STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056382	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post-Acute Care Center	14122 Hubbard Street Sylmar, CA 91342

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 59 of 63 residents on regular (diet with no restriction) and therapeutic diets (a meal plan tailored to a resident's specific medical condition to treat or manage it) including Resident 71 when [NAME] 1 did not follow the recipes for regular and puree corn bread for lunch. This failure had the potential to result in decrease in food flavor, decrease in food and nutrient intake resulting in unintended weight loss. Cross-reference F804.Findings: During a review of Resident 71's admission Record, the admission record indicated the facility admitted Resident 71 on 11/21/2025 with diagnosis including, but not limited to, type two (2) diabetes (too much sugar in the blood because the body cannot use insulin right away), hyperlipidemia (too much fat in the blood that can clog arteries and harm the heart) and essential hypertension (high blood pressure). During a review of Resident 71's History and Physical (H&P), dated 11/24/2025, the H&P indicated the residents can make needs known and make medical decisions. During a review of Resident 71's Order Summary Report, dated 11/26/2025, the order summary report indicated Resident 71 was ordered no added salt (no salt packet on the tray), consistent carbohydrate diet (diet containing the same amount of carbohydrate each meal to manage blood sugar), cardiac diet (diet containing foods with low fat and low cholesterol), soft and bite sized texture (foods that are soft, tender and moist with no liquid separation that could be mashed or broken down with pressure from fork, spoon or chopstick), thin liquid consistency. During an interview on 12/1/2025 at 11 a.m. with Resident 71, Resident 71 stated the food sucks and the food does not taste like anything. Resident 71 stated he had pancakes and rice for breakfast, and it tasted strange. During a review of the facility's daily cook's spreadsheet (a sheet that contains each diet and what food and portions each diet would get) titled Winter Menus, dated 12/1/2025, the spreadsheet indicated residents on regular diet would include the following foods in the tray: - Three bean chili 1 cup (c, household measurement) - Tossed green salad 1/2 c - Salad dressing 1/2 ounces (oz, unit of measurement) - Corn bread with green chilis 1 - Margarine 1 teaspoon (tsp, household measurement) - Citrus chiffon delight 2x2 1/2 inch 1 piece (pc) - Milk 4 oz During a review of the facility's daily cook's spreadsheet titled Winter Menus, dated 12/1/2025, the spreadsheet indicated residents on puree diet/IDDSI level 4 (food that are soft and pudding like consistency) would include the following foods in the tray: - Puree three bean chili 1 cup - Puree cauliflower 1/3 c - Puree cornbread 1/4 c - Puree coffee cake 1/3 c - Margarine 1 pc - Pudding 1/3 c During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 12/1/2025 at 12:44 p.m. of the regular diet tray with the Dietary Supervisor (DS), the DS stated the taste of the corn bread was good and she could taste the corn however it's not flavorful. The DS stated she needed to check the recipe for the corn bread as the spreadsheet indicated there would be green chili but there was no chili taste in the corn bread. During a concurrent test tray observation and interview on 12/1/2025 at 12:57 p.m. of the puree diet tray with the DS, the DS stated the puree corn bread tasted like regular bread and they used corn bread from the box. During an interview on 12/2/2025 at 8:48 a.m. with [NAME] 1, [NAME] 1 stated he made the corn bread yesterday following the ingredients and instructions from the recipe. [NAME] 1 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated he made the corn bread from the box and not from scratch, but he forgot to add the chiles and sour cream. [NAME] 1 stated not adding the chiles and sour cream affected the flavor of the corn bread and residents would not eat it and complain about it as a potential outcome. During an interview on 12/2/2025 at 8:56 a.m. with the DS, the DS stated the staff follow the standardized recipes for food so that residents could get the right nutrients, calories and the food would have good flavors. The DS stated since [NAME] 1 forgot to add the chili and sour cream to the corn bread, it changed the flavor of the corn bread. The DS stated residents might not like the food and would not eat it resulting in weight loss as a potential outcome for not following the recipe. During a review of the policies and procedures (P&P) titled Food Preparation, last reviewed 1/2/2025, the P&P indicated (1) The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. (2) Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines. During a review of the P&P titled Healthcare Menus Direct, LLC. Menu System Guide, last reviewed 1/2/2025, the P&P indicated This book contains information on general food safety and miscellaneous resources for the use of the menu system, along with all of the breakfast and vegetables (including all salad) recipes needed throughout the upcoming menu cycles. During a review of the facility's recipe titled Cornbread with [NAME] Chiles last reviewed 1/2/2025, the recipe indicated ingredients: corn bread mix, canned green chilies, sour cream. Directions: If using corn bread mix: 1. Follow package directions, making cornbread as you normally would for each resident to have 2x2 1/2 inches portion (2 oz) and then add chilies and sour cream, stirring to mix only. During a review of the facility's recipe titled Recipe: Pureed IDDSI Level 4) Breads, Cakes, Cookies, Pancakes, French Toast, Sweet Rolls, Waffles, Tortillas, Sandwiches and Other Bread Products, last reviewed 1/2/2025, the recipe indicated Item per recipe, warm milk or cold milk if product is to be served cold.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents' rights to formulate an Advance Directive (AD - a legal document that outlines an individual's wishes regarding medical care in the event they become incapacitated and unable to communicate their preferences) for three of three sampled residents (Resident 2, 11, and 59) reviewed under the AD care area by failing to: 1. Provide written information concerning the right to formulate an AD for Resident 2 and 11. 2. Ensure a copy of advance directive was readily available in the medical chart for Resident 59. These deficient practices had the potential to violate the resident's right to have their wishes honored regarding health care decisions. Findings: a. During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted the resident on 12/18/2018 and most recently re-admitted the resident on 12/30/2024 with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that is characterized by disturbances in thought), and epilepsy (chronic disorder that causes recurrent seizures [abnormal electrical activity in the brain]). During a review of Resident 2's Minimum Data Set (MDS – resident assessment tool), dated 9/30/2025, the MDS indicated the resident was able to understand others and was able to make himself understood and was dependent on staff for bathing, lower body dressing, and personal hygiene. During a review of Resident 2's History and Physical (H&P), dated 11/12/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 2's Advance Directive Acknowledgement form (ADAF), dated 12/23/2014, the form indicated the resident did not have an AD. The form was not completed regarding, Please read and initial the following statements:1.__ I have been given written materials about my right to accept or refuse medical treatments. 2.__ I have been informed of my rights to formulate an Advance Directive.3.__ I understand that I am not required to have an Advance Directive in order to receive medical treatment at this facility.4.__ I understand that the terms of any advance directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. During a concurrent interview and record review on 12/3/2025 at 1:21 p.m. with Minimum Data Set Coordinator (MDSC), the MDSC reviewed Resident 2's ADAF, dated 12/23/2014. The MDSC stated the Advance Directive Acknowledgement form did not indicate that the AD was discussed with the resident or that written information was provided regarding formulating an AD to the resident or resident representative (RP). The MDSC stated the Social Services Director (SSD) discussed ADs with residents and RPs. During a concurrent interview and record review on 12/4/2025 at 8:50 a.m. with the SSD, the SSD reviewed Resident 2's ADAF, dated 12/23/2014. The SSD stated the AD is a document that gives information on a resident's wishes regarding their care for when they are no longer able to make decisions for themselves. The SSD stated the facility AD process is to speak with the resident or RP upon admission, ask if the resident has an AD, discuss the resident's right to formulate an AD, and then document on the AD Acknowledgement form. The SSD stated Resident 2's AD Acknowledgement form is an old version and does not indicate the resident's initials to confirm that he was provided with written information regarding the right to formulate the AD. The SSD stated she has never (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discussed the AD with Resident 2 and there is no documented evidence that the resident was provided written information. During an observation on 12/4/2025 at 8:50 a.m., observed the SSD enter Resident 2's room and the resident stated he did not know what an AD was. Resident 2 stated he did not remember if he was ever provided information regarding an AD. During a concurrent interview and record review on 12/4/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedure (P&P) regarding ADs. The DON stated the AD is where a resident indicates their wishes for care when they become unable to make their own decisions. The DON stated when Resident 2 was not provided written information regarding the AD, the facility P&P was not followed with the potential that the facility staff may not be aware of the resident's wishes for care and the facility may be too aggressive with treatments or not aggressive enough. During a review of the facility provided P&P titled, Advance Directives, last reviewed 1/2/2025, the P&P indicated The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Advance care planning - a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated . Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative. Written information includes a description of the facility's policies to implement advance directives and applicable state law. b. During a review of Resident 11's AR, the AR indicated the facility admitted the resident on 10/12/0216, and readmitted the resident on 1/22/2025, with diagnoses including malignant neoplasm (cancerous tumors) of large intestine, cerebrovascular accident (another term for a stroke, which is a medical emergency that happens when blood flow to the brain is interrupted), and atrial fibrillation (an irregular heartbeat that occurs when the electrical signals in the atria [the two upper chambers of the heart] fire rapidly at the same time). During a review of Resident 11's H&P, dated 5/25/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 11's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental functions like thinking, reasoning, memory, and problem-solving are working well enough to manage daily life, showing sufficient judgment and organization, without significant impairment from dementia or other conditions, though some subtle age-related changes might still occur). The MDS indicated the resident actively participated in the assessment and goal setting of care in the facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's ADAF, dated 12/26/2014, the ADAF did not specify if the following information was provided to the resident: - given written materials about the resident's right to accept or refuse medical treatments. - have been informed of the resident's right to formulate an advance directive. - understood that the resident was not required to have an advance directive in order to receive medical treatment. - understood that the terms of the advance directive that the resident had executed will be followed by the health care facility. During a concurrent interview and record review on 12/2/2025 at 8:30 a.m. with Treatment Nurse (TN) 1, reviewed Resident 11's Advance Directive on chart. TN 1 stated he cannot find the ADAF on the medical chart of the resident. TN 1 stated he will ask the SSD, if they have them. TN 1 stated the ADAF should always be in the chart to ensure resident's wishes were followed. During a concurrent interview and record review on 12/2/2025 at 8:45 a.m. with the SSD, reviewed Resident 11's medical chart and electronic chart. The SSD stated she cannot find the latest ADAF on the medical chart and the electronic chart and it was probably filed on the old charts room; she will have it pulled out. The SSD found the old ADAF and stated the form was incompletely filled out. The SSD stated it did not indicate the following: - given written materials about the resident's right to accept or refuse medical treatments - have been informed of the resident's right to formulate an advance directive - understood that the resident was not required to have an advance directive in order to receive medical treatment - understood that the terms of the advance directive that the resident had executed will be followed by the health care facility The SSD stated the above information should be filled out to ensure the advance directive formulation was offered and understood by the resident. The SSD stated the failure of her department to completely fill out the ADAF form violated Resident 11's right to formulation of advance directive. During an interview on 12/4/2025, at 2:06 p.m., with the DON, the DON stated the Medical Records Department should have audited all charts for the presence of the ADAF. The DON stated Resident 11 should have the ADAF readily available in chart and completely filled out to ensure the resident was aware of their right to formulate advance directive. The DON stated the failure of the staff to ensure the ADAF was on the chart readily available for reference has denied the resident of their right to formulate an advanced directive and had predisposed the resident for aggressive or passive treatment during end-of-life care (holistic support [medical, emotional, spiritual, social] for people nearing the end of life, focusing on comfort, dignity, and quality of life, often involving palliative care and addressing the needs of both the patient and their family during the final stages of a serious illness). During a review of the facility's recent P&P titled Advance Directives, last reviewed on 1/2/2025, the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P&P indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Determining Existence of Advance Directive 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. If the Resident Has an Advance Directive 1. If the resident or the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. c. During a review of Resident 59's AR, the AR indicated the facility admitted the resident on 11/12/2025, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), parkinsonism (a brain disorder that makes it hard to control body movements, caused by nerve cells in the brain dying off and not making enough of a crucial chemical called dopamine), and long-term use of insulin (a crucial hormone from the pancreas that acts like a key, unlocking the body's cells to let sugar [glucose] in for energy or storage, which lowers blood sugar levels, especially after eating). During a review of Resident 59's H&P, dated 11/14/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 59's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and usually understands others and had moderately impaired cognition (signifies noticeable thinking or memory problems beyond normal aging, impacting complex daily tasks like managing finances or appointments, but still allowing independence in basic self-care [bathing, dressing]). The MDS indicated that the resident and family actively participated in the assessment and goal setting of the resident's care in the facility. During a review of Resident 59's ADAF, dated 11/20/2025, the ADAF indicated the resident had an advanced directive. During a concurrent interview and record review on 12/2/2025, at 8:30 a.m., with TN 1, reviewed Resident 59's Advance Directive on chart. TN 1 stated there is an ADAF on the medical chart of the resident and it indicated the resident had an advanced directive however, he cannot find the copy of the advance directive on the medical chart. TN 1 stated if the resident had an advanced directive, it should be readily available in the chart for reference to know the resident's wished during end-of-life care. TN 1 stated he will ask the Social Services Director (SSD), if they have them. During a concurrent interview and record review on 12/2/2025, at 8:45 a.m., with the SSD, reviewed Resident 59's medical chart and electronic chart. The SSD stated the resident had the ADAF on the medical chart and it indicated the resident had an advanced directive, however she cannot find the copy of the advanced directive on the medical chart of the resident. The SSD stated they were not able to follow up and secure a copy of the resident's advanced directive from the resident or (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	representative. The SSD stated the reasonable amount of time to secure a copy of the advanced directive was seven (7) days. The SSD stated it was more than 7 days since they last followed up for a copy of the advance directive to be placed on the chart readily available for staff to reference. The SSD stated the failure of her department to follow up and place a copy of the resident's advance directive had the potential to violate Resident 59's wishes regarding end-of-life care. During an interview on 12/4/2025, at 2:06 p.m., with the DON, the DON stated the Medical Records Department should have audited all charts for the presence of ADAF. The DON stated Resident 59 should have had the copy of the advance directive readily available in chart to ensure the resident wishes during end-of-life care is honored. The DON stated the failure of the staff to ensure a copy of the advanced directive was readily available on the has denied the resident of their right to honor their advanced directive and had predisposed the resident for aggressive or passive treatment during end-of-life care. During a review of the facility's recent P&P titled Advance Directives, last reviewed on 1/2/2025, the P&P indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Determining Existence of Advance Directive 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. If the Resident Has an Advance Directive 1. If the resident of the residents representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely for four of six sampled residents (Residents 20, 55, 19, and 69) reviewed under environment facility task by failing to ensure: 1. Resident 20's bed remote control cord did not have exposed/frayed wires. 2. Resident 55's hot water bathroom temperature was within 105 to 120 degrees Fahrenheit (F, a method of measuring temperature). 3. Residents 19 and 69's room wall clocks were maintained with accurate time readings.ˆ The deficient practices had violated the resident's right to a safe, clean, comfortable and homelike environment. Findings: 1. During a review of Resident 20's admission Record (AR), the AR indicated the facility admitted the resident on 8/9/2025, with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), muscle weakness, and other lack of coordination. During a review of Resident 20's History and Physical (H&P), dated 8/11/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS, a resident assessment tool), dated 11/20/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a concurrent observation and interview on 12/1/2025 at 9:14 a.m., with Treatment Nurse (TN) 1, inside Resident 20's room, observed Resident 20's bed remote control cord coiled on the left upper side rail of the resident with exposed/frayed wires on them. TN 1 stated the bed remote control cord should not have any exposed/frayed wires as the resident might experience an accident such as electrocution (the injury or killing of someone by electric shock) and can cause fire. TN 1 stated all staff were responsible for reporting broken equipment to the Maintenance Department for repairs and it should be reported immediately if it poses hazards to residents. During an interview on 12/4/2025, at 2:06 p.m., with the Director of Nursing (DON), the DON stated all staff were responsible for reporting hazards, such as broken equipment in the facility to the Maintenance Department. The DON stated the staff should have done environment safety checks on Resident 20 to identify hazards and broken equipment that can cause accidents or hazards at least every two (2) hours. The DON stated the failure of the staff to identify the hazard of frayed/exposed wires on the resident's bed remote control can lead to the resident not being able to reposition the bed according to his needs and could cause potential accidents such as electrocution and fire. The DON stated their Policy for Environmental Services Safety was not followed. During a review of the facility's recent policy and procedure (P&P) titled Environmental Services Safety, last reviewed on 1/2/2025, the P&P indicated the Maintenance Director shall be responsible for maintaining safety standards, developing safety rules, supervising and training staff in departmental standards. All Environmental Services Department employees shall adhere to the following: -Report defective equipment, unsafe conditions, acts or safety hazards to supervision/manager. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintain patient water temperature in bathroom and shower rooms at 105 degrees F to 120 degrees F. 2. During a review of Resident 55's AR, the AR indicated the facility admitted the resident on 9/22/2025, with diagnoses including cerebral infarction (when a section of brain tissue dies because its blood supply has been cut off), aphasia (a disorder that makes it difficult to speak), and unsteadiness on feet. During a review of Resident 55's H&P, dated 9/24/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 55's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. During a concurrent observation and interview on 12/1/2025 at 9:46 a.m., with Resident 55, Resident 55 stated the water in his bathroom does not warm up enough for him to bathe comfortably. Resident 55 stated the water remains cold and it does not warm up. The bathroom faucet in the bathroom was run for 5 to 10 minutes, yet the water temperature remained lukewarm. During a concurrent observation and interview on 12/1/2025, at 10:33 a.m., with the Manager of Housekeeping, Linens, and Maintenance (MHKLM), inside Resident 55's bathroom, the MHKLM ran the hot water for 5 to 10 minutes and measured the water temperature. The water temperature checks registered between 95 to 96 degrees F. The MHKLM stated the hot water should be within 115 degrees F. The MHKLM stated it was probably because the room was so far from the boiler that is why the hot water would not warm up. The MHKLM stated he will adjust the water temperature from the boiler to increase the temperature of the hot water in the resident's room. During an interview on 12/4/2025, at 2:06 p.m., with the DON, the DON stated the staff should have reported to the Maintenance Department Resident 55's issue with the hot water temperature not warming up. The DON stated the temperature of the hot water in the residents` bathrooms should be within 105 to 120 degrees F for them to comfortably take a bath. The DON stated the failure of the staff to report the issue of the hot water not warming up in Resident 55's bathroom to the Maintenance Department and keeping the hot water below 105 degrees F had caused Resident 55's discomfort in taking a bath because the water was not warm enough per resident's preference. The DON stated their Policy for Environmental Services Safety was not followed. During a review of the facility's recent P&P titled Environmental Services Safety, last reviewed on 1/2/2025, the P&P indicated the Maintenance Director shall be responsible for maintaining safety standards, developing safety rules, supervising and training staff in departmental standards. All Environmental Services Department employees shall adhere to the following: -Report defective equipment, unsafe conditions, acts or safety hazards to supervision/manager. Maintain patient water temperature in bathroom and shower rooms at 105 degrees F to 120 degrees F. 3. During a review of Resident 19's admission Record (AR) dated 12/3/2025, the AR indicated the facility admitted the resident on 8/23/2025, with diagnosis including but not limited to a cerebral infarction affecting of the left non dominant side (a blood vessel in the brain is blocked stopping blood flow and oxygen from reaching that part of the brain causing damage to the brain), anxiety disorder (a condition where a person feels a strong sense of worry) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 cognitive ability (thought process) was moderately impaired. The MDS indicated Resident 19 required substantial/maximal assistance partially (helper does more than half the effort) from staff for activities of daily living (ADL's – routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a review of Resident 19's Physician's Progress Note (PPN) dated 8/23/25, the PPN indicated Resident 19 had the capacity to understand and make her own decisions. During a concurrent observation and interview on 12/1/2025 at 9:10 a.m., inside Resident 19`s room, the resident stated that she (Resident 19) needed a battery for her wall clock, because the clock has shown the wrong time since her admission to the facility. Resident 19 stated she (Resident 19) has told the facility staff, but nothing was done. During an observation of the wall clock on 12/1/2025 at 9:10 a.m., the wall clock read 8:45 a.m. 4. During a review of Resident 69's AR dated 12/3/2025, the AR indicated that the facility admitted the resident on 11/26/2025 with diagnosis including but not limited to diabetes mellitus, major depressive disorder (a condition where a person feels deep sadness, loss of interests lasting for longer periods of time), and right arm fracture (broken arm). During a review of Resident 69's MDS dated [DATE], the MDS indicated Resident 69's cognitive ability was moderately impaired. The MDS indicated Resident 69 required substantial/maximal assistance partially from staff for activities of daily living. During a review of Resident 69'd Internal Medicine Initial Evaluation report (IMIE), dated 11/28/2025, the IMIE report indicated Resident 69 had the capacity to understand and make decisions. During a concurrent observation and interview on 12/1/2025 at 8:05 a.m., inside Resident 69`s room, the resident stated that the clock on the wall is wrong. Resident 69 asked the surveyor for the time and stated that staff have not been able to fix his clock. During an observation of the wall clock on 12/1/2025 at 9:10 a.m., the wall clock read 2:59. During an interview on 12/2/2025 at 8:20 a.m., with the Maintenance Supervisor (MS), MS stated wall clocks inside residents` rooms should be working and the batteries are required to be changed.  During an interview on 12/4/2025 at 7:10 a.m., with the Director of Nursing (DON), the DON stated that wall clocks inside residents` rooms should read the correct time to provide orientation to our residents. The DON stated it is the residents` right to have a working wall clock in their rooms for planning purposes to attend an activity at the correct time. The DON stated residents need to know the correct time especially alert and oriented residents. During a review of the facility policy titled Homelike Environment (P&P) dated 2/2021 the P&P indicated, Residents are provided with a safe, clean comfortable and homelike environment and encouraged to use their personal belonging to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort independence and personal need and preferences.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for three of three sampled residents (Residents 62, 11, and 59) reviewed for physical restraints care area by failing to ensure: 1. A. Resident 62's concave (a deluxe grade mattress that features concave sides, so the patient is encouraged to lie in the middle of it, thereby minimizing the possibility of falling) bed with bolster mattress (isˆdesigned with safety as the top priority, ensuring that no one slips out of bed accidentally, which can lead to falls or other injuries) had a physician's order, informed consent, restraint assessment, and care plan on its use. B. Resident 62's restraint mid-siderail (metal or plastic bars positioned along the side of a bed) had a physician's order, restraint assessment, and a care plan. 2. Resident 11's restraint mid-siderail had a physician's order, restraint assessment, and a care plan. 3. Resident 59's restraint mid-siderail had a physician's order, informed consent, restraint assessment, and care plan. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a resident being caught, trapped, entangled, or strangledˆin openings under, within, or between bed rails or in gaps between the mattress and side rails or head/footboards), and death of residents. Findings: 1. During a review of Resident 62's admission Record (AR), the AR indicated the facility admitted the resident on 3/26/2025, with diagnoses including encephalopathy (a group of conditions that cause brain dysfunction), epilepsy (a long-term (chronic) disease that causes repeated seizures due to abnormal electrical signals produced by damaged brain cells), and nontraumatic intracerebral hemorrhage (bleeding into the substance of the brain in the absence of trauma or surgery). During a review of Resident 62's History and Physical (H&P), dated 3/28/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 62's Minimum Data Set (MDS - a resident assessment tool), dated 10/6/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had highly impaired vision. The MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions) and was dependent to needing supervision assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 62's Order Summary Report (OSR), dated 12/5/2025, the OSR did not indicate an order for mid-siderails and concave/bed with bolsters. During a review of Resident 62's Care Plan (CP) Report titled, The resident is at risk for falls/injury related to confusion, unaware of safety needs etc., last revised on 4/8/2025, the CP indicated an intervention of bilateral 1/4 side rails (the quarter rail, approximately 18 inches long when mounted on a hospital bed, can be used as a head assist, head rail, or foot rail.) up in bed to aid in mobility/positioning and transfer. During a concurrent observation and interview on 12/1/2025, at 9:14 a.m., with Treatment Nurse (TN) 1, inside Resident 62's room, observed with TN 1 Resident 62 had a mid-siderail on both sides of the resident's bed. TN 1 stated the mid-siderail was a restraint as it makes it hard for the resident to get out of bed and the resident cannot place the mid-siderail down by himself as the staff could apply and remove them. TN 1 stated before they apply a restraint they need to have a physician's order, informed consent, restraint, assessment, and a person-centered care plan on its use. TN 1 stated applying the restraint without the components mentioned above predisposes the resident to accidents such as bed entrapment. During a concurrent observation and interview on 12/1/2025 at 10 a.m. with Certified Nursing Assistant (CNA) 3, inside Resident 62's room, observed with CNA 3 Resident 62's (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mattress had a built-in bolster on both the upper and lower sides of the bed tucked under the sheet. CNA 3 stated the bolsters were built-in and cannot be removed by the resident in bed. During a concurrent observation and interview on 12/2/2025 at 8:55 a.m. with Licensed Vocational Nurse (LVN) 1, inside Resident 62's room, observed with LVN 1 Resident 62's bed with both mid-siderails up. LVN 1 measured the length of the mid-siderail and recorded 26 inches in length. LVN stated if the mid-siderails applied is the same as 1/4 siderail. LVN 1 stated he does not know. During a concurrent interview and record review on 12/3/2025 at 8:14 a.m. with Registered Nurse (RN) 1, Resident 62's Medical Diagnoses, Restraint Assessment, Informed Consents, OSR, and CP were reviewed. RN 1 stated there was no order for bed with bolsters, no restraint assessment, no informed consent, and no care plan on the use of restraint bed with bolster. RN 1 stated applying the restraint bed with bolsters on Resident 62 without physician's order, informed consent, restraint assessment, and a care plan increases the risk of the resident from accidents such as falling from the bed on a higher level as they could climb up the wedge and fall and can potentially suffer from a fracture (break in bone). RN 1 also stated there was no order for mid-siderail on the resident, no assessment for entrapment, and a care plan on its use. RN 1 stated she found an order for 1/4 side rails but they applied a mid-siderail instead. RN 1 stated the mid-siderail can cause accidents to residents such as entrapment and falls with injury due to a higher level of fall when the resident climbs out of the rail and fall. During an interview on 12/4/2025 at 2:06 p.m. with the Director of Nursing (DON), the DON stated concave/bed with bolsters and mid-siderails are restraints because it restricts the freedom of movement of Resident 62. The DON stated before applying a restraint the licensed staff should obtain an order from the physician, obtain an informed consent from the resident or representative after explaining the risk and benefits of it use, perform a restraint assessment, and develop and implement a care plan on it use. The DON stated having all the required elements prior to application of a restraint ensures its safe use and to avoid accidents such as entrapment and fall with injury. The DON stated the licensed staff did not follow their policy on restraint application because they applied the restraint without the elements needed prior to application. 2. During a review of Resident 11's AR, the AR indicated the facility admitted the resident on 10/12/2016, and readmitted the resident on 1/22/2025, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) and cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain). During a review of Resident 11's H&P, dated 5/25/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 11's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had an intact cognition (a person's cognitive abilities like memory, understanding, problem-solving etc.ˆare working usually in all fundamental ways). The MDS indicated the resident was dependent to needing setup assistance on mobility and ADLs. During a review of Resident 11's OSR, dated 1/27/2022, indicated an order for Bilateral 1/4 side rails up in bed and aid in mobility, positioning and transfer (1 side rail only if bed is against the wall). During a review of Resident 11's Fall Risk Assessment (FRA), dated 10/2/2025, the FRA indicated the resident was high risk for falls. During a concurrent observation and interview on 12/1/2025, at 9:14 a.m., with TN 1, inside Resident 11's room, observed with TN 1 Resident 11 had a mid-side rail on both sides of the residents bed. TN 1 stated the mid-siderail was a restraint as it makes it hard for the resident to get out of bed and the resident cannot place the mid-siderail down by himself as the staff could apply and remove them. TN 1 stated before they apply a restraint they need to have a physician's order, informed consent, restraint, assessment, and a person-centered care plan on its use. TN 1 stated applying the restraint without the components mentioned above predisposes the resident to accidents such as bed entrapment. During a concurrent interview and record review on 12/3/2025 at 8:14 a.m. with RN 1, Resident 11's Medical Diagnoses, Restraint Assessment, Informed Consents, OSR, and CP were reviewed. RN 1 stated there was no order for mid-siderail on the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident, no assessment for entrapment, and a care plan on its use. RN 1 stated she found an order for 1/4 side rails but they applied a mid-siderail instead. RN 1 stated the mid-siderail can cause accidents to residents such as entrapment and falls with injury due to a higher level of fall when the resident climbs out of the rail and fall. During an interview on 12/4/2025 at 2:06 p.m. with the DON, the DON stated mid-siderails are restraints because it restricts the freedom of movement of Resident 11. The DON stated before applying a restraint the licensed staff should obtain an order from the physician, obtain an informed consent from the resident or representative after explaining the risk and benefits of it use, perform a restraint assessment, and develop and implement a care plan on it use. The DON stated having all the required elements prior to application of a restraint ensures its safe use and to avoid accidents such as entrapment and fall with injury. The DON stated the licensed staff did not follow their policy on restraint application because they applied the restraint without the elements needed prior to application. 3. During a review of Resident 59's AR, the AR indicated the facility admitted the resident on 11/12/2025, with diagnoses including parkinsonism (is a broad term comprising a clinical syndrome and presenting with various neurodegenerative diseases, which manifest with motor symptoms such as rigidity, tremors, bradykinesia, and unstable posture, leading to profound gait impairment), muscle weakness, and unsteadiness on feet. During a review of Resident 59's H&P, dated 11/14/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 59's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and usually understands others and had a highly impaired vision. The MDS indicated the resident had moderate cognitive impairment (more pronounced deficits emerge, interfering with daily activities) and was dependent to needing supervision assistance on mobility and ADLs. During a review of Resident 59's OSR, dated 12/4/2025, the OSR did not indicate an order for mid-siderails. During a review of Resident 59's FRA, dated 11/13/2025, the FRA indicated the resident was high risk for falls. During a concurrent observation and interview on 12/1/2025 at 9:14 a.m. with TN 1, inside Resident 59's room, observed with TN 1 Resident 59 had a mid-side rail on both sides of the residents bed. TN 1 stated the mid-siderail was a restraint as it makes it hard for the resident to get out of bed and the resident cannot place the mid-siderail down by himself as the staff could apply and remove them. TN 1 stated before they apply a restraint they need to have a physician's order, informed consent, restraint, assessment, and a person-centered care plan on its use. TN 1 stated applying the restraint without the components mentioned above predisposes the resident to accidents such as bed entrapment. During a concurrent interview and record review on 12/3/2025, at 8:14 a.m., with RN 1, reviewed with RN 1 Resident 59's Medical Diagnoses, Restraint Assessment, Informed Consents, OSR, and CP. RN 1 stated there was no order for mid-siderail on the resident, no assessment for entrapment, and a care plan on its use. RN 1 stated she found an order for 1/4 side rails but they applied a mid-siderail instead. RN 1 stated the mid-siderail can cause accidents to residents such as entrapment and falls with injury due to a higher level of fall when the resident climbs out of the rail and fall. During an interview on 12/4/2025 at 2:06 p.m. with the DON, the DON stated mid-siderails are restraints because it restricts the freedom of movement of Resident 59. The DON stated before applying a restraint the licensed staff should obtain an order from the physician, obtain an informed consent from the resident or representative after explaining the risk and benefits of it use, perform a restraint assessment, and develop and implement a care plan on it use. The DON stated having all the required elements prior to application of a restraint ensures its safe use and to avoid accidents such as entrapment and fall with injury. The DON stated the licensed staff did not follow their policy on restraint application because they applied the restraint without the elements needed prior to application. During a review of the facility's recent policy and procedure (P&P) titled Use of Restraints, last reviewed on 1/2/2025, the P&P indicated: Policy Statement Restraints shall only be used for safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. Policy (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interpretation and Implementation 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. If the resident cannot remove the device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climber over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. 9. Restraints shall only be used upon the written order a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 14. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use. 17. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). During a review of the facility's recent P&P titled Resident Rights Guidelines for All Nursing Procedures, last reviewed on 1/2/2025, the P&P indicated to provide general guidelines for resident's rights while caring for the resident. Preparation 1. Prior to having direct care responsibilities for residents, staff must have appropriate in-service training on resident rights, including: g. Use of restraints During a review of the facility-provided Installation Information of Side Rails, undated, the Information indicated a danger of risk of death, injury or damage. The Assist rails have three positions: - Guard (Down) (A): This position is intended to prevent an individual from inadvertently rolling out of bed. - Assist (Up) (B): Assist the user in standing or sitting up on bed. - Transfer (Back) (C): Allows unimpeded access to user. During a review of the facility-provided Drive Defined Perimeter Mattress Cover, undated, the Information indicated the defined perimeter mattress cover creates a raised rail, defined perimeter for enhanced fall prevention.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medication (medications that affect the mind, emotions, and behavior) and the use of chemical restraints (any drug that is used for discipline or staff convenience and not required to treat medical symptoms) by: 1. Failing to provide ongoing re-evaluation of the need for psychotropic medication and ensure as needed (PRN) lorazepam (medication to relieve symptoms of anxiety [a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear]) was ordered with an end date (time at which a medication will no longer be dispensed and will be required to be re-prescribed) for two sampled residents (Residents 5 and 32). 2. Failing to monitor the adverse effects (unintended or unwanted effects caused by medication) for the use of Seroquel (medication used to treat various mental health conditions) medication for one of five sampled residents (Resident 2) reviewed under unnecessary medication care area. These deficient practices had the potential to result in the administration of unnecessary psychotropic medication resulting in chemical restraints and placed residents at risk for decline in physical functioning, isolation (a state of reduced social interaction and lack of meaningful connections with others), and injury from falls. Findings: a.1. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on [DATE] and was most recently re-admitted on [DATE] with diagnoses that included unspecified chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute exacerbation (a sudden, significant worsening of a patient's usual chronic condition), human immunodeficiency virus (HIV - a virus that attacks the body's immune system), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 5's Minimum Data Set (MDS – resident assessment tool), dated [DATE], the MDS indicated the resident was able to make himself understood and able to understand others. The MDS further indicated Resident 5 required substantial staff assistance for bathing, required partial assistance with toileting and personal hygiene, and required supervision with eating. During a review of Resident 5's History and Physical (H&P), dated [DATE], the H&P indicated the resident could make his needs known but could not make decisions. The H&P further indicated Resident 5 had a terminal diagnosis of COPD with exacerbation. During a review of Resident 5's Care Plan (CP) regarding the resident uses anti-anxiety medication, lorazepam, initiated [DATE], the CP indicated a goal that the resident would be free from adverse reactions related to anti-anxiety therapy. The CP indicated to monitor for any adverse reactions to anti-anxiety therapy including drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset or blurred or double vision. During a review of Resident 5's Physician Orders, the Physician Orders indicated an order for lorazepam oral concentrate two milligrams (mg, a unit of measurement) per milliliter (mL, a unit of liquid measurement), give 0.25 mL sublingually (under the tongue) every four hours as needed for shortness of breath (SOB), anxiety, restlessness, dated [DATE] with no indicated end date. During a concurrent interview and record review on [DATE] at 2:49 p.m., with the Minimum Data Set Coordinator (MDSC), the MDSC reviewed Resident 5's physician orders. The MDSC stated lorazepam (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was a psychotropic medication with a high risk for adverse effects like a change in cognition potentially leading to falls in the elderly. The MDSC stated psychotropic medications require routine evaluations by the physician to determine if they are able to gradually reduce the dosage due to the potential side effects. The MDSC stated Resident 5 was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) and was prescribed PRN lorazepam for SOB, anxiety, and restlessness. The MDSD stated Resident 5's lorazepam order was ordered indefinitely and did not have a stop date. During an interview on [DATE] at 3:10 p.m., with the Director of Nursing (DON), the DON stated resident psychotropic medication use is continually re-evaluated to prevent the unnecessary administration of medications with a high risk of side effects like excessive drowsiness and appetite suppression. The DON stated PRN psychotropic medications are ordered with a 14 day stop date to ensure the need is evaluated. The DON stated even when a resident on hospice receives PRN psychotropics, there needs to be a stop date on the order. During a follow-up concurrent interview and record review on [DATE] at 2:30 p.m., with the DON, the DON reviewed the facility policy and procedure (P&P) regarding psychotropic medication. The DON stated that when PRN lorazepam is not ordered with a stop date and is not re-evaluated it may be considered a chemical restraint. The DON stated the facility P&P was not followed when Resident 5's PRN lorazepam was ordered without a stop date potentially leading to the unnecessary administration of psychotropic medication. During a review of the facility P&P titled, Psychotropic Medication Use, last reviewed [DATE], the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2.Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: c. Anti-anxiety medications; . 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: . c. duration. 4.Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.a. PRN orders for psychotropic medications are limited to 14 days.(1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order . a.2. During a review of Resident 32's AR, the AR indicated the facility admitted the resident on [DATE] and was most recently re-admitted on [DATE] with diagnoses that included post procedural peritoneal adhesions (bands of scar tissue that form between abdominal tissues and organs), anxiety disorder, and joint pain. During a review of Resident 32's MDS, dated [DATE], the MDS indicated the resident was able to make himself understood and able to understand others. The MDS further indicated Resident 32 required substantial staff assistance for oral hygiene and upper body dressing, and was dependent on (continued on next page)

