STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056413	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain comfortable water temperature between 100 degrees Fahrenheit (F) - 110 F in 2 of 3 shower rooms. In the Shower room [ROOM NUMBER] the temperature was 90 F and the Shower room [ROOM NUMBER] the temperature was 97 F, and the water temperature in the sink in Shower room [ROOM NUMBER] was 74 F. This deficient practice resulted in the resident's complaint of uncomfortable and discomfort when showering. Findings: During a review of Resident 10's admission Record the admission record indicated Resident 10 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including encephalopathy (damage or disease that affects the brain), muscle weakness, Parkinsons disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool) dated 12/30/2025, indicated that Resident 10's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact. During a concurrent observation and interview on 4/13/2026 at 10:20 AM with Maintenance Assistant (MS 1), the water temperature in the Shower room [ROOM NUMBER] was 90 F. MS 1 stated he was going to recheck the temperature since multiple residents had taken showers. MS 1 stated the importance of keeping comfortable water temperatures to ensure residents maintain comfort when taking showers. During an interview on 4/14/2026 at 8:42 AM, Resident 10 stated that the shower rooms water temperature fluctuates between hot and cold. During an observation on 4/14/2026 at 8:55 AM the water temperature in Shower room [ROOM NUMBER] was 94 F, the Shower room [ROOM NUMBER] was 97 degrees F the sink water temperature was 74 F. During a concurrent interview and record review on 4/14/2026 at 9:10 AM the Water Temperature 105 - 120 dated from 3/25/2026 - 4/17/2026 indicated the shower temperatures had not been checked per MS 1 he did not check the shower temperatures for 4/13/2026, and 4/14/2026 because he had not had a chance to do it. MS 1 stated that the log water temperature should be between 105-120 F, but the facility does not log shower temperatures because the sink water temperature is the same temperature as the shower's temperature. During a review of the facility's policy and procedure titled, Monitoring Water Temperatures dated 4/2015, indicated that the acceptable water temperature range for hot tap water was 100 (F) - 110 (F).

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 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 provide appropriate treatment and services to increase, prevent, or maintain ambulation by failing to provide range of motion ([ROM] full movement potential of a joint) and/or ambulation (the act of walking) services to five of seven residents (Resident 33, 10, 3, 6, and 18) reviewed for limited ROM and mobility (ability to move): 1. For Resident 33 the resident failed to: a. Restorative Nurse Assistant (RNA) failed to report to the licensed staff and Director of Nursing (DON 1) the decline in Resident 33's ability to ambulate from January to April 2026. b.Minimum Data Set Nurse Coordinator (MDSNC) failed to inaccurately code that Resident 33's was able to ambulate after she assessed the resident as not able to ambulate. c.The licensed Staff and the MDSNC did not report to the physician that Resident 33's decline in ambulation from January to April 2026. As a result of this deficient practice Resident 33's mobility declined and limited her participation in activities of daily living. 2. For Resident 10, the facility failed to: a. Indicate Resident 10's ambulation distance in the physician's order and the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) records after Resident 33's discharge from Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) on 7/4/2025. b. Provide Resident 10 with ambulation during 7/2025 in accordance with the physician's order, dated 7/4/2025. c. Complete an RNA Weekly Summary (summary of the treatment provided, specific distance, use of assistance devices, endurance or tolerance level, amount of assistance needed) from 7/2025 to 1/2025 in accordance with the facility's policy and procedure (P&P) titled, Standards for Restorative Nursing Program, dated 9/2019. d. Conduct an Interdisciplinary (IDT) Care Conferences to address Resident 10's mobility. e. Provide Resident 10 ROM exercises to both legs and ambulation from 2/1/2026 to 4/15/2026. f.Accurately assess Resident 10's RNA services during the Joint Mobility Assessment ([JMA] brief assessment of a resident's range of motion in each joint of both arms and legs), dated 4/1/2026. 3. For Resident 3, the facility failed to accurately assess Resident 3's left hand ROM during the JMA, dated 4/7/2026. 4. For Resident 6, the facility failed to: a. Provide ROM exercises to Resident 6's legs from 12/30/2026 to 2/25/2026. b.Provide PT and Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) services to improve Resident 6's mobility in accordance with Resident 6's Rehabilitation Screening Form, dated 12/30/2025. c. Conduct an Interdisciplinary (IDT) Care Conference and follow-up on recommendations for PT and OT services to address Resident 6's mobility. 5. For Resident 18, the facility failed to provide a right-hand roll (soft roll positioned in the palm of the hand and fastened with a strap) in accordance with OT recommendations and the physician's order, dated 4/9/2026. These failures had the potential to result in decline of ROM and mobility for Resident 10, 18, and 6. These failures resulted in Resident 3's decline in ROM from within functional limits ([WFL] sufficient joint movement without significant limitation) to moderate-to-severe ROM limitation (25-50 percent [%] available ROM, 50-75% loss of motion) in the left hand without additional interventions. Cross reference F580, F657, F725, F726, and F842. Findings: 1.During a review of Resident 33's admission Record (AR), the AR indicated Resident 33 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including difficulty in walking, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and dementia (a progressive state of decline in mental abilities). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Physical Therapy Evaluation Treatment, dated 9/8/2025 to 10/7/2025, indicated Resident 33's right and lower extremities strength and ROM were within functional limit (Variance due to normal aging process allowed). During a review of Resident 33's Joint Mobility Assessment (evaluates a person's ability to move) dated 9/8/2025, indicated Resident 33's left and right upper and lower extremities were within functional limitation. During a review of Resident 33's Order Summary Report dated 11/3/2025, indicated the RNA to ambulate the resident with front wheel walker (FWW - an assisting device with front wheels to assist in ambulation) every day, five times a week as tolerated every day shift every Monday, Tuesday, Wednesday, Thursday, Friday. During a review of the Physical Therapy (PT) Discharge summary, dated [DATE], indicated that Resident 33 was ambulating with front wheel walker up to 50 feet with two turns and partial/moderate assistance. PT recommended ambulation program with RNA ambulation with FWW five days a week as tolerated. During a review of Resident 33's Care Plan Resident Has Decrease Range of Motion dated 11/10/2025, indicated to be free of further decline in ROM, the facility will provide RNA assisted exercises for ambulation as ordered by the physician, and will refer to rehabilitation department for occupational therapy, physical therapy, speech therapy screening if needed, and will notify change nurse/rehab of any decline. During a review of Resident 33's Joint Mobility assessment dated [DATE], indicated the Resident was on RNA program and no changes on condition, Continue current RNA program as tolerated. During a review of Resident 33's Minimum Data Set (MDS – a resident assessment tool) dated 11/26/2025, the MDS indicated that Resident 33 had no functional impairment on both lower and upper extremities. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 33's MDS, dated [DATE], the MDS indicated that Resident 33's has severely impaired cognitive skills (ability to think, remember, reason and make decisions) and was dependent on staff for personal hygiene, lower body dressing, shower/bathe self, toileting, oral hygiene. The MDS also indicated Resident 33 was coded as Ambulation was not attempted due to medical condition or safety concerns. During a review of Resident 33's Restorative Treatment Record dated 1/1/2026 – 4/15/2026, the record indicated Resident 33 received treatments as ordered by the physician. On 4/13/2026 to 4/15/2026 (total 3 days) the document was not signed to indicate that the RNA provided treatment and ambulation to Resident 33. During an observation on 4/15/2026, at 9:39 AM, RNA 1 asked Resident 33 if he could assist her in ambulating, Resident 33 replied, I can't walk it takes two people to get me out of bed to the chair, I can't stand on my feet. RNA 1 stated that on 4/14/2026, and 4/15/2026, Resident 33 did not want to get out of bed and does not ambulate by herself. RNA stated he uses the gait belt (canvas, nylon, or leather strap fastened around a patient's waist to help them stand, sit, or walk safely) and the walker when assisting Resident 33 to ambulate. During a concurrent interview and record review on 4/15/2026, at 9:43 AM with RNA 1 Restorative Nursing Weekly Summary, dated 4/2026, was reviewed, the Nursing Weekly Summary did not indicate an entry on 4/7/2026, and 4/14/2026, RNA 1 stated that he did not document Resident 33's weekly summary report because he was busy. RNA 1 stated that he did not report Resident 33 refusal to ambulate to the licensed nurses for the last two days 4/13/2026 and 4/14/2026. During a concurrent record review and interview on 4/15/2026, at 10:07 AM with Certified Nurse Assistant (CNA) 9, the Certified Nurse Assistant Flowsheet dated 4/1/2026 – 4/14/2026, was reviewed. CNA 9 stated the code 9 means there was no attempt to assist Resident 33 to walk, and the resident did not walk. CNA 9 stated he has not observed Resident 33 walk or stand on her feet for the last 4 months (January to April 2026). During an interview on 4/15/2026, at 10:25 AM with the Director of Nurses (DON 1) stated that he did (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/1/2026, the MDS indicated Resident 10 had intact cognition (clear ability to think, understand, learn, and remember) During a review of PT Evaluation and Plan of Treatment, dated 4/28/2025, the PT Evaluation indicated Resident 10's was sent to a General Acute Care Hospital for left ankle swelling and pain and a left ankle stress fracture (broken bone due to a small or moderate amount of force applied to a bone repeatedly and over time). The PT evaluation indicated prior to 4/28/25, Resident 10 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steady assistance as resident completes the activity) for rolling in bed, moving from lying to sitting, transferring between bed and chair, and walking 135 feet with a front-wheeled walker. During a review of PT Discharge summary, dated [DATE], indicated Resident 10 achieved the long-term goal of requiring supervision or touching assistance at the time of discharge for moving from lying to sitting, transferring from sitting to standing, and walking 80 feet with a frontˆwheeled walker. The PT recommended Resident 10 to continue ambulating with the RNA using the FWW five times per week as tolerated. During a review of Resident 10's physician's orders, dated 7/7/2025, the physician's orders indicated for RNA to ambulate with Resident 10 using the FWW, five times per week as tolerated. During a review of Resident 10's RNA records, Resident 10's medical record did indicate that Resident 10 was assisted with ambulation using a FWW, five times per week as tolerated and no documentation of RNA weekly summaries for 7/2025. During a review of Resident 10's RNA records dated 8/2025, 9/2025, and 10/2025 did not include RNA Weekly Summaries. During a review of PT Evaluation dated 11/6/2025, Resident 10 was referred to PT therapy due to increased bilateral (both) legs weakness and worsening difficulty with bed mobility, transfers, and ambulation with limited ankle range of motion, measured at -10 degrees in both ankles. The PT evaluation indicated Resident 10 required substantial/maximal assistance for rolling in bed and moving from lying to sitting and dependent (helper does all the effort) for sitˆtoˆstand transfers, bedˆtoˆchair transfers, and for ambulating 50 feet. During a review of Resident 10's physician orders, dated 12/8/2025, indicated to continue skilled PT services, including therapeutic exercises, therapeutic activities, neuromuscular reeducation (a specialized physical therapy technique that retrains the brain, nerves, and muscles to improve movement, balance, coordination, and posture), gait training, safety training, and resident/caregiver training. These services were ordered three times per week for 30 days. During a review of the PT Discharge summary, dated [DATE], indicated the Resident 10 required (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	partial/moderate assistance for moving from lying to sitting on the side of the bed, and substantial/maximal assistance for sitˆtoˆstand transfers. The PT Discharge Summary indicated Resident 10 was not attempted to ambulate due to medical or safety concerns and continued to have ankle rangeˆofˆmotion limitations of -10 degrees. The PT recommended that the RNA perform ROM exercises to both legs five times per week as tolerated. During a review of Resident 10's physician's orders, dated 12/20/2025, indicated for the RNA to provide active range of motion ([AROM] performance of an exercise to move a joint without any assistance or effort of another person) or active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both legs (A/AAROM to both legs), five times per week as tolerated. During a review of Resident 10's RNA records, dated 12/1/2025 to 12/31/2025, indicated Resident 10 did not include A/AAROM to both legs, five times per week, in accordance with the physician's order, dated 12/20/2025. The RNA records for 12/2025 did not include RNA Weekly Summaries. During a review of Resident 10's physician's orders, dated 1/5/2026, indicated to discontinue RNA for ambulation using a FWW, five times per week as tolerated, and to discontinue RNA for A/AAROM to both legs, five times per week as tolerated. During a review of Resident 10's RNA records, dated 1/1/2026 to 1/31/2026, the RNA records indicated Resident 10 received RNA for A/AAROM to both legs, five times per week as tolerated, and RNA for ambulation, five times per week as tolerated. The RNA records for 1/2026 did not include RNA Weekly Summaries. During a review of Resident 10's JMA, dated 4/1/2026 and signed by Occupational Therapist 1 (OT 1), the JMA indicated Resident 10 did not have changes in ROM to both arms and legs. The JMA indicated to continue current RNA program as tolerated. During an interview on 4/13/2026 at 9:11 a.m., the Rehabilitation Coordinator (RC) stated that the purpose of PT is to improve functional mobility, range of motion, and strength to help residents return to their baseline level of function. The RC explained that mobility and ROM screening is conducted through the JMA, completed on admission, quarterly, annually, and as needed. The RC also stated that the RNA program serves as a maintenance program after a resident is discharged from therapy and includes ROM exercises, ambulation, sitˆtoˆstand transfers, and application of splints. During a review of the facility's Order Listing Report for RNA (list of residents with active orders for RNA), dated 4/13/2026 at 9:53 a.m., the Order Listing Report for RNA did not include Resident 10. During an observation and interview with Resident 10 on 4/13/2026 at 1:17 p.m., in Resident 10's room, the resident was awake, alert, and speaking clearly while lying in bed. Resident 10 reported (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being unable to stand or walk and stated the facility was supposed to provide daily leg exercises and walking but had not done so for a couple of months. Resident 10 stated that RNA 1 had come to the room months earlier, said they would return with equipment, but never returned, leaving a gait belt behind in the resident's closet. Resident 10 stated that one or two staff assisted with transfers from bed to wheelchair. Resident 10 became tearful and stated feeling neglected because they wanted to walk but had not received the services. During an observation on 4/14/2026 at 9:58 a.m., Resident 10 was assisted by CNA 3 in transferring from the bed to a wheelchair and lifted her upper body and moved both legs toward the left side of the bed. Then, CNA 3 assisted in bringing the legs fully off the bed. Resident 10 sat at the bedside without assistance while CNA 3 stood in front of them. A wheelchair was positioned at the resident's right side. CNA 3 then hugged Resident 10's upper body to assist with standing and transferred the resident into the wheelchair. CNA 3 pushed the resident to a horizontal grab bar near the restroom and held the wheelchair while the resident used the grab bar to pull into a modified standing position to reposition themselves in the wheelchair. During a concurrent interview and record review on 4/14/2026 at 3:03 p.m., the RC reviewed Resident 10's PT Evaluation dated 4/28/2025 and stated the resident required supervision for bed mobility and sitˆtoˆstand transfers, and partial/moderate assistance for ambulating at least 50 feet with a frontˆwheeled walker at PT discharge on [DATE]. The RC stated the PT discharge recommendations included RNAˆassisted ambulation with a FWW five times per week as tolerated. During another concurrent interview and record review on 4/14/2026 at 3:08 p.m., the RC stated the resident received a PT Evaluation on 11/6/2025 due to a decline in bed mobility, transfers, and ambulation. The RC stated the resident was discharged from PT on 12/20/2025 with recommendations for the RNA to provide ROM exercises to both legs five times per week as tolerated. During a concurrent interview and record review on 4/14/2026 at 4:08 p.m. with the RC, Resident 10's physician's orders were reviewed. The RC stated Resident 10 did not have active physician's orders for RNA. During a concurrent interview and record review on 4/14/2026 at 4:19 p.m. with the RC and the Director of Medical Records (DMR), Resident 10's physician orders and RNA records for 1/1/2026–1/31/2026 were reviewed. The DMR stated Resident 10 did not have active physician orders for RNA services. The DMR reported that the Director of Nursing (DON) discontinued the resident's RNA ambulation order (dated 7/8/2025) and the order for A/AAROM to both legs (dated 12/20/2025) on 1/5/2026, without documenting a reason. The DMR stated RNA 1 continued providing ambulation and A/AAROM in January 2026 because RNA 1 had not been informed the orders were discontinued. The DMR stated RNA records for February 2026 were not printed due to the discontinued orders, and confirmed Resident 10 had not received RNA services since January 2026. The RC stated the residents could experience a decline in mobility due to the lack of RNA services since that time. During an interview on 4/15/2026 at 8:51 a.m. with Resident 10 in the resident's room, Resident 10 stated she spoke with the RC (unknown date) and informed the RC that Resident 10 was not receiving any exercises including standing and walking. Resident 10 also spoke with RNA 1 (unknown date) about not receiving any exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/15/2026 at 2:02 p.m. with PT 1, Resident 10's PT Evaluations (dated 4/28/2025 and 11/6/2025) and PT Discharge Summaries (dated 7/4/2025 and 12/20/2025) were reviewed. PT 1 stated that the purpose of PT is to restore and maximize a resident's functional independence with transfers and gait, which supports overall quality of life, self^respect, and self^dignity. PT 1 stated that the 7/4/2025 PT Discharge Summary included recommendations for RNA^assisted ambulation with a FWW five times per week, but did not specify a walking distance, which should have been included to help monitor the resident's ambulation tolerance and identify decline. During a continued interview and record review on 4/15/2026 at 2:02 p.m., PT 1 stated that the 11/6/2025 PT Evaluation showed the resident was referred to due to decline in bed mobility, transfers, ambulation, and increased bilateral leg weakness. PT 1 explained that the resident had difficulty standing because both ankles had ROM limitations of ^10 degrees, placing the ankles in plantarflexion. PT 1 reviewed the 12/20/2025 PT Discharge Summary and stated the resident's lower^extremity weakness made standing difficult and prevented walking. PT 1 stated ROM exercises to both legs were recommended to maintain ROM and prevent contractures, as that was the resident's maximum tolerance at discharge. During an interview on 4/15/2026 at 2:42 p.m. with the DMR, the DMR stated Resident 10 did not have an RNA record for the month of 7/2025. During an interview on 4/15/2026 at 3:39 p.m. with the Social Services Director (SSD), the SSD stated Resident 10 spoke with SSD and the RC on 12/29/2025 in the resident's room about wanting to receive more therapy to walk. During a concurrent interview and record review on 4/15/2026 at 3:51 p.m., the RC reviewed Resident 10's JMA dated 4/1/2026. The RC stated vaguely recalling a conversation with Resident 10 and the SSD on 12/29/2025 in which the resident expressed wanting more therapy to walk but was unable to walk with PT. The RC stated Resident 10 was informed they could receive RNA services and might qualify for therapy again if improvement was shown through RNA. The RC stated Resident 10 could not improve because RNA services had not been provided from 2/1/2026 through 4/15/2026. The RC noted the JMA dated 4/1/2026 indicated to continue RNA as tolerated but Resident 10 could not continue a program that was not in place. The RC stated the current system for identifying changes in residents' mobility was not effective. During an interview on 4/15/2026 at 4:08 p.m. with OT 1, OT 1 stated process of completing the JMA for each resident (in general) included reviewing the medical record and speaking to the staff and the residents about their RNA ser[TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to ensure sufficient staff of Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) staff as indicated in the Facility Assessment Tool (assessment of the resident population to determine sufficient staffing) to provide treatment to 26 residents of 53 (total residents in the facility) residents receiving RNA services,This failure resulted in the inability to provide RNA services to the residents in accordance with the physician's order. Cross reference F688 and F842. Findings: During a review of the Facility Assessment Tool, dated 1/13/2026 and updated 3/25/2026, the Facility Assessment Tool indicated two RNAs staff were needed to provide support and care for the residents. During a review of the Nursing Staff Assignment and Sign-in Sheet, dated 3/4/2026, 3/5/2026, 3/6/2026, 3/19/2026, 3/20/2026 the assignment for Restorative Nursing Aide 1 (RNA 1) included providing RNA, covering the guard, and feeding one resident, there was not two RNAs in the assignment. During a review of the Nursing Staff Assignment and Sign-in Sheet, dated 3/11/2026 and 3/13/2026, 3/18/2026 the assignment for RNA 1 included providing RNA and feeding breakfast to two residents, there was not two RNAs in the assignment. During a review of the Nursing Staff Assignment and Sign-in Sheet, dated 3/17/2026, the assignment for RNA 1 included providing RNA, providing CNA care to one resident, covering the guard, and feeding two residents, there was not two RNAs in the assignment. During a review of the Nursing Staff Assignment and Sign-in Sheet, dated 3/30/2026, the assignment for Restorative Nursing Aide 2 (RNA 2) included providing RNA, covering the guard, and feeding one resident. During a review of the Nursing Staff Assignment and Sign-in Sheet, dated 3/31/2026, 4/1/2026 to 4/3/2026the assignment for RNA 1 included providing RNA, covering the guard, passing out nourishments (supplemental snack providing additional nutrients) at 10 a.m., and feeding one resident. During a review of the Nursing Staff Assignment and Sign-in Sheet, dated 4/6/2026 and 4/7/2026, the assignment for RNA 1 included providing RNA, providing CNA care to one resident, covering the guard, passing out nourishments at 10 a.m., and feeding one resident. During