with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated Resident 630 told him that he was allergic to peppers, and he was served food containing with bell peppers on his breakfast tray on 6/15/2025. LVN 8 stated Resident 630 got scrambled eggs with finely chopped bell peppers. LVN 8 stated he notified the Registered Dietitian (RD) and the DS, but he (LVN 8) did not enter the food allergies in the chart as he (LVN 8) thought Resident 630 was joking with him. LVN 8 further stated he did not follow up and did not endorse it to other health care team members. LVN 8 stated they only based allergies on the history and physical records for Resident 630. LVN 8 stated, they assumed that Resident 630 has no known food allergy because the H&P indicated that. LVN 8 stated he should have contacted Resident 630's physician so they could check the labs to confirm the food allergy. LVN 8 stated it was important to communicate and notify Resident 630's food allergies because they would not know what kind of allergic reaction Resident 630 would have. LVN 8 stated the DS told him that Resident 630 is allergic to peppers and heard that DS entered it in the system, but he was not sure. LVN 8 stated he should have notified the physician, updated the Medication Administration Record (MAR - a report detailing the medications and treatments administered to a resident by a healthcare professional), and Resident 630's medical records. LVN 8 stated that medication that would interact with Resident 630's food allergies should have been on hold. LVN 8 stated he should have notified the kitchen staff and should have endorsed to the nursing staff Resident 630's food allergies. LVN 8 stated they did not have any specific training about food allergies, but they had training for the medical records data entry. During an interview on 6/18/2025 at 3:40 p.m. with the Director of Nursing (DON), the DON stated the process of handling food allergies was to ask the resident what food allergies they have, notify the resident's physician, update the medical record, MAR and face sheets (admission records), notify the kitchen, update the care plan and communicate to staff. The DON stated it was important to know resident's food allergies to prevent giving food the residents are allergic to. The DON stated if residents eat the food that they are allergic to, they might have allergic reactions like hives (a skin reaction that causes itchy welts [raised red or pink bumps]), rash (an area of skin that has a noticeable change in color, texture, or appearance, often accompanied by irritation, swelling, or itching), respiratory issues such as shortness of breath that could lead to complications. The DON stated the facility staff have to document the allergy the same day they were made aware of as it could affect resident's care and quality of life. The DON stated LVN 8 should have obtained more detailed information to verify the accuracy of Resident 630's reported food allergy and to prevent Resident 630 from being served an allergen (substance that can cause an allergic reaction). During a review of the facility's Policies and Procedures (P&P) titled Food and Drink- Allergies and Preferences dated 1/8/2025, the P&P indicated Each resident shall receive food that accommodates residents' allergies, intolerances, and preferences. Guidelines: (1) The interdisciplinary team is aware of each resident's allergies, intolerances, and preferences, and provide appropriate alternatives. (4) Ask residents how the food meets their preferences, allergies and/or intolerances. (6) Resident's allergies, intolerances, preferences, or need for a therapeutic diet are comprehensively assessed and documented in the resident medical record. (7) The interdisciplinary team develop and revises each resident's comprehensive care plan including but not limited to the resident's food allergies, intolerances, preferences, or need for a therapeutic diet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen, as evidenced by the following: 1. There was no thermometer inside the reach-in freezer (refers to a standard freezer that allows for easy access to the frozen items stored inside) for temperature monitoring. 2. Kitchen equipment and kitchen areas were observed to be unclean and not sanitized. a. Walk-in freezer (a large, refrigerated room designed for storing frozen food items) curtains were observed to have stickers, sticker residues and food spills. b. Walk-in refrigerator (refers to a large, walk-in storage space, used to store perishable food items) vent had dust build-up. c. Dry storage vent (used to ensure proper air circulation and humidity control within areas where non-perishable foods and supplies are stored at room temperature) had dust build-up. 3. Eight (8) of eight dented canned goods were stored alongside non-dented cans, posing a potential food safety risk. 4. Staff failed to perform hand hygiene (refers to the practice of cleaning and sanitizing one's hands to remove dirt, germs, and bacteria) when on 6/16/2025: a. [NAME] 1 was observed picking sanitizing wipes from the floor and proceed without washing his hands before returning to the trayline (an area where foods were assembled from the steamtable to resident's plate) set up. [NAME] 1 did not perform hand hygiene and instead wiped his hands on his apron and continued cooking and taking food temperatures. b. [NAME] 1 was observed touching the trash can lid and then went back to (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preparing food. c. Dietary Aide 1 (DA 1) was observed opening the trash can lid then used her pinky finger to close the lid. DA 1 resumed work without washing her hands. 