STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of three sampled residents (Residents 2, 3, and 8) were treated with dignity and respect by CNA 1 who slapped Resident 2 on the hand, spoke rudely to Resident 2, refused to change the television channel for Resident 3, and did not provide perineal care (washing the genital and anal area) for Resident 8. This failure resulted in Residents 2, 3, and 8 feeling upset and frustrated at not having their needs met and had the potential for Residents 2, 3, and 8 to experience feelings of decreased self-worth. Findings: a). During a review of Resident 2 ' s admission Record (AR), the AR indicated the facility admitted Resident 2 on 6/19/2023 with a readmission date of 3/1/2024 with diagnoses including respiratory failure (a medical condition that happens when your lungs cannot get enough oxygen), dependence on a ventilator (a machine used to support or replace the breathing of a person), and lack of coordination (the ability of the body to work together to perform movements or actions). During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool), dated 6/12/2025, the MDS indicated Resident1 ' s cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with eating, substantial/maximal assist (helper does more than half the effort) with oral hygiene, and was dependent (helper does all the effort) with toileting, shower/bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 2 was dependent with rolling left and right (the ability to roll from lying on back to left and right side and returning to lying on back on the bed), sit to lying, lying to sitting on side of bed, and tub/shower transfer. b). During a review of Resident 3 ' s AR, the AR indicated the facility admitted Resident 3 on 6/25/2025 with diagnoses including respiratory failure and muscle wasting and atrophy (a decrease in muscle mass and tissue, often resulting in reduced strength and impaired mobility). During a review of Resident 3 ' s History and Physical (H&P), dated 6/27/25, the H&P indicated Resident 2 had the capacity to make decisions. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c). During a review of Resident 8 ' s AR, the AR indicated the facility admitted Resident 8 on 10/2/2024 with diagnoses including respiratory failure, muscle wasting and atrophy, and paraplegia (a loss of the ability to move and sometimes feel anything in the legs and lower body). During a review of Resident 8 ' s MDS, dated [DATE], the MDS indicated Resident 8 ' s cognitive skills for daily decision making were intact. The MDS indicated Resident 8 was dependent in oral hygiene, toileting, shower/bathing, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 8 was dependent with roll left and right and tub/shower transfer. During a review of Resident 8 ' s Grievance/Complaint Report Form, dated 6/9/2025, the grievance form indicated .CNA 1 has a bad attitude and only changed Resident 8 one time every shift . During an interview on 6/27/2025 at 10:30 a.m. with Resident 8, Resident 8 stated when CNA 1 was taking care of Resident 8 on 6/8/2025 CNA 1 did not change Resident 8 ' s brief (a type of disposable absorbent garment used to manage incontinence [lack of voluntary control over urination or defecation] in adults) when requested and Resident 8 had to wait over an hour to have the brief changed. Resident 8 stated this made Resident 8 feel frustrated at not receiving proper care. During an interview on 6/27/2025 at 10:40 a.m. with Resident 3, Resident 3 stated when Resident 3 requested CNA 1 to change the television channel on 6/26/2025, CNA 1 would not change the channel. Resident 3 stated Resident 3 felt upset because CNA 1 would not do what Resident 3 asked. During an interview on 6/27/2025 at 10:55 a.m. with Resident 2, Resident 2 stated CNA 1 slapped Resident 2 ' s hand and said don ' t do that when Resident 2 was scratching Resident 2 ' s hand. Resident 2 told CNA 1 that Resident needed some anti-itch cream applied to Resident 2 ' s perineal area and CNA 1 told Resident 2 not to tell CNA 1 how to do CNA 1 ' s job. Resident 2 stated this made Resident 2 feel angry. During an interview on 6/27/2025 at 11:35 a.m. with Resident 8 ' s Family Member (FM) 2, FM 2 stated Resident 8 had a soiled brief on 6/8/2025, FM 2 asked CNA 1 to help change Resident 8 ' s brief. CNA 1 told FM 2 CNA 1 was going to change another resident first and start showers for other residents before helping Resident 8. FM 2 stated Resident 8 had to wait for over an hour before a staff member came in and assisted with Resident 8 ' s brief change. During an interview on 6/27/2025 at 10 a.m. and 12 