a review of the Nursing Staff Assignment and Sign-in Sheet, dated 4/8/2026, to 4/10/2026 the assignment for RNA 1 included providing RNA, covering the guard, passing out nourishments at 10 a.m., and feeding one resident. During an interview on 4/13/2026 at 1:58 p.m. with RNA 1, RNA 1 stated RNA 1's working hours were from 7:00 a.m. to 3:30 p.m. RNA 1 stated daily duties included feeding breakfast to one specific resident in the morning, passing out nourishments at 10 a.m. and 2 p.m., and providing the RNA program. RNA 1 stated RNA 1's duties also included measuring residents' weights within 48 hours of admission, weekly weights, and monthly weights from the end of the month to the beginning of the next month. RNA 1 stated the facility sometimes pulled RNA 1 to provide CNA services for residents. During an interview on 4/15/2026 at 3:05 p.m. with RNA 1, the facility's Order Listing for RNA was reviewed and stated there were 26 residents receiving RNA services. RNA 1 stated RNA 1 was the only RNA assigned from Monday to Friday. RNA 1 stated some residents did not receive RNA if RNA 1 was pulled to provide CNA services. During an interview on 4/16/2026 at 8:00 a.m. with RNA 2, RNA 2 stated that the facility employed RNA 2 recently and had RNA experience at a previous facility. RNA 2 stated the facility assigned RNA 2 to provide RNA one time because RNA 1 was off. During an interview on 4/16/2026 at 8:06 a.m. with Restorative Nursing Assistant 3 (RNA 3), RNA 3 stated the main role was to assist the Director of Staff Development (DSD) and also provided CNA care. RNA 1 stated it was rare for RNA 3 to provide RNA services at the facility. During an interview on 4/16/2026 at 11:04 a.m. with the DSD, the DSD stated RNA 2 was a new hire with previous RNA experience and RNA 3 assisted with RNA as needed. The DSD stated RNA 1 was the facility's only full time RNA. During an interview on 4/16/2026 at 11:35 a.m. with the DSD, the DSD stated RNA 1 was sometimes assigned to provide CNA care but was not completely pulled from providing RNA services. The DSD stated RNA 1 was encouraged to stay overtime if RNA 1 needed to (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complete RNA treatment. During an interview on 4/17/2026 at 8:41 a.m. with the DSD, the facility's Order Listing Report for RNA (list of residents with active orders for RNA), dated 4/13/2026, and the Facility Assessment Tool, reviewed 1/13/2026 and updated 3/25/2026, were reviewed. The DSD stated the Order List Report for RNA included 26 residents receiving RNA services. The DSD stated RNA 1 was supposed to spend 10-15 minutes with each resident. The DSD stated RNA 1's duties included feeding, taking residents' weights upon admission, weekly and monthly, and providing ROM exercises, ambulation, and application of splints. The DSD stated one RNA did not have sufficient time to provide RNA services to 26 residents, especially if RNA 1 was also assigned to provide CNA care and to cover the smoking guard. The DSD reviewed the Facility Assessment Tool which indicated the facility required two RNAs and did not know the reason the facility did not provide two RNA staff. The DSD stated the Administrator (ADM) and Director of Nursing (DON) did not review the Facility Assessment Tool with the DSD. During an interview on 4/17/2026 at 9:10 a.m. with the ADM, the facility's Facility Assessment Tool was reviewed. The ADM stated the Facility Assessment Tool captured the residents' needs, the types of patients and equipment needed, and the facility's staffing needs. The ADM stated the Facility Assessment Tool indicated the need for two RNAs and determined one was sufficient to complete the job duties. The ADM stated the facility staff did not notify the ADM that one RNA was not sufficient. During a review of the facility's policy and procedure (P&P) titled, Staffing Sufficiency Based on Patient Acuity, dated 8/2019, the P&P indicated the facility will conduct an annual assessment of staffing patterns based on residents' conditions and services provided. The P&P indicated staffing guidelines will be based upon the annual assessment.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 3 out of 3 Restorative Nurse Assistants (RNA 1, RNA 2, RNA 3) had the competent skills necessary to care for one of ten sampled residents (Resident 33) who declined in ambulation (walking) as identified through resident assessment and described in the care plan and the facility's policy and procedure (P&P) titled Competency Evaluation. This deficient practice resulted in resident not receiving needed services in a timely manner resulting in the resident's decline with the ability to ambulate (walk) that could affect resident's quality of life. Findings: During a review of, Physical Therapy Discharge Summary, dated 11/5/2025, the Physical Therapy Discharge Summary indicated that Resident 33 was ambulating with Front wheel walker (FWW - an assisting device with front wheels to assist in ambulation) up to 50 feet with partial/moderate assistance. During a review of Resident 33's Order Summary Report dated 11/3/2025, the order summary report indicated the following: RNA to ambulate with Front wheel walker every day five times a week as tolerated every day shift every Monday, Tuesday, Wednesday, Thursday, Friday. During a concurrent interview and record review on 4/16/2026 at 9:37 AM with RNA 1, RNA 1 stated that the Restorative Nurse Weekly Summary dated 1/2026 indicated that in January Resident 33 was walking using the front wheel walker with a distance of 150-200 feet with an average time of 15 minutes with good balance, slow speed, follows directions, fair communication, good pattern. RNA 1 stated that in the month of March Resident 33 was walking less steps compared to January with 5-10 feet in distance in her room. RNA 1 stated that this month of April Resident 33 has not been walking and that the RNA treatment had consisted of transfers from the bed to the chair. RNA 1 stated that by transferring the resident he considered that task to be a treatment. RNA 1 stated I don't know what happened to the weekly summaries for February and March. RNA 1 stated that he did not know how to document when the residents refuse treatment or does not tolerate a treatment well. During a review of Resident 33's admission Record (AR), the AR indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including difficulty in walking, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and unspecified Dementia (a progressive state of decline in mental abilities). During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool) dated 2/11/2026, the MDS indicated that Resident 33's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 33 was dependent on staff for personal hygiene, lower body dressing, shower/bathe self, toileting hygiene. Substantial/maximal assistance in putting on/taking off footwear, upper body dressing, and oral hygiene. During a concurrent interview and record review on 4/16/2026 at 10:03 AM with DSD, RNA 1's employee file was reviewed. The DSD stated RNA 1 was hired on 1/27/2023 and there was no competency completed for RNA 1. DSD stated it is important to have competency completed to ensure that the RNA is competent in providing treatments as ordered by the physician such as ROM, splinting (a medical device that stabilizes a part of your body and holds it in place), and ambulation. DSD stated the importance of the RNA program is to ensure that the resident maintains range of motion and mobility and has no further decline. During a review of the facility's P&P titled Competency Evaluation dated 7/2019. Upon hire, each nursing staff's competency will be reviewed and completed by the end of the probationary period. The skills checklist will be completed for each nursing staff upon hire and annually to ensure that related services provided in the facility are maintained. During a review of the facility policy and procedure titled, Competency Evaluation dated 7/2019, indicated that it is the facility's policy to perform competency evaluation for all employees. The policy indicated that upon hire each nursing staff's competency will be reviewed and completed by the end of the probationary period.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure four of seven residents (Resident 18, 10, 3, and 6) reviewed for limited range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) had complete and accurate medical records. 1. For Resident 18, the facility: a. Indicated Resident 18 received active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to the left arm and passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) to the right arm followed by the application of the right hand roll (soft roll positioned in the palm of the hand and fastened with a strap) from 2/26/2026 to 2/28/2026 when Resident 18 was in the hospital. b. Indicated Resident 18 received PROM to both legs and application of both knee orthoses (also known as splints, material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) from 2/26/2026 to 2/28/2026 when Resident 18 was in the hospital. c. Provided RNA for AAROM to the left arm, PROM to the right arm and both legs, and application of the right-hand roll (soft roll positioned in the palm of the hand and fastened with a straps and both knee orthoses, five times per week, from 3/2/2026 to 3/31/2026 without a physician's order. d. Failed to document Resident 18's response to PROM exercises to both arms and legs and application of the right-hand splint and both knee splints from 4/13/2026 to 4/15/2026. 2. For Resident 10, the facility indicated Restorative Nursing Aide 1 (RNA 1) provided Resident 10 with ambulation (the act of walking) with the front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking) on 8/12/2025, 12/18/2025, and 12/19/2025 when RNA 1 was not working at the facility. 3. For Resident 3, the facility indicated RNA 1 provided Resident 3 with gentle PROM to both arms and both legs and application of both pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position) on 8/12/2025, 12/18/2025, and 12/19/2025 when RNA 1 was not working at the facility. 4. For Resident 6, the facility indicated Resident 6 received PROM to the left arm and leg, five times per week, when RNA 1 was unable to provide the exercises five times per week. These failures resulted in inaccurate medical records for the provision of services to address Resident 18, 10, 6 and 3 limitations in ROM a mobility, which placed the residents at increased risk for developing a decline in mobility and increased risk for the development of contractures (stiffening/shortening at any joint that reduces the joint's range of motion). Cross reference F688, F725, and F726. Findings: 1. During a review of Resident 18's admission Record, the admission Record indicated the facility initially admitted Resident 18 on 3/13/2025 and readmitted on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and contractures of both knees and the right hand. During a review of Resident 18's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 1/5/2026, the MDS indicated Resident 18 required substantial/maximal assistance (helper does more than half the effort) for eating and was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for hygiene, upper body dressing, lower body dressing, rolling to both sides in bed, and transferring from lying to sitting at the side of the bed. During a review of Resident 18's physician's order, dated 5/16/2025, the physician's order indicated RNA program for AAROM exercises to the left arm and PROM exercises to the right arm followed by the application of a right-hand roll for up to two hours, five times per week. During a review of Resident 18's physician's order, dated 5/20/2025, the physician's order indicated for RNA to perform daily ROM to both legs within the available ROM to prevent further contractures and to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	apply both knee orthoses for up to two hours as tolerated. During a review of Resident 18's undated Physician's Discharge Summary, the Physician's Discharge Summary indicated Resident 18 went to the General Acute Care Hospital (GACH) on 2/25/2026 for abdominal pain and generalized weakness. During a review of Resident 18's RNA records, dated 2/1/2025 to 2/28/2026, the RNA records Resident 18 received RNA for AAROM exercises to the left arm, PROM to the right arm and both legs, and application of the right-hand roll and both knee orthoses on 2/26/2026 and 2/27/2026. During a review of Resident 18's physician's orders, dated 3/1/2026, the physician's orders indicated Resident 18 was readmitted to the facility. Another physician's order, dated 3/1/2026, discontinued Resident 18's RNA for AAROM to the left arm, PROM to the right arm and both legs, and application of the right-hand roll and both knee orthoses. During a review of Resident 18's RNA records, dated 3/1/2026 to 3/31/2026, the RNA records were signed to indicate Resident 18 received AAROM to the left arm, PROM to the right arm, and application of the right-hand roll and both knee orthoses, five times per week, from 3/2/2026 to 3/31/2026. The RNA records for 3/2026 also indicated the physician's orders for RNA were discontinued on 3/1/2026 and contained x marks for each weekday (Monday to Friday). During a review of Resident 18's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 3/2/2026, the OT Evaluation indicated Resident 18 had WFL ROM in the left arm and ROM limitations in the right arm, including 0-45 degrees (unit of joint motion) of PROM for shoulder flexion (lifting the arm overhead, normal 0-180 degrees) and unspecified limitations in the right wrist and hand. The OT Evaluation indicated Resident 18 had contractures in the right wrist, hand, and fingers. During a review of Resident 18's PT Evaluation and Plan of Treatment, dated 3/2/2026, the PT Evaluation indicated Resident 18 had unspecified ROM limitations in both hips and ankles. The PT Evaluation indicated Resident 18's knees had ROM limitations of negative 80 degrees (-80 degrees) in left knee extension (straightening, normal is 0 degrees) and -85 degrees in right knee extension. The PT Evaluation indicated Resident 18 had flexion (bending) contractures in both hips, knees, and ankles. During a review of Resident 18's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated Resident 18 safely wore a right-hand roll for two hours. The OT Discharge Summary indicated recommendations for RNA to provide gentle PROM exercises to both arms followed by the application of the right-hand roll for one to two hours as tolerated. During a review of Resident 18's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated both of Resident 18's knees had -75 degrees of knee extension. The PT Discharge Summary indicated recommendations for RNA to provide PROM to both legs and application of both knee extension splints for two hours as tolerated, five times per week. During a review of Resident 18's physician's orders, dated 4/9/2026, the physician's orders indicated for the RNA program to provide gentle PROM to both arms followed by the application of the right-hand roll for one to two hours, five times per week. During a review of Resident 18's physician's orders, dated 4/13/2026, the physician's order indicated for RNA to provide gentle PROM and apply both knee extension (orthoses) for 2 hours, five times per week as tolerated. During an observation on 4/13/2026 at 10:23 a.m. in the resident's room, Resident 18 was lying in bed positioned in a fetal position (position with knees bent and tucked toward the chest resembling a fetus in the womb) while turned toward the right side. Resident 18 was observed moving the left arm at the elbow joint and the right wrist was bent downward. During an observation on 4/13/2026 at 11:23 a.m. with RNA 1 in the resident's room, Resident 18's RNA session was observed. Resident 18's right wrist was observed in flexion (bent downward), and the right-hand fingers were bent. RNA 1 attempted to place the rolled face towel into the right hand, but Resident 18 yelled, Leave my hand alone. RNA 1 stated Resident 18 would not tolerate the exercises and would return later. Resident 18's legs were observed rotated to the right side with both hips and knees bent. During a review of the RNA binder (binder with active RNA records) on 4/13/2026 at 11:54 a.m., the RNA binder did not include Resident 18's RNA record for 4/2026. During an observation on 4/13/2026 at 1:30 p.m. with RNA 1 in the resident's room, Resident 18's RNA session was observed. RNA 1 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attempted to adjust a right-hand roll, but Resident 18 stated, You're hurting me. RNA 1 removed the right-hand roll and did not perform exercises to both arms and legs. During an observation on 4/14/2026 at 9:41 a.m. with RNA 1 in the resident's room, Resident 18's RNA session was observed. RNA 1 provided PROM to the left elbow and shoulder. Resident 18 stated, Leave me alone. RNA 1 stopped providing Resident 18 with exercises to the left arm and did not provide ROM to the right arm and both legs. During a concurrent interview and record review on 4/15/2026 at 3:28 p.m. with RNA 1, the RNA binder was reviewed. RNA 1 stated Resident 18 was supposed to receive PROM exercises to both arms and legs and application of the right-hand roll and both knee extension splints. RNA 1 stated Resident 18's knee splints were not applied from 4/13/2026 to 4/15/2026 due to Resident 18's inability to tolerate exercises and splints. RNA 1 reviewed the RNA binder and stated Resident 18 did not have an RNA record for 4/2026. RNA 1 stated RNA 1 signed all the RNA records in the RNA binder and assumed the RNA binder contained Resident 18's records for 4/2026. During a concurrent observation, interview, and record review on 4/15/2026 at 4:26 p.m. with the Rehabilitation Coordinator (RC), the RC reviewed the RNA binder. Resident 18's RNA record, dated 4/1/2026 to 4/30/2026, was observed in the RNA binder and printed on 4/15/2026 at 1:58 p.m. (same day). The RC stated Resident 18's RNA record for 4/2026 was blank. During an interview on 4/16/2026 at 8:30 a.m. with RNA 1, RNA 1 stated the RNA records were signed at the end of the shift. RNA 1 stated RNA 1 did not have a system of keeping track of which residents received RNA services and which residents refused each day. RNA 1 did not know Resident 18's RNA record for 4/2026 was not in the RNA binder (until interview and record review on 4/15/2026 at 3:21 p.m.). During a concurrent interview and record review on 4/16/2026 at 9:14 a.m. with RNA 1, Resident 18's RNA records for 2/2026 and 4/2026, Physician's Discharge Summary for Resident 18's on 2/25/2026, and physician's order for readmission to the facility, dated 3/1/2026, were reviewed. RNA 1 stated signing the RNA records (in general) indicated the residents were seen for the specific RNA program. RNA 1 reviewed Resident 18's Physician's Summary, which indicated Resident 18 left the faciity on 2/25/2026. RNA 1 reviewed Resident 18's RNA record for 2/2026 which RNA 1 signed on 2/26/2026 and 2/27/2026. RNA 1 did know the reason RNA 1 signed Resident 18's RNA record when Resident 18 was not physically in the facility. RNA reviewed Resident 18's RNA record for 4/2026. RNA 1 stated Resident 18's RNA record was blank for 4/2026 because RNA 1 did not know Resident 18's RNA record for 4/2026 was not in the RNA binder. During a concurrent interview and record review on 4/16/2026 at 11:42 a.m. with the Director of Medical Records (DMR), Resident 18's RNA records for 3/2026 and 4/2026 were reviewed. The DMR stated the resident's medical records (in general) should be complete and accurate to ensure proper care was provided to the residents. The DMR stated Resident 18's RNA records for 3/2026 should not have been printed out because Resident 18 was receiving therapy and was not supposed to receive RNA services. The DMR stated the facility staff, including RNA 1, medical records, and the licensed nurse, should have initiated Resident 18's RNA record for 4/2026 once RNA 1 received the RNA program order from the therapists. During a concurrent interview and record review on 4/17/2026 at 9:10 a.m. with the Administrator (ADM), the ADM reviewed Resident 18's RNA records for 2/2026, Physician's Discharge Summary, and physician's order, dated 3/1/2026, for readmission. The ADM stated medical records were legal documents that indicated the provision of care to the residents. The ADM stated Resident 18's RNA records indicated exercises and splints were provided when Resident 18 was not present in the facility on 2/26/2026 and 2/27/2026. The ADM stated Resident 18's RNA records were inaccurate since Resident 18 could not have received RNA services. The ADM stated the possible negative outcome of inaccurate documentation included the residents not receiving the RNA services the residents were supposed to receive. During a concurrent interview and record review on 4/17/2026 at 10:15 AMˆwith the Director of Nursing (DON), the DON reviewed Resident 18's RNA records for 2/2026 and Physician's Discharge Summary for 2/25/2026. The DON stated the RNA program (in general) provided ROM exercises, ambulation (the act of walking) and application of splints to avoid declines in the residents' mobility (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and function. The DON stated the medical records (in general) were legal medical documents detailing the services provided. The DON stated RNA 1 signed for the provision of services in Resident 18's RNA record for 2/26/2026 and 2/27/2026 when Resident 18 was not physically present in the facility. The DON stated Resident 18's RNA records were not accurate. During a review of the facility's policy and procedure (P&P) titled, Record Content, dated 11/2017, the P&P indicated completed entries must be accurate. 