5. Kitchen equipment and utensils were not maintained in a condition that was smooth, and easily cleanable for sanitary use. a. 14 of 14 resident meal trays were observed to be cracked. b. [NAME] and blue chopping boards had cracks and scratches. These deficient practices placed 78 of 120 medically compromised residents who received food and ice from the kitchen at risk for foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) and cross-contamination (transfer of harmful bacteria from one food item to another, or from a surface to food). Findings: 1. During an initial kitchen tour observation on 6/16/2025 at 8:28 a.m., observed that there was no thermometer inside the reach-in freezer by the trayline. During an interview on 6/16/2025 at 9:28 a.m. with the Dietary Supervisor (DS), the DS stated they do not need to put a thermometer in the reach in freezer because they have a digital thermometer outside the freezer. During an interview on 6/17/2025 at 9:38 a.m. with the DS, the DS stated after checking the Food Code (provides guidance on food safety practices), they needed to have a thermometer inside the refrigerator and freezer because external digital thermometer would not be accurate and could cause food to spoil resulting to residents having diarrhea (a condition characterized by frequent, loose, and watery bowel movements) and infection as a potential outcome. During review of the facility`s Policy and Procedure (P&P) titled Food Receiving and Storage, dated 1/8/20245, the P&P indicated Monitoring food temperatures and functioning of the refrigeration equipment daily and at a routine interval during all hours of operation. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 4-204.112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit. (B) Except as specified in (C) of this section, cold or hot holding equipment used for time/temperature control for safety food shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display. (continued on next page)

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The Rehabilitation Center of North Hills	9655 Sepulveda Boulevard North Hills, CA 91343

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.a. During an observation on 6/16/2025 at 8:46 a.m., observed the walk-in freezer curtains have stickers, sticker residues and food spills. During concurrent observation and interview on 6/16/2025 at 9:35 a.m., with the DS, the walk-in refrigerator curtains were observed. The DS stated that the walk-in refrigerator curtains had sticker residues and food spills. The DS stated that the walk-in freezer curtains needed to be cleaned to prevent possible cross-contamination of food. b. During a concurrent observation and interview on 6/16/2025 at 9:44 a.m., with the DS, observed the walk-in refrigerator vent had dust build-up. The DS stated the vent in the walk-in refrigerator had dust build-up even if it was just cleaned last week. The DS stated the walk-in refrigerator vent needed to be cleaned to prevent food contamination. During a review of the facility's P&P titled Cleaning Schedule, dated 1/8/2025, the P&P indicated, To establish guidelines for maintain routine cleaning schedule. The dietary staff will maintain a sanitary environment in the dietary department by complying with the routine cleaning schedule developed by the dietary manager. II. The dietary manager monitors the cleaning schedule to ensure compliance. c. During an observation on 6/16/2025 at 9:53 a.m., observed the dry storage area vent had dust and web build-up. During an interview on 6/17/2025 at 9:34 a.m., with the DS, the DS stated that the dry storage area vent is cleaned once a week. The DS stated that the dry storage area vent needed to be cleaned more frequently as the build-up could lead to bacterial growth and pose a risk of cross contamination, potentially causing illness among residents. During a review of the facility's P&P titled Food Receiving and Storage, dated 1/8/2025, the P&P indicated, 2. The focus of protection for dry storage is to keep non-refrigerated foods, disposable dishware, and napkins in a clean, dry area, which is free from contaminants. (5) Food and food products should always be kept off the floor and clear of ceiling sprinklers, sewer/waste disposal piles, and vents to maintain food quality and prevent contamination. