STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056417	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
View Heights Conv Hosp	12619 S. Avalon Blvd Los Angeles, CA 90061

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to employ a dietary supervisor (DS) that met the qualifications of having an associate's degree or higher in food service management or in hospitality, was a certified dietary manager, certified food service manager or had national certification for food service management and safety. This deficient practice had the potential to affect 145 residents residing in the facility by potentially not receiving the nutritional assistance and guidance required to attain their highest practicable well-being.Findings:During an interview on 5/4/2026 at 8:30 a.m., a kitchen staff, introduced as Dietary Supervisor (DS) 1, was unable to produce credentials which indicated she was qualified as a Certified Dietary Manager (CDM). DS 1 stated she did not possess a CDM certification. DS 1 stated she was in the process of scheduling an examination to obtain the certification in June 2026. DS 1 stated there was a second dietary supervisor (DS 2) employed part-time.During an interview on 5/5/2026 at 9:00 a.m. with DS 2, DS 2 presented a certification titled Food Protection Manager dated 8/31/2025. DS 2 stated he was aware the certification did not meet the regulatory requirements to function as a CDM or equivalent. DS 2 stated he was enrolled in coursework to become eligible to take an examination to obtain CDM certification.During a concurrent observation, interview, and record review on 5/6/2026 at 11:00 a.m., with Dietary Aide (DA 1), the Dietary Work Schedules dated 2026 was reviewed. The document indicated DS 1 was not scheduled Wednesday, Thursday, or Saturday. Observed DS 1 and DS 2 were not in the kitchen or in the facility. DA 1 stated neither DS 1 nor DS 2 reported to work that day (5/6/2026) as they were both scheduled off on Wednesdays. DA 1 stated that it was a routine occurrence to have no supervisor on duty on Wednesdays in the seven months DA 1 has been employed at the facility. DA 1 stated DS 1 and DS 2 did not appear on the schedule.During an interview with the facility Administrator (ADM) on 5/6/2026 at 12:30 p.m., the ADM stated he was not aware DS 2 credentials did not meet regulatory requirements. The ADM stated he was expecting DS 2 to report to work however did not arrive due to unknown reasons. The ADM stated that hiring a CDM was required per regulations and the presence of a CDM in the kitchen would improve supervision, handling, and the preparation of food.During a review of the facility's job description titled Dietary Supervisor dated December 2025, the job description indicated a qualified Dietary Supervisor will be chosen by the Administrator, and they must meet the Federal and State laws or have met equivalent requirement.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to:1. Properly wash dishware using water temperature lower than manufacturer specifications.2. Practice standard hygienic practices in the kitchen when [NAME] 1 failed to wear a beard restraint during food preparation.3. Practice standard hygienic practices when [NAME] 2 wore 11 pieces of jewelry during food preparation.These deficient practices had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or toxins) in 145 of 145 residents.Findings:1. During a concurrent observation and interview on 5/4/2026 at 9:12 a.m. with Dietary Aides (DA 2 and DA 3), DA 2 and DA 3 were observed operating the dishwashing machine for soiled plate ware from breakfast service. The sink reservoir thermometer read 96 degrees Fahrenheit (F). The inlet pipe thermometer (meter which reads the temperature of water coming in from the water heater just before entering the dishwashing machine) read 117.6 F. DA 2 stated that the temperature of the dishwashing machine was logged using the inlet thermometer. DA 2 stated in the event temperatures were not to specifications, DA 2 would inform a supervisor.During a review of the facility document titled Dish Machine Temperature Log dated 5/2026, the document indicated Wash temperatures must be 120 F. Use manufacturer guidelines on machine for range of wash and rinse temperatures.During an observation on 5/5/2026 at 9:43 a.m., the dishwashing machine was observed operating at 105 F. The inlet thermometer read 116.4 F. During a concurrent observation and interview on 5/5/2026 at 9:48 a.m., with Dietary Supervisor (DS) 1, the dishwashing machine was observed. The temperature read 90 F. The inlet thermometer read 107.2 F. DS1 observed a verification of the temperatures using an external probe thermometer and was unable to produce any maintenance requests. DS 1 stated she was unaware of any issues. DS 1 stated that lower operating temperatures than manufacturer specifications may result in bacteria not being killed properly and was unsanitary. DS 1 stated that maintenance should be contacted to correct the issue. During a review of the manufacturer's Installation Instructions dated 5/4/2021, the instructions indicated, Failure to provide adequate water quantity, pressure and temperature to the machine will cause the machine to function improperly. and While the supply water must have a minimum of 120F degrees, 130-140F degrees is recommended for best results.During a review of the facility's document titled 2022 FDA Food Code section 4-501.110 , the document indicated The wash solution temperature in mechanical warewashing equipment is critical to proper operation. The chemicals used may not adequately perform their function if the temperature is too low. Therefore, the manufacturer's instructions must be followed and section 4-501.114 indicates The effectiveness of chemical sanitizers can be directly affected by the temperature.During a review of the facility's policy and procedure (P&P) titled Cleaning Dishes/Dish Machine dated 12/2024, the P&P indicated that dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitation, to run the machine until verification of proper temperatures and machine function is made, and that Staff should check the fish machine gauges throughout the cycle to assure proper temperatures for sanitation.2. During a concurrent observation and interview on 5/4/2026 at 9:30 a.m., with DS 1, [NAME] 1 was observed with a goatee beard approximately one inch in length. [NAME] 1 was without a beard restraint while preparing soup for lunch service. DS 1 stated [NAME] 1 should be wearing a beard net to prevent contamination of food. DS 1 stated that beard restraints were not kept at the entrance of the kitchen alongside hair nets, however, they were available in the office adjacent to the entrance of the kitchen. DS 1 then proceeded to retrieve a clear plastic bag of beard restraints from a cabinet located in DS 1's office. During an observation on 5/4/2026 at 11:00 a.m., [NAME] 1 was observed in the kitchen transferring a tray of food from the oven to the food preparation table. A beard restraint was off his beard and hung around his neck.During an observation on 5/4/2026 at 11:30 a.m., [NAME] 1 was observed standing at the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	serving counter placing pans of food onto the steam table. A beard restraint was off his beard and hung around his neck.During an interview with the Administrator (ADM) on 5/6/2026 at 12:30 p.m., the ADM stated that beard restraints should be treated in the same manner as hair nets for the purpose of safety and preventing potential bacterial contamination of food.During a review of the facility's P&P titled Code Dress, dated 12/2025, the P&P indicated that beards and mustaches (any facial hair) must wear beard restraint.During a review of the facility's P&P titled Food Safety and Sanitation, dated 12/2025, the P&P indicated that employees are required to wear beard nets when facial hair is visible.During a review of the facility document titled 2022 FDA Food Code section 2-402.11, the P&P indicated that food employees shall wear hair coverings, including nets or beard restraints that are designed and worn to effectively keep hair from contacting exposed food, clean equipment and utensils.3. During an observation on 5/4/2026 at 9:30 a.m., [NAME] 2 was observed preparing soup for lunch service. [NAME] 1 was wearing one necklace, five bracelets (two on the left wrist, three on the right wrist), one watch, and four earrings (two studs, two hoops). The eleven pieces of jewelry were visibly exposed throughout the duration of [NAME] 2's work shift on 5/4/2026.During an interview with the ADM on 5/6/2026 at 12:30 p.m., the ADM stated he was aware of the facility policy indicating that no excessive jewelry should be worn. The ADM stated [NAME] 2's jewelry was considered excessive.During a review of the facility's P&P titled Code Dress, dated 12/2025, the P&P indicated No excessive jewelry, just wedding rings on hand, non-dangling earrings on ears, and wristwatch. Wristwatch and wedding rings need to be covered with gloves with handling food.During a review of the facility's document titled 2022 FDA Food Code section 2-303.11, the document indicated Items of jewelry such as rings, bracelets, and watches may collect soil and the construction of the jewelry may hinder routine cleaning. As a result, the jewelry may act as a reservoir of pathogenic organisms transmissible through food.

