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	08/22/2025

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 protect the privacy and dignity of seven of seven sampled residents (Resident 11, Resident 27, Resident 33, Resident 45, Resident 116, Resident 136, and Resident 239), by failing to: A. Ensure the privacy curtain was closed while providing care and treatment to Resident 33.B. Ensure Resident 116 did not experience an extended waiting time for care for approximately one hour.C. Ensure Resident 45 and Resident 239 did not experience an extended wait time to receive care for approximately 30 minutes to 2.5 hours.D. Ensure Resident 136 did not experience an extended wait time for peri-care of more than four hours after requesting assistance.E. Ensure Resident 27's personal choices for showers instead of bed bath were respected.F. Ensure Resident 11 did not wait 20 minutes to be changed after soiling her diaper.Findings: a. During a review of Resident 33's admission Record (AR), the AR indicated Resident 33 was admitted to the facility on [DATE] with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support), and pneumonia (an infection/inflammation in the lungs) due to other specified bacteria. During a review of Resident 33's MDS dated [DATE], the Minimum Data Set (MDS - a federally mandated resident assessment tool) indicated Resident 33 had severely impaired cognition for daily decision making. The MDS indicated Resident 33 was dependent (helper did all the effort and lifted or held trunk or limbs) on staff for oral hygiene, toileting, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 8/19/2025 at 9:03am with Licensed Vocational Nurse 11 (LVN 11), while in Resident 33's room. Resident 33 was awake, lying in bed. LVN 11 pulled up Resident 33’s gown and checked Resident 33’s GT site. LVN 11 did not close and pull the privacy curtain to provide Resident 33’s privacy which exposed Resident 33’s abdominal area to the roommate and the hallway. LVN 11 stated the privacy curtain needed to be closed prior to providing care and treatment to the residents to provide privacy from the roommate and passerby. During a concurrent interview on 8/22/2025 at 9:51 am with the facility’s Director of Nursing(DON), the DON stated body parts should not be exposed during care and treatment. The DON stated the resident’s privacy curtain needed to be closed prior to providing care and treatment to residents in order to provide privacy and dignity to the residents. b. During a review of Resident 116's admission Record (AR), the AR indicated the facility readmitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus (sugar in blood is too (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	high) and chronic kidney disease (kidneys are unable to filter waste). During a review of Resident 116’s History & Physical (H&P), dated 12/17/24, the H&P indicated Resident 116 can make needs known and did not have the capacity to make medical decisions. During a review of Resident 116's Minimum Data Set (MDS, a resident assessment tool), dated 6/19/25, the MDS indicated Resident 116 was cognitively (ability to understand and process thoughts) intact and required partial to moderate assistance with toileting and personal hygiene, and was always bowel and bladder incontinent. c). During a review of Resident 239’s admission Record (AR), the AR indicated the facility readmitted to the facility on [DATE] with diagnoses that included methicillin resistant staphylococcus aureus (germ resistant to some antibiotics), and bacteremia (bloodstream infection). During a review of Resident 239's Minimum Data Set (MDS, a resident assessment tool), dated 8/18/25, the MDS indicated Resident 239 was cognitively (ability to understand and process thoughts) intact and required partial to moderate assistance with toileting and personal hygiene. During an interview on 8/19/25, at 10:55 a.m., with Resident 239, Resident 239 stated Resident 239 waited up to 2.5 hours for staff assistance to be changed at night. Resident 239 stated this made her feel awful. Resident 239 stated Resident 239 thinks they need more Certified Nurse Assistants (CNAs). During an interview, on 8/19/25, at 11 a.m. with Resident 116, Resident 116 stated Resident 116 was given a laxative a couple of days ago. Resident 116 stated Resident 116 wasn't taking any more of the laxative because Resident 116 had to keep sheets and blanket pulled back so that stool would not get on blankets. Resident 116 stated Resident 116 had loose stool that was all in between legs on the bed. Resident 116 stated Resident 116 had to wait one hour or more to be changed. Resident 116 stated this happens on all shifts. Resident 116 stated Resident 116 did not like it. Resident 116 stated Resident 116 thinks they need more CNAs. During an interview, on 8/19/25, at 12:32 p.m., with Resident 45, Resident 45 stated Resident 45 waits 30 minutes to one hour for staff assistance. Resident 45 stated Resident 45 has to wait for staff to get their breaks and lunches before getting help. Resident 45 stated staff turns off the call light and does not assist Resident 45 and if the CNA does not show up, we have to start all over. Resident 45 stated It is not cool but that's the way it is, so we don't make a big deal. Resident 45 stated they don’t have enough workers so we can’t expect much. During a review of the facility’s Policy and Procedure (P&P), titled, “Dignity,” revised 2021, the policy indicated each resident shall be cared for in a manner that promotes and enhances his of her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during procedures. During a record review of the facility’s Policy and Procedure (P&P), titled, “Answering Call Lights,” dated 2001, the policy indicated the purpose of this procedure is to ensure timely responses to the resident’s requests and needs. d. During a review of Resident 136’s AR, the AR indicated Resident 136 was admitted to the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE] with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD- is a common lung disease causing restricted airflow and breathing problems), type 2 diabetes (elevated sugar in the blood), pneumonia (is an infection that inflames the air sacs in one or both lungs), morbid obesity (a person's body has a lot of extra weight) with alveolar hypoventilation (is a breathing disorder that affects some people who have obesity). During a record review of Resident 136’s H&P, dated 7/17/2025, the H&P indicated Resident 136 did not have the capacity to understand and make decisions. During a review of Resident 136’s MDS, dated [DATE], the MDS indicated Resident 136 required dependent care (helper does all of the effort, the resident does none of the effort to complete the activity) from staff for toileting hygiene, shower/bathing self and putting on/taking off footwear. During a review of Resident 136’s Skin Check (SC) dated 7/17/2025 at 2:49 PM, the SC indicated Resident 136 had a new skin issue in the middle area of the sacrum (a triangular bone at the base of the lower back) that was present on admission which was considered to be a pressure ulcer/injury (damage to the skin caused by continuous pressure) Stage 3 full-thickness skin loss (a bedsore where the skin is destroyed and extending into deeper tissue and fat) and surrounding tissue to be fragile with skin that is at risk for breakdown. Additional care areas indicated incontinence management and mattress with pump. During a review of Resident 136’s CP dated 7/17/2025, the CP indicated Resident 136 had problems with Activities of Daily Living (ADL- referring to fundamental personal care tasks such as bathing, dressing, eating, transferring, toileting, and managing continence) decline in functional mobility skills and a potential for skin break down. The listed goal included to prevent skin breakdown, but there was no ADL maintenance or repositioning included or documented in any other CP in Resident 136’s medical record (MR). During a review of Resident 136’s Wound Evaluation & Treatment Progress Note (WETPN) dated 8/14/2025, the WETPN indicated Resident 136’s skin exam revealed Resident 136 had a sacrococcyx (the tail bone located at the base of the spine), sacral region (lower back) wound that had closed. The Recommendations indicated to provide aggressive offloading (refers to the practice of relieving or redistributing pressure from a specific area of a patient's body to prevent and treat wounds, especially pressure ulcers) every two (2) hour turning and no sitting beyond two hours; frequent diaper checks and changes. Additional recommendations indicated to turn the patient every two hours and to keep skin clean and dry. e. During a review of Resident 27’s AR, the AR indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (a severe and irreversible condition where the kidneys have lost most of their function and can no longer adequately filter waste products from the blood), cutaneous abscess (a collection of pus under the skin) of the groin (the area between the abdomen and the thigh), laceration with foreign body of right buttock, necrotizing fasciitis (a bacterial infection that enters the body, most commonly through a break in the skin such as a cut, scrape, or burn), morbid (severe) obesity due to excess calories, type 2 diabetes (sugar in the blood) and inflammation of vagina and vulva. During a review of Resident 27’s MDS dated [DATE], the MDS indicated Resident 27 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene and upper body dressing. Resident 27 was dependent on staff assistance for shower/bathing self and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	putting on/taking off footwear and lower body dressing. During a review of Resident 27’s untitled CP dated 7/24/2025, the CP indicated Resident 27 needs 1-1 activities for social/mental stimulation. The listed Interventions indicated to assess resident for activity preference, respect residents choices and respect resident rights. During a record review of Resident 27’s H&P, dated 8/17/2025, the H&P indicated Resident 27 does has the capacity to understand and make decisions. During an initial observation and interview with Resident 27 on 8/19/2025 at 10:04 AM, Resident 27 was observed sitting at the side of bed. Resident 27 stated, “I haven’t taken a shower since three weeks ago. I have only gotten a bed bath one time in three weeks. I do want to take a shower. I’ve been asking for the past three weeks. I brought all my stuff and my shampoo. I want to get clean. When they do peri-care, I don’t feel clean, the staff do it for me. I feel my hair is dirty. I’m all dirty. It makes me feel mad and sad at the same time. I’m a very clean person; it makes me feel staff is not listening to me.” During initial observation and interview with Resident 136 on 8/19/2025 at 11:03 AM, Resident was observed to be sitting up in bed watching television (TV). Resident 136 stated, “I’ve had a bowel movement (BM) since 7:30 AM. I've been calling them and its 11:07 AM now and I'm still waiting. I’m afraid my wounds will come back. I am very upset and embarrassed. Sometimes I wait up to three (3) hours to get cleaned up. I call and they don’t come.” During an interview with License Vocational Nurse (LVN9) on 8/19/2025 at 11:11 AM, LVN9 stated Resident 136 should not have been waiting since 7:30 AM to be cleaned up by staff especially if Resident 136 had a bowel movement. LVN9 stated it was not sanitary, and it must be uncomfortable for Resident 136 to be soiled for such a long period of time. LVN9 stated she would go look for Certified Nursing Assistant (CNA4) to have Resident 136 cleaned up. LVN9 stated that CNA4 was assigned to Resident 136 but CNA4 was busy with another resident and that CNA4 would clean up Resident 136 when there was a chance. During an interview with CNA4 on 8/19/2025 at 11:14 AM, CNA4 stated there were 10 residents on his assignment for the day and someone might have answered the call light earlier and not communicated to CNA4 that Resident 136 was soiled. CNA4 stated he was busy earlier because there was a room change. CNA4 stated that the cnas can feel overworked and burned out at times and feel like they don’t have time to change all the residents in their assignments in a timely manner. I am trying to get to everyone. During a concurrent interview with CNA4 on 8/20/2025 at 11:39 AM, CNA4 stated, “I do find some of the alert residents that have been waiting for a long period of time tell me the previous shift staff answered the call light but never provided the care