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	056382	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post-Acute Care Center	14122 Hubbard Street Sylmar, CA 91342

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff for personal hygiene, toileting, bathing, and lower body dressing. During a review of Resident 32's H&P, dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions. The H&P further indicated Resident 32 had transitioned to comfort care and his code status was do not resuscitate / do not intubate (DNR / DNI - a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating, and do not provide mechanical assistance with breathing). During a review of Resident 32's CP regarding the resident uses anti-anxiety medication, lorazepam, initiated [DATE], the CP indicated a goal that the resident would be free from adverse reactions related to anti-anxiety therapy. The CP indicated to monitor for any adverse reactions to anti-anxiety therapy including drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset or blurred or double vision. During a review of Resident 32's Physician Orders, the Physician Orders indicated an order for lorazepam oral concentrate two mg per mL, give 0.25 mL sublingually every four hours as needed for anxiety manifested by hyperventilating leading to SOB / fidgety, dated [DATE] with no indicated end date. During a concurrent interview and record review on [DATE] at 2:49 p.m., with the MDSC, the MDSC reviewed Resident 32's physician orders. The MDSC stated lorazepam was a psychotropic medication with a high risk for adverse effects like a change in cognition potentially leading to falls in the elderly. The MDSC stated psychotropic medications require routine evaluations by the physician to determine if they are able to gradually reduce the dosage due to the potential side effects. The MDSC stated Resident 32 was on hospice and was prescribed PRN lorazepam for SOB and anxiety. The MDSD stated Resident 32's lorazepam order was ordered indefinitely and did not have a stop date. During an interview on [DATE] at 3:10 p.m., with the DON, the DON stated resident psychotropic medication use is continually re-evaluated to prevent the unnecessary administration of medications with a high risk of side effects like excessive drowsiness and appetite suppression. The DON stated PRN psychotropic medications are ordered with a 14 day stop date to ensure the need is evaluated. The DON stated that even when a resident is on hospice and receives PRN psychotropics, there needs to be a stop date on the order. During a follow-up concurrent interview and record review on [DATE] at 2:30 p.m., with the DON, the DON reviewed the facility P&P regarding psychotropic medication. The DON stated that when PRN lorazepam is not ordered with a stop date and is not re-evaluated it may be considered a chemical restraint. The DON stated the facility P&P was not followed when Resident 32's PRN lorazepam was ordered without a stop date potentially leading to the unnecessary administration of psychotropic medication. During a review of the facility P&P titled, Psychotropic Medication Use, last reviewed [DATE], the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2.Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: c. Anti-anxiety medications; . 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	management includes: . c. duration. 4.Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. 12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.a. PRN orders for psychotropic medications are limited to 14 days.(1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order . b. During a review of Resident 2's AR, the AR indicated the facility originally admitted the resident on [DATE] and [DATE] with diagnosis including, vitamin D deficiency, schizophrenia (a mental illness that is characterized by disturbances in thought), and epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's Care Plan (CP) Report focused on use of Seroquel, dated [DATE], the CP indicated the resident with goals of free from psychotropic drug related complications with interventions including monitor for TCAP: tardive dyskinesia (characterized by involuntary movements of the face and jaw), cognitive impairment, akathisia (inability to remain still), and Parkinsonism (a set of movement symptoms associated with Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements] and other disorders) every shift and tally with hashmark. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident was able to makes self-understood and had the ability to understand others. During a review of Resident 2's H&P, dated [DATE], the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 2's Order Summary Report, dated [DATE], the Order Summary Report indicated Seroquel, give 12.5 milligrams (MG-a unit of measurement) by mouth at bedtime for schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) manifested by auditory and visual hallucinations. During a concurrent interview and record review on [DATE] at 9:08 a.m., reviewed Resident 2's Order Summary Report and Medication Administration Record for the month of 12/2025 with the MDS Coordinator (MDSC). The MDSC stated Seroquel is an antipsychotic medication (medication used to treat various mental health conditions) and needs monitoring for behavior, side effects, adverse effects including TCAP. The MDSC stated there was no order for TCAP monitoring and should have had an order for TCAP monitoring. The MDSC stated that they did not implement the care plan to monitor the adverse effects for the use of Seroquel. The MDSC stated that when adverse effects are not monitored the resident could potentially experience altered level of consciousness and falls. During an interview on [DATE] at 2:30 p.m. with the DON, the DON stated that there should be an order for adverse effects monitoring on the use of Seroquel including the TCAP to make sure the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident is not exhibiting these adverse effects and they would adjust the medication accordingly. The DON stated the resident would experience adverse effects and they would not be able to catch it. During a review of the facility's (P&P) titled, Psychotropic Medication Use, last reviewed [DATE], the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. 2.Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotic 13. Residents receiving psychotropic medications are monitored for adverse consequences, including: d. neurologic effects – agitation, distress, Parkinsonism, tardive dyskinesia. 14. If psychotropic medications are identified as possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be continued and document the rationale for this decision.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of eight sampled residents (Resident 29) was afforded the opportunity to participate in the development of the resident's care plan (a document outlining a detailed approach to care customized to an individual resident's need). This deficient practice had the potential to result in Resident 29 receiving inadequate care and supervision at the facility. Findings: During a review of Resident 29's admission Record (AR) dated 12/3/2025 , the AR indicated the facility admitted the resident on 2/21/2023, and readmitted on [DATE], with diagnosis including but not limited to diabetes mellitus (DM-a disorder characterized by difficulty in blook sugar control and poor wound healing) dementia with other behavioral disturbances (a progressive state of decline in mental abilities) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 29's Minimum Data Set (MDS-a resident assessment tool) dated 11/4/2025, the MDS indicated Resident 29 cognitive ability (thought process) was moderately impaired. The MDS indicated Resident 29 required substantial/maximal assistance partially (helper does more than half the effort) from staff for activities of daily living (ADL's - routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a review of Resident 29's physicians progress note (PPN) dated 11/14/2025, the PPN indicated Resident 29 was able to make her needs known but could not make medical decisions. During a review of the care plan report dated 7/18/2023, The care plan report indicated to encourage family involvement. Invite residents' family to attend special events, activities, meal. During an interview on 12/1/2025 at 10:11 a.m., with Resident 29's emergency contact (EC) 2, EC2 stated she had not been made aware of any care plan conferences or interdisciplinary team meetings scheduled by the facility for the resident. EC2 stated that Resident 29 has not attended any conferences and stated she (EC2) would attend any conference arranged to discuss Resident 29`s care if she (EC2) had received an invitation or notification. During a review of the MDS Quarterly/Annual Care Conference notes dated 2/7/2025, 5/6/2025, 8/5/2025, and 11/4/2025, the MDS indicated that Resident 29 and Responsible Party attended the conferences with a check mark placed in front of their names to indicate attendance. During an interview on 12/3/2025 at 2:00 p.m., with Resident 29's emergency contact (EC)1, EC1 stated he had not been invited to participate in Resident 29's care plan conferences or interdisciplinary team meetings. During an interview with the Social Service Director (SSD) on 12/2/2025 at 1:30 p.m., the SSD stated there was no documentation of invites, emails, or telephone calls inviting Resident 29 and their representatives to participate in patient care plan conferences. The SSD indicated there was no system in place that included notifications or invites to families regarding care plan conferences and indicated this oversight went against the facility policy. The SSD stated Resident 29 and her emergency contacts have not attended the care conferences. During an interview with the Director of Nursing (DON) on 12/3/2025 at 7:00 a.m., the DON indicated that he (DON) thought residents and their family members were being invited to care conferences and indicated failing to invite residents and families could impact residents' quality of care if their preferences and needs are not addressed and included in the plans of care. During a review of the facility's policy and procedure P&P titled Care Plans Comprehensive Person-Centered, dated 3/2022, the P&P indicated, The interdisciplinary team (IDT) in conjunction with the resident and his or her family or legal representative develops and implements a comprehensive person- centered care plan for each resident. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional standards were met by failing to: 1. Rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites for two of two sampled residents (Residents 6 and 4) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat), and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760. 2. Perform glucometer (a small, portable device used to measure the amount of sugar in a drop of blood) control solution testing (is used to test the accuracy of a glucometer) according to the glucometer User's Guide on 11/4/2025, 12/1/2025, and 12/2/2025 by Licensed Vocational Nurse (LVN) 1 for one of four sampled residents (Resident 33) observed during blood sugar checks. This deficient practice had the potential to result in falsely high or low blood sugar readings which could result in adverse consequences (unintended or unwanted effects caused by medication) and delay in care. Findings: a.1. During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted the resident on 7/24/2025, with diagnoses including type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys) and long-term use of insulin. During a review of Resident 6's History and Physical (H&P), dated 9/15/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 10/28/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was on a high-risk drug class hypoglycemic (aˆgroup of drugs used to help reduce the amount of sugar present in the blood, including insulin). During a review of Resident 6's Order Summary Report (OSR), dated 9/12/2025, the OSR indicated an order of Insulin Lispro Injection Solution 100 units per milliliter (unit/ml, the number of units of insulin in 1 milliliter) (Insulin Lispro). Inject as per sliding scale (the amount of insulin to be administered changes or slides up or down based on the person's blood sugar): 151 - 200 = 1 unit. Inject as per sliding scale: If; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units, 401+ blood sugar (BS) greater than (>) 400 or less than (<) 60, call MD, subcutaneously (SQ- injecting in the fatty layer of the skin) before meals and at bedtime for DM. During a review of Resident 6's Location of Administration Report (LAR) of Insulin for 11/2025, the LAR indicated Insulin Lispro Solution 100 unit/ml was administered on: 11/1/2025 at 6 a.m. on the Abdomen – Left Lower Quadrant (LLQ) 11/2/2025 at 5:45 a.m. on the Abdomen – LLQ 11/2/2025 at 4:53 p.m. on the Abdomen - LLQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/2/2025 at 9:55 p.m. on the Abdomen - LLQ 11/3/2025 at 4:30 a.m. on the Abdomen – LLQ 11/5/2025 at 12:19 p.m. on the Abdomen – Left Upper Quadrant (LUQ) 11/5/2025 at 4:15 p.m. on the Abdomen – LUQ 11/7/2025 at 5 p.m. on the Abdomen – Right Upper Quadrant (RUQ) 11/7/2025 at 8:53 p.m. on the Abdomen - RUQ 11/8/2025 at 5:51 a.m. on the Abdomen – RUQ 11/8/2025 at 4:44 p.m. on the Abdomen - LLQ 11/8/2025 at 9:47 p.m. on the Abdomen – LLQ 11/10/2025 at 4:18 p.m. on the Abdomen - LLQ 11/10/2025 at 8:45 p.m. on the Abdomen – LLQ 11/11/2025 at 12:26 p.m. on the Abdomen - LUQ 11/11/2025 at 4:29 p.m. on the Abdomen - LUQ 11/12/2025 at 12:13 p.m. on the Abdomen – LUQ 11/13/2025 at 11:37 a.m. on the Abdomen - LUQ 11/13/2025 at 4:58 p.m. on the Abdomen - LUQ 11/13/2025 at 8:57 p.m. on the Abdomen – LUQ 11/15/2025 at 4:17 p.m. on the Abdomen - LLQ 11/15/2025 at 9:12 p.m. on the Abdomen – LLQ 11/16/2025 at 4:17 p.m. on the Abdomen - LLQ 11/16/2025 at 8:28 p.m. on the Abdomen - LLQ 11/17/2025 at 4 a.m. on the Abdomen – LLQ 11/17/2025 at 5:49 p.m. on the Abdomen - LUQ 11/17/2025 at 9:23 p.m. on the Abdomen – LUQ 11/18/2025 at 4:37 p.m. on the Abdomen – Right Lower Quadrant (RLQ) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/18/2025 at 8:38 p.m. on the Abdomen – RLQ 11/19/2025 at 4:51 p.m. on the Abdomen - RUQ 11/19/2025 at 9:18 p.m. on the Abdomen – RUQ 11/20/2025 at 12:23 p.m. on the Abdomen – LUQ 11/20/2025 at 4:42 p.m. on the Abdomen – LUQ 11/21/2025 at 4:36 p.m. on the Arm - right 11/21/2025 at 9:49 p.m. on the Arm - right 11/22/2025 at 6:18 a.m. on the Abdomen - LUQ 11/22/2025 at 12:15 p.m. on the Abdomen – LUQ 11/24/2025 at 4 a.m. on the Abdomen - LUQ 11/24/2025 at 12:24 p.m. on the Abdomen - LUQ 11/24/2025 at 6:38 p.m. on the Abdomen - LUQ 11/24/2025 at 9:04 p.m. on the Abdomen – LUQ 11/2025/2025 at 6:17 a.m. on the Abdomen - RLQ 11/2025/2025 at 12:29 p.m. on the Abdomen - RLQ 11/2025/2025 at 5:01 p.m. on the Abdomen - LLQ 11/2025/2025 at 8:31 p.m. p.m. on the Abdomen – LLQ 11/27/2025 at 12:28 p.m. on the Abdomen - LUQ 11/27/2025 at 6:12 p.m. on the Abdomen – LUQ 11/28/2025 at 1:18 p.m. on the Abdomen - LLQ 11/28/2025 at 4:18 p.m. on the Abdomen - LLQ 11/28/2025 at 8:53 p.m. on the Abdomen – LLQ 11/29/2025 at 4:51 p.m. on the Abdomen - RLQ 11/29/2025 at 8:27 p.m. on the Abdomen – RLQ During a concurrent interview and record review on 12/3/2025, at 8:29 a.m., with Registered Nurse (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(RN) 1, reviewed with RN 1 Resident 6's Medical Diagnoses, OSR, and LAR. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration sites of Resident 6. RN 1 stated per policy and procedure of the facility insulin administration sites should be rotated to prevent trauma to the site and prevent lipodystrophy. RN 1 stated there should be no reason for not rotating insulin administration site as their electronic healthcare record shows where the last insulin administration site it given. RN 1 stated the licensed nurses were probably in a hurry to give their medications and was ignoring the administration instructions. RN 1 stated the failure of the licensed staff to rotate insulin administration sites can lead to skin trauma, bruising, and lipodystrophy on Resident 6. During an interview on 12/4/2025, at 2:06 p.m., with the Director of Nursing (DON), the DON stated the insulin administration sites of Resident 6 should have been rotated to prevent skin integrity issues on the resident such as bruising and scar tissue buildup. The DON stated the scar tissue buildup she is referring to was lipodystrophy. The DON stated the buildup of lipodystrophy on the frequented sites of administration of insulin affects the absorption (the process of absorbing or soaking up something) of the medication causing hypo (low) or hyperglycemia (high blood sugar) on residents. The DON stated the licensed staff did not follow the policy and procedure of insulin administration in the facility. During a review of the facility's recent policy and procedure (P&P) titled Insulin Administration, last reviewed on 1/2/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16.Select an injection site. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Instructions for Use of Insulin Lispro injection, for subcutaneous use 10 ml multiple-dose vial (100 units per mL, U-100), last revised 7/2023, the Instruction indicated to change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. a.2. During a review of Resident 4's AR, the AR indicated the facility admitted the resident on 7/20/2025, with a diagnosis of long-term use of insulin. During a review of Resident 4's H&P, dated 7/21/2025, the H&P indicated the resident can make needs known but cannot make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's cognitive abilities like memory, understanding, problem-solving etc.ˆare working usually in all fundamental ways). The MDS indicated the resident was on a high-risk drug class hypoglycemic (including insulin). During a review of Resident 4's OSR, dated 7/21/2025, the OSR indicated an order of Novolin R Injection Solution 100 unit/ml (Insulin Regular (Human)) Inject as per sliding scale: if 70 - 180 = 0 unit; 181 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units (continued on next page)