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on 6/16/2025 at 9:59 a.m., with the DS, observed the dry storage room with eight dented cans stored alongside the undented cans. The DS stated there were eight dented cans in the non-dented cans section and there was no clear separation between the dented cans and the non-dented cans. The DS stated it was important to separate the dented cans from non-dented cans to prevent contamination due to the damaged cans that could potentially cause botulism (a rare but serious illness caused by a toxin that attacks the body's nerves) to residents. During a review of the facility's P&P titled Food and Nutritional Services Equipment and Supplies dated 1/8/2025, the P&P indicated, All food will be good quality and obtained from sources approved or considered satisfactory by federal, state and local authorities. Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents or swells shall not be accepted or retained. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601. 12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of §3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victims to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 4.a. During an observation on 6/16/2025 at 11:48 a.m., observed [NAME] 1 pick up sanitizing wipes from the floor and proceed without washing his hands before returning to the trayline. [NAME] 1 did not perform hand hygiene and instead wiped his hands on his apron and continued cooking and taking food temperatures. b. During an observation on 6/16/2025 at 12:01 p.m., observed [NAME] 1 touched the trash can lid then resumed work in the trayline by setting up plates. During an observation on 6/16/2025 at 12:26 p.m., observed DA 1 open the trash can lid then used her pinky finger to close the lid. DA 1 then resumed work without washing her hands. During an interview on 6/16/2025 at 9:42 a.m., with the DS, the DS stated employees should be washing every time they change task, change their gloves, as soon as they touch garbage lids. The DS stated aprons should not be used to dry their hands and staff should use a towel. The DS stated handwashing is important to prevent cross-contamination and transfer of bacteria, infection and for resident's safety. During a review of the facility's P&P titled Handwashing and Hand Hygiene, dated 1/8/2025, the P&P indicated This facility considers hand hygiene means to prevent the spread of infections. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated 1/18/2023, the Food Code indicated 2-301.14 When to Wash. Food employees shall clean their hands and exposed portions of their arms as specified under § 2-301. 12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (D) Except as specified in § 2-401.11 (B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; (E) After handling soiled equipment or utensils; (F) During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw food and working with ready-to-eat food (H) Before donning gloves to initiate a task that involves working with food; and (I) After engaging in other activities that contaminate the hands. 5.a. During an observation on 6/16/2025 at 11:39 a.m. in the dishwashing station by the clean area, observed 14 of 14 cracked and chipped trays ready for lunch meal use. During an interview on 6/17/2025 at 10:03 a.m., with the DS, the DS stated the trays had scratches and cracks. The DS stated it was not okay as bacteria could grow in the cracks. The DS stated it could be a dignity issue for the residents, and it could cause illness to residents as a potential outcome. b. During concurrent observation and interview on 6/17/2025 at 10:19 a.m., with the DS, observed green and blue chopping boards had cracks and scratches. The DS stated she was aware of the cracked and chipped chopping boards, and they needed to be replaced to prevent cross-contamination. During a review of the facility's P&P titled Discarding of Chipped/Cracked Dishes and Single Service Items, dated 1/8/2025, the P&P indicated To establish guidelines for service ware and single service items including china and glassware safety. Policy: I. The dietary staff will maintain a sanitary environment in the dietary department by discarding compromised service ware and single service items. II. Chipped, cracked, or non-sanitizing surfaces on china and glassware will not be used. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. During a review of Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly (to dispose of waste materials [refuse] in a way that complies with regulations and best practices, minimizing environmental and health risks) when there were soiled gloves, empty plastic cups, liquid spills and other trash on the floor and surrounding areas of the dumpster bin (a movable waste container designed to be brought and taken away by a special collection vehicle, or to a bin that a specially designed garbage truck lifts). This deficient practice had potential to attract birds, flies, insects, and pests (any unwanted organism that can contaminate or interfere with food safety and hygiene), and possibly spread infection to 78 of 120 facility residents. Findings: During a concurrent observation and interview on 6/17/2025 at 12:54 p.m., with the Dietary Supervisor (DS), observed the dumpster and soiled gloves, wet spill under the dumpster bin and other