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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 implement its policy and procedure (P&P) titled Informed Consent, dated 12/2025, for three of three sampled residents (Resident 18, Resident 97, and Resident 24) when: 1. Informed consent was not obtained when Resident 18's dose of Clozapine (an antipsychotic [work by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions and disordered thinking] medication) was increased on [DATE].2. Resident 97's informed consents for Clozapine, Seroquel (an antipsychotic medication), Haldol (an antipsychotic medication), and lithium carbonate (a mood stabilizer and an antimanic agent) were not obtained or renewed every six (6) months.3. Resident 24's informed consent for Clozapine and lithium carbonate were not renewed every six (6) months. These deficient practices failed to honor Resident 18's, 97's, and 24's responsible parties' rights to consent to or decline new and/or continued treatment of the psychotropic medications (drugs that treat mental health disorders, affecting mood, thoughts, and behaviors). Findings: 1. During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was admitted to the facility on [DATE]. Resident 18's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). The admission Record indicated Resident 18 had a Public Guardian (PG, a court-appointed public official or agency responsible for managing the personal, medical, or financial affairs of individuals deemed legally incapacitated), PG 1. During a review of Resident 18's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 18 had severe cognitive impairment (difficulty with thinking, memory, concentration, judgment, and learning that exceeds normal aging). The MDS indicated Resident 18 was independent for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) except for personal hygiene and oral hygiene. During a review of Resident 18's physician order, dated [DATE], the order indicated to administer Clozapine 200 milligrams (mg, a unit of dose measurement) in the morning, and administer 300 mg at bedtime. During an interview on [DATE] at 2:23 p.m., with the Director of Nursing (DON), the DON stated Resident 18's dose of Clozapine was increased on [DATE] and the facility did not obtain informed consent. The DON stated a new informed consent form should have been obtained to ensure PG 1, was aware of the planned change, and to ensure PG 1 was agreeable to the new treatment. The DON stated it was PG 1's right to be notified of the change and make an informed decision to consent to or refuse the new dose. The DON stated the facility did not honor that right. 2. During a review of Resident 97's admission Record, the admission Record indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's diagnoses included schizoaffective disorder (a chronic mental health condition characterized by a combination of psychosis symptoms of hallucinations or delusions and mood disorder of anger or depression), insomnia (a common sleep condition characterized by persistent difficulty falling asleep, staying asleep, or waking too early, despite having adequate opportunity for sleep), and stimulant dependence. During a review of Resident 97's MDS, dated [DATE], the MDS indicated Resident 97's cognitive skills for daily decision making was intact. The MDS indicated Resident 97 was independent with ADLs. During a review of Resident 97's physician order dated [DATE], the physician order indicated to administer clozapine (an antipsychotic medication) 300 mg at bedtime for psychosis related to schizophrenia disorder. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 97's physician order dated [DATE], the physician order indicated to administer haloperidol (an antipsychotic medication) oral tablet 20 mg three times a day for psychosis related to schizophrenia disorder. During a review of Resident 97's physician order dated [DATE], the physician order indicated to administer clozapine oral tablet 50 mg in the morning for psychosis. During a review of Resident 97's physician order dated [DATE], the physician order indicated to administer clozapine oral tablet 50 mg, at noon for delusions and hallucinations. During a review of Resident 97's physician order dated [DATE], the physician order indicated to administer lithium carbonate (a mood stabilizer and an antimanic agent) oral capsule 900 mg in the morning for mood swings. During a review of Resident 97's physician order dated [DATE], the physician order indicated to administer Seroquel (an antipsychotic medication) oral tablet 25 mg at bedtime for lack of sleep at bedtime. During a concurrent interview and record review on [DATE] at 2:24 p.m., with the Director of Nursing (DON), Resident 97's physician orders for clozapine dated [DATE], haloperidol dated [DATE], lithium carbonate dated [DATE], and Seroquel dated [DATE] were reviewed. The physician orders did not indicate evidence of informed consent and/or evidence of renewal. The DON stated that psychotropic medications such as clozapine, haloperidol, lithium, and Seroquel required informed consent prior to initiation of treatment to ensure the resident and/or responsible party understands the risks, benefits and potential side effects. The DON stated that informed consent forms should be signed, dated, and maintained in the resident's medical record prior to the administration of the medications. The DON stated that informed consent for psychotropic medications should be renewed when there was an increase in the medication dose and upon expiration of the existing consent. The DON stated that failure to obtain or renew informed consent could place residents at risk of receiving medication without full knowledge and agreement of the treatment plan and would not follow facility policy and resident rights regulations. The DON stated it is the facility's responsibility to ensure informed consent documentation is current, accurate, and readily available in the clinical record. 3. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 24's diagnoses included schizophrenia. During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24's cognitive skills for daily decision making was intact. The MDS indicated Resident 24 was independent with ADLs. The MDS indicated Resident 24 received antipsychotic medication. During a review of Resident 24's physician order, dated [DATE], the physician order indicated to administer Lithium Carbonate 150 mg by mouth two times a day for manic disorder (a serious mental state). During a review of Resident 24's physician order, dated [DATE], the physician order indicated to administer Clozapine 200 mg by mouth two times a day for psychosis (a mental health symptoms). During a concurrent interview and record review on [DATE] at 9:56 a.m., with the DON, Resident 24's informed consents for Lithium, dated [DATE], and Clozapine, dated [DATE], were reviewed. The consent forms for Lithium and Clozapine did not indicate they were renewed. The DON stated this failure did not meet facility policy or regulatory standards and should have been completed to ensure compliance and protection of resident rights. The DON stated it was the facility's responsibility to ensure that (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed consent for all psychotropic medication were obtained and maintained current in the resident's medical record. The DON stated consents must be renewed at least every six months, including when medications were continued over time or when prior consents have expired. The DON stated medications such as Lithium and Clozapine required documented informed consent due to their potential risks and side effects, and that failure to maintain current consent forms may result in Resident 24 or the resident representative not being fully informed regarding continued use of psychotropic medication. During a review of the facility's policy and procedure (P&P) titled Informed Consent, dated 12/2025, the P&P indicated the use of an antipsychotic drug was not to be initiated until the facility is able to verify that the resident or their authorized representative has given informed consent. The P&P indicated the facility staff shall verify the resident or his/her surrogate has given informed consent to the proposed treatment or procedure prior to the initiation of psychotherapeutic drugs, antipsychotic drugs, physical restraints or the prolonged use of device that may lead to the inability to regain use of normal bodily function. The P&P indicated the facility must obtain written informed consent for treatment using psychotropic drugs, with renewal every six months.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled resident's (Resident 89 and Resident 54) responsible parties were provided the opportunity to be involved in their care. This deficient practice resulted in Resident 89's Responsible Party (RP 1) and Resident 54's Public Guardian (PG, a court-appointed public official or agency responsible for managing the personal, medical, or financial affairs of individuals deemed legally incapacitated), PG 6, being unaware of changes in the residents' conditions and unable to provide input in the plan of care and decision-making process.Findings: During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was admitted to the facility on [DATE]. The admission Record indicated Resident 89's diagnoses included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought). The admission Record indicated Responsible Party (RP) 1 was identified as Resident 89's responsible party. During a review of Resident 89's Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 89 cognitive skills for daily decision making were intact (ability to think and reason). The MDS indicated Resident 89 could eat independently. During a review of Resident 89's physician order, dated 5/6/2025, the physician order indicated to provide a low-fat diet. During a review of Resident 89's physician order, dated 3/13/2026, the physician order indicated to administer Metformin Hydrochloride (a medication used to treat high blood sugar levels) twice a day for overweight. During a telephone interview on 5/6/2026 at 1:45 p.m., with RP 1, RP 1 stated the facility never discussed Resident 89's weight, nutritional status, or planned weight loss with him. RP 1 stated it was better for Resident 89 to gain weight. RP 1 stated he would not want Resident 89 to lose weight. RP 1 stated weight loss would worry him and cause him to think something was wrong with Resident 89. RP 1 stated Resident 89 never mentioned wanting to lose weight, or expressed concerns about her weight. RP 1 stated he would not be agreeable to Resident 89 being on a weight loss program. RP 1 stated he would have wanted the facility to discuss this with him before implementing medications for weight loss and a low-fat diet. During an interview on 5/7/2026 at 1:31 p.m., with the Registered Dietician (RD), the RD stated that when she adjusted Resident 89's care plan, including the implementation of a low-fat diet and encouragement of weight loss, she did not notify RP 1. The RD stated the decision was based on her judgment and what she felt was best for Resident 89. The RD stated it was not her routine practice to consult with the RPs of the facility's residents when altering the plan of care. During an interview on 5/7/2026 at 3:39 p.m., with the Director of Nursing (DON), the DON stated the RD was expected to notify the residents' RPs when there were plans to change a resident's diet. The DON stated the RD would need to notify RP 1 of any planned changes to allow him the opportunity to accept or decline the change. The DON stated it was RP 1's right to be involved in the care planning process, and to accept or decline changes to the care plan. The DON stated the RD's role was to educate, but the RP was to make their own decision. The DON stated the RD was not to make decisions on behalf of the residents or their RPs. 2. During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was admitted to the facility on [DATE]. Resident 54's diagnoses included schizophrenia and obesity. The admission Record indicated Public Guardian (PG) 6 was Resident 54's public guardian. During a review of Resident 54's MDS, dated [DATE], the MDS indicated Resident 54 did not have cognitive impairment. The MDS indicated Resident 54 was independent with all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) except for personal and oral hygiene. During a review of Resident 54's record titled Initial Interdisciplinary (IDT, group of different disciplines working together towards a common goal of a resident) Case Conference/Patient Care Plan Review, undated, the record indicated a case conference meeting was conducted on 7/7/2025. The record did not indicate PG 6 was notified. The (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record did not indicate PG 6 attended the case conference meeting. The record did not indicate a reason for PG 6's absence. During a review of Resident 54's laboratory results, dated 12/22/2025, the results indicated Resident 54 had abnormal triglyceride levels (amount of fat in your blood). During a review of Resident 54's physician order, dated 2/5/2026, the order indicated Resident 54 was placed on a low-fat diet. During a review of Resident 54's record titled Interdisciplinary Quarterly Case Conference/Patient Care Plan Review, undated, the record indicated a case conference meeting was conducted on 3/2/2026. The record indicated Resident 54's PG, PG 6, was notified via email of the case conference meeting, and indicated PG 6 was not in attendance. The record indicated did not indicate PG 6's reason for the absence. During a telephone interview, on 5/6/2026 at 2:26 p.m., with PG 6, PG 6 stated she did not recall receiving any notification about care conference meetings to discuss Resident 54's plan of care. PG 6 stated she had not participated in any care planning meetings since Resident 54's admission to the facility. PG 6 stated she was responsible for Resident 54's overall care and well-being and stated she was unaware that Resident 54's diet had been changed or that she had abnormal laboratory results on 12/22/2025. PG 6 stated she wanted to be notified of abnormal labs to be aware and ensure that she followed up with the facility on repeat laboratory testing. PG 6 stated involvement in the care conference meetings would be helpful for her to adequately support Resident 54 and be aware of the care she was receiving. During an interview on 5/7/2026 at 3:11 p.m., with the DON, the DON stated Resident 54's PG was to be notified of all case conference meetings because they were actively providing input in care decisions. The DON stated it was the PG's right to be involved in and aware of these meetings. During an interview on 5/7/2026 at 4:04 p.m., with Registered Nurse (RN) 3, RN 3 stated she assisted in coordinating case conference meetings within the facility. RN 3 stated the facility was unable to locate records indicating PG 6 was notified of the case conference meetings conducted on 7/7/2025 and 3/2/2026. During a review of the facility's policy and procedure (P&P) titled Care Planning, dated 12/2025, the P&P indicated an interdisciplinary treatment team, in coordination with private or public guardians, were to develop and maintain a comprehensive Care Plan for each resident.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled residents (Resident 54 and Resident 89) were permitted to make choices about their diets and snack preferences. This deficient practice resulted in Resident 89 and Resident 54 reporting they did not receive enough food to feel full after meals, reported experiencing unaddressed hunger, and denial of additional food when requested.Findings: During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was admitted to the facility on [DATE]. The admission Record indicated Resident 89's diagnoses included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought). The admission Record indicated Resident 89 was not self-responsible and had a responsible party, RP 1. During a review of Resident 89's admission Minimum Data Set (MDS, a resident assessment tool), dated 5/6/2025 indicated Resident 89's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 89 reported it was very important for her to have snacks between meals. The MDS indicated Resident 89 was able to eat independently. The MDS indicated Resident 89 had not experienced any significant or severe weight loss or gain. During a review of Resident 89's quarterly MDS, dated [DATE], the MDS indicated Resident 89's cognitive skills for daily decision making were intact. The MDS indicated Resident 89 could eat independently. The MDS indicated Resident 89 had not experienced significant or severe weight loss or gain. During a review of Resident 89's physician order, dated 5/6/2025, the physician order indicated low-fat diet. The physician order did not indicate orders for snacks. During a review of Resident 89's record titled Nutritional Assessment, dated 8/1/2025, by the Registered Dietician (RD), the assessment indicated Resident 89 was on a low-fat diet, receiving regular-sized meal portions. The assessment indicated Resident 89 declined to change to small portions to promote [weight] loss. The assessment indicated the goals of care included Resident 89 having gradual weight loss. The assessment indicated the RD recommended Resident 89 to participate in the [physical activity] program two to three times per week for [weight] loss. During a review of Resident 89's record titled Nutritional Assessment, dated 11/4/2025, by the Registered Dietician (RD), the assessment indicated Resident 89 remained on a low-fat diet. The assessment indicated the RD asked Resident 89 to consider small portions to help promote lower caloric intake and to help with [weight] loss. The assessment indicated Resident 89 refused this intervention. The assessment indicated the RD encouraged Resident 89 to be more physically active to promote [weight] loss. The assessment indicated the goals of care remained gradual [weight] loss. During a review of Resident 89's record titled Nutritional Assessment, dated 1/30/2026, by the Registered Dietician (RD), the assessment indicated Resident 89 remained on a low-fat diet, and was not agreeable to small portions to help with weight loss. During an interview on 5/4/2026 at 1:33 p.m., with Resident 89, Resident 89 stated she would like extra snacks, such as a baloney sandwich or banana, between meals. Resident 89 stated she talked with the RD twice in the last year and the RD told her she was obese (excess in body weight). Resident 89 stated she was comfortable with her weight and did not want to lose weight. Resident 89 stated she still felt hungry after lunch and would like an extra snack when the bedtime (8:00 p.m.) snacks were distributed. During an interview on 5/4/2026 at 1:42 p.m., in the hallway, with Resident 89, Resident 89 approached the surveyor and said, I'm hungry. When asked if she had requested a snack, Resident 89 appeared fearful and replied, Can you ask?. When the surveyor approached the Northside Nurse's Station, Resident 89 appeared nervous and in a hushed voice stated, Never mind, it's ok. During an interview on 5/6/2026 at 1:28 p.m., with Resident 89, Resident 89 stated she received a snack at 2:00 p.m. after lunch, and 8:00 p.m. after dinner. Resident 89 stated she never received snacks at 10:00 a.m. but knew that other residents did. Resident 89 stated she was limited to one snack item at 8:00 p.m. but would like extra. When asked what extra meant to her, (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care she was receiving. During an interview on 5/7/2026 at 3:11 p.m., with the DON, the DON stated PG 6 was to be notified of all case conference meetings because PG 6 was actively providing input in care decisions. The DON stated it was PG 6's right to be involved in and aware of these meetings. During an interview on 5/7/2026 at 4:04 p.m., with Registered Nurse (RN) 3, RN 3 stated she assisted in coordinating case conference meetings within the facility. RN 3 stated the facility was unable to locate records to indicate PG 6 was notified of the case conference meetings conducted on 7/7/2025 and 3/2/2026. During a review of the facility's policy and procedure (P&P) titled Weight Assessment and Intervention, dated 12/2025, the P&P indicated interventions for undesired weight gain were to consider the resident's preferences and rights. The P&P indicated that a weight loss regimen was not to be initiated for a cognitively capable resident without his/her approval and involvement. During a review of the facility's P&P titled Care Planning, dated 12/2025, the P&P indicated an interdisciplinary treatment team, in coordination with private or public guardians, were to develop and maintain a comprehensive Care Plan for each resident.