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The Grove Post-Acute Care Center	14122 Hubbard Street Sylmar, CA 91342

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood sugar greater than 400 and less than 70 call PMD, subcutaneously before meals for DM. During a review of Resident 4's LAR for 11/2025, the LAR indicated Novolin R was administered on: 11/3/2025 at 3:36 p.m. on the Abdomen - RUQ 11/7/2025 at 4:44 p.m. on the Abdomen – RUQ 11/16/2025 at 4:42 p.m. on the Abdomen - LLQ 11/17/2025 at 12:17 p.m. on the Abdomen - LLQ 11/17/2025 at 4:38 p.m. on the Abdomen - LUQ 11/18/2025 at 12:28 p.m. on the Abdomen – LUQ 11/29/2025 at 12:09 p.m. on the Arm - right 11/29/2025 at 5:07 p.m. on the Arm – right During a concurrent interview and record review on 12/3/2025, at 8:29 a.m., with RN 1, reviewed with RN 1 Resident 4's Medical Diagnoses, OSR, and LAR. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration sites of Resident 4. RN 1 stated per policy and procedure of the facility insulin administration sites should be rotated to prevent trauma to the site and prevent lipodystrophy. RN 1 stated there should be no reason for not rotating insulin administration site as their electronic healthcare record shows where the last insulin administration site it given. RN1 stated the licensed nurses were probably in a hurry to give their medications and was ignoring the administration instructions. RN 1 stated the failure of the licensed staff to rotate insulin administration sites can lead to skin trauma, bruising, and lipodystrophy on Resident 4. During an interview on 12/4/2025, at 2:06 p.m., with the DON, the DON stated the insulin administration sites of Resident 4 should have been rotated to prevent skin integrity issues on the resident such as bruising and scar tissue buildup. The DON stated the scar tissue buildup she is referring to was lipodystrophy. The DON stated the buildup of lipodystrophy on the frequented sites of administration of insulin affects the absorption of the medication causing hypo or hyper glycemia on residents. The DON stated the licensed staff did not follow the policy and procedure of insulin administration in the facility. During a review of the facility's recent policy and procedure (P&P) titled Insulin Administration, last reviewed on 1/2/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16.Select an injection site. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility-provided Instructions for Use of Insulin Lispro injection, for subcutaneous use 10 ml multiple-dose vial (100 units per mL, U-100), last revised 7/2023, the Instruction indicated to change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. b. During a review of Resident 33's AR, the AR indicated that the facility originally admitted the resident on 1/12/2019, and readmitted on [DATE], with diagnoses including DM, end stage renal disease (ESRD-irreversible kidney failure), and long term (current) use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). During a review of Resident 33's H&P, dated 12/20/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 33's OSR, the OSR indicated: - Insulin lispro injection solution 100 unit/milliliter (ml- a unit of measurement), inject four (4) units subcutaneously (sq- administered under the skin) one time a day for DM in addition to sliding scale, hold if blood sugar is less than 100, dated 12/20/2024; - Insulin lispro injection solution 100 unit/ml, inject as per sliding scale: if 151-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; sq three times a day for DM less than 150, no coverage; greater than 400 call MD, dated 12/20/2024. During a review of Resident 33's Care Plan (CP) Report focused on the resident has DM, dated 1/6/2022, the CP indicated the resident with goals of no complications related to DM with interventions including diabetes medication as ordered and to monitor or document for side effects and effectiveness. During a review of Resident 33's Minimum Data Set (MDS- a resident assessment tool), dated 10/8/2025, the MDS indicated the resident makes self-understood and as the ability to understand others. The MDS indicated that the resident required assistance with activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) including eating, toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. During an observation on 12/2/2025 at 11:26 a.m., LVN 2 obtained Resident 33's blood sugar level using a glucometer, reading 304. LVN 2 prepared Resident 33's medications including Humalog (lispro) total of 8 units and administered on Resident 33's left arm. During a concurrent interview and record review on 12/2/2025 at 1:30 p.m. with LVN 2, glucometer QA log for GLM 1 and GLM 2 for the months of 11/2025 and 12/2025 was reviewed. LVN 2 stated LVN 3 signed the glucometer QA log on 11/4/2025, 12/1/2025, and 12/2/2025. LVN 2 stated there were no high and low results documented on the GLM 1 and GLM 2's QA log on 11/4/2025 and 12/2/2025. LVN 2 stated that there should be a result recorded when the control testing was done. LVN 2 stated the night shift licensed nurses perform the control testing daily and they document on the QA log that it was completed. During a concurrent interview and record review on 12/03/2025 at 6:48 a.m. with LVN 3, the GLM 1 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and GLM 2's QA log for the months of 11/2025,12/2025 and the stored readings in GLM 1 and GLM 2 were reviewed. LVN 3 stated glucometer control testing is performed every night by the night shift (11 p.m. to 7 a.m.). LVN 3 stated he could not find the control results on the dates 12/1/2025 and 12/2/2025 on GLM 1 and GLM 2 to confirm the results documented on the GLM 1 and GLM 2's QA log. LVN 3 stated on 11/4/2025 he did not have results documented on both QA logs. LVN 3 stated he could not show documentation and confirmation of the results. LVN 3 stated he did not do the control solution testing on the glucometer machine on dates 11/4/2025 and 12/2/2025. During a concurrent observation and interview on 12/3/2025 at 7:23 a.m. with LVN 3, LVN 3 demonstrated how to perform the glucometer solution testing using GLM 1 and GLM 2. LVN 3 powered on both GLM 1 and GLM 2 and placed test strip on GLM 1 and squeezed a drop of high control solution directly to the strip from the control solution bottle. LVN 3 stated he does not press the arrow buttons for the control, he does it like this: power it on, insert test strip, and then squeeze a drop of the high control solution bottle and do it all over again for the low control solution bottle. LVN 3 stated GLM 1 is using high control solution, first reading 199 and second reading 239 showing error. LVN 3 stated he will dispose of GLM 1. LVN 3 stated he will test GLM 2. LVN 3 powered the machine on, inserted a test strip, and squeezed a drop of the high control solution directly to the test strip. LVN 3 reviewed stored values on GLM 2 and stated the control test he (LVN 3) performed does not show CTL for control and he wondered why. LVN 3 stated he (LVN 3) is unable to review the results on GLM 1 because it stopped working. LVN 3 stated that when the control solution testing is not done the blood sugar readings would be inaccurate and potentially, they are not treating the resident appropriately. During an interview on 12/3/2025 at 11:33 a.m. with LVN 2, LVN 2 stated she used GLM 2 on 12/2/2025 to check Resident 33's blood sugar that was scheduled at 11:30 a.m. During an interview on 12/4/2025 at 9:41 a.m., with the DON, the DON stated the control solution testing is done daily by 11 p.m. to 7 a.m. licensed nurses. The DON stated once completed they document the readings on the glucometer Quality Assurance log. The DON stated the calibration is done to ensure the machine is functioning properly and accurately. DON stated if it is not up to calibration could get wrong results such as falsely high blood sugar or low blood sugar readings and either administer extra insulin or not administer insulin.^ During a review of the facility's P&P titled, Obtaining a Fingerstick Glucose Level, last reviewed 1/2/2025, the P&P indicated The purpose Of this procedure is to obtain a blood sample to determine the residents blood glucose level. Preparation:. 4. Ensure that the equipment and devices are working properly by performing any calibrations or checks instructed by the manufacturer or this facility. During a review of GLM 1 and GLM 2 User's Guide titled, Blood Glucose Monitoring System, undated, the User's Guide indicated that the icon CTL indicates a control solution test or the stored value is a control solution result and low control range 53-79 and high control range 135-203. The User's Guide indicated that the purpose of the control solution testing is to make sure that the glucometer and test strips are working properly. The User's Guide indicated that perform control solution testing should be performed when: using the meter for the first time; at least one per week to make sure the meter and test strips ae working properly; using new bottle of test strips; the test strip bottle cap was left open for a while; the meter was dropped; suspect that the meter and test strips are not working properly; the blood glucose test results do not reflect how you feel; and you want to practice the testing procedure. The User's Guide indicated the steps including: 1. Take out GLM 1/GLM 2 Test Strip from the test strip bottle and close the bottle immediately. Insert the test strip to turn on the meter. 2. Wait until the flashing blood drop and arrow icons appear on the metered display screen. The meter will (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also announce, please apply blood onto the test strip if you have the voice feature turned on. Press the down arrow button one time to enter L1 (low) control solution testing. 3. ctl icon Will appear next to the test strip icon and L1 will appear on the meter display screen. 4. Squeeze a drop of low control solution onto a clean, dry, non-absorbent surface. Do not apply control solution the test strip directly from the control solution bottle. Replace the bottle cap on the control solution bottle immediately after use. 5. Gently touch the tip of the test strip to the drop of control solution. The meter will indicate it has received the solution. The screen will start to count down. After 6 seconds, the control solution test result will appear on the meter display screen.6. Compare the reading on the screen to the low range printed on the test strip bottle. 7. Remove the use destroyed. The meter will automatically turn off. Discard the used test strips. Follow steps 8 through 14 to perform the high control solution testing. 8. Take out GLM 1/GLM 2 Test Strip from the test strip bottle and close the bottle immediately. Insert the test strip to turn on the meter. 9. Wait until the flashing blood drop and arrow icons appear on the metered display screen. The meter will also announce, please apply blood onto the test strip if you have the voice feature turned on. Press the arrow down button two times to enter L2 (high) control solution testing. 10. ctl icon Will appear next to the test strip icon and L2 will appear on the meter display screen. 11. Squeeze a drop of high control solution onto a clean, dry, non-absorbent surface. Do not apply control solution the test strip directly from the control solution bottle. Replace the bottle cap on the control solution bottle immediately after use. 12. Gently touch the tip of the test strip to the drop of control solution. The meter will indicate it has received the solution. The screen will start to count down. After 6 seconds, the control solution test result will appear on the meter display screen. 13. Compare the reading on the screen to the high range printed on the test strip bottle. 14. Remove the use destroyed. The meter will automatically turn off. Discard the used test strips.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcer/injury (ulcers that happen on areas of the skin that are under pressure from lying in bed, sitting in a wheelchair, or wearing a cast for a long period) for three of three sampled residents (Residents 75, 9,10) reviewed for pressure ulcers by failing to ensure: 1. Resident 75's low air loss mattress (LALM, a special type of air mattress that uses a constant, gentle flow of air through microscopic holes to keep the skin dry and prevent pressure wounds) had a physician's order. 2. Low air-loss mattresses were set at the accurate pressure setting for wound healing for Residents 9 and 10. 3. A wound vacuum (a machine that is applied to a patients wound that gently removes fluid to aid in faster wound healing) was continuously on for Resident 9. These deficient practices had the potential for development and worsening of pressure ulcers/injuries to residents. Findings: 1. During a review of Resident 75's admission Record (AR), the AR indicated the facility admitted the resident on 8/25/2025, with diagnoses including pressure ulcer of sacral region (the triangular area at the very bottom of the spine), unstageable (a severe wound where the base is hidden by yellow, tan, gray, brown, or black dead tissue (slough or eschar), making its true depth and stage [e.g., Stage 3 or 4] impossible to determine until that tissue is removed through debridement), pressure ulcer of right and left buttock unstageable, and pressure ulcer of left heel, stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible). During a review of Resident 75's History and Physical (H&P), dated 8/27/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 75's Minimum Data Set (MDS- a resident assessment tool), dated 9/4/2025, the MDS indicated the resident had the ability to make self-understood and usually understands others and had moderate cognitive impairment (signifies noticeable thinking or memory problems beyond normal aging, impacting complex daily tasks like managing finances or appointments, but still allowing independence in basic self-care [bathing, dressing]). The MDS indicated the resident was dependent to needing supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was at risk for developing pressure injuries and had one or more unhealed pressure injuries on admission and reentry to the facility. The MDS indicated the resident was on a pressure-reducing device for bed. During a review of Resident 75's Order Summary Report (OSR), dated 9/30/2025, the OSR did not indicate any order for pressure reducing devices such as LALM. During a review of Resident 75's Wound Care Plan (WCP), Location: Coccyx, dated 8/29/2025, the WCP indicated an intervention of pressure relief/reduction mattress. During a concurrent interview and record review on 12/4/2025, at 10 a.m., with Treatment Nurse (TN) 1, reviewed Resident 75's Medical Diagnoses, OSR, Weekly Wound Documentation, Wound MD documentation, and Care Plans. TN 1 stated Resident 75 had multiple pressure injuries on the right buttock, left heel, left buttock, right heel, coccyx, and bilateral buttocks. TN 1 stated they placed the resident on a LALM however, he (TN 1) was not able to get a physician's order for its use. TN 1 stated it was important to obtain an order from the physician to ensure its safe use. TN 1 stated the failure of the facility to obtain an order for the LALM could lead to resident harm and the attending physician unaware of the medical treatment being provided to the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/4/2025, at 2:06 p.m., with the Director of Nursing (DON), the DON stated TN 1 should have obtained an order for Resident 75's LALM to ensure it is safe to use. The DON stated that it is important for licensed nurses that interventions were backed by physicians to ensure that proper care is provided to the resident. During a review of the facility's recent policy and procedure (P&P) titled, Physician Orders and Telephone Orders, last reviewed on 1/2/2025, the P&P indicated Physician's orders shall be obtained prior to the initiation of any medication or treatment from a person lawfully authorized to prescribe for and treat human illness. All orders must be specific and complete, and no standing orders shall be accepted. 2. During a review of Resident 9's admission Record (AR) dated 12/3/2025, the AR indicated the facility admitted the resident on 7/11/2025 with diagnosis including but not limited to pressure ulcer of the sacral region stage three (3), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), moderate intellectual disabilities (below average thinking ability), and quadriplegia (paralysis from the neck down, including legs and arms usually due to a spinal cord injury). During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9's cognition (thought Process) was severely impaired and indicated Resident 9 was dependent upon staff to complete all activities of daily living (ADLs- activities such as bathing, dressing, and toileting). The MDS indicated Resident 9 weighed 70 pounds. During a review of Resident 9`s Physicians Progress Notes (PPN) dated 7/14/2025, the PPN indicated Resident 9 was nonverbal (did not speak) and did not have the capacity to understand and make her own decisions.  During a review of Resident 9`s physician orders dated 11/27/2025, the physician orders indicated LALM for wound management (setting at lowest weight) every shift. During a review of Resident 9`s Treatment Administration Record (TAR) for 12/1/2025, the TAR indicated the air mattress was signed off by staff indicating the air mattress was in use for Resident 9.  During review of Resident 9`s WCP dated 7/17/2025, the WCP indicated interventions like a pressure relieving/reducing mattress, as ordered with a goal to maintain or develop clean and intact skin by the next review date for the resident. During observation on 12/1/2025 between 8:55 a.m. and 11:45 a.m., Resident 9 was observed in bed on a Low Air Loss Mattress at the following settings: - Comfort Setting was set at 120-130. - Cycle Time was off - Therapy Mode was set at Static During review of Serene Mattress Manual dated 2019, the manual indicated the following setting definitions: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Comfort setting- controls the air pressure output. - Cycle time - there are four cycle times 5 10 15 and 20 minutes. Users can select one of the four cycle times based upon patient comfort and desired outcome - Therapy Mode- a. Static redistributes body mass over a greater surface b. Alternate press 1 in 2 alternating cell cycle achieves periodic pressure relief. During a review of Resident 10's AR, the AR indicated the facility admitted the resident on 11/17/2025, with diagnosis including but not limited to pressure ulcer on the sacral region unstageable, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10's cognition was severely impaired and indicated Resident 10 was dependent upon staff to complete all activities of daily living. The MDS indicated Resident 10 weighed 95 pounds. During a review of Resident 10's H&P dated 3/20/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10`s physician's order dated 11/17/2025, the physician order indicated to place a low air loss mattress every shift for pressure injury management.  During a review of Resident 10`s Treatment Administration Record (TAR) for the month of 12/2025, the TAR indicated a staff signature for the low air loss mattress for pressure injury management for 12/1/2025, indicating the mattress was in use for Resident 10. During a review of Resident 10`s WCP dated 6/26/2025, the WCP indicated an intervention for Resident 10's fragile skin would be the use of the low air loss mattress used at the setting between 70-105 pounds. During observation on 12/1/2025 between 8:55 a.m. and 11:45 a.m., Resident 10 was observed in bed on the Micro Air Alternating Pressure with low air loss mattress set at 3, a setting for 106-140. During an interview on 12/2/2025 at 12:30 p.m. with Treatment Nurse (TN)1, TN1 stated Resident 9 and Resident 10 were in bed on air mattresses set at incorrect settings.TN1 stated this error puts the residents at risk for further skin breakdown. 3. During a review of Resident 9's physician's orders dated 11/27/2025, the physician's orders indicated, Medela wound Vacc to sacrum 125mmHg continuous suction. This order was initiated on 11/12/2025. During a review of Resident 9`s Treatment Administration Record (TAR) for the 12/1/2025, the TAR indicated the [NAME] wound Vacuum was signed off by staff, indicating the wound vacuum was on for Resident 9 and was in use. During observation on 12/1/2025 at 8:55 until 11:45 a.m., Resident 9's wound vacuum was turned off and not functioning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/2/2025 at 12:30 p.m. with Treatment Nurse (TN) 1, TN1 stated Resident 9's wound vacuum was off and should not have been turned off. TN1 stated the wound vacuum order is for continuous use and should be turned on. TN1 indicated that the wound vacuum being turned off puts Resident 9 at risk for wound maceration and wound deterioration. During an interview with the Wound Care MD (WMD) on 12/3/2025, the WMD indicated the wound vacuum for Resident 9 is continuous and should not be off. The WMD stated that air mattress settings are appropriately set for each resident for wound healing and prevention of further skin breakdown, any deviation from that setting can cause the wound to become worse. During an interview on 12/4/2025 at 7:00 a.m., with the DON, DON indicated that the air mattresses not set at the appropriate setting put residents at risk for further skin break down and added that Resident 9's wound vacuum being left off could cause further damage to her skin integrity and cause the wound to become worse. During a review of the Medela negative pressure wound therapy system manufacture's manual undated, the manual indicated, warning the pump must be used 24 hours per day. Do not stop the pump unless instructed by your health professional.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received services and assistance for three of four sampled residents (Residents 11, 42, and 15) reviewed for urinary tract infection (UTI - a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) by failing to ensure residents urinal bottles (portable container for collecting urine) were labeled with the name, room number, and date it was provided to the residents. The deficient practice had the potential for residents for cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) and to develop UTI due to switching of urinals. Findings: 1. During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted the resident on 10/12/2016, and readmitted the resident on 1/22/2025, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing). During a review of Resident 11's History and Physical (H&P), dated 5/25/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 10/2/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident needed substantial assistance on toileting hygiene and was always incontinent of urine. During a review of Resident 11's Care Plan (CP) Report titled, Resident might have underlying health conditions that make him at greater risk for Coronary Disease 2019 (COVID-19 - an infectious disease caused by the SARS-CoV-2 virus), last revised on 10/13/2023, the CP indicated an intervention to implement infection control precautions between residents/staff. During a concurrent observation and interview on 12/1/2025 at 9:14 a.m. with Treatment Nurse (TN) 1, inside Resident 11's room, observed Resident 11's urinal hanging at the left side rail not labeled with the name, room number, and date it was provided to the resident. TN 1 stated the staff should label the urinal of Resident 11 with the name, room number, and the date the urinal was provided to the resident to prevent switching of urinals among residents causing cross-contamination causing infections such as UTI. During an interview on 12/4/2025 at 2:06 p.m. with the Director of Nursing (DON), the DON stated Resident 11's urinal should have been labeled with the name, room number, and date the urinal was provided for infection control prevention. The DON stated labeling them with the name and room number prevents switching of urinals that can cause infections such as UTI and placing the date on them helps us to monitor how long the resident has been using the urinal because they replace the urinal weekly. The DON stated the failure of the staff to label the urinal with the name, room number, and date it was provided can lead to residents developing UTI. The DON stated the staff did not follow the policy and procedure titled Infections-Clinical Protocol. 2. During a review of Resident 42's AR, the AR indicated the facility admitted the resident on 7/19/2021, with diagnoses including benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland that happens to most men as they age) and urge incontinence (urine leaks because the bladder muscles squeeze, or contract, at the wrong times). During a review of Resident 42's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and sometimes had the ability to understand others. The MDS indicated that the resident had moderate cognitive impairment (thinking and memory problems are noticeable and sometimes frustrating, affecting things like remembering appointments or finding words, but not severe enough to stop someone from managing daily life independently) and was dependent on toileting hygiene. The MDS indicated the resident was always incontinent of urine (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and bowels. During a review of Resident 42's CP Report titled Resident might have underlying health conditions that make him at greater risk for COVID-19, last revised on 10/17/2023, the CP indicated an intervention to implement infection control precautions between residents/staff. During a concurrent observation and interview on 12/1/2025 at 9:14 a.m. with TN 1, inside Resident 42's room, observed Resident 42's urinal hanging at the left side rail not labeled with the name, room number, and date it was provided to the resident. TN 1 stated the staff should label the urinal of Resident 42 with the name, room number, and the date the urinal was provided to the resident to prevent switching of urinals among residents causing cross-contamination causing infections such as UTI. During an interview on 12/4/2025 at 2:06 p.m. with the DON, the DON stated Resident 42's urinal should have been labeled with the name, room number, and the dated the urinal was provided for infection control. The DON stated labeling them with the name and room number prevents switching of urinals that can cause infections such as UTI and placing the date on them helps us to monitor how long the resident has been using the urinal because they replace the urinal weekly. The DON stated the failure of the staff to label the urinal with the name, room number, and date it was provided can lead to residents developing UTI. The DON stated the staff did not follow the policy and procedure titled Infections-Clinical Protocol. 3. During a review of Resident 15's AR, the AR indicated the facility admitted the resident on 9/18/2025, with diagnoses including hemiplegia and hemiparesis, and benign prostatic hyperplasia. During a review of Resident 15's H&P, dated 9/19/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 15's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. The MDS indicated the resident required supervision on toileting hygiene and was always continent of urine. During a review of Resident 15's CP Report titled, Resident might have underlying health conditions that make him at greater risk for COVID-19, last revised on 9/19/2025, the CP indicated an intervention to implement infection control precautions between residents/staff. During a concurrent observation and interview on 12/1/2025 at 9:14 a.m. with TN 1, inside Resident 15's room, observed Resident 15's urinal hanging at the left side rail not labeled with the name, room number, and date it was provided to the resident. TN 1 stated the staff should label the urinal of Resident 15 with the name, room number, and the date the urinal was provided to the resident to prevent switching of urinals among residents causing cross-contamination causing infections such as UTI. During an interview on 12/4/2025 at 2:06 p.m. with the DON, the DON stated Resident 15's urinal should have been labeled with the name, room number, and the dated the urinal was provided for infection control. The DON stated labeling them with the name and room number prevents switching of urinals that can cause infections such as UTI and placing the date on them helps us to monitor how long the resident has been using the urinal because they replace the urinal weekly. The DON stated the failure of the staff to label the urinal with the name, room number, and date it was provided can lead to residents developing UTI. The DON stated the staff did not follow the policy and procedure titled Infections-Clinical Protocol. During a review of the facility's recent policy and procedure (P&P) titled Infections-Clinical Protocol, last reviewed on 1/2/2025, the P&P indicated: Cause Identification 4. The physician or provider and staff will identify infection transmission risks and (in conjunction with the Infection Preventionist) will implement relevant precautions. Monitoring and Follow-Up 7. The physician or provider will identify and address possible complications of antibiotic treatment including adverse drug reactions, drug interactions, and antibiotic-related colitis or diarrhea.