dirt debris. The DS stated it was not okay to have liquid spills, soiled gloves and other dirt debris around the dumpster areas because it would attract pests, and the facility environment needed to be cleaned for infection control. During an interview on 6/17/2025 at 1:03 p.m. with the Housekeeping Supervisor (HKS), the HKS stated the dumpster surrounding areas should be clean, no trash on the floors but there were soiled gloves and empty plastic cups on the floor. The HKS stated they clean the dumpster surrounding areas every morning, but they were short staffed, and they had a manpower issue but would go back to normal now that they were fully staffed. The HKS stated it was important to maintain the cleanliness of the dumpster areas for infection control. During a review of the facility's policies and procedures (P&P) titled Dispose of Garbage and Refuse dated 1/8/2025, the P&P indicated The facility properly disposes of garbage and refuse. (1) Garbage and refuse containers are maintained in good condition (no leaks) and waste is properly contained in dumpsters or compactors with lids covered. (2) (3) Garbage storage shall be maintained in a sanitary condition to prevent harborage and feeding of pests. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain accurate and complete resident medical records for two of 10 sampled residents (Resident 82 and 48) when nursing staff failed to: 1. Document when nursing staff did not put on a left hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) on Resident 82 three to four hours a day, seven days a week as ordered by a physician. These deficient practices resulted in inaccurate medical documentation and had the potential for worsening of contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the left wrist and hand in Resident 82. 2. Ensure there was a diagnosis of anxiety (intense, excessive, and persistent worry and fear about everyday situations) documented prior to starting a routine anti-anxiety medication, clonazepam (anti-anxiety medication) for Resident 48. This deficient practice resulted in inaccurate documentation in Resident 48's medical record and possible missed opportunity for services related to anxiety. Findings: a. During a review of Resident 82's admission Record (AR), the AR indicated Resident 82 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to acute and chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) with hypoxia (low oxygen level in tissues), quadriplegia (paralysis from the neck down, including legs, and arms), contracture of muscle, unspecified site, and complete traumatic amputation (surgical removal of a limb) at right shoulder joint. During a review of Resident 82's Minimum Data Set (MDS, resident assessment tool) dated 3/15/2025, the MDS indicated Resident 82 had no speech and was severely impaired in cognitive skills (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) for daily decision making. The MDS indicated Resident 82 required dependent assistance from staff for bed mobility, personal hygiene, dressing, and toileting. The MDS also indicated Resident 82 had functional limitation impairments in range of motion (ROM, full movement potential of a joint) on both sides of the upper extremity (UE, shoulder, elbow, wrist, hand) and functional limitation impairments on both sides of the lower extremity (LE, hip, knee, ankle, foot). During a review of Resident 82's Order Summary Report (OSR) dated 6/17/2025, the OSR indicated an order dated 3/7/2025 for licensed nurse to provide left elbow, left hand and bilateral (both sides) knee splints for three to four hours seven times a week as tolerated. The OSR indicated an order dated 3/7/2025 for licensed nurse to passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to left upper extremity (LUE), and bilateral lower extremity (BLE) seven times a week as tolerated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 82's Care Plan (CP) dated 6/17/2025, the CP indicated Resident 82 was at high risk for decline in ROM, decreased muscle strength and at risk for contracture formation. The CP goal indicated Resident 82 will decrease complaints of pain and discomfort and will maintain ROM. The CP interventions included licensed nurse to provide PROM exercises to LUE and BLE seven times a week as tolerated and licensed nurse to provide left elbow, left hand and both knee splints for three to four hours seven times a week as tolerated. During an observation on 6/17/2025 at 12:15 p.m., observed Resident 82 lying in bed. Resident 82's left elbow was bent and had a splint on the left elbow, the left wrist was fully bent, and left fingers were partly bent. There were no splints observed on Resident 82's left wrist or hand. Resident 82's both knees were bent and there were splints on both knees. During an interview on 6/17/2025 at 3:48 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the charge nurse (LVN) assigned to Resident 82 completed the PROM exercises and put on the splints every day. LVN 2 stated he completed the ROM exercises with Resident 82 today and put on the left elbow splint and both knee splints