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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 interview and record review, the facility failed to notify the physician of abnormal laboratory results for two of two sampled residents (Resident 89 and Resident 57) when:1. Resident 89 had:a. An abnormal valproic acid level (the level of valproic acid [an anticonvulsant medication] in the bloodstream) on 8/6/2025.b. An abnormal triglyceride level (amount of fat in the blood) and valproic acid level on 10/23/2025.c. An abnormal valproic acid level on 1/23/2026.d. Abnormal blood urea nitrogen (BUN, a waste product that forms as your body breaks down proteins) and creatinine (a measure of how well the kidneys are doing their job of filtering waste from the blood) levels on 4/23/2026.2. Resident 57 had abnormal valproic acid levels on 5/8/2025, 9/2/2025, and 10/24/2025. This deficient practice placed Residents 89 and 57 at risk of not receiving timely interventions to address the abnormal laboratory values, including monitoring and/or adjustments to medications and treatments.Findings: During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was admitted to the facility on [DATE]. The admission Record indicated Resident 89's diagnoses included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), hypokalemia (low potassium levels in the blood), hypo-osmolality (a low concentration of electrolytes, proteins, and/or nutrients) in the blood plasma), hyponatremia (low sodium levels in the blood), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 89's admission Minimum Data Set (MDS, a resident assessment tool), dated 2/6/2026 indicated Resident 89 cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 89 was independent for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) except for personal and oral hygiene. During a review of Resident 89's laboratory results, dated 8/6/2025, the results indicated Resident 89's valproic acid level was 44.0 micrograms (mcg) per milliliter (mL) (mcg/mL, a unit of measurement [normal reference range, NRR, 50 to 100 mcg/mL]). During a review of Resident 89's laboratory results, dated 10/23/2025, the results indicated Resident 89's valproic acid level was 45.0 mcg/mL. Resident 89's triglyceride level was 185 milligrams (mg) per mL (mg/mL, a unit of measurement [NRR and normal triglyceride levels were indicated as 35 to 160 mg/mL. During a review of Resident 89's laboratory results, dated 1/23/2026, the results indicated Resident 89's valproic acid level was 39.8 mcg/mL. During a review of Resident 89's laboratory results, dated 4/23/2026, the results indicated Resident 89's BUN was six (6) mg per deciliter (dL) (mg/dL, a unit of measurement [NRR seven (7) to 23 mg/dL]). The laboratory results indicated Resident 89's creatinine was 0.5 mg/dL (NRR 0.6 mg/dL to 1.4 mg/dL). During an interview on 5/7/2026 at 3:44 p.m., with the Director of Nursing (DON), the DON stated there was no documentation in Resident 89's medical record to indicate the abnormal lab values on 8/6/2025, 10/23/2025, 1/23/2026, and 4/23/2026 were reported to Resident 89's physician. Resident 89 stated the abnormal laboratory results should have been reported to ensure the physician was aware in case interventions or changes to the resident's care might be needed. The DON stated that it was best practice to notify the doctor of all abnormal laboratory results. 2. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. Resident 57's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 had moderate cognitive impairment. The MDS indicated Resident 57 was independent for all ADLs, except personal and oral hygiene. During a review of Resident 57's care plan titled Anti-convulsant medication Depakote (valproic acid) related to behavior management, dated 3/19/2025, the care plan indicated staff were to monitor labs as ordered by the physician. During a review of Resident 57's laboratory results, dated 5/8/2025, the results indicated Resident 57's (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	valproic acid level was 35.7 mcg/mL. During a review of Resident 57's laboratory results, dated 9/2/2025, the results indicated Resident 57's valproic acid level was 107.1 mcg/mL. During a review of Resident 57's laboratory results, dated 10/24/2025, the results indicated Resident 57's valproic acid level was 100.5 mcg/mL. During an interview on 5/7/2026 at 2:46 p.m., with the DON, the DON stated there was no documentation in Resident 89's medical record to indicate her physician was notified of the abnormal valproic acid levels on 5/8/2025, 9/2/2025, and 10/24/2025. The DON stated the licensed nurse was expected to notify the physician as soon as the results were reviewed, or at least within 24 hours. During a review of the facility's policy and procedure (P&P) titled Laboratory, Radiological, and Diagnostic Results, dated 12/2025, the P&P indicated the resident's attending physician was to be notified of the results of diagnostic tests.

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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 ensure adequate monitoring of psychotropic medications (any drug that changes brain function resulting in alteration to mood, thoughts, feelings or behavior) for four of seven sampled residents (Resident 5, Resident 18, Resident 57 and Resident 109) when the facility failed to: 1. Monitor Resident 5's behaviors of manic speech (speaking urgently and rapidly often jumping between unrelated topics) and rapid thought process. 2. Ensure adequate behavior monitoring for Resident 18's use of ativan (a medication that works to slow down the nervous system and create a calming effect), lithium carbonate (used as a mood stabilizer to treat and prevent manic and depressive episodes in bipolar disorder), and clozapine (a medication used to treat mental health conditions).3. Ensure a behavior manifestation was indicated and monitored for Resident 57's use of ativan.4. Reassess Resident 109's continued need for remeron (Mirtazapine, a medication used to treat major depressive disorder and increase appetite).These deficient practices had the potential to place Residents 5, 18, 57, and 109 at risk for unnecessary psychotropic medication use and unidentified and unaddressed changes in behavior.Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought) and insomnia (persistent difficulty falling or staying asleep). During a review of Resident 5's History and Physical (H&P) dated 6/5/2025, the H&P indicated Resident 5 was alert and oriented with intact cognitive (ability to think and understand) function. During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 4/10/2026, the MDS indicated Resident 5 had moderate cognitive impairment. The MDS indicated Resident 5 was independent with eating, toileting and bathing. During a review of Resident 5's care plan titled, Uses Antipsychotic medication Lithium related to schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior) and manic speech rapid thought process dated 1/9/2026, the care plan indicated to administer psychotropic medications as ordered by physician, and monitor for side effects and effectiveness Q (every) shift. During a concurrent interview and record review on 5/5/2026 at 11:22 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 5's medical record and physician order's dated 1/8/2026 were reviewed. The physician orders indicated, Lithium Carbonate oral capsule 150 milligrams (mg- a metric unit of measurement, used for medication dosage and/or amount) Give one capsule by mouth in the morning for manic speech, rapid thought process. The medical records did not indicate there was a physician order for the behavior monitoring of Resident 5's manic speech or rapid thought process. LVN 3 stated there should always be orders to monitor for the indicated behavior of psychotropic medications. LVN 3 stated there should have been an order to monitor Resident 5's manic speech and rapid thought process to ensure effectiveness of medication regimen and to determine the need of physician reassessment. LVN 3 stated not monitoring Resident 5's manic speech or rapid thought process placed the resident at risk of unidentified and unaddressed changes in behavior. During an interview on 5/7/2026 at 9:42 a.m. with the Director of Nursing (DON), the DON stated monitoring indicated behaviors for psychotropic medications was important to ensure any significant (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trends or changes in behavior were identified and communicated to the physician. The DON stated adequate monitoring of behavior ensured appropriate physician reassessment or medication adjustment. 2. During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was admitted to the facility on [DATE]. Resident 18's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 18's MDS dated [DATE], the MDS indicated Resident 18 had severe cognitive impairment. The MDS indicated Resident 18 was independent for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) except for personal hygiene and oral hygiene. During a review of Resident 18's physician order, dated 2/17/2023, the order indicated to administer Ativan 0.5 mg twice a day for anxiety manifested by tearful and irritable behavior. During a review of Resident 18's physician order, dated 5/23/2024, the order indicated to administer lithium carbonate 300 mg twice a day for manic symptoms. The order did not indicate what Resident 18's specific manic symptoms were. During a review of Resident 18's physician order, dated 2/6/2026, the order to administer clozapine 200 mg in the morning, and 300 mg at bedtime, for psychosis. The order did not indicate what Resident 18's specific psychosis behaviors were. During an interview on 5/7/2026 at 2:31 p.m., with the DON, the DON stated the behavioral indications for Resident 18's Ativan, lithium carbonate, and clozapine were different. The DON stated all three medications would require behavior monitoring for their specific behavioral indications. The DON stated manic symptoms was not a specific behavior that staff could quantify. The DON stated Resident 18's order for lithium carbonate needed to be more specific. The DON stated psychosis was also not specific enough for staff to monitor the effectiveness of Resident 18's clozapine. During a concurrent interview and record review on 5/7/2026 at 2:37 p.m., with the DON, Resident 18's records titled Monitoring, dated from 1/2026 to 5/2026 were reviewed. The DON stated the records indicated staff were not documenting the frequency of Resident 18's tearful and irritable behavior related to his Ativan use. The DON stated staff were also unable to monitor the effectiveness of Resident 18's lithium carbonate and clozapine due to the lack of specific indicated behavior. The DON stated accurate record of behavior frequency affected the plan of care, including attempts for gradual dose reduction (GDR, stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued). 3. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. Resident 57's diagnoses included schizoaffective disorder. During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 had moderate cognitive impairment. The MDS indicated Resident 57 was independent for all ADLs except personal and oral hygiene. During a review of Resident 57's care plan titled Uses anti-anxiety medications., dated 2/12/2025, the care plan indicated staff were to assess degree and manifestations of anxiety and mental status prior to and periodically during therapy. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 57's discontinued physician order, dated 7/5/2025, the order indicated staff were to administer Ativan 1 mg in the morning for anxiety for 14 days. The order did not indicate the specific anxious behavior. During a review of Resident 57's Electronic Medication Administration Record (EMAR), dated 7/1/2025 to 7/31/2025, the EMAR indicated Resident 57 was administered Ativan every day, from 7/5/2025 to 7/18/2025. During a review of Resident 57's record titled Monitoring, dated 7/1/2025 to 7/31/2025, the record did not indicate behavior monitoring was conducted for anxiety, a specific anxious behavior, or Resident 57's use of Ativan. During a review of Resident 57's active physician order, dated 8/16/2025, the order indicated to administer Ativan 1 mg in the morning for anxiety. The order did not indicate the specific anxious behavior. During a review of Resident 57's records titled Monitoring, dated from 1/2026 to 5/2026, the records did not indicate behavior monitoring was conducted for anxiety, a specific anxious behavior, or Resident 57's use of Ativan. During an interview on 5/7/2026 at 2:55 p.m., with the DON, the DON stated Resident 57's active Ativan order, dated 8/16/2025, indicated it was for anxiety. The DON stated that the order, as currently written, was not specific enough for staff to adequately monitor effectiveness of the medication. The DON stated the order should be more specific and include the manifesting anxious behavior. The DON stated there was also no documentation that staff were monitoring the effectiveness of Resident 57's current Ativan orders. During an interview on 5/7/2026 at 3:00 p.m., with the DON, the DON stated there was no documentation in Resident 57's medical record indicating why Ativan was started on 8/16/2025. The DON stated there should be a clearly documented indication to justify the continued use of Ativan following completion of her previous Ativan order on 7/19/2025. The DON stated Ativan was a psychotropic medication, and stated staff should attempt non-pharmacological interventions prior to initiation psychotropic medication. The DON stated non-pharmacological interventions assisted in avoiding potential adverse effects associated with Ativan, such as drowsiness, dizziness, nausea, confusion, and risk for falls. The DON stated there was no documentation to indicate Resident 57's Ativan was a necessary medication. 