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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 interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for two of two sampled residents (Residents 6 and 4) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F658. Findings: 1. During a review of Resident 6's admission Record (AR), the AR indicated the facility admitted the resident on 7/24/2025, with diagnoses including type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), and long-term use of insulin. During a review of Resident 6's History and Physical (H&P), dated 9/15/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 10/28/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was on a high-risk drug class hypoglycemic (aˆgroup of drugs used to help reduce the amount of sugar present in the blood) (including insulin). During a review of Resident 6's Order Summary Report (OSR), dated 9/12/2025, the OSR indicated an order of Insulin Lispro (a type of insulin) Injection Solution 100 units per milliliter (unit/ml, the number of units of insulin in 1 milliliter) (Insulin Lispro). Inject as per sliding scale (the amount of insulin to be administered changes or slides up or down based on the person's blood sugar): 151 - 200 = 1 unit. Inject as per sliding scale: If; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units, 401+ blood sugar (BS) greater than (>) 400 or less than (<) 60, call MD, subcutaneously before meals and at bedtime for DM. During a review of Resident 6's Location of Administration Report (LAR) of Insulin for 11/2025, the LAR indicated Insulin Lispro Solution 100 unit/ml was administered on: 11/1/2025 at 6 a.m. on the Abdomen - Left Lower Quadrant (LLQ) 11/2/2025 at 5:45 a.m. on the Abdomen - LLQ 11/2/2025 at 4:53 p.m. on the Abdomen - LLQ 11/2/2025 at 9:55 p.m. on the Abdomen - LLQ 11/3/2025 at 4:30 a.m. on the Abdomen - LLQ 11/5/2025 at 12:19 p.m. on the Abdomen - Left Upper Quadrant (LUQ) 11/5/2025 at 4:15 p.m. on the Abdomen - LUQ 11/7/2025 at 5 p.m. on the Abdomen - Right Upper Quadrant (RUQ) 11/7/2025 at 8:53 p.m. on the Abdomen - RUQ 11/8/2025 at 5:51 a.m. on the Abdomen - RUQ 11/8/2025 at 4:44 p.m. on the Abdomen - LLQ 11/8/2025 at 9:47 p.m. on the Abdomen - LLQ 11/10/2025 at 4:18 p.m. on the Abdomen - LLQ 11/10/2025 at 8:45 p.m. on the Abdomen - LLQ 11/11/2025 at 12:26 p.m. on the Abdomen - LUQ 11/11/2025 at 4:29 p.m. on the Abdomen - LUQ 11/12/2025 at 12:13 p.m. on the Abdomen - LUQ 11/13/2025 at 11:37 a.m. on the Abdomen - LUQ 11/13/2025 at 4:58 p.m. on the Abdomen - LUQ 11/13/2025 at 8:57 p.m. on the Abdomen - LUQ 11/15/2025 at 4:17 p.m. on the Abdomen - LLQ 11/15/2025 at 9:12 p.m. on the Abdomen - LLQ 11/16/2025 at 4:17 p.m. on the Abdomen - LLQ 11/16/2025 at 8:28 p.m. on the Abdomen - LLQ 11/17/2025 at 4 a.m. on the Abdomen - LLQ 11/17/2025 at 5:49 p.m. on the Abdomen - LUQ 11/17/2025 at 9:23 p.m. on the Abdomen - LUQ 11/18/2025 at 4:37 p.m. on the Abdomen - Right Lower Quadrant (RLQ) 11/18/2025 at 8:38 p.m. on the Abdomen - RLQ 11/19/2025 at 4:51 p.m. on the Abdomen - RUQ 11/19/2025 at 9:18 p.m. on the Abdomen - RUQ 11/20/2025 at 12:23 p.m. on the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Abdomen - LUQ 11/20/2025 at 4:42 p.m. on the Abdomen - LUQ 11/21/2025 at 4:36 p.m. on the Arm - right 11/21/2025 at 9:49 p.m. on the Arm - right 11/22/2025 at 6:18 a.m. on the Abdomen - LUQ 11/22/2025 at 12:15 p.m. on the Abdomen - LUQ 11/24/2025 at 4 a.m. on the Abdomen - LUQ 11/24/2025 at 12:24 p.m. on the Abdomen - LUQ 11/24/2025 at 6:38 p.m. on the Abdomen - LUQ 11/24/2025 at 9:04 p.m. on the Abdomen - LUQ 11/2025/2025 at 6:17 a.m. on the Abdomen - RLQ 11/2025/2025 at 12:29 p.m. on the Abdomen - RLQ 11/2025/2025 at 5:01 p.m. on the Abdomen - LLQ 11/2025/2025 at 8:31 p.m. p.m. on the Abdomen - LLQ 11/27/2025 at 12:28 p.m. on the Abdomen - LUQ 11/27/2025 at 6:12 p.m. on the Abdomen - LUQ 11/28/2025 at 1:18 p.m. on the Abdomen - LLQ 11/28/2025 at 4:18 p.m. on the Abdomen - LLQ 11/28/2025 at 8:53 p.m. on the Abdomen - LLQ 11/29/2025 at 4:51 p.m. on the Abdomen - RLQ 11/29/2025 at 8:27 p.m. on the Abdomen - RLQ During a concurrent interview and record review on 12/3/2025, at 8:29 a.m., with Registered Nurse (RN) 1, reviewed with RN 1 Resident 6's Medical Diagnoses, OSR, and LAR. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration sites of Resident 6. RN 1 stated per policy and procedure of the facility insulin administration sites should be rotated to prevent trauma to the site and prevent lipodystrophy. RN 1 stated there should be no reason for not rotating insulin administration site as their electronic healthcare record shows where the last insulin administration site it given. RN 1 stated the licensed nurses were probably in a hurry to give their medications and was ignoring the administration instructions. RN 1 stated the failure of the licensed staff to rotate insulin administration sites can lead to skin trauma, bruising, and lipodystrophy on Resident 6. RN 1 stated not rotating insulin administration site is a medication error. During an interview on 12/4/2025, at 2:06 p.m., with the Director of Nursing (DON), the DON stated the insulin administration sites of Resident 6 should have been rotated to prevent skin integrity issues on the resident such as bruising and scar tissue buildup. The DON stated the scar tissue buildup she is referring to was lipodystrophy. The DON stated the buildup of lipodystrophy on the frequented sites of administration of insulin affects the absorption (the process of absorbing or soaking up something) of the medication causing hypo (low) or hyperglycemia (high blood sugar) on residents. The DON stated the licensed staff did not follow the policy and procedure of insulin administration in the facility. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent policy and procedure (P&P) titled Adverse Consequences and Medication Errors, last reviewed on 1/2/2025, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled Insulin Administration, last reviewed on 1/2/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16.Select an injection site. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Instructions for Use of Insulin Lispro injection, for subcutaneous use 10 ml multiple-dose vial (100 units per mL, U-100), last revised 7/2023, the Instruction indicated to change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. 2. During a review of Resident 4's AR, the AR indicated the facility admitted the resident on 7/20/2025, with a diagnosis of long-term use of insulin. During a review of Resident 4's H&P, dated 7/21/2025, the H&P indicated the resident can make needs known but cannot make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's cognitive abilities like memory, understanding, problem-solving etc.^are working usually in all fundamental ways). The MDS indicated the resident (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was on a high-risk drug class hypoglycemic (including insulin). During a review of Resident 4's OSR, dated 7/21/2025, the OSR indicated an order of Novolin R Injection Solution 100 unit/ml (Insulin Regular (Human)) Inject as per sliding scale: if 70 - 180 = 0 unit; 181 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units blood sugar greater than 400 and less than 70 call PMD, subcutaneously before meals for DM. During a review of Resident 4's LAR for 11/2025, the LAR indicated Novolin R was administered on: 11/3/2025 at 3:36 p.m. on the Abdomen - RUQ 11/7/2025 at 4:44 p.m. on the Abdomen - RUQ 11/16/2025 at 4:42 p.m. on the Abdomen - LLQ 11/17/2025 at 12:17 p.m. on the Abdomen - LLQ 11/17/2025 at 4:38 p.m. on the Abdomen - LUQ 11/18/2025 at 12:28 p.m. on the Abdomen - LUQ 11/29/2025 at 12:09 p.m. on the Arm - right 11/29/2025 at 5:07 p.m. on the Arm - right During a concurrent interview and record review on 12/3/2025, at 8:29 a.m., with RN 1, reviewed with RN 1 Resident 4's Medical Diagnoses, OSR, and LAR. RN 1 stated there were multiple instances that the licensed staff did not rotate the insulin administration sites of Resident 4. RN 1 stated per policy and procedure of the facility insulin administration sites should be rotated to prevent trauma to the site and prevent lipodystrophy. RN 1 stated there should be no reason for not rotating insulin administration site as their electronic healthcare record shows where the last insulin administration site it given. RN1 stated the licensed nurses were probably in a hurry to give their medications and was ignoring the administration instructions. RN 1 stated the failure of the licensed staff to rotate insulin administration sites can lead to skin trauma, bruising, and lipodystrophy on Resident 4. RN 1 stated not rotating insulin administration site is a medication error. During an interview on 12/4/2025, at 2:06 p.m., with the DON, the DON stated the insulin administration sites of Resident 4 should have been rotated to prevent skin integrity issues on the resident such as bruising and scar tissue buildup. The DON stated the scar tissue buildup she is referring to was lipodystrophy. The DON stated the buildup of lipodystrophy on the frequented sites of administration of insulin affects the absorption of the medication causing hypo or hyper glycemia on residents. The DON stated the licensed staff did not follow the policy and procedure of insulin administration in the facility. The DON stated not rotating insulin administration site is a medication error. During a review of the facility's recent P&P titled Adverse Consequences and Medication Errors, last reviewed on 1/2/2025, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent policy and procedure (P&P) titled Insulin Administration, last reviewed on 1/2/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16.Select an injection site. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Instructions for Use of Insulin Lispro injection, for subcutaneous use 10 ml multiple-dose vial (100 units per mL, U-100), last revised 7/2023, the Instruction indicated to change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites.

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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 ensure safe handling of medications and maintain safe and secure storage for two of two medication carts (Med Cart 3 and Med Cart 1) reviewed under Medication Storage and Labeling task, by: 1. Failing to store Resident 32 and 5's lorazepam (a psychotropic medication that affects the mind, emotions, and behaviors) oral solution in the medication refrigerator according to manufacturer's instructions in Med Cart 3. 2. Failing to store Resident 18's diclofenac gel (a topical pain relief medication) and lidocaine cream (numbing cream) separately from orally administered medications in Med Cart 3. These deficient practices had the potential to result in the use of ineffective medications for the resident 3. Failing to remove and dispose Resident 74's ipratropium/albuterol (breathing treatment medication) solution from the Med Cart 1 when the resident was discharged on 11/11/2025.ˆ This deficient practice had the potential to result in inadvertently administering medications to other residents. Findings: a.1. During a concurrent observation and interview on 12/2/2025 at 10:55 a.m. of Med Cart 3 with Licensed Vocational Nurse (LVN) 1, the following medications were found stored in a manner contrary to their respective manufacturer's requirements, or not labeled with storage instructions as required by their respective manufacturer's specifications: - One opened bottle of lorazepam for Resident 32, filled 11/12/2025. No label to keep refrigerated. - One opened bottle of lorazepam for Resident 32, filled 11/23/2025. No label to keep refrigerated. - One bottle of lorazepam for Resident 5, filled date 10/31/2025. No label to keep refrigerated. a.2. In Med Cart 3, 3p.m. to 11 p.m. drawers for medication bubbles stored: - One diclofenac gel one (1) percent (%- a unit of measurement) for Resident 18, filled date 10/22/2025. -Lidocaine Cream five (5) % for Resident 18, filled date 10/23/2025. LVN 1 stated the lorazepam solutions are kept in the locked drawer with the controlled medications and are stored there right after it is delivered to the facility. LVN 1 stated lorazepam solution does not have a label for storage. LVN 1 stated there is usually a label that indicates to keep refrigerated. However, lorazepam solutions for Residents 32 and 5 do not have labels. LVN 1 stated that they keep Resident 18's diclofenac gel and lidocaine gel in the medication cart in the same drawer where 3 p.m. to 11 p.m. routine scheduled oral medications in bubble packs are stored because they are the one administering it and not the treatment nurse. During an interview on 12/4/2025 at 7:40 a.m. with LVN 1 of Med Cart 3, LVN 1 stated Resident 32's lorazepam was reordered yesterday because it was running low and was kept in the cart when it was delivered. LVN 1 stated there are no storage directions to keep refrigerated on the new lorazepam bottle, filled date 12/3/2025. During an interview on 12/4/2025 at 9:53 a.m. with Registered Pharmacist (RPH) 2, RPH 2 stated lorazepam oral solution has to be refrigerated at all times if not, it will reduce efficacy of the medication. RPH 2 stated lorazepam oral solution has to be refrigerated and once it is open it is only good for 90 days. RPH 2 stated he was made aware of the labeling directions, and they send out a replacement today, 12/4/2025. During an interview on 12/4/2025 at 2:38 p.m. with the Director of Nursing (DON), the DON stated medication not properly stored could affect the medication. The DON stated lorazepam is used for treatment of anxiety and it could not be effective causing residents` agitation. The DON stated PH 1 sent the updated medication label for the lorazepam oral solutions for Resident 32 and Resident 5. During a review of the manufacturer specifications for Lorazepam Oral Concentrate, revised 8/2022, the specifications indicated to Store the lorazepam at cold temperatures. Refrigerate at 36 degrees Fahrenheit [F-a unit of measurement] to 46 degrees F) Discard opened bottle after 90 days. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, last reviewed 1/2/2025, the P&P indicated that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The P&P indicated medications requiring ?refrigeration' or temperatures between 36F to 46F are kept in a refrigerator (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with a thermometer to allow temperature monitoring. The P&P indicated medications requiring storage in a cool place are refrigerated unless otherwise directed on the label. The P&P indicated orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. During a review of the facility's P&P titled, Medication Labeling and Storage, last reviewed 1/2/2025, the P&P indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. The P&P indicated medications for external use, as well as hazardous drugs and biologicals, are clearly marked as such, are stored separately from other medications. The P&P indicated if medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items. b. During a concurrent observation and interview on 12/2/2025 at 1:20 p.m. with LVN 2 of Med Cart 1, LVN 2 stated Resident 74's ipratropium/albuterol solution, filled date 11/5/2025. LVN 2 stated there is no date of when it was opened and the resident has been discharged from the facility for a while, and this medication should have been removed from the med cart. During an interview on 12/4/2025 at 9:31 a.m. with the DON, the DON stated when the medication is discontinued it should be removed from the med cart right away. The DON stated it should not be in the cart to prevent it from being potentially used by other residents. During a review of the facility's P&P titled, Disposal of Medications and Medication-Related Supplies: Discontinued Medications, last reviewed 1/2/2025, the P&P indicated When medications are discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as discontinued and destroyed. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed or picked up by pharmacy. The P&P indicated medications are removed from the medication cart immediately upon receipt of an order to discontinue (to avoid inadvertent administration).

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The Grove Post-Acute Care Center	14122 Hubbard Street Sylmar, CA 91342

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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 flavor and temperature for lunch when: a. Puree turkey was at 136 degrees Fahrenheit (F, a degree of temperature) at the start of trayline (an area where foods were assembled from the steamtable to resident's plate), puree (foods that are soft with pudding like consistency) cauliflower at 105 F and salad with dressing was at 46 F during test tray (a process of tasting, temping, and evaluating the quality of food) b. [NAME] 1 did not follow the recipes corn bread for all diets. This failure had potential to result in 59 of 63 facility residents at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Cross-reference F803. Findings: a. During a concurrent observation and interview on 12/1/2025 at 11:43 a.m. with [NAME] 1, observed [NAME] 1 took the temperatures of food in trayline using the facility thermometer. [NAME] 1 stated puree turkey was at 136 F. During a concurrent test tray observation and interview on 12/1/2025 at 12:42 p.m. of the puree diet test tray with the Dietary Supervisor (DS), the DS took the temperature of the puree cauliflower using the facility thermometer. The DS stated the temperature of the puree cauliflower was 105 F. During a concurrent test tray observation and interview on 12/1/2025 at 12:44 p.m. of the regular diet test tray with the DS, observed the DS take the temperature of the salad with dressing using the facility thermometer. The DS stated the temperature of the salad with dressing was 46 F. The DS stated the food had to be at the right temperatures and the acceptable range is 135 F for hot food and 41 F for cold food during distribution of trays for palatability and acceptability of food. The DS stated it is expected food is served hot for hot food and served cold for cold food. The DS stated residents would not want to eat the food as it would be cold potentially resulting in weight loss. During a review of the facility's policies and procedures (P&P) titled, Food Preparation, last reviewed 1/2/2025, the P&P indicated Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. During a review of the facility's P&P titled Meal Service, last reviewed 1/2/2025, the P&P indicated (7) Temperature of food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. See table below for suggested temperatures. Recommended temperatures at delivery to residents: salads-equal or less than 45 F, vegetables- equal or more than 120 F. During a review of the facility's standardized recipe titled, Recipe: Pureed (IDDSI Level 4) Meats, dated 1/2/2025, the recipe indicated, Directions: (7) Serve on trayline at the recommended temperature of 160 F -180 F. During a review of the facility's standardized recipe titled, Recipe: Pureed (IDDSI Level 4) Vegetables, dated 1/2/2025, the P&P indicated (7) Serve on trayline at the recommended temperature at 160 F-180 F. During a review of the facility's standardized recipe titled, Recipe: Tossed [NAME] Salad with Dressing, dated 1/2/2025, the recipe indicated Directions: (4) Serve with a choice of dressing, mix in salad or serve separately. Refrigerate. Serve on trayline at the recommended temperature of 41 F or less. b. During a review of the facility's daily cook's spreadsheet (a sheet that contains each diet and what food and portions each diet would get) titled Winter Menus, dated 12/1/2025, the spreadsheet indicated residents on regular diet would include the following foods in the tray: - Three bean chili 1 cup (c, household measurement) - Tossed green salad 1/2 c - Salad dressing 1/2 ounces (oz, unit of measurement) - Corn bread with green chilis 1 - Margarine 1 teaspoon (tsp, household measurement) - Citrus chiffon delight 2x2 1/2 inch 1 piece (pc) - Milk 4 oz During a review of the facility's daily cook's spreadsheet titled Winter Menus, dated 12/1/2025, the spreadsheet indicated residents on puree diet/IDDSI] level 4 would include the following foods in the tray: - Puree three bean chili 1 cup (c, household measurement) - Puree cauliflower 1/3 c - Puree cornbread 1/4 c - Puree coffee cake 1/3 c - Margarine 1 pc - Pudding 1/3 c During a concurrent test tray observation and interview on 12/1/2025 at 12:44 p.m. of the regular diet tray with the DS, the DS stated the taste of the corn bread was good and she could taste the corn however it's not flavorful. The DS stated she needed to check the recipe for the corn bread as the spreadsheet indicated there would be green chili but there was no (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chili taste in the corn bread. During a concurrent test tray observation and interview on 12/1/2025 at 12:57 p.m. of the puree diet tray with the DS, the DS stated the puree corn bread tasted like regular bread and they used corn bread from the box. During an interview on 12/2/2025 at 8:48 a.m. with [NAME] 1, [NAME] 1 stated he made the corn bread yesterday following the ingredients and instructions from the recipe. [NAME] 1 stated he made the corn bread from the box and not from scratch, but he forgot to add the chiles and sour cream. [NAME] 1 stated not adding the chiles and sour cream affected the flavor of the corn bread and residents would not eat it and complain about it as a potential outcome. During an interview on 12/2/2025 at 8:56 a.m. with the DS, the DS stated the staff follow the standardized recipes for food so that residents could get the right nutrients, calories and the food would have good flavors. The DS stated since [NAME] 1 forgot to add the chili and sour cream to the corn bread, it changed the flavor of the corn bread. The DS stated residents might not like the food and would not eat it resulting in weight loss as a potential outcome for not following the recipe. During a review of the policies and procedures (P&P) titled, Food Preparation, last reviewed 1/2/2025, the P&P indicated (1) The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. (2) Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines. During a review of the P&P titled, Healthcare Menus Direct, LLC. Menu System Guide, last reviewed 1/2/2025, the P&P indicated This book contains information on general food safety and miscellaneous resources for the use of the menu system, along with all of the breakfast and vegetables (including all salad) recipes needed throughout the upcoming menu cycles. During a review of the facility's recipe titled, Cornbread with [NAME] Chiles, last reviewed 1/2/2025, the recipe indicated Ingredients: corn bread mix, canned green chilies, sour cream. Directions: If using corn bread mix: 1. Follow package directions, making cornbread as you normally would for each resident to have 2x2 1/2 inches portion (2 oz) and then add chilies and sour cream, stirring to mix only.