they were requesting. Sometimes when I check a resident to clean them up, they are very soiled. They have gone urine or poo once or twice in the same diaper.” Per CNA4, the LVNs or Charge Nurses (CN) are supposed to help, and they can also do the job. During the same interview with CNA4 on 8/20/2025 at 11:42 AM, CNA4 stated that the residents get showers every other day. Per CNA4 the resident should get the showers for hygiene. CNA4 stated not giving a resident a shower when the resident requests it is not respecting the residents rights and neglecting them. Per CNA4 it would make the resident feel bad, abandoned, neglected, self-conscious (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and affect their self-esteem. During a concurrent interview with Resident 27 on 8/20/2025 at 11:54 AM, Resident 27 stated she still had not gotten a shower. Resident 27 stated that the day before, after dinner she had a BM and felt dirty and was itchy on her vaginal area. Resident 27 stated asked the night shift cna to clean her. Per Resident 27, the CNA4 did clean her but did not provide a shower. Resident 27 stated that when the night shift cna cleaned her, the cna showed Resident 27 the towel she used to clean her, and Resident 27 still had poop in her vagina. Per Resident 27 the day shift cna (CNA4) had not cleaned her properly. During an interview with LVN10 on 8/20/2025 at 11:56 AM, LVN10 stated “Residents have shower schedules either for mornings or evenings, but they all get three (3) showers a week. “They should get showers and peri-care often for hygiene and to prevent infections, skin problems. It is not acceptable to have a resident sitting in their own filth for long periods of time. This can make them feel terrible, helpless, neglected, sad and depressed. Feeling this way puts them at risk for depression or anxiety withdrawal.” During a concurrent interview with CNA4 while inside Resident 27’s room in the presence of Resident 27 on 8/21/2025 at 8:51 AM, CNA4 stated that Resident 27 should have gotten a shower on Monday 8/18/2025 but that CNA4 still had not been able to give Resident 27 a shower. CNA4 stated Resident 27 would be getting a shower later on that day. During interview and observation of Resident 27 on 8/21/2025 8:52 AM, Resident 27 begin to cry. Resident 27 stated she was crying because she was so happy that she will finally get a shower today. Resident 27 stated, I have been so embarrassed. The last time my daughter visited me she told me I stink. During an interview with the Infection Prevention Nurse (IPN) on 8/21/2025 at 3:10pm, IPN stated every resident is scheduled to take a shower at least two times a week. Every resident needs to be provided with peri-care as needed. It’s not acceptable to leave a resident for long periods of time if they are soiled. If there are no restrictions from the wound doctor it’s not acceptable to not give a resident a shower because it’s not good hygiene. IPN also stated that not giving the residents a shower as they requested would make the resident feel uncomfortable, embarrassed and neglected, and their self-esteem would go down making them feel depressed. The IPN stated a resident that is left in soiled conditions for extended periods of time can have serious infection risks, like skin tears, skin inflammation and bedsores. The combination of moisture and bacteria from urine and feces creates an environment that can quickly lead to skin breakdown, and other health complications. During an interview with the DON on 8/22/2025 at 9:10 AM, the DON stated that it is not acceptable for a resident to be in bed soiled for hours. The DON stated that as soon as a staff identify the resident needs to be changed, the resident needs to be cleaned immediately. The DON stated, “Anyone can do it, including an LVN or RN. This is part of the supervision and mentoring the license nurses must provide to the cna.” The DON further stated if the resident does not receive proper ADLs including peri-care, the resident will be uncomfortable causing them discomfort and irritating their skin. During an interview with the Treatment Nurse (TN1) on 8/22/2025 at 1:33 PM, TN1 stated that ADLs and timely peri-care must be provided to all residents. TN1 stated especially when residents are at (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk of skin breakdown or have wounds it’s extremely important to prevent infections. TN1 stated the main thing is to prevent infections and provide comfort. It’s not acceptable for a resident to be soiled and just have the resident sit there from 7 AM to 11:30 AM. The residents with wounds need to be repositioned as well. Even if the staff is busy, under no circumstances should the resident go for a long period of time without being changed. Per TN1, if a resident is left for long periods of time soiled or not being cleaned completely, it would make the resident feel uncomfortable, embarrassed and neglected. f. During a review of Resident 11's admission Record (AR), the AR indicated Resident 11 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood). During a review of Resident 11's “Minimum Data Set (MDS, a resident assessment tool),” dated 8/5/2025, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 11 was dependent (helper does all the effort) on staff for bathing, dressing, and toileting hygiene. During a review of Resident 11’s History and Physical (H&P), dated 6/7/2025, the “H&P” indicated, Resident 11 had the mental capacity to understand and make medical decisions. During an interview on 8/19/2025 at 1:29 PM with Resident 11, Resident 11 stated Resident 11 had to sometimes wait a long time for help from nurses (in general). Resident 11 stated Resident 11 pressed the call light earlier in the morning of 8/19/2025 because Resident 11 needed Resident 11’s diaper changed. Resident 11 stated Resident 11 waited so long that Resident 11 fell asleep. During an interview on 8/22/2025 at 8:34 AM with CNA 5, CNA 5 stated facility staff (in general) should respond to residents’ (in general) call lights immediately. CNA 5 stated if residents (in general) were not responded to promptly, residents (in general) would feel like facility staff (in general) were not paying attention to the residents (in general) and that other things were more important than the residents (in general). CNA 5 stated a resident (unidentified) was frustrated with CNA 5 on 8/19/2025 because the unidentified resident waited 10 minutes for CNA 5 to change the unidentified resident’s soiled diaper. During an interview on 8/22/2025 at 8:47 AM with CNA 6, CNA 6 stated CNA 6 often was assigned to care for Resident 11. CNA 6 stated it sometimes took CNA 6 20 minutes to respond to Resident 11’s request to change Resident 11’s soiled diaper. During a review of the facility's policy and procedure (P&P) titled, Dignity, revised February 2021, the P&P indicated, “Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example…promptly responding to a resident's request for toileting assistance…” The P&P indicated, “Staff are expected to knock and request permission before entering residents' rooms.” During a review of the facility's P&P titled, Answering the Call Light, revised September 2022, the P&P indicated, “Answer the resident call system immediately.”

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accommodate the residents' needs and preferences in accordance with the facility's policy and procedures (P&P) for five of five sampled residents (Residents 8, 41, 163,165, and 218) by failing to:a. Provide Resident 8 with an appropriate call light consistent with Resident 8's functional capability.b. Ensure Resident 41's call light was within reach.c. Ensure Resident 163's call light was within reach.d. Ensure Resident 165's bed was not too short causing Resident 165's feet to rest against the footboard. e. Ensure to accommodate Resident 218's request for room change due to noise from the roommate (Resident 209). These failures had the potential for Residents 8, 41, 163, 165, and 218 not to receive necessary care or receive delayed services and could affect the residents' quality of life.Findings: a. During the review of Resident 8’s admission Record (AR), the AR indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and osteoporosis (weak and brittle bones, due to lack of calcium and vitamin D). During a review of Resident 8’s untitled Care Plan (CP) dated 10/25/2024, the CP indicated Resident 8 was at risk for falls related to poor safety awareness. The CP interventions included for staff to ensure the call light was within reach and to encourage Resident 8 to use it for assistance. During a review of Resident 8’s Minimum Data Set (MDS, a resident assessment tool) dated 7/26/2025, the MDS indicated Resident 8 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 8 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. During a concurrent observation inside Resident 8’s room and interview on 8/19/2025 at 9:35 am with Certified Nurse Assistant 2 (CNA 2), Resident 8 was lying in bed, on Resident 8’s back. Resident 8 had a push button (a call light that resident presses to signal a nurse or other staff member when they need assistance) type of call light. CNA 2 stated Resident 8 had bilateral (affecting both sides) arms and hands contracture (a stiffening/shortening at any joint, that reduces the joint’s range of motion). CNA 2 stated Resident 8 could not push the call light button and would benefit to use the pad sensor (a communication device used by residents in healthcare facilities to signal for assistance from nursing staff) to call for assistance. During an interview on 8/21/2025 at 10:01 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated residents with limited mobility would benefit to have the pad sensor for the resident to use to call for assistance and staff could address the resident’s needs timely. During an interview on 8/21/2025 at 11:50 am with the Director of Nursing (DON), the DON stated call light should be appropriate to the resident’s functional capability for the residents to use and call for assistance whenever help was needed. During a review of the facility’s policy and procedures (P&P) titled, “Call System, Residents,” dated September 2022, the P&P indicated, “Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the floor. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.” b. During a review of Resident 41’s AR, the AR indicated Resident 41 was admitted to the facility on [DATE] with diagnoses that included acute embolism (a medical emergency caused by a sudden blockage in a blood vessel by a traveling clot) and thrombosis (a blood clot) of unspecified deep veins of the right lower extremity (right leg), type 2 diabetes mellitus (elevated sugar in the blood), chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood) and major depressive disorder (persistent feeling of sadness and loss of interest). During a review of Resident 41’s History and Physical (H&P) dated 7/29/2025, the H&P indicated Resident 41 can raise needs known but cannot make medical decisions. During a review of Resident 41’s MDS dated [DATE], the MDS indicated Resident 41 was dependent on staff for personal and toileting hygiene, shower/bathing self, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 41’s untitled CP dated 8/4/2025, the CP indicated Resident 41 was high risk for falls related to deconditioning and psychoactive drugs use. The CP interventions indicated for staff to ensure the resident’s call light was within reach and to encourage the resident to use it if assistance was needed. During an observation in Resident 41’s room and interview with Resident 41 on 8/19/2025 at 9:58 AM, Resident 41 was resting in bed and the call light was hanging down from the side of the bed. Resident 41 stated Resident 41 could not reach the call light to call for assistance. During an interview with CNA 4 on 8/20/2025 at 11:39 AM, CNA 4 stated the call light was supposed to be next to the resident’s hands and within reach so that the resident could get hold of the staff if assistance was needed. During an interview with Registered Nurse Supervisor (RN5) on 8/21/2025 at 9:18 AM, RN5 stated the resident’s call light needed to be within reach, near the resident’s hands, to give access for the resident to call for assistance from staff. RN5 stated, if the resident does not have the call light access the resident could not call for help and the resident could have an accident. During an interview with the facility’s Director of Nursing (DON) on 8/22/2025 at 8:58 AM, the DON stated it was