4. During a review of Resident 109's admission Record, the admission Record indicated Resident 109 was admitted to the facility on [DATE]. Resident 109's diagnoses included schizophrenia. During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 109 was independent for ADLs. During a review of Resident 109's care plan titled Mirtazapine, dated 12/4/2025, the care plan indicated staff would monitor for fatigue, weakness, and decreased appetite. The care plan interventions indicated the facility would discuss with Resident 109's physician and conservator (public guardian [PG]- a court-appointed public official or agency responsible for managing the personal, medical, or financial affairs of individuals deemed legally incapacitated) regarding ongoing need for the use of the medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 109's physician order, dated 12/10/2025, the physician order indicated to administer Remeron (Mirtazapine) 15 mg by mouth at bedtime for appetite. During an observation on 5/4/2026 at 8:40 a.m., 11:35 a.m., and 2:20 p.m., at Resident 109's bedside, Resident 109 was observed lying in bed with eyes closed, unarousable. Resident 109 did not respond to verbal prompts or attempts to engage the resident during the observation. During an observation on 5/5/2026 at 10:10 a.m., 12:10 p.m., and 3:20 p.m., at Resident 109's bedside, Resident 109 was observed lying in bed with eyes closed, unarousable. During a concurrent observation and interview on 5/6/2026 at 8:55 a.m., at Resident 109's bedside, with Certified Nursing Assistant (CNA) 2, Resident 109 was observed lying in bed with eyes closed, unarousable. CNA 2 attempted to verbally prompt Resident 109, however, Resident 109 did not respond. CNA 2 stated Resident 109 was usually sleepy and difficult to wake up especially in the morning. CNA 2 stated Resident 109 did not eat breakfast often but had a good appetite for lunch and dinner. During an interview on 5/6/2026 at 11:35 a.m., with LVN 4, LVN 4 stated Resident 109 received Mirtazapine 15 mg at bedtime for appetite stimulation. LVN 4 stated Mirtazapine may cause sleepiness or sedation. LVN 4 stated there was no documented assessment indication for Resident 109's continued need for Mirtazapine or whether the medication remained effective for appetite stimulation. LVN 4 stated he was not aware that Resident 109 had a poor appetite. LVN 4 stated Resident 109 often skipped breakfast because he was sleepy but had a good appetite for lunch and dinner. LVN 4 stated Resident 109's increased sleepiness and inability to be aroused were not evaluated as possible adverse effects of Mirtazapine. During an interview on 5/7/2026 at 9:30 a.m., with the DON, the DON stated residents receiving psychotropic medications should be monitored for continued clinical need, effectiveness, and possible side effects. The DON stated Mirtazapine may cause sleepiness and sedation. The DON stated if Resident 109 was repeatedly difficult to arouse, the licensed nurse should have assessed the resident, notified the physician, and documented the resident's condition and any follow-up actions taken. The DON stated there was no documented evidence that the facility assessed the continued need for Mirtazapine, evaluated the medication's effectiveness for appetite stimulation, monitored for adverse effects, or notified the physician regarding Resident 109's repeated sleepiness and inability to be aroused. The DON stated this placed Resident 109 at risk for unnecessary psychotropic medication use, chemical restraint, over-sedation, decline in condition, and adverse medication effects. During a review of the facility's P&P titled Psychotropic Medication Use and Monitoring, dated 12/2025, the P&P indicated psychotropic medications were to be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use. The P&P indicated all medications used to treat behaviors must have clinical indication and be used in the lowest possible doses to achieve the desired therapeutic effect. The P&P indicated the prescriber will not use psychotropic medications to address behaviors without first determining if a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors. The P&P indicated all residents receiving medications used to treat behaviors should be monitored for efficacy, risks, benefits, harm or adverse consequences. The P&P indicated facility staff will monitor the resident for side effects for residents receiving psychotropic medications.

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View Heights Conv Hosp	12619 S. Avalon Blvd Los Angeles, CA 90061

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Minimum Data Set ([MDS]- a resident assessment tool) for a significant change was completed within fourteen (14) days for one of two sampled residents (Resident 30) after the resident experienced significant weight loss.This deficient practice resulted in delayed assessment and transmitting Resident 30's significant change in condition to the Centers for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the resident's care planning, and delivery of necessary care and services to address significant weight loss.Cross Reference F657 and F692Findings: During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was admitted to the facility on [DATE]. Resident 30's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 30's Minimum Data Set ([MDS]- a resident assessment tool), dated 2/8/2026, the MDS indicated Resident 30's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 30 was independent (resident completes the activities by himself) with activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 5/7/2026 at 11:10 a.m., with Registered Nurse (RN) 3, Resident 30's records, including weight and vitals summary, dated 1/27/2026 through 2/23/2026, were reviewed. The weight and vitals summary indicated Resident 30's weighed 225.6 pounds (lbs.) on 1/27/2026 and 206 lbs. on 2/23/2026. Resident 30 experienced a total weight loss of 19.6 lbs. and 8.8 percentage [%] of body weight, in approximately one month. RN 3 stated she was responsible for completing the MDS assessments for the facility. RN 3 stated Resident 30's weight loss was significant and should have triggered further assessment to determine the cause of the weight loss and whether current nutritional interventions were effective. RN 3 stated the facility should have evaluated Resident 30's weight loss, nutritional status, intake, and need for updated care and services. RN 3 stated the facility should have completed a MDS for significant change after the weight loss was identified. RN 3 stated there was no documented evidence that a significant change MDS assessment was completed within 14 days after Resident 30's significant weight loss was identified on 2/23/2026. During an interview on 5/7/2026 at 9:45 a.m., with the Director of Nursing (DON), the DON stated residents with significant weight loss should be assessed to determine whether the resident had a significant change in condition. The DON stated a MDS for significant change should be completed within 14 days when the resident's condition declined, and the change required review and revision of the resident's care and services. The DON stated the interdisciplinary team (a coordinated group of healthcare professionals who collaborate and evaluate comprehensive care for a resident) should have evaluated the resident's intake, weight trends, food preferences, and need for additional nutritional approaches. The DON stated failure to complete a significant change MDS assessment may delay identification of the resident's current needs, negatively affect care planning and delivery of necessary care and services. The DON stated this placed Resident 30 at risk for continued weight loss, inadequate nutritional intake, weakness, decline in ADLs, and further decline in overall condition. During a review of the facility's policy and procedure (P&P) titled Frequency of Conducting Resident Assessments, dated 12/2025, the P&P indicated the assessment coordinator must ensure the interdisciplinary team conducts and reviews resident assessments within 14 days of a significant change in condition.

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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 interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was accurately coded following a fall for one of one sampled resident (Resident 57). This deficient practice created the potential for Resident 57 to not receive the necessary care and interventions to prevent further falls and possible injuries.Findings: During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. Resident 57's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 57 had moderate cognitive impairment (a significant decline in memory, language, or reasoning that interferes with daily life, such as managing finances or complex tasks). The MDS indicated Resident 57 was independent for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) except personal and oral hygiene. During a review of Resident 57's Change of Condition (COC) assessment, dated 8/29/2025, the assessment indicated Resident 57 slipped and fell to the floor while in the shower. The COC assessment indicated Resident 57's fall was unwitnessed. During a review of Resident 57's Quarterly MDS, dated [DATE], the MDS indicated Resident 57 had no falls since admission. During an interview on 5/7/2026 at 11:26 a.m., with Registered Nurse (RN) 3, RN 3 stated she conducted the MDS assessments. RN 3 stated she completed Resident 57's MDS assessment dated [DATE]. RN 3 stated Resident 57 had an unwitnessed fall on 8/29/2025. RN 3 stated the fall should have been coded in her MDS assessment dated [DATE], but it was not. RN 3 stated that accurately indicating Resident 57's fall would have prompted staff to develop a care plan to monitor fall complications, identify the cause of the fall, and try to prevent additional falls. During a review of the facility's policy and procedure (P&P) titled Falls Management System, dated 12/2025, the P&P indicated it was the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. During a review of the facility's P&P titled Resident Assessment Instrument (MDS 3.0), dated 12/2025, indicated the purpose of the MDS assessment was to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. The P&P indicated that information derived from the comprehensive assessment enabled the staff to plan care that allows the resident to reach his/her highest practicable level of functioning.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan for psychotropic medications (medications that affect the mind, emotions, and behavior) for one of five residents sampled for unnecessary medication review (Resident 18). This deficient practice had the potential to result in Resident 18 not receiving non-pharmacological (non-medicinal) interventions to address his lack of sleep, for which staff were administering Trazodone (a prescription medication, with sedative properties, typically used to treat major depressive disorder [a serious, common mood disorder characterized by at least two weeks of persistent, severe low mood, sadness, or loss of interest in activities]).Findings: During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was admitted to the facility on [DATE]. Resident 18's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 18's Minimum Data Set (MDS, a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 18 had severe cognitive impairment (difficulty with thinking, memory, concentration, judgment, and learning that exceeds normal aging). The MDS indicated Resident 18 was independent for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) except for personal hygiene and oral hygiene. During a review of Resident 18's physician order, dated 2/29/2024, the order indicated to administer Trazodone 50 milligrams (mg, a unit of dose measurement) at bedtime for lack of sleep. During an interview on 5/7/2026 at 2:41 p.m., with the Director of Nursing (DON), the DON stated Resident 18 received Trazodone at bedtime for lack of sleep. The DON stated there should be a care plan to monitor for side effects. The DON stated Trazodone should also have a care plan to include non-pharmacological interventions to reduce or discontinue the use of Trazodone. The DON stated the least restrictive measures should always be attempted, if possible, to address a behavior prior to the use of psychotropic medications like Trazodone. During a review of the facility's policy and procedure (P&P) titled Care Planning, dated 12/2025, the P&P indicated the purpose of a care plan was to identify the resident's needs and develop a comprehensive, standardized plan of care for each resident to meet the resident's psychiatric, psychosocial, and medical needs. During a review of the facility's P&P titled Psychotropic Medication Use and Monitoring, dated 12/2025, the P&P indicated the resident or the resident's representative should be involved in the discussion of potential non-drug and medication interventions to address the management of behaviors. The P&P indicated this involvement should be documented in the resident's medical record.