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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 residents on puree diet (foods that are smooth with pudding like consistency)/International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) level four (4) received puree cauliflower and puree corn bread that did not hold it shape on the plate and were weeping liquid. This failure had a potential to result in difficulty eating, coughing, choking (to keep from breathing the normal way) and death for 13 of 63 residents on puree/IDDSI level 4 diet. Findings: During a review of the facility's daily cook's spreadsheet (a sheet that contains each diet and what food and portions each diet would get) titled, Winter Menus, dated 12/1/2025, the spreadsheet indicated residents on puree diet/IDDSI] level 4 would include the following foods in the tray: - Puree three bean chili 1 cup (c, household measurement) - Puree cauliflower 1/3 c - Puree cornbread 1/4 c - Puree coffee cake 1/3 c - Margarine 1 piece - Pudding 1/3 c During an observation on 12/1/2025 at 12:19 p.m. of the trayline (an area where foods were assembled), observed puree food looked flat on the resident's plate. During a concurrent observation and interview on 12/1/2025 at 12:57 p.m. of the puree test tray (a process of tasting, temping, and evaluating the quality of food) with the Dietary Supervisor (DS), the DS stated the puree cauliflower and puree cornbread had fluid separating and it was coming from the plate cover. The DS stated it was not okay for the puree food to fluid separating from the food as it would change the food texture. The DS stated puree food must hold its shape on the plate, and the puree cauliflower and puree corn bread is not holding their shapes. The DS stated residents could choke as a potential outcome if there was fluid coming out of the puree foods. During a review of the facility's policy and procedure (P&P) titled, Food Preparation, dated 12/2/2025, the P&P indicated The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. During a review of the facility's Diet Manual titled, IDDSI Level 4: Regular Pureed Diet, dated 12/2/2025, the diet manual indicated Description: The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the prepared pureed food items included on this diet should be smooth and free of lumps, hold their shape, while not being too firm or sticky, and should not weep. Detailed recipes and procedures for pureeing foods may be found in book 1, under the food safety/miscellaneous section. During a review of the facility's recipe titled, Recipe: Pureed (IDDSI Level 4) Breads, Cakes, Cookies, Pancakes, French Toast, Sweet Rolls, Waffles, Tortillas, Sandwiches and Other Breads, dated 12/2/2025, the recipe indicated (4) The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished puree item must pass IDDSI level 4 testing requirements (i.e. the fork drip, fork pressure, and spoon tilt test). During a review of the facility's recipe titled, Recipe: Pureed (IDDSI Level 4) Hot Cereal, dated 1/2/2025, the recipe indicated, (4) The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished product must pass IDDSI level 4 testing requirements. During a review of the facility's recipe titled, Recipe: Pureed (IDDSI Level 4) Vegetables, dated 1/2/2025, the recipe indicated, (5) the finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished puree items must pass IDDSI Level #4 testing requirements. During a review of the IDDSI guideline website titled, IDDSI dated 7/2019, the IDSSI website indicated, Level 4 Pureed 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 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 when: a. Food preparation surfaces and kitchen equipment were not cleaned and sanitized. 1. The walk-in refrigerator vent had dust and dirt build up 2. Two (2) silver racks in the walk-in refrigerator had dust and dirt buildup. 3. Soiled towel was on the walk-in refrigerator floor b. Shredded jack cheese at 44 degrees Fahrenheit (F, a degree of temperature) and shredded cheddar cheese at 43 F in the walk-in refrigerator. c. Kitchen equipment and utensils were not in good condition and repaired 1. Black rack paint was peeling off in the walk-in freezer 2. [NAME] and brown chopping boards had scratches 3. Can opener blade had amber discoloration d. The refrigerator had no internal thermometer. e. Staff hair (Cook 1 and [NAME] 2) was not fully covered with hairnet when cooking and dishing out food on trayline (an area where foods were assembled from the steamtable to resident's plate). f. Staff failed to follow manufacturer's guidelines when checking quaternary ammonium compound (QUAT, a chemical that disinfect) sanitizer concentration. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 59 of 63 medically compromised residents who received food and ice from the kitchen. Findings: a. 1. During an observation during the initial kitchen tour on 12/1/2025 at 8:19 a.m. of the walk-in refrigerator, the vent had dust and dirt buildup. During an interview on 12/1/2025 at 8:50 a.m. with the Dietary Supervisor (DS), the DS stated the vent in the walk-in refrigerator was cleaned by the maintenance department and it was last cleaned two weeks ago. The DS stated it was important to clean the vent so it could circulate air. The DS stated the vent was dusty and it was not okay as it could contaminate the food. During a review of the facility's policy and procedure (P&P) titled, Vents, last reviewed 1/2/2025, the P&P indicated Vents must be free of dust and dirt. 2. During an observation during the initial kitchen tour on 12/1/2025 at 8:19 a.m. of the walk-in refrigerator, 2 silver racks had dust and dirt buildup. During a concurrent observation and interview on 12/2/2025 at 8:58 a.m. of the walk-in refrigerators' silver racks with the DS, the DS stated the silver racks in the walk-in refrigerator had dirt buildup and it needed to be cleaned because it could contaminate food. The DS stated contaminated food could potentially cause food borne illnesses if consumed by the residents. The DS stated the refrigerator racks are cleaned once a week. During a review of the facility's P&P titled, Refrigerator and Freezer, last reviewed 1/2/2025, the P&P indicated Maintaining a clean refrigerator and freezer can improve the safety and quality of your food. For the best cleaning results, always refer to your owner's manual. (6) Remove all items and clean shelves. Wipe with sanitizer. 3. During an observation during the initial kitchen tour on 12/1/2025 at 8:19 a.m. of the walk-in refrigerator, there was soiled and wet towel on the floor. During an interview on 12/1/2025 at 8:45 a.m. with the DS, the DS stated they clean the walk-in refrigerator every Wednesday and it was important to maintain the cleanliness of the walk-in refrigerator so residents would not get sick of food borne illness due to bacterial growth. The DS stated there was a cleaning rag on the floor and it should have been disposed after use as it could spread bacteria to food. The DS stated the rag looked like it was soiled. During a review of the facility's P&P titled, Refrigerator and Freezer, last reviewed 1/2/2025, the P&P indicated (7) Sweep freezer floor and mop with a freezer cleaner product obtained from your chemical company. 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 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. b. During an observation during the initial kitchen tour on 12/1/2025 at 8/19/2025 at 8:19 a.m. of cheese temperatures in the walk-in refrigerator, shredded jack cheese was 44.5 F and shredded cheddar cheese was at 43.5 and 44.1 F. During a concurrent observation and interview on 12/1/2025 at 8:52 a.m. with the DS, the DS stated the walk-in refrigerator temperature is maintained to 41 F and below as they were trying to avoid the danger zone temperatures between 41 to 135 F because this is when bacteria grow. The DS took the temperature of the following food using the facility's thermometer: - shredded jack cheese 44 F; - shredded cheddar cheese at 43 F. The DS stated both cheeses were in the danger zone and had to be disposed of because bacteria could grow in it and During a review of the facility's P&P titled, Food Preparation, last reviewed on 1/2/2025, the P&P indicated (7) Hold food prior to service for a short a time as practical. A maximum of 1-hour holding time is recommended. Hot food should be held prior to service at 135 F or above and cold foods at 41 F or below. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less. c. 1. During an observation on 12/1/2025 at 8:37 a.m. of the walk-in freezer rack, observed the black rack paint was coming off and had dirt accumulation. During a concurrent observation and interview on 12/1/2025 at 9:00 AM of the black rack in the walk-in freezer with the DS, the DS stated the paint of the black rack was coming off and it was not acceptable because the paint could fall in the food and contaminate it. During a review of the facility's P&P titled, Refrigerator and Freezer, last reviewed 1/2/2025, the P&P indicated How to keep your refrigerator and freezer working efficiently: (9) Periodically inspect shelves and replace if coating is chipped away exposing metal shelves. 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. 2. During an observation on 12/1/2025 at 12:29 p.m. of the chopping boards, the green and brown chopping boards had scratches. During a concurrent observation and interview on 12/2/2025 at 9:07 a.m. of the chopping boards with the DS, the DS stated the chopping boards had scratches and the expectation was to have a smooth, crack-free and clean chopping boards. The DS stated food surfaces should be smooth to prevent bacterial growth on the scratched surfaces. During a review of the facility's P&P titled, Sanitation, last reviewed 1/2/2025, the P&P indicated 12. Plastic ware, china and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining. 20. Separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized. During a review of the facility's P&P titled, Policy for Replacing of Cutting Board, last reviewed on 1/2/2025, the P&P indicated Based California food code, the policy for replacing food service cutting boards requires replacement when they become excessively worn, develop deep grooves, or are warped, crack or difficult to clean, as these conditions can harbor bacteria and lead to food contamination. While there isn't a specific time frame mandated by state law, food facilities must ensure their boards are kept in sanitary condition to prevent cross-contamination, and local health codes may also apply. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.12 Cutting Surfaces. Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may be transferred to foods that are prepared on such surfaces. 3. During (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an observation on 12/2/2025 at 10:17 a.m. of the can opener, observed amber discoloration on the blade and body of the can opener. During a concurrent observation and interview on 12/2/2025 at 10:47 a.m. of the can opener with the DS, the DS stated there was a discoloration on the body and blade of the can opener and it was not okay due to cross-contamination of food. The DS stated she was not sure why the can opener had discoloration, and she would need to change than opener. During a review of the facility's P&P titled, Sanitation, last reviewed 1/2/2025, the P&P indicated All equipment shall be maintained as necessary and kept in working order. (11) All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped area. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 4-101 Characteristics. Materials that are used in construction of utensils and food-contact surfaces of equipment may not allow the mitigation of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be (a) safe; (b) durable, corrosion-resistant, and non-absorbent; (c) sufficient in weight and thickness to withstand repeated warewashing; (d) Finished to have a smooth, easily cleanable surface. d. 1. During an observation on 12/1/2025 at 9:08 a.m. of the reach-in refrigerator, there was no internal thermometer in the reach-in refrigerator. During an interview on 12/1/2025b at 9:21 a.m. with the DS, the DS stated they do not put an additional thermometer inside the reach-in refrigerator as they always just check the temperature gauge outside. During a concurrent interview and record review on 12/2/2025 at 2:02 p.m. of food code titled, 2022 Food Code, dated 1/18/2023 was reviewed. The guidelines indicated, 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. The DS stated they followed retail food code and the thermometer should have been placed in the warmest area of the reach-in refrigerator to ensure the food storage is meeting the temperature of 41 F and below and since they do not have a thermometer, there would not be a reading of temperatures in the warmest area of the refrigerator and food could spoil if temperatures were not maintained. The DS stated foodborne illness would be the potential outcome of not maintaining refrigerator temperatures for the residents. During a review of the facility's P&P titled, Sanitation, last reviewed 1/2/2025, the P&P indicated 21. Correct temperatures for the storage and handling of foods are used. Thermometers will be used to check temperatures of refrigerators, freezers, and food storerooms. Thermometers will also be used to check the food at mealtimes. e. During an observation on 12/1/2025 at 12:33 p.m. of the lunch trayline service, [NAME] 1 was wearing a hat and his back hair was not covered and [NAME] 2's hairs were sticking out from the hair net. During an observation on 12/2/2025 at 10:13 a.m. of the cooking process, observe two cooks with their hair sticking out from their hat and hairnet while cooking food. During a concurrent observation and interview on 12/2/2025 at 10:42 a.m. of the cooking process with the DS, the DS stated [NAME] 2 had her hair sticking out and [NAME] 1's hair was not completely covered while cooking. The DS stated the staff needed to wear hairnets so their hairs would be completely covered so it would not fall on the food. The DS stated cross-contamination would be the potential outcome if hair falls into food. During a review of the facility's P&P titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, last reviewed 1/2/2025, the P&P indicated Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Hair nets. (15) Hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. During a review of Food Code 2022, the Food Code 2022 indicated 2-402 Hair Restraints. 2-402.11 Effectiveness (A) except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens, and unwrapped single-service and single use article. f. (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 concurrent observation and interview on 12/2/2025 at 10:37 a.m. of the red bucket QUAT sanitizer testing process with Dietary Aide 1 (DA 1), DA 1 demonstrated the process of testing the QUAT sanitizer: 1. Filled the red bucket with a pre-mix solution from the faucet 2. Pull one test strip from the container. 3. Dip the test strip for six (6) seconds (surveyor looking at the clock) 4. Compared the test strip to the color chart. DA 1 stated she dipped the test strip for ten (10) seconds by silently counting 1,2,3,4,5,6,7,8,9,10. DA 1 stated she did not take the temperature of the testing solution. DA 1 stated the test strip read 300-400 parts per million (ppm, a unit to measure very small concentrations of a substance in a mixture or solution) for the QUAT sanitizer concentration. During an interview on 12/2/2025 at 10:47 a.m. with the DS, the DS stated the process of testing QUAT sanitizer was as follows: 1. Fill the red bucket in the morning and as needed 2. After filling the red bucket, they test for the QUAT sanitizer concentration 3. Dip the test strips for 20 seconds then compare them to the color chart, and she knows its 20 seconds by counting 1.2.3.4.5.6.7.8.9.10 . 4. Compare the test strips to the color chart and it should be 200-400 ppm. The DS stated they do not check the temperature of the testing solution. The testing solution was at 63 degrees Fahrenheit (F, a degree of temperature). The DS stated they should be following the test strips manufacturer's guidelines. During a concurrent interview and record review on 12/2/2025 at 10:50 a.m. of the facility's test strip manufacturer's guidelines titled, Hydrion QT-10 Instructions, undated, was reviewed. The guidelines indicated, 1. Dip paper in quat solution. 2. Not foam surface for 10 seconds. 3. Don't shake.^ Compare colors at once. - Testing solution should be between 65-75 F - Testing solution should have a neutral ph - Follow manufacturer's dilution instructions carefully. The DS stated they should be following the manufacturer's guidelines of the QUAT sanitizer test strips to ensure the test strips reading was correct for the Quat sanitizer concentration to work for cleaning of surfaces. The DS stated cross-contamination would be the potential outcome if the test strips were not accurately reading the correct concentration of the Quat sanitizer. During a review of the facility's P&P titled, Quaternary Ammonium Log Policy, last reviewed 1/5/2025, the P&P indicated The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. Read instructions on quaternary containers and test strips for proper concentration, length of time the strip needs to be in contact with the solution, and if temperature of the solution is to be considered when testing for concentration. This may differ from policy. Follow container and test strip instructions. A high concentration may be potentially hazardous and may be a chemical contaminate of food. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using test kit or other device. During a review of Food Code 2022, the Food Code 2022 indicated, 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11 (C) shall meet criteria specified under 7-204.11 Sanitizers, criteria shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows: (C) A quaternary ammonium compound solution shall (1) Have a minimum temperature of 24 C (75 F), (2) Have a concentration as specified under 7-204.11 and as indicated by the manufacturer's use directions included in the labeling.