p.m. with the Director of Staff Development (DSD), the DSD stated a resident (no name recall) complained of feeling uncomfortable when CNA 1 touched the resident ' s arm and told the resident not to scratch. The DSD stated it is the policy of the facility for staff members to treat the residents with dignity and respect. The DSD stated CNA 1 should not touch the residents in any way that would make the residents feel uncomfortable. The DSD stated residents ' requests should be provided, if possible. During an interview on 6/27/2025 at 12:24 p.m. with the Assistant Director of Nursing (ADON), the ADON stated if requested, the CNA should change the television channel for the resident, and it is never acceptable for a CNA to slap a resident ' s hand. The ADON stated it is the right of the residents to be treated with kindness, dignity, and respect. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s Policy and Procedure (P&P) titled, Resident Rights, dated 2001, with a revision date of December 2016, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' right to: a dignified existence, be treated with respect, kindness, and dignity, be free from abuse, self-determination . During a review of the facility ' s P&P titled, Perineal Care, dated 2001, with a revision date of February 2018, the P&P indicated, The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident ' s skin condition.

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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. Based on interview and record review, the facility failed to obtain informed consent (the voluntary agreement of a resident or a resident ' s representative to accept a treatment or procedure after receiving information regarding risks and benefits of the treatment) from one of one sampled resident (Resident 9) prior to administering the covid vaccine (a substance that helps the body ' s immune system learn to recognize and fight off the coronavirus [an infectious disease caused by the SARS-Cov-2 virus]) when Infection Prevention Nurse (IPN) 2 requested consent for the covid vaccine from Resident 9 ' s Family Member (FM) 1 instead of Resident 9. This failure resulted in Resident 9 receiving the covid vaccine without giving consent. Findings: During a review of Resident 9 ' s admission Record (AR), the AR indicated the facility admitted Resident 1 on 4/24/2025 with diagnoses including encephalopathy (a disturbance of brain function) and hemiplegia and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue damage) affecting the right dominant side (the preference of a person to use the right side of their body for everyday tasks). During a review of Resident 9 ' s History and Physical (H&P), dated 4/24/25, the H&P indicated Resident 9 had the capacity to understand and make decisions. During a review of Resident 9 ' s Pharmacist Order, dated 6/20/2025, the pharmacist order indicated Spikevax (a brand name for the covid vaccine) was ordered and given to Resident 9 on 6/20/2025. During an interview on 6/25/2025 at 11:36 a.m. with IPN 2, IPN 2 stated IPN 2 called FM 1 to get consent for the covid vaccine for Resident 9. IPN 2 stated IPN 2 called FM 1 to get consent because Resident 9 is Spanish speaking and non-verbal. During an interview on 6/25/2025 at 1:10 p.m. with Resident 9 and FM 1, Resident 9 stated Resident 9 did not give consent to receive the covid vaccine. FM 1 stated FM 1 never spoke to anyone from the facility to get a consent for Resident 9 to receive the covid vaccine. Resident 9 stated Resident 9 received a shot in Resident 9 ' s right arm on 6/20/2025. Resident 9 stated prior to receiving the shot, Resident 9 was told the shot would help Resident 9 ' s right arm to move better. Resident 9 stated Resident 9 was not told the shot was a covid vaccine. During an interview on 6/26/2025 at 1:50 p.m. with the Assistant Director of Nursing (ADON), the ADON stated since Resident 9 had the capacity to make decisions IPN 2 should have gotten consent for the covid vaccine from Resident 9. During a review of the facility ' s Policy and Procedure (P&P) titled, Coronavirus Disease (Covid-19)-Vaccination of Residents, dated 2001, with a revision date of June 2022, the P&P indicated, .The resident (or resident representative) has the opportunity to accept or refuse a COVID-19 vaccine, and to change his/her decision.