important for the residents to know they can access the call light at any time specially if they feel the need to call for assistance. The DON stated, not having the call light within reach placed the resident at a greater risk for falls, injury, and delayed medical care, which can lead to serious complications. During a review of the facility’s P&P titled, “Answering the Call Light”, revised September 2022, the P&P indicated to ensure timely responses to the resident’s requests and needs. During a review of the facility’s P&P titled, “Call System”, revised September 2022, the P&P indicated, “Residents are provided with a means to call staff for assistance (continued on next page)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through a communication system that directly calls a staff member of centralized workstation.” During a review of the facility’s P&P titled, “Accommodation of Needs”, revised March 2021, the P&P indicated the facility’s environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being.” During a review of the facility’s P&P titled, “Dignity”, revised February 2021, the P&P indicated, “Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.” c. During a review of Resident 163's AR, the AR indicated Resident 163 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (decrease in size or wasting away of a body part or tissue). During a review of Resident 163's untitled CP dated 8/27/2024, the CP indicated Resident 163 was at risk for falls related to resident’s unawareness of safety needs. The CP intervention indicated for nursing staff to ensure Resident 163’s call light was within reach and encourage the resident to use it for assistance as needed. The CP intervention also indicated Resident 163 needed a prompt response to all requests for assistance. During a review of Resident 163's Fall Risk Evaluation (FRE) dated 10/22/2024, the FRE indicated Resident 163 had intermittent confusion and required the use of assistive devices. During a review of Resident 163's MDS dated [DATE], the MDS indicated Resident 163 had moderately impaired cognition for daily decision making. The MDS indicated Resident 163 needed moderate assistance for eating and oral hygiene. The MDS indicated Resident 163 was dependent on staff for showering/bathing self, lower body dressing and putting on/taking off footwear. During an observation on 8/19/2025 at 9:19 am, Resident 163 was awake, lying in bed. Resident 163 stated “I don’t know where my call button is. I couldn’t reach it.” During a concurrent observation and interview on 8/19/2025 at 9:21 am, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 163’s call light was clipped on Resident 163’s upper left side of the bed. LVN 1 stated, the call light needed to be within reach of the resident all the time. LVN 1 stated Resident 163’s needs would not be met if the call light was not within reach. During a concurrent observation and interview on 8/22/2025 at 10:16 am with Director of Nursing (DON), the DON stated the resident’s call light needed to be accessible by the resident at all times. The DON stated, if the call light was not within reach, the resident would not be able to request help or assistance from staff and staff would not be able to accommodate the resident’s needs. During a review of the facility's P&P titled, Call System, Residents, dated 9/2022, the P&P indicated each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 209’s AR, the AR indicated Resident 209 was admitted on [DATE] with diagnoses including Metabolic Encephalopathy (a brain dysfunction due to chemical imbalance in the body), Oropharyngeal phase dysphagia (a problem with swallowing process that moves food from the mouth to the throat). During a review of Resident 209’s MDS dated [DATE], the MDS indicated Resident 209 had severely impaired cognitive skills for daily decision making. During a review of Resident 209’s untitled CP dated 7/10/2025, the CP indicated Resident 209 had impaired communication related to Aphasia (difficulty understanding and speaking). During an observation on 8/19/2025 at 11:55 a.m., Resident 209 was lying supine (positioned on back) in bed with a call light within reach. Resident 209 was screaming loudly but did not press the call light. During an interview on 8/19/2025 at 8:59 a.m. with Resident 218’s Family Member 1 (FM1), FM 1 stated Resident 218’s has had four roommates that have died in the same room where Resident 218 was and Resident 218 was sad and would cry because of the deaths. FM 1 stated Resident 218 could not sleep well because of the nose from Resident 209. FM 1 stated a room change was requested by FM 1 “four months ago” for Resident 218 and requested a roommate that could communicate with Resident 218. FM1 stated it would be better if the roommates could communicate with Resident 218. During an interview and record review of Residents 218 and 209’s medical records on 8/21/2025 at 2:08 p.m. with the Social Services Director 1 (SSD 1), SSD 1 stated roommates were assigned based on their age and health condition, such as the same type of infection. SSD 1 stated it was the facility’s responsibility to review roommate selections and determine recommendations. SSD 1 stated there was no warning when Resident 209 made noise and SSD 1 did not find a pattern why Resident 209 made the noise. SSD 1 stated due to isolation, Resident 218 and 209 needed to stay in one room. A review of both residents’ admission records did not indicate a common infection. The current (active) Social Services care plan for Resident 218 dated November 2024 did not include a care plan to address Resident 218’s concerns about the noise from the roommate (Resident 209) nor any documentation of social services visiting Resident 218 regarding a room change. During a review of the facility’s P&P titled “Care Plans, Comprehensive Person-Centered” dated March 2022, the P&P indicated the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure its policies and procedures (P&P) for Advance Directive (AD, a written preference regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions) was implemented for three of three sampled residents (Resident 7, 16 and 119) by failing to: a. Ensure Resident 7's AD was discussed and written information was provided to the residents and/or responsible parties.b. Ensure Resident 16's AD was discussed and written information was provided to the residents and/or responsible parties.c. Ensure Resident 119's Advance Directive Acknowledgement (ADA) Form was completed upon admission.These failures had the potential to result in facility staff to provide medical treatment and services against the residents' will. Findings: a. During a review of Resident 7’s admission Record (AR), the AR indicated Resident 7 was admitted on [DATE] with diagnoses that included anxiety (emotion characterized by an unpleasant state of inner turmoil), depression (a feeling of severe sadness or hopelessness) and bipolar disorder (mental disorder with periods of depression and periods of elevated mood). During a review of Resident 7’s Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 7/5/2025, the MDS indicated Resident 7 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 7 needed maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) to staff for lower body dressing. The MDS indicated Resident 7 needed moderate assistance (helper did less than half the effort) from staff for toileting hygiene, shower, upper body dressing and putting on/taking off footwear. During an interview and concurrent record review on 8/19/2025 at 10:41 am, with Licensed Vocational Nurse 4 (LVN 4) of Resident 7’s medical records (chart), LVN 4 stated their was no ADA Form in the physical chart or the PointClickCare (PCC, a cloud-based software used in long-term and post-acute care facilities and chart). LVN 4 stated ADAF should be accessible in the resident's chart in order to know the residents' medical wants in cases of emergency. b. During a review of Resident 16's AR, the AR indicated Resident 16 was admitted to the facility on [DATE] with diagnoses that included Chronic kidney disease (CKD) is a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood and diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). During a review of Resident 16’s MDS dated [DATE], the MDS indicated, Resident 16’s had moderately impaired cognition for daily decision making. The MDS indicated Resident 16 needed moderate to staff for eating and oral hygiene. During an interview and concurrent record review on 8/19/2025 at 10:16 am, with the LVN 4 of Resident 16’s medical records (chart) the LVN 4 stated their was no ADAF in the physical chart and PCC. The LVN 4 stated ADAF should be accessible in the chart to know the residents (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical wants and in cases of emergency. During an interview and concurrent record review on 8/19/2025 at 10:19 am, with the Social Service Designee (SSD), the SSD stated he was unable to find Resident 16’s ADA Form in the chart. The SSD stated, ADA Form needed to be in Resident 16’s clinical records upon admission to know Resident 16’s wishes and to access the form immediately in case of emergency. During an interview on 8/22/2025 at 9:56 am, with the facility's Director of Nursing (DON), the DON stated, ADAF needed to be initiated and filled out completely upon admission by Social Services to assess if resident executed an AD or wanted to execute to know the residents preference of care and to proceed what treatment to be given to the resident in case of emergency. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, dated 9/2022, the P&P indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. The P&P indicated advance directives are honored in accordance with state law and facility policy. The P&P indicated prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The P&P indicated the resident, or representative is provided with written information… to formulate an advance directive if he or she chooses to do so. The P&P indicated information about whether or not the resident has executed an advance directive is displayed prominently in the medical record that is retrievable by any staff. c. During a review of Resident 119’s admission Record (AR), the admission Record indicated Resident 119 was admitted on [DATE] with diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 119’s History & Physical (H&P), dated 2/19/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 119’s Minimum Data Set assessment (MDS – a federally mandated resident assessment tool), dated 7/26/2025, the MDS indicated Resident 119 had moderately impaired cognition (ability to think). During a review of Resident 119’s undated Advance Directive Acknowledgment Form, the ADA Form indicated there was no acknowledgement from the resident or responsible party (RP) of being given written material and being informed about rights to accept or refuse medical treatments. There was no information of rights to formulate an AD, no obligation to formulate an AD and if any AD was executed and it would be followed by the facility and it’s caregivers, and if the resident or RP declined or wished to execute an AD. During a concurrent interview and record review on 8/20/2025 at 9:38 am with Social Services Director 1 (SSD 1), Resident 119’s undated, Advance Directive Acknowledgment Form (AD - a legal document indicating resident preference on end-of-life treatment decisions) form was reviewed. The AD Acknowledgement Form was blank except the resident’s name, physician, date of admission, and medical record name. SSD 1 stated, it was his job to talk about the resident’s rights to formulate an Advance Directive with the responsible party. SSD 1 stated he was responsible for completing the AD Acknowledgement Form, which should have been completed upon the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident’s admission. During an interview on 8/22/2025 at 9:56 am with the Director of Nursing (DON), the DON stated the AD Acknowledgement Form should be done upon the resident’s admission to allow the staff to know the resident’s preference of care and treatments in case of an emergency. During a review of the facility’s policy and procedure (P&P) titled, “Advance Directives,” last revised 9/2022, the P&P indicated, prior to or upon admission of a resident, the SSD or designee inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written AD. The P&P indicated the resident or representative be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an AD if he or she chooses to. The P&P indicated, written information included a description of the facility’s policies to implement AD and applicable law. The P&P indicated if the resident was incapacitated and unable to receive information about his/her right to formulate an AD, the information may be provided to the resident’s legal representative.