STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056405	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerritos Vista Healthcare Center	17836 Woodruff Avenue Bellflower, CA 90706

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when:There was trash of paper, plastic and soiled gloves left in the bottom of the dumpster (a movable waste container designed to be brought and taken away by special collection vehicle, or to a bin that a specially designed garbage truck lifts)One trash can was not covered and has no lid near the residents' refrigerator in Hall 1 when actively not used. These failures had potential to attract birds, flies, insects, pests and possibly spread infection to 129 of 129 facility residents.Findings: a. During a concurrent observation and interview on 2/24/2026 at 11:03 a.m., of the dumpster area, with the Dietary Supervisor (DS), trash was observed (plastic, gloves on the ground, and paper trash) in the bottom of the dumpster. The DS stated there was plastic trash on the ground of the dumpster surroundings and it should be cleaned. The DS stated trash attracts pests (destructive animals that spread diseases), cockroaches, rodents which could potentially go to the kitchen and make the residents sick. b. During a concurrent observation and interview on 2/24/2026 at 11:27 a.m. of the residents' refrigerator in Hall 1 with the DS, a trach can was observed without a lid. The DS stated the trash was not covered and it should not be near the residents' refrigerator. The DS stated the trash should be covered to prevent cross-contamination (transfer of harmful bacteria from one place to another). The DS stated trash could attract flies and cockroaches if not covered and infection could spread as a potential outcome. During a review of the facility's policies and procedures (P&P) titled Waste Control and Disposal, dated 3/15/2025, the P&P indicated, All waste will be disposed of daily and as needed throughout the day.2) Trash bin should be covered at all times.6) Outside garbage bin should be kept closed at all times and surrounding area must be kept clean. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility failed to provide care in a manner that promoted dignity and respect by failing to ensure residents were served in China wares during lunch time.This deficient practice had the potential to affect 116 of 129 residents' self-esteem and self-worth. Findings:During an observation on 2/23/2026 at 12:06 p.m., observed [NAME] 2 using paper bowls for the chili.During an observation on 2/23/2026 at 12:20 p.m., observed dietary staff using paper plates for fruit salad and sandwiches sides for lunch.During a concurrent observation and interview on 2/23/2026 at 1:06 a.m. with a test tray (a process of tasting, temping, and evaluating the quality of food) of the regular diet meal with the Dietary Supervisor (DS) and the Registered Dietitian (RD), observed chili was served on paperware. The DS stated the presentation of the food tray was okay, but the chili should be in a bowl. The DS stated they had insulated bowls, but she was unsure why the cooks did not use them. The DS stated serving in insulated bowls would keep the food hot and the presentation would be better. The RD stated the presentation of the food could improve by using a regular bowl instead of disposable bowl. The RD stated they might have run out of bowls during lunch time, but it affected the attractiveness of the food presentation, and it did not make it look like a home environment. The RD stated residents could potentially question why their food was in paperware and could complain about it. During a review of the facility's policies and procedures (P&P) titled Dignity, dated 2/2021, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. (1) Residents are treated with dignity and respect at all times.During a review of the facility's P&P titled Food Preparation, dated 3/15/2026, the P&P indicated, Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. Procedure: 1. All food will be prepared in such a manner as to maximize flavor, appearance, and nutritional value. Tray set up must be: (a) neat (b) dishes, utensils, glasses, cups, and flatware free of rust, chips, cracks.

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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 formulate Advance Directives ([AD]-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) correctly in the medical records for three of 14 sampled residents (Resident 7, 15 and 126) by not:Completing the AD form for Resident 7Completing the AD form for Resident 15Providing written information to Resident 126 and/or responsible parties and had a completed AD Acknowledgement/Physician Orders for Life-Sustaining Treatment ([POLST]- a medical order that helps give people with serious illness more control over their care during a medical emergency)These failures had the potential for delay of care and treatment and/ or inadvertently missed health care wishes/ decisions of the residents during emergencies, end of life, and changes in condition.Findings: a. During a review of Resident 7's admission Record, the admission Record indicated, Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including aphasia (a language disorder caused by brain damage that impairs speaking, writing, reading, and understanding, without affecting intelligence) and cardiac arrhythmia (an abnormal heart rhythm where the heart beats too fast, too slow, or irregularly). During a review of Resident 7's History and Physical (H&P), dated [DATE], the H&P indicated, Resident had fluctuating capacity (ability) to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 7's cognition (functions your brain uses to think, pay attention, process information, and remember things) was severely impaired. The MDS indicated the resident required moderate assistance (helper does less than half the effort to complete the task) with toileting hygiene, showering, personal hygiene, supervision assistance (helper provides verbal cues and/ or touching/ steading and/or contact guard assistance as resident completes activity) with eating, oral hygiene, dressings. During a concurrent interview and record review on [DATE], at 9:50 a.m., with the Social Services Director (SSD), Resident 7's Advance Healthcare Directive Acknowledgement (AHDA), dated [DATE] was reviewed. The SSD stated the AHDA form, dated [DATE] was left blank except for the physician's signature, the form was not discussed and completed by the resident or the resident's representative, and this was not compliant practice. The SSD stated an AD is a legal document that expresses a resident or resident representative's wishes regarding end-of-life or emergency care, it allows the resident to appoint a health care agent to make decisions if the resident becomes unable to do so, health care providers must respect and follow the resident's expressed wishes. The SSD stated an AD ensures care aligns with the resident's preferences, reduces family burden, and provides clear guidance to medical professions and should be completed. During an interview on [DATE], 9:28 a.m., with the Director of Nursing (DON), the DON stated, the facility failed to formulate the resident's AHDA accordingly, the ADHA form should be completed upon a resident's admission as soon as possible at least within 72 hours. The DON stated if the AHDA form indicated the resident executed an AD, the copy of AD should be obtained and maintained in the chart. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, undated, 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. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. If the resident or the resident's 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 residents medical record and are readily retrievable by any facility staff. b. During a review of Resident 15 's admission Record, the admission Record indicated Resident 15 was initially admitted to facility on [DATE] and readmitted on [DATE] with diagnosis including but not limited to: perforation of intestines (a small hole or tear in the wall of the intestine), muscle weakness, chronic pain, and hypertension (high blood pressure). During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 15 cognitively intact, can make decision for himself. During a concurrent interview and record review on [DATE] at 12:20 p.m. with Registered Nursing Supervisor (RNS) 1, Advance Healthcare Directive Acknowledgement (AHDA), dated [DATE], was reviewed. The AHDA form did not indicate whether Resident 15 had an advance directive executed or not. RNS 1 stated the Resident 15's AHDA form was incomplete. The advance directive is a legal document; it expresses the residents' wishes regarding end-of-life care and if they appoint someone to make decision for them if residents become unable to do so. RNS 1 also stated Resident 15's AHDA form should be completed, in case of emergency, facility would follow Resident 15's advance directive. Failing to complete the AHDA form had potential to affect Resident 15's care. c. During a review of Resident 126's admission Record, the admission Record indicated, Resident 126 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). During a review of Resident 126's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 126 did not have the capacity (ability) to understand and make decisions. During a review of Resident 126's MDS, dated [DATE], the MDS indicated Resident 126 required dependent assistance (Helper does all of the effort) from two or more staff for eating, hygiene, shower/bath, dressing, bed mobility, and transfer. During a concurrent interview and record review on [DATE], at 10:53 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 126's Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE] was reviewed. The POLST indicated, Resident 126 had an order for Do Not Attempt Resuscitation (DNR- 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). The POLST indicated, Section D for AD was left blank and it was not completed. RNS 1 stated, the POLST was not completed because there was missing information. RNS 1 stated, if the POLST was not completed, the resident would be treated as a full code and all life sustaining measures would be done during the emergency per policy. RNS 1 stated, the resident would be treated against his/her wishes. During a review of Resident 126's Order Summary Report (OSR), dated [DATE], the OSR indicated, Do Not Attempt Resuscitation/DNR, comfort focused treatment, no hospitalization, and no artificial means of nutrition including feeding tube was ordered on [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 10:56 a.m., with the SSD, the SSD stated, there was no AD Acknowledgement done. The SSD stated, she did not provide written materials regarding AD to Resident 126's Responsible Party (RP- a family member or agent assisting with admission, often asked to manage the resident's funds to pay for care). The SSD stated, she did not complete and update the POLST after the code status changed from full code to DNR. The SSD stated, it was her responsibility to ensure documenting the availability of AD and educating regarding AD with the resident or RP on POLST to honor the resident's wishes regarding care and treatment. During an interview on [DATE], 10:44 a.m., with the Director of Nursing (DON), the DON stated, AD and POLST should be available for all residents regardless. The DON stated, the SSD and staff should have ensured the completion of POLST and provided written information regarding AD to the residents and RP. The DON stated, AD and POLST were important to honor residents' wishes and the guideline for how to treat residents in emergency situation. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, undated, the P&P indicated, Policy Statement: 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. Policy Interpretation and Implementation: 2. 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. 3.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 . 5. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the residents' legal representative.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 (meal tickets) containing protected information ([PHI]- any health information that can be used to identify specific individual which must remain confidential to prevent harmful consequences) were not shredded prior to disposing in the waste container. This failure had the potential to violate 116 of 129 residents' rights for privacy and confidentiality of personal and medical records. Findings: During an observation on 2/24/2026 at 2:00 p.m. of the dishwashing area, Dietary Aide 2 (DA 2) was observed throwing meal tickets in a grey trash can.During a concurrent observation and interview on 2/24/2026 at 2:05 a.m. of the dishwashing process with the Dietary Supervisor (DS), DA 2 was observed throwing meal tickets in the trash. The DS stated she saw DA 2 throw the meal tickets in the trash and the trash will go to the dumpster. The DS stated DA 2 should have separated the meal tickets and placed it in the corodata (secure onsite destruction services for confidential documents) to shred. The DS stated the meal ticket contained residents' name, diet, room number, food preferences and identification number (ID, residents' number in the chart). The DS stated the meal ticket needed to be shredded for privacy as somebody could access the residents' chart because of their ID number. The DS stated the residents' identity could be stolen as a potential outcome of throwing the menu tickets in the trash. The DS stated they were not protecting residents' information because anyone can access the meal tickets in the trash.During a review of the facility's policies and procedures (P&P) titled Confidentiality of Information and Personal Privacy, dated 10/2017, the P&P indicated, Our facility will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and ImplementationThe facility will safeguard and personal privacy and confidentiality of all resident personal and medical records.The facility will strive to protect the resident's privacy regarding his or her:Accommodations;Medical treatment;Written and telephone communications;Personal care;Visits; andFamily and resident group meetingsProviding a private room for each resident is not required to maintain or protect resident privacy.Access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of six sampled residents (Resident 9, Resident 46 and Resident 56)'s Preadmission Screening and Resident Review (PASARR, a screening that helps decide whether a person moving into a nursing home has a serious mental illness, an intellectual disability, or another condition that needs special care.) was complete correctly.This failure had the potential to affect Resident 9, 46 and 56's care and treatment.Findings:During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to facility on 3/16/2023 and readmitted on [DATE] with the diagnosis that included but not limit to: diabetes (a condition where a person's body has trouble controlling the amount of sugar in their blood), anemia (a condition where a person does not have enough healthy red blood cells), chronic kidney disease, and schizoaffective disorder (a mental health conditions, schizophrenia can cause someone to have trouble knowing what is real).During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool) dated 12/4/2025, the MDS indicated an active diagnosis of schizoaffective disorder.During a review of Resident 9's care plan revision date 6/20/2025, the care plan indicated Resident 9 had schizophrenia.During a review of Resident 9's PASARR, dated 1/31/2026, the PASSAR did not indicate the resident was diagnosed for serious mental illness therefore it also did not indicate a referral for a Level II PASSAR.During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was initially admitted to facility on 12/30/2024 and readmitted on [DATE] with the diagnosis that included but not limit to: end stage renal disease (a condition a person's kidney is not working well), dialysis (a medical treatment that helps clean a person's blood when their kidneys are not working well), hypertension (high blood pressure), and depression (a mental health condition that makes a person feel very sad, empty, or hopeless for a long time).During a review of Resident 46's MDS dated [DATE], the MDS indicated an active diagnosis of depression.During a review of Resident 46's care plan revision date 1/14/2026, the care plan indicated Resident 46 had depression.During a review of Resident 46's PASARR, dated 1/31/2026, the PASSAR did not indicate the resident was diagnosed for serious mental illness therefore it also did not indicate a referral for a Level II PASSAR.During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was initially admitted to facility on 2/24/2018 and readmitted on [DATE] with the diagnosis included but not limit to: type 2 diabetes mellitus (a condition where a person's body has trouble controlling the amount of sugar in their blood), seizures (a condition a person to lose control of their body for a short period of time), depression (a mental health condition that makes a person feel very sad, empty, or hopeless for a long time), anxiety disorder (a condition where a person feels very worried, nervous, or scared much more often than most people).During a review of Resident 56's MDS dated [DATE], the MDS indicated an active diagnosis of depression and anxiety disorder.During a review of Resident 56's PASARR, dated 1/31/2026, the PASSAR did not indicate the resident was diagnosed for serious mental illness therefore it also did not indicate a referral for a Level II PASSAR.During an interview on 2/24/2026 at 10:19 a.