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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 interview and record review, the facility failed to revise the comprehensive care plan and interventions for one of two sampled residents (Resident 30) after the resident experienced a significant weight loss. This deficient practice had the potential to result in Resident 30 not receiving individualized and updated nutritional interventions to address significant weight loss, placing the resident at risk for continued weight loss, nutritional decline, and further decline in health status.Cross Reference F637 and F692Findings: During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was admitted to the facility on [DATE]. Resident 30's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 30's Minimum Data Set ([MDS]- a resident assessment tool), dated 2/8/2026, the MDS indicated Resident 30's cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 30 was independent with activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 5/6/2026 at 11:30 a.m., with the Registered Dietitian (RD), Resident 30's weight and vitals summary, dated 1/27/2026 through 5/2/2026, was reviewed. The weight and vitals summary indicated Resident 30's weight was 225.6 pounds ([lbs.]- a unit of weight) on 1/27/2026 and 189.2 lbs. on 5/2/2026, a total weight loss of 36.6 lbs. in approximately three months. The RD stated Resident 30's weight loss was significant. The RD stated Resident 30's care plan should have been revised with updated and individualized nutritional interventions to address the significant weight loss. The RD stated new updated interventions were necessary to help prevent continued weight loss and nutritional decline. During a concurrent interview and record review on 5/7/2026 at 11:10 a.m., with Registered Nurse (RN) 3, Resident 30's care plan titled Weight, dated 1/26/2026, was reviewed. The care plan did not indicate additional interventions after Resident 30's significant weight loss was identified. RN 3 stated Resident 30 had a care plan that addressed the resident's risk for weight loss; however, the care plan was not revised with additional interventions after Resident 30's significant weight loss was identified. During an interview on 5/7/2026 at 9:45 a.m., with the Director of Nursing (DON), the DON stated residents with significant weight loss should have their comprehensive care plans reviewed and revised to include updated interventions based on the resident's current condition and needs. The DON stated licensed staff should have evaluated Resident 30's weight loss and updated the care plan with resident centered interventions to address the risk for continued weight loss. The DON stated these new interventions would guide staff in providing consistent care for Resident 30 and help ensure staff were aware of the resident's current nutritional risks and needs. The DON stated failure to revise the care plan after significant weight loss placed Resident 30 at risk for continued weight loss, inadequate nutritional intake, weakness, and decline in ADLs. During a review of the facility's policy and procedure (P&P) titled Care Plans- Comprehensive, dated 12/2025, the P&P indicated residents' care plans were reviewed and revised whenever a resident's condition changes.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician orders for orthostatic (measures changes in blood pressure and heart rate when moving from lying down to standing up) blood pressure monitoring and recording by failing to accurately obtain, document, and evaluate orthostatic blood pressure readings for three of three sample residents (Resident 57, Resident 124, and Resident 2).This deficient practice had the potential to place Residents 57, 124, and 2 at risk for undetected orthostatic hypotension, dizziness, syncope (fainting), falls, injury, delayed medical intervention, and adverse cardiovascular complications related to changes in blood pressure upon position changes.Findings: 1. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE]. Resident 57's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 57's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 57 had moderate cognitive impairment (a significant decline in memory, language, or reasoning that interferes with daily life, such as managing finances or complex tasks). The MDS indicated Resident 57 was independent for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) except personal and oral hygiene. During a review of Resident 57's Change of Condition (COC) assessment, dated 8/29/2025, the assessment indicated on 8/29/2026, Resident 57 slipped and fell to the floor while in the shower. The assessment indicated Resident 57's fall was unwitnessed. During a review of Resident 57's care plan titled Remains at risk for fall and injuries related to combine usage of different class of psychoactive drugs ., dated 2/11/2025 and revised 9/1/2025, the care plan indicated staff were to remind and explain risks and benefits of safety measures to Resident 57. During an interview on 5/6/2026 at 10:34 a.m., with Resident 57, Resident 57 stated she fell a few weeks ago at her bedside. Resident 57 stated she was getting up to use the bathroom and felt dizzy when she stood up. Resident 57 stated that after the fall she had pain in her back that lasted a few days. During a review of Resident 57's physician order, dated 1/11/2026, the order indicated staff were to administer Norvasc (a medication to treat high blood pressure) 5 milligrams (mg, a unit of dose measurement) at bedtime. During a review of Resident 57's physician orders, dated 2/18/2025, the orders indicated staff were to monitor and record Resident 57's orthostatic blood pressure (the measurement of blood pressure while sitting or lying down compared to standing up) while standing, lying, and sitting. The orders indicated these measurements were to be taken every four weeks, on Tuesday evening. During a review of Resident 57's record titled Monitoring, dated 1/1/2026 to 1/31/2026, the record indicated on 1/20/2026, Registered Nurse (RN) 2 documented three orthostatic blood pressure readings for Resident 57. The record indicated the lying, sitting, and standing blood pressure readings were 113/81 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	millimeters of mercury (mmHg, a unit for measuring blood pressure). During a review of Resident 57's record titled Monitoring, dated 2/1/2026 to 2/28/2026, the record indicated on 2/17/2026, RN 2 documented three orthostatic blood pressure readings for Resident 57. The record indicated the lying, sitting, and standing blood pressure readings were 118/75 mmHg. During a review of Resident 57's record titled Monitoring, dated 3/1/2026 to 3/31/2026, the record indicated on 3/17/2026, Licensed Vocational Nurse (LVN) 1 documented three orthostatic blood pressure readings for Resident 57. The record indicated the lying, sitting, and standing blood pressure readings were 118/83 mmHg. During a review of Resident 57's record titled Monitoring, dated 4/1/2026 to 4/30/2026, the record indicated on 4/14/2026, RN 2 documented three orthostatic blood pressure readings for Resident 57. The record indicated the lying, sitting, and standing blood pressure readings were 132/70 mmHg. During an interview on 5/6/2026 at 3:55 p.m., with RN 2, RN 2 stated the certified nursing assistants (CNAs) obtained the residents' blood pressure readings. RN 2 stated she only checked blood pressures in emergencies. RN 2 stated all blood pressures were taken in the Utility Room, or in the hallway immediately outside of the Utility Room. During a concurrent observation and interview on 5/6/2026 at 3:59 p.m., with RN 2, in the Utility Room, a folding chair was observed. RN 2 stated blood pressures were taken while the resident was seated in the folding chair. RN 2 stated the folding chair could be moved into the hallway if needed. RN 2 stated that to her knowledge, there were no blood pressures taken in a lying or standing position and stated there was no surface in the utility room for residents to lay on. RN 2 stated the CNAs took Resident 57's blood pressure while sitting and she used that blood pressure measurement when documenting the lying and standing blood pressure readings. RN 2 stated the purpose of monitoring orthostatic blood pressures was to identify low blood pressure. RN 2 stated that low blood pressure could cause dizziness, lethargy, and create a fall risk. During an interview, on 5/7/2026 at 2:12 p.m., with the Director of Nursing (DON), the DON stated that when checking orthostatic blood pressures, staff were to obtain three different readings, each with the resident in a different position. The DON stated the significance of taking orthostatic blood pressure readings was to identify if there were changes in the resident's blood pressure when the resident changed positions because changes increased the risk for falls. The DON stated low orthostatic blood pressure was a side effect of psychotropic medications (that affect the central nervous system, altering an individual's mental state, mood, emotions, and behavior). The DON stated Resident 57 was receiving multiple psychotropic medications. The DON stated it was not correct for staff to document a seated blood pressure reading for all three orthostatic readings because the order required an orthostatic blood pressure to be taken in three different positions. The DON stated that using the same readings for all three positions was not appropriate and could negatively impact care. During an interview, on 5/6/2026 at 10:45 a.m., with CNA 1, CNA 1 stated stated she did not know if Resident 57 had a history of falls or if she was a fall risk. During an interview 5/6/2026 at 11:03 a.m., with LVN 2, LVN 2 stated she was not aware of any residents in the Northside Unit (unit where Resident 57 resided) that were currently at risk for falls. LVN 2 stated she was not aware Resident 57 had a history of falls and stated she did not know Resident 57 was at risk for falls. During an interview, on 5/7/2026 at 2:17 p.m., with the DON, the DON stated that if a resident had a history of falls, they were at increased risk for repeat falls. The DON stated that the use of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic medications and blood pressure medications also increased the resident's risk for falls. The DON stated all the facility's residents were at risk of falls and stated it was expected that staff knew this. The DON stated it was important for staff to know this to ensure resident safety and stated it was not appropriate for a CNA or LVN to say that they were not sure if a resident was a fall risk. 2. During a review of Resident 124's admission Record, the admission Record indicated Resident 124 was admitted to the facility on [DATE]. Resident 124's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior), insomnia (persistent difficulty falling or staying asleep) and suicidal ideations (contemplation of self-harm or ending one's life). During a review of Resident 124's MDS dated [DATE], the MDS indicated Resident 124 had no cognitive impairment. The MDS indicated Resident 124 was independent with eating, toileting, dressing and bathing. During a review of Resident 124's physician order dated 11/5/2025, the physician order indicated staff were to monitor and record Resident 124's orthostatic blood pressure while lying, sitting and standing. The physician order indicated the orthostatic blood pressure was to be taken every four weeks, on Tuesday evening. During a review of Resident 124's record titled Monitoring dated 3/1/2026 to 3/31/2026, the record indicated on 3/3/2026, LVN 6 documented Resident 124's orthostatic blood pressure readings. Resident 124's lying, sitting, and standing blood pressure readings were 127/89 mmHg. During a review of Resident 124's record titled Monitoring dated 3/1/2026 to 3/31/2026, the record indicated on 3/31/2026, LVN 6 documented Resident 124's orthostatic blood pressure readings. The record indicated Resident 124's lying, sitting, and standing blood pressure readings were 133/88 mmHg. During a review of Resident 124's record titled Monitoring dated 4/1/2026 to 4/30/2026, the record indicated on 4/28/2026, LVN 6 documented Resident 124's orthostatic blood pressure readings. Resident 124's lying, sitting, and standing blood pressure readings were 108/83 mmHg. During a concurrent interview and record review on 5/6/2026 at 2:50 p.m. with LVN 2, Resident 124's Monitoring record dated 3/1/2026 – 3/31/2026 was reviewed. The record indicated on 3/3/2026, Resident 124's lying, sitting, and standing blood pressure readings were 133/88 mmHg. LVN 2 stated both the CNAs or LVN's took the residents orthostatic blood pressure. LVN 2 stated she had never taken an orthostatic blood pressure that resulted with the same value for lying, sitting, and standing. LVN 2 stated it appeared as if Resident 124's orthostatic blood pressure was not actually taken and only one blood pressure value was used and documented for all three values (lying, sitting, and standing). LVN 2 stated it was important to check the residents orthostatic blood pressure to ensure staff were monitoring for orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from a sitting or lying position) a common side effect of psychotropic medications. LVN 2 stated not checking the orthostatic blood pressure placed residents at risk of unidentified and unaddressed orthostatic hypotension, accidents, and falls. During an interview on 5/7/2026 at 12:03 p.m. with the Director of Staff Development (DSD), the DSD stated orthostatic blood pressure taking was not a skill LVN's or CNA's were taught or evaluated on upon hire to the facility. The DSD stated the facility had not conducted any in-services regarding (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orthostatic blood pressure taking but should have because staff should be competent in the skills they were expected to perform. During an interview with the DON on 5/7/2026 at 9:42 a.m., the DON stated orthostatic blood pressures should be accurately taken and documented. The DON stated checking orthostatic blood pressures were important for ensuring appropriate psychotropic side effect monitoring was performed, such as orthostatic hypotension. 3. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included schizoaffective disorder and major depressive disorder (a serious mood disorder characterized by a persistent low mood, loss of interest and low energy, lasting at least two weeks). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 was independent with ADLs. During a review of Resident 2's physician order dated 7/2/2025, the physician order indicated to monitor and record Resident 2's orthostatic blood pressure while standing, lying, and sitting. The orders indicated these measurements were to be taken every four weeks, on Tuesday evening. During a review of Resident 2's record titled Monitoring, dated 3/1/2026 to 3/31/2026, the record indicated on 3/17/2026, Resident 2's lying, sitting, and standing blood pressure readings were 116/77 mmHg. During a concurrent interview and record review on 5/6/2026 at 3:13 p.m., with the DON, Resident 2's physician order dated 7/2/2025 and the clinical record titled Monitoring dated 3/1/2026 through 3/31/2026 were reviewed. The record indicated on 3/17/2026, Resident 2's blood pressure readings were 116/77 mmHg in all three positions. The DON stated the blood pressure readings would typically vary between positions due to positional changes affecting blood pressure and pulse. The DON stated that identical readings for lying, sitting, and standing positions were not an appropriate or expected orthostatic blood pressure result. The DON stated that the documentation suggested staff likely obtained only one blood pressure reading and recorded the same result for all three positions instead of performing the ordered orthostatic assessment correctly. The DON stated that inaccurate orthostatic blood pressure monitoring could prevent the physician from identifying significant positional blood pressure changes, including hypotension, dizziness, or increased fall risk. The DON stated that nursing staff were expected to follow physician orders, accurately obtain orthostatic blood pressures in all required positions, and ensure documentation reflected the actual readings obtained for each position. During a review of the facility's policy and procedure (P&P) titled Falls Management System, dated 12/2025, the P&P indicated it was the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. During a review of the facility's document titled, Charge Nurse Job Description the document indicated, Nursing Care Functions: Take and record blood pressures.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate nutritional interventions were implemented and evaluated for one of two sampled residents (Resident 30) after the resident experienced significant weight loss. This deficient practice had the potential to place Resident 30 as risk for further weight loss and could lead to harm. Cross Reference F637 and F657 Findings: During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was admitted to the facility on [DATE]. Resident 30's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 30's Minimum Data Set ([MDS]- a resident assessment tool), dated 2/8/2026, the MDS indicated Resident 30's cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 30 was independent (resident completes the activities by himself) for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 5/6/2026 at 11:30 a.m., with the Registered Dietitian (RD), Resident 30's Weight and Vitals Summary, dated 1/27/2026 through 2/23/2026, was reviewed. The weight and vitals summary indicated on 1/27/2026, Resident 30 weighed 225.6 pounds (lbs.). The weight and vitals summary indicated on 2/23/2026, Resident 30 weighed 206 lbs. Resident 30 had a total weight loss of 19.8 lbs. or 8.8 percentage [%] of body weight in approximately one month. The RD stated Resident 30's weight loss was significant. The RD stated Resident 30 should have been assessed to determine the cause of the weight loss and whether current nutritional interventions were effective. The RD stated that updated nutritional interventions were necessary to help prevent continued weight loss and nutritional status. The RD stated additional interventions may have included increased monitoring of meal intake, calorie counts, high calorie snacks, increased supplemental review, and additional dietitian follow-up. During a concurrent interview and record review on 5/7/2026 at 11:10 a.m., with Registered Nurse (RN) 3, Resident 30's care plan titled Weight, dated 1/26/2026 was reviewed. The care plan did not indicate additional nutritional interventions after Resident 30's significant weight loss was identified. RN 3 stated Resident 30 had a care plan that addressed the resident's risk for weight loss; however, the care plan was not revised with additional nutritional interventions after Resident 30's significant weight loss was identified. RN 3 stated the facility should have evaluated whether the exsisting interventions were effective and implemented additional nutritional interventions to address Resident 30's continued weight loss. During an interview on 5/7/2026 at 9:45 a.m., with the Director of Nursing (DON), the DON stated residents with significant weight loss should be assessed and monitored to ensure they receive appropriate nutrition based on current condition. The DON stated significant weight loss may indicate that the current interventions were not effective and that the interdisciplinary team (a coordinated group of healthcare professionals who collaborate and evaluate comprehensive care for a resident) should have evaluated the resident's intake, weight trends, food preferences, and need for additional nutritional approaches. The DON stated failure to implement and evaluate appropriate nutritional interventions placed Resident 30 at risk for continued weight loss, inadequate nutritional intake, weakness, decline in ADLs, and further decline in overall condition. During a review of the facility's policy and procedure (P&P) titled Weight Assessment and Intervention, dated 12/2025, the P&P indicated: Any weight changes of 5% or more since the last weight assessment is retaken the next day for confirmation.If the weight was verified, nursing will immediately notify the dietitian in writing. Undesirable weight changes was elevated by the treatment team. The physician and multidisciplinary team identify conditions and medications that may cause weight loss or increase risk of weight loss.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure the physician orders for metoprolol tartrate ([treats increased heart rate] medication administered for tachycardia [abnormally high resting heart rate]) included heart rate parameters (specific, clinical rules (like dose ranges, lab results, or symptom thresholds) that dictate how, when, or if a drug should be safely) prior to administration for one of one sampled resident (Resident 121).This deficient practice placed Resident 121 at risk for adverse cardiovascular complications, including bradycardia (slow heart rate), hypotension (low blood pressure), dizziness, syncope (faintness), and potential decline in condition related to the unsafe administration of Metoprolol without clear physician guidance.Findings:During a review of Resident 121's admission Record, the admission Record indicated Resident 121 was admitted to the facility on [DATE]. Resident 121's diagnoses included schizoaffective disorder (a chronic mental health condition characterized by a combination of psychosis symptoms of hallucinations or delusions and mood disorder of anger or depression), alcohol dependent, opioid dependent, anemia (a condition where the blood lacks enough healthy red blood cells reducing oxygen flow to organs), and thrombocytopenia (a condition characterized by an abnormally low blood clotting factors increasing the risks of bleeding).During a review of Resident 121's Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 121's cognitive skills for daily decision making was intact. The MDS indicated that Resident 121 was independent (resident completes the activities by themselves with no assistance from helper) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a concurrent interview and record review on 5/6/2026 at 3:09 p.m., with the Director of Nursing (DON), Resident 121's physician order for metoprolol dated 1/27/2026 was reviewed. The physician order indicated to administer metoprolol oral tablet 25 milligrams (mg, unit metric of measurement) twice daily for tachycardia. The DON stated that Metoprolol had been ordered and administered to Resident 121 for tachycardia management. The DON stated that the physician order failed to include specific parameters and clinical instructions regarding when the medication should be administered or held depending on the resident's acceptable heart rate ranges. The DON stated that medications such as Metoprolol require clear and complete parameters to ensure safe administration and appropriate monitoring of the resident's cardiovascular status. The DON stated that the incomplete order should have been clarified with the physician prior to administration of the medication to Resident 121. The DON stated that nursing staff were responsible for reviewing the physician orders for completeness, accuracy, and safety before carrying out the order. The DON stated that administering Metoprolol without defined parameters placed the resident at risk for adverse outcomes, including bradycardia (slow heart rate), hypotension (low blood pressure), dizziness, syncope (faintness), and potential cardiac complications. The DON stated that the facility failed to ensure the physician order contained adequate instructions for the safe administration and monitoring of Metoprolol for Resident 121.During a review of the facility's document titled, Charge Nurse Job Description the document indicated, Report all discrepancies noted concerning physician orders to the nurse supervisor.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Lisinopril (a medication used to treat hypertension ([HTN- high blood pressure) was administered within the ordered parameters (specific, measurable, and objective clinical criteria set by a healthcare provider that dictate when a medication should be given, withheld, or adjusted) for one of one sampled residents (Resident 60). This deficient practice increased Resident 60's risk of hypotension (low blood pressure) and bradycardia (slower heart rate) that could cause dizziness, fainting, weakness, or sudden cardiac arrest (when the heart suddenly and unexpectedly stops pumping).Findings: During a review of Resident 60's admission Record, the admission Record indicated Resident 60 was admitted to the facility on [DATE] with diagnoses including hypertension (low blood pressure). During a review of Resident 60's Minimum Data Set ([MDS] - a resident assessment tool), dated 3/23/2026, the MDS indicated Resident 60's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 60 was independent (resident completes the activities by himself) with activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 60's care plan titled Hypertension, dated 3/16/2026, the care plan indicated to administer Lisinopril as ordered by the physician. During a review of Resident 60's physician order, dated 3/20/2026, the order indicated to administer Lisinopril 20 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount), one tablet by mouth at bedtime for hypertension. The order indicated to hold (not give) if systolic blood pressure ([SBP]-the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood out) was less than 110 millimeters of mercury (mm Hg, unit of pressure measurement).During an interview on 5/7/2026 at 11:05 a.m., with Registered Nurse (RN) 1, RN 1 stated prior to administering Lisinopril, the licensed nurse was responsible for checking Resident 60's blood pressure and checking the orders for hold parameters (specific instructions that dictate whether the medication is safe to administer). RN 1 stated if Resident 60's blood pressure was within the parameters, the licensed nurse would administer Lisinopril, however, if Resident 60's blood pressure was less than 110 mm Hg, the nurse would hold the Lisinopril. RN 1 stated whether Lisinopril was administered or held, the licensed nurse was responsible for documenting accurately on the Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident).During a concurrent interview and record review on 5/7/2026 at 1:34 p.m., with the Director of Nursing (DON), Resident 60's MAR, dated 3/21/2026 through 4/30/2026, was reviewed. The MAR indicated