2. During a review of Resident 10's admission Record, the admission Record indicated the facility admitted Resident 10 on 4/26/2025 with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area), left ankle stress fracture (small crack or severe bruising in a bone, usually in the lower leg or foot, caused by overuse), right femoral (thigh bone) neck fracture (break in the uppermost part of the hip bone just below the ball of the hip joint), muscle weakness, and Parkinson's disease. During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had clear speech, clear comprehension, expressed ideas and wants, and had intact cognition. The MDS indicated Resident 10 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists only prior to or following the activity) for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 10 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for rolling to both sides in bed and transferring from lying to sitting on the side of the bed. The MDS also indicated Resident 10 required partial/moderate assistance (helper does less than half the effort) for lower body dressing, sit-to-stand transfer, and chair/bed-to-chair transfers. During a review of Resident 10's physician's orders, dated 7/7/2025, the physician's orders indicated RNA for ambulation with Resident 10 using the FWW, five times per week as tolerated. During a review of RNA 1's Time Detail Report (timecard), dated 8/12/2025, RNA 1's Time Detail Report indicated RNA 1 did not work on 8/12/2025. During a review of Resident 10's RNA record, dated 8/1/2025 to 8/31/2025, RNA 1 signed Resident 10's RNA record on 8/12/2025 for the provision of RNA for ambulation using the FWW. The RNA record indicated Resident 10 received RNA for ambulation, five times per week. During a review of Resident 10's PT Evaluation and Plan of Treatment, dated 11/6/2025, the PT Evaluation indicated Resident 10 was referred to PT due to increased weakness in both legs and increased difficulty with bed mobility, transfers, and ambulation. The PT Evaluation indicated Resident 10 had ROM limitations in both ankles, measuring negative 10 degrees ([-10 degrees] measure of joint motion). The PT Evaluation indicated Resident 10 required substantial/maximal assistance for rolling to both sides in bed and transferring from lying to sitting on the side of the bed. The PT Evaluation also indicated Resident 10 was dependent for sit-to-stand transfers, chair/bed-to-chair transfers, and ambulation of 50 feet. During a review of Resident 10's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated Resident 10 required partial/moderate assistance for transferring from lying to sitting on the side of the bed, substantial/maximal assistance for transferring to a standing position from sitting in a chair, wheelchair, or the side of the bed, and ambulation was not attempted to due medical conditions or safety concerns. The PT Discharge Summary indicated Resident 10 continued to have ROM limitation of -10 degrees at the ankle joints. The PT Discharge Summary indicated recommendations for RNA to perform ROM to both legs, five times per week as tolerated. During a review of Resident 10's physician's orders, dated 12/20/2025, the physician's order indicated for the RNA to provide active range of motion ([AROM] performance of an exercise to move a joint without any assistance or effort of another person) or active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both legs (A/AAROM to both legs), five times per week as tolerated. During a review of RNA 1's Time Detail Report, dated 12/18/2025 and 12/19/2025, RNA 1's Time Detail Report indicated RNA 1 did not work on 12/18/2025 and 12/19/2025. During a review of Resident 10's RNA records, dated 12/1/2025 to 12/31/2025, the RNA records indicated RNA 1 signed Resident 10's RNA record on 12/18/2025 and 12/19/2025. The RNA records indicated Resident 10 received RNA for ambulation using a FWW, five times per week as (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tolerated. Resident 10's RNA record for 12/2025 did not include A/AAROM to both legs, five times per week, in accordance with the physician's order, dated 12/20/2025. During a concurrent observation and interview on 4/13/2026 at 1:17 p.m. with Resident 10 in the resident's room, Resident 10 was observed awake, alert, and spoke clearly while lying in bed. Resident 10 stated Resident 10 was unable to stand and walk. Resident 10 stated the facility was supposed to provide exercises to both legs and walking every day but has not provided those services for a couple of months (unspecified date). Resident 10 stated RNA 1 came to Resident 10's room a couple of months ago (unspecified date), asked if Resident 10 wanted to perform exercises, stated an intent to return to Resident 10's room after retrieving equipment (unspecified), and never came back. Resident 10 cried and stated feeling neglected because Resident 10 cannot walk and wanted to walk. During an interview on 4/16/2026 at 8:30 a.m. with RNA 1, Resident 10's RNA records for 12/2025 were reviewed. RNA 1 stated the RNA records were signed at the end of the shift. RNA 1 did not have a system of keeping track of which residents received RNA services and which residents refused each day. RNA 1 stated Resident 10's RNA record for 12/2025 Resident 10 received RNA for ambulation, five times per week. During an interview on 4/16/2026 at 9:14 a.m. with RNA 1, RNA 1 stated signing the RNA records (in general) indicated the residents were seen for the specific RNA program. During a concurrent interview and record review on 4/17/2026 at 9:10 a.m. with the ADM, Resident 10's RNA records for 8/2025 and 12/2025 and RNA 1's Time Detail Report for 8/12/2025, 12/18/2025, and 12/19/2025 were reviewed. The ADM stated medical records were legal documents that indicated the provision of care to the residents. The ADM reviewed RNA 1's Time Detail Report and stated RNA 1 did not work on 8/12/2025, 12/18/2025, and 12/19/2025. The ADM reviewed Resident 10's RNA records which indicated RNA 1 provided Resident 10 with ambulation on 8/12/2025, 12/18/2025, and 12/19/2025. The ADM stated Resident 10's RNA records were inaccurate since RNA 1 was not physically present to provide RNA services. The ADM stated the possible negative outcome of inaccurate documentation included the residents not receiving the RNA services the residents were supposed to receive. During a review of the facility's P&P titled, Record Content, dated 11/2017, the P&P indicated completed entries must be accurate. 3. During a review of Resident 3's admission Record, the admission Record indicated the facility initially admitted Resident 3 on 7/26/2024 and readmitted on [DATE] with diagnoses including acute respiratory failure (sudden inability of the lunch to provide oxygen to the blood or remove [NAME] dioxide) with hypercapnia (abnormally high levels of carbon dioxide), attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feeding to be administered directly to the stomach for people with swallowing problems), dementia, and multiple contractures of muscle. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had unclear speech, had difficulty communicating some words, usually understood verbal content, and had severely impaired cognition. The MDS indicated Resident 3 required substantial/maximal assistance for rolling to both sides and dependent for toilet hygiene, bathing, upper and lower body dressing, and transferring from lying to sitting on the side of the bed. During a review of Resident 3's physician's orders, dated 9/13/2024, the physician's orders indicated for RNA to perform daily gentle PROM to prevent further contractures and to apply both PRAFOs for up to hours per day as tolerated. During a review of Resident 3's physician's orders, dated 5/28/2025, the physician's orders indicated RNA program for gentle PROM to both arms and legs, five times per week as tolerated. During a review of RNA 1's Time Detail Report, dated 8/12/2025, RNA 1's Time Detail Report indicated RNA 1 did not work on 8/12/2025. During a review of Resident 3's RNA record, dated 8/1/2025 to 8/31/2025, RNA 1 signed Resident 3's RNA record on 8/12/2025 for the provision of RNA for PROM to both arms and legs and the application of both PRAFOs. Resident 3's RNA record indicated Resident 3 received RNA services, five times per week. During a review of RNA 1's Time Detail Report, dated 12/18/2025 and 12/19/2025, RNA 1's Time Detail Report indicated RNA 1 did not work on 12/18/2025 and 12/19/2025. During a review of Resident 3's RNA record, dated 12/1/2025 to 12/31/2025, RNA 1 signed Resident 3's RNA record on 12/18/2025 and 12/19/2025 for the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provision of RNA for PROM to both arms and legs and the application of both PRAFOs. Resident 3's RNA record indicated Resident 3 received RNA services, five times per week. During a review of Resident 3's Joint Mobility Assessment ([JMA] brief assessment of a resident's range of motion in each joint of both arms and legs), dated 1/5/2026, the JMA indicated Resident 3 had within functional limits ([WFL] sufficient joint movement without significant limitation) ROM to both wrists and hands. During an observation on 4/13/2026 at 2:50 p.m. in the resident's room, Resident 3 was observed lying awake in bed and unable to speak. Resident 3's left-hand was observed with the middle, ring, and small fingers completely bent and index finger extended (straight). During an observation on 4/14/2026 at 9:00 a.m. with RNA 1 in the resident's room, Resident 3's RNA session was observed. Resident 3's left-hand middle, ring, and small fingers were observed completely bent toward the palm. RNA 1 attempted to extend the left-hand middle finger, and Resident 3 screamed. RNA 1 did not perform any ROM exercises to the left-hand middle, ring, and small fingers. During an interview on 4/16/2026 at 8:30 a.m. with RNA 1, RNA 1 stated the RNA records were signed at the end of the shift. RNA 1 did not have a system of keeping track of which residents received RNA services and which residents refused each day. During an interview on 4/16/2026 at 9:14 a.m. with RNA 1, RNA 1 stated signing the RNA records (in general) indicated the residents were seen for the specific RNA program. During a concurrent interview and record review on 4/17/2026 at 9:10 a.m. with the ADM, Resident 3's RNA records for 8/2025 and 12/2025 and RNA 1's Time Detail Report for 8/12/2025, 12/18/2025, and 12/19/2025 were reviewed. The ADM stated medical records were legal documents that indicated the provision of care to the residents. The ADM reviewed RNA 1's Time Detail Report and stated RNA 1 did not work on 8/12/2025, 12/18/2025, and 12/19/2025. The ADM reviewed Resident 3's RNA records which indicated RNA 1 provided Resident 3 with PROM to both arms and legs and application of PRAFOs on 8/12/2025, 12/18/2025, and 12/19/2025. The ADM stated Resident 3's RNA records were inaccurate since RNA 1 was not physically present to provide RNA services. The ADM stated the possible negative outcome of inaccurate documentation included the residents not receiving the RNA services the residents were supposed to receive. The ADM stated Resident 3 could not verbalize whether RNA services were received. During a review of the facility's P&P titled, Record Content, dated 11/2017, the P&P indicated completed entries must be accurate. 4. During a review of Resident 6's admission Record, the admission Record indicated the facility initially admitted Resident 6 on 11/6/2025 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side. During a review of Resident 6's History and Physical (H&P), dated 1/1/2026, the H&P indicated the physician assessed Resident 6 as demonstrating capacity to make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had clear speech, usually understood verbal content, had difficulty communicating or finishing some words, and had severely impaired cognition. During a review of Resident 6's physician's orders, dated 2/25/2026, the physician's orders indicated for RNA to provide gentle PROM on the left arm and left leg, five times per week as tolerated. During a review of Resident 6's RNA record, dated 3/1/2026 to 3/3/2026, the RNA record indicated the RNA provided PROM to the left arm and left leg, five times per week. During a concurrent observation and interview on 4/14/2026 at 8:36 a.m. in the resident's room, Resident 6 stated RNA 1 provided exercises two times per week and the days were inconsistent. Resident 6 stated RNA 1 provided exercises yesterday but did not know if RNA 1 would return for the rest of the week. Resident 6 stated RNA 1 did not provide exercises five times per week. Resident 6 stated the exercises were necessary to maintain the bones and the muscles, especially for the left leg which had some movement. Resident 6 was observed to slightly move the left leg and did not have active movement in the left arm. During an interview on 4/16/2026 at 9:14 a.m. with RNA 1, RNA 1 stated signing the RNA records (in general) indicated the residents were seen for the specific RNA program. During an interview on 4/16/2026 at 9:24 a.m. with RNA 1, RNA 1 stated Resident 6 sometimes did not receive exercises five times per (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	week because RNA 1 would be assigned to provide CNA services or help the other CNAs. During a concurrent interview and record review on 4/17/2026 at 9:10 a.m. with the ADM, Resident 6's RNA records for 3/2026 were reviewed. The ADM stated medical records were legal documents that indicated the provision of care to the residents. The ADM stated the possible negative outcome of inaccurate documentation included the residents not receiving the RNA services the residents were supposed to receive. The ADM stated Resident 6's RNA records for 3/2026 indicated Resident 6 received RNA services five times per week. The ADM stated Resident 6's RNA records could be inaccurate after reviewing RNA 1's documentation inaccuracies with other residents reviewed for limitations in ROM and mobility. During a review of the facility's P&P titled, Record Content, dated 11/2017, the P&P indicated completed entries must be accurate.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, interview, and record review, the facility failed to implement an effective Quality Assurance and Performance Improvement Program (QAPI, a data-driven, proactive framework used to improve safety, resident care, and quality of life) as indicated in the facility's policy and procedure (P&P) for QAPI when the facility's QAPI program did not identify issues related requirement for F688, F656, F678 and F638 identified by the survey team. This deficient practice resulted in the resident's care and needs not to receive or received delayed care to achieve their highest potential. Cross reference to F-636, F-656, F-678, F-688 Findings: During a concurrent interview and record review on 4/16/2026 at 1:13 PM with the Administrator (ADM), the facility's QAPI program was reviewed. The ADM stated that the facility's QAPI program topics of discussions are focused on two topics: resident falls and infection control. The ADM stated that the QAPI program has not identified any issues regarding the facility's staffing, development of care plans, Restorative Nursing Program, and Trauma Informed Care implementation. The ADM stated that during the facility's QAPI program meetings, which meet quarterly throughout the year, the QAPI attendees discuss issues that are identified. The ADM added that the QAPI meetings do not include topics unless the QAPI attendees present such issues during the meeting. During an interview on 4/17/2026 at 9:10 AM with the ADM, the ADM stated that she oversees the facility's QAPI Program. The ADM also stated that it is her responsibility to ensure that the facility's policies and procedures are followed and implemented. The ADM further added that the facility's QAPI system for identifying systemic issues needs improvement because [the facility's] system is not working. During an interview on 4/17/2026 at 12:05 PM with the Director of Nursing (DON), the DON stated that an effective QAPI program is essential to identify areas that can be improved in the facility. During a review of the facility's P&P titled, Quality Assurance and Performance Improvement Program (QAPI) Feedback, Data & System Monitoring, dated 8/2017, the P&P indicated that it is the policy of the facility to establish and implement procedures for feedback, data collection systems and monitoring. The P&P also indicated that the purpose of QAPI if to provide the facility an effective system to obtain and use of feedback to identify problems. The P&P further indicated that the facility will maintain an effective system to obtain, use feedback, review available data and measures to determine improvement priorities based on facility identified concerns. The P&P even further indicated that sources of data may include, but are not limited to: State Quality Measures and Indicators and/or facility's own quality indicator reports, Facility Management Goals Quality Review Reports for consultants, Survey reports and deficiencies with Plans Corrections, Survey preparation worksheets, Infection Control sub-committee reports, Safety Team reports, MDS Accuracy Review Tool, Incident/Accident Reports, Complaint/Grievance Logs, Resident, family, employee satisfaction surveys Department Audits. Financial Reports, Medical Records, Internal Audit reports and Self-assessments, Facility Assessment

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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 follow and implement its infection control practices in accordance with the facility's policies and procedures (P&P) titled Scope of Infection Control Program, dated July 2022, by failing to: 1. Ensure that Certified Nurse Assistant (CNA) 7 used personal protective equipment (PPE, isolation gown, gloves, masks to minimize exposure to hazards that cause injuries or infection) such as an isolation gown while providing care to Resident 3, who was placed on Enhanced Barrier Precautions (EBP, an infection control strategy in nursing homes requiring staff to wear gowns and gloves during high-contact care for residents at risk for harboring multi-drug resistant organisms (MDRO, germs that are resistant to many antibiotics]) on 4/13/2026. 2. Ensure that CNA 1 washed his hands prior to feeding Resident 18 during a dining observation on 4/13/2026. 3. Ensure that Restorative Nursing Aide (RNA) 1 donned (put on) PPE while performing Range of Motion (ROM, the extent and direction a joint can move in the body) exercises with Resident 3 on 4/14/2026. 4. Ensure that Treatment Nurse (TXN) 1 used an isolation gown while removing Resident 39's old wound dressing during wound care observation on 4/15/2026. 5.Ensure that the water temperature of Shower room [ROOM NUMBER] had appropriate temperature as indicated on the Monitoring Water Temperature P&P dated April 2015. The water temperature of Shower room [ROOM NUMBER] was 90 degrees Fahrenheit (F, unit of temperature). 6. Ensure that Water Heaters 1, 2, 3, and 4 had thermometers (temperature gauge) to measure the temperature of the Water Heaters and did not provide any documented evidence the temperature of the Water Heater 1, 2, 3, and 4 were monitored as indicated on the Monitoring Water Temperature P&P dated April 2015. 7. Ensure that the water temperatures of Room A, Room B, and Shower room [ROOM NUMBER] were the appropriate water temperature as indicated on the Monitoring Water Temperature P&P dated April 2015. The water temperatures of Room A, Room B, and Shower room [ROOM NUMBER] were between 111 F and 115 F. 8. Ensure the in-built thermometer for Dryer A was functioning properly. On 4/15/2026, the in-[NAME] thermometer for Dryer A did not indicate a temperature of the running dryer machine. 9.Ensure the accurate water temperature for Washer 1 and Washer 2 were documented accurately. 10.Ensure the Infection Preventionist (IP) was knowledge about the facility's Water Management Program related to the program's annual review, the facility's Legionella Environmental Assessment Form, and the facility's water temperature monitoring. These failures had the potential to result in a widespread infection to other residents, staff members, and visitors in the facility. In addition, the failure to implement a Water Management Program had the potential to result in a legionella (opportunistic water-borne pathogen found in water supplies) bacteria within the facility's water system, which may lead to contaminated water supply and the facility's residents, staff members, and visitors developing Legionnaire's disease pneumonia (a serious lung infection caused by breathing in the contaminated water mist of a water system contaminated by the legionella bacteria). Findings 1. During a review of Resident 3's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included respiratory failure (condition where the lungs cannot adequately supply oxygen to the blood), pneumonitis (inflammation of the lung tissue, causing breathing difficulties, dry cough, and fatigue), and asthma (a condition in which the airways narrow and swell and can make breathing difficult and trigger coughing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's History and Physical (H&P), dated 12/28/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 3's Order Summary Report (OSR), the OSR indicated Resident 3 had a physician order on 12/29/2025 for enhanced barrier precautions every shift for PPE (personal protective equipment) gown, gloves during high contact care (daily nursing or therapy activities that require close, hands-on physical contact with a resident) of GT (gastrostomy tube, a tube surgically inserted into the stomach to allow access for food fluids and medications), stoma site (a surgically created opening on the surface of the abdomen that allows waste [stool or urine] to leave the body) care and feeding. During a review of Resident 3's care plan (CP) for enhanced barrier precautions (EBP), revised on 12/29/2025, the CP indicated that Resident 3 requires EBP related to the presence of an indwelling medical device (a device that is left inside the body), GT feeding. The CP included an intervention for staff to implement strict PPE use, gloves and gowns, face protection from splashes. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 1/5/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). The MDS also indicated that the resident is dependent (helper does all of the effort) on activities such as oral hygiene, upper and lower body dressing, personal hygiene, and bathing. During an observation on 4/13/2026 at 10:05 AM inside Resident 3's room, Certified Nursing Assistant (CNA) 7 was changing Resident 3's position in bed while wearing a pair of gloves, but without wearing an isolation gown. During the care, CNA 7's clothes were touching Resident 3's environment, including the resident's clothes and bed linens. During a concurrent observation and interview on 4/13/2026 at 10:13 AM outside Resident 3's room, there was a signage posted outside Resident 3's door that read Enhanced Barrier Precautions. CNA 7 stated that the signage indicated that staff are to wear gloves and an isolation gown when providing high-contact care to Resident 3. CNA 7 stated he forgot to wear an isolation gown while he provided care to the resident. During an interview on 4/13/2026 at 10:16 AM with Registered Nurse (RN) 1, RN 1 stated that Resident 3 has a GT. RN 1 stated that staff must wear an isolation gown when providing high-contact care to Resident 3 such as changing the resident's position because of the presence of the GT. RN 1 stated that wearing an isolation gown prevents the spread of infection between residents. During an interview on 4/16/2026 at 4:23 PM with the Director of Nursing (DON), the DON stated that EBP must be practiced when staff are providing care to residents that have medical devices such as GT. The DON stated that staff are expected to wear an isolation gown, gloves, and a mask, before providing care to the residents. The DON further added that the PPE prevent the spread of infection to the residents. (continued on next page)