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated she completed the PASARR screen for Resident 9, 46 and 56. RNS 1 also stated she did not review residents' MDS and care plan when she did PASARR screening for them, so the PASARR screening was done incorrectly. RNS 1 stated inaccurate assessment have negative affect on Resident 9, 46 and 56's care and treatment.During an interview on 2/26/2026 at 8:37 a.m. with MDS supervisor (MDS RN), MDS RN stated Resident 9, 46 and 56 the PASARR screening had discrepancies, the nurse should review the MDS and care plan to ensure accurate assessment on the screening. Inaccurate PASARR screenings could negatively affect Resident 9, 46, and 56's care and treatment.During a review of facility policy and procedure (P&P) Resident Assessment dated 03/2022, the P&P indicated, MDS should be used to conduct resident assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review the facility failed to to ensure:a. Residents' care plans were implemented for two of four sample residents (Resident 9 and 46).b. Ensure resident's request for hospice (end of life care ensuring the person feels comfortable and supported) care for one of four sampled residents (Resident 89).These deficient practices resulted in Resident's 9 and 46 not receiving person centered care and Resident 89 not receiving necessary comfort-focused interventions, pain management supports, and coordinated endˆofˆlife services. Findings: A. During a review of Resident 9's admission record, the admission record indicated Resident 9 was initially admitted to facility on 3/16/2023 and readmitted on [DATE] with the diagnoses but not limited to diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). anemia (a condition where a person doesn't have enough healthy red blood cells), chronic kidney disease, and schizoaffective disorder (a mental health conditions, schizophrenia can cause someone to have trouble knowing what is real). During a review of Resident 9's Minimum Data Set (MDS – a comprehensive resident assessment tool), dated 12/4/2025, the MDS indicated an active diagnosis of diabetes. During a review of Resident 9's care plan, dated 12/8/2025, the care plan indicated, Resident is at risk for hypoglycemia and hyperglycemia related to diabetes mellitus. During a review of Resident 9's physician's orders, dated 11/4/2025, the orders indicated Resident 9 should get 6 units of lispro (a fast-acting insulin medication used to treat diabetes by controlling blood sugar) before meals and at the bedtime for diabetes if Resident 9's blood sugar is between 200-249 mg/dL (milligrams per deciliter, a unit of measurement). During a review of Resident 9's medication administration record (MAR), dated February 2026, the MAR indicated on 2/16/2026 at 6:30 a.m. Resident 9's blood sugar was 243 mg/dL and lispro was not given to the Resident 9. During a review of Resident 46's admission record, the admission record indicated Resident 46 was initially admitted to facility on 12/30/2024 and readmitted on [DATE] with the diagnoses but not limited to hypertension (high blood pressure), hypertensive heart failure (when long-term high blood pressure forces the heart to work too hard), end stage renal disease (a condition a person's kidney is not working well), and dialysis (a medical treatment that helps clean a person's blood when their kidneys are not working well) During a review of Resident 46's MDS, dated [DATE], the MDS indicated an active diagnosis of hypertension. During a review of Resident 46's physician's orders, dated 11/19/2025, the orders indicated clonidine (a medication to help lower blood pressure) 0.2 mg (milligrams, unit of measurement) tablet to be given every 6 hours as needed for high blood pressure, if systolic (the top number in a blood pressure reading) is greater than 160 mmHg (millimeters of mercury, a unit of measurement). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 46's care plan, dated 1/12/2026, the care plan intervention indicated the Resident will be administered prn (given as needed) clonidine 0.2 mg for elevated (high) blood pressure. During a review of Resident 46's MAR, dated February 2026, the MAR indicated: On 2/2/2026 at 6:00 a.m. Resident 46's blood pressure was 197/112 mmHg and clonidine was not given to the resident. On 2/21/2026 at 6:00 a.m. Resident 46's blood pressure was 168/88 mmHg and clonidine was not given to the resident. During a review of Resident 56's admission record, the admission record indicated Resident 56 was initially admitted to facility on 2/24/2018 and readmitted on [DATE] with the diagnoses but not limited to diabetes mellitus (a condition where a person's body has trouble controlling the amount of sugar in their blood), seizures (a condition a person to lose control of their body for a short period of time), depression (a mental health condition that makes a person feel very sad, empty, or hopeless for a long time), anxiety disorder (a condition where a person feels very worried, nervous, or scared much more often than most people). During a review of Resident 56's MDS, dated [DATE], the MDS indicated an active diagnosis of diabetes. During a review of Resident 56's physician order, dated 7/29/2025, the order indicated Resident 56 should get 20 units of Lantus (a long-acting insulin medication used to treat diabetes by controlling blood sugar) two times a day for diabetes, hold it if blood sugar less than 120 mg/dL. During a review of Resident 56's physician order, dated 7/29/2025, the order indicated Resident 56 should not get any HumaLOG (a rapid acting insulin medication used to treat diabetes by controlling blood sugar) injection before meals if Resident 56's blood sugar is between 50 -149 mg/dL. During a review of Resident 56's MAR, dated Feburary 2026, the MAR indicated: On 2/7/2026 at 6:00 a.m. Resident 56's blood sugar was 110 mg/dL and 20 units of Lantus was given. On 2/7/2026 at 6:30 a.m. Resident 56's blood sugar was 110 mg/dL, and 2 units of HumaLOG was given. On 2/13/2026 at 6:00 a.m. Resident 56's blood sugar was 114 mg/dL and 20 units of Lantus was given. On 2/23/2026 at 6:00 a.m. Resident 56's blood sugar was 118 mg/dL and 20 units of Lantus was given. During an interview on 2/24/2026 at 8:35 a.m. with RNS (Registered Nurse Supervisor) 1, RNS 1 stated: For Resident 9: the nurse did not follow physician's order on date 2/16/2026. Resident 9's blood sugar level indicated insulin injection needed, nurse failed to give medication, it could cause harm to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 9. For Resident 46: the nurse did not follow physician's order on date 2/2/2026 and 2/21/2026. Resident 46's blood pressure level indicated medication should be given, nurse failed to give medication, it could cause stroke to Resident 46. For Resident 56: the nurse did not follow physician's order on date 2/7/2026, 2/13/2026 and 2/23/2026. Resident 56's blood sugar level did not indicated any insulin injection, nurse given insulin to Resident 56 will further lower the Resident 56's blood sugar and cause hypoglycemia (low blood sugar) to Resident 56. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 03/2023, the P&P indicated medications are to be administered in accordance with prescriber orders. B. During a review of Resident 89's admission Record, the admission Record indicated the facility admitted Resident 89 on 1/18/2017, and readmitted on [DATE] with diagnoses including metabolic encephalopathy (any disease, damage, or malfunction of the brain that alters its structure or function) and Alzheimer's disease (a progressive, irreversible brain disorder that destroys memory and thinking skills over time). The admission Record indicated Resident 89's Family Member (FM)1 was considered an authorized responsible party and a Power of Attorney ([POA]- a legal document that lets you appoint a trusted person to manage your finances, property, or medical care if you become unable to do so) for Resident 89. During a review of Resident 89's Physician Orders for Life-Sustaining Treatment (POLST-a medical form that tells doctors and nurses what kind of treatment a patient wants or does not want, especially in a serious illness or emergency), dated 2/12/2026, the POLST indicated FM 1 signed consent for do not attempt resuscitation (DNR) if patient has no pulse and is not breathing. During a review of Resident 89's admission History and Physical (H&P), dated 2/13/2026, the H&P indicated Resident 89 was forgetful and confused. During a review of Resident 89's MDS, dated [DATE], the MDS indicated Resident 89's cognitive (functions your brain uses to think, pay attention, process information, and remember things) skills for daily decision making were severely impaired. The MDS indicated Resident 89 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, showering dressings, and personal hygiene. During a telephone interview on 2/24/2026 at 9:05 a.m., with FM 1, FM 1 stated Resident 1 had been declining over the past 10 years, and FM 1 did not want to see Resident 89 suffer. FM 1 stated the family had asked the facility about the possibility of hospice care, the facility has not followed up on the request. During a telephone interview on 02/24/2026 at 9:46 a.m. with FM 2 stated FM 1 had asked the facility about hospice care for Resident 89 on multiple occasions. FM 2 stated the most recent request was on 2/19/2026 while FM 1 and FM 2 were visiting Resident 89. FM 2 stated the facility had not followed up on the request. During a concurrent interview and record review on 2/24/2026 at 9:50 a.m., with the Social Services Director (SSD), Resident 89's Progress Notes, for the month of February 2026, were reviewed. The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SSD stated FM 1 expressed their wish for hospice care for Resident 89 on 2/12/2026 and updated the POLST on the same day. The SSD stated nursing staff were expected to notify the physician to obtain an order for hospice care. The SSD stated 12 days had passed since the request and there was no documentation regarding hospice care in the resident's medical record. The DSD stated the resident and family have the right to request hospice care and their wishes should be respected. During an interview on 2/26/2026 at 9:28 a.m., with the Director of Nursing (DON), the DON stated the facility should follow up on a resident's or resident representative's request for hospice services, as it is the resident's right. The DON stated the facility failed to follow up on the request in this case. During a review of the facility's policy and procedure (P&P) titled, Resident rights, revised February 2021, the P&P indicated resident's rights include communication with and access to people and services, both inside and outside the facility; be informed of, and participate in, his or her care planning and treatment. During a review of the facility's policy and procedure (P&P) titled Hospice Program, revised March 2023, the P&P indicated Upon admission and periodically during their stay, residents are informed of the availability of hospice services coordinated through the facility.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of 10 sampled residents (Residents 9, 6, and 136) received appropriate services to prevent a decline in joint range of motion (ROM, full movement potential of a joint) and mobility by failing to:1a. For Resident 9, put on right and left ankle foot orthosis (AFO, an orthotic device designed to correct or address problems with the ankle and foot) during Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatment for no more than three hours, as ordered by a physician.1b. Indicate objective ROM measurements for impaired joints on Resident 9's Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation dated 11/4/2025.1c. Complete an annual Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) joint mobility screen for Resident 9 in 6/2025.2a. Indicate objective ROM measurements for impaired joints on Resident 6's OT Evaluation dated 2/20/2026.2b. Complete an admission OT joint mobility screen for Resident 6 in 7/2025.3. Complete an admission OT joint mobility screen for Resident 136 in 7/2025.These deficient practices had the potential to cause injury and pain due to prolonged wearing of AFOs for Resident 9, and prevent accurate monitoring and provision of appropriate care for decline in range of motion and mobility for Residents 9, 6, and 136.Findings:1. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to Type 2 Diabetes Mellitus (condition in which the body does not metabolize blood sugar correctly) with diabetic chronic kidney disease (loss of ability to remove waste and balance fluids) and contracture (loss of motion of a joint) of left elbow and right elbow. During a review of Resident 9's Minimum Data Set (MDS, resident assessment tool) dated 12/4/2025, the MDS indicated Resident 9 was severely impaired for cognitive skills for daily decision making (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 9 had functional limitations in ROM impairments on both sides of the upper extremities (BUE, shoulder, elbow, wrist/hand) and both sides of the lower extremities (BLE, hip, knee, ankle/foot). The MDS indicated Resident 9 required dependent assistance with eating, dressing, hygiene, bathing, and chair to bed transfers. During a review of Resident 9's Care Plan Report (CP) initiated 7/25/2024 and revised on 2/13/2025, the CP indicated Resident 9 was at risk for decrease in ROM and strength to BLE due to immobility. The CP goal indicated RNA will provide splints and perform passive range of motion (PROM, movement at a given joint with full assistance from another person) to BLE without adverse effects and communicate new findings or need for reassessment/modification to rehab team if necessary. The CP intervention indicated to refer to RNA program from rehab services. During a review of Resident 9's CP initiated on 6/6/2024 and revised on 2/13/2025, the CP indicated Resident 9 had alteration in joint mobility as evidenced by limitations in both arms and both feet. The CP goal indicated Resident 9 will minimize the risk for further loss of ROM daily. The CP interventions indicated initial, quarterly, annual assessment of joint mobility or as needed, monitor for pain or stiffness, and provide ROM exercises if ordered. During a review of Resident 9's Order Summary Report dated 2/25/2026, the Order Summary Report indicated the following orders:-dated 1/23/2026 for RNA for PROM of BUE followed by both elbow splints and both resting hand splints for three to four hours or as tolerated five times a week or as tolerated.-dated 1/23/2026 for RNA to apply both AFO for three hours a day, five times a week or as tolerated.-dated 1/23/2026 for RNA to apply both knee splints for fours a day, five times a week or as tolerated.-dated 1/23/2026 for RNA to perform PROM exercises to both lower extremities five times a week or as tolerated. During an observation on (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/23/2026 at 9:39 a.m., Resident 9 was lying in bed and could not speak. Resident 9's elbows were bent more than halfway, both wrists were straight, and both hands were in a fisted position, and both ankles were pointed away from Resident 9's body. 1a. During a review of Resident 9's January 2026 RNA Documentation Survey Report, the RNA DSR indicated RNA put on left and/or right AFO for more than three hours a day on the following days: 1/26/2026, 1/29/2026, 1/30/2026. During a review of Resident 9's February 2026 RNA Documentation Survey Report, the RNA DSR indicated RNA put on left and/or right AFO for more than three hours a day on the following days: 2/3/2026, 2/4/2026, 2/5/2026, 2/9/2026, 2/10/2026, 2/11/2026, 2/16/2026, 2/17/2026, and 2/19/2026. During an interview and record review on 2/26/2026 at 8:48 a.m., Restorative Nursing Aide (RNA 1) stated Resident 9's RNA treatment orders were for PROM exercises on both UE and both LE and splinting on both elbows, both wrist/hands, both knees, and both ankle/feet. RNA 1 reviewed 1/2026 and 2/2026 RNA Documentation Survey Report and confirmed RNAs put on left and/or right AFOs for longer than three hours during RNA treatment. RNA 1 stated if the RNA order was to put on left and right AFOs for three hours, then RNA should take off the splints at three hours, because RNA need to follow the RNA orders. During an interview and record review on 2/26/2026 at 8:58 a.m., Physical Therapist (PT 1) stated PTs use splints to help prevent further contractures from developing. PT 1 stated during PT treatment, PT assessed how long a resident could tolerate a splint safely and slowly increase the wear time for a splint. PT 1 stated Resident 9's RNA order was to put on left and right ankle AFOs for three hours and three hours should be the maximum time Resident 9 should wear the AFOs. PT 1 stated if Resident 9 was wearing the AFOs for longer than three hours, then the AFOs could cause Resident 9 pain or cause skin integrity issues. During an interview on 2/26/2026 at 11:24 a.m., the Director of Nursing (DON) stated the RNA program helped to maintain a resident's joint mobility and current functional status. DON stated an RNA program was created by therapists for each resident and RNAs were to follow the RNA orders. DON stated RNAs could not change anything from the RNA order and if the RNA could not complete the RNA order for any reason, then RNAs should report it to the charge nurse and inform therapy. During a review of the facility's undated policies and procedures (P&P), titled, Joint Mobility Contracture Management Program, the P&P indicated RNA responsibilities included apply splint daily according to instructions. 1b. During a review of Resident 9's OT Evaluation and Plan of Treatment dated 11/4/2025, the OT Evaluation indicated Resident 9 had impaired ROM in both shoulders, elbows, wrists, hands, thumbs, index fingers, middle fingers, ring fingers, and little fingers. The OT Evaluation did not indicate an objective measurement of the ROM in both elbows, wrists, thumbs, index fingers, middle fingers, ring fingers, or little fingers. During an interview and record review on 2/26/2026 at 9:11 a.m., Occupational Therapist (OT 1) stated OTs evaluate and assess ROM during every OT evaluation and if the ROM at a certain joint was impaired, the OT should indicate the remaining objective ROM measurements in that specific impaired joint. OT 1 stated OTs needed to document and evaluate the impaired ROM, because it was the objective measurement and how OTs would know if the ROM at the joint improved or worsened. OT 1 stated the goal was to improve, maintain ROM. OT 1 reviewed Resident 9's OT Evaluation dated 11/4/2025 and stated the objective ROM measurements were not documented for Resident 9's elbows, wrists, thumbs, index fingers, middle fingers, ring fingers, or little fingers. OT 1 stated based on the OT Evaluation, OT 1 could not know what Resident 9's ROM was in the impaired joints. OT 1 stated it was important to capture the objective data of ROM measurements, because therapists were the only profession that was able to measure ROM. OT 1 stated it was important to measure ROM to keep track of a resident's ROM and to help create goals in therapy. During a review of the facility's undated Occupational Therapist Job Description, the OT Job Description indicated job responsibilities included provide comprehensive evaluations using standardized or non-standardized tests, document results, and interpret findings. During a review of the facility P&P revised 7/2017, titled, Charting and Documentation, the P&P indicated documentation in the medical record will be objective, complete, and accurate. 