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 two of two sampled residents' (Resident 9's and Resident 13's), Minimum Data Set (MDS - a resident assessment tool) assessments were accurately documented to reflect:a. Resident 9's use of oxygen.b. Resident 13 was receiving hospice care.These failures had the potential to negatively affect Resident 9?s and Resident 13's plan of care and delivery of necessary care and services.Findings: a. During a review of Resident 9’s admission Record (AR), the admission Record indicated Resident 9 was admitted on [DATE] with diagnoses that included respiratory failure (a condition caused by inadequate supply of oxygen and/or the inability to remove carbon dioxide from the lungs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 9’s History & Physical (H&P), dated 5/12/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 9’s Minimum Data Set assessment MDS, dated [DATE], the MDS indicated Resident 9 had moderately impaired cognition (ability to think) and did not indicate oxygen therapy was used in the last 14 days while the resident was in the facility. During a review of Resident 9’s Care Plan (CP), dated 1/18/2025, the CP indicated, Resident 9 had oxygen therapy related to heart failure and respiratory illness. During a review of Resident 9’s Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 7/1/2025 to 7/31/2025, the MAR indicated Resident 9 received oxygen every day from 7/1/2025 to 7/31/2025. During an interview on 8/19/2025 at 9:04 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 9 was on two liters of oxygen via nasal cannula. During a concurrent interview and record review on 8/22/2025 at 9:59 am with Minimum Data Set Coordinator (MDS C), MDS C reviewed Resident 9's MDS, dated [DATE]. MDS C stated Resident 9 was on oxygen at the time of the assessment and was on oxygen during the whole month of July 2025. MDS C stated the MDS assessment was done to accurately collect the data of what a patient received for their plan of care. MDS C stated not indicating in the MDS, dated [DATE], that Resident 9 used oxygen was a data entry error. During an interview on 8/22/2025 at 12:12 pm with the Director of Nursing (DON), DON stated MDS was a comprehensive assessment of patient care and what they were doing for their care. DON stated, the data was transmitted to CMS and needed to be accurate, and if it wasn’t, it would need a correction. During a review of the facility’s policy and procedure (P&P) titled, “Resident Assessments,” last revised March 2022, the P&P indicated “all persons who completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of such information.” b. During a review of Resident 13's admission Record (AR), the AR indicated Resident 13 was readmitted to the facility on [DATE] with diagnoses that included encephalopathy (brain disease), respiratory failure, and Parkinsonism (brain conditions that cause slowed movements, stiffness and tremors). During a review of Resident 13’s H&P, dated 6/10/2025, the H&P indicated Resident 13 did not have the capacity to make medical decisions. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 was severely cognitively impaired and was dependent on others with toileting and personal hygiene. The MDS did not indicate Resident 13 was receiving hospice services. During a review of the Physician’s Certification for Hospice Services (PCHS), dated 6/20/2025, the PCHS indicated Resident 13’s hospice services certification period was 6/20/2025 to 9/17/2025. During a review of Resident 13’s MDS, dated [DATE], the MDS did not indicate Resident 13 was receiving hospice services. During a concurrent interview and record review, on 8/22/2025, at 4:10 p.m., with Minimum Data Set Assistant (MDS A), MDS A stated the MDS, dated [DATE], was miscoded. MDS A stated Resident 13’s MDS should have been coded as hospice because Resident 13 was on hospice services. MDS A stated Resident 13 was placed on hospice on 6/20/2025. During a review of the facility’s P&P, titled, “MDS Error Correction,” revised September 2010, the P&P indicated, If an error is discovered after encoding period and the record in error is an OBRA assessment, determine if the error is major or minor. A minor error is one related to the coding of the MDS. For minor errors, correct the record and submit to QIES ASAP system. A major error is one that accurately reflects the resident’s clinical status and/or may result in an inappropriate plan of care .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 an individualized and person-centered care plan for two of five sampled residents (Resident 13 and Resident 33) in accordance with the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, by failing to ensure:a. Resident 13, who had a diagnosis of dementia (a progressive stated of decline in mental abilities), had a plan of care for dementia.b. Resident 33's peripherally inserted central catheter (PICC - a long, thin catheter inserted into a vein in the arm, usually in the upper arm, and threaded to a large vein near the heart, used to administer fluids and or medications) was included in Resident 33's plan of care.These deficient practices had the potential for Resident 13 and Resident 33 to not receive appropriate care, treatment, and or services.Findings: a. During a review of Resident 13's admission Record (AR), the AR indicated Resident 13 was readmitted to the facility on [DATE] with diagnoses that included encephalopathy (brain disease), dementia (a progressive state of decline in mental abilities), and Parkinsonism (brain conditions that cause slowed movements, stiffness and tremors). During a review of Resident 13’s History & Physical (H&P), dated 6/10/2025, the H&P indicated Resident 13 did not have the capacity to make medical decisions. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool), dated 8/9/2025, the MDS indicated Resident 13 was severely cognitively (ability to understand and process thoughts) impaired and was dependent on staff with toileting and personal hygiene. During a concurrent interview and record review, on 8/22/2025, at 11:45 a.m., with Registered Nurse (RN 6), RN 6 stated Resident 13 had a diagnosis of dementia. RN 6 reviewed Resident 13’s electronic medical record (EMR) and stated there was no care plan for dementia found in Resident 13’s EMR. RN 6 reviewed Resident 13’s hospice (end of care) binder and was unable to find a care plan for dementia. RN 6 stated Resident 13 should have a care plan for dementia because Resident 13 had a diagnosis of dementia. b. During a review of Resident 33's AR, the AR indicated Resident 33 was admitted to the facility on [DATE] with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support), and pneumonia (an infection/inflammation in the lungs). During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 had severely impaired cognition for daily decision making. The MDS indicated Resident 33 was dependent (helper did all the effort and lifted or held trunk or limbs) on staff for oral hygiene, toileting, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent interview and record review on 8/20/2025 at 3:30 pm with Registered Nurse 1 (RN 1) of Resident 33’s electronic medical records, RN 1 stated there was no clinical documentation that a care plan was initiated for the management of Resident 33’s PICC line. RN 1 stated a care plan should have been initiated and implemented for Resident 33’s PICC line use. (continued on next page)

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Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/2025 at 10:01 am with the facility’s Director of Nursing (DON), the DON stated, Resident 33’s care plan for PICC line use must be initiated and implemented to provide proper care and interventions to Resident 33’s PICC line. During a review of the facility's P&P titled, “Comprehensive Person – Centered,” revised 3/2022, the P&P indicated, “A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial, and functional needs is developed and implemented for each resident.”

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three of three sampled residents (Residents 8, 11, and 58) received treatment and care in accordance with physician's orders/professional standards of practice when:a. The facility failed to provide a bolstered mattress to Resident 8, as ordered. b. The facility failed to provide treatment for Resident 11's complaint of burning pain when urinating. c. The facility failed to manage the pain & burning sensation upon urination for Resident 58. These failures resulted in Residents 11 and 58 continuing to experience burning pain when urinating and had the potential for Residents 8, 11, and 58 to experience a decline in health and wellbeing.(Cross Reference F580 and F697) Findings: a. During the review of Resident 8’s admission Record (AR), the AR indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and osteoporosis (weak and brittle bones, due to lack of calcium and vitamin D). During a review of Resident 8’s Order Summary Report (OSR), dated 9/10/2024, the OSR indicated Resident 8 had an order to have bolstered mattress when in bed for mobility and positioning. During a review of Resident 8’s untitled Care Plan (CP) dated 10/25/2024, the CP indicated Resident 8 was at risk for falls related to poor safety awareness. The CP interventions included following the facility fall protocol. During a review of Resident 8’s Fall Risk Evaluation (FRE) dated 7/24/2025, the FRE indicated Resident 8 was at risk for fall. During a review of Resident 8’s Minimum Data Set (MDS, a resident assessment tool) dated 7/26/2025, the MDS indicated Resident 8 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 8 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. During a concurrent observation inside Resident 8’s room and interview on 8/19/2025 at 9:35 am with Certified Nurse Assistant 2 (CNA 2), Resident 8 was lying in bed, on Resident 8’s back. CNA 2 stated Resident 8 did not have a bolstered mattress in place. During a concurrent interview and record review on 8/20/2025 at 10:00 am with Licensed Vocational Nurse 1 (LVN 1), Resident 8’s OSR dated 9/10/2024 was reviewed. LVN 1 stated Resident 8 had an order for a bolstered mattress when in bed. LVN 1 stated the doctor’s order should have been carried out as soon as the order was received for the safety of Resident 8. During an interview on 8/21/2025 at 11:48 am with the Director of Nursing (DON), the DON stated all doctor’s orders should be carried out immediately to avoid delay in care and treatment. During a review of the facility’s Policy and Procedure (P&P) titled, “Medication and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Treatment Orders, Dental Services,” revised February 2014, the P&P indicated, “Medication orders and treatment will be administered by nursing service personnel as soon as possible as the order has been received. All orders must be charted and made part a part of the resident’s medical record and care plan.” b. During a review of Resident 11's AR, the AR indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood). During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 11 was dependent (helper does all the effort) on staff for bathing, dressing, and toileting hygiene. During a review of Resident 11’s History and Physical (H&P) dated 6/7/2025, the H&P indicated Resident 11 had the capacity to understand and make medical decisions. During a review of Resident 11’s CP titled “Risk for Impaired Urinary Elimination…,” dated 7/29/2025, the CP indicated facility staff needed to notify Resident 11’s healthcare provider immediately if Resident 11 had any voiding (urinating) abnormalities. The care plan indicated to monitor signs and symptoms of UTI. During an interview on 8/19/2025 at 1:35 PM with Resident 11, Resident 11 stated Resident 11 had been recently treated for a urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra). Resident 11 stated Resident 11 currently had another UTI because Resident 11 felt a burning pain when Resident 11 urinated. Resident 11 stated Resident 11 had told multiple nurses (unidentified) about Resident 11’s burning pain with urination, but the unidentified nurses told Resident 11 that Resident 11 was “fine.” During an interview on 