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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. Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by: 1. Failing to ensure ice scoopers were placed in a closed container when not in use reviewed under infection control facility task. 2. Ensure the cart used for distributing linens was covered with non-permeable (any surface material that will not allow water-vapor, air, small particles to pass through) cover to prevent exposure of the clothing from environment contaminants reviewed under infection control facility task. 3. Failing to ensure Resident 29's padded side rails (safety features designed to help prevent falls and provide support for residents) were not disinfected with a chemical not intended for porous (something that has lots of tiny holes or openings, allowing liquids or air to pass through) surfaces. These deficient practices had the potential to result in the spread of infections that could lead to serious harm to all residents. Findings: 1. During a concurrent observation and interview on 12/1/2025 at 9:57 a.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 confirmed and stated there were two (2) carts with ice chests with ice scoopers placed in a container made of mesh material. During a concurrent observation and interview on 12/3/2025 at 9:35 a.m., with the Infection Preventionist (IP), in the hallway outside the dietary department, observed one (1) cart with the ice scooper missing from the mesh material container upon. The IP stated the ice scooper should have been placed in the storage container after use as it was already contaminated when the staff touched the handle. The IP stated it was an infection control issue and can potentially spread infection from the possibly contaminated ice scooper. The IP stated it was not appropriate to store the ice scooper in a permeable sack because the scooper was permeable to dust and contaminants in the environment. The IP stated it should be stored in a closed container to prevent infection that can be spread to residents causing illness. During a review of the facility's recent policy and procedure (P&P) titled, Ice Procedures, last reviewed on 1/2/2025, the P&P indicated ice is to be handled properly to prevent infection. The P&P further indicated: - A covered plastic or stainless container will be used to hold the scoop. - The scoop is not to be left in the ice at any time. During a review of the facility's P&P titled, Policies and Practices - Infection Control, last reviewed on 1/2/2025, indicated the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and mange transmission of diseases and infections. The P&P further indicated the objective of the infection control policies and practices is to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. 2. During an observation on 12/1/2025 at 10:37 a.m., observed a linen cart along the hallway in Station 1 that had a breathable/permeable mesh cover not protecting the linens from contaminants. During a concurrent interview and record review on 12/1/2025, at 9:45 a.m., reviewed a photograph of the linen cart with the breathable/permeable mesh cover with the IP. The IP stated the linen cart had a breathable/permeable mesh not protecting the linens from contaminants. The IP stated the linen cart cover should have a non-permeable cover to protect the linens from dust and other bacteria that is dispersed in the environment. The IP stated the failure to cover the linens with a non-permeable cover can be contaminated and spread infection to residents as it can accumulate dust and bacteria even when covered. During a review of the facility's recent P&P titled, Laundry and Bedding, Soiled, last reviewed on 1/2/2025, indicated clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. 3. During an observation on 12/1/2025, at 9:23 a.m., observed Resident 29's quarter upper bilateral side rails were padded with foam/porous tube noodles. During a concurrent observation and interview on 12/2/2025, at 8:58 a.m., with Housekeeper (HK) 1, inside Resident 29's room, observed the resident's bed with upper side rails padded with foam/porous tube noodles. HK 1 stated they clean the padded side rails using the Disinfectant Chemical (DC) 1 to sanitize the side rails covered with porous materials. HK 1 stated she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gets a piece of DC 1 wipe from the tub and wipe the foam pads to sanitize the siderails padded with tube foam/porous foam. During a concurrent observation and interview 12/3/2025 at 10:49 am inside Resident 29's room with the Infection Preventionist (IP), stated Resident 29's bilateral upper side rails were padded with foam noodle and is porous. During a concurrent interview and record review on 12/3/2025 at 11 a.m., reviewed the DC 1's product label and safety data sheet with the IP. The IP stated the product label and safety data sheet indicated the direction for use stated to use the product on hard, non-porous surfaces and can cause eye irritation. The IP stated the foam cannot absorb the chemical and when residents touch the foam, they can touch their mouth or any part of the face and cause irritation. During a concurrent interview and record review on 12/3/2025 at 11:15 a.m., reviewed DC 2's safety data sheet and product label with Central Supply Staff (CSS) 1. CSS 1 stated the facility uses DC 2 to disinfect porous surfaces not DC 1 such as pillows, cloth chairs, and foam side rails. CSS 1 stated the safety data sheet and product label in the back of the bottle indicated the product is designed as a general cleaner and disinfectant for use on hard, non-porous surfaces. During an interview and record review on 12/3/2025, at 3:37 p.m., with the Director of Nursing (DON), reviewed the product information and safety data sheet provided by the facility for DC 1 and DC 2. The DON stated the product information indicated DC 1 and DC 2 are used for general cleaning of hard, non-porous inanimate surfaces. The DON stated the foam tube covering their siderails are made of porous materials that can absorb the chemicals and can be harmful to residents when they get in contact with them or ingested. During a review of the photograph of DC 1 and DC 2, the photograph indicated that DC 1 is a one-step germicidal disinfectant cleaner and deodorant designed for general cleaning of hard, non-porous inanimate surfaces. During a review of the facility-provided Safety Data Sheet (SDS) on the use of DC 1, undated, the SDS indicated to observe good industrial practices, and wash hands after handling. The SDS further stated: IF ON SKIN: rinse well with water. IF IN EYES: Hold eye open and rinse slowly and gently with water for 15-20 minutes. attention. Inhalation: If breathed in, move person into fresh air. Remove person to fresh air and keep comfortable for breathing. If problem persists, call a Poison Center or get medical attention. Most important symptoms/effects, acute, and delayed: irritation of eyes. During a review of the facility provided SDS on the use of DC 2, undated, the SDS indicated: - Section 2. Hazards Classification: - Causes eye irritation - Wash hands thoroughly after handling - If in eyes: rinse cautiously with water for several minutes - Section 4. First Aid Measures - Eye contact: immediately flush eyes with plenty of water, occasionally lifting the upper and lower eyelids - Inhalation: remove victim to fresh air and keep at rest in a position comfortable for breathing. - Skin contact: flush contaminated skin with plenty of water. Remove contaminated clothing and shoes. Get medical attention if symptoms occur. Wash clothing before reuse. Clean shoes thoroughly before reuse. - Ingestion: wash out mouth with water. Remove victim to fresh air and kept at rest in a comfortable position for breathing. Do not induce vomiting. - Potential acute health effects, over-exposure signs and symptoms include eye irritation.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy for antibiotic (medication used to treat infection) stewardship (efforts in long-term care facilities to ensure that antibiotics are used only when necessary and appropriate [means prescribing the right drug at the right dose at the right time for the right duration]) program and infection prevention and control program for two of seven sampled residents (Residents 8 and 29) by: 1. Failing to complete Resident 8's Surveillance Data Collection Form (a checklist used in nursing homes to help healthcare workers identify if a resident actually has a significant infection, rather than just having symptoms) for Urinary Tract Infection (UTI - an infection in the bladder/urinary tract) that the resident met the criteria for the use of antibiotic. 2. Failing to complete Resident 29's Surveillance Data Collection Form for Respiratory Tract Infections (infections of parts of the body involved in breathing, such as the sinuses, throat, airways or lungs) that the resident met the criteria for the use of antibiotic. 3. Failing to complete the Infection Prevention and Control Surveillance Log (a document or system used to track and monitor infections within a specific setting, like a healthcare facility, to identify trends, outbreaks [a sudden increase in the number of cases of a disease], and potential areas for improvement in infection prevention and control practice), dated 11/2025. The Infection Control Surveillance log did not indicate Residents 8 and 29's signs and symptoms of infection, mental status (mental state), and culture result (a laboratory procedure where a sample of body fluid or tissue is tested to know what organism is growing). These failures had the potential to increase antibiotic resistance (when bacteria develop the ability to withstand the effects of antibiotics, making it difficult or impossible to treat infections) from unnecessary or inappropriate antibiotic use and had the potential for the residents to experience an unmonitored adverse reaction. Findings: 1. During a review of Resident 8's admission Record, the admission Record indicated the facility admitted the resident on 10/1/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), enterocolitis (an inflammation of the large intestine that results in diarrhea) due to clostridium difficile (also known as c. diff, a bacteria that causes inflammation of the large intestine), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 8's History and Physical (H&P), dated 9/15/2025, the H&P indicated Resident 8 was able to make needs known but unable to make medical decisions. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 10/8/2025, the MDS indicated Resident 8 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and usually understands and makes her needs known. The MDS further indicated Resident 8 required total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 8's physician's order, dated 12/3/2025, the physician's order indicated a physician's order dated 11/21/2025 for ciprofloxacin 500 milligrams (mg - a unit of measurement) give one tablet via gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) two times a day for UTI x seven days. During a review of the Infection Prevention and Control Surveillance Log, for 11/2025, the surveillance log did not indicate if Resident 8 had signs and symptoms of UTI. During a review of Resident 8's urinalysis result, collected on 11/19/2025, the urinalysis indicated the following: - Nitrite: positive (a sign of possible UTI often used alongside other clinical signs and symptoms). - Leukocyte esterase: 2+ (a screening test used to detect a substance that suggests there are white blood cells [WBC - help the body fight infection and other diseases] in the urine). - WBC: 10- 20 (normal range is zero to five) - Bacteria: Few During a review of Resident 8's Change of Condition SBAR - Acute COC (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents) form, dated 11/21/2025, the Change of Condition SBAR - Acute COC form indicated that (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the only problem is UTI. The Change of Condition SBAR - Acute COC form further indicated that the Nurse Practitioner (NP - a nurse who has advanced education and training and share many of the same duties as doctors) was notified with order to start the resident on ciprofloxacin 500 mg give one tablet via GT two times a day for seven days. During a review of Resident 8's Surveillance Data Collection form for residents with UTIs without an indwelling catheter, dated 11/21/2025, there were no check marks in the Surveillance Data Collection form that Resident 8 meet both criteria for the use of antibiotic. During a concurrent interview and record review, on 12/1/2025, at 1:05 p.m., with the Director of Staff Development (DSD), Resident 8's physician's order, vital signs, care plans, nurses' notes, Change of Condition SBAR - Acute COC form, urinalysis, Surveillance Data Collection form, and Infection Prevention and Control Surveillance Log, for 11/2025, were reviewed. The DSD stated the Infection Prevention and Control Surveillance Log, Change of Condition SBAR - Acute COC form, and nurses' notes did not indicate that Resident 8 had clinical signs and symptoms of UTI such as fever, or changes in mental status. The DSD stated there was no culture and sensitivity test done on Resident 8's urine. The DSD stated the Surveillance Data Collection form indicated Resident 8 did not meet the criteria for the use of ciprofloxacin as ordered by the NP for UTI. During a concurrent interview and record review, on 12/2/2025, at 3:03 p.m., with the Infection Preventionist (IP), Resident 8's physician's order, vital signs, care plans, nurses' notes, Change of Condition SBAR - Acute COC form, urinalysis, Surveillance Data Collection form, and Infection Prevention and Control Surveillance Log, for 11/2025, were reviewed. The IP stated Resident 8's nurse' notes, vital signs flow sheet, the Infection Prevention and Control Surveillance Log, and Change of Condition SBAR - Acute COC form did not indicate that Resident 8 had signs and symptoms of UTI. The IP stated Resident 8's Surveillance Data Collection form, dated 11/21/2025, did not indicate check marks that the resident met criteria for the use of antibiotic. The IP stated the facility has the responsibility to notify the physician if a resident does not meet the criteria for the use of antibiotic. The IP stated she did not notify the physician that Resident 8 did not meet the criteria for the use of ciprofloxacin for UTI. The IP stated she should have notified the physician as it placed Resident 8 at risk for developing resistance to antibiotic which can lead to development of multidrug resistant organisms (MDROs - a germ that is resistant to many antibiotics and becomes difficult to treat since many antibiotics won't work or are less effective). During a concurrent interview and record review, on 12/2/2025, at 3:30 p.m., with the Director of Nursing (DON), Resident 8's physician's order, vital signs, nurses' notes, Change of Condition SBAR - Acute COC form, urinalysis, Surveillance Data Collection form, and Infection Prevention and Control Surveillance Log, for 11/2025, was reviewed. The DON stated Resident 8's nurse' notes, vital signs flow sheet, the Infection Prevention and Control Surveillance Log, and Change of Condition SBAR - Acute COC form did not indicate that Resident 8 had signs and symptoms of UTI. The DON stated Resident 8's Surveillance Data Collection form, dated 11/21/2025, did not indicate check marks that the resident met criteria for the use of antibiotic. The DON stated if a resident does not meet criteria for the use of antibiotic according to the Surveillance Data Collection form, the physician should be notified as soon as possible. The DON stated the physician should have been notified that Resident 8 did not meet the criteria for the use of ciprofloxacin for UTI and placed Resident 8 at risk for resistance to many antibiotics and lead to development of MDROs. 2. During a review of Resident 29's admission Record, the admission Record indicated the facility originally admitted the resident on 2/21/2023 and readmitted in the facility on 11/11/2025 with diagnoses including pneumonia (an infection/inflammation in the lungs, dementia (a progressive state of decline in mental abilities), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 29's H&P, dated 11/12/2025, the H&P indicated Resident 29 was able to make needs known but unable to make medical decisions. During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and sometimes understands and sometimes able to make her needs (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	known. The MDS further indicated Resident 29 required partial/moderate assistance with eating and total assistance from staff with all other ADLs. The MDS further indicated that Resident 29 received antibiotic during the last seven days. During a review of Resident 29's physician's order, dated 12/3/2025, the physician's order indicated a physician's order, dated 11/11/2025, for ceftriaxone sodium intravenous solution reconstituted two grams (gm - a unit of measurement) use two gm intravenously one time a day for community acquired pneumonia for seven days and was changed to Augmentin oral tablet 500-125 mg give one tablet by mouth every 12 hours for six days. During a review of the Infection Prevention and Control Surveillance Log, for 11/2025, the surveillance log indicated that Resident 29 had a positive chest x-ray (a test that uses radiation to create an image of the heart, lungs and bones and can diagnose health conditions like pneumonia) but did not indicate if Resident 29 had signs and symptoms of respiratory tract infection or pneumonia. During a review of Resident 29's Surveillance Data Collection form for residents with Respiratory Tract Infections, dated 11/11/2025, the Surveillance Data Collection form indicated that three criteria must be present for the use of antibiotic for pneumonia. The Surveillance Data Collection form indicated check marks that Resident 29 had an interpretation of chest radiograph (also known as chest x-ray) demonstrating pneumonia or presence of new infiltrate (abnormal substances or fluids within the lung tissue that can arise from various causes), and oxygen (O2) saturation less than 94% on room air or a reduction in O2 saturation of more than 3% from baseline. During a concurrent interview and record review, on 12/1/2025, at 1:05 p.m., with the DSD, Resident 29's physician's order, nurses' notes, Surveillance Data Collection form, Infection Prevention and Control Surveillance Log, for 11/2025, and the hospital physician's Discharge summary, dated [DATE], was reviewed. The DSD stated the Infection Prevention and Control Surveillance Log, and nurses' notes did not indicate that Resident 29 had clinical signs and symptoms associated with respiratory tract infections or pneumonia. The DSD stated the hospital physician discharge summary indicated Resident 29's sputum culture and blood culture while the resident was in the hospital were normal and the chest x-ray, dated 11/5/2025, indicated lung infiltrates with improvement when repeated on 11/10/2025. The DSD stated the Surveillance Data Collection form indicated that Resident 29 did not meet the criteria for the use of ceftriaxone and Augmentin for pneumonia. During a concurrent interview and record review, on 12/2/2025, at 3:20 p.m., with the IP, Resident 29's physician's order, nurses' notes, Surveillance Data Collection form, Infection Prevention and Control Surveillance Log, for 11/2025, and the hospital physician's Discharge summary, dated [DATE], were reviewed. The IP stated Resident 29's Infection Prevention and Control Surveillance Log, and nurses' notes did not indicate that Resident 29 had clinical signs and symptoms associated with respiratory tract infections or pneumonia. The IP stated the hospital physician discharge summary indicated Resident 29's sputum culture and blood culture results were normal while Resident 29 was in the hospital and that the chest x-ray, dated 11/5/2025, indicated lung infiltrates with improvement during a follow up on 11/10/2025. The IP stated the Surveillance Data Collection form indicated that Resident 29 did not meet the criteria for the use of ceftriaxone and Augmentin for pneumonia. The IP stated if a resident comes from the hospital with antibiotic, she still had to complete the Surveillance Data Collection form to ensure that the resident still meets the criteria for the use of antibiotic and notify the physician if the resident does not meet the criteria per the data collection form. The IP stated she did not notify the physician that Resident 29 did not meet the criteria for the use of antibiotic when ceftriaxone was changed to Augmentin tablet two days after readmission to the facility. The IP stated she should have notified the physician as it placed Resident 29 at risk for developing resistance to antibiotic which can lead to development of MDROs. During a concurrent interview and record review, on 12/2/2025, at 3:30 p.m., with the DON, Resident 29's physician's order, nurses' notes, Surveillance Data Collection form, and Infection Prevention and Control Surveillance Log, for 11/2025, were reviewed. The DON stated Resident 29's Infection Prevention and Control Surveillance Log, and nurses' notes did not indicate that Resident 29 had clinical signs and symptoms associated with respiratory tract infections or pneumonia. The DON (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the Surveillance Data Collection form indicated that Resident 29 did not meet the criteria for the use of ceftriaxone and Augmentin for pneumonia. The DON stated if a resident comes from the hospital with antibiotic, the IP still had to complete the Surveillance Data Collection form to ensure that the resident still meets the criteria for the use of antibiotic and notify the physician if the resident does not meet the criteria per the data collection form. The DON stated the physician should have been notified as it placed Resident 29 at risk for developing resistance to antibiotic which can lead to development of MDROs. 3. During a concurrent interview and record review, on 12/2/2025, at 1:45 p.m., with the IP, the facility's Infection Prevention and Control Surveillance Log, dated 11/2025, was reviewed. The IP stated she (IP) did not completely fill up the Infection Prevention and Control Surveillance Log. The IP stated she (IP) should have completed the Infection Prevention and Control Surveillance Log to keep an accurate tracking of Residents 8 and 28's infections. The IP stated for Residents 8 and 29, the Infection Control Surveillance was missing information on the following: 1. signs and symptoms of infection, 2. residents' mental status, 3. organism or culture result. During an interview on 12/2/2025 at 3:35 p.m. with the DON, the DON stated it was the IP's responsibility to complete the monthly Infection Prevention and Control Surveillance Log. The DON stated every part of the Infection Prevention and Control Surveillance Log should be answered if applicable to help the nurses track if the antibiotic was effective or not and to know if the resident was experiencing any adverse reaction. During a review of the facility's policy and procedure (P&P) titled, Policy for Antimicrobial Stewardship Program, last reviewed on 1/2/2025, the P&P indicated the facility will promote appropriate use of antimicrobials while optimizing the treatment of infection, at the same time reducing the possible adverse events associated with antibiotic use. The P&P further indicated: 4. Action a. Facility may consider time-out (TO) practices and can be considered a stop order of an antibiotic when a diagnostic test or symptoms of resident do not support the diagnosis of infection. 5. Tracking a. IP will be responsible for infection surveillance and MDRO tracking b. IP will collect and review: i. Type of antibiotic ordered, route of administration, antibiotic costs ii. Whether the order was made by phone, if order was given by attending physician or on-call doctor. iii. Whether a culture was obtained before ordering antibiotic iv. Whether the antibiotic was changed during the course of treatment 6. Reporting c. Feedback will be given to physicians on their individual prescribing patterns of cultures ordered, and antibiotics prescribed, on a regular basis. 7. Education a. Educational opportunities, repeated regularly, should be provided for clinical staff as well as residents and their families on appropriate use of antibiotics.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (CL, an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for one of five residents (Resident 56) reviewed during the Environment task. This deficient practice had the potential to result in a delay of care and services and possible injury to residents when they are unable to summon health care workers. Findings: During a review of Resident 56's admission Record (AR), the AR indicated the facility admitted the resident on 5/10/2024 with diagnoses that included unspecified dementia (a progressive state of decline in mental abilities), cerebral palsy (a brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), muscle weakness, and lack of coordination. During a review of Resident 56's Minimum Data Set (MDS - resident assessment tool), dated 11/11/2025, the MDS indicated the resident was sometimes able to make herself understood and sometimes able to understand others. The MDS further indicated Resident 56 was totally dependent on staff for eating, mobility, dressing, bathing, toileting, and oral and personal hygiene. During a review of Resident 56's History and Physical (H&P), dated 5/11/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 56's Fall Risk Assessment form, dated 11/11/2025, the Fall Risk Assessment form indicated that Resident 56 was always disoriented, chair bound, required assistance with elimination, and was at a high risk for falls. During a review of Resident 56's Care Plan (CP) regarding risk for falls / injury related to deconditioning, balance problems, and history of falls, initiated 5/13/2024, the CP indicated a goal that the resident would be free from falls and injuries. The CP indicated an intervention to be sure the resident's CL is within reach and encourage the resident to use the CL for assistance as needed. The CP indicated Resident 56 needs prompt response to all requests for assistance. During an observation on 12/1/2025 at 9:47 a.m., observed Resident 56 awake in bed. Observed the call light cord was wrapped around the residents left bedside rail (SR - rigid plastic bars attached to the bed) and resting on the floor. Observed the CL was not within reach of the resident. Resident 56 stated she needed assistance and did not have a CL. During an observation on 12/1/2025 at 9:59 a.m., observed Certified Nursing Assistant (CNA) 2 entered Resident 56's room and spoke with Resident 56. Observed CNA 2 then exited Resident 56's room and the CL remained on the floor and out of reach of the resident. During an observation on 12/1/2025 at 10:04 a.m., observed CNA 1 entered Resident 56's room, walked to the left side of Resident 56's bed and described the function of Resident 56's magnetic clip alarm (a fall prevention monitor designed to alert caregivers when a resident attempts to move or stand up). Observed CNA 1 then exited Resident 56's room and the CL remained on the floor and out of reach of the resident. During a concurrent observation and interview on 12/1/2025 at 10:04 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 56 was a high risk for falls because she tries to get up unassisted. LVN 2 stated Resident 56 uses the CL every now and then and should always have the CL within reach to ask for help from staff. LVN 2 entered Resident 56's room and stated the CL was on the floor and not within reach of the resident, but it should have been. During a concurrent interview and record review on 12/4/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure (P&P) regarding CLs and fall prevention. The DON stated regardless of any resident's risk for falls, the CL should always be within reach of residents. The DON stated every time a staff member enters a resident's room, the staff should assess the environment including that the CL is within reach. The DON stated Resident 56 is at an increased risk of falls because the resident may mistakenly believe that she is able to walk alone and attempt to walk to the restroom unassisted. The DON stated the facility P&P and plan of care was not followed when Resident 56's CL was not within reach potentially resulting in falls with injuries like fractures (broken bones). During a review of the (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility P&P titled, Fall and Fall Risk, Managing, last reviewed 1/2/2025, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. During a review of the facility P&P titled, Call System, Residents, last reviewed 1/2/2025, the P&P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station.The resident call system remains functional at all times.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' rights to forms of communication with privacy by failing to ensure one of seven sampled residents (Resident 5) present during the Resident Council task received their personal mail unopened. This deficient practice resulted in Resident 5 feeling upset that mail was delivered opened and had the potential to result in psychosocial harm to the resident. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on 3/27/2025 and was most recently re-admitted on [DATE] with diagnoses that included unspecified chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute exacerbation (a sudden, significant worsening of a patient's usual chronic condition), human immunodeficiency virus (HIV - a virus that attacks the body's immune system), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 5's Minimum Data Set (MDS - resident assessment tool), dated 11/12/2025, the MDS indicated the resident was able to make himself understood and able to understand others. The MDS further indicated Resident 5 required substantial staff assistance for bathing, required partial assistance with toileting and personal hygiene, and required supervision with eating. During a review of Resident 5's History and Physical (H&P), dated 11/4/2025, the H&P indicated the resident could make his needs known but could not make decisions. During a review of Resident 5's Care Plan (CP) regarding the resident is at risk for depression due to medical / physical process, initiated 5/13/2024, the CP indicated a goal that the resident would function at an optimal level. The CP indicated an intervention to encourage the resident to verbalize his needs / concerns / feelings and offer support and reassurance. During a Resident Council interview on 12/1/2025 at 1:17 p.m., Resident 5 stated he received his mail opened. During a follow-up interview on 12/2/2025 at 9:56 a.m., Resident 5 stated he had an issue with the Social Services Director (SSD) because the SSD opened his personal mail regarding financial payments to the facility. During an interview on 12/4/2025 at 8:35 a.m. with the SSD, the SSD stated residents have the right to receive their personal mail unopened. The SSD stated personal mail should only be opened by the resident or in the resident's presence with assistance from staff when requested. The SSD stated within the last month, the SSD opened Resident 5's personal mail, not in the presence of the resident, because the SSD needed to know the resident's share of cost (a monthly amount some Medi-Cal [a public health insurance] subscribers pay before benefits) for payment to the facility. The SSD stated the share of cost letter was addressed to Resident 5 and not the facility. The SSD stated Resident 5 was upset with the SSD when the SSD opened Resident 5's personal mail. The SSD stated the SSD could have opted to receive a copy of the share of cost letter addressed to the facility, but the SSD did not because it would just be a duplication of the mail the resident already received. The SSD stated the SSD should have requested a facility copy of the share of cost letter and not opened Resident 5's personal mail because it resulted in the resident becoming upset. During a concurrent interview and record review on 12/4/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure (P&P) regarding resident rights and privacy to communication. The DON stated residents have the right to not have other people open their personal mail. The DON stated facility staff should not open a resident's personal mail without consent. The DON stated the SSD told the DON that the SSD opened Resident 5's share of cost letter that was addressed to the resident. The DON stated the SSD did not follow the facility P&P when the SSD opened Resident 5's personal mail creating a privacy issue for the resident. During a review of the facility P&P titled, Resident Self Determination and Participation, last reviewed 1/2/2025, the P&P indicated, Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. 5. Residents are encouraged to interact with members of the community and participate in community activities (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inside and outside the facility. Examples of accommodations that support community participation include: . communicate in person and by mail, email and telephone with privacy. During a review of the facility P&P titled, Resident Rights, last reviewed 1/2/2025, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. I. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . f. communication with and access to people and services, both inside and outside the facility; .h. be supported by the facility in exercising his or her rights; . t. privacy and confidentiality; .

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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 interview and record review, the facility failed to inform the resident's physician when a significant change in the resident's physical condition had deteriorated for one of three sampled residents (Resident 75) by failing to inform the primary physician of the resident's newly inserted peripherally inserted central catheter (PICC - a long, thin, flexible tube inserted into a vein in your upper arm, threaded up to a large vein near your heart, used for long-term IV fluids, meds [like chemo], nutrition, or blood draws, avoiding many needle sticks) line bleeding from the insertion site on 9/30/2025. The deficient practice had the potential for further complications of PICC line insertion and harm to resident. Findings: During a review of Resident 75's admission Record (AR), the AR indicated the facility admitted the resident on 8/25/2025, with diagnoses including iron deficiency anemia (happens when the body does not get enough iron or loses too much iron), atrial fibrillation (an irregular and often rapid heartbeat caused by abnormal electrical signals in the heart's upper chambers [atria], which causes them to quiver instead of contracting properly), and heart failure (occurs when the heart muscle does not pump blood as well as it should). During a review of Resident 75's History and Physical (H&P), dated 8/27/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 75's Minimum Data Set (MDS - a resident assessment tool), dated 9/4/2025, the MDS indicated the resident had the ability to make self-understood and usually understands others and had moderate cognitive impairment (thinking, memory, or judgment problems are noticeable to others and make daily tasks harder, but the person can still live independently). The MDS indicated the resident was on a high-risk drug class anticoagulant (a substance that prevents blood from clotting too easily, slowing down the body's ability to form clots in blood vessels) and antiplatelet (a medicine that stops tiny blood cells called platelets from sticking together and forming a dangerous blood clot). During a review of Resident 75's Order Summary Report (OSR), the OSR indicated at order for: 8/25/2025 Monitor for bleeding every shift for Aspirin (antiplatelet)/Dabigatran Etexilate/Enoxaparin (anticoagulant) Uses. 8/26/2025 Aspirin EC tablet delayed release 81 milligrams (mg - a unit of weight) (Aspirin). Give 1 tablet by mouth one time a day for (Circulation). Take with food. 8/26/2025 Dabigatran Etexilate Mesylate Oral Capsule 150 mg (Dabigatran Etexilate Mesylate). Give 1 capsule by mouth two times a day for atrial fibrillation. Do not stop this medication unless instructed by your doctor. 9/30/2025 Insert PICC line catheter for intravenous (IV - within a vein) antibiotic (ATB, a medicine that fights infections caused by bacteria by either killing them or stopping them from multiplying) administration by Contracted Company A. During an interview on 12/4/2025 at 9:30 a.m. with Registered Nurse (RN) 1, RN 1 stated she was the RN Supervisor when Resident 75 had a PICC line insertion on 9/30/2025. RN 1 stated the PICC line was inserted by PICC RN 1, a contracted company. RN 1 stated at around 2 p.m. on 9/30/2025, she saw the right upper arm PICC line insertion site with fresh blood around the dressing. RN 1 stated she placed 4X 4 gauze dressing on top of the PICC line and applied pressure for 15 minutes to stop the bleeding. RN 1 stated the bleeding stopped after 15 minutes of pressure application. RN 1 stated PICC RN 1 is aware that the PICC line insertion site bled and is still in the facility but continued charting in the nurse's station. RN 1 stated she should have documented the incident and did an Situation, Background, Assessment, and Recommendation (SBAR - a structured communication framework that can help teams share information about the condition of a resident or team member or about another issue your team needs to address)/Change of Condition (COC) for Resident 75 to ensure that the incident was communicated to the resident representative and specially to the primary physician because he might give further orders to manage the situation. During an interview on 12/4/2025 at 12:30 p.m. with the PICC Chief Nursing Officer (CNO), the CNO stated the expectation for PICC RN 1 is to attend to be the primary person to control the bleeding at the PICC insertion site because he is still in the facility and he is the one who inserted the PICC line. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CNO stated he will speak to her PICC RN 1 regarding the situation. During an interview on 12/4/2025 at 1 p.m. with PICC RN 1, on the phone, PICC RN 1 stated he was the one who inserted the PICC line of Resident 75. PICC RN 1 stated he started the PICC insertion at around 1 p.m. and completed the procedure approximately at 2 p.m. RN 1 stated he was made aware that PICC insertion site was bleeding after few minutes of insertion but he cannot remember who it was. PICC RN 1 stated he went in the room and saw three people in the room including RN 1 controlling the bleeding so he decided to continue documenting in the nurses' station. PICC RN 1 stated their PICC line insertion kit had limited supplies of four-by-four gauzes that is why also he did not step in to help control the bleeding of Resident 75's PICC insertion site. RN 1 also stated he did not go back to Resident 75's room to check if the bleeding was managed by RN 1. PICC RN 1 stated he should have been the one who managed the bleeding and just asked assistance from the facility staff. During an interview on 12/4/2025, at 2:06 p.m., with the Director of Nursing (DON), the DON stated the licensed staff should have documented the incident of PICC line insertion bleeding on 9/30/2025 on the SBAR/COC notes to capture in detail what happened and to have the primary provider manage the incident through new orders. The DON stated the SBAR/COC serves as a communication to healthcare providers of incidents that involved the care of the resident to guide their interventions. The DON stated the failure of the staff to document the incident in SBAR/COC can lead to mismanaged care. During a review of the facility's recent policy and procedure (P&P) titled, Change in a Resident's Condition or Status, last reviewed on 1/2/2025, the P&P indicated our facilities promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): d. significant change in the resident's physical/emotional/mental condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-limiting); b. Impacts more than one area of the resident's health status; c. Requires interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. 8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide in writing the completed Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN - a notification to the resident or responsible party [RP] of the potential liability charges for services not covered when the resident was discharged from Medicare Part A services with benefit days remaining) and the Notice of Medicare Non-Coverage (NOMNC - a notification to inform the resident or RP of the pending termination of coverage and of his/her right to an expedited review of service determination) for two of three sampled residents (Residents 10 and 72) reviewed during the Beneficiary Notification task. This deficient practice had the potential to result in residents or RPs not being able to exercise their rights to be informed in advance of financial responsibilities, request an expedited review upon appeal, or determine in advance the course of their care. Findings: a. During a review of Resident 10's admission Record (AR), the AR indicated the facility admitted the resident on 6/11/2024 and was most recently re-admitted on [DATE] with diagnoses that included urinary tract infection (UTI - an infection in the bladder/urinary tract), pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of sacral region (area at the tailbone), and cerebral palsy (a brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination). During a review of Resident 10's Minimum Data Set (MDS - resident assessment tool), dated 11/24/2025, the MDS indicated the resident was rarely / never able to understand others and was rarely / never able to make herself understood. During a review of Resident 10's History and Physical (H&P), dated 12/3/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 10's SNF Beneficiary Protection Notification Review form, the form indicated the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The document indicated that the last covered day of Medicare Part A service was 9/30/2025. During a review of Resident 10's NOMNC form, signed by the Social Services Director (SSD) on 9/26/2025, the form indicated the SSD received verbal consent where the form indicated Please sign below to indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision. There was no signature of the resident or RP on the form. During a review of Resident 10's SNF ABN form, signed by the SSD on 9/26/2025, the form indicated Resident 10 no longer met the Medicare part A guidelines for skilled nursing care and rehab services. The SNF ABN form was not completed for the selection of the following: Option 1. I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on the MSN . Option 2. I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed. Option 3. I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay. The SNF ABN form indicated the SSD received verbal consent where the form indicated Signing below means that you've received and understand this notice. You'll also get a copy for your records. If a representative signs for the beneficiary, write (rep) or (representative), next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed. There was no signature of the resident or RP on the SNF ABN form. b. During a review of Resident 72's AR, the AR indicated the facility admitted the resident on 9/9/2025 with diagnoses that included fracture (break) of the upper end of the right femur (thigh bone), dysphagia (difficulty swallowing), and schizophrenia (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 72's MDS, dated [DATE], the MDS indicated the resident was usually able to understand others and was able to make herself (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understood. During a review of Resident 72's H&P, dated 9/17/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 72's SNF Beneficiary Protection Notification Review form, the form indicated the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The document indicated that the last covered day of Medicare Part A service was 10/5/2025. During a review of Resident 72's NOMNC form, signed by the SSD on 10/2/2025, the form indicated the SSD received verbal consent where the form indicated Please sign below to indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision. There was no signature of the resident or RP on the form During a review of Resident 72's SNF ABN form, signed by the SSD on 10/2/2025, the form indicated Resident 72 no longer met the Medicare part A guidelines for skilled nursing care and rehab services. The SNF ABN form was not completed for the selection of the following: Option 1. I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on the MSN . Option 2. I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed. Option 3. I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay. The SNF ABN form indicated the SSD received verbal consent where the form indicated Signing below means that you've received and understand this notice. You'll also get a copy for your records. If a representative signs for the beneficiary, write (rep) or (representative), next to the signature. If the representative's signature is not clearly legible, the representative's name must be printed. There was no signature of the resident or RP on the SNF ABN form. During a concurrent interview and record review on 12/3/2025 at 9:50 a.m., with the SSD, the SSD reviewed Resident 10's SNF ABN form and NOMNC forms dated 9/26/2025 and Resident 72's SNF ABN form and NOMNC forms dated 9/9/2025. The SSD stated the forms are provided to residents or their RP before the last day of Medicare Part A coverage to notify that the resident will be responsible for paying their share of costs and the residents have a right to appeal. The SSD stated the SSD calls or speaks to residents or RPs in person to notify regarding the SNF ABN and NOMNC forms and does not provide the written forms to the residents or RP. The SSD stated Resident 10 and 72s SNF ABN forms were not complete because they did not include the selection of any listed options and there was no documented evidence of who was notified. The SSD stated if there was no documentation of who was notified, then it was considered not done. The SSD stated the SNF ABN and NOMNC forms are important to provide so the residents and their RPs can make informed decisions and plan for the residents' care. The SSD stated when the SNF ABN and NOMNC are not provided, the residents or RP may not know that they have the right to appeal and may lose the benefit. During an interview on 12/3/2025 at 10:11 a.m., with the Director of Nursing (DON), the DON stated the importance of providing the SNF ABN and NOMNC forms is to make sure the residents and RPs are aware of the last day of covered services and to ensure they are aware of the right to appeal the decision. The DON stated the SSD did not provide the completed forms in writing to Resident 10 or 72 or their RPs. During a follow-up concurrent interview and record review on 12/3/2025 at 12:08 p.m., with the DON, the DON reviewed the facility policy and procedure (P&P) regarding Medicare Advanced Beneficiary Notices. The DON stated the facility policy was not followed when the SSD did not provide the completed forms in writing to Resident 10 or 72 or their RPs. During a review of the facility P&P titled, Policy: Notice of Medicare Non-Coverage (NOMNC - CMS-10123), last reviewed 1/2/2025, the P&P indicated, Medicare beneficiaries and their representatives receive timely and accurate notice when Medicare-covered skilled services are ending, in compliance with CMS requirements. The NOMNC will be issued when the facility determines that all Medicare-covered skilled services will end. The notice must be provided no fewer than two (2) calendar days before the final covered day. Staff must:.1. Complete all (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required fields, including.3. Provide the notice in person whenever possible and obtain the resident's or representative's signature and date acknowledging receipt. If the resident has a representative:. Staff must notify the representative by phone and document the call. A copy of the NOMNC must be delivered to the representative (in person, by mail, email, or fax as permitted).If mailed, the notice is considered delivered on the date of mailing. A copy of the completed and signed NOMNC will be placed in the resident's medical record. All attempts to contact a representative and delivery methods will be documented. During a review of the facility untitled Policy Statement regarding SNF ABN, undated, he Policy Statement indicated, Purpose: To ensure that the Facility complies with all Medicare requirements related to the issuance of the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) (CMS- 10055), and to uphold resident rights by providing timely, accurate, and understandable notice when Medicare may not pay for certain services, items, or continued skilled care. It is the policy of this Facility to provide residents (or their legal representatives) with a valid ABN or SNF ABN before furnishing any item or service that may not be covered or may no longer be covered by Medicare. The Facility will ensure that residents understand their potential financial liability and their right to accept or refuse the affected services. The responsible staff will complete all required fields, ensuring that the form includes: . Options to accept or refuse the service.Resident/representative signature and date. They must receive a copy of the signed notice. If the resident refuses to sign, staff must document refusal and may note Refused to Sign on the form with a witness signature.