1c. During a review of Resident 9's Annual Joint Mobility Screen (JMS) - Upper (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Extremities dated 6/5/2025, the JMS indicated Resident 9 had minimal ROM loss in both wrists, right hand/fingers, and both elbows. The JMS indicated Resident 9 had moderate ROM loss in left hand/fingers and severe ROM loss in both shoulders. During a review of Resident 9's admission JMS - Upper Extremities (JMS) dated 11/4/2025, the JMS indicated Resident 9 had minimal ROM loss in both wrists, right hand/fingers, and both elbows. The JMS indicated Resident 9 had moderate ROM loss in left hand/fingers and severe ROM loss in both shoulders. During a review of Resident 9's readmission JMS - Lower Extremities dated 11/4/2025, the JMS indicated Resident 9 had severe ROM loss in both knees, both knees, and both ankles. During a review of Resident 9's JMS, there was no Annual JMS - Lower Extremities completed in 6/2025. During a concurrent interview and record review on 2/25/2026 at 2:44 p.m. with the Director of Rehabilitation (DOR), Resident 9's JMS were reviewed. DOR stated PT and OT completed JMS on admission, annually, and as needed such as a change in condition. DOR reviewed Resident 9's JMS and stated an annual JMS for lower extremities was not completed in June 2025. DOR stated it was important for PT and OT to complete JMS because the JMS provided a baseline for ROM for residents when they were admitted to the facility and on an annual basis. DOR stated the JMS helped to monitor residents for ROM and if there was any decline, it would be an indication to provide PT and OT if needed. DOR stated if a resident declined in ROM, it could affect the resident's ability to perform ADLs and ambulation. During an interview on 2/26/2026 at 8:58 a.m., the Physical Therapist (PT 1) stated JMS were completed on admission and annually. PT 1 stated therapists checked the integrity of the joints and to monitor if there were any decreases in ROM. PT 1 stated it was important to check and monitor joint ROM, because if the joints were getting tighter and contractures were developing, therapy could address it as soon as possible. PT 1 stated if therapists missed a JMS, then a resident's joints and ROM get tighter and stiffer. During an interview on 2/26/2026 at 9:11 a.m., the Occupational Therapist (OT 1) stated therapists completed JMS on admission and annually. OT 1 stated therapists completed JMS to get a baseline for ROM on admission or readmission and annually to see if there were any changes. OT 1 stated ROM affected residents functionally so it was important to keep track of a resident's ROM, for example a resident could lose their ability to use their hand if their joints were stiffer and stuck in a fist and a resident's skin integrity could also get worse. During a review of the facility's undated policies and procedures (P&P) titled, Joint Mobility Contracture Management Program, the P&P indicated new admissions are to be screened by the therapy staff for appropriateness for intervention including contracture management. During a review of the facility's Memorandum dated 11/3/2025, titled Rehab Screening and Joint Mobility Update, the Memorandum indicated the following guidelines reflect the most current rehab screening and joint mobility forms and policy: rehab will complete the joint mobility screening on admission, annually and with change of condition. 2. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to aphasia (a disorder that makes it difficult to speak) following cerebrovascular disease (disease of the blood vessels, especially blood vessels to the brain), hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting right dominant side. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had moderate cognitive impairment (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 6 had functional limitations in ROM impairments on one side of the upper extremity and no impairment on the lower extremities. The MDS indicated Resident 6 required dependent assistance with dressing, hygiene, bathing, and chair to bed transfers. During a review of Resident 6's Care Plan (CP) dated 7/9/2025, the CP indicated Resident 6 was at risk of decreased strength and ROM due to cognition. The CP goal indicated Resident 6 will maintain current level of ROM and strength. During a review of Resident 6's CP initiated 7/3/2024 and revised on 8/6/2025, the CP indicated Resident 6 had self-care deficits. The (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CP interventions indicated a rehab screen on admission, quarterly and as needed. During an observation on 2/23/2026 at 1:19 p.m., Resident 6 was lying on a geriatric chair (a large, padded chair designed to help persons with limited mobility). Resident 6's left elbow was bent about halfway, the left wrist was straight and fingers were slightly bent. Resident 6's right hand was behind Resident 6's head and Resident 6 was able to move the right arm. 2a. During a review of Resident 6's Occupational Therapy Evaluation and Plan of Treatment dated 2/20/2026, the OT Evaluation indicated Resident 6 had impaired ROM in the left shoulder, elbow, wrist, and hand. The OT Evaluation did not indicate an objective measurement of the ROM in left wrist or left hand. During an interview and record review on 2/26/2026 at 9:11 a.m., Occupational Therapist (OT 1) stated OTs evaluate and assess ROM during every OT evaluation and if the ROM at a certain joint was impaired, the OT should indicate the remaining objective ROM measurements in that specific impaired joint. OT 1 stated OTs needed to document and evaluate the impaired ROM, because it was the objective measurement and how OTs would know if the ROM at the joint improved or worsened. OT 1 stated the goal was to improve, maintain ROM. OT 1 reviewed Resident 6's OT Evaluation dated 2/20/2026 and stated the objective ROM measurements were not documented for Resident 6's left wrist and hand. OT 1 stated based on the OT Evaluation, OT 1 could not know for certain what Resident 6's ROM was in the impaired joints but had to assume what the ROM could be. OT 1 stated it was important to capture the objective data of ROM measurements, because therapists were the only profession that was able to measure ROM. OT 1 stated it was important to measure ROM to keep track of a resident's ROM and to help create goals in therapy. During a review of the facility's undated Occupational Therapist Job Description, the OT Job Description indicated job responsibilities included provide comprehensive evaluations using standardized or non-standardized tests, document results, and interpret findings. During a review of the facility P&P revised 7/2017, titled, Charting and Documentation, the P&P indicated documentation in the medical record will be objective, complete, and accurate. 2b. During a review of Resident 6's readmission JMS - Lower Extremities dated 7/31/2025, the JMS indicated Resident 6 had full range of motion on both hips, knees, and ankles. During a review of Resident 6's JMS, there was no readmission JMS - Upper Extremities completed in 7/2025. During a concurrent interview and record review on 2/25/2026 at 2:44 p.m. with the Director of Rehabilitation (DOR), Resident 6's JMS were reviewed. DOR stated PT and OT completed JMS on admission, annually, and as needed such as a change in condition. DOR stated Resident 6 readmitted to the facility on [DATE] and PT/OT should complete a JMS due to the readmission. DOR reviewed Resident 6's JMS and stated a readmission JMS for upper extremities was not completed. DOR stated it was important for PT and OT to complete JMS because the JMS provided a baseline for ROM for residents when they were admitted to the facility and on an annual basis. DOR stated the JMS helped to monitor residents for ROM and if there was any decline, it would be an indication to provide PT and OT if needed. If residents decline with ROM, it could affect the resident's ability to perform ADLs and ambulation. During an interview on 2/26/2026 at 8:58 a.m., the Physical Therapist (PT 1) stated JMS were completed on admission and annually. PT 1 stated therapists checked the integrity of the joints and to monitor if there were any decreases in ROM. PT 1 stated it was important to check and monitor joint ROM, because if the joints were getting tighter and contractures were developing, therapy could address it as soon as possible. PT 1 stated if therapists missed a JMS, then a resident's joints and ROM get tighter and stiffer. During an interview on 2/26/2026 at 9:11 a.m., the Occupational Therapist (OT 1) stated therapists completed JMS on admission and annually. OT 1 stated therapists completed JMS to get a baseline for ROM on admission or readmission and annually to see if there were any changes. OT 1 stated ROM affected residents functionally so it was important to keep track of a resident's ROM, for example a resident could lose their ability to use their hand if their joints were stiffer and stuck in a fist and a resident's skin integrity could also get worse. During a review of the facility's undated policies and procedures (P&P) titled, Joint Mobility Contracture Management Program, the P&P indicated new admissions are to be screened by the therapy staff for appropriateness for intervention (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including contracture management. During a review of the facility's Memorandum dated 11/3/2025, titled Rehab Screening and Joint Mobility Update, the Memorandum indicated the following guidelines reflect the most current rehab screening and joint mobility forms and policy: rehab will complete the joint mobility screening on admission, annually and with change of condition. 3. During a review of Resident 136's admission Record, the admission Record indicated Resident 136 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to encephalopathy (any damage or disease that affects the brain), (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left non-dominant side, and contracture (loss of motion of a joint) left elbow, left hand, and left knee. During a review of Resident 136's MDS dated [DATE], the MDS indicated Resident 136 had moderate cognitive impairment (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 136 had functional limitations in ROM impairments on both sides of the upper extremities and both sides of the lower extremities. The MDS indicated Resident 136 required moderate assistance with eating and dependent assistance with dressing, hygiene, bathing, and chair to bed transfers. During a review of Resident 136's Care Plan Report (CP), the CP initiated 10/16/2025 indicated Resident 136 was at risk for decline in ROM status of both lower extremities and left upper extremities. The CP goal indicated to minimize complications related to decreased mobility or contractures through appropriate through the next assessment. The CP intervention indicated restorative nursing referral by rehab, RNA to perform PROM exercises to both lower extremities once a day, five times a week or as tolerated. During a review of Resident 136's readmission JMS - Lower Extremities dated 7/25/2025, the JMS indicated Resident 136 had minimal ROM loss in right hip, moderate ROM loss in right knee, left ankle, and severe ROM loss in left hip, left knee, and right ankle. During a review of Resident 136's Annual JMS - Lower Extremities dated 12/2/2025, the JMS indicated Resident 136 had minimal ROM loss in right hip, moderate ROM loss in right knee, left ankle, and severe ROM loss in left hip, left knee, and right ankle. During a review of Resident 136's Annual JMS - Upper Extremities (JMS) dated 12/2/2025, the JMS indicated Resident 136 had full range of motion in right wrist, hand/fingers, elbow, and shoulder. The JMS indicated Resident 136 had full severe ROM loss in left wrist, hand/fingers, elbow, and shoulder. During a review of Resident 136's JMS, there was no readmission JMS - Upper Extremities completed in July 2025. During an observation and interview on 2/23/2026 at 1:53 p.m., Resident 136 was lying in bed and stated she had a stroke and could not move her left arm or leg. Resident 136's left arm was bent, the left wrist was straight, and the left hand was in a fisted position. During a concurrent interview and record review on 2/25/2026 at 2:44 p.m. with the Director of Rehabilitation (DOR), Resident 136's JMS were reviewed. DOR stated PT and OT completed JMS on admission, annually, and as needed such as a change in condition. DOR stated Resident 136 readmitted to the facility on [DATE] and PT/OT should complete a JMS due to the readmission. DOR reviewed Resident 136's JMS and stated a readmission JMS for upper extremities was not completed. DOR stated it was important for PT and OT to complete JMS because the JMS provided a baseline for ROM for residents when they admitted to the facility and on an annual basis. DOR stated the JMS helped to monitor residents for ROM and if there was any decline, it would be an indication to provide PT and OT if needed. If residents decline with ROM, it could affect the resident's ability to perform ADLs and ambulation. During an interview on 2/26/2026 at 8:58 a.m., the Physical Therapist (PT 1) stated JMS were completed on admission and annually. PT 1 stated therapists checked the integrity of the joints and to monitor if there were any decreases in ROM. PT 1 stated it was important to check and monitor joint ROM, because if the joints were getting tighter and contractures were developing, therapy could address it as soon as possible. PT 1 stated if therapists missed a JMS, then a resident's joints and ROM get tighter and stiffer. During an interview on 2/26/2026 at 9:11 a.m., the Occupational Therapist (OT 1) stated therapists completed JMS on admission and annually. OT 1 stated therapists completed (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	JMS to get a baseline for ROM on admission or readmission and annually to see if there were any changes. OT 1 stated ROM affected residents functionally so it was important to keep track of a resident's ROM, such as a resident could lose their ability to use their hand if their joints were stiffer and stuck in a fist, the skin integrity could also get worse. During a review of the facility's undated policies and procedures (P&P) titled, Joint Mobility Contracture Management Program, the P&P indicated new admissions are to be screened by the therapy staff for appropriateness for intervention including contracture management. During a review of the facility's Memorandum dated 11/3/2025, titled Rehab Screening and Joint Mobility Update, the Memorandum indicated the following guidelines reflect the most current rehab screening and joint mobility forms and policy: rehab will complete the joint mobility screening on admission, annually and with change of condition.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and appropriate management of enteral tube feeding (a method of delivering liquid nutrients, fluids, and medications directly into the stomach or small intestine via a flexible tube) and hydration bag for two of five sampled residents (Resident 11 and 129) by failing to:Ensure Resident 11's hydration bag did not run for more than 24 hours against the physician's order.Ensure Resident 129's tube feeding was labeled including date and time the formula was hung/administered.These deficient practices had the potential to increase the risk of infection prevention and compromised resident health.a. During a review of Resident 11's admission Record, the admission Record indicated the facility admitted Resident 11 on 7/25/2024, and readmitted on [DATE] with diagnoses including attention to gastrostomy (a small, safe surgical opening made through the belly skin directly into the stomach) and dysphagia (having trouble swallowing food or liquids, making them pass slowly or painfully from the mouth to the stomach). During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 11's cognition (functions your brain uses to think, pay attention, process information, and remember things) was severely impaired. The MDS indicated Resident 11 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, showering, and personal hygiene. During a review of Resident 11's Order Summary Report, orders as of 2/24/2026, the Order Summary Report indicated the following enteral tube feeding orders: Starting 5/2/2025, change open bag system and Gastrostomy Tube Feeding (GTF-administration of nutrition, fluids, or medication directly into the stomach through a surgically placed feeding tube) every night shift.Starting 5/2/2025, change hydration bag (a container, similar to a plastic pouch or infusion bags, used to deliver water or fluids into the stomach through a feeding tube) every 24 hours.Starting 7/14/2025, feeding Jevity 1.5 (calorically dense, fiber-fortified therapeutic nutrition) at 55 milliliter (ml- a unit of measure for volume) per hour for 20 hours via (through) pump to provide 1100 cubic centimeter (cc- a unit of measure for volume)/1650 kilocalorie (kcal-a unit of measure for energy) per day.During a review of Resident 11's care plan titled ?Resident is on Gastrostomy Tube Feeding', revised 1/21/2026, the care plan interventions included to administer enteral feedings as ordered, and change tubing's per policy or as ordered.During an observation on 2/23/2026 at 10:15 a.m., in Resident 11's room, observed a hydration bag connected to the resident without a label indicating the date and time of initiation. There was also a tube feeding bag labeled with the date 2/22/2026 and time 2:30 a.m. The hydration bag and tube feeding were connected to the resident.During a concurrent interview and record review