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 1) received care and services to prevent maggot (immature, worm-like stage in the life cycle of flies) infestation (when fly larvae (maggots) develop in a living organism's tissues or decaying organic matter) inside Resident 1's right ear, right nostril (openings in the nose) and mouth, by failing to: a. Ensure Certified Nurse Assistant (CNA 4) obtained help from licensed nurses (Licensed Vocational Nurses (LVNs) and Registered Nurses (RNs) and/or Respiratory Therapists (RTs) in the facility's Sub Acute Unit (SAU- specialized area for residents requiring more intensive skilled nursing care) to provide oral care (the practices and procedures aimed at maintaining and improving the health and well-being of the oral cavity, including the teeth, gums, tongue, and mouth) to Resident 1 in accordance with the facility's Policies and Procedure (P&P) titled Mouth Care, and Activities of Daily Living (ADL, basic self-care tasks that individuals perform to maintain their health and well-being) Supporting, to prevent the buildup of thick white material on Resident 1's tongue and dried reddish-brown dirt on Resident 1's teeth and the gums (tissue that surrounds the teeth). b. Ensure facility's doors were closed and the screen doors (an exterior door with a mesh screen, typically made of wire or plastic, that allows air to pass through while blocking insects and other small debris from entering a building) were intact to prevent flies (insects) going inside the facility in accordance with the facility's P&P titled, Pest Control. As a result, on 6/20/25, an in-house (within the facility) Dialysis (procedure to remove waste products from the blood) Technician (DT) 1, LVN 1 and RN 1 noticed five to eight maggots coming from Resident 1's right ear, right nostril, and mouth. Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) on 6/20/25 at 4:20 pm and was diagnosed with septic shock (serious medical condition when an infection spreads throughout the body and causes very low blood pressure (force of blood). On 6/26/25 at 4:02 pm, while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) situation. The IJ was called in the presence of the Administrator (ADM), due to the facility's failure to ensure Resident 1 was free from maggot infestation. The ADM was aware that the deficient practice resulted in serious harm that threatened the health and safety of Resident 1. On 6/27/25, the ADM provided an acceptable IJ Removal Plan (IJRP, a detailed plan that includes interventions to immediately correct the deficient practices in the IJ) for the facility's failure to ensure Resident 1 was free from maggot infestation in the facility. While onsite at the facility, the surveyor verified/confirmed implementation of the IJRP through observation, interview and record review, and determined the IJ situation of maggot infestation was no longer present. The surveyor removed the IJ on 6/27/25 at 8:08 pm in the presence of the ADM, Assistant Director of Nursing (ADON), Registered Dietitian (RD), Social Services Director (SSD), Dietary Services Supervisor (DSS), Quality Assurance (QA) Nurse, and Clinical Consultants. The facility provided an acceptable IJRP as follows: A. Immediate Corrective Actions: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.On 6/20/25, Resident 1's nasal, ears and oral cavities were cleaned by facility medical team. A full body assessment was completed to check for additional infestations, none was identified. Resident 1 was transferred to GACH 1 for further evaluation. 2, On 6/20/25, the ADON verified all residents in the SAU received oral care, and scheduled shower and bed bath were provided. All residents in the SAU unit were assessed by the facility clinical team, complete body assessment done and no other resident was identified to be affected. 3. On 6/20/25, Resident 1's room underwent deep cleaning and was thoroughly disinfected by the housekeeping team. B. Preventive and Corrective Actions: 1. From 6/24/25 - 6/25/25- Subacute Consultant provided in-service to all LVNs, RNs and RTs on Oral Care Procedure, Tracheostomy Site (a surgically created opening in the trachea [windpipe] that allows for the insertion of a tracheostomy tube) Care and Use and Handling of Toothbrush with Suction. The SAU Consultant conducted Clinical Skills Competency Checklist on nursing team and Respiratory Therapists. 2. On 6/26/25, the Exterminator company was called to service the conference room and surrounding areas of the facility. 