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The Grove Post-Acute Care Center	14122 Hubbard Street Sylmar, CA 91342

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of residents were protected by failing to ensure documents containing protected health information ([PHI]- any health information that can be used to identify a specific individual which must remain confidential to prevent harmful consequences) were shredded prior to disposing in the waste container. These failures had the potential to violate 59 of 63 residents' rights for privacy and confidentiality of personal and medical records. Findings: During an observation on 12/1/2025 at 8:15 a.m. of the dishwashing process by the dish machine area, observed dietary aide throw the residents' meal tickets into the trash. The meal tickets had residents' names, room numbers, diet orders, and food allergies information. During an interview on 12/2/2025 at 9:16 a.m. with the Dietary Supervisor (DS), the DS stated their process of dishwashing was to remove the food and trash including the menu tickets and throw them in the trash. The DS stated the trash is taken out and thrown in the dumpster (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) outside. The DS stated the menu tickets contained residents' name which is protected information. The DS stated the menu tickets also contained resident's diet, diet texture, diet consistency, allergies, food likes and dislikes information. The DS stated they put away the other documents in the bin, and it gets shredded, but the menu tickets were thrown away in the trash and then to the dumpster. The DS stated she forgot what the facility does to protect resident's information. During an interview on 12/2/2025 at 10:02 a.m. with the Registered Dietitian (RD), the RD stated they were starting a new policy for the menu to be thrown away to a confidential bin because the current practice was to throw it in the dumpster. The RD stated the menu contained residents' name, room number and diet and if it was thrown away in the dumpster, they were not protecting personal information of the residents. During an interview on 12/2/2025 at 2:55 p.m. with the Director of Nursing (DON), the DON stated he was not aware the kitchen staff were throwing menus with resident's name is a privacy issue. The DON stated shredding the menu ticket is the best way to protect the privacy of the residents. During a review of the facility's policies and procedures (P&P) titled Confidentiality of Information and Personal Privacy last reviewed 1/2/2025, the P&P indicated, Our facility will protect and safeguard resident confidentiality and personal privacy. Policy interpretation and implementation: 1. The facility will safeguard the personal privacy and confidentiality of all residents personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his or her: a. Accommodation b. Medical treatment c. Written and telephone communications d. Personal care e. Visits f. Family and resident group meetings During a review of the facility's P&P titled Policy for Disposal of Dietary Tray Cards and HIPPA Compliance dated 12/2/2025, the P&P indicated The policy proper disposal of dietary meal tray cards after meal service to comply with HIPPA. When cleaning trays after meal service, all tray cards will be placed in assigned bin for disposal in shredder service bin, not in garbage bin used for food/trash waste.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for two of two sampled residents (Residents 37 and 75) reviewed for peripherally inserted central catheter (PICC - is a thin, flexible tube that is inserted into a vein in the upper arm and guided [threaded] into a large vein above the right side of the heart called the superior vena cava) lines. This deficient practice had a potential for delays in the delivery of necessary care and services related to PICC line management and care. Findings: 1. During a review of Resident 37's admission Record (AR), the AR indicated the facility admitted the resident on 11/12/2025, with diagnoses including cellulitis (a skin infection that causes swelling and redness) of left lower limb, type two diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (open sores or lesions that will not heal or that return over a long period of time), and non-pressure chronic ulcer of left foot. During a review of Resident 37's History and Physical (H&P), dated 11/14/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool), dated 11/24/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's overall thinking, memory, and mental function appear normal and satisfactory during a general or gross [naked-eye, overall] examination, with no obvious major deficits, though it does not rule out subtle issues requiring deeper testing). The MDS indicated the resident was on a high-risk drug class antibiotic (a medicine that fights infections caused byˆbacteriaˆby killing them or stopping them from growing), on intravenous (IV - within a vein) medications, and had an IV access. During a review of Resident 37's Order Summary Report (OSR), the OSR indicated an order on: 11/14/2025 Change PICC dressing on the right upper arm (RUA) every Wednesday, change injection cap, measure arm circumference 2 inches above the insertion site, and measure PICC line insertion site to hub in centimeters. May change if needed (PRN) if dressing is soiled/pulled off as needed and every day shift every Wednesday. During a concurrent observation and interview on 12/1/2025 at 9:29 a.m. with Treatment Nurse (TN) 1, inside Resident 37's room, observed with TN 1 Resident 37 had a PICC line with a dressing dated 11/26/2025. TN 1 stated the PICC line was for the IV antibiotics prescribed to the resident. During a concurrent interview and record review on 12/3/2025 at 8:38 a.m. with Registered Nurse (RN) 1, Resident 37's Medical Diagnoses, OSR, and Care Plans were reviewed. RN 1 stated there were orders for PICC maintenance and management, however, there was no care plan developed and implemented on the use of PICC line on the resident. RN 1 stated it was important to develop and implement a person-centered care plan on Resident 37's PICC line to ensure its safe use and to prevent infection to set in on the PICC line. RN 1 stated the care plan contains the goals of care and interventions to reach the goal to provide high-quality care to the resident. RN 1 stated the failure of the licensed staff to develop and implement a person-centered care plan on the use of PICC line on the resident predisposed the resident to infection and substandard care of the PICC line. During an interview on 12/4/2025 at 2:06 p.m. with the Director of Nursing (DON), the DON stated the licensed staff should have developed and implemented a care plan on the use of PICC line on Resident 37 to ensure its safe use. The DON stated the care plan ensures all healthcare providers were aware of the resident's goal of care and interventions to meet the goal. The DON stated the failure of the licensed staff to develop and implement the care plan for PICC line could potentially cause miscommunication and variations of care that could lead to PICC line infection to set it. During a review of the facility's recent policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/2/2025, the P&P indicated a comprehensive, person-centered (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops, and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 2. During a review of Resident 75's AR, the AR indicated the facility admitted the resident on 8/25/2025, with diagnoses including pneumonia (an infection/inflammation in the lungs), heart failure (the heart cannot pump enough oxygen-rich blood to meet the body's needs), and urinary tract infection (UTI, an infection in the bladder/urinary tract). During a review of Resident 75's H&P, dated 8/27/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 75's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and usually understands others and had moderate cognitive impairment (the memory, thinking, or judgment has noticeably worsened compared to how it used to be). The MDS indicated the resident was on high-risk drug class antibiotic. During a review of Resident 75's OSR, dated 9/30/2025, the OSR indicated an order of insert PICC line catheter for IV antibiotic administration by Contracted Company A. During a concurrent interview and record review on 12/4/2025 at 9:30 a.m. with RN 1, Resident 75's Medical Diagnoses, OSR, and Care Plans were reviewed. RN 1 stated there was orders for PICC maintenance and management, however, there was no care plan developed and implemented on the use of PICC line on the resident. RN 1 stated it was important to develop and implement a person-centered care plan on Resident 75's PICC line to ensure its safe use and to prevent infection to set in on the PICC line. RN 1 stated the care plan contains the goals of care and interventions to reach the goal to provide high-quality care to the resident. RN 1 stated the failure of the licensed staff to develop and implement a person-centered care plan on the use of PICC line on the resident predisposed the resident to infection and substandard care of the PICC line. During an interview on 12/4/2025 at 2:06 p.m. with the DON, the DON stated the licensed staff should have developed and implemented a care plan on the use of PICC line on Resident 75 to ensure its safe use. The DON stated the care plan ensures all healthcare providers were aware of the resident's goal of care and interventions to meet the goal of care. The DON stated the failure of the licensed staff to develop and implement the care plan for PICC line could potentially cause miscommunication and variations of care that could lead to PICC line infection to set it. During a review of the facility's recent P&P titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/2/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops, and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for one of one sampled resident (Resident 33) who had a diagnosis of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and was on blood sugar checks by failing to ensure that glucometer (GLM- a small, portable medical device used to measure the concentration of glucose [sugar] in the blood) 1 and GLM 2 were working properly by performing any calibration or checks as instructed by the manufacturer or this facility. This deficient practice had the potential to result in false high or low blood sugar readings which could result in adverse consequences (unintended or unwanted effects caused by medication) such as hospitalizations. Findings: During a review of Resident 33's admission Record, the admission Record indicated that the facility originally admitted the resident on 1/12/2019 and readmitted on [DATE] with diagnoses including DM, end stage renal disease (ESRD-irreversible kidney failure), and long term (current) use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). During a review of Resident 33's History and Physical (H&P), dated 12/20/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 33's Order Summary Report, the Order Summary Report indicated: - Insulin lispro (a rapid-acting insulin: a medicine used to control the amount of sugar in the blood of patients with diabetes. It starts to work very quickly, and you take it before meals to stop your blood sugar from going too high) injection solution 100 unit/milliliter (ml- a unit of measurement), inject four (4) units subcutaneously (sq- administered under the skin) one time a day for DM in addition to sliding scale, hold if blood sugar is less than 100, dated 12/20/2024. - Insulin lispro injection solution 100 unit/ml, inject as per sliding scale: if 151-200=1 unit; 201-250=2 units; 251-300=3 units; 301-350=4 units; sq three times a day for DM less than 150, no coverage; greater than 400 call MD, dated 12/20/2024. During a review of Resident 33's Care Plan (CP) Report focused on the resident has DM, dated 1/6/2022, the CP indicated the resident with goals of no complications related to DM with interventions including diabetes medication as ordered and to monitor or document for side effects and effectiveness. During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 10/8/2025, the MDS indicated the resident made self-understood and had the ability to understand others. The MDS indicated that the resident required assistance with activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) including eating, toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. During an observation on 12/2/2025 at 11:26 a.m., Licensed Vocational Nurse (LVN) 2 obtained Resident 33's blood sugar level using a glucometer, reading 304. LVN 2 prepared Resident 33's medications including Humalog (lispro) total of eight (8) units and administered on Resident 33's left arm. During a concurrent interview and record review on 12/2/2025 at 1:30 p.m. with LVN 2, glucometer quality assurance (QA- a systematic process of monitoring, evaluating, and improving nursing practices to ensure high-quality, safe, and effective patient care) log for GLM 1 and GLM 2 for the months of 11/2025 and 12/2025 was reviewed. LVN 2 stated LVN 3 signed the glucometer QA log on 11/4/2025, 12/1/2025, and 12/2/2025. LVN 2 stated there were no high and low results documented on the GLM 1 and GLM 2's QA log on 11/4/2025 and 12/2/2025. LVN 2 stated that there should be a result recorded when the control testing was done. LVN 2 stated the night shift licensed nurses perform the control testing daily and they document on the QA log that it was completed. During a concurrent interview and record review on 12/03/2025 at 6:48 a.m. with LVN 3, GLM 1 and GLM 2's QA log for the months of 11/2025, 12/2025 and stored readings in GLM 1 and GLM 2 were reviewed. LVN 3 stated glucometer control testing is performed every night by the night shift (11 p.m. to 7 a.m.). LVN 3 stated he (LVN 3) could not find the control results on the dates 12/1/2025 and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/2/2025 on GLM 1 and GLM 2 to confirm the results documented on the GLM 1 and GLM 2's QA log. LVN 3 stated on 11/4/2025 he (LVN 3) did not have results documented on both QA logs. LVN 3 stated he (LVN 3) could not show documentation and confirmation of the results. LVN 3 stated he (LVN 3) did not do the control solution testing on the glucometer machine on dates 11/4/2025 and 12/2/2025. LVN 3 stated that when the control solution testing is not done the blood sugar readings would be inaccurate and potentially, they are not treating the resident appropriately. During an interview on 12/3/2025 at 11:33 a.m. with LVN 2, LVN 2 stated on 12/2/2025, she (LVN 2) used GLM 2 to check Resident 33's blood sugar that was scheduled at 11:30 a.m. During an interview on 12/4/2025 at 9:41 a.m., with the Director of Nursing (DON), the DON stated the control solution testing is done daily by 11 p.m. to 7 a.m. licensed nurses. The DON stated once testing is completed, they document the readings on the glucometer Quality Assurance log. The DON stated the calibration is done to ensure the machine is functioning properly and accurately. The DON stated if licensed staff do not perform the calibration of glucometers, they may obtain inaccurate results such as falsely high or low blood sugar readings when checking the residents` blood sugar and this could lead to either administering too much insulin or not enough insulin.ˆ During a review of the facility's policy and procedure (P&P) titled, Obtaining a Fingerstick Glucose Level, last reviewed 1/2/2025, the P&P indicated The purpose of this procedure is to obtain a blood sample to determine the residents blood glucose level. Preparation 4. Ensure that the equipment and devices are working properly by performing any calibrations or checks instructed by the manufacturer or this facility. During a review of GLM 1 and GLM 2 User's Guide titled, Blood Glucose Monitoring System, undated, the User's Guide indicated that the icon CTL indicates a control solution test or the stored value is a control solution result. The User's Guide indicated that the purpose of the control solution testing is to make sure that the glucometer and test strips are working properly. The User's Guide indicated that perform control solution testing should be performed when: using the meter for the first time; at least one per week to make sure the meter and test strips ae working properly; using new bottle of test strips; the test strip bottle cap was left open for a while; the meter was dropped; suspect that the meter and test strips are not working properly; the blood glucose test results do not reflect how you feel; and you want to practice the testing procedure.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for one of two sampled residents (Resident 52) reviewed for accidents by failing to ensure Resident 52 did not have creams/ointments left at the bedside. This deficient practice increases the risk of accidents such as accidental ingestion of harmful chemicals/biologicals of residents in the facility. Findings: During a review of Resident 52's admission Record (AR), the AR indicated the facility admitted the resident on 5/30/2025, with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), gastro-esophageal reflux disease (GERD - when stomach acid frequently splashes back up into your food pipe [esophagus], causing persistent heartburn, a sour taste, or irritation), and dysphagia (difficulty swallowing). During a review of Resident 52's History and Physical (H&P), dated 6/2/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 52's Minimum Data Set (MDS - a resident assessment tool), dated 9/10/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of decline in cognitive abilities like memory and thinking that is more significant than normal aging but less severe than dementia). During a review of Resident 52's Order Summary Report (OSR), dated 12/4/2025, the OSR did not indicate any order for topicals (creams/ointments). During a review of Resident 52's Care Plan (CP) Report titled, The resident has communication problem related to language barrier, speak Spanish, last revised on 6/2/2025, the CP indicated an intervention to ensure/provide a safe environment. During a concurrent observation and interview on 12/1/2025 at 9:33 a.m. with Treatment Nurse (TN) 1, inside Resident 52's room, observed with TN 1 Resident 52 had a cream/ointment left at the bedside in a medication cup on top of the resident's drawer. TN 1 stated there should be no medications left at the bedside of the resident as it can cause potential ingestion of the medication of other residents, such as the confused ones. TN 1 stated the cream/ointment in the medication cup looks like zinc oxide (in sunscreens for UV protection, in skin creams for soothing irritation [like diaper rash, eczema], and as an antibacterial agent). TN 1 stated ingestion of creams/ointments can lead to adverse effects (an unwanted, unfavorable, or harmful result of a treatment, medical procedure, or exposure to a substance) on the residents such as poisoning. During a concurrent interview and record review on 12/1/2025 at 10:18 a.m. with Registered Nurse (RN) 1, Resident 52's Diagnoses, OSR, Medication Self-Administration Assessment (MSA), and CP were reviewed. RN 1 stated there was no order for topicals (cream/ointment) on the resident's chart, and there was no MSA done on the resident. RN 1 also stated there was a CP regarding the resident having communication problem and had an intervention to provide a safe environment. RN 1 stated there should be no medications left at bedside because other confused residents can get a hold of the medication and accidentally ingest them causing chemical poisoning. During an interview on 12/4/2025 at 2:06 p.m. with the Director of Nursing (DON), the DON stated licensed staff should not have left a medication at the bedside of Resident 52 to prevent accidental ingestion of the medication of other residents. The DON stated licensed staff are not supposed to leave medications at the bedside as it is against the facility policy. During a review of the facility's recent policy and procedure (P&P) titled, Medication Labeling and Storage, last reviewed on 1/2/2025, the P&P indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation Medication Storage 1. Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. During a review of the facility's recent policy and procedure titled Self-Administration of Medications, last reviewed on 1/2/2025, the P&P indicated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of one sampled resident (Resident 73) reviewed under the Medication Storage and Labeling task by failing to ensure the insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) emergency kit (e-kit - a small quantity of medications that can be dispensed when pharmacy services are not available) was replaced within 72 hours according to facility's policy and procedure. This deficient practice had the potential to result in delayed or inadequate response to emergency situations. Findings: During a review of Resident 73's admission Record (AR), the AR indicated the facility admitted the resident on 9/12/2025 with diagnoses including diabetes mellitus (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and long term (current) use of insulin. The AR indicated the facility discharge the resident on 10/10/2025 from the facility. During a review of Resident 73's order, dated 9/12/2025, the order indicated insulin Lispro (a fast-acting type of insulin) injection solution 100 unit/milliliter (ml - a unit of measurement), inject as per sliding scale: if 151 - 200 = 1 unit Inject as per sliding scale: If; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units 401+ blood sugar greater than 400 or less than 60, call doctor (MD), subcutaneously (under the skin) before meals and at bedtime for DM. During a concurrent observation and interview on 12/2/2025 at 1:32 p.m. with Licensed Vocational Nurse (LVN) 1, in medication room (Med RM [ROOM NUMBER]), LVN 1 stated the insulin e-kit was opened on 9/12/2025 and obtained insulin Lispro for Resident 73. LVN 1 stated insulin lispro was taken out of the e-kit and needs to be replaced. LVN 1 stated he does not know how soon this e-kit needs to be replaced. LVN 1 stated his supervisor, Registered Nurse (RN) 1, would know. LVN 1 stated inside the e-kit is the e-kit slip of what was taken out containing the white, original, and yellow paper which is the copy. LVN 1 stated both original and copy of the slip goes back to the pharmacy. During an interview on 12/2/2025 at 2:44 p.m. with RN 1, RN 1 stated they do not have an e-kit log to document what was taken out of the insulin e-kit. RN 1 stated they have another e-kit in Station 2. RN 1 stated she also does not know when the e-kit should be replaced. RN 1 stated the Director of Nursing (DON) might know. During an interview on 12/4/2025 at 9:38 a.m. with the DON, the DON stated the e-kit is replaced within 72 hours. The DON stated an e-kit is an emergency kit and in an emergency medication should be available and needs to be replaced within 72 hours once opened. The DON stated this is to make sure that medication is available for the following time it is needed. The DON stated when the medications in the e-kit are not available this would cause a delay in care and defeats the purpose of the e-kit. The DON stated the licensed nurse who removed the medication and filled out the e-kit slip should keep the yellow copy of the e-kit slip and the white copy is placed back inside the insulin emergency drug kit. The DON stated the facility does not have an e-kit log. The DON stated the facility's process for accounting the medications in the e-kit once the insulin e-kit is opened included keeping the copy of the e-kit slip as proof of acknowledgement of who took out the medication, for which resident, what was it taken for and monitor the reason it was taken out for. During a review of the facility's policy and procedure (P&P) titled, Emergency Pharmacy Service and Emergency Kits, last reviewed 1/2/2025, the P&P indicated that Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facilities approved emergency medication supply or by special order from the provider pharmacy. Y. As soon as possible, the nurse records the medication use on the medication order form and calls the pharmacy for replacement of the kit/dose and flags the kit with a color-coded lock to indicate need for replacement of kit/dose. AA. Before reporting off duty, the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charge nurse indicates the ?opened' status of the emergency kit at the shift change report, and transfers the new medication orders to oncoming staff. CC. If exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening. If replacing used medications, the replacement doses are added to the kit within 72 hours of opening.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the resident's drug regimen was free from unnecessary drugs for two of two sampled residents (Residents 1 and 55) investigated under anticoagulants (a substance that is used to prevent and treat blood clots in blood vessels and the heart) by failing to ensure there was adequate monitoring for adverse effects (an unfavorable, unintended, or harmful outcome that results from a medical treatment or procedure) on: Resident 1's use of rivaroxaban (commonly known by the brand nameˆXarelto, is a type of medicine called aˆblood thinnerˆ[anticoagulant]). Resident 55's use of warfarin ([brand names Coumadin, Jantoven] is a medicine that acts as aˆblood thinnerˆ[anticoagulant]). These deficient practices had the potential to predispose the residents to unnecessary medications and adverse effects of anticoagulant use such as bleeding. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 8/28/2025, with diagnoses including epilepsy (a brain disorder characterized by recurrent seizures, which are sudden bursts of abnormal electrical activity), heart failure (the heart muscle is too weak or stiff to pump blood as well as it should), and gastro-esophageal reflux disease (GERD - is a common condition in which the stomach contents move up into the esophagus). During a review of Resident 1's History and Physical (H&P), dated 8/29/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/1/2025, the MDS indicated the resident had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a high-risk drug class anticoagulant medication. During a review of Resident 1's Order Summary Report (OSR), dated 10/13/2025, the OSR indicated an order for rivaroxaban oral tablet 20 milligrams (mg - a unit of weight). Give one tablet by mouth in the evening for deep vein thrombosis (DVT - a blood clot that forms within the deep veins, usually of the leg, but can occur in the arms and the mesenteric and cerebral veins) prophylaxis (PPX - preventive care to stop disease before it starts). The OSR did not indicate an order to monitor for adverse effect on the use of rivaroxaban. During a review of Resident 1's Medication Administration Record (MAR), for 11/2025, the MAR did not indicate monitoring for adverse effect on the use of rivaroxaban. During a review of Resident 1's Care Plan (CP) Report titled, At risk for bleeding and spontaneous bruising related to use of anticoagulant therapy, last revised on 12/2/2025, the CP indicated an intervention to inspect skin daily during routine care, report any unusual bleeding/bruising. During a concurrent interview and record review on 12/3/2025 at 8:16 a.m. with Registered Nurse (RN) 1, Resident 1's Diagnoses, OSR, MAR, for 11/2025, and CP were reviewed. RN 1 stated there was no order for monitoring for adverse effects on the use of rivaroxaban on Resident 1. RN 1 stated she found an order for monitoring for bleeding for aspirin (ASA) but not for rivaroxaban. RN 1 stated rivaroxaban has more potent chemicals that can cause adverse effects on the residents and needed to be monitored more closely. RN 1 stated monitoring for adverse effects of medications should be specific to the drug used to ensure its safe use on residents. During an interview on 12/4/2025 at 2:06 p.m. with the Director of Nursing (DON), the DON stated the licensed staff should have obtained an order for monitoring for adverse effects on the use of rivaroxaban on Resident 1. The DON stated that ASA and rivaroxaban cannot be treated the same as rivaroxaban has more potent chemicals that made the medications more prone to development of serious adverse effects. The DON stated the failure of the staff to monitor for adverse effects of rivaroxaban can potentially lead to severe bleeding that could lead to death. The DON stated the policy on Anticoagulation-Clinical Protocol was not followed. 2. During a review of Resident 55's AR, the AR indicated the facility admitted the resident on 9/22/2025, with diagnoses including cerebral infarction (when a part of the brain dies because its blood supply has been cut off), paroxysmal atrial fibrillation (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(an irregular and often fast heartbeat that happens when the heart's upper chambers [atria] beat in a disorganized way, like a quivering or fluttering), and long-term use of anticoagulants. During a review of Resident 55's H&P, dated 9/24/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 55's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. The MDS indicated the resident was on a high-risk drug class anticoagulant medication. During a review of Resident 55's OSR, dated 10/23/2025, the OSR indicated an order of warfarin sodium oral tablet (warfarin sodium). Give seven mg by mouth in the evening for DVT PPX. The OSR did not indicate an order to monitor for adverse effects on the use of warfarin sodium. During a review of Resident 55's MAR, for 11/2025, the MAR did not indicate monitoring for adverse effect on the use of warfarin sodium. During a review of Resident 55's CP Report titled, At risk for bleeding and spontaneous bruising related to use of anti-coagulant therapy, last revised on 10/28/2025, the CP indicated an intervention to inspect skin daily during routine care, report any unusual bleeding/bruising. During a concurrent interview and record review on 12/3/2025 at 9:15 a.m. with RN 1, Resident 55's Diagnoses, OSR, MAR, for 11/2025, and CP were reviewed. RN 1 stated there was no order for monitoring for adverse effects on the use of warfarin sodium on Resident 55. RN 1 stated she found an order for monitoring for bleeding for rivaroxaban but not for warfarin sodium. RN 1 stated warfarin sodium has more potent chemicals that can cause adverse effects on the residents and needed to be monitored more closely. RN 1 stated monitoring for adverse effects of medications should be specific to the drug used to ensure its safe use on residents. During an interview on 12/4/2025 at 2:06 p.m. with the DON, the DON stated the licensed staff should have obtained an order for monitoring for adverse effects on the use of warfarin sodium on Resident 55. The DON stated that rivaroxaban and warfarin sodium cannot be treated the same as warfarin sodium has more potent chemicals that made the medications more prone to development of serious adverse effects. The DON stated the failure of the staff to monitor for adverse effects of warfarin sodium can potentially lead to severe bleeding that could lead to death. The DON stated the policy on Anticoagulation-Clinical Protocol was not followed. During a review of the facility's recent policy and procedure (P&P) titled, Anticoagulation-Clinical Protocol, last reviewed 1/2/2025, the P&P indicated (1) the physician will prescribe anticoagulation therapy (for example, low molecular weight heparin, warfarin, or other oral anticoagulant) appropriately, consistent with recognized guidelines. (2) The physician will collaborate with the consultant pharmacist and nursing staff to identify potentially serious medication interactions with anticoagulants . Monitoring and Follow-Up 2. If warfarin is used, staff should use a warfarin flow sheet or some comparable means to follow trends in anticoagulant dosage and response in individuals on warfarin. 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. During a review of the facility-provided Highlights of Prescribing Information on the use of Xarelto (rivaroxaban) tablets, for oral use, with initial U.S. approval in 2011, the Information indicated a warning: (A) Premature discontinuation of Xarelto increases the risk of thrombotic events, (B) Spinal/epidural hematoma. Monitor patients frequently for signs and symptoms of neurological impairment and if observed, treat urgently . Risk of bleeding: Xarelto can cause serious and fatal bleeding. During a review of the facility-provided information on the use of Warfarin Sodium Tablets USP, undated, the information indicated a warning risk: Bleeding Risk. Warfarin sodium can cause major or fatal bleeding.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to maintain medical records in accordance with accepted professional standards for one of six residents (Resident 11) reviewed during medication administration facility task when the facility documented Resident 11's docusate sodium (also known as Colace, medication used to soften stool) as administered on 12/2/2025 when Resident 11 refused the medication. This deficient practice had the potential to result in delay in necessary care and treatment. Findings: During a review of Resident 11's admission Record, the admission Record indicated the facility originally admitted the resident on 10/12/2016 and readmitting on 1/22/2025 with diagnoses including gout (sudden and intense attacks of joint pain, often in the big toe and at night), atrial fibrillation (an irregular and often very rapid heart rhythm), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 11's History and Physical (H&P), dated 5/25/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 10/2/2025, the MDS indicated the resident has the ability to understand others and makes self-understood. The MDS indicated the resident required assistance with toileting hygiene. During a review of Resident 11's Order Summary Sheet, dated 8/9/2019, the Order Summary Sheet indicated docusate sodium capsule 250 milligrams (mg - a unit of measurement), give one capsule by mouth one time a day for constipation, hold for loose stools. During an observation on 12/2/2025 at 8:04 a.m. with Licensed Vocational Nurse (LVN) 1, at Resident 11's bedside, Resident 11 told LVN 1 he does not want his Colace and he had a bowel movement. During an observation on 12/2/2025 at 8:08 a.m. with LVN 1, LVN 1 prepared Resident 11's morning medications, LVN 1 stated Resident 11 refused docusate sodium so he did not include it in the medication cup. During an observation on 12/2/2025 at 8:23 a.m. with LVN 1, LVN 1 stated he completed medication administration for Resident 11. During a concurrent interview and record review on 12/02/2025 at 2:49 p.m. with LVN 1, Resident 11's Medication Administration Record, for the month of 12/2025, was reviewed. LVN 1 stated today, 12/2/2025, for Resident 11's 9 a.m. scheduled medications, the resident refused Colace. LVN 1 stated he marked it as given, but he did not administer it. LVN 1 stated he made a mistake and should have marked it as refused. LVN 1 stated he should have documented it accurately it could leave the resident constipated and result in a delay in care. During an interview on 12/4/2025 at 2:28 p.m. with the Director of Nursing (DON), the DON stated the purpose of Colace, which is a stool softener, is to make sure the resident is passing bowel movement. The DON stated the resident has the right to refuse to take medications and the licensed nurse then explains the risks and benefits of refusing medications. The DON stated when the licensed nurse documented the resident took the stool softener and the resident did not have a BM this could affect the patient's bowels in a negative way. The DON stated that it is inaccurate documentation and could result in a delay in care. A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed and approved on 1/2/2025, the P&P indicated that All services provided to the resident, Progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical records should facilitate communication between the turn disciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation: . 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure on pneumonia (an infection/inflammation in the lungs) vaccination by failing to offer the pneumococcal vaccine (helps protect against some types of bacterial infections that can cause serious lung illnesses) to one (1) out of five (5) sampled residents (Resident 59). This deficient practice placed Resident 59 at a higher risk of acquiring and transmitting pneumonia to other residents in the facility. Findings: During a review of Resident 59's admission Record, the admission Record indicated the facility admitted the resident on 11/12/2025, with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), type two (2) diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing), and generalized muscle weakness. During a review of Resident 59's History and Physical (H&P) dated 11/14/2025, the H&P indicated Resident 59 had the capacity to understand and make decisions. During a review of Resident 59's Minimum Data Set (MDS, a resident assessment tool) dated 11/24/2025, the MDS indicated Resident 59 was able to understand and make her needs known. The MDS further indicated Resident 59 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required supervision or touching assistance with eating; partial or moderate assistance with oral hygiene, upper body dressing, personal hygiene; maximal assistance with lower body dressing, and roll left and right; total assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 59's Pneumococcal vaccine was not up to date. During a review of Resident 37's Pneumococcal Vaccination Consent Form dated 1/31/2024, the consent form indicated that the resident gave consent to receive the vaccine. During a concurrent interview and record review on 2/18/2024 at 11:18 a.m., with Assistant Director of Nursing (ADON), Resident 59's Pneumococcal Vaccination Consent Form dated 1/31/2024 was reviewed. The ADON stated resident gave consent to receive the vaccine on 1/31/2024. The ADON stated they need a physician order before they can administer the vaccine and as of today physician was still not informed, and medication was not yet ordered from the pharmacy. The ADON admitted there was a delay in pneumococcal vaccine administration. During a review of the facility provided Pneumonia Vaccine Log for residents dated 11/30/2025, the Pneumonia Vaccine Log indicated Resident 59 last received the pneumonia vaccine was 6/15/201,9 and that another dose of the vaccine was recommended. During a concurrent interview and record review on 12/2/2025 at 3:06 p.m., reviewed Resident 59's vaccination records in the California Immunization Registry (CAIR2 - a secure, confidential, statewide computerized immunization information system for California residents) website with the Infection Preventionist. The IP stated that according to CAIR 2, Resident 59 last received the pneumococcal conjugate vaccine 13, 1 of 2 vaccines, on 6/15/2019 and that there was a recommendation to administer another pneumococcal conjugate vaccine dated 6/15/2020. The IP stated pneumonia vaccines are offered to all residents over [AGE] years old admitted in the facility if they are due for a dose and upon receipt of consent, the physician will be notified and obtain an order to administer the vaccine. The IP stated she is responsible to offer the vaccine to the residents upon confirmation from the resident, family members, or CAIR2. The IP stated she did not offer the vaccine to Resident 59 upon admission as the vaccine was not available in the facility. The IP stated she should have offered the pneumococcal vaccine to Resident 59 upon admission and if the patient gave consent, the IP would obtain a physician's order and order the vaccine from the pharmacy. The IP stated the purpose of the vaccine is to protect adults over 50 years from developing pneumonia or serious lung infection. The IP stated if the vaccine was not offered to Resident 59, it placed Resident 59 at risk for acquiring and transmitting pneumonia to other residents in the facility. During an interview with the Director of Nursing (DON) on 12/2/2025 at 4:30 p.m., the DON stated the facility's policy is to offer pneumonia vaccines to all residents over (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[AGE] years old upon admission per Centers for Disease Control and Prevention (CDC - the nation's leading science-based, data-driven, service organization that protects the public's health) recommendation as these residents are very risk for acquiring illnesses and infection. The DON stated the IP is responsible in making sure that the vaccine is offered, consented, and administered after obtaining orders from the physician. The DON stated the pneumonia vaccine should have been offered to Resident 59 upon admission if there was a recommendation in CAIR 2 that there was a recommendation to administer the second dose since 6/15/2020. The DON stated if the pneumonia vaccine was not offered to Resident 59, the resident or responsible party would not be aware of the recommendation and placed Resident 59 at a high risk for acquiring lung infection or pneumonia. During a review of the facility's policy and procedure (P&P) titled Flu and Pneumococcal Vaccine Administration, last reviewed on 1/2/2025, the P&P indicated that it is the policy of the facility to provide flu and pneumococcal vaccines to residents in accordance with the CDC recommendations and physician orders. The P&P further indicated: - A licensed staff member will initiate and complete the appropriate forms for consent to administer vaccinations. - The resident or responsible party/legal representative will be given the information to make a decision regarding the administration of the pneumococcal or flu vaccinations during the admission process.