on 2/24/2026 at 2:04 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 11's Order Summary Report as of 2/24/2026, were reviewed. LVN 1 stated staff should change Resident 11's tube feeding daily according to the physician's order. LVN 1 confirmed staff (unknown) initiated Resident 11's feeding on 2/22/2026 at 2:30 a.m., and the tube feeding bag remained running for more than 24 hours at the time of her (LVN 1) rounding on 2/23/2026 at 8 a.m. LVN 1 confirmed staff (unknown) had not labeled the hydration bag.b. During a review of Resident 129's admission Record, the admission Record indicated the facility admitted Resident 129 on 10/5/2023, and readmitted on [DATE] with diagnoses including attention to gastrostomy and dysphagia. During a review of Resident 129's Minimum Data Set (MDS- a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 129 Cognitive (functions your brain uses to think, pay attention, process information, and remember things) Skills for Daily Decision Making were severely impaired. The MDS indicated Resident 129 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, showering, dressings, putting and taking off/taking off, and personal hygiene. During a review of Resident 129's Order Summary Report, orders as of 2/24/2026, the Order Summary Report indicated the following enteral feeding order:Starting (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/25/2024, change hydration bag every 24 hours.Starting 4/22/2025, feed Jevity 1.5 at 60cc per hour for 20 hours via pump to provide 1200ml/1800kcal per day.During a review of Resident 129's care plan titled, ?Resident is on Gastrostomy Tube feeding with adequate water flushing, revised 12/16/2025, the care plan's intervention included to change tubing per policy or as ordered, and administer enteral feedings as ordered.During an observation on 2/23/2026 at 10:49 a.m., in Resident 129's room, observed a tube feeding and an empty hydration bag connected to the resident. Both bags lacked labels indicating the resident's name, the date and time the formula was hung/administered, and staff initials.During a concurrent interview and record review on 2/24/2026 at 2:04 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 129's Order Summary Report, orders as of 2/24/2026, were reviewed. LVN 1 stated Resident 129's Order Summary Report indicated staff should change Resident 129's hydration bag daily per the physician's order. LVN 1 stated the tube feeding and hydration bag connected to Resident 129, which was observed on 2/23/2026 at 10:49 a.m., were not labeled. LVN 1 stated, without labels, LVN 1 could not determine when the tube feeding, or hydration bag was initiated. LVN 2 stated staff should administer tube feeding and hydration according to the physician's order and label the tube feeding and hydration bag with the resident's name, feeding rate, and the date and time of initiation. LVN 1 explained proper labeling ensures the feeding is administered as prescribed, prevents infection, maintains formular freshness, and ensures the feeding has not expired for the resident's safety.During an interview on 2/26/2026 at 9:28 a.m., with the Director of Nursing (DON), the DON stated staff must follow the physician's order and the resident's care plan when providing tube feeding care and must verify the order with the physician if any concerns arise, in accordance with the standard of care. The DON stated staff must label and date on the tube feeding and hydration bag when initiating a new bag.During a review of the facility's policy and procedure (P&P) titled Enteral Tube Feeding via Continuous Pump, revied November 2018, the P&P indicated, staff should label on the formula: document initials, date and time the formula was hung/administered, and initial that the label was checked against the order.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically related social services (professional interventions provided by social workers to help residents manage the emotional, social, and financial impacts of illness) for two of five sampled residents (Resident 2 and Resident 8) as evidence by:A. Failing to initiate conservatorship [a court-ordered arrangement where a judge appoints a responsible person or organization (conservator) to manage the financial affairs and/or daily care of an adult (conservatee) who is unable to do so themselves due to physical or mental limitations] or public guardian (a court-appointed official or agency that acts as a conservator for individuals unable to care for themselves or manage their finances due to age, illness, or incapacity) to protect Resident 2 who had no mental capacity (ability) to make decisions.B. Failing to intervene and ensure Resident 8 received social security checks when public guardian was unable to provide it since 10/2025.This failure had the potential to result in delay in the delivery of care and services.Findings:A. During a review of Resident 2's admission Record (Face Sheet), the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including dementia (a progressive state of decline in mental abilities), aphasia (a disorder that makes it difficult to speak) followed by cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).During a review of Resident 2's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 2 had no capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 2 required dependent assistance (Helper does all of the effort) from two or more staff for toilet hygiene, dressing, transfer, maximal assistance (Helper does more than half the effort) from one staff for shower, personal hygiene, and moderate assistance (Helper does less than half the effort) from one staff for bed mobility, eating.During a review of Resident 2's Care Plan Report (CPR) titled, Resident 2 has cognitive deficit and moderately impaired decision making related to dementia, revised on [DATE], the CPR Goal indicated, Resident 2 will be able to maximize decision making capabilities daily by target date of [DATE]. The CPR Interventions indicated, use yes/no questions and encourage choices of care.During a review of Resident 2's Consent for Medical Treatment, dated [DATE], the Consent for Medical Treatment indicated, it was signed by Resident 2.During a review of Resident 2's Physical Restraint Informed Consent, dated [DATE], the Physical Restraint Informed Consent indicated, FM 3 verbally consented via telephone regarding using side rails for safety purposes.During a review of Resident 2's admission Record (Face Sheet), dated [DATE], the admission Record indicated, Resident 2 was the primary decision maker and FM 3 was the emergency contact.During a concurrent interview and record review on [DATE], at 10:40 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 2's Psychotherapeutic Drug (medications designed to treat mental health disorders to improve mood, behavior, and thought patterns) Informed Consent Form, dated [DATE] was reviewed. The Psychotherapeutic Drug Informed Consent Form indicated, it was verbally consented via telephone by Resident 2's Family Member (FM) 3 with two witnesses on [DATE] for Aripiprazole (a medication to treat mental disorder such as schizoaffective disorder) 5 milligram (mg) one tablet two times a day by mouth for schizoaffective disorder manifested by anger outburst. RNS 1 stated Resident 2 was to be self-responsible, but the staff noticed Resident 2's mental capacity had declined. RNS 1 stated, the staff contacted FM 3 for the consent because she was listed as emergency contact. RNS 1 stated, the staff should have identified Resident 2's Responsible Party (RP- the party responsible for making health care decisions when the principal party is unable to make said health care decisions for him or herself) before obtaining the consent from FM 3.During an interview on [DATE], at 4:15 p.m., with the Social Service Director (SSD), the (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SSD stated she was not aware of the situation. The SSD stated there was no discussion during the Interdisciplinary Team (IDT- a regular, structured collaboration among healthcare professionals) meeting. The SSD stated, she would initiate public guardianship or conservatorship to protect Resident 2 if the staff notified her regarding lack of RP. The SSD stated, initiating and applying public guardianship/conservatorship was important to protect Resident 2's rights and interests when Resident 2 lost her capacity to make decisions.During an interview on [DATE], at 10:44 a.m., with the Director of Nursing (DON), the DON stated, the staff and the SSD should have identified FM 3 as her authorized representative prior to having her sign the informed consent for medications and treatment. The DON stated having someone who is not an authorized representative of the resident sign for informed consent increases the risk that Resident 2 may not be able to exercise her right to opt out of treatment.B. During a review of Resident 8's admission record, the admission record indicated Resident 8 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including dementia (a progressive state of decline in mental abilities), respiratory failure (not enough oxygen passes from your lungs to the blood), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).During a review of Resident 8's H&P, dated [DATE], the H&P indicated, Resident 8 was able to make her own medical decisions.During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 required dependent assistance (Helper does all the effort) from two or more staff for bed mobility, transfer, dressing, shower, hygiene, and moderate assistance (Helper does less than half the effort) from one staff for eating.During an interview on [DATE], at 11:46 a.m., with Resident 8 in her room, Resident 8 stated, she had not received her social security check since 11/2025 and she was worried about her bills not getting paid on time.During a concurrent interview and record review on [DATE], at 9:27 a.m., with the Business Office Manager (BOM), Resident 8's Statement for Share of Cost (the amount of money the residents must pay each month towards medical related services, supplies, or equipment), dated from 11/2025 to [DATE] was reviewed. The Statement for Share of Cost indicated Resident 8's total balance due was $3,618 as of [DATE]. The BOM stated, Resident 8 was under Public Guardian (PG) 1 and the facility did not receive Social Security benefit money from PG 1 since 11/2025. The BOM stated, she contacted PG 1 many times, but PG 1 kept telling her that this matter was handled by another department investigating this matter.During an interview on [DATE], at 10:56 a.m., with the SSD, the SSD stated, she was not aware of this issue, and no one informed her regarding not receiving payments since 11/2025. The SSD stated, she would have helped Resident 8 out of Public Guardianship since recent H&P indicated that Resident 8 could make her decisions. The SSD stated, she would have taken her to Social Security Office to correct the problems. The SSD stated, Resident 8 should not go through issues such as this.During a telephone interview on [DATE], at 8:39 a.m., with PG1, PG 1 stated, there were discrepancies regarding mailing address and other personal information. PG 1 stated, Social Security Office was holding Resident 8's benefit checks until the information discrepancies cleared out.During an interview on [DATE], at 10:54 a.m., with the DON, the DON stated, the SSD should be proactive with assisting the residents. The DON stated it was SSD's responsibility to assist the residents with all aspects of their lives. The DON stated, PG 1 was difficult to contact and could not solve this Social Security Benefit issues. The DON stated, the SSD should help Resident 8 to regain her decision-making right and resolve this issue.During a review of the facility's Policy and Procedure (P&P) titled, Job Description: Social Service Designee, dated [DATE], the P&P indicated, ESSENTIAL DUTIES AND RESPONSIBILITIES: Assists in the provision of the medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident . Assists residents with financial needs . Conducts in-service programs to educate staff regarding psychosocial issues and patient rights . Must be aware of and understand the needs of the residents.During a review of the facility's Policy and Procedure (P&P) titled, Social Services, revised 9/2021, the P&P indicated, Policy Statement: Our facility provides medically related social services to assure that each resident can attain or maintain his/her (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	highest practicable physical, mental, or psychosocial well-being. Policy Interpretation and Implementation: The director of social services is a qualified social worker and is responsible for meeting or assisting with the medically related social service needs of residents . 3.The facility staff is able to identify and address factors that have a potentially negative effect on psychosocial functioning of a resident, for example: financial needs or problems.During a review of the facility's Policy and Procedure (P&P) titled, GUARDIANSHIP: REFERRAL, undated, the P&P indicated, PROCEDURE: 1. If a resident does not have capacity and there is no responsible party, family member or interested party with legal authority to make decisions, the Social Worker/Social Service Designee will make a referral to the Public Guardian. 2. The Social Worker/Social Services Designee will document referrals to the Public Guardian.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when:The Dietary Supervisor (DS) was unable to verbalize the International Dysphagia Initiative/Level 4 ([IDDSI] level 4 testing process-cohesive, pudding-like foods and liquids that hold their shape on a spoon, require no chewing, and do not flow easily) diet.Cooks (Cook 1 and [NAME] 2) were unable to verbalize proper thawing of food in the sink.Dietary Aide (DA) 1 unable to verbalize Quaternary Ammonium Compounds (QUAT, a chemical used a disinfectant, sanitizer to kill bacteria and viruses) sanitizer ratio with water. These failures had 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 and drinks that are contaminated with germs or chemicals) for 116 of 129 medically compromised residents who received food from the kitchen.Findings:1.During a review of the facility's cook spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Winter Menus, dated 2/23/2026, the spreadsheet indicated residents on puree diet/International Dysphagia Initiative/Level 4 would include the following foods on the tray:Pureed three (3) bean chili one (1) cup (c, household measurement)Pureed tossed green salad 1/3 cPureed corn bread with green chilis 1/4 cMargarine (pureed with bread)Pudding 1/3 cMilk four (4) ounces (oz, a unit of measurement)During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 2/23/2026 at 1:15 p.m. of the puree diet with the DS and Registered Dietitian (RD), it was observed that the puree Jello had lumps. The DS stated puree foods should be an applesauce-like consistency and smooth to swallow. The DS stated they would know the puree food was in the right consistency by seeing and tasting the food. The DS stated she could not think of any other test they performed to identify the food was in proper texture and consistency. The DS stated she was the one providing in-services to the staff with the RD.During a review of the facility's diet manual (a manual containing different diets descriptions, foods allowed and avoided and sample menus the facility have) titled IDDSI Level 4: Regular Pureed Diet, dated 3/15/2025, the diet manual indicated, The pureed diet is a regular diet that has been designed for resident who have difficulty chewing and/or swallowing. The texture of the prepared 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. All foods are to be prepared in a blender. This diet has texture specifications that must pass IDDSI Level #4 testing requirements. IDDSI Testing Requirements: The finished puree food item must pass IDDSI Level #4 testing requirements (i.e. appearance, fork drip, and spoon tilt tests).During a review of the facility's job description (JD) titled, Job Description: Dietary Supervisor, dated 2019, the JD indicated, Qualifications: Have a thorough knowledge of food service supervision, therapeutic diets, and leadership skills. Responsibilities: Directs the food service operation following the facility and Dietary Policy and Procedure Manuals. (10) Ensures residents receive the proper food items to meet their dietary needs and that food is served at the appropriate temperature for safety and palatability.During a review of the facility's checklist titled, Competency Checklist, dated 2/16/2026, the checklist indicated, DS was able to demonstrate how prepare or assist in meal preparation according to menus and recipes provided. The checklist did not specifically indicate competencies for IDDSI testing methods.2. During an observation on 2/24/2026 at 10:34 a.m. of the preparation sink, it was observed that the dietary staff thawed chicken in the kitchen sink.During an interview on 2/25/2026 at 10:25 a.m. with [NAME] 1, [NAME] 1 stated she was the one thawing the chicken in the sink yesterday and it came from the refrigerator then she thawed it in the sink with running water. [NAME] 1 stated they pull the chicken out from freezer to the refrigerator two (2) days before use which was 2 days ago then thawed it in the preparation sink from (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:00-11:00 am. [NAME] 1 stated she cooked the chicken around 1:00 p.m. to 1:30 p.m. [NAME] 1 stated she did not check the temperature of the chicken during thawing and before cooking and there was no log for it., [NAME] 1 stated she has not attended in-services for thawing of food. During a concurrent observation and interview on 2/25/2026 at 10:34 a.m. of the preparation sink with [NAME] 2, turkey and tilapia was observed thawing under a running water. [NAME] 2 stated the tilapia, and turkey came from the freezer, and it has been out for 45 minutes, and these foods are for today's use.During an interview on 2/25/2026 at 10:35 a.m. with the DS, the DS stated their process of thawing is pulling the food from the freezer and it stayed in the refrigerator for a maximum of three (3) days and thawing in the sink under a room temperature running water. The DS stated the dietary staff feel the meat from the refrigerator if it's thawed all the way and if it's not, they could thaw it in the sink.During an interview on 2/25/2026 at 10:41 a.m. with the RD, the RD stated the dietary staff thaw food the night before from the freezer to the refrigerator then transfer it to the sink with cold water for 1-2 hours before cooking. The RD stated she did not train the dietary staff to log time and temperature during thawing process in the sink.During an interview on 2/25/2026 at 10:43 a.m. with the DS, the DS stated the dietary staff should thaw food in a manner that is safe and the temperature of the food should not go above 40 F as the bacteria could start growing and multiply causing foodborne illnesses.During an interview on 2/25/2026 at 10:52 a.m. with the RD, the RD stated the safest way to thaw is under the refrigerator with a food temperature under 41 F and below. The RD stated the dietary staff should be thawing in the sink under cold running water with a temperature of 70 F or below for a maximum of 2 hours.During a concurrent observation and interview on 2/25/2026 at 11:12 a.m., of the preparation sink with the RD, the DS and [NAME] 2, observed the RD took the temperature of the running water used to thaw the fish. The RD stated the water temperature was at 77 F and it should be below 70 F. [NAME] 2 stated she took the fish out from the refrigerator at 10:00 a.m. and she did not take the temperature because it was still frozen. The temperature of the fish was observed at 69 F. The RD stated the fish was not safe to cook because the water temperature was above 70 F. The RD stated the hot water knob was turned on during the thawing process, that was why the water used for thawing was hot. During a review of the facility's P&P titled, Thawing Food, dated 3/15/2025, the P&P indicated, All food will be thawed in a safe and sanitary manner. (2) Under potable, running water at a temperature 70 F or lower, with sufficient velocity to agitate and float off loose food particles into the overflow. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.13 Except specified in (D) of this section, Time/Temperature control for safety food shall be thawed: (B) Completely submerged under running water: (1) At a water temperature of 21 C (70 F) or below. (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (4) For a period of time does not allow thawed portions of a raw animal food requiring cooking as specified under 3-401.11 (A) or (B) to be above 41 for more than 4 hours including (a) the time the food is exposed to the running water and the time needed for preparation for cooking or (b) the time it takes under refrigeration to lower the food temperature to 5 C (41 F).During a review of the facility's JD, titled Dietary [NAME] Job Description, dated and signed by [NAME] 2 on 10/1/2017, the JD indicated, Essential Duties and Responsibilities: Prepares all foods according to the menu and standardized recipes in a safe and sanitary manner.During a review of the facility's checklist titled, titled Dietary Competency Checklist, dated 10/20/2025 and 2/16/2026, the checklist indicated [NAME] 2 was able to demonstrate proper thawing of food.During a review of facility's records titled Record of Inservice Training dated 3/2025 to 1/5/2026, the records indicated there was no training about thawing process.3.During a concurrent observation and interview on 2/24/2026 at 2:35 a.m. with DA 1, DA 1 stated the red bucket contained QUAT sanitizer for sanitizing the cart. DA 1 stated he pours the QUAT sanitizer to cold water in the red bucket with a ratio of five (5) liters of water is to 75 milliliters (ml, a unit of measurement) of QUAT sanitizer.During an interview on 2/24/2026 at 2:50 a.m. with the DS, the DS stated the ratio of QUAT sanitizer to water is four (4) quarts of water is to 7.5 ml based on manufacturer's guidelines. The DS stated using 5 quarts of (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water to 7.5 ml ratio would be diluted and the solution would not be effective to get 200-400 parts per million (ppm, a unit of concentration) concentration of the sanitizer. The DS stated the sanitizer concentration would be below 200 ppm, and it would not sanitize the surface right, causing foodborne illnesses and viruses to the residents.During a review of the facility's P&P titled Red Bucket (Quaternary Ammonium Sanitizer) Policy, dated 3/15/2025, the P&P indicated, To ensure proper preparation, use, monitoring, and disposal of quaternary ammonium (QUAT) sanitizer used in red sanitizer buckets for food contact surfaces in the kitchen. Red sanitizer buckets containing QUAT solution will be used for wiping cloth storage and sanitizing food contact surfaces during food preparation and service. The solution will be prepared according to manufacturer instructions and maintained at safe and effective concentration (200-400 ppm). Preparation: Red buckets must be clearly labeled SANITIZER. Fill bucket with 1 gallon of water. Add 1/2 -1 tablespoon of Sani-Tech QUAT sanitizer per gallon (per manufacturer instructions. Mix thoroughly.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.During a review of the facility's JD titled Dietary Aide/Dishwasher Job Description, dated and signed by DA 1, the JD indicated Essential Duties and Responsibilities: Follows all policies and procedures regarding sanitation, safety, and fire prevention.During a review of the facility's checklist titled Dietary Infection Prevention Competency Checklist, dated 2/16/2026, the checklist indicated DA 1 was able to demonstrate the ability to identify appropriate ppm and/or bleach but there was no competency on how to mix QUAT sanitizer to water.During a review of facility's records titled Record of Inservice Training dated 3/2025 to 1/5/2026, the records indicated there was no training about mixing QUAT sanitizer ratio to water.

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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 follow the methods that conserved appearance and temperature for lunch when hot food (chili) served on paperwares was not hot, cold foods were not served cold, and tossed green salad was watery.This failure had the potential to result in decrease in food intake to 116 of 129 residents on regular and therapeutic diets, resulting in unplanned weight loss.Findings:During a review of the facility's cook spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Winter Menus dated 2/23/2026, the spreadsheet indicated residents on regular and therapeutic diets would include the following foods on the tray:Three bean chili one (1) cup (c, a household measurement)Tossed green salad 1/2 cSalad dressing 1/2 ounces (oz, a unit of measurement)Cornbread with green chilis 1 pieceCitrus chiffon delight 2x2 1/2 inch 1 pieceMilk 4 ozDuring a test tray process (a process of tasting, temping, and evaluating the quality of food) observation on 2/23/2026 at 12:58 p.m. of the regular diet with the Dietary Supervisor (DS), observed the DS took the temperature of the foods, using the facility thermometer, with temperatures as follows:Chili 120 degrees Fahrenheit (F, a scale of temperature)Corn bread 84 F.Citrus chiffon delight 60 F.Tossed green salad 64 F.During a test tray process observation on 2/23/20206 at 1:02 p.m. of the puree diet with the DS, observed the DS took the temperature of the foods, using a facility thermometer with temperature as follows:Puree chili 94 FPuree salad 56 FPuree citrus chiffon delight 52 F.During an interview on 2/23/2026 at 12:53 p.m. with the DS and the Registered Dietitian (RD), the DS stated the chili was served on paperware and it did not hold heat. The DS stated the food temperatures were affected because the food was not hot and residents could lose their appetite and weight loss in the long run as a potential outcome. During a concurrent observation and interview on 2/23/2026 at 1:30 p.m. with the DS, it was observed that the tossed green salad was drenched (wet thoroughly) with liquid. The DS stated the recipe for the tossed green salad to mix with the salad dressing during preparation. The DS stated the tossed salad was watery and it should not be watery. The DS stated the lettuce was soggy and the liquid in the salad came from the lettuce. The DS stated the salad should have dressings, but it should not be soggy (wet and soft). The DS stated salad would have less nutrition because it was watery and residents would eat less or would not eat it as a potential outcome.During a review of the facility's policies and procedures (P&P) titled Food Preparation Policy dated 3/15/2025, the P&P indicated, Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. All meals must comply with the physician-ordered diet, approved menu, and portion control standards to ensure consistency, adequate nutrition, and regulatory compliance. (1) All food will be prepared by methods that preserve nutritional value, flavor, and appearance, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident.During a review of the facility's P&P titled Menu, dated 3/15/2025, the P&P indicated, (5) Menus will be prepared as written using standardized recipes. The dietary service supervisor and cooks are trained and responsible for the preparation and service of therapeutic diets prescribed.

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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 food in a form designed to meet individual needs when pureed chili was too sticky and left a thick film during a spoon tilt test (a method used to determine the stickiness of food and ability of the food to hold together) and pureed tossed salad was too watery. These failures had the potential to result in difficulty in swallowing, decrease in food and nutrient intake to 13 of 129 residents on puree diet, resulting in unintended (not planned) weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs).Findings:During a review of the facility's cook spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Winter Menus, dated 2/23/2026, the spreadsheet indicated residents on puree diet/International Dysphagia Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4 (foods that are soft and pudding like consistency) would include the following foods on the tray:Pureed three (3) bean chili one (1) cup (c, household measurement)Pureed tossed green salad 1/3 cPureed corn bread with green chilis 1/4 cMargarine (pureed with bread)Pudding 1/3 cMilk four (4) ounces (oz, a unit of measurement)During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 2/23/2026 at 1:15 p.m. of the puree diet with the Dietary Supervisor (DS) and the Registered Dietitian (RD),it was observed that the puree Jello had lumps in it. The DS stated puree foods should be an applesauce-like consistency and smooth to swallow. The DS stated they would know the puree food was in the right consistency by seeing and tasting the food. The DS stated she could not think of any other test they performed to identify the food was in proper texture and consistency. The DS stated she was the one providing in-services to the staff with the RD.During an interview on 2/23/2026 at 1:19 p.m. with the RD, the RD stated they used spoon tilt test to check puree food consistency and puree foods should have no clumps, grains with little to no residue on the spoon. The DS stated the puree food should retain its shape. The RD performed a spoon tilt test for the puree chili and stated there was a lot of puree chili sticking on the spoon. The RD stated the puree salad was a bit runny and it should not look like it was lying flat on the plate. The DS stated the Jello looked like it was regular Jello because it was lumpy. The DS stated residents on puree diets could have aspirated (accidental breathing in of food and liquid into the airway and lungs) and choked on the food if the puree food was not on the right texture and consistency. The DS stated they performed a spoon tilt test during the food preparation and corrected the food texture and consistency if there were issues, however, they do not do the spoon tilt test after food preparation.During a review of the facility's policies and procedures (P&P) titled Menus, dated 3/15/2025, the P&P indicated, Twenty-eight-day cycle menus are prepared by the dietitian and modifications of individual resident menus are made as necessary to comply with physician orders and or resident preferences.The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amounts at each meal, and a standardized food production. The menus will be prepared as written using standardized recipes.During a review of the facility's diet manual (a manual containing different diets descriptions, foods allowed and avoided and sample menus the facility have) titled IDDSI Level 4: Regular Pureed Diet, dated 3/15/2025, the diet manual indicated, The pureed diet is a regular diet that has been designed for resident who have difficulty chewing and/or swallowing. The texture of the prepared 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. All foods are to be prepared in a blender. This diet has texture specifications that must pass IDDSI Level #4 testing requirements. IDDSI Testing Requirements: The finished puree food item must pass IDDSI Level #4 testing requirements (i.e. appearance, fork drip, and spoon tilt tests).During a review of the facility's standardized recipe titled Recipe: 3 Bean Chili (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 2025, the recipe indicated, IDDSI #4 Puree 1 cup. Puree following recipes in the Food Safety/Misc. section of Book 1. Utilize the critical test and IDDSI audit to confirm texture meets level #4 specification.During a review of the facility's standardized recipe titled Recipe: Pureed (IDDSI Level 4) Salad, the recipe indicated, (3) 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 pureed item must pass IDDSI level 4 testing requirements (i.e. the fork drip, fork pressure, and spoon tilt tests).During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline 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:One (1) of four (4) racks in the walk-in refrigerator had rust and amber discoloration.Kitchen equipment and utensils were not free from dirt, dust and food debris.Vent in the walk-in refrigerator had dust buildup.Walk-in refrigerator wall had dressing spillsWalk-in freezer wall had a black dirt spill coming from the ceiling and the racks had dirt, dust, and food particles in the walk-in freezer.Corn starch spilled into the lentil's container.Pans had burnt plastic debris and sticker residue.Two (2) of three (3) food warmers had food and dirt debris.Six (6) of 6 dented cans were stored with non-dented cans.Pots and pans were stacked wet in the storage area.Staff were thawing fish under water temperature of 77 degrees Fahrenheit (F, a scale of temperature) and fish was at 67 F. There was no temperature and time monitoring during thawing. Staff did not use the proper Quaternary Ammonium Compounds (QUAT, a chemical used a disinfectant, sanitizer to kill bacteria and viruses) sanitizer dilution.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 116 of 126 medically compromised residents who received food and ice from the kitchen. Findings: 1.During an observation on 2/23/2026 at 8:52 a.m. of the walk-in refrigerator, 1 of 4 racks was observed with amber discoloration. During an interview on 2/23/202026 at 9:06 a.m. with the Dietary Supervisor (DS), the DS stated the rack has rust. During an interview on 2/23/2026 at 9:19 a.m. with the DS, the DS stated the rust from the rack could go to the food and could cause cross-contamination. During a review of the facility's policies and procedures (P&P) titled Sanitizing Equipment and Surfaces, dated 3/15/2025, the P&P indicated, (6) Dietary staff should ensure that all equipment, shelves, serving utensils, utility carts, cutting boards, vents, and surface areas are clean and in good condition. (7) Dietary staff should notify maintenance of any issues using the maintenance log sheet. 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. 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.a. During an observation on 2/23/2026 at 8:52 a.m. of the walk-in refrigerator, observed the vent had dirt buildup. During an interview on 2/23/2026 at 9:14 a.m. with the DS, the DS stated the refrigerator vents are cleaned by maintenance once a week. During an interview on 2/23/2026 at 9:16 a.m. with the Registered Dietitian (RD), the RD stated the last time the maintenance staff cleaned the vent was two weeks ago however, there were still dark spots, dirt, dust buildup and mold. During an interview on 2/23/2026 at 9:19 a.m. with the DS, the DS stated they needed to clean the vent because they store food in the refrigerator. The DS stated the vent is blowing air and it could blow dust the food causing cross-contamination. The DS stated residents could get sick of nausea, vomiting and diarrhea as a potential outcome. b. During an observation on 2/23/2026 at 8:52 a.m. of the walk-in refrigerator, the refrigerator wall was observed with food spills on it. During an interview on 2/23/2026 at 9:04 a.m. with the DS, the DS stated there was a dressing spill and it should be cleaned. The DS stated dietary staff clean two times a week and they wipe spills as soon as they drop something. c. During an observation on 2/23/2026 at 8:57 a.m. of the walk-in freezer, the freezer wall was observed with (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dried up black liquid spills and the racks have dirt, dust and food particles. During an interview on 2/23/2026 at 9:12 a.m. with the DS, the DS stated freezer racks had food debris, and the wall had a black water residue coming from the ceiling. The DS stated the liquid was dripping from the top and it's black and it was dirt. d. During a concurrent observation and interview on 2/23/2026 at 9:48 a.m. of the lentil storage container with the DS, the container was observed with white powder looking spill. The DS stated the corn starch spilled in the lentil container and it could cause cross-contamination. The DS stated the dietary staff should have cleaned right away when they spilled it. The DS stated residents allergic to corn starch who ate lentil could get anaphylactic reaction (allergic reaction causing breathing difficulties, low blood pressure, and shock) as a potential outcome. The DS stated the spilled corn starch could attract pests and can nibble on the corn starch. The DS stated the pest could cause infection to the residents. e. During an observation on 2/24/2026 at 10:27 a.m. of the pots and pans storage rack, the pans were observed with dirt debris. During an observation on 2/24/2026 at 10:28 a.m. of the food container stored in the clean area, the food container was observed with sticky residue. During a concurrent observation and interview on 2/24/2026 at 10:42 a.m. of the storage area for clean pans with DS, pans were observed wet. The DS stated the pans had dried up plastic and it should have been scrubbed and cleaned before storing to prevent cross-contamination. The DS stated the food container had sticker and the dietary staff forgot to remove it during dishwashing. f. During an observation on 2/24/2026 at 10:31 a.m. of the plate warmer, observed the plate warmer have dirt debris. During a concurrent observation and interview on 2/24/2026 at 10:53 a.m. of the plate warmer, 2 of 3 plate warmers used for plate storage were observed with dirt debris on them. The DS stated there was dirt and food debris in the plate warmer and it should have been clean after every use and it should be free from debris. The DS stated dirt debris in the plate warmer could cause cross contamination and residents could get sick of nausea, vomiting and diarrhea as a potential outcome. During a review of the facility's P&P titled Refrigerator and Freezer, dated 3/15/2026, the P&P indicated, The refrigerator and freezer area will be clean, dry, well-ventilated at all times. During a review of the facility's P&P titled Sanitizing Equipment and Surfaces, dated 3/15/2025, the P&P indicated, Sanitizing solution will be used to sanitize equipment and surfaces after each use or as often as needed. During a review of the facility's P&P titled Storage of Canned and Dry Goods, dated 3/15/2025, the P&P indicated, Food and supplies will be stored properly and in a safe manner. (1) The storage area will be clean, dry, well ventilated at all times. (8) Storage area will be cleaned regularly and checked for any evidence of pests. During a review of Food Code 2022, 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. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At anytime when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306. 3. During a concurrent observation and interview on 2/23/2026 at 9:27 a.m. of the dry storage area with the DS, a dented can was observed stored with non-dented cans. The DS stated dented cans are separated in the dented cans area by the entrance door. The DS stated they should not have found dented cans with the non-dented can because if the can is dented it could cause botulism (food poisoning caused by bacteria growing in dented cans). The DS stated botulism is when the can is dented it could be open and bacteria could come in and grow. The DS stated if residents consumed foods from the dented cans, the residents could get hospitalized and get sick. During an interview on 2/23/2026 at 9:30 a.m. with the RD, the RD stated when a can is dented there is a chemical reaction that could cause botulism causing double vision, paralysis and if not treated it could lead to death. During a concurrent observation and interview on 2/23/2026 at 9:38 a.m. of the dry storage area, observed 6 dented cans stored with non-dented cans. The DS stated the dented cans should not be stored with non-dented cans and dented cans include dents on the rim of the cans. During a review of the facility's P&P titled, Storage of Canned and Dry Goods, dated 3/15/2026, the P&P indicated, Canned items should be inspected for damage such as dented, leaking or bulging cans. These items will be stored separately in the designated area-DENTED CANS for return to the vendor or disposed of properly. During a review of the facility's P&P titled, Safe Food Transfer and Cross-Contamination Prevention Policy, dated 3/15/2025, the P&P indicated, All canned food products must be transferred to clean, sanitized containers in a way that prevents any risk of cross-contamination to ensure the health and safety of residents. (2). Inspecting the can: all cans must be checked for swelling, dents, rust, or signs of contamination. Damaged or expired cans must be discarded per facility policy. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 4. During an observation on 2/24/2026 at 10:32 a.m. of the pots and pans storage area, pans were observed stacked wet. During an interview on 2/24/2026 at 10:46 a.m. with the DS, the DS stated the dishes needed to be air dried before storing. The DS stated the pans could not be stacked wet because the chemicals could still be in there and it would not be safe to use due contamination. During an interview on 2/24/2026 at 10:50 a.m. with the RD, the RD stated if the pots and pans were not properly air dried, water could pull out in the dish and bacteria could build up. The DS stated there were still water particles on the pans and they were stacked wet and not properly air dried. The DS stated resident could get sick as a potential outcome. During review of the facility's P&P titled Dishwashing Procedures-Dish machine, dated 3/15/2026, the P&P indicated, Dishes will be properly sanitized through the dish machine. The dish machine will be kept clean and in good condition. (5). Dishes, utensils, pots and pans will be air dried before storage. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. 5. During an observation on 2/24/2026 at 10:34 a.m. of the preparation sink, dietary staff was observed thawing chicken in the kitchen sink. During an interview on 2/25/2026 at 10:25 a.m. with [NAME] 1, [NAME] 1 stated she was the one thawing the chicken in the sink yesterday and it came from the refrigerator then she thawed it in the sink with running water. [NAME] 1 stated they pull the chicken out from freezer to the refrigerator two (2) days before use which was 2 days ago then thawed it in the preparation sink from 10:00-11:00 am. [NAME] stated she cooked the chicken around 1:00 p.m. to 1:30 p.m. [NAME] 1 stated she did not take the temperature of the chicken during thawing and before cooking and there was no log for it., [NAME] 1 stated she has not attended in-services for thawing of food. During a concurrent observation and interview on 2/25/2026 at 10:34 a.m. of the preparation sink with [NAME] 2, observed turkey and tilapia thawing under a running water. [NAME] 2 stated the tilapia, and turkey came from the freezer, and it has been out for 45 minutes, and these foods are for today's use. During an interview on 2/25/2026 at 10:35 a.m. with the DS, the DS stated their process of thawing is pulling the food from the freezer and it stayed in the refrigerator for a maximum of three (3) days and thawing in the sink under a room temperature running water. The DS stated the dietary staff feel the meat from the refrigerator if it's thawed all the way and if it's not, they could thaw it in the sink. During an interview on 2/25/2026 at 10:41 a.m. with the RD, the RD stated the dietary staff thaw food the night before from the freezer to the refrigerator then transfer it to the sink with cold water for 1-2 hours before cooking. The RD stated she did not train the dietary staff to log time and temperature during thawing process in the sink. During an interview on 2/25/2026 at 10:43 a.m. with the DS, the DS stated the dietary staff should thaw food in a manner that is safe and the temperature of the food should not go above 40 F as the bacteria could start growing and multiply causing foodborne illnesses. During an interview on 2/25/2026 at 10:52 a.m. with the RD, the RD stated the safest way to thaw is under the refrigerator with a food temperature under 41 F and below. The RD stated the dietary staff should be thawing in the sink under cold running water with a temperature of 70 F or below for a maximum of 2 hours. During a concurrent observation and interview on 2/25/2026 at 11:12 a.m. of the preparation sink with the RD, the DS and [NAME] 2, observed the RD took the temperature of the running water used to thaw the fish. The RD stated the water temperature was at 77 F and it should be below 70 F. [NAME] 2 stated she took the fish out from the refrigerator at 10:00 a.m. and she did not take the temperature because it was still frozen. Observed the temperature of the fish at 69 F. The RD stated the fish was not safe to cook because the water temperature was above 70 F. The RD stated the hot water knob was turned on during the thawing process, that was why the water used for thawing was hot. During a review of the facility's P&P titled, Thawing Food, dated 3/15/2025, the P&P indicated, All food will be thawed in a safe and sanitary manner. (2) Under potable, running water at a temperature 70 F or lower, with sufficient velocity to agitate and float off loose food particles into the overflow. During a review of Food Code 22, dated 1/18/2023, the Food Code 2022 indicated, 3-501.13 Except specified in (D) of this section, Time/Temperature control for safety food shall be thawed: (B) Completely submerged under running water: (1) At a water temperature of 21 C (70 F) or below. (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (4) For a period of time does not allow thawed portions of a raw animal food requiring cooking as specified under 3-401.11 (A) or (B) to be above 41 for more than 4 hours including (a) the time the food is exposed to the running water and the time needed for preparation for cooking or (b) the time it takes under refrigeration to lower the food temperature to 5 C (41 F). 6. During a concurrent observation and interview on 2/24/2026 at 2:35 a.m. with Dietary Aide 1 (DA 1), DA 1 stated the red bucket contained QUAT sanitizer for sanitizing the cart. DA 1 stated he pours the QUAT sanitizer to cold water in the red bucket with a ratio of 5 liters of water is to 75 ml of QUAT sanitizer During an interview on 2/24/2026 at 2:50 a.m. with the DS, the DS stated the ratio of QUAT (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitizer to water is 4 quarts of water is to 7.5 ml based on manufacturer's guidelines. The DS stated using 5 quarts of water is to 7.5 ml ratio would be diluted and the solution would not be effective to get 200-400 parts per million (ppm, a unit of concentration) concentration of the sanitizer. The DS stated the sanitizer concentration would be below 200 ppm, and it would not sanitize the surface right causing foodborne illnesses and viruses to the residents. During a review of the facility's P&P titled Red Bucket (Quarternary Ammonium Sanitizer) Policy, dated 3/15/2025, the P&P indicated, To ensure proper preparation, use, monitoring, and disposal of quarternary ammonium (QUAT) sanitizer used in red sanitizer buckets for food contact surfaces in the kitchen. Red sanitizer buckets containing QUAT solution will be used for wiping cloth storage and sanitizing food contact surfaces during food preparation and service. The solution will be prepared according to manufacturer instructions and maintained at safe and effective concentration (200-400 ppm). Preparation: Red buckets must be clearly labeled SANITIZER. Fill bucket with 1 gallon of water. Add 1/2 -1 tablespoon of Sani-Tech QUAT sanitizer per gallon (per manufacturer instructions. Mix thoroughly. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control measures by failing to:A. Ensure a visitor was wearing Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) properly for Resident 35 who was on Enhanced Barrier Precaution [EBP-an infection control measures, primarily in nursing homes, requiring staff to wear gowns and gloves during high-contact care for residents with multidrug-resistant organisms or increased risk factors like wounds/devices, expanding beyond Standard Precautions to prevent multidrug-resistant organism(MDRO) spread where direct contact is likely].B. Ensure padded side rails that were wrapped with porous (having minute spaces or holes through which liquid or air may pass) foams were disinfected properly for Resident 59.C. Prevent spread of infection for Resident 37 when yankauer (a rigid, commonly disposable oral suctioning instrument) was observed on the floor. ([NAME])D. Ensure one Certified Nurse Assistant (CNA) performs hand hygiene when she goes from one resident's room to another resident's room. ([NAME])This failure had the potential to result in compromised infection control measures to prevent the spread of infection among residents, staff, and visitors.Findings: A. During a review of Resident 35's admission record, the admission record indicated Resident 35 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with sepsis (a life-threatening blood infection), Extended Spectrum Beta Lactamase infection (infection that caused by bacteria resistant to many common antibiotics), and cellulitis (a skin infection that causes swelling and redness)of left lower extremities. During a review of Resident 35's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 35 was able to make needs known and Resident 35's family member was the power of Attorney (POA- a legally appointed agent who has authority to act on behalf of the resident) to make medical decisions. During a review of Resident 35's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 35 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, bed mobility, maximal assistance (Helper does more than half the effort) from one staff for dressing, shower, toilet hygiene, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance) from one staff for eating. During a review of Resident 35's Order Summary Report (OSR), dated [DATE], the OSR indicated, place Enhanced Barrier Precaution Colonized ESBL was ordered on [DATE]. During a review of Resident 35's Care Plan Report (CPR) titled, Enhanced Barrier Precaution: High risk for infection and history of colonization with ESBL, revised [DATE], the CPR Goal indicated, reduce risk for active infection daily for three months. The CPR Interventions indicated, post signage for EBP and provide gloves, gowns, and masks. During a concurrent observation and interview on [DATE], at 10:14 a.m., with Resident 35's Family Member (FM) 1 in Resident 35's room, FM 1 was at the bedside and did not wear any PPE such as gloves, mask, and gowns. FM 1 was holding Resident 35's hands and stroking Resident 35's hair. FM 1 stated, he did not see EBP signage (signage informing persons entering the room to wear PPE to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent exposure to an infection) at the entrance and did not realize the EBP signage was on the wall. FM 1 stated, the facility staff did not inform him of the importance of wearing PPE. During an interview on [DATE], at 10:20 a.m., with Licensed Vocational Nurse (LVN) 2 in Resident 35's room, LVN 2 stated, she should have educated FM 1 regarding wearing PPE in EBP room. LVN 2 stated, there was EBP signage in the room on the wall above the head of Resident 35's bed, but there was no signage outside of the room. LVN 2 stated, the staff forgot to wear PPE. LVN 2 stated, all visitors and the staff should wear PPE to prevent infection from spreading. During an interview on [DATE], at 10:18 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated, the staff and visitors should wear mask, gown, and gloves before performing high contact activities such as bathing, hygiene care, changing, transferring, and touching to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) when they were caring for the residents who were on EBP. The IPN stated, the staff should have provided education to visitors and asked them to wear PPE as well. During an interview on [DATE], at 10:44 a.m., with the Director of Nursing (DON), the DON stated, PPE should be worn correctly according to different types of isolation. The DON stated, Resident 35 met the criteria for EBP due to history of colonization (the presence, growth, and multiplication of microorganisms [bacteria, fungi, viruses] on or in a host) of high risk infection such as ESBL and sepsis which was invasive line and EBP required to wear mask, gown, and gloves before performing high contact cares that required touching the residents. The DON stated, the staff and visitors must wear proper PPE to protect themselves and vulnerable residents. During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, dated [DATE], the P&P indicated, Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. Policy Interpretation and Implementation: 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity . 12. Residents, families and visitors are notified of the implementation of EBPs throughout the facility. During a review of the facility's P&P titled, Personal Protective Equipment, revised 10/2018, the P&P indicated, Policy Interpretation and Implementation: 4. PPE required for transmission-based precautions is maintained outside and inside the resident's room, as needed . 