3. On 6/27/25, the Administrator placed an order for four heavy duty rubber curtains to be installed at the patio doors to provide additional support and prevent insects from entering the facility. Three additional Fly Trap Lights were installed by Maintenance staff by the patio doors next to the social services office, smoking patio and hallway next to the kitchen. The Maintenance staff placed large fans by the patio doors to help blow air towards the patio and prevent insects flying inside the facility. The Maintenance Supervisor, Infection Preventionist (IP) and Clinical Consultants conducted a visual inspection of Resident 1's room, including furniture, under the bed, door frame and storage areas. The Clinical Consultant provided in-service to subacute clinical staff on the process to store supplies according to infection prevention practices. The Clinical Consultant provided in-service to housekeeping staff on ensuring all doors including patio, cabinets, bed frames, and furniture are kept clean and sanitized. C. Systematic Change: 1. As of 6/27/25, all patients in the SAU have an updated order for oral care for ventilator (a machine or device used medically to support or replace the breathing of a person who is ill, injured) and non-ventilator residents as ordered by the residents' health practitioners. The completion of oral care will be documented in the residents' clinical records. 2. As of 06/27/25, the Director of Staff Development (DSD) updated the annual in-service calendar to include oral care/hygiene every month for the first three months and quarterly thereafter. 3. The pest control vendor will increase frequency during the summer season to a minimum of twice a month and as needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Physician's Order (PO) dated 6/12/25, the PO indicated bedside dialysis on Monday, Wednesday and Friday, one time a day for ESRD. During a review of Resident 1's Physician History and Physical (H&P) dated 6/14/25, the H&P indicated Resident 1 was on mechanical ventilation (a machine that supports breathing) secondary to pulmonary edema (fluid buildup in the lungs making it hard to breathe). During a review of Resident 1's Interdisciplinary Team (IDT- a group of health care professionals who work together toward the goals of their patients) Conference Record dated 6/16/25 at 8:34 pm, the IDT conference record indicated Resident 1 required total assistance with bed mobility (ability to move and change positions in bed), toileting, dressing, and bathing. During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 6/17/25, the MDS indicated Resident 1 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 1 was dependent (helper does all the effort and the resident does none of the effort to complete the activity) with staff for oral hygiene, toileting, bathing, and personal hygiene. During a review of Resident 1's Situation Background Assessment Recommendation (SBAR- communication tool used in healthcare setting to help share important information among team members) form, dated 6/20/25, untimed, the SBAR indicated DT 1observed whitish moving objects coming from the resident's right nostril, mouth and right ear. During a review of Resident 1's Progress Note (PN) dated 6/20/25, the PN indicated on 6/20/25 at 1:30 p.m. Treatment Nurse 1 (TN1) informed RN 1 of whitish moving bodies (maggots) from Resident 1's mouth. RN 1 assessed Resident 1's mouth and removed the whitish moving bodies from the mouth, right ear, and right nostril. The PN indicated Resident 1 was transferred to GACH 1 on 6/20/25 at 4:20 PM. During a review of Resident 1's GACH 1 Intensive Care Discharge Summary (ICDS) dated 7/1/25, the ICDS indicated Resident 1 had hypotension (low blood pressure) and tachycardia (fast heart rate) upon arrival at the Emergency Department (ED). The ICDS indicated Resident 1 was given medications to increase Resident 1's blood pressure. The ICDS indicated Resident 1 was non-responsive to painful stimuli (to create a reaction) in the ED with multi-organ failure (a critical condition that occurs when two or more organs fail to function) a debilitated condition (a state of physical or mental weakness that decreases normal function). The ICDS indicated Resident 1 was placed on comfort care (medical care focused on relieving pain rather than curing/treating an illness). The ICDS indicated Resident 1 had discharge diagnoses including septic shock, severe sepsis (infection spreads throughout the body) and meal worm in naris (nostrils). During an observation on 6/24/25 at 12:01pm, the facility's trash dumpster located outside of the facility, in front of the back double door, near the SAU was uncovered. The dumpster's lid was open and overflowing with trash. During an interview on 6/24/25 12:05pm with Certified Nurse Assistant (CNA 3), CNA 3 stated CNA 3 have seen flies in some of the residents' rooms (unable to recall which rooms). CNA 3 stated all the screen doors needed to be closed and fly lights should be working. CNA 3 stated CNA 3 saw flies inside of the facility this morning (6/24/25). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation inside of the conference room, on 6/24/25 at 1:45 pm, one live fly was flying up and down in the conference room. During an interview on 6/24/25 at 2:15pm with the Maintenance Assistant (MA), the MA stated, it was important that nurses (in general) report right away when they see pests or flies due to some residents not being able to move and the flies and gnats could get on the residents. During an observation in the conference room on 6/25/25 at 9:45 am, one live gnat was observed flying inside the conference room. During an observation in the hallway on 6/25/25 at 11:33 am, one live fly was flying back and forth from the hallway. During an interview on 6/26/25 at 9:10 am with the ADON, the ADON stated in the SAU where Resident 1 was housed, oral care was done by RTs, and licensed nurses. The ADON stated CNAs only clean the outside of the residents' (residents in the SAU) mouth. The ADON stated oral care to residents in the SAU must be done every shift and as needed. The ADON stated the oral care must be documented on the RT flow sheet and nurses' notes. The ADON stated suctioning was done by RTs or licensed nurses. The ADON stated it was important to check the windows and ensure the doors were closed to prevent flies and insects from going into the facility and into the residents' rooms, lay eggs and develop maggot infestation on the residents (residents in the SAU). The ADON stated, in the SAU, residents were immobile, unresponsive and unable to protect themselves nor remove the bugs/pests. The ADON stated, this time of the year with the hot weather, there would be a lot of bugs/pests that could go inside the facility. The ADON stated licensed nursing staff should ensure oral care was provided to the residents, especially those residents with tracheostomy and or on ventilator. During an interview on 6/26/15 at 9:38 am with RN 1, RN 1 stated Resident 1 was transferred to GACH 1 on 6/20/25 and had not returned back to the facility. RN 1 stated, on 6/20/25 during Resident 1's dialysis session, DT 1, Resident 1's family member and TN 1 saw two little white moving objects (maggots) coming out of Resident 1's right nostril, one coming outside Resident 1's right ear, and five coming out of Resident 1's mouth. RN 1 stated it was important not to have flies in the facility because the residents in the SAU cannot move on their own and flies could lay eggs inside their mouth and tracheostomy. RN 1 stated she had not performed oral care to Resident 1 on the morning of 6/20/25 due to Resident 1's dialysis session. During an interview with LVN 1 on 6/26/25 at 10:45 am, LVN 1 stated, Resident 1 slept with Resident 1's mouth wide open. LVN 1 stated Resident 1always kept Resident 1's mouth open. LVN 1 stated Resident 1 had a thick white layer on Resident 1's tongue that was not easily removed when LVN 1 provided oral care to Resident 1 on 6/20/25. LVN 1 stated there were flies in the SAU hallway and stated after Resident 1 was found with maggots on 6/20/25, flies could still be found in the facility. LVN1 stated on 6/20/25 at 4:30 pm, the dialysis RN supervisor came to inform LVN 1 that DT 1 noticed worms/maggots coming from Resident 1's nose. LVN 1 stated LVN 1 accompanied TN 1 to assess Resident 1 and found one worm hanging from Resident 1's right nostril. LVN 1 stated TN 1 went to get RN 1. LVN 1 stated RN 1 removed the worms and had to dig into Resident 1's mouth to remove all of them (5 maggots). LVN 1 stated there was also one worm on the right side of Resident 1's pillow and others in Resident 1's nose. LVN 1 stated, RN1 described the moving objects from Resident 1's mouth and nose as whitish moving objects, but the RN Dialysis Supervisor and DT 1 stated they were worms/maggots. (continued on next page)

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	056431	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/26/25 at 2:26 pm with CNA 4, CNA 4 stated CNA 4 took care of Resident 1 on the night shift (11pm-7am) of 6/19/25. CNA 4 stated CNA 4 performed oral care for Resident 1, but CNA 4 only cleaned around Resident 1's lips. CNA 4 stated CNA 4 did not clean the inside of Resident 1's mouth because Resident 1's mouth was closed. CNA 4 stated CNA 4 did not ask the assigned RT or licensed nurse for Resident 1 to assist CNA 4 with oral care due to Resident 1's mouth looked clean from the outside. During an interview on 6/26/25 at 2:35 pm with DT 1, DT 1 stated, on 6/20/25 during Resident 1's dialysis session, while