up to three to four hours a day. LVN 2 stated Resident 82 had orders to put on left elbow splint and both knee splints only. LVN 2 stated Resident 82 did not have any orders to put a left hand splint and LVN 2 had not put any left hand splints on Resident 82. During a concurrent observation and interview on 6/18/2025 at 12:30 p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 completed PROM exercises to Resident 82 on the left upper extremity and both lower extremities. After PROM exercises, LVN 3 put on the right knee splint and requested assistance from Registered Nurse Supervisor 3 (RN 3) to assist with putting on the left knee splint. RN 3 reminded LVN 3 to put on the left elbow splint. LVN 3 proceeded to retrieve an elbow splint in the closet and put the left elbow splint on Resident 82. RN 3 reminded LVN 3 to put on the left hand splint. LVN 3 stated the left hand splint was still missing and stated she could not put on the left hand splint. During an interview on 6/18/2025 at 1:11 p.m., with LVN 3. LVN 3 stated she had not put on the left hand splint on Resident 82 for at least two weeks, but could not remember exactly how long Resident 82 did not put on the left hand splint. LVN 3 stated if the left hand splint or any splint was not put on, then it should be documented in Resident 82's medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/18/2025 at 1:18 p.m., with RN 3, reviewed Resident 82's medical records including progress notes, RNA weekly summary, nursing notes from 3/7/2025 to 6/18/2025. RN 3 stated Resident 82 had an order dated 3/7/2025 for licensed nurse to provide left elbow, left hand and bilateral knee splints for three to four hours seven times a week as tolerated, and an order dated 3/7/2025 for licensed nurse to provide PROM exercises to LUE and BLE times a week as tolerated. RN 3 stated nursing staff should put on the left hand splint every day and stated she was not aware of any nurses reporting to her that Resident 82 did not put on the left hand splint for any reason, including the left hand splint missing. RN 3 reviewed Resident 82's medical records including progress notes, RNA weekly summary, nursing notes and stated nursing staff did not document Resident 82 did not wear the left hand splint since the order was written on 3/7/2025. RN 3 stated if the licensed nurses could not put on the left hand splint for any reason, it needed to be documented because staff needed to know what was happening with Resident 82 and can address issues before it worsened. RN 3 stated licensed nursing staff should put on the left hand splint every day, because Resident 82 could get more contracted, and it could be harder to put on the splints later. RN 3 stated if Resident 82 was more contracted, it would be impossible to do anything with Resident 82 because moving Resident 82 would cause more pain, it could cause more pressure between the skin and put Resident 82 at risk for yeast infection and the skin would be harder to clean. During an interview on 6/18/2025 at 2:17 p.m., with the Director of Nursing (DON), the DON stated if there was an order to put a left hand splint, then this was the intervention to help Resident 82 prevent further contractures and the order must be completed as ordered. The DON stated if the licensed nurses could not put on the splint that day for any reason, staff should document and report this and notify the family and the physician. The DON stated if nursing staff did not put on the left hand splint, this needed to be documented in the progress notes and then notify the physician. The DON stated staff needed to document it and communicate it so that facility staff could determine what to do for Resident 82, such as have therapy assess the resident. During a review of the facility's policy and procedure (P&P) titled, Documentation Policy, approved 1/8/2025, the P&P indicated it is the policy of this facility to document relevant findings in the clinical record. b. During a review of Resident 48's admission Record, the admission Record indicated the facility admitted Resident 48 on 1/25/2023 with diagnoses that included, but not limited to heart failure (a condition where the heart muscle is unable to pump enough blood to meet the body's needs), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A diagnosis of anxiety is not listed. During a review of Resident 48's Minimum Data Set (MDS - a resident assessment tool) dated 5/3/2025, the MDS indicated Resident 48 was able to understand others and make himself understood. The MDS further indicated Resident 48 was using a high-risk drug class of antianxiety medication, but anxiety was not checked off in active diagnoses. During a review of Resident 48's physician's order indicated an order for clonazepam one (1) milligram (mg-a unit of measurement), give one tablet two times a day for anxiety manifested by agitation and restlessness. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/19/2025 at 11:18 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 48's diagnoses list and physician's orders. The ADON stated Resident 48 is currently taking clonazepam twice a day without a diagnosis of anxiety listed. The ADON stated there must be a documented diagnosis when taking a psychotropic (drugs that affect the mind and brain) such a clonazepam to validate the resident is receiving the right medication. The ADON further stated the nurse that transcribes the order must ensure all the proper documentation such as the diagnosis is present in their medical record, including their face sheet (admission Record) and MDS. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment, last reviewed on 1/8/2025, the P&P indicated the facility conducts a comprehensive, accurate, reproduceable assessment. The P&P further indicated the assessment minimally includes the documentation of disease diagnosis and health conditions. During a review of the facility's P&P titled, Documentation Policy, last reviewed on 1/8/2025, the P&P indicated it is the policy of the facility to document relevant findings in the clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** (b.) During a review of Resident 16's admission Record, the admission Record indicated the facility originally admitted the resident on 5/12/2009 and readmitted the resident on 7/7/2015 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated the resident had severely impaired cognition (thought processes) and was dependent for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 77's admission Record, the admission Record indicated the facility originally admitted the resident on 4/18/2023 and readmitted the resident on 1/16/2024 with diagnoses including dysphagia (difficulty swallowing). During a review of Resident 77's History and Physical (H&P - a comprehensive assessment of a patient's health status, combining a patient's reported medical history with a physical examination conducted by a healthcare professional), dated 5/1/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 77's MDS, dated [DATE], the MDS indicated the resident had moderately impaired cognition and was dependent on staff for all ADLs. On 6/16/2025 at 12:31 p.m., during the dining observation, observed Licensed Vocational Nurse 1 (LVN 1) in the dining room assisting Resident 16 with eating. Also observed Resident 77 sitting next to LVN 1 while being assisted with eating by another nurse. Observed Resident 77 coughing. Observed LVN 1 tap Resident 77's chest to assist him with coughing. Observed LVN 1 turn back to Resident 16 to continue feeding him and wipe his mouth with a napkin. Observed LVN 1 not performing hand hygiene between contact with both residents. On 6/16/2025 at 12:41 p.m., during an interview, LVN 1 stated she should have performed hand hygiene between assisting Resident 16 with eating and assisting Resident 77 with his cough. On 6/18/2025 at 2:41 p.m., during an interview, the Director of Nursing (DON), the DON stated she expected her staff to perform hand hygiene before and after any contact with residents to prevent the spread of infection. The DON stated if nurses did not perform hand hygiene between resident contact, then it can lead to the spread of infection amongst residents. During a review of the facility's policy and procedure titled, Hand Washing - Hand Hygiene, last reviewed and revised on 1/8/2025, the policy and procedure indicated that the facility considered hand hygiene as the primary means to prevent the spread of infection .Personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .When indicated, employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program by failing to: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(a.) Ensure a bed rail padding was free of gouges (grooves or cuts) and frayed (worn or tattered) areas for one resident (Resident 103) randomly observed during the initial pool observation. This deficient practice had the potential to result in contamination of the resident's bed rail padding and risk of transmission of bacteria that could lead to infection. (b.) Ensure a licensed nurse performed hand hygiene (the practice of cleaning and disinfecting one's hands to remove dirt, germs, and bacteria) between contact with two residents during dining observation for two (Residents 77 and 16) out of three sampled residents investigated under the care area of infection control. This deficient practice had the potential to place the residents at increased risk of developing an infection. Findings: (a.) During a review of Resident 103's admission Record, the admission Record indicated the facility admitted Resident 103 on 4/21/2025 with diagnoses that included, but not limited to tracheostomy status (an opening in the windpipe to allow for breathing, often with the insertion of a tracheostomy tube), anoxic brain damage (occurs when the brain receives absolutely no oxygen, leading to brain cell death and potential permanent damage), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 103's History and Physical (H&P), dated 4/23/2025, the H&P indicated Resident 103 was non-verbal, unable to follow commands and did not have the capacity to understand and make decisions. During a review of Resident 