7. Visitors and residents who are asked to comply with transmission-based precautions are educated on the proper use of PPE and provided with equipment at no charge. B. During a review of Resident 59's admission record, the admission record indicated Resident 59 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and urinary tract infection (UTI- an infection in the bladder/urinary tract) During a review of Resident 59's H&P, dated [DATE], the H&P indicated, Resident 59 was able to make decisions for activities of daily living. During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, hygiene, (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:Obtain an informed consent (a process during which residents or caregivers are educated regarding the potential risks and benefits of medication therapy) from the resident or their authorized responsible party (RP - a person delegated to make medical decisions for the resident in the event they are unable to do so) prior to treatment with Abilify (a medication used to treat mental illness) for one of five residents sampled for unnecessary medications (Resident 2.)Obtain a new informed consent pursuant to a dosage increase for Cymbalta (a medication used to treat mental illness) for one of five residents sampled for unnecessary medications (Resident 111.)These deficient practices of failing to obtain informed consent prior to initiating treatment with psychotropic (medications that affect brain activities associated with mental processed and behavior) medications could have prevented Residents 2 and 111 from exercising their right to decline treatment with Abilify and Cymbalta, respectively and had the potential for increased risk that Residents 2 and 111 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to Abilify or Cymbalta leading to impairment or decline in their mental or physical condition or functional or psychosocial status.Findings:A. During a review of Resident 2's admission Record (a record containing diagnostic and demographic resident information), dated 2/25/26, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness characterized by hearing or seeing things that are not there, mood swings, and paranoia.) The admission Record further indicated that Resident 2 was considered self-responsible and did not have an authorized RP.During a review of Resident 2's History and Physical (H&P - a record of a physician's comprehensive medical assessment and plan) dated 10/17/25, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Order Summary Report (a summary of all current physician orders), dated 2/25/26, the order summary report indicated, on 10/16/25, Resident 2's attending physician prescribed Abilify 5 milligrams (mg - a unit of measure for mass) by mouth twice daily for delusions interfering with daily care causing fear, anger, or stress.During a review of Resident 2's available informed consent documentation for Abilify, dated 1/30/26, the informed consent indicated the facility obtained the informed consent to use Abilify from Resident 2's daughter despite not having her daughter listed as a responsible party.During an interview on 2/25/26 at 10:44 a.m. with the Director of Nursing (DON), the DON stated Resident 2 has been self-responsible, however, recently her physician determined that she did not have the capacity to make or understand decisions. The DON stated the facility failed to properly identify Resident 2's daughter as her authorized representative prior to having her sign the informed consent for the use of Abilify. The DON stated the facility had no record of a conference with Resident 2's daughter to identify her as a responsible party prior to asking for her authorization to use Abilify. The DON stated having someone who is not an authorized representative of the resident sign for informed consent increases the risk that Resident 2 may not be able to exercise her right to opt out of treatment with Abilify. The DON stated this could cause Resident 2 to experience side effects related to Abilify use which could possibly lead to a decline in her quality of life.B. During a review of Resident 111's admission Record), dated 2/25/26, the admission Record indicated Resident 111 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus due to underlying condition with diabetic neuropathy (a medical condition characterized by impaired control of blood sugar levels with nerve pain.)During a review of Resident 111's History and Physical dated 10/23/25, the H&P indicated Resident 111 had the capacity to make healthcare decisions.During a review of Resident 111's Order Summary Report, dated 2/25/26, the order summary report indicated, on 2/24/26, Resident 111's attending physician prescribed Cymbalta 30 mg to give three capsules by mouth (90 mg) once daily for neuropathic pain. During a review of Resident (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	111's most recent informed consent documentation for Cymbalta, dated 5/14/25, the informed consent indicated the facility obtained the informed consent to use Cymbalta from Resident 111 for a dose of 30 mg by mouth twice daily (60 mg total.)During an interview on 2/25/2026 at 10:48 a.m. with the DON, the DON stated the facility failed to obtain a new informed consent when the dosage of Cymbalta was increased in August of 2025. The DON stated this is required because Resident 111 may experience an increase of adverse effects as well which could cause a decline in his quality of life. The DON stated failing to obtain a new informed consent also increased the risk that Resident 111 may not have been able to exercise his right to opt out of the dosage increase. A review of the facility's policy Informed Consent, revised December 2024, indicated .Informed consent for psychotherapeutic drugs. must be renewed. whenever there is an increase in dosage.A review of the facility's policy Psychotropic Medication Use, revised March 2023, indicated Residents (and/or representatives) have the right to decline treatment with psychotropic medications.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor for adverse effects (unwanted or dangerous medication-related side effects) related to the use of Cymbalta (a medication used to treat mental illness) between 11/2/25 and 2/24/26 in one of five residents sampled for unnecessary medications (Resident 111.)The deficient practices of failing to monitor adverse effects related to the use of psychotropic medications (medications that affect brain activities associated with mental processes and behavior) increased the risk that Resident 111 could have experienced adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in his mental or physical condition or functional or psychosocial status.Findings:During a review of Resident 111's admission Record (a record containing diagnostic and demographic resident information), dated 2/25/26, the admission record indicated he was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus due to underlying condition with diabetic neuropathy (a medical condition characterized by impaired control of blood sugar levels with nerve pain.)During a review of Resident 111's History and Physical (H&P - a record of a physician's comprehensive medical assessment and plan) dated 10/23/25, the H&P indicated Resident 111 had the capacity to make healthcare decisions.During a review of Resident 111's physician orders, dated 8/1/25, the physician orders indicated his attending physician prescribed Cymbalta 30 milligrams (mg - a unit of measure for mass) and Cymbalta 60 mg (90 mg daily total) to be taken together once daily for neuropathic pain.During a review of Resident 111's Medication Administration Record (MAR - a record of medication administration and monitoring), indicated the facility did not monitor for adverse effects related to the use of Cymbalta between 11/2/25 and 2/24/26.During an interview on 2/25/26 at 10:48 a.m. with the Director of Nursing (DON), the DON stated the facility failed to monitor the adverse effects of Cymbalta for Resident 111 between 11/2/25 and 2/24/26. The DON stated even when an antidepressant is being used to manage nerve pain, it must be monitored for adverse effects to ensure that the medication is safe and effective. The DON stated failing to monitor for adverse effects increased the risk that Resident 111 may have experienced adverse effects related to Cymbalta possibly leading to a decline in his quality of life. A review of the facility's policy Psychotropic Medication Use, revised March 2023, indicated Psychotropic medication management includes: . adequate monitoring for efficacy and adverse consequences. Residents receiving psychotropic medications are monitored for adverse consequences.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and report a change in condition for one of five sampled residents (Resident 89) when Treatment Nurse (TXN) 1 identified multiple open areas of skin breakdown on the resident's arm, did not complete an assessment or notify the physician.This deficient practice had the potential to delay medical evaluation and treatment and increased the risk of infection for Resident 89 Findings:During an observation on 2/24/2026 at 7:52 a.m. in Resident 89's room, there were multiple open skin breakdown areas on Resident 89's left upper arm.During an observation on 2/25/2026 at 9:16 a.m. in Resident 89's room, there were multiple blood-tinged stains on the resident's left upper sleeve over the multiple areas of skin breakdown.During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was admitted on [DATE] , and readmitted on [DATE] with diagnoses including metabolic encephalopathy (any disease, damage, or malfunction of the brain that alters its structure or function) and Alzheimer's disease (a progressive, irreversible brain disorder that destroys memory and thinking skills over time).During a review of Resident 89's Minimum Data Set (MDS- a resident assessment tool), dated 2/15/2026, the MDS indicated Resident 89's cognitive (functions your brain uses to think, pay attention, process information, and remember things) skills for daily decision making were severely impaired. The MDS indicated Resident 89 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, showering dressings, and personal hygiene.During a concurrent interview and record review on 2/25/2026 at 10:22 a.m. with TXN 1, Resident 89's Non-Pressure Sore Skin Problem Report, for the month of February 2026, were reviewed. TXN 1 stated Resident 89 did not currently have any open skin breakdown on her left upper arm and there was no documentation indicating open wound.During a concurrent observation and interview on 2/25/2026 at 10:31 a.m. in Resident 89's room, with TXN 1, TXN 1 assessed Resident 89's left upper arm. TXN 1 stated there are four open areas of skin breakdowns on the resident's left upper arm. TXN 1 stated she first noticed the areas approximately two days earlier. TXN 1 stated she did not complete an assessment, including measuring the areas, and did not notify the physician. TXN 1 stated she believed reporting the areas to the physician was not necessary because there was no active bleeding. During the observation, TXN1 measured the area of skin breakdown with the following results:Superior - 0.3 x 0.2 centimeters ([cm] a measuring unit for length)Superior-0.2 x 0.2 cmSuperior-0.5 x 0.5 cmInferior -1.0 x 1.0 cmDuring an interview on 2/26/2026 at 9:28 a.m. with the Director of Nursing (DON), the DON stated staff must assess and report any identified open wound immediately, as it represents a change in condition, and that requires prompt physician notification. The DON stated TXN 1 cannot independently determine the severity of the condition or the risk of infection without notifying the physician. The DON stated facility failed to assess and notify the condition of the change of condition.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised February 2021, the P&P indicated following:The nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physician condition.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 Situation, Background, Assessment, Recommendation (SBAR-helps people share important information quickly and clearly) Communication Form.Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: there is a significant change in the resident's physical, mental, or psychosocial status;Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments.If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted.During a review of the facility's job description titled, (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment Nurse (TXN), dated 8/23/2011, the job description stated TXN's essential duties and responsibilities include following:Identify, manage, and treat specific skin disorders and primary and secondary lesions, such as skin abrasions, foot problems such as corns and callouses, decubitus ulcers, bacterial, parasitic and viral skin infections, scaling papular diseases, and benign tumors.Documents any pressure sores or other problems accurately with proper size, stage, site, length, width, depth, presence of drainage, discoloration, etc.Monitors condition changes and properly documents and follows-up as necessary.Reports skin breakdown (new and decline) lo physician and family in a timely manner.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide accurate information in the Minimum Data Set ([MDS], a resident assessment tool) for one of three sampled residents (Resident 37) who had a suctioning machine (a medical device designed to remove obstructions such as mucus, blood, saliva, or vomit from a person's airway, for easier breathing) at the bedside. This deficient practice had the potential to result in inaccurate assessment and services for the residents due to inaccurate MDS assessment and care screening tool practices.Findings:During an observation on 2/23/2026 at 11:16 a.m. in Resident 37's room, Resident 37 was resting in bed with eyes closed. The bedside dresser near Resident 37's bed had a suction machine, with a canister (a medical receptacle used with suction devices to collect bodily fluids and waste during procedures, facilitating safe disposal and infection control), and the tubing with the yankauer device (a rigid, bulb-tipped instrument used to clear blood, saliva, and secretions from the mouth and throat to maintain a clear airway) attached to the canister.During a review of Resident 37's admission Record (face sheet), the admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gastrostomy tube ([G-Tube], a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and hypertension ([HTN], high blood pressure). During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37 was rarely/never understood so the brief interview for mental status cannot be conducted. The MDS indicated Resident 37 was dependent (helper does all the effort to complete the activity) on self-care abilities such as hygiene, showers, and dressing. The MDS indicated Resident 37 was dependent on mobility such as turns and transfers. The MDS indicated Resident 37 did not require suctioning as scheduled or as needed.During a concurrent interview and record review on 2/25/2026 at 2:36 p.m. with the MDS Registered Nurse (MDS RN), the MDS dated [DATE] was reviewed. The MDS RN stated the MDS assessment should have indicated Resident 37 had a suctioning machine at bedside and that he was receiving suctioning as needed. The MDS RN stated the services the facility provides for the residents should be indicated on the MDS assessment. During an interview on 2/26/2026 at 11:37 a.m. with the Director of Nursing (DON), the DON stated the MDS assessment should have been coded as yes for suctioning on an as needed schedule. The DON stated the importance of accurate MDS assessment was that the comprehensive care plan would be initiated from the MDS assessment done on the residents. The DON stated the MDS assessment was how the staff are to provide the care for the residents, and the type of care the residents needed so the MDS assessment should match what the staff are providing for the residents.During a review of the facility's policy and procedures (P&P) titled, Resident Assessments, revised 03/2022, indicated a comprehensive assessment of every resident's needs is made at intervals . the resident assessment coordinator is responsible for ensuring that the interdisciplinary team ([IDT], professionals from multiple disciplines working interdependently in a shared setting to achieve common, patient-centered goals) conducts timely and appropriate resident assessments and reviews. all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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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 failedto develop communication barrier care plans for two out of four sampled residents (Residents 42, 112). to ensure residents' care plans were implemented for two of four sample residents (Resident 9 and 46).These failures affected Resident 9, 42, 46, and 112's care and safety.Findings: 1a. During a review of Resident 42's admission record, dated 6/12/2025, the admission record indicated Resident 42's primary language was Spanish and was admitted to the facility on [DATE] with diagnoses but not limited to diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). During a review of Resident 42's Minimum Data Set (MDS – a comprehensive resident assessment tool), dated 12/18/2025, the MDS indicated Resident 42's preferred language was Spanish. During an interview on 2/25/2026 at 4:15 p.m. with RNS (Registered Nurse Supervisor) 2, RNS 2 stated Resident 42's primary language was Spanish and did not have a communication barrier care plan in their medical record. During an interview on 2/26/2026 at 8:50 a.m. with the MDS Registered Nurse (RN), the MDS RN stated Resident 42 was admitted to the facility on [DATE] and the communication barrier care plan should have been added to the medical record within 21 days of admission per facility policy. The MDS RN stated it was important to have a communication barrier care plan in place for the residents to communicate effectively with the staff. 1b. During a review of Resident 112's admission Record, the admission Record indicated Resident 112 was initially admitted to facility on 9/23/2024 and readmitted on [DATE] with the diagnosis included but not limit to: thrombocytopenia (a condition that low blood platelet count), diabetes (a condition a person's body has trouble controlling the amount of sugar in their blood.) muscle weakness. During a review of Resident 112's Minimum Data Set (MDS, a resident assessment tool) dated 12/23/2025, the MDS indicated Resident 112 preferred language is Spanish, and she needs interpreter to help communicate with a doctor or health care staff. During a review of Resident 112's care plan, the care plan did not indicate that a language barrier care plan was developed for Resident 112. During a concurrent observation and interview on 2/23/2026 at 9:20 a.m. with Assistant Director of Nursing (ADON) in Resident 112's room. Resident 112 was sitting in the wheelchair and trying to ask for help from ADON. ADON stated she does not speak Spanish, and Resident 112's communication board was missing. During an interview on 2/25/2026 at 3:30 p.m. with ADON, ADON stated Resident 112 speaks Spanish. A missing a communication board will cause miscommunication between Resident 112 and staff who do not speak Spanish, and it will negatively impact Resident 112's care and treatment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/2026 at 8:37 a.m. with MDS Supervisor (MDS RN), MDS RN stated Resident 112 had a language barrier, a language barrier care plan is essential for Resident 112. Failing to develop the language barrier care plan can cause miscommunication, delay treatment and negatively impact Resident 112's care and safety. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, the Interdisciplinary Team develops and implements a comprehensive, person-centered care plan for each resident no more than 21 days after admission. 2a. During a review of Resident 9's admission record, the admission record indicated Resident 9 was initially admitted to facility on 3/16/2023 and readmitted on [DATE] with the diagnoses but not limited to diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). anemia (a condition where a person doesn't have enough healthy red blood cells), chronic kidney disease, and schizoaffective disorder (a mental health conditions, schizophrenia can cause someone to have trouble knowing what is real). During a review of Resident 9's Minimum Data Set (MDS – a comprehensive resident assessment tool), dated 12/4/2025, the MDS indicated an active diagnosis of diabetes. During a review of Resident 9's care plan, dated 12/8/2025, the care plan indicated, Resident is at risk for hypoglycemia and hyperglycemia related to diabetes mellitus. During a review of Resident 9's physician's orders, dated 11/4/2025, the orders indicated Resident 9 should get 6 units of lispro (a fast-acting insulin medication used to treat diabetes by controlling blood sugar) before meals and at the bedtime for diabetes if Resident 9's blood sugar is between 200-249 mg/dL (milligrams per deciliter, a unit of measurement). During a review of Resident 9's medication administration record (MAR), dated February 2026, the MAR indicated on 2/16/2026 at 6:30 a.m. Resident 9's blood sugar was 243 mg/dL and lispro was not given to the resident. During an interview on 2/26/2026 at 8:37 a.m. with MDS supervisor (MDS RN), MDS RN stated the nurse did not follow Resident 9's care plan on dated 2/16/2026 when Resident 9's blood sugar level indicated insulin injection needed, but the medication was not given. This could cause harm to Resident 9. MDS RN also stated care plan gives a clear picture to facility staff, it had the details for each resident's need and how to support them safely. 2b. During a review of Resident 46's admission record, the admission Record indicated Resident 46 was initially admitted to facility on 12/30/2024 and readmitted on [DATE] with the diagnoses but not limited to hypertension (high blood pressure), hypertensive heart failure (when long-term high blood pressure forces the heart to work too hard), end stage renal disease (a condition a person's kidney is not working well), and dialysis (a medical treatment that helps clean a person's blood when their kidneys are not working well) During a review of Resident 46's MDS, dated [DATE], the MDS indicated an active diagnosis of hypertension. During a review of Resident 46's physician's orders, dated 11/19/2025, the orders indicated clonidine (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(a medication to help lower blood pressure) 0.2 mg (milligrams, unit of measurement) tablet to be given every 6 hours as needed for high blood pressure, if systolic (the top number in a blood pressure reading) is greater than 160 mmHg (millimeters of mercury, a unit of measurement). During a review of Resident 46's care plan, dated 1/12/2026, the care plan intervention indicated the Resident will be administered prn (given as needed) clonidine 0.2 mg for elevated (high) blood pressure. During a review of Resident 46's MAR, dated February 2026, the MAR indicated: On 2/2/2026 at 6:00 a.m. Resident 46's blood pressure was 197/112 mmHg and clonidine was not given to the resident as order. On 2/21/2026 at 6:00 a.m. Resident 46's blood pressure was 168/88 mmHg and clonidine was not given to the resident as order. During an interview on 2/26/2026 at 8:37 a.m. with MDS RN, MDS RN stated nurse did not follow Resident 46's care plan on dated 2/2/2026 and 2/21/2026 when Resident 46's blood sugar level indicated medication should be given, but it was not. Failing to treat Resident 46's high blood pressure could lead to stroke. MDS RN also stated care plan gives a clear picture to facility staff, it had the details for each resident's need and how to support them safely. During a review of the facility's policy and procedure (P&P) titled, Care Plan, Comprehensive Person-Centered dated 03/2022, the P&P stated facility should develops and implement a comprehensive, person-centered care plan for each resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interviews and record review, the facility failed to ensure the comprehensive person-centered care plan was revised to include the intervention no blood pressure on left arm after one of five sampled residents (Resident 16) received an arteriovenous (av) shunt (device that connects an artery and vein) for hemodialysis (dialysis treatment to clean blood and remove excess fluids because the kidneys failed). This failure had the potential to place the resident at risk for av shunt failure, clotting, and bleeding. During an observation on 02/23/2026 at 3:25 p.m., at Resident 16's bedside, Resident 16 was observed with dialysis access on the left upper arm and right chest. During a review of Resident 16's admission Record (Face Sheet), the admission Record indicated the facility admitted Resident 16 on 8/30/2024 with diagnoses including hypotension (low blood pressure), end stage renal failure (irreversible kidney failure), and dependence on dialysis. During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool) dated 2/6/2026, the MDS indicated Resident 16 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 16's care plan, revised on 1/16/2026, the care plan indicated No blood pressure/intravenous (IV)/intramuscular (IM) blood drawn on Right arm. During a review of Resident 16's care plan, revised on 2/19/2026, the care plan indicated Left upper arm status post (s/p) av shunt placement. During an interview on 2/25/2026 at 9:10 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated, Resident 16's care plan should include no blood pressure on left arm. RN stated, taking blood pressure on left arm could impede blood supply and delay of treatment causing risk of harm to resident. During an interview on 2/25/2026 at 4:20 p.m., with the Director of Nursing (DON), the DON stated the care plan was a guide for nurses to provide safety and cause no harm. The DON stated failing to update Resident 16's care plan could lead to blood pressure being taken to left arm which could cause injury such as clotting and bleeding. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered Policy Statement, dated March 2022, the P&P indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition.

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	056405	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cerritos Vista Healthcare Center	17836 Woodruff Avenue Bellflower, CA 90706

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 112) had a communication board (a tool that helps residents, especially those who have trouble speaking, share their needs. It usually has simple words, pictures, or symbols that residents can point to.) This failure had the potential to negatively affect Resident 112's care and treatment. Findings: During a review of Resident 112's admission Record, the admission Record indicated Resident 112 was initially admitted to facility on 9/23/2024 and readmitted on [DATE] with the diagnosis included but not limit to: thrombocytopenia (a condition that low blood platelet count), diabetes (a condition a person's body has trouble controlling the amount of sugar in their blood.) and muscle weakness. During a review of Resident 112's Minimum Data Set (MDS, a resident assessment tool) dated 12/23/2025, the MDS indicated Resident 112 preferred language is Spanish, and she needs an interpreter to communicate with doctor or health care staff. During a concurrent observation and interview on 2/23/2026 at 9:20 a.m. with Assistant Director of Nursing (ADON) in Resident 112's room. Resident 112 was sitting in the wheelchair and trying to ask for help from ADON. ADON stated she does not speak Spanish, and Resident 112's communication board was missing. During an interview on 2/25/2026 at 3:30 p.m. with ADON, ADON stated Resident 112 speaks Spanish. A missing a communication board will cause miscommunication between Resident 112 and staff who do not speak Spanish, and it will negatively impact Resident 112's care and treatment. During a review of facility's policy and procedure (P&P) titled, Accommodation of Needs Related to Communication Deficits dated 4/2013, the P&P indicated the residents' communication needs will be identified and appropriate intervention will be developed for each resident.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to Identify and to intervene for one of three sampled residents (Resident 6) history of trauma and triggers which may cause re-traumatization (a person encounters a new event or stimulus that triggers them to re-experience the intense stress, emotional distress, and even flashbacks of a previous traumatic event as if it were happening again).This failure had the potential to result in Resident 6 experiencing re-traumatization.Findings:During a review of Resident 6's admission record (Face Sheet), the admission record indicated Resident 6 was admitted initially to the facility on [DATE] and last readmission was on [DATE] with diagnoses including post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), aphagia (a language disorder caused by brain damage that impairs speaking, writing, reading, and understanding), and cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain).During a review of Resident 6's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 6 was able to make decisions for activities of daily living.During a review of Resident 6's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 6 required dependent assistance (Helper does all of the effort) from two or more staff for shower, bed mobility, dressing, transfer, hygiene, and eating.During a telephone interview on [DATE], at 9:16 a.m., with Resident 6's Family Member (FM) 2, FM 2 stated, Resident 6 was a war veteran and was diagnosed with PTSD. FM 2 stated, Resident 6 used to have nightmares about war and startled with loud noises.During a concurrent interview and record review on [DATE], at 11:06 a.m., with the Social Service Director (SSD), Resident 6's Trauma Care Evaluation (TCE), dated [DATE] was reviewed. The TCE was done and signed by the SSD. The TCE indicated, there was no trauma and triggers identified. The SSD stated, she should have assessed and identified the triggers of PTSD and the severity of possible re-traumatization from the triggers to prevent recurrent events. The SSD stated, she could not get much information regarding trauma and its triggers from Resident 6. The SSD stated, she should have contacted Resident 6's psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) and FM 2 to obtain information regarding his PTSD.During a concurrent interview and record review on [DATE], at 3:15 p.m., with the Minimum Data Set Registered Nurse (MDS RN), Resident 6's Care Plan Report (CPR) from [DATE] to [DATE] was reviewed. The CPR indicated, there was no CPR regarding PTSD or Trauma. The MDS RN stated, if there was no care plan for PTSD, Resident 6 was at risk of suffering from re-traumatization due to lack of individualized interventions.During a concurrent interview and record review on [DATE], at 10:44 a.m., with the Director of Nursing (DON), Resident 6's Care Plan Report (CPR) titled, Trauma Informed Care: Ineffective coping related to past trauma incident-Veteran, revised [DATE] was reviewed. The CPR Goal indicated, Resident 6 will have reduced episodes of behavior daily through the next assessment date of [DATE]. The CPR Interventions indicated, implement useful interventions to reduce stress and provide a safe environment. The DON stated, she did not know why the staff was unable to find the CPR for Trauma. The DON stated, when the resident who has PTSD as a part of diagnosis was admitted to the facility, SSD should be assessed for its triggers, and past history to prevent re-traumatization. The DON stated, the care plan could not be resident centered, and resident focused if the trauma assessment was not done correctly. The DON stated, staff should have assessed the residents' PTSD and made the plan of care according to the findings. The DON stated re-traumatization would harm Residents' psychosocial well-being.During a review of the facility's Policy and Procedure (P&P) titled, Trauma Informed and Culturally Competent Care, revised on 8/2022, the P&P indicated, Purpose: To address the needs of trauma survivors by minimizing triggers and/or re-traumatization. Preparation: 2. Nursing staff are trained on trauma screening and assessment tools. 3. All staff are guided in evidence-based organizational and interpersonal (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	strategies that support trauma-informed and culturally competent care. 4. All staff receive orientation and in-service training regarding cultural competency as an aspect of resident centered care . General Guidelines: 3. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. 4. Triggers are highly individualized. Some common triggers may include b. exposure to loud noises, or bright/flashing lights .Resident Assessment: 1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers. 2. Utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments .Resident Care Planning: 1. Develop individualized care plans that address past trauma 2. Identify and decrease exposure to triggers that may re-traumatize the residents. 3. Recognize the relationship between past trauma and current health concerns. 4. Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 140)'s History and Physical (H&P) was completed within 72 hours per the facility policy. This failure had potential to affect Resident 140's care and treatment. Findings:During a review of Resident 140's admission Record, the admission Record indicated Resident 140 was admitted to facility on 12/9/2025 with diagnosis included but not limit to: lymphoma (a type of cancer that starts in a part of the body called the lymphatic system, which helps fight infections), hydrocephalus (a condition where too much cerebrospinal fluid [clear liquid that protects and cushions the brain] builds up inside the spaces of the brain), hypertension (high blood pressure), and seizure (a condition a person to lose control of their body for a short period of time). During a review of Resident 140's MDS dated [DATE], the MDS indicated Resident 140 passed away in the facility on 12/17/2025. During a concurrent interview and record review on 2/24/2026 at 2:50 p.m. with Medical Record Director (MR), Resident 140's H&P dated 12/10/2025 and her physician communication log dated 12/1/2025 to 12/16/2025 were reviewed. The Resident 140's H&P indicated, it was incomplete, and physician did not see Resident 140. Resident 140's physician communication log indicated: On 12/9/2025, Resident 140 was admitted . On 12/10/2025, attending physician was notified Resident 140 need to be seen.On 12/11/2025, attending physician was notified again, Resident 140 need to be seen.On 12/16/2025, Medical Director was notified, Resident had not be seen by her attending physician yet. MR stated attending physician did not complete Resident 140's H&P, it is usually done within 72 hours after admission. During an interview on 2/25/2026 at 9:50 a.m. with Director of Nursing (DON), the DON stated that Resident 140's H&P was not completed within the required 72 hours by the attending physician. If the attending physician was unavailable, the facility should have notified the medical director to ensure timely completion. The DON added that the attending physician should have assessed Resident 140 promptly and accurately so a comprehensive, personˆcentered care plan could be developed. The failure to do so negatively affected Resident 140's care and treatment. During a review of facility policy and procedures (P&P) titled, Physician Visit, dated 1/2004, indicated the physician need to visit and see the resident within 72 hours of admission to completed Resident's H&P.

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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. Based on observation, interview, and record review, the facility failed to accurately account for one dose of alprazolam (a controlled medication used to treat mental illness) 0.5 milligrams (mg - a unit of measure for mass) for one of one residents (Resident 117) in one of four inspected medication carts (Medication Cart 3.)This deficient practice increased the risk of diversion (any use other than that intended by the prescriber) of controlled mediations (medications with a high risk for diversion) and the risk that Resident 117 could have received too much or too little medication due to lack of documentation possibly resulting in serious health complications requiring hospitalization.During a concurrent observation and interview on 2/24/26 at 11:45 a.m. of Medication Cart 3 with the Licensed Vocational Nurse (LVN) 2, the following discrepancies were found between the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication):Resident 117's Controlled Drug Record for alprazolam 0.5 mg indicated there were 11 doses left; however, the medication card contained 10 doses.During a concurrent interview and record review with LVN 2, LVN 2 stated the Controlled Drug Record for Resident 117's alprazolam indicated that there were 11 doses left, however the medication supply contains only 10 doses. LVN 2 stated she administered the missing dose of alprazolam to Resident 117 earlier this morning but failed to sign the dose off on the Controlled Drug Record. LVN 2 stated the Controlled Drug Record must be signed immediately after each dose is administered to the resident. LVN 2 stated failing to sign out doses of controlled medications increases the risk for diversion and possibly providing the medication more often than prescribed which could lead to medical complications. A review of the facility's policy Controlled Substances, revised March 2023, indicated Upon administration. the nurse administering the medication is responsible for recording: .time of administration. signature of nurse administering medications.