talking to Resident 1's sister, DT 1 noticed something was moving on Resident 1's beard, and something coming out of Resident 1's nostrils. DT 1 stated it was a maggot or something like a worm. DT 1 called Dialysis RN and Dialysis RN saw more than five worms coming out of Resident 1's nostrils. DT 1 stated Resident 1 kept Resident 1's mouth open all the time. DT 1 stated DT 1 did not check the inside of Resident 1's mouth and DT 1 assumed Resident 1's mouth was clean. During a review of the facility's P&P titled, Mouth Care, revised 2/2018, the P&P indicated to keep the resident's lips and oral tissues moist, to cleansed and freshen the resident's mouth and to prevent oral infection. The P&P indicated for staff to thoroughly wipe the roof of a resident's mouth, inside the cheeks, the tongue, and teeth with an applicator. The P&P indicated to change the applicators frequently and to moisten the inside of the resident's mouth, tongue and lips using a prepared swab or water-soluble lubricant (lubricant that dissolves in water). During a review of the facility P&P titled Activities of Daily Living (ADL) Supporting, revised 3/2018, the P&P indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLS. The P&P indicated residents who are unable to carry out ADL independently will receive the services necessary to maintain good grooming and personal and oral hygiene. During a review of the facility's P&P titled Pest Control, revised 5/2018, the P&P indicated the facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. The P&P indicated windows are screened at all times.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review, the facility failed to provide occupational (a treatment focused on improving the performance of activities required in daily life) and physical therapy (a treatment focused on improving or restoring physical movement and function) to one of one sampled residents (Resident 9) who was discharged from physical therapy after receiving four days of physical therapy and occupational therapy after receiving five days of occupational therapy. This failure resulted in Resident 9 not receiving rehabilitative services and had the potential to result in further decline of physical, functional, and psychosocial well-being. Findings: During a review of Resident 9 ' s general acute care hospital (GACH) H&P record, dated 4/23/2025, the GACH record indicated, Will plan for transfer to rehab if remains clinically stable. Will do aggressive physical therapy/occupational therapy, discussed with Family Member (FM) 1 the need for long-term rehab given his weakness. During a review of Resident 9 ' s GACH Occupational Therapy Inpatient Weekly Progress Note, dated 4/23/2025, the GACH progress note indicated, Assessment: Patient displays improved self-care abilities and functional balance/endurance as compared to last week. Resident 9 also displays increased right upper extremity strength. Patient will benefit from additional occupational therapy intervention based on above findings . Recommendations: Patient may benefit from skilled therapy with good potential to progress towards prior level of function. During a review of Resident 9 ' s admission Record (AR), the AR indicated the facility admitted Resident 1 on 4/24/2025 with diagnoses including encephalopathy (a disturbance of brain function) and hemiplegia and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (a medical condition where blood flow to the brain is disrupted, causing brain tissue damage) affecting the right dominant side (the preference of a person to use the right side of their body for everyday tasks). During a review of Resident 9 ' s History and Physical (H&P), dated 4/24/25, the H&P indicated Resident 9 had the capacity to understand and make decisions. During a review of Resident 9 ' s Physical Therapy Initial Evaluation, dated 4/25/2025, the evaluation indicated Resident 9 had a rehab potential of fair with a frequency and duration of six times per week for four weeks. The evaluation indicated a discharge from physical therapy date of 4/29/2025. During a review of Resident 9 ' s undated Physical Therapy Treatment Record, the treatment record indicated Resident 9 received physical therapy on 4/25/2025, 4/26/2025, 4/28/2025, and 4/28/2025. During a review of Resident 9 ' s Occupational Therapy Initial Evaluation, dated 4/25/2025, the evaluation indicated a treatment diagnosis of lack of coordination (the ability of the body to work together to perform movements or actions) and a patient goal as get better. The evaluation indicated a rehab potential of good with a frequency and duration of six times a week for four weeks. The evaluation indicated a discharge from occupational therapy date on 4/29/2025. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9 ' s undated Occupational Therapy Treatment Record (no date), the treatment record indicated Resident 9 received occupational therapy 4/25/2025-4/29/2025. During a review of Resident 9 ' s Minimum Data Set (MDS- a resident assessment tool), dated 4/30/2025, the MDS indicated Resident 9 ' s cognitive (the ability to think and process information) skills for daily decision making were severely impaired. The MDS indicated Resident 9 required supervision or touching assistance (helper provides verbal cues, and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper/lower body dressing, and putting on/taking off footwear, and dependent (helper does all of the effort) with toileting, shower/bathing, and personal hygiene. The MDS indicated Resident 9 was dependent on rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed) sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and tub/shower transfer. During an interview on 6/25/2025 at 1:10 p.m. with FM 1, FM 1 stated Resident 9 had not been receiving physical and occupational therapy since being admitted to the facility. During an interview on 6/25/2025 at 12:30 p.m. with Registered Physical Therapist (RPT) 1, RPT 1 stated Resident 9 was admitted to the facility with an order to receive physical therapy six times a week. RPT 1 stated Resident 9 was discharged from physical therapy after receiving four days of physical therapy because Resident 9 was not making progress. During an interview on 6/25/2025 at 12:45 p.m. with the Registered Occupational Therapist (ROT) 1, ROT 1 stated Resident 9 was evaluated on 4/25/2025 for occupational therapy and received five occupational therapy sessions before being discharged from occupational therapy on 4/29/2025. ROT 1 stated Resident 9 was discharged from occupational therapy because Resident 9 was not making progress. During a concurrent interview and record review on 6/26/2025 at 10:10 a.m. with RPT 1, Resident 9 ' s undated Physical Therapy Treatment Record was reviewed. The treatment record indicated Resident 9 required maximum assistance x 2 (resident requires 2 helpers to assist with exercise) with supine (lying in bed) to stand on 4/25/2025. The treatment record indicated Resident 9 required maximum assistance with supine to stand on 4/29/2025. RPT 1 stated maximum assistance is an improvement from maximum assistancex2. RPT 1 stated Resident 9 would have benefited from receiving more than four days of physical therapy. RPT 1 stated it is important for residents to receive physical therapy to improve their physical functioning and independence. During a concurrent interview and record review on 6/26/2025 at 10:30 a.m. with ROT 1, Resident 9 ' s undated Occupational Therapy Treatment Record was reviewed. The treatment record indicated Resident 9 required set up assistance (requires a helper to assist) with eating on 4/25/2025 and set up assistance/modified independent (the resident can do the exercise themselves) on 4/29/2025. ROT 1 stated a resident who goes from set up assistance to set up assistance/modified independent is showing signs of improvement. ROT 1 stated Resident 9 would have benefited from receiving more occupational therapy services. During an interview on 6/26/2025 at 1:50 p.m. with the Assistant Director of Nursing (ADON), the ADON stated it was reasonable to have given Resident 9 more than four days of physical therapy and five days of occupational therapy. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s undated Policy and Procedure (P&P) titled, Purpose of Physical Therapy Services, (the P&P indicated, Purpose of physical therapy service: to provide optimum quality of physical therapy patient care for in-and-outpatients .patients are accepted with the following diagnosis: .neurological disabilities, other disabilities which may be improved by services provided by physical therapy. During a review of the facility ' s undated P&P titled, Therapy Referral Procedures, the P&P indicated, Accurate, thorough and timely documentation is essential in providing quality patient care. Thes enables therapists to communicate to the facility, the physician and other team members, the progress the patient is making along with justifying therapy that is being given Documentation by therapists is an important aspect along with quality treatment of his/her job performance.