103's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/19/2025, the MDS indicated Resident 103 was not able to understand others and make himself understood. The MDS further indicated Resident 103 was dependent on facility staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and any mobility such as rolling from side to side. During an observation on 6/16/2025 at 9:06 am in Resident 103's room, Resident 103 was lying in bed with an off gaze and was non-verbal. Resident 103's bed upper side rails had a black color padding covering them. The left rail had a two inch by half an inch gouge and both left and right rails had mini gouges and were frayed in appearance. During a concurrent observation and interview on 6/16/2025 at 9:20 am in Resident 103's room with Registered Nurse 4 (RN 4), RN 4 looked at Resident 103's bed rail padding and stated there was a large gouge in the left rail padding and both left and right padding had small gouges and were frayed. RN 4 stated a staffs clean the rails every shift and as needed with antibacterial (a substance that kills bacteria or stops them from growing and causing disease) cloth wipes, but with gouges or tears in the padding there is no way to guarantee they are sanitized properly and could lead to an infection to residents. RN 4 stated staff must report any integrity issues to the bed rail padding to a supervisor or maintenance staff so they could be replaced immediately. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/16/2025 at 11:22 am with the Administrator, (ADM), the ADM stated that staff should have reported any defects to the bed rail padding immediately so they could be changed. The ADM stated when the padding is intact, it is designed to resist bacteria, but if there are tears or gouges in padding, they must be replaced right away. During a review of the facility provided Policy and Procedure (P&P) titled, Homelike Environment last reviewed on 1/8/2025, the P&P indicates it is the responsibility of the facility staff to promptly address any cleaning needs. During a review of the facility provided P&P titled, Cleaning and Disinfection of Resident Care Items and Equipment last reviewed on 1/8/2025, the P&P indicates single resident-use items are cleaned and/or disinfected, as required.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain one of six rehabilitation therapy (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) equipment for resident use. This failure had the potential for injury and spreading of infections to residents using the therapy equipment. Findings: During an observation and interview on 6/17/2025 at 8:43 a.m., inside the therapy gym, with the Director of Rehabilitation (DOR), the DOR stated the facility maintenance staff completed maintenance on the therapy equipment. The DOR observed the therapy mat and confirmed there were five open tears along the middle and right side outer edge of the therapy mat and a black plastic protective border was falling off the left side of the outer edge of the therapy mat. The DOR stated the therapy staff did not inform the maintenance staff of the tears in the therapy mat or the black plastic protective border was falling off and not secured. The DOR stated staff should report the equipment issues to maintenance staff so that maintenance staff can fix the equipment issues. The DOR stated the tears in the therapy mat could cause skin tears or skin irritation for residents who sat on the mat. The DOR stated therapy staff used sanitizing wipes or alcohol sprays on the mat and the open tears to clean the therapy mat and stated these methods could keep the therapy mat clean. During an interview on 6/17/2025 at 10:48 a.m., with the Infection Prevention Nurse (IP), the IP stated if there was a tear in the therapy mat, then the therapy mat could not be cleaned effectively, because the inside could not be cleaned. The IP stated bacteria could go inside the therapy mat and the sanitizing wipes and alcohol spray would not be effective to clean the open tears of the mat because the sanitizing wipes and alcohol spray could only be used on non-porous surfaces. During a concurrent interview and record review on 6/18/2025 at 9:04 a.m., with the Director of Maintenance (DMN), reviewed the maintenance logbook for the therapy mat. The DMN stated there were no reports of tears in the therapy mat or a black plastic protective edge piece coming off the therapy mat. The DMN stated staff should report any issues with therapy equipment so that maintenance staff could start the process of fixing the issue or call an outside vendor. During an interview on 6/18/2025 at 2:17 p.m., with the Director of Nursing (DON), the DON stated therapy equipment needed to be safely maintained, and the therapy mat should not have any tears. The DON stated the tears in the mat could cause skin tears or injuries to residents using the therapy mat. During a review of the facility's policy and procedure (P&P) titled, Equipment in Safe Operating Condition, approved 1/8/2025, the P&P indicated, The facility maintains mechanical, electrical, and [resident] care equipment in safe operating condition.