8/19/2025 at 2:00 PM with Licensed Vocational Nurse 9 (LVN 9), the surveyor informed LVN 9 that Resident 11 complained of burning pain when Resident 11 urinated. LVN 9 stated LVN 9 would go and evaluate Resident 11. During an interview on 8/20/2025 at 10:06 AM with Resident 11, Resident 11 stated Resident 11 still felt burning pain when Resident 11 urinated. Resident 11 stated Resident 11 had complained to multiple staff (unidentified) about the pain on 8/19/2025 but no one did anything about Resident 11’s complaint. During an interview on 8/20/2025 at 10:09 AM with LVN 9, LVN 9 confirmed Resident 11 had complained to LVN 9 that Resident 11 experienced burning pain when Resident 11 urinated. LVN 9 stated LVN 9 did not notify Resident 11’s doctor of Resident 11’s complaint of burning when urinating. LVN 9 stated LVN 9 notified Registered Nurse 4 (RN 4) about Resident 11’s complaint of burning when urinating. During an interview on 8/20/2025 at 10:15 PM with RN 4, RN 4 stated burning when urinating is a symptom of a UTI. RN 4 stated if a resident (in general) complained of burning when urinating, staff should call the resident’s (in general) physician. RN 4 stated the doctor would usually order laboratory, including a urine analysis (urine sample to screen for UTI as well as other diseases and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conditions). RN 4 stated RN 4 did not notify Resident 11’s doctor of Resident 11’s complaint of feeling burning pain when urinating. RN 4 stated Resident 4 would likely need an antibiotic (a medication that kills or inhibits the growth of bacteria) if Resident 11 had a UTI. During a concurrent interview and record review on 8/21/2025 at 9:06 AM with RN 1, Resident 1’s laboratory report (LR) titled, “Urinalysis”, collected 8/20/2025 was reviewed. The LR indicated Resident 11’s urine showed a large amount of Leukocyte esterase (an enzyme test that detects the presence of white blood cells [WBCs] or their enzymes in the urine, which often signals a UTI) and positive for nitrite (could indicate a bacterial UTI). RN 4 stated Resident 11’s LR indicated Resident 11 had a UTI. RN 4 stated LVN 9 should have notified Resident 11’s doctor about Resident 11’s complaint of feeling burning pain when urinating on 8/19/2025, to get a treatment order to address Resident 11’s discomfort. During a review of the facility's Policy and Procedure (P&P) titled, “Change in a Resident’s Condition or Status” revised 11/2015, the P&P indicated the facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The P&P indicated the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been…A significant change in the resident's physical/emotional/mental condition…A need to alter the resident's medical treatment significantly. c. During a review of Resident 58's AR, the AR indicated Resident 58 was admitted to the facility on [DATE] with diagnoses that included pericardial effusion (buildup of fluid in the membrane that surrounds the heart), Type 2 diabetes mellitus (elevated blood sugar levels) with chronic kidney disease (kidneys unable to filter waste), and chronic obstructive pulmonary disease (blocked airflow making it difficult to breathe). During a review of Resident 58’s Physician’s Order (PO) dated 9/7/24, the PO indicated for licensed staff to administer Acetaminophen Oral Tablet 325 milligrams (mg-unit of measurement), 2 tablets by mouth, every four hours as needed for pain management, mild pain (1-3). During a review of Resident 58’s PO dated 9/7/24, the PO indicated for licensed staff to administer Acetaminophen-Codeine Oral tablet 300-60 mg, one tablet by mouth, every four hours as needed for pain management for moderate to severe pain. During a review of Resident 58's History & Physical (H&P) dated 9/9/24, the H&P indicated Resident 58 had the capacity to make medical decisions. During a review of Resident 58’s Physician Orders (PO) dated 11/10/24, the PO indicated pain assessment every shift: 0-No Pain, 1-3 mild pain,4-6 moderate pian, 7-10 severe pain.\ During a review of Resident 58's Minimum Data Set (MDS, a resident assessment tool) dated 6/6/25, the MDS indicated Resident 58 was cognitively intact (ability to understand and process thoughts), and required substantial/maximal assistance with toileting and personal hygiene. During a review of Resident 58’s short term care plan dated 7/21/25 for pain when urinating, the CP indicated for nursing staff to notify Resident 58’s physician (MD) of any changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/25 at 8:34 a.m., Resident 58 stated Resident 58 had pain when urinating for three weeks. Resident 58 stated Resident 58 had taken two antibiotics but Resident 58 had no relief. Resident 58 stated Resident 58 told “everybody” in the facility that Resident 58 still had urinary pain but the facility staff did not address her complaint of pain. During an interview on 8/20/25 at 3:45 p.m., Resident 58 stated Resident 58 had radiating 10/10 back pain when urinating, based on the pain scale (0= no pain, 10=worst pain). During a concurrent interview and record review on 8/20/25 at 4:30 p.m. with Licensed Vocational Nurse (LVN 3) of Resident 58’s Progress Notes (PN) dated 8/18/25, the PN indicated Urine Analysis (UA) and Culture and Sensitivity (C&S- used to identify the specific bacteria causing infection). LVN 3 stated the UA and C&S were not carried out. LVN 3 stated licensed staff needed to check the physician (MD)/ Family Nurse Practitioner (FNP) Progress Note following a physician’s assessment. During an interview on 8/20/25 at 5:20 p.m. at Resident’s 58’s bedside, Resident 58 stated Resident 58 had pain when urinating. During a phone interview on 8/22/25, at 8:55 a.m. with the FNP, the FNP stated the plan for a UA and CS was communicated to the nursing staff on 8/18/25 after FNP assessed Resident 58 but the FNP stated the FNP did not know the licensed nurse’s name to whom the plan was communicated. The FNP stated the UA & CS for Resident 58 was missed. The FNP stated, the FNP would communicate orders verbally after resident assessments during on site to the nursing staff and a telephone order was written. The FNP stated Pyridium (a urinary analgesic that relieves pain) administration for pain upon urination was delayed. The FNP stated the FNP would refer residents to Urology (medical specialty that focuses on diagnosis and treatment of disorders related to the urinary tract system) but Resident 58 was not referred to Urology. During an interview on 8/22/25 at 10:34 a.m., with LVN 15, LVN 15 stated Resident 58 had a history of UTI. LVN 15 stated the care plan to address pain upon urination was not revised. LVN 15 stated the care plan was important because the care plan had interventions to manage the problem and track actions being taken to prevent further symptoms on the resident. During a record review of Resident 58’s electronic medical record (EMR), a Situation, Background, Assessment, and Recommendation (SBAR- helps team share information), was not found indicating Resident 58 complained of pain when urinating, indicating a change in Resident 58's condition. During a review of Resident 58’s Electronic Medical Record (EMR), the EMR did not indicate a Situation, Background, Assessment, and Recommendation (SBAR- helps team share information) for Resident 58’s complaint of dysuria noted in the MD progress note dated 8/18/25. During a review of the facility’s Policy and Procedure (P&P), titled, “Pain Assessment and Management,” revised April 2018, the P&P indicated the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident’s choices related to pain management.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for five of five sampled residents, the facility failed to ensure:a. Resident 218's blisters under the ostomy bag were assessed.b. Resident 212's LAL mattress (tiny laser made air holes in the mattress top surface continually blowing out air causing the resident to float) was set up accurately according to manufacturer's instruction and not on static mode.c. Resident 213's LAL mattress was not set to static while the resident was in bed.d. The LAL mattress was set according to Residents 41 and 136's weight. These deficient practices placed the residents at risk for altered skin integrity and had the potential to result in the development/worsening of pressure ulcers (PU - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence).Findings: a. A review of Resident 218’s admission Record (AR) dated 10/19/2024, the AR indicated that Resident 218 has hemiplegia (partial paralysis) and hemiparesis (weakness or inability to move on one side of the body) following a cerebral infarction (a condition where blood flow to the brain is interrupted, leading to damage or death of brain cells) affecting the left non-dominant (no control over) side and functional quadriplegia (a condition in which a person is completely immobile due to sever disability or frailty, but without any underlying brain or spinal cord injury). A review of Resident 218’s Care Plan Report (CP) dated 12/2/2024, the CP indicated that Resident 218’s body was to be checked for skin breaks and treated promptly as ordered by doctor. Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length, width, and depth). A review of Resident 218’s Minimum Data Summary (MDS) dated [DATE], the MDS indicated that Resident 218 was dependent on staff for personal hygiene. During an observation on 8/19/2025 at 8:59 a.m., two blisters were seen at the left lower side of Resident 218’s abdomen, under an ostomy bag. A review of Resident 218’s Order Summary Report dated 8/20/2025, the order summary report did not indicate there were blisters at the left lower area of the abdomen, beneath or near the ostomy bag. During an observation and interview on 8/20/2025 at 2:08 pm with LVN 9, LVN 9 stated they did not know about the blisters under the ostomy bag and would report it to the treatment nurse. LVN 9 continued to explain, whoever sees it is responsible for reporting and taking care of it. A review of the Prevention of Pressure Injuries policy, dated December 2016, under Skin Assessment, item 3, the facility is to inspect the skin on a daily basis when performing or assisting with personal care or ADLs; and under Monitoring, item 1, Evaluate, report, and document potential changes in the skin. b. During a review of Resident 212's admission Record (AR), the AR indicated Resident 212 was admitted to the facility on [DATE] with diagnoses that included pressure ulcer (lesion/wound caused by type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) with other specified complication and non-pressure chronic ulcer of left heel and midfoot with unspecified (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	severity. During a review of Resident 212's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/2/2025, the MDS indicated Resident 212 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 212 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/off footwear and personal hygiene. During a review of Resident 212's Order Summary Report (OSR) dated 8/30/2024, the OSR indicated Resident 212 may have a low air loss mattress for skin management. During a review of Resident 212’s Monthly Weight Report (MWR), the MWR indicated Resident 212 was 114 pounds (lbs, unit of measurement) on 8/2025. During an observation on 8/19/2025 at 9:49 am, Resident 212 was awake and lying on bed with LAL mattress. Resident 212’s LAL mattress was set at 320 lbs. The light was switched to “ON” indicating on static setting. During an observation and concurrent interview on 8/19/2025 at 9:52 am, with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated the LAL mattress was set on 320 lbs. The LVN 4 stated the LAL mattress needed to be set up according to Resident 212’s actual weight. LVN 4 stated the light was on and it indicated the LAL was set on static setting. The LVN 4 stated, LAL mattress needed to be on alternating mode and not on static setting to alternate the airflow in the mattress to prevent Resident 212 from developing a pressure injury. During an interview on 8/22/2025 at 10:11 am with the facility's Director of Nursing (DON), the DON stated the LAL mattress needed to be set up based on residents actual weight for it would not serve the purpose which to prevent from developing pressure injury if not set up based on the residents’ weight. The DON stated, LAL should not be on static mode and needed to be on alternating mode to avoid firmness and to take off the pressure from the residents back. During a review of the