Resident 60 was administered Lisinopril 20 mg for the following SBP readings:3/21/2026- SBP of 108 mm Hg.3/22/2206- SBP of 108 mm Hg.3/23/2206- SBP of 108 mm Hg.4/3/2026- SBP of 106 mm Hg.4/4/2026- SBP of 106 mm Hg.The DON stated Lisinopril should not have been administered when Resident 60's SBP was below 110 mm Hg. The DON stated Lisinopril was a medication used to help decrease blood pressure. The DON stated the licensed nurses were responsible for checking the resident's blood pressure before administering and holding Lisinopril when the SBP was below the ordered parameters. The DON stated Lisinopril was not administered in accordance with the physician's ordered parameters. The DON stated administering Lisinopril when Resident 60's SBP was below 110 mm Hg placed the resident at risk for hypotension, dizziness, weakness, falls, and other adverse effects related to low blood pressure. The DON stated this resulted in Resident 60 receiving medication outside the ordered parameters. During a review of the facility's policy and procedure (P&P) titled Physician's/Psychiatrist (Prescriber's) Orders', dated 12/2025, the P&P indicated the licensed nurse was to administer medications and hold parameters when necessary. During a review of the facility's P&P titled RN Supervisor- Job Description, undated, the P&P indicated the RN Supervisor was responsible for monitoring medication passes to ensure that medications were being administered 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:1. Ensure Resident 89's discontinued trazadone hydrochloride (HCl) (drug used to treat depression and anxiety disorders) was removed from one of three inspected medication carts (North Station Medication Cart 2) and properly disposed.2. Ensure an expired bottle of Rybelsius (drug used to help lower blood sugar and slow digestion) was removed from one of three inspected medication carts (North Station Medication Cart 2) and labeled with the resident's name.3. Ensure three different medications were not transferred into another container found in one of three inspected medication carts (North Station Medication Cart 2).4. Ensure Resident 121's Ozempic [(generic name - semaglutide) injectable medication used to treat diabetes and chronic weight management by reducing appetite and increasing feelings of fullness] prefilled pen was stored in accordance with manufacturer's specifications and per facility policy.These deficient practices had the potential to compromise medication effectiveness placing 144 residents at risk of uncontrolled blood sugar levels, uncontrolled appetite, ingestion of unidentified medications and medication errors. Findings:1. During a review of Resident 89's admission Record, the admission Record indicated Resident 89 was admitted to the facility on [DATE]. Resident 89's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), anemia (a condition where the body does not have enough healthy red blood cells) and alcohol abuse (pattern of drinking that results in harm to one's health).During a review of Resident 89's History and Physical (H&P) dated 4/2/2026, the H&P indicated Resident 89 was alert and oriented with intact cognitive (ability to think and understand) functioning.During a review of Resident 89's Minimum Data Set (MDS- a resident assessment tool) dated 2/26/2026, the MDS indicated Resident 89 was cognitively intact. The MDS indicated Resident 89 was independent for eating, toileting and bathing.During a concurrent observation and interview on 5/5/2026 at 1:15 p.m. with Licensed Vocational Nurse (LVN) 2 of North Station Medication Cart 2, a bubble pack (pharmacy prepared secure packaging system that organizes pills into individual, clear plastic sealed compartments labeled by date and time of day) of Trazadone HCl 100 milligram (mg, metric unit of measurement used for medication dosage and/or amount) for Resident 89 was observed in the bottom drawer. LVN 2 stated she usually did not work with North Station Medication Cart 2 and was not sure why the Trazadone HCl bubble pack was found in the bottom drawer, where the blood pressure cuff and vital sign equipment was usually stored.During a concurrent interview and record review on 5/5/2026 at 1:15 p.m. with LVN 2, Resident 89's physician orders dated 4/13/2026 were reviewed. The physician orders indicated, Trazadone HCl oral tablet give 100 mg by mouth at bedtime for insomnia (trouble falling asleep or staying asleep) was discontinued. LVN 2 stated the Trazadone HCl bubble pack should have been removed from the medication cart and disposed of in the destruction bin located in the locked medication storage room in the north station. LVN 2 stated failure to remove discontinued medication from the medication cart placed residents at risk of medication errors.During an interview on 5/7/2026 at 9:42 a.m. with the Director of Nursing (DON), the DON stated it was important to ensure discontinued medications were removed from medication carts and properly disposed. The DON stated failure to ensure proper disposal of discontinued medications placed residents at risk of administration of discontinued medications and medication errors.During a review of the facility's Policy and Procedure (P&P), titled, Disposition of Drugs revised 10/2019, the P&P indicated, Medications must be removed for destruction if: the physician issues an order to discontinue the medication.2. During a concurrent observation and interview on 5/5/2026 at 1:15 p.m. with LVN 2 of North Station Medication Cart 2, a bottle of Rybelsius was observed without a resident label and an expiration date of 7/31/2025. LVN 2 stated she did not know which resident the bottle of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rybelsius was ordered for. LVN 2 stated the bottle of Rybelsius should have been labeled with a resident name and removed from the medication cart when it expired. LVN 2 stated removal of expired medications from medication cart was important because medications may no longer be effective after the expiration date. LVN 2 stated failure to ensure medication was labeled with resident's name placed residents at risk of medication errors.During an interview on 5/7/2026 at 9:42 a.m. with the DON, the DON stated not removing expired medications from the medication cart placed residents at risk of administration of medications with reduced efficacy. The DON stated medications should be labeled with residents names to ensure they were administered to the correct resident.During a review of the facility's P&P titled, Disposition of Drugs revised October 2019, indicated, Medications must be removed for destruction if: .the expiration date on the label has been reached.During a review of the facility's P&P titled, Medication Labeling revised October 2019, indicated, The required elements of a prescription label will include: Resident's name.3. During a concurrent observation and interview on 5/5/2026 at 1:15 p.m. with LVN 2 of North Station Medication Cart 2, a container of three different medications with a handwritten label of Hydroxyzine 50 mg was observed. LVN 2 stated the three medications observed were transferred from their original bottle and placed into a urine specimen cup (medical-grade plastic container used to collect and transport urine samples). LVN 2 stated she did not know which medications were in the urine specimen cup, which residents they were ordered for, or their expiration dates. LVN 2 stated only pharmacists were able to place medications into a container. LVN 2 stated once medications were removed from their original bottle, nursing staff must either administer to a resident or waste the medication. LVN 2 stated the storage of a urine specimen cup with three unidentified medications placed residents at risk of being administered unidentified medications and medication errors.During an interview on 5/7/2026 at 9:42 a.m. with the DON, the DON stated nursing staff should never transfer medications from their original packaging. The DON stated storage of unidentified medications in medication carts placed residents at risk of being administered the wrong medication.During a review of the facility's P&P titled, Administration of Medications - Medication Pass dated 12/2025, the P&P indicated, Only a pharmacist may place medications into a container. A nurse may not transfer medications from one bottle to another or return medications to a container after they have been poured. If not administered, the medications must be wasted (destroyed).4. During a review of Resident 121's admission Record, the admission Record indicated Resident 121 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 121's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anemia (a condition where the body does not have enough healthy red blood cells), and insomnia (trouble fallingDuring a review of Resident 121's Minimum Data Set (MDS- a resident assessment tool) dated 3/27/2026, the MDS indicated Resident 121 was cognitively (ability to think and understand) intact. The MDS indicated Resident 121 was independent for toileting, eating and bathing.During a concurrent observation and interview on 5/6/2026 at 9:53 a.m. with LVN 5 of south station front medication cart, observed a single, unopened Ozempic prefilled pen, labeled for Resident 121. LVN 5 stated the medication had not been opened or used. LVN 5 stated the Ozempic prefilled pen should have been stored in the refrigerator until first use. LVN 5 stated lack of refrigeration had the potential to compromise the medication effectiveness for Resident 121.During a record review of the manufacturer guidelines for Ozempic (semaglutide) (undated), the guidelines indicated unopened insulin must be stored under refrigeration until first use.During a review of the facility's Policy and Procedure (P&P) titled, Storage of Medications revised October 2019, indicated the facility would ensure medications were stored in an environment that maintained the integrity of the product.During an interview on 5/7/2026 at 9:42 a.m. with the DON, the DON stated not removing expired medications from the medication cart placed residents at risk of administration of medications with reduced efficacy. The DON stated medications should be labeled with residents names to ensure they were administered to the correct resident.During a review of the facility's P&P titled, Disposition of Drugs revised October 2019, indicated, Medications must be removed for (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	destruction if: .the expiration date on the label has been reached.During a review of the facility's P&P titled, Medication Labeling revised October 2019, indicated, The required elements of a prescription label will include: Resident's name.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of nine sampled residents observed during dining observations (Resident 105) received meals in accordance with their preferences when: 1. Resident 105's diet order was not updated following the Registered Dietician's (RD) recommendations for double portions of protein on 4/7/2026. 2. Resident 105 was provided with milk and fish for lunch on 5/5/2026, which were documented as food items he disliked. 3. Staff did not follow Resident 105's diet order for double portions of protein during lunch on 5/6/2026. These deficient practices had the potential to negatively impact Resident 105's meal intake and placed him at risk of not receiving the nutrients and calories needed to maintain a stable body weight. These deficient practices also negatively impacted Resident 105's overall satisfaction during meals.Findings:a. During a review of Resident 105's admission Record, the admission Record indicated Resident 105 was admitted to the facility on [DATE] and was recently re-admitted on [DATE]. Resident 105's diagnoses included hypocalcemia (low calcium levels in the blood) and idiopathic hypoparathyroidism (an endocrine disorder that causes hypocalcemia and elevated levels of phosphorus in the blood).During a review of Resident 105's Minimum Data Set (MDS, a resident assessment tool), dated 4/8/2026, the MDS indicated Resident 105 had disorganized thinking. The MDS indicated Resident 105 was independent for all activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 105's Nutritional Assessment, dated 4/7/2026, the assessment indicated that in the last 30 days, Resident 105 sustained a gradual weight loss of 0.6 percent (%). The assessment indicated Resident 105's caloric needs might not be met and that he might benefit from more calories to promote weight stability. The assessment indicated the Registered Dietician's (RD) recommendation was to remove large portions at all meals and update the diet order to include double portions of protein at all meals. The assessment indicated Resident 105 also requested double portions of protein.During a review of Resident 105's physician order, dated 5/4/2026, the order indicated that on 5/4/2026, Resident 105's diet order was updated to double portions of protein at all meals as recommended in his Nutritional assessment dated [DATE]. During an interview on 5/7/2026 at 12:24 p.m., with the RD, the RD stated that while completing Resident 105's Nutritional Assessment on 4/7/2026, she indicated a goal for Resident 105 to maintain a stable weight. The RD stated her recommendation was to add double portions of protein to all meals. The RD stated double portions of protein would