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	056413	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 3's admission Record, the admission Record indicated the facility initially admitted Resident 3 on 12/27/2025 with diagnoses including acute respiratory failure (sudden inability of the lunch to provide oxygen to the blood or remove [NAME] dioxide) with hypercapnia (abnormally high levels of carbon dioxide), attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feeding to be administered directly to the stomach for people with swallowing problems), dementia (progressive state of decline in mental abilities), and multiple contractures of muscle. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had unclear speech, had difficulty communicating some words, usually understood verbal content, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 3 was required substantial/maximal assistance for rolling to both sides and dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for toilet hygiene, bathing, upper and lower body dressing, and lying to sitting on the side of the bed. During a review of Resident 3's physician's orders, dated 2/13/2026, the physician's orders indicated for Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to provide gentle passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) to both arms and legs, five times per week as tolerated. The physician's order, dated 2/13/2026, also indicated to apply both pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position), five times per week as tolerated. During an observation on 4/14/2026 at 8:14 a.m. in the resident's room, Resident 3 was awake with the head-of-bed elevated. Resident 3 was receiving G-tube feeding. During an observation on 4/14/2026 at 9:00 a.m. with Restorative Nursing Aide 1 (RNA 1) in the resident's room, Resident 3's RNA session was observed. An EBP cart was observed directly outside of Resident 3's room which contained gowns and gloves. RNA 1 went into the room without a gown but applied disposable gloves. Resident 3 was observed lying awake in bed. RNA 1 performed ROM exercises to the left shoulder, elbow, wrist, thumb, and index finger. Resident 3's left-hand middle, ring, and small fingers were observed completely bent toward the palm. RNA 1 attempted to extend the left-hand middle finger, and Resident 3 screamed. RNA 1 did not perform any ROM exercises to the left-hand middle, ring, and small fingers. RNA 1 performed ROM to the right arm, both hips, both knees, and both ankles. Both of Resident 3's ankles were positioned in plantarflexion (ankles bent away from the body). RNA 1 applied both PRAFOs and placed pillows underneath both legs. RNA 1 disposed both gloves and washed their hands in Resident 3's bathroom sink. During an interview on 4/14/2026 at 9:32 a.m. with RNA 1, RNA 1 stated Resident 3 was on EBP because of the G-tube. RNA 1 stated the EBP precautions were implemented when changing Resident 3's incontinence brief. During an interview on 4/15/2026 at 10:12 a.m. with the IPN, the IPN stated EBP were additional precautions implemented on residents with G-tubes, indwelling devices (medical instruments inserted partially or fully into the body for an extended period), and wounds to minimize transmission of germs to the resident. The IPN stated EBP should be implemented during high contact activity including providing exercises in the resident's room. The IPN stated a gown, and gloves should be worn during high contact activity. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Enhanced Barrier Precaution, dated 6/2022, the P&P indicated EBP referred hand hygiene and the use of gown and gloves during high-contact resident care activities. 3. During a review of Resident 18's admission Record, the admission Record indicated the facility initially admitted Resident 18 on 3/13/2025 and readmitted on [DATE] with diagnoses including Parkinson's disease, dementia, dysphagia (difficulty swallowing), and contractures of both knees and the right hand. During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18 required substantial/maximal assistance for eating and was dependent for hygiene, upper body dressing, lower body dressing, rolling to both sides in bed, and transferring from lying to sitting at the side of the bed. During a dining observation on 4/13/2026 at 12:36 PM in Resident 18's room, Resident 18 was upright in bed with the lunch tray on the bedside table. Certified Nursing Assistant 1 (CNA 1) came into the room and put on disposable gloves. CNA 1 repositioned Resident 18's bed, disposed of the gloves, and left the room. During an observation on 4/13/2026 at 12:39 PM, CNA 1 was observed walking down the hallway with a towel. CNA 1 walked into Resident 18's room and placed the towel over Resident 18's chest. CNA 1 did not perform hand hygiene prior to sitting down in a chair and opening the lunch tray containers. Resident 18 stated, I want bread. CNA 1 removed white bread from a plastic container, tore a piece of bread using both hands, and brought the bread to Resident 18's mouth. Resident 18 was left sitting upright after eating. CNA 1 placed Resident 18's lunch tray into the large food container and performed hand hygiene using alcohol-based hand sanitizer. During an interview on 4/13/2026 at 12:56 PM with CNA 1, CNA 1 stated both hands were washed in the break room prior to getting the towel from the clean linen cart. CNA 1 stated both hands should have also been washed prior to feeding Resident 18. During an interview on 4/15/2026 at 8:45 AM with CNA 1, CNA 1 stated both hands were washed in the break room prior to feeding Resident 18. CNA 1 stated both hands touched multiple surfaces including the break room door handle and cover of the clean linen cart. CNA 1 stated both hands could have had germs that could be transferred to Resident 18 while eating. During an interview on 4/15/2026 at 9:48 AM with the Infection Prevention Nurse (IPN), the IPN stated hand hygiene included using alcohol-based hand sanitizer and washing hands with soap and water. The IPN stated hand hygiene (in general) stopped the transmission of germs to and from the residents. The IPN stated staff should wash their hands prior to handling any food. The IPN stated the expectation was for staff to use utensils to cut bread into small portions prior to feeding bread to the residents. The IPN stated there was an issue with infection control if hand washing was not performed prior to feeding a resident. During a review of the facility's P&P titled, Hand Hygiene, dated 8/2017, the P&P indicated all staff providing direct resident contact will use appropriate hand hygiene. The P&P indicated All employees having direct resident contact will sanitize their hands at least under the following situations:.d. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before and after any procedure with residents. 4. During a review of Resident 39's admission Record (AR), the facility admitted Resident 39 on 12/15/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), acute kidney failure (AKF, a sudden loss of kidney function), and hypertension (HTN, high blood pressure). During a review of Resident 39's Order Summary Report, the order, dated 2/25/2026, indicated that Resident 39 had Enhanced Barrier Precautions (EBP) due to wound care treatments every shift. The order's instructions included to use personal protective equipment (PPE) during high contact care and wear gown, gloves, and follow hand hygiene protocol. During a review of Resident 39's Minimal Data Set (MDS, a resident's assessment), dated 3/24/2026, the MDS indicated that Resident 39's cognitive (a resident's thought process) skills were severely impaired. The MDS indicated that Resident 39 had one venous and arterial ulcer (a small open sore or wound generally found in the stomach or on the skin) present and the wound care treatments included application of nonsurgical dressing and applications of ointment and medications. During observation on 4/15/2026 at 10:40 PM with TXN 1, Resident 39's wound care treatment was observed in Resident 39's room. TXN 1 was observed entering Resident 39's room wearing only gloves and no other PPE such as a gown. TXN 1 was observed removing Resident 39's old dressing and removed dirty gloves. During an interview on 4/16/2026 at 2:02 PM with the Infection Preventionist (IPN), the IPN stated EBP isolation was used during high contact activities with residents who were at risk for multi-resistant drug organisms (MRDO). The IPN stated PPE included gown, gloves, and a face shield if splashing of body liquids was anticipated. The IPN stated that PPE should be used during wound care was considered a high contact activity as an open wound provided an opening in the body for an infection. 5.During a concurrent observation and interview on 4/13/2026 at 10:20 AM with Maintenance Supervisor (MS) 1 in Shower room [ROOM NUMBER], MS 1 was observed checking the water temperature of the shower. MS 1 stated that the water temperature of shower room was 90 degrees Fahrenheit (degrees F, unit of temperature). During a concurrent observation and interview on 4/14/2026 at 8:55 AM with MS 2 in Shower room [ROOM NUMBER], MS 2 was observed checking the water temperature of the shower. MS 2 stated the water temperature of the shower room was 94 degrees F -97 degrees F. MS 2 was observed checking the water temperature of the sink in Shower room [ROOM NUMBER]. MS 2 stated that the water temperature of the sink was 74 degrees F. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/14/2026 at 9:12 AM with MS 2, MS 2 stated that the temperature of Water Heater 3 was set to 110 degrees F this morning. MS 2 stated that the water temperature check was done daily. 6. During a concurrent observation and interview on 4/14/2026 at 09:30 AM with MS 2, Water Heater 1 by the kitchen was observed. MS 2 stated that the thermostat (temperature-sensitive switch that controls when the heating source of the water heater turns on or off to maintain a specific water temperature) of Water Heater 1 was set to C, which meant very hot. MS 2 stated, he did not know what the numerical temperature of very hot meant. MS 2 stated there was no method to check the actual water temperature of Water Heater 1. During the same concurrent observation and interview on 4/14/2026 at 9:33 AM with MS 2, Water Heater 2 by the kitchen was observed. MS 2 stated the thermostat of Water Heater 2 was set at 120 degrees F, but there was no method to check the actual water temperature of Water Heater 2. During the same concurrent observation and interview on 4/14/2026 at 9:35 AM with MS 2, Water Heater 3 in the Washer Room was observed. MS 2 stated the thermostat was Water Heater 3 was 3 set at 123 degrees F. MS 2 stated the temperature gauge of Water Heater 3 was set at 120 degrees F, but there was no method to check the actual water temperature of Water Heater 3. 7.During a concurrent observation and interview on 4/14/2026 at 9:40 AM with MS 2, the sink in Room A was observed. MS 2 stated the water temperature of Room A was 119 degrees F to 120 degrees F per portable digital thermometer. MS 2 stated that the sink temperature should be between 110 degrees F and 120 degrees F. During a concurrent observation and interview on 4/14/2026 at 9:45 AM with MS 2, the sink in Room B was observed. MS 2 stated the water temperature of Room B was 115 degrees F per portable digital thermometer, and the water temperature of the sink should be between 110 degrees F and 120 degrees F. During a concurrent observation and interview on 4/14/2026 at 9:47 AM with MS 2, the sink in Shower room [ROOM NUMBER] was observed. MS 2 stated the water temperature of Shower room [ROOM NUMBER] was between 111 degrees F and 113 degrees F per portable digital thermometer. MS 2 stated the water temperature of the sink should be between 110 degrees F and 120 degrees F. During a concurrent record review and interview on 4/14/2026 at 9:50 AM with MS 2, the Water Temperature records, dated from February 2026 to April 2026 were reviewed. MS 2 stated, the records indicated that Shower room [ROOM NUMBER]'s water temperature on 2/27/2026, 3/20/2027, and 4/10/2026 were 114 degrees F. MS 2 stated there was no documented evidence that the water temperature in Shower room [ROOM NUMBER] was checked. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same concurrent record review and interview on 4/14/2026 at 9:53 AM with MS 2, the Water Temperature records, dated from February 2026 to April 2026 were reviewed. MS 2 stated, the records indicated that Room B's water temperature on 2/24/2026, 3/17/2026, and 4/7/2026 was between 114 degrees F to 115 degrees F. During the same concurrent record review and interview on 4/14/2026 at 9:55 AM with MS 2, the Water Temperature records, dated from February 2026 to April 2026 were reviewed. MS 2 stated there was no documented evidence that the water temperatures of Water Heaters' 1, 2, 3, and 4 were checked. 8.During an observation and interview on 4/15/2026 at 10:15 AM with Laundry Services 1, Dryer A was observed in the Dryer Room. Laundry Services 1 stated that Dryer A's built-in thermometer was not working because the machine was working but the built-in thermometer did not indicate a temperature. Laundry Services 1 stated that he was not aware that the built-in thermometer had malfunctioned and there was no other way to check the temperature of Dryer A. During the same interview on 4/15/2026 at 10:25 AM with Laundry Services 1, Laundry Services 1 stated that since the built-in thermometer was broken, the laundry staff do not know if the temperature of Dryer A was too high or too low, which may affect the drying of the resident's clothes and linens. 9. During a concurrent record review and interview on 4/15/2026 at 10:35 AM with Laundry Services 1, the Daily Washer Temperature Log record, dated for April 202 was reviewed. Laundry Services 1 stated that according to the documentation the water temperature for Washer 1 and Washer 2 was 135 degrees F. During a concurrent observation and interview on 4/15/2026 at 11:25 AM with Laundry Services 2, Washer 1, Washer 2, and Water Heater 4 in the Washer Room were observed. Water Heater 4's thermostat indicated a temperature of 135 degrees F. Washer 1 and Washer 2's water temperature gauge indicated a temperature of about 122 degrees F. Laundry Services 2 stated, she checked the temperature of Washer 1 and Washer 2 daily and documented it in the Daily Washer Temperature Log. Laundry Services 2 pointed to the thermostat on Water Heater 4 and stated Washer 1 and Washer 2's water temperature was 135 degrees F. During a concurrent observation and interview on 4/15/2026 at 12 PM with MS 2, Washer 1 and Washer 2's temperature gauge in the Washer Room were observed. MS 2 stated that the temperature gauge against the wall was the temperature of the water used in Washer 1 and Washer 2. MS 2 stated, the current water temperature of Washer 1 and Washer 2 was between 120 degrees F and 125 degrees F. 10.During an interview on 4/16/2026 at 2:30 PM with the Infection Preventionist Nurse (IPN), the IPN stated she was not familiar with the facility's water management program. The IPN stated that she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was unaware of a system in place in case of an outbreak related to legionella bacteria (opportunistic water-borne pathogen that can be found in water) that may cause Legionnaire's disease pneumonia (pneumonia [lung infection] caused by Legionella's bacteria when a person breathes in the mist or vapor of a water source contaminated with the legionella bacteria). The IPN stated, she was not aware of the water temperature that Legionella's bacteria can grow in. During the same concurrent interview and record review on 4/16/2026 at 2:35 PM with the IPN, the facility's Water Management Program, dated 1/16/2024, was reviewed. The IPN stated, she did not know how often the Water Management program should be reviewed. The IPN stated, according to the documentation, the last time the Water Management program was reviewed on 1/16/2026. During the same concurrent interview and record review on 4/16/2026 at 2:38 PM with the IPN, the facility's Legionella Environmental Assessment Form record, date unknown, was reviewed. The IPN stated she did not know when the facility's Legionella Environment Assessment Form was last reviewed. The IPN stated, she was not aware of this document. During the same concurrent interview and record review on 4/16/2026 at 2:40 PM with the IPN, the facility's policies and procedures (P&P) titled Water Management Program, dated June 2022, was reviewed. The IPN stated, according to the P&P, the facility's Water Management Program should been reviewed annually. The IPN stated she did know the last time the Water Management Program was reviewed. During the same concurrent interview and record review on 4/16/2026 at 2:55 PM with the IPN, the facility's P&P titled Monitor Water Temperature, dated April 2015, was reviewed. The IPN stated, according to the P&P, the accepted temperature range for hot tap water from the resident use areas was 100 degrees F to 110 degrees F. During the same concurrent interview and record review on 4/16/2026 at 3 PM with the IPN, the facility's P&P titled Monitor Water Temperature, dated April 2015, was reviewed. The IPN stated, according to the P&P, there should be a random water temperature check on Water Heater 1, 2, 3, and 4. The IPN stated, according to the P&P, if facility's water heaters do not have a temperature gauge, sample flow from drain valve. During the same concurrent interview and record review on 4/16/2026 at 3:15 PM with the IPN, the facility's Water Temperature records, dated from February 2026 to April 2026, were reviewed. The IPN stated that the water temperature checks in the resident use areas were above the facility's acceptable temperature range of 100 degrees F to 110 degrees F. The IPN stated, if the water temperature was too high, the facility's residents would be at risk for burns. The IPN stated, if the water temperature was too low, the facility's residents would feel uncomfortable. During the same concurrent interview and record review on 4/16/2026 at 3:18 PM with the IPN, the facility's Water Temperature records, dated from February 2026 to April 2026, were reviewed. The IPN (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, it was important to ensure Washer 1 and Washer 2's water temperature was at the acceptable temperature range to ensure proper cleaning and sanitization of the residents' clothes and linens for infection control to prevent the spread of infectious bacteria or viruses throughout the facility. During the same concurrent interview and record review on 4/16/2026 at 3:25 PM with the IPN, the facility's Water Temperature records, dated from February 2026 to April 2026, were reviewed. The IPN stated there was no documented evidence of the water temperature of Water Heaters 1, 2, 3, and 4, were checked. The IPN stated that it was important to sample and check the temperature of the water heaters to ensure there was no mineral or bacteria build-up, such as the Legionella's bacteria, that may contaminate the water system and affect the facility's residents, visitors, and staff members. During a concurrent interview and record review on 4/17/2026 at 12:25 PM with the Administrator (ADM), the facility's Water Management program, dated 1/16/2024, was reviewed. The ADM stated that the IPN oversaw the IP Management Program. The ADM stated, the Water Man[TRUNCATED]

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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 follow obtain informed consent prior to administration of psychotropic medications (medication that affects mood and behavior) for two out of five sampled residents (Resident 8 and Resident 11) in accordance with the facility's policy and procedure (P&P) titled, Informed Consent (a process in which a healthcare professional educates a patient about the risks, benefits, and alternatives of a given treatment) dated 12/2018. This deficient practice had the potential to violate the rights of the residents and responsible party to be informed prior to administering medications without their knowledge or approval. a. During a review of Resident 8's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included dementia (brain disorder that slowly destroys a person's memory and thinking skills), psychosis (a mental disorder characterized when an individual loses touch with reality), and anxiety (mental health condition that cause fear, dread and other symptom). The AR also indicated that Family Member (FM) 1 is Resident 8's responsible party. During a review of Resident 8's History and Physical (H&P), dated 8/15/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). During a review of Resident 8's Order Summary Report (OSR), the OSR indicated Resident 8 had a physician order on 4/13/2026 for Lorazepam (a medication used to manage anxiety) oral (given by mouth) tablet 2 MG (milligram, a unit of measuring weight) Give 2 MG by mouth every 8 hours as needed for increased anxiety. During a review of Resident 8's electronic and physical medical records from 8/13/2025 to 4/16/2026, the records did not indicate the presence of an informed consent for Resident 8's use of Lorazepam. During a review of Resident 8's Medication Administration Record (MAR), for the month of April 2026, the MAR indicated that Resident 8 has been given Lorazepam on 4/13/2026, 4/14/2026, and 4/15/2026. During a concurrent interview and record review on 4/16/2026 at 8:36 AM with Registered Nurse (RN) 1, Resident 8's electronic and paper medical records, from 8/13/2025 to 4/16/2026, were reviewed. RN 1 stated that there is no informed consent for Resident 8's use of Lorazepam, which was ordered on 4/13/2026. RN 1 stated that informed consent must be obtained prior to the administration of any psychotropic medications, such as Lorazepam. b. During a review of Resident 11's AR, the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included dementia and schizophrenia (a mental health condition that affects how people think, feel and behave). The AR also indicated that FM 2 is Resident 11's responsible party. During a review of Resident 11's H&P, dated 5/8/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 11's Order Summary Report (OSR), the OSR indicated Resident 11 had a physician order on 11/19/2025 for Quetiapine fumarate (a medication used to manage schizophrenia) oral tablet give 12.5 MG by mouth at bedtime for schizophrenia seeing things not exist. During a review of Resident 11's MDS, dated [DATE], the MDS indicated that the resident has severely impaired cognition. During a concurrent interview and record review on 4/16/2026 at 8:45 AM with RN 1, Resident 11's electronic and paper medical records from 11/19/2025 to 4/16/2026, were reviewed. RN 1 stated Resident 11 had been receiving Quetiapine since 11/2025 but there was no informed consent for the use of Quetiapine found the records. RN 1 stated that informed consent must be obtained prior to the administration of any psychotropic medications, such as Quetiapine. During an interview on 4/16/2026 at 4:23 PM with the Director of Nursing (DON), the DON stated that an informed consent must be obtained prior to the administration of psychotropic medications. The DON added that it is the resident's right to be informed of risks and benefits of medications. The DON further added that by not informing the resident or their responsible party, the facility places the resident at risk of not (continued on next page)

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Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understanding the risks associated with the consumption of the psychotropic medication. During a review of the facility's P&P titled, Informed Consent, dated 12/2018, the P&P indicated the following: 1. It is the policy of the facility to uphold the residents and dignity of [the facility's] residents, including the resident to make informed decisions about their care. 2. For every [resident] receiving antipsychotic medications, the facility must maintain a written record of the [resident's] decision to consent to such medications. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 6/2021, the P&P indicated that the informed consent will be obtained by the prescriber prior to initiation of the psychotropic medication. The P&P further indicated that the facility shall verify informed consent prior to the administration of a psychotropic medication for a resident.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the interdisciplinary team (IDT - a coordinated group of experts from several different fields who work together) conducted an assessment for one of ten sampled residents (Resident 65) to determine the resident's ability to safely self-administer medications, identify which medications could be self-administered, and determine whether the medications could be kept at the bedside. This deficient practice increased the resident's risk of missing doses, doubleˆdosing due to taking medications at incorrect times, and improperly mixing medications. The deficient practice had a potential for other residents to access or share the resident's medications if they were not stored securely. Findings: During a review of Resident 65's admission Record (AR) the AR indicated Resident 65 was admitted to the facility on [DATE]. During a review of Resident 65's Order Summary Report (OSR), dated 4/14/2026, the OSR indicated Resident 65 had diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 65's OSR, the OSR indicated Resident 65 had a physician order on 4/14/2026 for Magnesium Glycinate oral (given by mouth) capsule, 400 mg (milligram, unit of weight) by mouth one time a day for supplement. During a concurrent observation and interview on 4/15/2026 at 4:16 PM with Resident 65, an unattended bottle of Magnesium Glycinate (a supplement used to improve sleep quality, reduce anxiety [a feeling of fear, dread, and uneasiness], and relieve muscle cramps) of 100 mg with 78 tablets was on top of Resident's 65 bedside table. Resident 65 stated that it was his own personal supplement bottle. During a review of Resident 65's Medication Administration Record (MAR) for the month of April 2026, the MAR indicated on 4/15/2026 at 9 AM, Resident 65 had a dose of Magnesium Glycinate 400 mg. During an interview on 4/15/2026 at 4:16 PM with Licensed Vocational Nurse (LVN 4), LVN 4 stated that Resident 65 had a physician order for Magnesium Glycinate, but the medication was not available in the facility's stock. LVN 4 stated, there was no self-administration of medication assessment completed by the IDT to evaluate Resident 65's ability to safely self-administer Magnesium Glycinate and to keep a bottle of the medication at the resident's bedside. During a facility of the facility's policy and procedure (P&P) titled, Self-Administration of Medication undated, the P&P indicated that alert residents will be informed of their right to self-administer medication. If a resident desires to participate in self-administration the IDT will assess the competence of the resident to participate by completing the Self-administration of Medication Assessment form if the resident is a candidate, it will be indicated by a physician order and a care plan.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report a significant change of condition to the physician and/or the responsible party for two of seven residents (Resident 33 and 3) reviewed for limited range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) by failing to: 1. Notify the licensed nurse of Resident 3's decline of ROM in the left hand during ROM exercises for approximately one month, after performing the Joint Mobility Assessment ([JMA] brief assessment of a resident's range of motion in each joint of both arms and legs) on 4/7/2026, and after an observation with the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) and Occupational Therapist ([OT] professional aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) on 4/15/2026. 