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure facility's doors were closed and facility's screen doors and windows (an exterior door/window with a mesh screen, typically made of wire or plastic, that allows air to pass through while blocking insects and other small debris from entering a building) were intact to prevent flies and other insects from going inside the facility, in accordance with the facility's policy and procedure (P&P) titled, Pest Control. This failure resulted in flies and other insects entering the facility and had the potential for flies and other insects to spread diseases to all 220 residents in the facility. Findings: During an interview on 6/24/25 at 11:41 am with Licensed Vocational Nurse (LVN) 3, LVN 3 stated LVN 3 sees gnats (insects) in residents' rooms especially in the rooms with juices, drinks, and foods. LVN 3 stated staff (in general) would inform the Maintenance Department (MD), whenever staff (in general) saw insects inside the facility. During an observation on 6/24/25 at 12:01 pm, the facility's trash dumpster located outside of the facility, in front of the back double door, near the Subacute Unit (SAU - specialized area for residents requiring more intensive skilled nursing care) was uncovered. The dumpster's lid was open and overflowing with trash. During an interview on 6/24/25 at 12:05 pm with Certified Nursing Assistant (CNA) 3, CNA 3 stated CNA 3 saw flies in room [ROOM NUMBER] and room [ROOM NUMBER] today (6/24/25). CNA 3 stated all staff were supposed to make sure that all the window and door screens were closed and fly lights were working. CNA 3 stated CNAs were also supposed to report to the licensed nurses as soon as possible whenever CNAs see flies or other insects. CNA 3 stated CNA 3 saw MD staff inside room [ROOM NUMBER] and room [ROOM NUMBER] this morning (6/24/25) to take care of the flies. During an interview on 6/24/25 at 12:19 pm with Resident 4, Resident 4 stated Resident 4 saw gnats around the sandwiches in Resident 4's room (room [ROOM NUMBER]) this morning (6/24/25). During an interview on 6/24/25 at 12:23 pm with Resident 5, Resident 5 stated Resident 5 saw either a fly or a gnat flying around in Resident 5's room (room [ROOM NUMBER]) a minute ago. During an interview on 6/24/25 at 12:45 pm with Resident 6, Resident 6 stated Resident 6 had seen flies and gnats in Resident 6's room (room [ROOM NUMBER]) the day before yesterday (6/22/25). During an interview on 6/24/25 at 1:03 pm with Resident 7, Resident 7 stated Resident 7 had seen flies in Resident 7's room (room [ROOM NUMBER]). Resident 7 stated Resident 7 and Resident 7's visitors were trying to kill the flies inside Resident 7's room with a newspaper the day before yesterday (6/22/25). During an observation inside of the conference room, on 6/24/25 at 1:45 pm, one live fly was flying up and down in the conference room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/24/25 at 2:15pm with the Maintenance Assistant (MA), the MA stated, it was important that nurses (in general) report right away when they see pests or flies due to some residents not being able to move and the flies and gnats could get on the residents. During an observation in the conference room on 6/25/25 at 9:45 am, one live gnat was observed flying inside the conference room. During an interview on 6/26/25 at 9:10 am with the Assistant Director of Nursing (ADON), the ADON stated it was important to check the windows and ensure the doors were closed to prevent flies and insects from going into the facility and into the residents' rooms, lay eggs, and develop maggot infestation on the residents especially on residents with tracheostomy (a surgically created opening in the trachea [windpipe] that allows for the insertion of a tracheostomy tube [artificial airway for breathing]) and or on the ventilator (a medical device to help support or replace breathing) in the SAU. The ADON stated, in the SAU, residents were immobile, unresponsive and unable to protect themselves nor remove the bugs/pests. The ADON stated, this time of the year with the hot weather, there would be a lot of bugs/pests that could go inside the facility. During an interview on 6/26/15 at 9:38 am with Registered Nurse (RN)1, RN 1 stated it was important not to have flies in the facility because the residents in the SAU cannot move on their own and flies could lay eggs inside their mouth and tracheostomy. During an interview on 6/26/25 at 10:45 am with LVN 1, LVN 1 stated there were flies in the SAU hallway and in the facility. During a review of the facility's P&P titled Pest Control, revised 5/2018, the P&P indicated the facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. The P&P indicated windows are screened at all times.