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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. Based on observation, interview, and record review, the facility failed to ensure that 27 out of 55 resident rooms (Rm 103, 105, 106, 107, 108, 109, 110, 111, 112, 201, 210, 211, 213, 215, 216, 217, 301, 302, 303, 309, 311, 312, 313, 315, 321, 323, 325) met the square footage requirement of 80 square feet (sq ft- unit of measure) per resident. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the resident. Findings: During a review of the facility's letter request of room waiver submitted by the Administrator dated 6/16/2025, the letter indicated 27 resident rooms did not meet the 80 square foot requirement per resident. The letter indicated there was still enough space to provide for each resident's care, dignity, and privacy. Room Number: Number of Beds: Sq. Ft: Sq.Ft per Resident: 201 2 159.81 79.91 210 2 156.86 78.43 211 2 156.86 78.43 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	103 3 215.74 71.91 105 3 219.46 73.15 106 3 211.75 70.58 107 3 213.79 71.26 108 3 212.09 70.69 109 3 212.67 70.89 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	110 3 224.02 74.67 111 3 211.86 70.62 112 3 219.09 73.03 213 3 221.18 73.72 215 3 229.96 76.65 216 3 217.59 72.53 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	217 3 224.30 74.76 301 3 211.58 70.52 302 3 208.20 69.40 303 3 210.38 70.12 309 3 212.30 70.76 311 3 213.40 71.13 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	312 3 213.40 71.13 313 3 213.40 71.13 315 3 213.40 71.13 321 3 211.98 70.66 323 3 215.76 71.92 325 3 217.97 72.65 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	The minimum requirement for a 2 bedroom should be at least 160 sq. ft. The minimum requirement for a 3 bedroom should be at least 240 sq. ft. During the initial observation tour on 6/16/2025, from 9:00 a.m. to 2:30 p.m., the surveyors inspected the rooms and observed that nursing staff had enough space to provide care to the residents. There were curtains to provide privacy for each resident and the rooms had direct access to the corridors. During an interview with the resident council on 6/17/25 at 11:08 a.m., there were no concerns regarding the size of the rooms during the resident council meeting.

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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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observation, interview and record review the facility failed to provide one of one resident (Resident 103), reviewed under the privacy care area, full visual privacy (a resident has a means of completely withdrawing from public view, without staff assistance, while occupying their bed [for example, curtain, moveable screens]) by not ensuring that ceiling suspended curtains extended fully around the resident's bed. This deficient practice prevented Resident 103 from having full privacy from public view. Findings: During a review of Resident 103's admission Record, the admission Record indicated the facility admitted Resident 103 on 4/21/2025 with diagnoses including tracheostomy status (an opening in the windpipe to allow for breathing), gastrostomy status(the surgical creation of an opening (stoma) into the stomach, typically for the purpose of feeding or administering medications) and cachexia (unintentional weight loss, primarily muscle mass, due to an underlying illness, not intentional dieting). During a review of Resident 103's History and Physical (H&P), dated 4/23/2025, the H&P indicated Resident 103 was non-verbal, unable to follow commands and did not have the capacity to understand and make decisions. During a review of Resident 103's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/19/2025, the MDS indicated Resident 103 was not able to understand others and make himself understood. The MDS further indicated Resident 103 was dependent on facility staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and any mobility such as rolling from side to side. During an observation on 6/16/2025 at 9:06 am in Resident 103's room, Resident 103 was lying in bed and non-verbal. Resident 103's bed was closest to the entrance, with the right side of his bed nearest to the door. The right side of the ceiling suspended curtain track does not extend fully to the wall, preventing full privacy. During a concurrent observation and interview on 6/16/2025 at 9:15 am in Resident 103's room with Maintenance Worker 1 (MW 1), MW 1 attempted to pull the ceiling suspended curtain towards the wall on the right side of Resident 103's bed but stated he was unable to due to the large gap from the end of the curtain track and the right wall. MW 1 stated that without the curtain closing completely, full privacy is not being provided to the resident. During a concurrent observation and interview 6/19/2025 at 10:55 am in Resident 103's room with the Director of Maintenance DM), the DM measured, with a measuring tape and a step stool, the distance from the end of the ceiling curtain tract and right wall and the gap measured eight and a half inches. The MS stated there should not be any gap at all and the eight-and-a-half-inch gap present prevented Resident 103 from having the full privacy Resident 103 is entitled to. During a review of the facility provided Policy and Procedure (P&P) titled, Resident Rights last reviewed on 1/8/2025, the P&P indicated that residents have the right to privacy. (continued on next page)

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility provided P&P titled, Privacy and Confidentiality, last reviewed on 1/8/2025, the P&P indicated all resident's have a right to personal privacy, including accommodations.