2. Notify the licensed nurse of Resident 33's decline in mobility and stopped ambulating. These failures resulted in Resident 3 experiencing a decline in ROM to the left hand from within functional limits ([WFL] sufficient joint movement without significant limitation) upon discharge from OT on 2/13/2026 to moderate-to-severe ROM limitations (25-50% available ROM, 50-75% loss of motion) in the left hand on 4/15/2026, which caused Resident 3 pain upon movement of the left-hand middle, ring, and small fingers and placed Resident 3 at increased risk for pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and further contracture. This deficient practice had the potential to delay care and services to Resident 33 and result in further deterioration of mobility. Cross reference F688. Findings: 1. During a review of Resident 3's admission Record, the admission Record indicated the facility initially admitted Resident 3 on 12/27/2025 with diagnoses including acute respiratory failure (sudden inability of the lunch to provide oxygen to the blood or remove [NAME] dioxide) with hypercapnia (abnormally high levels of carbon dioxide), attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feeding to be administered directly to the stomach for people with swallowing problems), dementia (progressive state of decline in mental abilities), and multiple contractures (stiffening/shortening at any joint that reduces the joint's range of motion) of muscle. During a review of Resident 3's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 1/5/2026, the MDS indicated Resident 3 had unclear speech, had difficulty communicating some words, usually understood verbal content, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 3 was required substantial/maximal assistance (helper does more than half the effort) for rolling to both sides and dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for toilet hygiene, bathing, upper and lower body dressing, and lying to sitting on the side of the bed. During a review of Resident 3's OT Evaluation and Plan of Treatment, dated 12/29/2025, the OT Evaluation indicated Resident 3 had ROM limitations in both shoulders, measuring 0-90 degrees (unit of joint measurement) of shoulder flexion (lifting the arm overhead, normal 0-180 degrees), and negative 30 degrees (-30 degrees) of elbow extension (straightening the elbow, normal 0 degrees). The OT Evaluation indicated Resident 3's right elbow, both wrists, and both hands were within functional limits ([WFL] sufficient joint movement without significant limitation). During a review of Resident 3's JMA, dated 1/5/2026, the JMA indicated Resident 3 had ROM limitations in both arms and legs, including both shoulders limited to 90 degrees in shoulder flexion (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and shoulder abduction (lifting the arm upward and away from the body, normal 0-180 degrees), moderate ROM limitation (50-75 percent [%] available motion, 25-50% loss of motion) in the right elbow, moderate-to-severe ROM limitation in the left elbow, minimal ROM limitation (75-100% available ROM, 0-25% loss of motion) in both hips and knees, and moderate ROM limitation in both ankles. The JMA indicated both of Resident 3's wrists and hands/fingers were WFL. During a review of Resident 3's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated recommendations for RNA to provide PROM exercises to both arms, five times per week as tolerated. During a review of Resident 3's physician's orders, dated 2/13/2026, the physician's orders indicated for RNA to provide gentle PROM to both arms, five times per week as tolerated. During a review of Resident 3's JMA, dated 4/7/2026 and completed by OT 1, the JMA indicated Resident 3 had no ROM changes in both arms and legs and to continue the RNA program as tolerated. During an observation on 4/13/2026 at 2:50 PM in the resident's room, Resident 3 was observed lying awake in bed and unable to speak. Resident 3's left-hand was observed with the middle, ring, and small fingers completely bent and index finger extended (straight). Resident 3 had a bed sheet covering the right arm and both legs. During an observation on 4/14/2026 at 9:00 AM with RNA 1 in the resident's room, Resident 3's RNA session was observed. Resident 3 was observed lying awake in bed. RNA 1 performed ROM exercises to the left shoulder, elbow, wrist, thumb, and index finger. Resident 3's left-hand middle, ring, and small fingers were observed completely bent toward the palm. RNA 1 attempted to extend the left-hand middle finger, and Resident 3 screamed. RNA 1 did not perform any ROM exercises to the left-hand middle, ring, and small fingers. RNA 1 performed ROM to the right arm. During an interview on 4/14/2026 at 9:32 AM with RNA 1, RNA 1 stated Resident 3 received PROM to both arms. RNA 1 stated Resident 3's left arm was stiffer than the right arm. RNA 1 stated Resident 3 screamed in pain when RNA 1 extended left middle finger because the left-hand middle, ring, and small fingers had contractures. During a concurrent observation and interview on 4/14/2026 at 9:36 AM with RNA 1 in the resident's room, Resident 3's left-hand was observed. The fingernails of Resident 3's left-hand middle, ring, and small fingers were bent and pushing into the palm. Resident 3 screamed in pain as RNA 1 extended the tips of the fingers away from the palm. RNA 1 stated the left-hand middle, ring, and small fingers developed the bent position in the past month. During a concurrent observation and interview on 4/15/2026 at 8:36 AM with Certified Nursing Assistant 4 (CNA 4) in the resident's room, Resident 3's left hand was observed. CNA 4 stated the left-hand middle, ring, and small fingers had contractures and would need to use force to open Resident 3's the hand. CNA 4 did not feel comfortable attempting to extend Resident 33's the fingers. During an observation on 4/15/2026 at 9:34 AM in the resident's room, Resident 3 was sitting in a Geri chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported). Resident 3's left hand was observed with a towel placed in the palm. During a concurrent observation and interview on 4/15/2026 at 9:35 AM with Certified Nursing (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant 1 (CNA 1) in the resident's room, Resident 3's left hand was observed. CNA 1 stated Resident 3's left-hand middle, ring, and small fingers had contractures for the past two months. During an interview on 4/15/2026 at 9:38 AM with CNA 4, CNA 4 stated CNA 4 slid a face towel into the left-hand and did not have to extend the fingers. CNA 4 stated the face towel was placed in the left hand to prevent pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) to the palm. During an interview on 4/15/2026 at 12:31 PM with OT 1, OT 1 stated ROM exercises, positioning, and devices could assist with preventing ROM limitations. OT 1 stated dependent residents required another person to perform the ROM exercises. During a concurrent interview and record review on 4/15/2026 at 1:09 PM with OT 1, Resident 3's OT Evaluation, dated 12/29/2025, and OT Discharge summary, dated [DATE], were reviewed. OT 1 stated Resident 3's left hand ROM was WFL without any contracture. OT 1 stated PROM exercises to both arms were recommended upon discharge to maintain Resident 3's ROM since Resident 3 was dependent and required assistance to move. During a concurrent observation and interview on 4/15/2026 at 1:23 PM with OT 1 and RNA 1 in the resident's room, Resident 3's left hand was observed. OT 1 stated Resident 3's left-hand index finger was positioned in extension while the middle, ring, and small fingers were completely bent. Resident 3 screamed as RNA 1 attempted to extend the tips of the bent fingers. RNA 1 stated Resident 3's fingers have been in a bent position for about one month and did not report it to the licensed nurse. RNA 1 stated Resident 3's left-hand contractures should have been reported to the nurse because it was a change in condition. During an interview on 4/15/2026 at 1:35 PM with OT 1, OT 1 stated Resident 3's left hand was observed with moderate-to-severe ROM limitations. OT 1 stated Resident 3 could be experiencing pain or shock when the bent fingers were extended. OT 1 stated the bent position of Resident 3's left middle, ring, and small fingers could affect Resident 3's hygiene and ability to assist with rolling while lying in bed. During an interview on 4/16/2026 at 9:29 AM with RNA 1, when asked if Resident 33's left hand contractures were reported, RNA 1 stated, I just didn't and forgot to inform the licensed nurse Resident 3's left-hand fingers were bending toward the palm for the entire month. During a concurrent interview and record review on 4/16/2026 at 10:00 AM with OT 1, Resident 3's JMA, dated 4/7/2026, was reviewed. OT 1 stated Resident 3's JMA, dated 4/7/2026, was an inaccurate assessment because the JMA indicated Resident 3 did not have any changes in ROM. OT 1 stated the inaccurate JMA prevented Resident 3 from receiving intervention to the left hand to prevent pain and improve positioning. During a concurrent interview and record review on 4/14/2026 at 10:15 AM with the Director of Nursing (DON), Resident 3's Change of Condition documentation was reviewed. The DON stated the RNA program (in general) provided ROM exercises, ambulation and application of splints to avoid declines in the residents' mobility and function. The DON stated the RNA was supposed to inform the licensed nurse of any changes with residents on the RNA program so the licensed nurse could further assess the resident, complete the change of condition documentation, and notify the physician and responsible party. The DON reviewed Resident 3's change of condition documentation which did not (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include changes to Resident 3's left hand. The DON stated contractures (in general) progressively develop. The DON stated Resident 3's left finger contractures could place Resident 3 at risk for skin injury, pain, and further contractures. The DON stated Resident 3 could be in pain if Resident 3 yelled upon extension of the left-hand fingers. The DON stated the absence of Resident 3's change of condition documentation indicated that the licensed nurse, physician, and responsible party were not informed about Resident 3's ROM decline in the left hand. The DON stated Resident 3's decline in left hand ROM should have been reported to the licensed nurse to obtain further orders from the physician. During a review of the facility's policy and procedure (P&P) titled, Standards for Restorative Nursing Program, dated 9/2019, the P&P indicated the RNA will report any change in a patient's status to the therapist and DON. During a review of facility's P&P titled, Change of Condition, dated 8/2017, the P&P indicated the facility shall promptly notify the resident, his or her Attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. 2 During a review of Resident 33's admission Record (AR), the AR indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including difficulty in walking, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and unspecified Dementia (a progressive state of decline in mental abilities). During a review of Resident 33's Minimum Data Set (MDS – a resident assessment tool) dated 2/11/2026, the MDS indicated that Resident 33's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 33 was dependent on staff for personal hygiene, lower body dressing, shower/bathe self, toileting hygiene. Substantial/maximal assistance in putting on/taking off footwear, upper body dressing, and oral hygiene. During a review of, Physical Therapy Discharge Summary, dated 11/5/2025, the Physical Therapy Discharge Summary indicated that Resident 33 was ambulating with Front wheel walker (FWW - an assisting device with front wheels to assist in ambulation) up to 50 feet with partial/moderate assistance. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 33's Order Summary Report dated 11/3/2025, the order summary report indicated the following: Restorative nursing assistant (RNA) to ambulate with Front wheel walker every day five times a week as tolerated every day shift every Monday, Tuesday, Wednesday, Thursday, Friday. During a concurrent interview and record review on 4/16/2026 at 9:37 AM with RNA 1, RNA 1 stated that the Restorative Nurse Weekly Summary dated 1/2026 indicated that in January Resident 33 was walking using the front wheel walker with a distance of 150-200 feet with an average time of 15 minutes with good balance, slow speed, follows directions, fair communication, good pattern. RNA 1 stated that in the month of March 2026 Resident 33 was walking less steps compared to January 2026 with 5-10 feet in distance in her room. RNA 1 stated that this month of April 2026 Resident 33 has not been walking and that the RNA 1 care consisted of transfers from the bed to the chair. RNA 1 stated that by transferring the resident from bed to chair was considered ambulation. RNA 1 stated I don't know what happened to the weekly summaries for February and March. RNA 1 stated that he did not know how to document when the resident's refused treatment or did not tolerate a treatment well. During an interview on 4/17/2026 at 10:16 AM with the Director of Nurses (DON), DON stated that if the RNA does not provide the treatments as ordered by the physician this can potentially lead to a decline in function. DON stated once the RNA completed the treatment for a resident, the RNA would document on the Restorative Treatment Records to indicate treatment was completed. The DON further stated that the RNA should have notified the nursing staff of Resident 33's decline in mobility, since Resident 33 was no longer ambulating. During a review of the facility's P&P titled, Change of Condition, dated 8/2017, medical changes manifested by a marked change in physical, mental and psychosocial status the license nurse will notify the physician and the legal surrogate for any change of condition. The care plan for change of condition will be developed.

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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 observation, interview, and record review, the facility failed to prevent unnecessary use of psychotropic medication (any medication that affects brain activities associated with mental processes and behavior) for two out of five sampled residents (Resident 8 and Resident 11) in accordance with the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 6/2021 by failing to: 1.Ensure Resident 8's physician order for Lorazepam (a medication used to manage anxiety (mental health condition that cause fear, dread and other symptoms) included the resident's symptom or behavior for the facility staff to monitor. 2. Ensure Resident 11's behavior that associated with the use of Quetiapine Fumarate (a medication used to manage schizophrenia [a mental health condition that affects how people think, feel and behave]) was monitored. As a result of the failure, the facility placed the residents at risk for experiencing side effects of the medication and prolonged use of the medication that may be unnecessary. 1. During a review of Resident 8's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included dementia (brain disorder that slowly destroys a person's memory and thinking skills), psychosis (a mental disorder characterized when an individual loses touch with reality), and anxiety. During a review of Resident 8's History and Physical (H&P), dated 8/15/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). During a review of Resident 8's Order Summary Report (OSR), the OSR indicated Resident 8 had a physician order on 4/13/2026 for Lorazepam oral (given by mouth) tablet 2 mg (milligram, a unit of measuring weight) Give 2 mg by mouth every 8 hours as needed for increased anxiety. The OSR did not indicate Resident 8's specific behavior that is associated with the use of Lorazepam. During a review of Resident 8's Medication Administration Record (MAR), for the month of April 2026, the MAR indicated that Resident 8 has been given Lorazepam on 4/13/2026, 4/14/2026, and 4/15/2026. The MAR did not indicate Resident 8's behavior that was associated with Lorazepam was monitored. During a concurrent interview and record review on 4/16/2026 at 8:36 AM with RN 1, Resident 8's physician order for Lorazepam, dated 4/13/2026, was reviewed. RN 1 stated that the order did not include Resident 8's behavior that needed to be monitored. RN 1 stated that the order should include Resident 8's specific behavior that associated with the use of Lorazepam for staff to monitor because the frequency of that behavior would indicate the effectiveness of the medication use. 2. During a review of Resident 11's AR, the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included dementia and schizophrenia. During a review of Resident 11's H&P, dated 5/8/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 11's Order Summary Report (OSR), the OSR indicated Resident 11 had a physician order on 11/19/2025, for Quetiapine fumarate oral tablet give 12.5 MG by mouth at bedtime for schizophrenia seeing things (that do) not exist. During a review of Resident 11's MDS, dated [DATE], the MDS indicated that the resident has severely impaired cognition. During a review of Resident 11's MAR for April 2026, the MAR did not indicate that the resident was being monitored for the behavior of seeing things that do not exist. During a concurrent interview and record review on 4/16/2026 at 8:45 AM with RN 1, Resident 11's medical records including the MAR for April 2026, were reviewed. RN 1 stated that the MAR does not indicate that Resident 11's behavior of seeing things [that do] not exist was monitored. RN 1 stated that the resident's behavior must be monitored. During an interview on 4/16/2026 at 4:23 PM with the Director of Nursing (DON), the DON stated that all psychotropic medications must have a behavior associated with them. The DON added that the behavior must be monitored by the staff to know if the (continued on next page)

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Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication is working as intended or not. The DON also stated that it is important to know if the medication is working to determine if the medication needs to be continued or not. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 6/2021, the P&P indicated the following: Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms. All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All residents receiving medications used to treat behaviors should be monitored for efficacy, risks, benefits, and harm or adverse consequences. Facility staff should monitor resident's behavior pursuant to Facility policy using behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set ([MDS] a federally mandated resident assessment tool) for two of seven residents (Resident 3 and 10) reviewed for limited range of motion ([ROM] full movement potential of a joint) and mobility (ability to move). This failure also resulted in delayed transmission of Resident 3 and 10's MDS assessments to the Federal database. Cross reference F657 and F688. Findings: a. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 12/27/2025 with diagnoses including acute respiratory failure (sudden inability of the lunch to provide oxygen to the blood or remove [NAME] dioxide) with hypercapnia (abnormally high levels of carbon dioxide), attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feeding to be administered directly to the stomach for people with swallowing problems), dementia (progressive state of decline in mental abilities), and multiple contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) of muscle. During a review of Resident 3's Annual MDS, dated [DATE], the Annual MDS had an assessment reference date ([ARD], specific endpoint for the observation period in the MDS assessment process) of 1/5/2026. The Annual MDS indicated Resident 3 had unclear speech, had difficulty communicating some words, usually understood verbal content, and had severely impaired cognition (ability to think, understand, learn, and remember). The Annual MDS indicated Resident 3 was required substantial/maximal assistance (helper does more than half the effort) for rolling to both sides and dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for toilet hygiene, bathing, upper and lower body dressing, and transferring from lying to sitting on the side of the bed. Resident 6's Annual MDS was signed as completed on 1/28/2026. During an interview on 4/16/2026 at 3:03 PM with the MDS Coordinator (MDSC), the MDSC stated the MDS (in general) was an assessment completed for each resident to assess the resident's functional level, determine functional declines, and determine how to address functional declines. The MDSC also stated the MDS assessments assisted in the development of a resident's care plan. The MDSC stated the MDS had to be complete and accurate and submitted to the Federal database. During a review of Page 2-17 of the Resident Assessment Instrument ([RAI] full resident assessment which includes the MDS) User Manual, revised 10/1/2025, the RAI User Manual indicated Annual (Comprehensive) completion date was the ARD plus 14 calendar days. During a concurrent interview and review on 4/16/2026 at 3:57 PM with the MDSC, Resident 6's MDS, dated [DATE], was reviewed. The MDSC stated Resident 6's MDS was completed and submitted on 1/28/2026, which was late. The MDSC stated Resident 6's MDS submission was overlooked. During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Transmission and Validation Reports, dated 3/2019, the P&P indicated the interdisciplinary team (IDT) completed the MDS for each resident according to the scheduled assessments due. b. During a review of Resident 10's admission Record, the admission Record indicated the facility admitted Resident 10 on 4/26/2025 with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area), left ankle stress fracture (small crack or severe bruising in a bone, usually in the lower leg or foot, caused by overuse), right femoral (thigh bone) neck fracture (break in the uppermost part of the hip bone just below the ball of the hip joint), muscle weakness, and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 10's Annual MDS, dated [DATE], the Annual MDS's ARD date was 9/29/2025. The MDS indicated Resident 10 Resident 10 had clear speech, clear comprehension, expressed ideas and wants, and had intact cognition. The MDS indicated Resident 10 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists only prior to or (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following the activity) for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 10 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for rolling to both sides in bed and transferring from lying to sitting on the side of the bed. The MDS also indicated Resident 10 required partial/moderate assistance (helper does less than half the effort) for lower body dressing, sit-to-stand transfer, and chair/bed-to-chair transfers. Resident 10's Annual MDS was signed as completed on 10/16/2025. During an interview on 4/16/2026 a 3:03 p.m. with the MDS Coordinator (MDSC), the MDSC stated the MDS (in general) was an assessment completed for each resident to assess the resident's functional level, determine functional declines, and determine how to address functional declines. The MDSC also stated the MDS assisted in the development of a resident's care plan. The MDSC stated the MDS had to be complete and accurate and submitted to the Federal database. During a review of Page 2-17 of the Resident Assessment Instrument ([RAI] full resident assessment which includes the MDS) User Manual, revised 10/1/2025, the RAI User Manual indicated Annual (Comprehensive) completion date was the ARD plus 14 calendar days. During a concurrent interview and record review on 4/16/2026 at 3:36 PM with the MDSC, Resident 10's MDS, dated [DATE], was reviewed. The MDSC stated Resident 10's Annual MDS should have been signed and completed on 10/13/2025. The MDSC stated Resident 19's Annual MDS was signed and completed on 10/16/2025, which was late. During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Transmission and Validation Reports, dated 3/2019, the P&P indicated the interdisciplinary team (IDT) completed the MDS for each resident according to the scheduled assessments due.