increase his calorie intake and stated this diet update should have been completed within 24 to 48 hours. The RD stated timely update of Resident 105's diet order was important to ensure Resident 105's preference for double portions of protein was honored, and to ensure he was receiving the additional calories.During a concurrent interview and record review, on 5/7/2026 at 12:42 p.m., with the RD, Resident 105's diet order was reviewed. The RD stated on 4/7/2026, she made a recommendation for double portions of protein, but the order was not updated until 5/4/2026. b. During an observation on 5/5/2026 at 12:11 p.m., in the dining room, observed Resident 105's tray tag (a plastic card that indicates the resident's diet order, preferences, and allergies) and lunch tray. Resident 105's tray tag indicated he disliked milk and fish. Resident 105's lunch tray had a filet of fried fish and two cartons of milk. During an interview on 5/7/2026 at 12:42 p.m., with the RD, the RD stated Resident 105 should not have received fish or milk on his lunch tray. The RD stated the licensed nurse who checked the meal trays before serving should have informed the kitchen to remove the milk and provide a substitution instead. The RD stated staff could offer juice instead of milk. The RD stated that for the main entree, Resident 105 should have been provided with a sandwich with double portions of deli meat. The RD stated this was a missed opportunity to offer Resident 105 with an alternative meal option.During a review of the facility document titled (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Spring Cycle Menus, dated 5/6/2026, the document indicated that lunch on Wednesday, 5/6/2026, consisted of a main dish of green chili cheese squares. The document indicated that a single portion included one (1) 3-inch by 2.5-inch green chili cheese square. The document indicated that a large portion included one 3-inch by 2.5-inch square, and another half-sized square.c. During an observation on 5/6/2026 at 12:26 p.m., in the dining room, Resident 105's lunch tray was observed. Resident 105's tray tag indicated Resident 105 was to receive large portions. The tray tag did not reflect Resident 105's current order for double portions of protein. Resident 105's plate had one whole green chili cheese square, and a half-sized square.During an interview on 5/7/2026 at 12:42 p.m., with the RD, the RD stated the kitchen staff referenced Resident 105's tray tag when plating his tray.During an interview on 5/7/2026 at 1:02 p.m., with the RD, the RD stated it was important for the tray tag to be up to date and aligned with the resident's current diet order to prevent malnutrition, weight loss, and to honor the resident's preferences.During a review of the facility's policy and procedure (P&P) titled Weight Assessment and Intervention, dated 12/2025, the P&P indicated interventions for undesirable weight loss were to be based on careful consideration of the Resident's choices and preferences, and the nutrition and hydration needs of the resident. During a review of the facility's P&P titled Food Preferences Policy, dated 12/2025, the P&P indicated a resident's food preferences were to be adhered to within reason, and substitutes for all foods disliked were to be given from the appropriate food group.During a review of the facility's P&P titled Nutritional Screening/Assessments/Resident Care Planning, dated 12/2025, the P&P indicated the resident's nutritional status and nutritional needs were to be assessed, and a nutritional program specific to the resident's needs was to be planned and implemented. The P&P indicated the facility's RD should complete and/or review the Nutritional Assessment and dietary recommendations were to be completed within three days.

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	056417	A. Building B. Wing	05/07/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' Public Guardian ([PG]- a court-appointed public official responsible for managing a person's financial assets and making medical decisions) information was reviewed and updated in the medical record for two of two sampled residents (Resident 109 and Resident 105).This deficient practice had the potential to result in delayed communication with Resident 109 and 105's PG and may affect timely notification, consent, and involvement in Residents 109 and 105's care planning and treatment decisions.Findings: 1. During a review of Resident 109's admission Record, the admission Record indicated Resident 109 was admitted to the facility on [DATE]. Resident 109's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 109's Minimum Data Set ([MDS]- a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 109's cognitive skills for daily decision making (the ability to think and process information) was severely impaired. The MDS indicated Resident 109 was independent with activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a telephone interview on 5/5/2026 at 9:26 a.m., with Resident 109's Public Guardian (PG 3), PG 3 stated as of 1/2026, she was no longer Resident 109s' PG. PG 3 stated she was no longer responsible for making decisions or receiving notification regarding Resident 109's care. During a concurrent interview and record review on 5/6/2026 at 9:45 a.m., with Social Services (SS) 2, Resident 109's PG information was reviewed. The record indicated Resident 109's PG information was not current and continued to list PG 3's information who was no longer the resident's representative. SS 2 stated the facility was responsible for ensuring the resident records were complete, accurate, and current. SS 2 stated Resident 109's PG information should be updated in the resident's medical record to ensure when changes occur the appropriate person could be contacted regarding the resident's care, treatment decisions, changes in condition, and other important matters. During an interview on 5/7/2026 at 9:10 a.m., with the Director of Nursing (DON), the DON stated residents' responsible party and/or legal representative information should be reviewed and updated when the facility becomes aware of a change, including when a listed representative, such as PG 3, was no longer responsible for the resident. The DON stated Resident 109's record should not have continued to list PG 3 as the resident's representative after PG 3 was no longer serving in that role as of 1/2026. The DON stated the facility failed to update Resident 109's PG information in the medical record. The DON stated this failure did not meet the facility's expectation for maintaining accurate and current resident records and had the potential to delay communication with the appropriate representative regarding Resident 109's care and treatment decisions. 2. During a review of Resident 105's admission Record, the admission Record indicated Resident 105 was admitted to the facility on [DATE] and was recently re-admitted on [DATE]. Resident 105's diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). PG 2 was indicated as Resident 105's public guardian. During a review of Resident 105's MDS, dated [DATE], the MDS indicated Resident 105 had (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorganized thinking. The MDS indicated Resident 105 was independent for all ADLs. During an interview on 5/4/2026 at 9:29 a.m., with Resident 105, Resident 105 stated he did not make medical decisions for himself. During a telephone interview, on 5/6/2026 at 9:26 a.m., a telephone call was placed to the telephone number indicated for PG 2 on Resident 105's admission Record. An unidentified individual stated the number contacted was for the Public Guardian's office and stated there was no one by the name of PG 2. During a review of Resident 105's progress note, dated 3/19/2026, by Social Services Designee (SSD) 1, the progress note indicated SSD 1 was informed that Resident 105's PG was now PG 5. The progress note did not indicate contact information for PG 5, including an email address or telephone number. During an interview on 5/7/2026 at 10:34 a.m., with Social Worker (SW) 1, SW 1 stated Resident 105's PG's contact information was located on the resident's admission Record. SW 1 stated Resident 105's current public guardian was indicated as PG 2. During an interview on 5/7/2026 at 10:43 a.m., with SW 1, SW 1 stated there was no documentation in Resident 105's medical record to indicate how to contact PG 5. SW 1 stated Resident 105's medical record should have been updated. SW 1 stated it was important to have PG 5's contact information because it was important for PG 5 to be involved in the care planning process to ensure Resident 105 received the best care, and to ensure Resident 105 was making progress to eventually downgrade to a lower level of care (a care environment where a resident functions more independently). SW 1 stated the public guardian also had the final say in care planning decisions and served as an advocate for the resident. During a review of the facility's policy and procedure (P&P) tiled Charting and Documentation, dated 12/2025, the P&P indicated the resident's medical record will be complete and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 4 performed hand hygiene in between residents during medication preparation. This deficient practice had the potential to place all residents at risk of infection.Findings:During an observation on 5/6/2026 at 8:00 a.m., in the South Back Nursing Station, Licensed Vocational Nurse (LVN) 4 was observed touching a paper bag filled with medications for a new admission. LVN 4 then prepared medications for another resident without performing hand hygiene.During an interview on 5/6/2026 at 9:33 a.m. with LVN 4, LVN 4 stated he did not perform hand hygiene after touching the paper bag and before preparing medications for the next resident. LVN 4 stated he should have performed hand hygiene before proceeding to the preparation of the next resident's medications. LVN 4 stated he did not know where the paper bag had been and could not consider it clean. LVN 4 stated failure to perform hand hygiene placed residents at risk of infection.During an interview on 5/7/2026 at 9:42 a.m. with the Director of Nursing (DON), the DON stated during medication preparation, licensed nurses should perform hand hygiene after touching an object that has not been disinfected. The DON stated hand hygiene during medication preparation was important to ensure infection control.During a review of the facility's policy and procedure (P&P), titled, Handwashing/Hand Hygiene dated, 12/2025, the P&P indicated, If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95 percent (%) ethanol or isopropanolol for all the following situations: .Before preparing or handling medications .

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F 0910 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure resident rooms meet each resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure privacy curtains were in place for one of one sampled residents (Resident 15).This deficient practice had the potential to not honor Resident 15's right to privacy. Findings:During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was admitted to the facility on [DATE]. Resident 15's diagnoses include schizophrenia (a mental illness that is characterized by disturbances in thought), hyperglyceridemia [abnormally high levels of triglycerides (a type of fat) in the blood], and nicotine dependence [chronic condition characterized by a physical and psychological compulsion to use nicotine (an addictive chemical found in tobacco)].During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool) dated 4/18/2026, the MDS indicated Resident 15 was cognitively (ability to think and understand) intact. The MDS indicated Resident 15 was independent for eating, toileting and bathing.During an observation on 5/4/2026 at 10:10 a.m. in Resident 15's room, no room curtains were observed hanging.During a concurrent observation and interview on 5/4/2026 at 2:36 p.m. with Housekeeping (HK), HK stated when a room is due for room curtain cleaning, the Janitor will remove curtains in the morning and replace with extra curtains to ensure for resident privacy. room [ROOM NUMBER] was observed with no room curtains hanging. HK stated staff should have replaced curtains immediately after taking curtains down. HK stated failure to ensure rooms had curtains hanging placed residents at risk of not having privacy.During an interview on 5/7/2026 at 11:17 a.m. with the Environmental Director (ED), the ED stated when staff take down curtains to be washed, staff should replace with extra curtains to ensure resident privacy is maintained. The ED stated the facility did not have extra curtains available on 5/4/2026 when Resident 15's curtains were being washed. The ED stated the facility should have had extra curtains to help replace Resident 15's curtains while they were being washed.During an interview on 5/7/2026 at 9:42 a.m. with the Director of Nursing (DON), the DON stated ensuring privacy was a residents right.During a record review of the facility's Policy and Procedure (P&P), titled, Privacy/Window Curtains Cleaning Policy dated 12/2025, the P&P indicated, Window curtains are wash semi-annual or when they are identified as soiled or upon request by residents or staff. Curtains will be replaced immediately if spare curtains are available or if found damaged or torn.