undated user manual titled, Proactive Medical Products Operation Manual, the user manual indicated the pressure adjust knob (adjustable by patient’s weight) to determine the patients weight and set the control knob to that weight setting on the control unit. The manual indicated static/alternating control, press ON to set the air mattress to static mode or OFF to set alternating pressure mode. The manual indicated to press the static button to shift between alternating mode and static mode. When in static mode, the static indicator will come on. The static mode will be started approximately six minutes/on alternating pressure mode. Air cell will alternate in 10 minute cycles. In static mode, the mattress provides a firm surface that makes it easier for the patient to transfer or reposition. The static mode will help ensure the patient does not bottom out when in a sitting position. c. During a review of Resident 213’s admission Record (AR), the admission Record indicated Resident 213 was admitted on [DATE] with diagnoses that included pressure ulcers of the sacral region (bottom of the spine) and left buttock. During a review of Resident 213’s History & Physical (H&P), dated 9/1/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 213’s Care Plan (CP), the CP indicated: Resident 213 had a stage 4 PU on the sacrococcyx (lower part of the spine and tail bone) extending to the left buttock. The CP listed interventions included to follow treatment as ordered and a goal to heal without complications, dated 10/19/2024. Resident 213 had a right trochanter (bony prominence of the thigh bone, near the hip bone) PU stage 4 development related to a history of ulcers. The CP indicated a listed intervention to administer treatments as ordered and monitor effectiveness with a goal to heal and have intact skin, dated 6/5/2025. During a review of Resident 213’s Minimum Data Set assessment (MDS – a federally mandated resident assessment tool), dated 7/14/2025, the MDS indicated Resident 213 had severely impaired cognition (ability to think) and was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers were required for the resident to complete the activity, to roll left and right or move from sitting to lying. The MDS indicated Resident 213 had two stage 4 PUs (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and an ulcer treatment was a pressure reducing device for the bed. During a review of Resident 213’s Braden Scale (Braden Scale - assessment tool used to assess a resident’s risk of developing a pressure ulcer) for Predicting Pressure Sore Risk, dated 7/14/2025, the Braden Scale indicated Resident 213 was at high risk for developing a PU. During a review of Resident 213’s Wound Evaluation and Treatment by the wound healing care specialist, dated 8/15/2025, the wound evaluation and treatment indicated Resident 213 was bedbound and recommendations included aggressive offloading with a low air loss mattress and to follow facility pressure injury prevention/relief protocol for the PUs. During a review of Resident 213’s Order Summary Report, dated 8/21/2025, the Order Summary indicated Resident 213 had an order for a pressure relieving LAL (low air loss) mattress set to alternating and weight of resident for wound management, every shift, ordered on 1/17/2025. During a review of Resident 213’s Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 8/1/2025 through 8/31/2025, the MAR indicated Resident 213’s LAL mattress settings were checked three times a day by nursing staff during day, evening, and night. During an observation on 8/19/2025 at 9:06 am while in Resident 213’s room, Resident 213 was in bed with the LAL mattress on the static mode (a setting that creates a firm surface). During a concurrent observation and interview on 8/19/2025 at 9:21 am with Licensed Vocational Nurse 2 (LVN 2) while in Resident 213’s room, LVN 2 confirmed the LAL mattress setting was on the static mode. LVN 2 stated Resident 213 had PUs and received wound treatments, but was unaware of what the LAL static setting was used for. During a concurrent observation and interview on 8/19/2025 at 9:40 am with Treatment Nurse 1 (TN 1), the static light on the LAL mattress was observed on. TN 1 stated Resident 213 was on the LAL mattress for wound management to aid in healing the stage 4 PUs on his sacrococcyx and right hip (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area. TN 1 stated the LAL mattress was on static setting to make the bed more stable. TN 1 then stated they don’t normally use static and someone must have changed it. TN 1 then turned the static setting off. During an interview on 8/22/2025 at 10:11 am with the Director of Nursing (DON), the DON stated the LAL mattress wouldn’t serve its purpose if it was not on the appropriate setting to offload the weight. The DON stated the LAL mattress should not be on static mode and should be alternating to avoid a firm surface. During a review of undated “Proactive Medical Products: Operation Manual for Protekt Aire 2000,” the manual indicated it was for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive PU management program. The manual indicated when in static mode, the static indicator would come on and the overlay provided a firm surface that makes it easier for the resident to transfer or reposition. During a review of the facility’s policy and procedure (P&P) titled, “Support Surface Guidelines,” last revised 9/2013, the P&P indicated for residents at risk of skin breakdown, redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. d. During a review of Resident 136’s admission Record (AR), the AR indicated Resident 136 was admitted to the facility on [DATE] with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD- is a common lung disease causing restricted airflow and breathing problems), type 2 diabetes (elevated sugar in the blood), pneumonia (is an infection that inflames the air sacs in one or both lungs), morbid obesity (a person's body has a lot of extra weight) with alveolar hypoventilation (is a breathing disorder that affects some people who have obesity). During a record review of Resident 136’s History and Physical (H&P), dated 7/17/2025, the H&P indicated Resident 136 does has the capacity to understand and make decisions. During a review of Resident 136’s Care Plan (CP) dated 7/17/2025 indicated, “The resident has a left upper extremity scattered skin discoloration. The listed Interventions indicated LALM for skin maintenance. During a review of Resident 136’s Minimum Date Set (MDS – a resident assessment tool), dated 7/22/2025, indicated Resident 136 required dependent care (helper does all of the effort, the resident does none of the effort to complete the activity) from staff for toileting hygiene, shower/bathing self and putting on/taking off footwear. During a review of Resident 136’s Wound Evaluation and Treatment Progress Note dated 8/14/2025 recommendations indicated, “Every 2 hour turning, no sitting beyond 2 hours, frequent diaper checks and changes, keep the skin clean and dry, follow facility pressure injury prevention/relief protocol, low air loss mattress.” During a review of Resident 136’s Order Summary Report (OSR) dated 8/22/2025 at 4:06 PM, the OSR indicated “Low air loss mattress for skin maintenance. Monitor pressure settings according to patients weight and comfort every shift.” During a review of Resident 136’s weight documentation dated 8/18/2025, the weight (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation indicated Resident 136’s was 190 lbs. (a common abbreviation for the word pounds (plural), referring to the unit of weight or mass). e). During a review of Resident 41’s AR, the AR indicated Resident 41 was admitted to the facility on [DATE] with a diagnosis of acute embolism and thrombosis of unspecified deep veins (a new onset blood clot forming in a deep vein, which may also involve a traveling clot) of right lower extremity (right leg) , chronic kidney disease stage 4 (severe damage and are functioning at only 15%-29% of the kidney normal capacity), type 2 diabetes (sugar in the blood), morbid (severe) obesity due to excess calories and generalized edema (fluid retention and swelling that affects the entire body, rather than just one area). During a review of Resident 41’s H&P dated 7/29/2025, the H&P indicated Resident 41 can make needs known but cannot make medical decisions. During a review of Resident 41’s Order Summary Report (OSR) dated 7/29/2025, the OSR indicated, “Low air loss mattress for wound management. Monitor pressure settings according to patient’s weight and comfort every shift. During a review of Resident 41’s MDS dated [DATE], the MDS indicated Resident 41 required dependent care (helper does all of the effort, the resident does none of the effort to complete the activity) from staff for personal and toileting hygiene, shower/bathing self and putting on/taking off footwear and upper body dressing. During a review of Resident 41’s weight documentation dated 8/20/2025 the weight for Resident 41 was 180.2 lbs. During an initial observation of Resident 41 on 8/19/2025 at 9:58 AM, Resident 41 was resting in bed on LALM which had a setting of 350+ lbs. During an initial observation of Resident 136 on 8/19/2025 at 11:03 AM, Resident 136 was resting in bed on LALM which had a setting of 350+ lbs. During an interview with Registered Nurse Supervisor (RN5) on 8/21/2025 at 9:11 AM, RN5 stated that for residents on a LALM, the settings are determined by the residents' weight. Per RN5 all license nurses must check the settings on the LALM every shift when they are doing their initial assessments to make sure the settings are correct by residents weight. RN5 stated that the purpose of the LALM is to prevent and assist in pressure ulcer development. Per RN5, if the LALM is too firm, it might cause the resident to actually develop a pressure injury or pressure ulcer. RN5 stated “If the settings aren’t set to the resident's weight, it defeats the purpose of having the LALM instead of preventing a pressure ulcer it can cause more harm than good by causing a pressure ulcer.” During an interview with the IPN on 8/21/2025 at 3:03 PM, the IPN stated the settings are according to the doctor’s order. We have placed little stickers to show depending on their weight. The CN should see if it’s on the right setting every shift and the cnas need to be vigilant they don’t move the settings on accident. During an interview with the DON on 8/22/2025 at 9:07 AM, the DON stated the settings for a LALM needs to be according to the resident's weight. Per the DON, if the settings aren’t correct, it (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doesn't serve the purpose to promote wound healing. The DON stated the purpose of a LALM is to prevent and treat pressure ulcers by redistributing pressure and managing moisture on the resident's skin. During an interview with TN1 on 8/22/2025 at 1:33 PM, TN1 stated the LALM settings are supposed to be per resident's body weight. Per TN1, if the LALM is too firm, it will not help promote wound healing and can cause more harm than good. TN1 stated the mattress is supposed to distribute weight and maintain airflow to prevent bedsores by reducing pressure on bony prominences (areas of the body where bones are close to the skin's surface) which are areas at a higher risk for residents of developing pressure ulcers. During an interview and record review with Medical Record (MR) staff on 8/22/2025 at 3:38 PM, the MR confirmed that there is no specific care plan for LALM for Resident 41. The MR stated if any resident was on LALM, there should have been a care plan including interventions in the residents' medical records. During a record review of the facilities LALM operational manual titles, “Proactive medical products” the operational manual indicated, “Protekt Aire 3000 pump and mattress system, is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program.” Operating instructions indicate to determine the patient’s weight and set the control knob to that weight setting on the control unit. During a review of the facilities P&P titled, “Quality of Life-Dignity” revised February 2020 indicated, “Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem.” Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. For example, promptly responding to a resident’s request for toileting assistance. During a review of the facilities P&P titled, “Accommodation of Needs” revised March 2021, the P&P indicated, “Our facility’s environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well-being.”