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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 accurately assess two of seven sampled residents (Resident 33 and 6) with limited range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) on the ([MDS] a federally mandated resident assessment tool) by failing to: 1. Accurately assess Resident 33's MDS for entries related to related to Restorative Nursing Programs (nursing aide program in which Restorative Nursing Assistants [RNA] help residents to maintain their function and joint mobility) to reflect the current programs performed. 2. Accurately assess Resident 6's functional limitation in range of motion (limited ability to move a joint that interferes with daily functioning or places a resident at risk for injury). This failure had the potential to affect the provision of intervention to address Resident 33 and 6's mobility and ROM limitations and provided inaccurate information to the Federal database. Cross reference F688. Findings: 1.During a review of Resident 33's admission Record (AR), the AR indicated Resident 33 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including difficulty in walking, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and unspecified Dementia (a progressive state of decline in mental abilities). During a review of Resident 33's Order Summary Report (OSR), dated 11/3/2025, the OSR indicated Resident 33 had a physician order for RNA to ambulate with Front wheel walker every day five times a week as tolerated every day shift every Monday, Tuesday, Wednesday, Thursday, Friday. During a review of Resident 33's Physical Therapy Discharge Summary (PTDS), dated 11/5/2025, the PTDS indicated that Resident 33 was ambulating with a Front wheel walker (FWW - an assisting device with front wheels to assist in ambulation) up to 50 feet with partial/moderate assistance. During a review of Resident 33's MDS, dated [DATE], the MDS indicated that Resident 33's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 33 was dependent (helper does all of the effort) on staff for personal hygiene, lower body dressing, shower/bathe self, toileting hygiene; and Resident 33 required substantial/maximal assistance (helper does more than half the effort) in putting on/taking off footwear, upper body dressing, and oral hygiene. The MDS also indicated that Resident 33's ambulation was not attempted due to medical condition or safety concerns. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 33's MDS, dated [DATE], the MDS indicated that Resident 33 received 5 days in the past 7 days of at least 15 minutes per day of Restorative Nursing Program services for walking. However, the same MDS also indicated walking 10 feet was not attempted due to the resident's medical condition or safety concerns. During an interview on 4/15/2026 at 11:09 AM with MDS Coordinator (MDSC), the MDSC stated that she completed the MDS assessment dated [DATE] based on the physician orders but has not physically seen Resident 33 ambulating. The MDSC stated that she needs to complete a new MDS to reflect the change of condition when Resident 33 was no longer able to walk. The MDSC stated that it is important to accurately complete the MDS since this can affect and delay the resident's care. During an interview 4/17/2026 at 12:24 PM with the Director of Nurses (DON), the DON stated discrepancies on the MDS can affect the resident's wellbeing. The DON stated Resident 33 will not receive proper care due to incorrect documentation on the MDS. During a review of the facility's policy and procedure (P&P) titled Minimum Data Set (MDS) Accuracy dated 10/2023, indicated the facility should ensure that every resident receives an accurate assessment by staff that are qualified to assess relevant care areas and are knowledgeable of the resident's status, needs, strengths and areas of potential or actual decline. 2. During a review of Resident 6's admission Record, the admission Record indicated the facility initially admitted Resident 6 on 11/6/2025 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction affecting the left non-dominant side. During a review of Resident 6's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 11/13/2025, the MDS indicated Resident 6 had no functional limitation in ROM to both arms. The MDS indicated Resident 6 had functional limitation in ROM to one leg. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had clear speech, usually understood verbal content, had difficulty communicating or finishing some words, and had severely impaired cognition. The MDS indicated Resident 6 required supervision for eating, partial/moderate assistance for oral hygiene and upper body dressing, and substantial/maximal (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance with bathing, rolling to both sides in bed, and transferring from lying to sitting on the side of the bed. The MDS indicated Resident 6 had no functional limitation in ROM to both arms and functional limitation in ROM to one leg. During a review of Resident 6's physician's orders, dated 2/25/2026, the physician's orders indicated for Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) to provide gentle passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) on the left arm and left leg, five times per week as tolerated. During an observation on 4/13/2026 at 10:30 AM in the resident's room, Resident 6 used the right hand to hold onto a phone over the right ear while speaking on the phone. During an observation on 4/13/2026 at 1:36 PM with Restorative Nursing Aide 1 (RNA 1) in the resident's room, Resident 6's RNA session was observed. RNA 1 performed ROM exercises to the left arm and left leg. Resident 6 was observed moving the right arm and right leg normally. During an interview on 4/13/2026 at 1:58 PM with RNA 1, RNA 1 stated Resident 6 received PROM to the left arm and leg. During an observation on 4/14/2026 at 8:36 AM in the resident's room, Resident 6 was observed to slightly move the left leg and did not have active movement in the left arm. During an interview on 4/16/2026 a 3:03 p.m. with the MDS Coordinator (MDSC), the MDSC stated the MDS (in general) was an assessment completed for each resident to assess the resident's functional level, determine functional declines, and determine how to address functional declines. The MDSC also stated the MDS assisted in the development of a resident's care plan. The MDSC stated the MDS had to be complete and accurate and submitted to the Federal database. During a concurrent interview and record review on 4/16/2026 at 3:11 p.m. with the MDSC, Resident 6's MDS, dated [DATE] and 2/13/2026, were reviewed. The MDSC stated Resident 6's MDS for function limitation in ROM indicated Resident 6 had no ROM limitations in the arms and ROM limitation in one leg. The MDSC stated Resident 6's MDS assessments were inaccurate. The MDSC stated Resident 6 had hemiplegia affecting the left side and should have also indicated Resident 6 had functional ROM limitation in one arm. During an interview on 4/17/2026 at 11:08 a.m. with the Director of Nursing (DON), the DON stated Resident 6's inaccurate MDS assessments resulted in inaccurate reporting to the Federal database and had the potential to prevent the development of care plans. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Page Z-5 of the Resident Assessment Instrument ([RAI] full resident assessment which includes the MDS) User Manual, revised 10/1/2025, the RAI User Manual indicated signature of persons completing any part of the MDS was a legal attestation of accuracy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedure (P&P) for the development of care plans for one out of three sampled residents (Resident 38) when: The facility did not develop a care plan to address the communication needs of Resident 38, a resident who did not speak English. This deficient practice placed the residents to not receive resident specific care and services according their individual needs. During a review of Resident 38's admission Record (AR), the AR indicated that the resident was admitted on [DATE] with diagnoses that included hypertension (elevated blood pressure), diabetes mellitus (elevated blood sugar levels), and repeated falls. The AR also indicated that the resident's primary language is not English. During a review of Resident 38's History and Physical (H&P), dated 3/30/2026, the H&P indicated that the resident does have the capacity to understand and make decisions. During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool), dated 4/1/2026, the MDS indicated that the resident has intact cognition (the ability to process thoughts). The MDS also indicated that the resident's preferred language is not English. During a review of Resident 38's Nursing admission Assessment (NAA), dated 3/30/2026, the NAA indicated that Resident 38's primary language is not English. During a review of Resident 38's Social Service Assessment (SSA), dated 3/30/2026, the SSA indicated that Resident 38's primary language is not English. During a review of Resident 38's entire care plans, the care plans did not include any care plan that addressed Resident 38's communication needs. During a concurrent observation and interview on 4/15/2026 at 8:03 AM inside Resident 38's room, an interaction between Resident 38 and Licensed Vocational Nurse (LVN) 3 was observed. LVN 3 asked Resident 38 if the resident was experiencing pain. Resident 38 responded to LVN 3 in a non-English language. LVN 3 stated he did not understand Resident 38's response. LVN 3 stated whenever he needed information from Resident 38, he requested another staff to translate. LVN 3 stated he is not aware of any other way to communicate with Resident 38 other than having another staff member translate for Resident 38. LVN 3 further stated that Resident 38 does not have a communication board (a board with pictures that help non-English speaking individuals communicate). During a concurrent interview and record review on 4/16/2026 at 4:23 PM with the Director of Nursing (DON), Resident 38's records were reviewed, including the resident's care plans. The DON stated that there was no care plan to address the resident's communication needs. The DON stated that if a resident does not speak English, facility staff must develop a care plan on how to address the resident's language barrier. The DON added that the care plan could include interventions such as providing a communication board as a tool to facilitate communication with the resident. The DON stated that the facility must accommodate the language needs of the resident because accurate communication is important in providing care to residents. During a review of the facility's P&P titled, Comprehensive Plan of Care, dated 12/2016, the P&P indicated the following: It is the policy of this facility to provide each resident with a comprehensive plan of care developed that includes goals, measurable objectives and timetables to meet their medical, nursing, mental, psychosocial needs identified during comprehensive assessment. The comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Comprehensive care plans will be fully developed within 7 days after completing the comprehensive assessment (MDS). The comprehensive plan of care will include interventions to meet both short and long-term resident goals.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise and update the care plan (CP) for two of seven residents (Resident 10 and 6) with limited range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) by failing to: 1. Revise and update Resident 10's CP for Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) services for ambulation (the act of walking). 2. Revise and update Resident 6's CP to specify the RNA program and discontinuation of PT services. These failures had the potential to result in inaccurate provision of services for ROM and mobility to Resident 6 and resulted in the absence of intervention for Resident 10's ability to walk. Cross reference F688. Findings: 1. During a review of Resident 10's admission Record, the admission Record indicated the facility originally admitted Resident 10 on 9/13/2018 and readmitted on [DATE] with diagnoses including cerebral infarction (brain damage due to a loss of oxygen to the area), left ankle stress fracture (small crack or severe bruising in a bone, usually in the lower leg or foot, caused by overuse), right femoral (thigh bone) neck fracture (break in the uppermost part of the hip bone just below the ball of the hip joint), muscle weakness, and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 10's CP for activities of daily living ([ADLs] basic tasks that individuals perform to maintain their daily lives and independence) self-care performance, revised 5/28/2025 with target date of 6/30/2026, the CP interventions included RNA to perform ambulation with the front wheeled walker ([FWW] an assistive device with two front wheels used for stability when walking), five times per week as tolerated. During a review of Resident 10's Order Summary Report (OSR), the OSR indicated Resident 10 had a physician order on 7/7/2025 for RNA to ambulate with Resident 10 using the FWW, five times per week as tolerated. During a review of Resident 10's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 9/29/2025, the MDS indicated Resident 10 had clear speech, clear comprehension, expressed ideas and wants, and had intact cognition. The MDS indicated Resident 10 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists only prior to or following the activity) for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 10 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for rolling to both sides in bed and transferring from lying to sitting on the side of the bed. The MDS also indicated Resident 10 required partial/moderate assistance (helper does less than half the effort) for lower body dressing, sit-to-stand transfer, and chair/bed-to-chair transfers. Resident 10's MDS indicated walking 10 feet was not attempted due to medical or safety concerns. During a review of Resident 10's PT Evaluation and Plan of Treatment, dated 11/6/2025, the PT Evaluation indicated Resident 10 was referred to PT due to increased weakness in both legs and increased difficulty with bed mobility, transfers, and ambulation. The PT Evaluation indicated Resident 10 had ROM limitations in both ankles, measuring negative 10 degrees ([-10 degrees] measure of joint motion). The PT Evaluation indicated Resident 10 required substantial/maximal assistance (helper does more than half the effort) for rolling to both sides in bed and transferring from lying to sitting on the side of the bed. The PT Evaluation also indicated Resident 10 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for sit-to-stand transfers, chair/bed-to-chair transfers, and ambulation of 50 feet. During a review of Resident 10's CP for difficulty in gait (manner of walking), muscle weakness, decline in functional mobility skills, balance deficits, impaired positioning, potential for skin breakdown (tissue damage caused by surfaces (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rubbing against each other, strain produced by pressure, moisture, or pressure), safety awareness problems, and at risk for falls, initiated 11/6/2025 with target date of 6/30/2026, the CP indicated interventions that included PT interventions three times per week for 30 days. During a review of Resident 10's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated Resident 10 required partial/moderate assistance for transferring from lying to sitting on the side of the bed, substantial/maximal assistance for transferring to a standing position from sitting in a chair, wheelchair, or the side of the bed, and ambulation was not attempted to due medical conditions or safety concerns. The PT Discharge Summary indicated Resident 10 continued to have ROM limitation of -10 degrees at the ankle joints. The PT Discharge Summary indicated recommendations for RNA to perform ROM to both legs, five times per week as tolerated. During a review of Resident 10's Order Summary Report (OSR), the OSR indicated Resident 10 had a physician order on 12/20/2025 for the RNA to provide active range of motion ([AROM] performance of an exercise to move a joint without any assistance or effort of another person) or active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both legs (A/AAROM to both legs), five times per week as tolerated. During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had clear speech, had clear comprehension, expressed ideas and wants, and had intact cognition. The MDS indicated Resident 10 required setup or clean-up assistance for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 10 required supervision or touching assistance for rolling to both sides in bed and transferring from lying to sitting on the side of the bed. The MDS also indicated Resident 10 required partial/moderate assistance for lower body dressing, sit-to-stand transfer, and chair/bed-to-chair transfers. Resident 10's MDS indicated walking 10 feet was not attempted due to medical or safety concerns. During a review of the facility's Order Listing Report for RNA ([OLR for RNA] list of residents with active orders for RNA) dated 4/13/2026 at 9:53 AM, the OLR for RNA did not include Resident 10. During a concurrent observation and interview on 4/13/2026 at 1:17 PM with Resident 10 in the resident's room, Resident 10 was awake, alert, and spoke clearly while lying in bed. Resident 10 stated Resident 10 was unable to stand and walk. Resident 10 stated the facility was supposed to provide exercises to both legs and walking every day but has not provided those services for a couple of months (unspecified date). Resident 10 stated one or two people were needed to assist with transferring Resident 10 from the bed to the wheelchair. Resident 10 cried and stated feeling neglected because Resident 10 cannot walk and wanted to walk. During an interview on 4/16/2026 at 3:03 PM with the MDS Coordinator (MDSC), the MDSC stated the MDS (in general) was an assessment completed for each resident to assess the resident's functional level, determine functional declines, and determine how to address functional declines. The MDSC also stated the MDS assisted in the development of a resident's CP. During a concurrent interview and record review on 4/16/2026 at 3:36 PM with the MDSC, Resident 10's CPs were reviewed. The MDSC stated Resident 10's CPs were revised on 10/15/2025. The MDSC stated Resident 10 was not receiving PT and RNA services for ambulation but had active CPs for PT and RNA for ambulation. The MDSC stated the therapist was supposed to update the therapy and RNA CPs. During an interview on 4/16/2026 at 3:57 PM with MDSC, the MDSC stated the facility could overlook a resident's care if the revised CPs were inaccurate. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Plan of Care, dated 12/2016, the P&P indicated the comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated to modify care plans as necessary to reflect changes in care, service and treatment. 2. During a review of Resident 6's admission Record, the admission Record indicated the facility initially admitted Resident 6 on 11/6/2025 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction affecting the left non-dominant side. During a review of Resident 6's CP for difficulty in gait, muscle weakness, decline in functional mobility skills, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	balance deficits, impaired positioning, potential for contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) formation, potential for skin breakdown, safety awareness problems, and at risk for falls, initiated 12/23/2025 with target date on 5/14/2026, the CP indicated the interventions that included PT intervention five times per week for 30 days. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had clear speech, usually understood verbal content, had difficulty communicating or finishing some words, and had severely impaired cognition. The MDS indicated Resident 6 required supervision for eating, partial/moderate assistance for oral hygiene and upper body dressing, and substantial/maximal assistance with bathing, rolling to both sides in bed, and transferring from lying to sitting on the side of the bed. The MDS indicated Resident 6 had no functional limitation in ROM to both arms and functional limitation in ROM to one leg. During a review of Resident 6's Order Summary Report (OSR), the OSR indicated Resident 10 had a physician order on 2/25/2026 for RNA to provide gentle passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) on the left arm and left leg, five times per week as tolerated. During a review of Resident 6's CP for decline in mobility and RNA for PROM exercises, initiated 3/16/2026, the CP indicated to provide RNA treatments as ordered. During an observation on 4/13/2026 at 10:30 AM in Resident 6's room, the resident used the right hand to hold onto a phone over the right ear while speaking on the phone. During an observation on 4/13/2026 at 1:36 PM with RNA 1 in Resident 6's room, Resident 6 was having an RNA session with RNA 1. RNA 1 performed ROM exercises to the left arm and left leg. Resident 6 was moving the right arm and right leg normally. During an interview on 4/13/2026 at 1:58 PM with RNA 1, RNA 1 stated Resident 6 received PROM to the left arm and leg. During an observation on 4/14/2026 at 8:36 AM in Resident 6's room, Resident 6 slightly moved the left leg and did not have active movement in the left arm. During an interview on 4/16/2026 a 3:03 PM with the MDS Coordinator (MDSC), the MDSC stated the MDS (in general) was an assessment completed for each resident to assess the resident's functional level, determine functional declines, and determine how to address functional declines. The MDSC also stated the MDS assisted in the development of a resident's CP. During a concurrent interview and record review on 4/16/2026 at 3:11 PM with the MDSC, Resident 6's CPs were reviewed. The MDSC stated Resident 6's CPs would not be reviewed and revised until 5/14/2026 because of the facility's process to revise the CP during the quarterly review. The MDSC stated revising the CP quarterly would not reflect Resident 6's current plan of care. The MDSC stated Resident 6's CP for PT should have been discontinued upon discharge from PT services. The MDSC stated the RNA CP indicated Resident 6 was receiving RNA for PROM but did not indicate the joints to provide PROM. During a review of the facility's P&P titled, Comprehensive Plan of Care, dated 12/2016, the P&P indicated the comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated to modify care plans as necessary to reflect changes in care, service and treatment.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that two of 53 nursing staff (Director of Nursing [DON] and Certified Nurse Assistant [CNA] 10) Basic Life Support (BLS, the level of care provided to victims of life-threatening illness or injuries until medical care is available, including recognition of cardiac arrest and activation of the emergency response system), that included cardiopulmonary resuscitation (CPR, an emergency procedure combing chest compressions and rescue breaths to circulate blood and oxygen when the heart stops or breathing ceases) licenses were not expired. This deficient practice had the potential to place the residents, who were identified as full code, at risk for not receiving adequate and proper life-saving measures during a code blue (a life-threatening medical emergency requiring an immediate trained response for CPR), potentially leading to greater harm and/or death to other residents residing in the facility.Findings: During a concurrent interview and record review and interview on [DATE] at 5 PM with the Director of Staff Development (DSD), the DON's employee file was reviewed. The DSD stated the employee filed indicated that the DON's BLS/CPR certification had expired in 11/2025. The DSD stated, she was unaware that the DON's BLS/CPR certification had expired because she did not keep his employee file in her office nor did she check his employee file. During the same interview on [DATE] at 5:20 PM with the DSD, the DSD stated it was important for the licensed nurses, especially the DON, to be up to date and demonstrate continued proficiency in the BLS/CPR guidelines in the event of an emergency. During an interview on [DATE] at 11:33 AM with the DON, the DON stated he was not aware that his own BLS/CPR certification had expired on 11/2025. The DON stated he was not aware whether staff members were permitted to provide direct patient care while holding an expired BLS/CPR certification. During the same interview on [DATE] at 11:35 AM with the DON, the DON stated that it was important for all nursing staff to remain up to date with the latest BLS/CPR guidelines to ensure staff retained the skills necessary to perform CPR. During a concurrent interview and record review on [DATE] at 12:05 PM with the DSD, the Employee Log record, was reviewed. The DSD stated there were 28 CNAs and 25 LVNs employed in the facility. The DSD stated that CNA 10's BLS/CPR certification expired on 1/2026. During the same interview on [DATE] at 12:10 PM with the DSD, the DSD stated that CNA 10 did not renew her BLS/CPR card. The DSD stated, she did not know that a staff member should not be assigned to provide direct patient care if the staff member had an expired BLS/CPR certification. During a review of the facility's policies and procedures (P&P) titled Cardiopulmonary Resuscitation (CPR), dated [DATE], the P&P indicated that nurses and other care staff are educated to initiate CPR, as recommended by the American Heart Association (AHA). During a review of the same facility's P&P titled Cardiopulmonary Resuscitation (CPR), dated [DATE], the P&P indicated that CPR certified staff will be available at all times. The P&P indicated that staff will maintain current CPR certification for healthcare providers including hands-on skills practice and in-person assessment and demonstration of skills. During a review of the same facility's P&P titled Cardiopulmonary Resuscitation (CPR), dated [DATE], the P&P indicated that all direct patient care personnel will re-certify in BLS/CPR annually. During a review of the facility's job description titled Certified Nursing Assistant (CNA), dated [DATE], the job description stated the CNA's licensure, and certification included a current California CNA certification and a current BLS/CPR certification. During a review of the facility's job description titled Director of Nursing (DON), dated [DATE], the job description stated that the DON has 24-hour accountability is responsible for the delivery of high-quality and cost-effective health care while achieving positive clinical outcomes, and patient/family and employee satisfaction. During a review of the same facility's job description titled Director of Nursing (DON), dated [DATE], the job description stated that the DON ensures education, training, and competency validation is completed per state and federal regulations. During a review of (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's P&P titled License Verification, dated [DATE], the P&P indicated that the Director of Staff Development will be responsible for overseeing, maintaining, and completing education in-services and training.