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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 the electrical resident care equipment was in safe operating condition for one of six sampled residents (Resident 59) reviewed under environmental task by failing to ensure the Resident 59 in Bed A had a functional call light (a bedside button, typically tethered to the wall in a resident's room directing signals to the nursing station to indicate when residents have perceived a need requiring the attention of the nurses on duty) and the alternate call light provided did not have a broken/ frayed wires on them. The deficient practice had the potential for residents to be unable to call for help and sustain accidents such as electrical shock and falls. Findings: During a review of Resident 59's admission Record (AR), the AR indicated the facility admitted the resident on 11/12/2025, with diagnoses including parkinsonism (a cluster of movement problems like slow movements, stiffness, tremors, and balance issues), muscle weakness, unsteadiness on feet. During a review of Resident 59's History and Physical (H&P), dated 11/14/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 59's Minimum Data Set (MDS - a resident assessment tool), dated 11/24/2025, the MDS indicated the resident had the ability to make self-understood and usually understand others, and had highly impaired vision. The MDS indicated the resident had moderately impaired cognition (signifies noticeable thinking or memory problems beyond normal aging, impacting complex daily tasks like managing finances or appointments, but still allowing independence in basic self-care [bathing, dressing]) and was dependent to needing supervision assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 59's Fall Risk Assessment (FRA), dated 11/13/2025, the FRA indicated the resident was high risk for falls. During a review of Resident 59's Care Plan (CP) Report titled, The resident has diagnosis of Parkinson's, last revised on 11/13/2025, the CP indicated an intervention to monitor for risks of fall. During a concurrent observation and interview on 12/1/2025 at 9:43 a.m. with Licensed Vocational Nurse (LVN) 4, inside Resident 59's room, observed with LVN 4 Resident 59's call light on Bed A attached to the wall panel not working and the call light button provided was from Bed B had a frayed/exposed wires on the call light cord. LVN 4 stated the call light attached to Bed A was not functioning and the alternative call light provided to Resident 59 was for Bed B had a frayed/exposed wires on them. LVN 4 stated the failure of the staff to provide functional and safe equipment to the resident can cause accidents such as falls, fires, and electrocution on Resident 59. During an interview on 12/3/2025 at 8:46 a.m. with Registered Nurse (RN) 1, RN 1 stated all staff should check the call lights for functionality and there should be no frayed wires on them. RN 1 stated on admission they check the call light and explain to the resident how it works. RN 1 stated the staff should have reported the non-functioning call light panel on Bed A and should not have provided the Bed B call light with frayed exposed wires on them because it can cause accidents to Resident 59 such as falls, fires, and electrocution. During an interview on 12/4/2025 at 2:06 p.m. with the Director of Nursing (DON), the DON stated it was everyone's responsibility to ensure the call lights are working in the facility. The DON stated the Department Heads, including the licensed and unlicensed staff, should be inspecting the environment of the resident for safety when they do their rounds. The DON stated the failure of the staff to report the non-functional wall panel on Bed A and providing a call light with frayed wires predisposed Resident 59 to accidents such as electrocution, falls, and fires in the facility. During a review of the facility's recent policy and procedure (P&P) titled, Call System, Residents, last reviewed on 1/2/2025, the P&P indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation 3. The resident call system remains functional at all times. If audible communication is used, the volume is maintained at an audible level that can be easily heard. If visual communication is used, the lights remain functional. 5. The resident call system is routinely (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintained and tested by the maintenance department. During a review of the facility's recent P&P titled, Hazardous Areas, Devices and Equipment, last reviewed on 1/2/2025, the P&P indicated all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Identification of Hazards 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to the following: a. Equipment and devices that are left unattended or are malfunctioning; b. Devices and equipment that are improperly used or poorly maintained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056382	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post-Acute Care Center	14122 Hubbard Street Sylmar, CA 91342

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure nurse staffing information was posted and updated on a daily basis. This failure resulted in staffing information not readily accessible to residents and visitors. Findings: During an observation on 12/1/2025 at 7:30 a.m. at the facility's reception desk and the white board next to the activity room entrance, the staffing information posted indicated the postings were dated 11/28/2025. During another observation on 12/1/2025 at 8:28 a.m. the staffing information posted at the facility's reception desk and the whiteboard next to the activity room entrance were dated 11/28/2025. During a concurrent observation and interview on 12/1/2025 at 8:46 a.m. with Registered Nurse (RN) 1, photographs of the whiteboard next to the activity room entrance and daily staffing posting dated 11/28/2025 were reviewed. RN 1 stated the photographs indicated the daily staffing information were dated 11/28/2025. RN 1 stated the Director of Staff Development (DSD) is responsible for updating the whiteboard and posting the paper at the reception desk. RN 1 stated the daily staffing posting should have been updated as the visitors and family members would not be aware of the number of staff working for the day and thinking that there would not be enough staff working to provide the care the residents need. During an interview on 12/1/2025 at 9:21 a.m. with the DSD, the DSD stated the staff information posting should be updated and posted daily. The DSD stated he is responsible for changing the daily staffing posting. The DSD stated the importance of posting staff information daily was to show that the facility could provide quality of care within normal staffing hours. The DSD stated the staff information on Saturday (11/29/2025) to Monday (12/1/2025) was not updated timely and he just changed it as he arrived in the facility. The DSD stated the receptionist was previously tasked to change the daily staffing posting during the weekends and holidays. The DSD stated the daily staffing posting should have been changed so the visitors and/or family members would be aware that the facility has enough staff to provide quality care to the residents. During an interview on 12/2/2025 at 9 a.m. with the Director of Nursing (DON), the DON stated he was made aware that the daily staffing posting was not changed since 11/28/2025. The DON stated the facility's policy for posting daily staffing numbers indicates the daily staffing posting is to be updated and posted at the start of each shift. The DON stated the reception desk staff were tasked to post the daily staffing numbers and should have been posted daily for the visitors and/or family members to be aware that the facility has enough staff to provide quality care to the residents. During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Number, last reviewed 1/2/2025, the P&P indicated, the facility will post on a daily basis for each shift nursing data, including the number of nursing personnel responsible for providing direct care to residents. The P&P further indicated: Within two (2) hours of the beginning of each shift, the number of licensed nurses and the number of unlicensed personnel directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format Directly responsible for resident care means that individuals are responsible for resident's total care or some aspect of the resident's care including but not limited to: assisting with activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), administering medications, supervising care provided by Certified Nursing Assistants (CNAs), and performing nursing assessments. Shift staffing information is recorded on a form for each shift. The information recorded on the form shall include the following information: - The name of the facility - The current date (the date for which the information is posted) - The current census at the beginning of the shift for which the information was posted - 24-hour shift schedule operated by the facility - The shift for which the information is posted - Type and category of nursing staff working during that shift who are paid by the facility (including contract staff) - The actual time worked during that shift for each category and type of nursing staff; and - Total number of licensed and non-licensed nursing staff working for the posted shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the requirement for no more than four (4) residents per room for one out of 25 rooms (room [ROOM NUMBER]). This deficient practice had the potential to result in inadequate space to provide safe nursing care, privacy for the residents, and limit the residents' ability to maneuver personal care devices. Findings: During an observation tour of the facility on 12/1/2025 at 9:30 a.m., observed room [ROOM NUMBER] with five (5) beds, 4 residents were occupying the room. The residents had adequate space to move about freely inside the room and nursing staff had enough space to safely provide care to these residents. There was space for beds, hanging curtains, side tables, dressers, and resident care equipment. During an interview on 12/1/2025 at 9:35 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated room [ROOM NUMBER] normally had 5 beds, but currently only had 4 residents in the room. CNA 1 stated there were no issues with room space and the staff can safely perform all care and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily) for residents without any issue. During a concurrent interview and record review, on 12/2/2023, at 8:30 a.m., with the Director of Nursing (DON), a facility letter, dated 12/1/2025, was reviewed. The letter indicated a request for a waiver for the 5-bed capacity in room [ROOM NUMBER], each bed will allow for 92.23 square feet (sq ft - unit of measurement) of space, the residents have freedom of movement, and their safety is not jeopardized. The DON stated a request for room waiver was made for room [ROOM NUMBER] because the facility was not compliant with regulations that indicate rooms must have 4 residents or less. The DON stated there was adequate space for each resident. During a review of the facility provided Client Accommodation Analysis form, undated, the Client Accommodation Analysis form indicated Resident room [ROOM NUMBER] measured 14 ft 6 inches by 31 ft 6 inches equaling 461.15 sq ft. During a review of the facility's policy and procedure (P&P) titled, Policy for Resident Room Size, last revised on 10/30/2024, the P&P indicated, Resident rooms require a minimum floor area, essential furniture, storage space, and privacy. Each resident must have a bed with a mattress and bedding, a nightstand, and a closet or locker for personal items. Rooms must also be labeled and allow for easy passage between furniture. During a review of the facility provided California Code of Regulations Title 22 State Regulation regarding Patient Rooms, undated, the California Code of Regulations Title 22 State Regulation regarding Patient Rooms indicated, Each resident shall be provided clean, comfortable and reasonably private living accommodations with no more than four residents occupying a room.