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents on oxygen therapy (treatment that provides supplemental, or extra oxygen) in accordance with the facility's Policy and Procedure (P&P) on Oxygen Administration for three of four sampled residents (Residents 9, 25, and 122).These failures had the potential for Residents 9, 25, and 122 to result in respiratory complications and infections. Findings: a. During a review of Resident 9’s admission Record (AR), the admission Record indicated Resident 9 was admitted on [DATE] with diagnoses that included respiratory failure (a condition caused by inadequate supply of oxygen and/or the inability to remove carbon dioxide from the lungs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 9’s Care Plan (CP), dated 1/18/2025, the CP indicated, Resident 9 had COPD and the goal indicated Resident 9 would remain free of signs and symptoms of respiratory infections. During a review of Resident 9’s History & Physical (H&P), dated 5/12/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 9’s Minimum Data Set assessment (MDS – a federally mandated resident assessment tool), dated 7/14/2025, the MDS indicated Resident 9 had moderately impaired cognition (ability to think). During a review of Resident 9’s Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 8/1/2025 through 8/31/2025, the MAR indicated Resident 9 may be given oxygen at 2-3 liters per minute (lpm) via NC to keep the oxygen saturation greater than 93% for shortness of breath. The MAR indicated, Resident 9’s oxygen saturation was documented during day, evening, and night. During a concurrent observation and interview on 8/19/25 at 9:04 am with Licensed Vocational Nurse 2 (LVN 2) while in Resident 9’s room, Resident 9 was receiving oxygen through a nasal cannula labeled 8/4/2025 with the oxygen tubing touching the floor. LVN 2 stated Resident 9’s oxygen tubing should not be touching the floor because it could contaminate her equipment. LVN 2 stated the oxygen tubing was changed weekly to prevent the resident from getting an infection and if it was over a week, it should be changed and new. During an interview on 8/22/2025 at 12:05 pm with the Director of Nursing (DON), the DON stated the oxygen tubing should not be touching the floor when in use and was changed once every week on Sunday. The DON stated it was done for infection prevention and control for the resident. During a review of the facility’s policy and procedure (P&P) titled “Departmental (Respiratory Therapy)-Prevention of Infection,” last revised November 2011, the P&P indicated it’s purpose was to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff. The P&P indicated, to review the resident’s care plan to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assess for any special circumstances or precautions related to the resident. The oxygen cannula and tubing be changed every seven days or as needed for infection control. During a review of the facility’s policy and procedure (P&P) titled, “Oxygen Administration,” last revised October 2010, the P&P indicated for nursing to verify that there was a physician order or facility protocol for oxygen administration and that “No Smoking/Oxygen in Use” signs were outside of the room entrance door and in a designated place on or over the resident’s bed. b. During a review of Resident 25’s admission Record (AR), the AR indicated Resident 25 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included congestive heart failure (CHF, a heart disorder which causes the heart to not pump blood efficiently, sometimes resulting in leg swelling), dyspnea (difficulty breathing), and pulmonary embolism (medical condition where a blood clot travels from another part of the body, usually the legs and blocks an artery in the lungs). During a review of Resident 25’s Order Summary Report (OSR), dated 7/6/2024, the OSR indicated Resident 25 had an order for oxygen at 2-4 liters (L, unit of volume) via nasal cannula (NC, a thin, flexible tube which on one end splits inti two prongs which are placed in the nostrils to deliver oxygen). During a review of Resident 25’s Minimum Data Set (MDS, a resident assessment tool), dated 8/9/2025, the MDS indicated Resident 25 had intact cognition (ability to understand and process information). The MDS indicated Resident 25 required partial/moderate assistance (helper did less than half the effort) with toileting, shower, upper body dressing and required substantial/maximal assistance (helper did more than half the effort) with lower body dressing and personal hygiene. During a concurrent observation inside Resident 25’s room and interview on 8/19/2025 at 9:14 am with Certified Nurse Assistant 3 (CNA 3), Resident 25 was in bed with oxygen at 4 L/NC. CNA 3 stated nasal cannula tubing was not labeled with the date when it was changed. CNA 3 stated there was no cautionary sign of “no smoking/oxygen in use” posted outside Resident 25’s room. CNA 3 stated the cautionary sign outside the room reminded staff, visitors and other residents that a resident was on oxygen and a potential risk for fire. During a concurrent interview and record review on 8/22/2025 at 9:42 am with Registered Nurse Supervisor 2 (RN 2), Resident 25’s care plans were reviewed. RN 2 stated Resident 25 did not have a care plan developed to address the resident’s chronic (long-time) use of oxygen and for the staff to know the interventions specific for the resident. c. During a review of Resident 122’s AR, the AR indicated Resident 122 was admitted to the facility on [DATE] with diagnoses that included quadriplegia (paralysis from the neck down, including legs, and arms, usually from a spinal cord injury), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). During a review of Resident 122’s MDS, dated [DATE], the MDS indicated Resident 122 had intact cognition. The MDS indicated Resident 122 required partial/moderate assistance with oral hygiene and dependent (helper did all the effort, resident did none of the effort to complete the activity) with toileting, shower, upper and lower body dressing and personal hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 122’s Order Summary Report (OSR), dated 8/11/2025, the OSR indicated Resident 122 had an order for oxygen at 2-4 liters per minute via nasal cannula. During a concurrent observation inside Resident 122’s room and interview on 8/19/2025 at 9:48 am with CNA 1, Resident 122 was in bed with oxygen at 3.5 L via NC. CNA 1 stated nasal cannula tubing was not labeled with the date when it was changed. CNA 1 stated there was no cautionary sign of “no smoking/oxygen in use” posted outside Resident 122’s room. CNA 1 stated the cautionary sign outside the room was necessary for fire precautions. During an interview on 8/22/2025 at 9:42 am with RN 2, RN 2 stated all residents on oxygen therapy should have the oxygen tubing change weekly and as needed and labeled with the date when it was changed to make sure that oxygen tubing was changed to keep it clean and prevent infection. RN 2 stated all residents on oxygen therapy should have a “no smoking/oxygen in use” sign posted outside the residents’ room for the safety of the residents and staff in the facility. During an interview on 8/22/2025 at 12:05 pm with the Director of Nursing (DON), the DON stated all residents’ oxygen tubing should be labeled with date to know when it was changed and due to be changed to prevent the spread of infections. The DON stated all residents on oxygen therapy should have a “no smoking/oxygen in use” sign posted outside the residents’ rooms to alert the staff, visitors and residents that oxygen was present in the room for the safety of everyone in the facility. The DON stated all residents on oxygen therapy should have a care plan developed to assist and guide the staff on how to provide care and treatment to the residents. During a review of the facility’s policy and procedures (P&P) titled, “Oxygen Administration,” revised October 2010, the P&P indicated, “Review the resident’s care plan to assess for any special needs of the resident. Place a “No Smoking/Oxygen In Use” sign on the outside of the room entrance door.” During a review of the facility’s P&P titled, “Departmental (Respiratory Therapy)-Prevention of Infection,” revised November 2011, the P&P indicated, “Change the oxygen cannula and tubing every seven days, or as needed.”