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pressure relieving devices to one of seven sampled residents (Resident 18) reviewed for limited range of motion ([ROM] full movement potential of a joint) and mobility (ability to move) who was assessed as high risk for the developing pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). This failure had the potential for Resident 18 to develop pressure injuries, which could lead to pain and discomfort. Findings: During a review of Resident 18's admission Record, the admission Record indicated the facility initially admitted Resident 18 on 3/13/2025 and readmitted on [DATE] with diagnoses including Parkinson's disease, dementia, dysphagia (difficulty swallowing), and contractures (stiffening/shortening at any joint that reduces the joint's range of motion) of both knees and the right hand. During a review of Resident 18's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 1/5/2026, the MDS indicated Resident 18 required substantial/maximal assistance for eating and was dependent for hygiene, upper body dressing, lower body dressing, rolling to both sides in bed, and transferring from lying to sitting at the side of the bed. During a review of Resident Joint Mobility Assessment ([JMA] brief assessment of a resident's range of motion in each joint of both arms and legs), dated 4/6/2026, the JMA indicated the ROM in Resident 18's left shoulder, both elbows, the left wrist, the left hand, and both ankles were within functional limits ([WFL] sufficient joint movement without significant limitation). The JMA indicated Resident 18 did not have active movement in the right arm. The JMA indicated Resident 18 had limitations in the right arm, including 0-45 degrees of passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) for right shoulder flexion (lifting the arm overhead, normal 0-180 degrees), 0-45 degrees PROM for right shoulder abduction (lifting the arm upward and away from the body, normal 0-180 degrees), moderate-to-severe ROM limitation (25-50 percent [%] available ROM, 50-75% loss of motion) in the right wrist, and moderate ROM limitations (50-75% available ROM, 25-50% loss of motion) in both hips and both knees. During a review of Resident 18's Braden Scale for Predicting Pressure Sore (pressure injury) Risk, dated 4/8/2026, the Braden Scale indicated Resident 18 was at high risk for developing pressure injuries. During an observation on 4/13/2026 at 10:23 AM in the resident's room, Resident 18 was lying in bed positioned in a fetal position (position with knees bent and tucked toward the chest resembling a fetus in the womb) while turned toward the right side. During an observation on 4/13/226 at 11:23 AM with Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) 1 (RNA 1) in the resident's room, Resident 18's legs were observed rotated to the right side with both hips and knees bent. Resident 18's left knee joint was directly on top of the right inner thigh. During an observation on 4/13/2026 at 2:53 PM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 18's incontinence brief was just changed. CNA 2 removed the blanket from Resident 18's legs. Resident 18's legs were rotated toward the right with the left knee observed directly on top of the right inner thigh. CNA 2 stated Resident 18 had contractures to both legs which causes Resident 18 to have pain when changing the incontinence briefs. During a concurrent observation and interview on 4/17/2026 at 8:16 AM with Licensed Vocational Nurse 2 (LVN 2) in the resident's room, Resident 18's legs were observed rotated to the right side with both hips and knees bent into a fetal position. Resident 18 had a pillow in between the knees. LVN 2 stated Resident 18 had contractures to both legs with both hips and knees in a bent position. LVN 2 stated Resident 18 had a pillow in between the knees to prevent any pressure injuries. LVN 2 stated Resident 18 could develop pressure injuries between the legs without pillow placement. During an interview on 4/17/2026 at 10:49 AM with the Director of Nursing (DON), the DON stated Resident 18's legs were usually rotated toward the right side with the hips and knees bent. The DON stated Resident 18 should have a pillow placed in between the legs to prevent the knees from rubbing (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	together and to prevent skin injuries. During a review of the facility's policy and procedure (P&P) titled, Skin Care Management, dated 4/2015, the P&P indicated Each resident receives the care and services necessary to retain or regain optimal skin integrity to the extent possible.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of three sampled residents (Resident 3) received oxygen (the most critical gas for human survival) therapy with the oxygen nasal cannula (NC, a thin and hollow plastic tube that is placed under an individual's nostril to deliver oxygen) placed in the nostril and not over the resident's left cheek. This deficient practice placed Resident 3, who had diagnoses that affect the respiratory system (the body's way of bringing in oxygen), at risk of experiencing complications associated with the lack of oxygen. During a review of Resident 3's admission Record (AR), the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included respiratory failure (condition where the lungs cannot adequately supply oxygen to the blood), pneumonitis (inflammation of the lung tissue, causing breathing difficulties, dry cough, and fatigue), and asthma (a condition in which the airways narrow and swell and can make breathing difficult and trigger coughing). During a review of Resident 3's care plan for the resident's risk of ineffective airway clearance, created on 3/15/2024, the care plan included a goal for the resident to have no signs and symptoms of respiratory distress (a condition when a person is having trouble breathing and their body is working too hard to get enough oxygen). The care plan included an intervention for the resident to have oxygen via NC to maintain the resident's oxygen saturation above 92%. During a review of Resident 3's care plan for shortness of breath, revised on 4/23/2025, the care plan included a goal for the resident's oxygen saturation to remain above 92%. The care plan also included an intervention for the resident to have oxygen via NC to maintain the resident's oxygen saturation above 92%. During a review of Resident 3's History and Physical (H&P), dated 12/28/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 1/5/2026, the MDS indicated that the resident has severely impaired cognition (the ability to process thoughts and emotions). The MDS also indicated that the resident is dependent (helper does all of the effort) o activities such as oral hygiene, upper and lower body dressing, personal hygiene, and bathing. The MDS also indicated that Resident 3 experiences shortness of breath. During a review of Resident 3's Order Summary Report (OSR), the OSR indicated Resident 3 had a physician order on 3/24/2026 for oxygen order- may have [oxygen] at 1-2 L/NC (Liters via nasal cannula) if [oxygen] saturation below 92%. Keep [oxygen saturation] above 92% every shift. During a review of Resident 3's Weekly Nursing Summary (WNS), dated 4/9/2026, the WNS indicated that the resident's respiratory treatments include oxygen. During an observation on 4/13/2026 at 10:05 AM inside Resident 3's room, Resident 3 was lying in bed with a NC was on the resident's left cheek. The NC prongs were not in the resident's nostrils. During a concurrent observation and interview on 4/13/2026 at 10:16 AM inside Resident 3's room with Certified Nursing Assistant (CNA) 7, CNA 7 stated that Resident 3's NC was not placed under Resident 3's nostrils. CNA 7 stated that he observed that the resident's NC was not under the resident's nostrils a few minutes ago, but he forgot to inform the licensed nurses. During a concurrent observation and interview on 4/13/2026 at 10:23 AM inside Resident 3's room with Registered Nurse (RN) 1, RN 1 stated that Resident 3 was not receiving oxygen because the NC was not placed correctly, which should be under the resident's nostril. RN 1 assessed Resident 3's oxygen saturation and RN 1 stated that Resident 3's oxygen saturation was below 92%. RN 1 stated that nursing staff, including CNAs, must ensure that the resident's NC was placed correctly. RN 1 added that the resident could experience shortness of breath if the resident did not receive oxygen. During an interview on 4/16/2026 at 4:23 PM with the Director of Nursing (DON), the DON stated that if a resident has a NC in place, all nursing staff are responsible for ensuring that the resident's nasal cannula was placed correctly, which means the nasal prongs should be placed in the resident's nostrils. The DON stated that if a staff member observes that a resident's NC is not placed correctly, the staff member should place the resident's NC (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the right place immediately. The DON added that if the resident's NC is not placed right away, the resident will not receive the oxygen that they require. During a review of the facility's P&P titled, Oxygen Therapy, undated, the P&P indicated that it is the facility's P&P that oxygen therapy is administered as ordered by the physician. The P&P also indicated for staff to place the nasal cannula on resident and adjust head straps to have a snug fit. The P&P also indicated that staff are to monitor oxygen usage frequently.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) for the administration of medications for two out of four sampled residents (Resident 38 and Resident 1) when: 1.Licensed Vocational Nurse (LVN) 3 did not verify the frequency of Resident 38's medication order for Tylenol (or Acetaminophen, a medication used to manage pain) prior to its administration. 2. LVN 3 did not follow Resident 1's physician order for Hydrocodone-Acetaminophen (a medication used to manage pain). These deficient practices had the potential for the facility's staffs to increase a risk for medication errors, including missed doses, delayed administration, or over-administration. These deficient practices had a potential to result in Resident 38 and Resident 1's experience of inadequate pain control or adverse medication effects. Findings: 1. During a review of Residentˆ38's admission Record (AR), the ARˆindicatedˆthat the resident was admitted on [DATE]ˆwith diagnoses that includedˆhypertension (elevated blood pressure), diabetes mellitus (elevated blood sugar levels), and repeated falls.ˆ ˆ Duringˆa reviewˆof Residentˆ38's History and Physical (H&P), datedˆ3/30/2026, the H&Pˆindicatedˆthat the residentˆhas the capacity to understand and make decisions.ˆ During a review of Resident 38's Order Summary Report (OSR), the OSR indicated Resident 38 had a physician order on dated 3/30/2026 for Tylenol Tablet (Acetaminophen, a medication used to manage pain) Give 325 MG (milligram, a unit of measuring weight) by mouth as needed for MILD PAIN give 2 tabs to equal 650 MG Not to exceed 3000MG/3GM (GM, gram, a unit of measuring weight) of Acetaminophen in 24 hours. The order did not include the medication's frequency, or how often the medication can be administered. During a review of Residentˆ38's Minimum Data Set (MDS, a resident assessment tool), datedˆ4/1/2026, the MDS indicated that the residentˆhas intact cognition (the ability to process thoughts). During a concurrent observation and interview on 4/15/2026 at 8:03 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 was preparing Resident 38's Tylenol for medication administration. LVN 3 stated that he has reviewed the order for Tylenol and he will administer the medication to Resident 38. During a concurrent interview and record review on 4/15/2026 at 8:21 AM after LVN 3 administered Resident 38's Tylenol, Resident 38's physician order for Tylenol was reviewed with LVN 3. LVN 3 stated that the order for Tylenol did not include how often the medication can be administered. LVN 3 stated that he should have verified with the physician on how often the medication can be administered prior to administering the medication to Resident 38. LVN 3 added that it is important not to give the medication too frequently because it could harm the resident. During an interview on 4/16/2026 at 4:23 PM with the Director of Nursing (DON), the DON stated that medication orders must include the frequency of how often the medication can be administered. The DON stated that the frequency is important because if medications are administered too frequently, the resident could potentially get overmedicated. During a review of the facility's P&P titled, Medication Therapy, dated 12/2017, the P&P indicated that all medication orders will be supported by appropriate care processes and practices. The P&P also indicated that staff will review the resident's medication regimen to identify whether the frequency of administration and duration of use are appropriate. During a review of the facility's P&P titled, Medication Administration-General Guidelines, dated 10/2017, the P&P indicated that if there is any other reason to question the dosage or directions, the physician orders are checked for the correct dosage schedule. 2. During a review of Resident 1's AR, the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included low back pain, history of falling, and difficulty in walking. During a review of Resident 38's care plan for pain medication therapy, initiated on 3/12/2026, indicated a goal that the resident will be free of any discomfort or adverse side effects from pain medication. The care plan also included an intervention to administer analgesic medications as ordered by [the] physician. During an interview (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident 1's Order Summary Report (OSR), the OSR indicated Resident 1 had a physician order on 3/16/2026 for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for moderate pain rated 4-6. During a review of Resident 1's MDS, dated [DATE], the MDS indicated that the resident has intact cognition. During a review of Resident 1's H&P, dated 3/31/2026, the H&P indicated that the resident has the capacity to understand and make decisions. During a medication administration observation and interview on 4/15/2026 at 9:18 AM inside Resident 1's room with LVN 3, Resident 1 stated he had pain that was rated 7 out of 10. LVN 3 stated he has reviewed the order for Hydrocodone-Acetaminophen, and he will administer Resident 1's Hydrocodone-Acetaminophen. During a concurrent interview and record review on 4/15/2026 at 9:34 AM after LVN 3 administered Resident 1's Hydrocodone-Acetaminophen, Resident 1's physician order for Hydrocodone-Acetaminophen was reviewed with LVN 3. LVN 3 stated that the order for Hydrocodone-Acetaminophen specified that the medication is to be administered for a pain rate of 4 to 6 out of 10. LVN 3 stated it was not correct to administer the medication to Resident 1 because the resident stated that his pain rate was 7 out of 10. During an interview on 4/16/2026 at 4:23 PM with the DON, the DON stated that it is important for nurses to follow the physician order. The DON stated that if the physician order for pain medication is not followed, there is a risk of overmedicating the resident. The DON also stated that the medication could also be ineffective to manage the resident's pain if the nurse does not follow the order. During an interview of the facility's P&P titled, Pain Management Program, dated 11/2024, the P&P indicated that the pain management program is based on a facility-wide commitment to resident comfort. The P&P also indicated that pain management interventions shall reflect the sources, type, and severity of pain. The P&P also indicated for staff to implement the medication regimen as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper storage of the medications and biologicals when: 1.Two out of two sampled Medication Carts (MC) contained expired medications- Ibuprofen (a medication used to control pain) and Hyoscyamine Sulfate (or brand name Levsin, a medication used to treat symptoms of gastrointestinal diseases [sicknesses that affect the digestive system]). 2. One of ten sampled residents (Resident 65) who was admitted to the facility with two bags containing a total of 19 medications that was kept at bedside. This deficient practice placed the residents at risk for receiving expired medications, which placed the residents at risk for reduced therapeutic effect (meaning the medication may not work as intended to treat the resident's condition). This deficient practice increased the risk of inadequate symptom management, unwanted effects, and potential harm to the residents. This deficient practice resulted in a medication bottle left at the resident's bedside table with potential of loss, possibly ingested by other residents and misuse. 1. During a review of Residentˆ8's admission Record (AR), the AR indicated that the resident was admitted on [DATE]ˆwith diagnoses that includedˆdementia (brain disorder that slowly destroys a person's memory and thinking skills),ˆpsychosis (a mental disorder characterizedˆwhen an individual loses touch with reality), and anxiety (mental health condition that cause fear, dread and other symptoms).ˆˆ During a review of Resident 8's Order Summary Report (OSR), the OSR indicated Resident 8 had a physician order on 8/13/2025 for Levsin Oral (given by mouth) Tablet 0.125 MG (milligram, a unit of measuring weight) (Hyoscyamine Sulfate) Give 1 tablet by mouth every 6 hours as needed for excessive secretions. During a review of Residentˆ8's History and Physical (H&P), datedˆ8/15/2025, the H&Pˆindicatedˆthat the residentˆdoes notˆhave the capacity to understand and make decisions.ˆ During a review of Residentˆ8's Minimum Data Set (MDS, a resident assessment tool), datedˆ2/20/2026, the MDS indicated that the residentˆhas severely impaired cognition (the ability toˆprocess thoughts and emotions).ˆ b. During a review of Resident 4's AR, the AR indicated that the resident was originally admitted on [DATE], and readmitted on [DATE], with diagnoses that included diabetes mellitus (elevated blood sugar levels), dysphagia (difficulty swallowing), and dementia. During a review of Resident 4's H&P, dated 3/11/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 4's Order Summary Report (OSR), the OSR indicated Resident 4 had a (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician order on 3/16/2026 for Ibuprofen Oral Tablet 200 MG (Ibuprofen) Give 2 tablet by mouth every 6 hours as needed for pain management. During a review of Resident 4's MDS, dated [DATE], the MDS indicated that the resident has moderately impaired cognition. During a concurrent inspection of the facility's MC 2 and interview on 4/15/2026 at 11:05 AM with Licensed Vocational Nurse (LVN) 2, Resident 4's Ibuprofen with the expiration date of 4/14/2026 was found in MC 2. LVN 2 stated that the medication should have been removed on 4/13/2026, the day before its expiration date. LVN 2 added that it is the responsibility of the licensed nurse to ensure that there are no expired medications in the MCs. During a concurrent inspection of the facility's MC 1 and interview on 4/15/2026 at 11:19 AM with LVN 3, Resident 8's Hyoscyamine Sulfate with the expiration date of 4/1/2026 was found in MC 1. LVN 3 stated that the medication should have been removed before its expiration date. During an interview on 4/15/2026 at 11:38 AM with LVN 2, LVN 2 stated that if expired medications are left in the MCs, residents are placed at risk for being administered expired medications. LVN 2 stated that expired medications may have less efficacy or may cause unwanted side effects on the residents. During an interview on 4/16/2026 at 4:23 PM with the Director of Nursing (DON), the DON stated that the licensed nurses are responsible for checking the contents of the MCs and removing expired medications from the MCs. The DON stated that expiring medications must be removed from the MCs before the expiration date. The DON added that expired medications may not be as effective as non-expired medications. During a review of the facility's policies and procedures (P&P) titled, Storage of Medications, dated 4/2008, the P&P indicated that outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures. The P&P also indicated that medication storage conditions are monitored on a routine basis. 2. During a review of Resident 65's admission Record, (AR) the AR indicated Resident 65 was admitted to the facility on [DATE]. During a review of Resident 65's Order Summary Report (OSR), dated 4/14/2026 Resident 65 had (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses that included, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a concurrent observation and interview on 4/15/2026 at 4:16 PM with Resident 65, an unattended bottle of Magnesium Glycinate (a supplement used to improve sleep quality, reduce anxiety [a feeling of fear, dread, and uneasiness], and relieve muscle cramps) of 100 mg (milligram, unit of weight) with 78 tablets was on top of Resident 65's bedside table. Resident 65 stated that it was his own personal supplement bottle. During a concurrent observation and interview on 4/15/2026 at 4:16 PM with Licensed Vocational Nurse (LVN 4), LVN 4 stated that Resident 65 had a physician order on 4/14/2026 for Magnesium Glycinate oral (given by mouth) capsule, 400 mg by mouth one time a day for supplement. During a concurrent interview and record review on 4/15/2026 at 4:24 PM with LVN 5 the Resident 65's Clothing and Possession inventory log, dated 4/14/2026, did not include documentation of the resident's medications. LVN 5 stated that the log should have included all residents' possessions including the medications. During an observation on 4/17/2026 at 11:41 AM, LVN 5 brought in 2 bags of Resident 65's medications that were brought in to the facility: Aspirin 81 mg (30) pills, Plavix 75 mg (30) pills, Tamsulosin 0.4 mg (29) pills, Meclizine 25 mg (29) pills, Carvedilol 12.5 mg (58) pills, Furosemide 40 mg (29) pills, Atorvastatin (29) pills, Keppra 500 mg (9) pills, Esidrix 25 mg (30) pills, Entresto 24/26 mg (54) pills, Eliquis (58) pills, Ezetimibe 10 mg (30) pills, Prilosec 40 mg (29) pills, Synjardy 12.5 /1,000 mg (58) pills, Naproxen 500 mg (29) pills, Glimepiride 4 mg (58) pills, Artificial Tears Refresh (sealed bottle), GNP pen needles (100), Magnesium Glycinate 400 mg (78) pills. During an interview on 4/17/2026 with the Director of Nurses (DON), DON stated that all the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's belongings need to be logged in the residents' possessions log. DON stated that the bottle of Magnesium Glycinate should not have been left at the bedside table. During a review of the facility's policy and procedure (P&P) titled admission to the Facility dated 1/2023, indicated, upon admission all valuables will be itemized on the inventory of Personal effects.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs by failing to: 1.Provide a palatable (describes food that is pleasant to taste, or an idea that is acceptable, satisfactory, or agreeable to the mind) and appetizing therapeutic diet for Resident 58 in accordance with the facility Policy and Procedure (P&P) titled, Food: Quality and Palatability 2. Provide the correct pureed (foods blended to a smooth, pudding-like consistency, free of lumps, seeds, or skins to aid those with severe chewing or swallowing difficulties) texture for Resident 24 in accordance with the facility's P&P titled, Diet and Nutrition Care Manual These deficient practices had the potential to result in Resident 58 and Resident 24 not finding their foods palatable and placed Resident 58 and Resident 24 at risk for potential choking, aspiration (occurs when food, liquid, saliva, or vomit enters the airway and lungs instead of the esophagus, often causing coughing, wheezing, or shortness of breath), and weight loss. Cross Reference F808 Findings: 1. During a review of Resident 58's admission Record (AR), the AR indicated the facility admitted Resident 58 on 9/3/2024 and readmitted Resident 58 on 6/9/2025 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (stroke, blockage of blood flow to the brain) affecting the left non-dominant side, hyperlipidemia (high cholesterol), and unspecified protein-calorie malnutrition (severe protein deficiency leading to reduced body mass, muscle wasting, and impaired function). During a review of Resident 58's Speech Therapy Evaluation and Plan of Treatment record written by Speech Language Pathologist (SLP) 1, dated 6/10/2025, the Evaluation and Treatment record indicated SLP 1 recommended thin liquids and mechanical soft diet (foods that are naturally soft, ground, or finely diced to require minimal chewing and easier swallowing) and ground textures for Resident 58. During a review of Resident 58's Minimal Data Set (MDS, a resident assessment), dated 9/16/2025, the MDS indicated that Resident 58's cognitive (resident's thought process) skills were moderately impaired. The MDS indicated that Resident 58 required set up or clean up assistance (helper sets up or cleans up trays) for meals and Resident 58 was able to complete the activity of eating. The MDS indicated that Resident 58 had possible signs and symptoms of a swallowing disorder such as holding food in mouth/cheeks or residual food in mouth after meals and coughing or choking during meals or when swallowing medication. The MDS indicated that Resident 58 had a therapeutic (physician ordered diet) mechanically altered diet (require change in texture of food or liquids). The MDS indicated that Resident 58's dental status indicated obvious or likely cavity or broken natural teeth. During a review of Resident 58's Order Summary Report, the order, dated 12/20/2025, indicated Resident 58 had a fortified (added supplement in food) mechanical soft no added salt (NAS) diet, mechanical soft texture, regular consistency, fortified mechanical soft texture/ground meat, regular consistency, veggies/bread/tortilla/fresh fruits/cocktails for aspiration (inhaling small particles of food or drops of liquid into the lungs) safety precautions. During a review of Resident 58's MDS, dated [DATE], the MDS indicated that Resident 58's cognitive skills were moderately impaired. The MDS indicated that Resident 58 required set up or clean up assistance for meals and Resident 58 was able to complete the activity of eating. The MDS indicated that Resident 58 had possible signs and symptoms of a swallowing disorder such as complaints of difficulty or pain with swallowing. The MDS indicated that Resident 58 had a therapeutic mechanically altered diet. The MDS indicated that Resident 58's dental status indicated mouth or facial pain, discomfort or difficulty with chewing. During a review of Resident 58's care plan, date unknown, the care plan indicated that Resident 58's therapeutic diet was mechanically altered diet. The care plan interventions indicated to provide the Resident 58's diet as order: mechanical soft diet, mechanical soft texture, regular consistency, mechanical soft (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	texture/ground meat, regular consistency, puree veggies/bread/tortilla/fresh fruits/ cocktails for aspiration safety precautions. 2.During a review of Resident 24's AR, the AR indicated the facility admitted Resident 24 on 10/8/207 and readmitted Resident 24 on 1/19/2026 with diagnoses that include Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), Chronic Systolic (Congestive) Heart Failure (CHF ,a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dysphagia (difficulty swallowing). During a review of Resident 24's MDS, dated [DATE], the MDS indicated that Resident 24's cognitive skills were severely impaired. The MDS indicated that Resident 24 required supervision (helper provides verbal cues and/or touch cues as assistance for the resident to complete the activity). The MDS indicated that Resident 24's had possible signs and symptoms of swallowing disorders such as complaints of difficulty or pain with swallowing. The MDS indicated that Resident 24's therapeutic diet was mechanically altered. The MDS indicated that Resident 24's dental status indicated obvious or likely cavity or broken natural teeth and mouth or facial pain, discomfort or difficulty with chewing. During a review of Resident 24's MDS dated [DATE], the MDS indicated that Resident 24's cognitive skills were severely impaired. The MDS indicated that Resident 24 required moderate assistance (helper does less than half the effort) when performing activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) such as eating. The MDS indicated that Resident 24 had signs and symptoms of a possible swallowing disorder as indicated by Resident 24 holding food in her mouth/cheeks or residual foods in mouth after meals and coughing or choking during meals or when swallowing medications. The MDS indicated that Resident 24's therapeutic diet was mechanically altered. During a review of Resident 24's history and physical (HP), dated 1/21/2026, the HP indicated that Resident 24 has fluctuating capacity to understand and make decisions. During a review of Resident 24's Order Summary Report, the order, dated 3/3/2026, indicated that Resident 24's order consisted of a fortified carb consistent diet, level 4 pureed texture (smooth, thick, pudding-like) and thick consistency for DM and variable oral intake, three times a day. During a review of Resident 24's Order Summary Report, the order, dated 4/15/2026, indicated that Resident 24's order consisted of a pureed carb consistent fortified diet, pureed texture, thin consistency, and fortified level 4 (pureed diet as indicated by the International Dysphagia Diet Standardization Initiative). During a concurrent interview and record review and interview on 4/14/2026 at 12:05 PM with the Dietary Supervisor (DS), the recipes for Meat sauce, Beef date unknown, Cauliflower, Balsamic and Parmesan Roasted date unknown, and Dinner Roll, Parsley date unknown, were reviewed. The DS stated the recipe instructions for pureed foods were indicated on the recipe with the instructions: measure out desired number of servings into a food processor. Blend until smooth. Add thin liquid if the product needs thinning. Add commercial thickener (a powder or gel added to liquids or pureed foods to thicken the consistency for residents to easily swallow) if product needs thickening. The DS stated, per the recipe, liquids and thickener measures are approximate and slightly more or less may be required to achieve desired pureed consistency. During a concurrent observation and interview on 4/14/2026 at 12:28 PM, during a test tray tasting testing with the DS and the Dietary District Manager (DDM), the pureed test tray was sampled. There were four different scoops on the plate; one puree scoop appeared thick and yellow in color, one puree scoop appeared thick and reddish orange in color, one puree scoop appeared smooth and light tan, brown in color, and one puree scoop appeared thick, shiny, and off-white in color. The DS stated the yellow food scoop was pureed spaghetti noodles, the reddish-orange food scoop was pureed spaghetti meat sauce, the tan-brown food scoop was the garlic bread roll, and the off-white food scoop was the roasted cauliflower with balsamic vinegar. During the same concurrent observation and interview on 4/14/2026 at 12:35 PM with the DS and the DDM, the DDM stated the consistency of the pureed food should not be too thick that it does not fall off the spoon and not too thin that it was dripping on the plate. The DDM tested the pureed cauliflower and pureed dinner roll mixture by pressing the back of the spoon into the puree and spreading it across the surface. The (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	portion of the pureed mixture held its form after being spread. The DDM then tested the pureed spaghetti noodles and pureed meat-sauce by tilting a spoonful of each food item; each food item adhered to the spoon. When the DDM flicked the spoon, part of the puree fell off, but a portion remained adhered to the spoon. During an observation on 4/15/2026 at 6:45 AM in the kitchen, Head [NAME] 1 was observed taking out a metal container with a pureed mixture out of the oven and placed it on the preparation countertop. Head [NAME] 1 was observed grabbing the thickener powder container and used a non-measuring teaspoon to remove a spoonful of thicker powder and mixed it into the pureed mixture. Head [NAME] 1 was observed mixing the thickener powder and pureed mixture with a whisk, and she was observed lifting the whisk out of the pureed mixture before adding another non-measuring teaspoonful of thickener in the mixture. Head [NAME] 1 was observed mixing in a total of three non-measuring teaspoons of thickener powder in the puree mixture before placing the newly thickened mixture into the oven. During an interview on 4/15/2026 at 7:16 AM with Head [NAME] 1, Head [NAME] 1 stated the pureed mixture was a bread and milk mixture. Head [NAME] 1 stated she could not remember how many pieces of bread she placed in the blender with eight (8) ounces (oz -a measurement of weight) of 2% milk. Head [NAME] 1 stated after the pureed mixture was done, she placed the pureed mixture in a container and put it in the oven to keep warm. Head [NAME] 1 stated she used a regular spoon to scoop out a spoonful of thickener powder to put in the pureed bread mixture. Head [NAME] 1 stated she mixed the pureed bread mixture and thickener powder well with a whisk and tested the consistency of the mixture by observing how the pureed mixture would fall from the whisk back into the container. Head [NAME] 1 stated the consistency of the pureed mixture should not be too liquidly and not too thick. Head [NAME] 1 stated, the consistency of the texture should be like mash potatoes. Head [NAME] 1 stated, I think I put four or five spoonfuls of thickener into the mixture this morning. During an interview on 4/15/2026 at 7:29 AM with the DS, the DS stated Head [NAME] 1 observed the consistency of the bread and milk pureed mixture after each non-measured teaspoonful of thickener because the consistency should be like mash potatoes. The DS stated, too little thickener added to the pureed mixture results in a watery pureed mixture, but too much thickener added to the pureed mixture results in a rock hard pureed mixture after being rewarmed in the oven. The DS stated, the amount of thickener added depends on what food was pureed because each food has a different water content. The DS stated, some foods like cucumber need more thickener than other foods such as pancakes. During an interview on 4/15/2026 at 2:30 PM in Resident 58's room, Resident 58 stated that the food in the facility was not the best. Resident 58 stated that the food looks like mush sometimes. Resident 58 stated when he ate the ground meat, the ground meat sits at the back of my throat making it hard to swallow. During an interview on 4/15/2026 at 3:27 PM with the Registered Dietitian (RD), the RD stated, the kitchen cooks follow the recipe to ensure the correct consistent of pureed food. The RD stated there was no standard amount of thickener powder to add to the pureed food because each food item has a different consistency, so some food items need more thickener powder than other foods. The RD stated, the kitchen cooks add the thickener powder little by little into the pureed food item with a non-measuring spoon. The RD stated, a non-measuring spoon was used because kitchen cooks gradually put the thickener powder into the food and visually check the consistency of the pureed food. During the same interview on 4/15/2026 at 3:30 PM with the RD, the RD stated she and the kitchen staff check the consistency of the pureed mixture visually. The RD stated, she visually checks that the pureed mixture was not too thick or not too watery and visually checks for any big lumps or clumps in the pureed mixture. The RD stated another method to test the consistency of the pureed food was by using the back of a spoon or fork and pressing it into the plated pureed food to check for any big clumps of non-pureed foods. The RD stated, the consistency of all pureed food items should be a mash potato-like consistency. During a concurrent observation and interview on 4/15/2026 at 5:45 PM in Resident 58's room, Resident 58's dinner tray and meal card ticket were on the overbed table (portable and [NAME] adjustable table with lockable wheels) in front of Resident (continued on next page)

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	056413	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple City Healthcare	5101 Tyler Avenue Temple City, CA 91780

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	58. Resident 58's meal card ticket indicated Resident 58's dinner consisted of a cheese quesadilla, pureed Mexican rice, pureed cream style corn, pureed scalloped apples, and sour cream. Resident 58's dinner plate consisting of a few pieces of eaten cheese quesadilla and three different scoops of food; one scoop of pureed food appeared thick, did not demonstrate smooth consistency, and orange in color, one scoop of pureed food was smooth and white in color, and one scoop of pureed food appeared shiny, thick, and yellow-brown in color. Resident 58 stated that the brown scoop of food look thick. Resident 58 stated since he did not know what the brown scoop of food was, he was not going to eat it Resident 58 stated the orange and white scoop of food tasted okay, but he did not know what it was. During a concurrent observation and interview on 4/16/2026 at 7:39 AM in Resident 24's room, Resident 24's breakfast tray and meal card ticket were on the overbed table in front of Resident 24. Resident 24's meal card ticket indicated Resident 24's breakfast consisted of pureed buttermilk pancake, diet syrup, margarine, pureed sausage patty, and brown gravity. Resident 24's breakfast plate consisted of two different scoops of food, one scoop colored brown-gray and one scoop colored light tan/brown. Resident 24 stated that the food was not good or tasty. Resident 24 stated, she did not know what food was on her plate and it did not look appetizing. Resident 24 stated that sometimes the food on her plate was thick and sticks to the inside of her mouth, which Resident 24 stated makes it hard to swallow the food. During an interview on 4/17/2026 at 8:59 AM with the RD, the RD stated that the recipe indicated the amount of thickener added to achieve a mashed potato like consistency for pureed foods, but there was not an exact measurement of the number of tablespoons to add to the pureed foods. The RD stated that adding too much thicker may result in a thicker and harder pureed mixture, which was not the desired mashed potato like consistency. The RD stated that residents could have difficulty swallowing the overly thick purees or might find them unpalatable, which may result in choking, aspiration, dehydration, weight loss, or impaired wound healing. During a review of the facility's policies and procedures (P&P) titled Food: Quality and Palatability, dated 2/2023, the P&P indicated that food will be prepared by methods that conserve nutritive value, flavor and appearance. The P&P indicated that food will be palatable, attractive, and served at a safe and appetizing temperature. During a review the facility's P&P titled Diet and Nutrition Care Manual, 2024 edition, the P&P indicated that puree food should appear and taste like real food (as close to the regular diet as possible), while easing the chewing and swallowing process. During a review of the facility's P&P titled Diet and Nutrition Care Manual, 2024 edition, the P&P indicated that the pureed food consistency was described as eaten with a spoon, shows some very slow movement under gravity but cannot be poured, falls off spoon in a single spoonful when tilted and continues to hold shape on a plate, and not sticky.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet (physician order diet) was served as prescribed by the physician for one of four sample residents (Resident 58). This deficient practice had the potential to result in Resident 58 not wanting to eat their food and had the potential to result in their nutritional requirements not being met, which may lead to dehydration, weight loss, and decreased quality of life. Cross Reference F805Findings: During a review of Resident 58's admission Record (AR), the AR indicated the facility admitted Resident 58 on 9/3/2024 and readmitted Resident 58 on 6/9/2025 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (stroke, blockage of blood flow to the brain) affecting the left non-dominant side, hyperlipidemia (high cholesterol), and unspecified protein-calorie malnutrition (severe protein deficiency leading to reduced body mass, muscle wasting, and impaired function). During a review of Resident 58's Speech Therapy Evaluation and Plan of Treatment record written by Speech Language Pathologist (SLP) 1, dated 6/10/2025, the Evaluation and Treatment indicated that SLP 1 recommended thin liquids and mechanical soft diet (foods that are naturally soft, ground, or finely diced to require minimal chewing and easier swallowing) and ground textures. During a review of Resident 58's Minimal Data Set (MDS, a resident assessment), dated 9/16/2025, the MDS indicated that Resident 58's cognitive (resident's thought process) skills were moderately impaired. The MDS indicated that Resident 58 required set up or clean up assistance (helper sets up or cleans up trays) for meals and Resident 58 was able to complete the activity of eating. The MDS indicated that Resident 58 had possible signs and symptoms of a swallowing disorder such as holding food in mouth/cheeks or residual food in mouth after meals and coughing or choking during meals or when swallowing medication. The MDS indicated that Resident 58 had a therapeutic (physician ordered diet) mechanically altered diet (require change in texture of food or liquids). The MDS indicated that Resident 58's dental status indicated obvious or likely cavity or broken natural teeth. During a review of Resident 58's Order Summary Report, the order, dated 12/20/2025, indicated Resident 58 had a fortified (added supplement in food) mechanical soft no added salt (NAS) diet, mechanical soft texture, regular consistency, fortified mechanical soft texture/ground meat, regular consistency, pureed (generally cohesive, moist mashed potato or pudding-like consistency for people who cannot tolerate regular or mechanical soft foods) veggies/bread/tortilla/fresh fruits/cocktails for aspiration (inhaling small particles of food or drops of liquid into the lungs) safety precautions. During a review of Resident 58's MDS, dated [DATE], the MDS indicated that Resident 58's cognitive skills were moderately impaired. The MDS indicated that Resident 58 required set up or clean up assistance for meals and Resident 58 was able to complete the activity of eating. The MDS indicated that Resident 58 had possible signs and symptoms of a swallowing disorder such as complaints of difficulty or pain with swallowing. The MDS indicated that Resident 58 had a therapeutic mechanically altered diet. The MDS indicated that Resident 58's dental status indicated mouth or facial pain, discomfort or difficulty with chewing. During a review of Resident 58's care plan, date unknown, the care plan indicated that Resident 58's therapeutic diet was mechanically altered diet. The care plan interventions indicated to provide the Resident 25's diet as order: mechanical soft diet, mechanical soft texture, regular consistency, mechanical soft texture/ground meat, regular consistency, puree veggies/bread/tortilla/fresh fruits/ cocktails for aspiration safety precautions. During a concurrent interview and record review on 4/15/2026 at 11:20 AM with the Speech Language Pathologist (SLP) 1, Resident 58's Speech Therapy Evaluation and Plan of Treatment record, was reviewed. SLP 1 stated, she recommended thin liquids and mechanical soft and ground texture diet for Resident 58. During an interview on 4/15/2026 at 2:30 PM in Resident (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	58's room, Resident 58 stated that the food in the facility was not the best. Resident 58 stated that the food looks like mush sometimes. Resident 58 stated when he ate the ground meat, the ground meat sits at the back of my throat making it hard to swallow. During a concurrent observation and interview on 4/15/2026 at 5:45 PM in Resident 58's room, Resident 58's dinner tray and meal card ticket were on the overbed table (portable and [NAME] adjustable table with lockable wheels) in front of Resident 58. Resident 58's meal card ticket indicated Resident 58's dinner consisted of a cheese quesadilla, pureed Mexican rice, pureed cream style corn, pureed scalloped apples, and sour cream. Resident 58's dinner plate consisting of a few pieces of eaten cheese quesadilla and three different scoops of food; one scoop of pureed food appeared thick, did not demonstrate smooth consistency, and orange in color, one scoop of pureed food was smooth and white in color, and one scoop of pureed food appeared shiny, thick, and yellow-brown in color. Resident 58 stated that the brown scoop of food look thick. Resident 58 stated since he did not know what the brown scoop of food was, he was not going to eat it Resident 58 stated the orange and white scoop of food tasted okay, but he did not know what it was. During an interview on 4/17/2026 at 8:59 AM with the Registered Dietitian (RD), the RD stated it was important for the kitchen staff to follow the recipe of the physician prescribed therapeutic diet whether the diet was regular, mechanical soft, or pureed. The RD stated that the physician prescribed a specific diet for Resident 58 based on SLP 1's evaluation and the physician's assessment to decrease the risk of choking and aspiration). During a review of the facility's policies and procedures (P&P) titled Food: Quality and Palatability, dated February 2023, the P&P indicated that the food and liquids/beverages are prepared in a manner, form, and texture that meets each patient's needs. During a review of the facility's P&P titled Physician Services, dated June 2022, the P&P indicated that the physician supervises the medical care of residents by means of participating in the resident's assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment when contacted by the facility.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide one of 16 sampled residents (Resident 6) with Speech Language and Pathology ([SLP] profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) Evaluation or Screening in accordance with the physician's orders, dated 12/30/2025 and 1/12/2026. These failures resulted in Resident 6 receiving a puree diet (food altered into a smooth and creamy texture for people with difficulty chewing or swallowing) and did not receive intervention to improve Resident 6's speech. Findings: During a review of Resident 6's admission Record, the admission Record indicated the facility initially admitted Resident 6 on 11/6/2025 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the left non-dominant side. During a review of Resident 6's SLP Discharge summary, dated [DATE], the SLP Discharge Summary indicated recommendations for soft and bite-sized foods and thin liquid. During a review of Resident 6's Census List (record of hospitalizations, room changes, and payer source changes), the Census List indicated Resident 6 was discharged from the facility to the General Acute Care Hospital (GACH) on 12/15/2025, readmitted to the facility on [DATE], discharged to the GACH on 12/23/2025, and readmitted to the facility on [DATE]. During a review of Resident 6's physician's order, dated 12/30/2025, the physician's order indicated to provide a puree diet with thin consistency. Another physician's order, dated 12/30/2025, indicated to provide a SLP Evaluation/Screening upon admissions and quarterly as indicated. During a review of Resident 6's History and Physical (H&P), dated 1/1/2026, the H&P indicated the physician assessed Resident 6 as demonstrating capacity to make decisions. During a review of Resident 6's physician's order, dated 1/12/2026, the physician's order indicated SLP evaluation for difficulty speaking after stroke (loss of blood flow to a part of the brain). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had clear speech, usually understood verbal content, had difficulty communicating or finishing some words, and had severely impaired cognition. During an interview on 4/13/2026 at 9:32 AM in the resident's room, Resident 6 stated Resident 6 had pureed food and did not know the reason for the pureed food. During an observation on 4/13/2026 at 10:30 AM in the resident's room, Resident 6 used the right hand to hold onto a phone over the right ear while speaking on the phone. During an observation on 4/14/2026 at 8:36 AM in the resident's room, Resident 6 was observed to slightly move the left leg and did not have active movement in the left arm. During a concurrent interview and record review on 4/14/2026 at 2:07 PM with the Rehabilitation Coordinator (RC), the RC reviewed Resident 6's SLP Discharge summary, dated [DATE]. The RC stated the SLP Discharge Summary recommendations included for Resident 6 to receive thin liquids and soft and bite-sized foods. The RC stated the facility used the term mechanical soft diet (foods that are physically altered-chopped, ground, mashed, or pureed-to require minimal chewing) instead of soft and bite-sized foods. During a concurrent interview and record review on 4/14/2026 at 2:12 PM with the RC, the RC reviewed Resident 6's physician's order, dated 12/30/2025, for SLP Therapy Evaluation/Screening upon admission and quarterly as indicated. The RC stated the facility had standing physician's orders (written, pre-approved protocols authorized by the physician or medical doctor to allow other qualified health professional to initiate specific treatment and tests) for therapy services to complete a screening and then an evaluation based on the screening. During a concurrent interview and record review on 4/15/2026 at 11:22 AM with Speech and Language Pathologist 1 (SLP 1), Resident 6's SLP Discharge summary, dated [DATE], was reviewed. SLP 1 stated Resident 6's recommended diet upon discharge from SLP was for mechanical soft foods and thin liquid consistencies. SLP 1 stated Resident 6 went to the hospital and returned on 12/30/2025. SLP 1 stated Resident 6 was placed on pureed foods and thin liquid consistencies upon readmission to the (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE]. SLP 1 stated the SLPs usually completed SLP screenings upon readmission to the facility to ensure the diet texture was appropriate and requested an evaluation if the resident had potential to improve. SLP 1 reviewed Resident 6's medical record and stated Resident 6 did not receive the SLP screening or SLP Evaluation upon readmission to the facility on [DATE]. During a concurrent interview and record review on 4/15/2026 at 11:58 AM with the RC, the RC reviewed Resident 6's physician's order, dated 1/12/2026, for SLP Evaluation for difficulty speaking after stroke. The RC stated Resident 6's physician's order for the SLP Evaluation was not carried out. During a review of the facility's undated job description titled, Staff Therapist, the job description indicated essential functions included to Evaluate patients based upon the physician referral/orders.