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) an emergency kit (E-kit, contains the main items needed in an emergency) at the bedside for two of six sampled residents (Residents 111 and 219) in accordance with the residents' comprehensive care plan.These failures had the potential for Residents 111 and 219 not to receive or receive delayed care and emergency treatment from complications caused by unexpected bleeding from the hemodialysis access site. Findings:a. During a review of Resident 111's admission Record (AR), the AR indicated Resident 111 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (ESRD, irreversible kidney failure), congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control).During a review of Resident 111's untitled Care Plan (CP) dated 10/2/2024, the CP indicated Resident 111 had the potential for bleeding on the site with hemodialysis access. The CP interventions and goals included to place a [NAME] clamp (a type of surgical hemostat used to clamp and control bleeding from blood vessels or tissue during surgery and emergency procedures) at bedside for management of emergency bleeding on central line access site and emergency bleeding will be managed with immediate implementation of appropriate interventions.During a review of Resident 111's Minimum Data Set (MDS, a resident assessment tool) dated 6/26/2025, the MDS indicated Resident 111 had moderately impaired cognition (ability to understand and process interventions). The MDS indicated Resident 111 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff with toileting, upper and lower body dressing. The MDS indicated Resident 111 required partial/moderate assistance (helper did less than half the effort) from staff with shower and personal hygiene.During a review of Resident 111's Order Summary Report (OSR) dated 7/9/2025, the OSR indicated Resident 111 had a tunneled catheter (a thin, flexible tube that is inserted into a vein and tunneled under the skin) hemodialysis access site on the right upper chest. The OSR indicated Resident 111 was scheduled for hemodialysis every Tuesdays, Thursdays, and Saturdays. During a concurrent observation and interview on 8/19/2025 at 10:00 am with Certified Nurse Assistant 1 (CNA 1), Resident 111 was lying in bed with hemodialysis access site on the right chest. CNA 1 stated Resident 111 did not have an E-kit at bedside. CNA 1 stated Resident 111 needed to have an E-kit at bedside for use in case of bleeding from the dialysis access site.b. During a review of Resident 219's AR, the AR indicated Resident 219 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included ESRD, anemia (a condition where the body does not have enough healthy red blood cells), and dependence on hemodialysis.During a review of Resident 219's MDS dated [DATE], the MDS indicated Resident 219 had severely impaired cognition. The MDS indicated Resident 219 was dependent (helper did all the effort) from staff with oral hygiene, toileting, shower, upper and lower body dressing.During a review of Resident 219's OSR dated 7/29/2025, the OSR indicated Resident 219 had a quinton catheter (non-tunneled catheter, large-bore, dual-lumen central venous catheter used to provide immediate temporary access for hemodialysis) hemodialysis access site on the left upper thigh. The OSR indicated Resident 219 was scheduled for hemodialysis every Mondays, Wednesdays, and Fridays.During a review of Resident 219's CP dated 8/7/2025, the CP indicated Resident 219 had the potential for bleeding from the central line site related to hemodialysis. The CP interventions included to place [NAME] clamp at bedside for management of emergency bleeding on the central line access site.During a concurrent observation and interview on 8/19/2025 at 9:18 am with CNA 3, Resident 219 was lying in bed with hemodialysis access site on the left upper thigh. CNA 3 stated Resident 219 did not have an E-kit at (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedside. CNA 3 stated Resident 219 should have an E-kit at bedside to use in case of emergency like bleeding from the hemodialysis access siteDuring an interview on 8/21/2025 at 11:54 am with the facility's Director of Nursing (DON), the DON stated all hemodialysis residents needed to have an E-kit at bedside, close and easily accessible to the staff to use to stop and control if bleeding occurs from the hemodialysis access site. During a review of the facility's Policy and Procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident With, revised September 2010, the P&P indicated, How to recognize and intervene in medical emergencies such as hemorrhage and septic infection. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide sufficient staffing, resulting in toileting and/or incontinent care not being provided for two of three sampled residents (Residents 11 and 136) in a timely manner. This failure had the potential to result in Residents 11and 136 experiencing skin breakdown and/or placing the residents at risk of experiencing a urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra). (Cross Reference F550) Findings: a. During a review of Resident 11's admission Record (AR), the AR indicated Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood). During a review of Resident 11’s History and Physical (H&P), dated 6/7/2025, the H&P indicated Resident 11 had the capacity to understand and make medical decisions. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool) dated 8/5/2025, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 11 was dependent (helper does all the effort) on staff for bathing, dressing, and toileting hygiene. During an interview on 8/19/2025 at 1:29 PM with Resident 11, Resident 11 stated Resident 11 had to sometimes wait a long time for help from nurses (in general). Resident 11 stated Resident 11 pressed the call light earlier in the morning of 8/19/2025 because Resident 11 needed Resident 11’s diaper changed. Resident 11 stated Resident 11 waited so long that Resident 11 fell asleep. During a Resident Council Meeting on 8/20/2025 at 1:54 PM, four of the eight residents present indicated the residents had to wait “too long” for assistance from facility staff when the residents pressed their call lights. During an interview on 8/21/2023 at 9:23 AM with Registered Nurse 4(RN 4), RN 4 stated Station 1 was one of the heavier stations regarding caring for residents (in general). RN 4 stated it would be beneficial if Station 1 had another CNA in addition to the three CNAs already assigned. RN 1 stated call lights would be answered faster if Station 1 had an additional CNA. RN 4 stated residents (in general) and family members (in general) complained to RN 4 about waiting too long for call light responses from the staff (in general). During a concurrent interview and record review on 8/21/2025 at 2:24 PM with Activities Director 1 (AD 1), the facility’s “Resident Council Minutes (RCM),” dated 5/20/2025, 6/17/2025, 7/15/2025, and 7/30/2025 were reviewed. Each of the “RCM” documents indicated facility staff (in general) were not answering call lights in a timely manner. AD 1 confirmed that some of the residents (in general) who attended the monthly Resident Council Meeting had been (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complaining regularly about staff (in general) not answering call lights promptly for the past six months. During an interview on 8/22/2025 at 8:34 AM with CNA 5, CNA 5 stated facility staff (in general) should respond to residents’ call lights immediately. CNA 5 stated CNA 5 worked in CNA 5’s assigned unit of Station 1. CNA 5 stated CNA 5 usually was assigned to care for 10 residents during CNA 5’s shift (7AM – 3 PM). CNA 5 stated it was hard to provide care to residents (in general) in a timely manner because Station 1 only had three CNAs. CNA 5 stated a resident (unidentified) was frustrated with CNA 5 on 8/19/2025 because the unidentified resident waited 10 minutes for CNA 5 to change the unidentified resident’s soiled diaper. During an interview on 8/22/2025 at 8:47 AM with CNA 6, CNA 6 stated CNA 6 usually worked in Station 1. CNA 6 stated Station 1 only had three CNAs assigned to Station 1 during the morning shift (7 AM – 3 PM). CNA 6 stated the residents (in general) in Station 1 required a lot of care. CNA 6 stated that sometimes CNA 6 only had time to change soiled diapers for incontinent residents (in general) once during the entire shift. CNA 6 stated CNA 6 often was assigned to care for Resident 11. CNA 6 stated it sometimes took CNA 6, 20 minutes to respond to Resident 11’s request to change Resident 11’s soiled diaper because CNA 6 was busy caring for other residents (in general) in Station 1. During a concurrent interview and record review on 8/22/2025 at 11:52 AM with the Director of Staff Development (DSD), the facility’s “Station 1 C.N.A. Assignment Sheet(s) (AS),” dated 8/4/2025 to 8/18/2025 were reviewed. The “AS(s)” dated 8/4/2025 to 8/9/2025 and 8/15/2025 to 8/18/2025 indicated CNA’s (in general) were assigned to care for 10 residents during the 7AM – 3 PM shift. The DSD stated CNAs should be assigned to care for 8-9 residents (in general) during the 7 AM – 3 PM shift. The DSD stated if the CNA’s (in general) were assigned 10 residents then the delivery of care to the residents would be delayed. During a review of the facility's Facility Assessment, titled, “HSAG-File--Facility Assessment Tool,” undated, the facility assessment indicated the facility’s staffing plan included that CNAs would be assigned to care for 8-9 residents during the 7 AM – 3 PM shift. During a review of the facility's Policy and Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, revised August 2022, the P&P indicated, the facility provides sufficient numbers of nursing staff … to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. The P&P indicated staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment. During a review of the facility's P&P titled, Answering the Call Light, revised September 2022, the P&P indicated, “Answer the resident call system immediately.” b. During a review of Resident 136’s AR, the AR indicated Resident 136 was admitted to the facility on [DATE] with diagnoses that included COPD, pneumonia (an infection that inflames one or both lungs) and morbid obesity (a person's body has a lot of extra weight). During a record review of Resident 136’s H&P dated 7/17/2025, the H&P indicated Resident 136 had the capacity to understand and make decisions. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 136’s MDS dated [DATE], the MDS indicated Resident 136 was dependent care (helper does all of the effort, the resident does no effort to complete the activity) from staff for toileting hygiene, shower/bathing self and putting on/taking off footwear. During a review of Resident 136’s Skin Check (SC) dated 7/17/2025, the SC indicated Resident 136 had a skin issue in the middle area of the sacrum (a triangular bone at the base of the lower back) that was present on admission considered a pressure ulcer/injury (damage to the skin caused by continuous pressure) Stage 3 full-thickness skin loss (a bedsore where the skin is destroyed and extending into deeper tissue and fat) and surrounding tissue to be fragile with skin that was at risk for breakdown. The SC indicated additional care areas for incontinence management and mattress with pump. During a review of Resident 136’s untitled Care Plan (CP) dated 7/17/2025, the CP indicated Resident 136 had Activities of Daily Living (ADL) decline and potential for skin breakdown. The CP goal was to prevent skin breakdown. There were no ADL maintenance or repositioning included or documented in any other CP in Resident 136’s medical record (MR). During a review of Resident 136’s Wound Evaluation & Treatment Progress Note (WETPN) dated 8/14/2025, the WETPN indicated Resident 136’s sacrococcyx (the tail bone located at the base of the spine), sacral region (lower back) wound was closed. The WETPN indicated recommendations including aggressive offloading (refers to the practice of relieving or redistributing pressure from a specific area of a resident's body to prevent and treat wounds, especially pressure ulcers), every two hours turning, no sitting beyond 2 hours and frequent diaper checks and changes. The WETPN indicated additional recommendations to turn Resident 136 every two hours and to keep the skin clean and dry. During an observation and interview with Resident 136 on 8/19/2025 at 11:03 AM, Resident 136 was sitting up in bed watching television (TV). Resident 136 stated, “I’ve had a bowel movement (BM) since 7:30 AM. I've been calling them (staff) and it’s 11:03 AM now and I'm still waiting. I’m afraid my wounds will come back. I am very upset and embarrassed. Sometimes I wait up to three hours to get cleaned up. I called and they(staff) do not come.” During an interview with Licensed Vocational Nurse 9 (LVN 9) on 8/19/2025 at 11:11 AM, LVN 9 stated Resident 136 should not have been waiting since 7:30 AM to be cleaned by staff especially if Resident 136 had a bowel movement. LVN 9 stated it was not sanitary and uncomfortable for Resident 136 to be soiled for a long period of time. LVN 9 stated CNA 4 was assigned to care for Resident 136, but CNA 4 was busy with another resident. During an interview with CNA 4 on 8/19/2025 at 11:14 AM, CNA 4 stated there were 10 residents assigned to CNA 4 for the day (8/19/2025) and someone (unidentified) could have answered the call light earlier and not communicated to CNA 4 that Resident 136 was soiled and needed to be changed. CNA 4 stated CNA 4 was busy earlier because there was a room change. During an interview with LVN 10 on 8/20/2025 at 11:56 AM, LVN 10 stated residents should get peri-care (cleaning of the area between the anus and genitals) often for hygiene and to prevent infections and skin problems. LVN 10 stated it was not acceptable to have a resident sitting in their own bowel movement for long periods of time as this could make them feel terrible, helpless, neglected and sad, putting the resident at risk for depression or anxiety. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Infection Prevention Nurse (IPN) on 8/21/2025 at 3:10pm, the IPN stated every resident needed to be provided with peri-care as needed. The IPN stated it was not acceptable to leave a resident for long periods of time if they are soiled and if a resident was not cared for in a timely manner, it would make the resident feel uncomfortable, embarrassed and neglected, resulting in lowered self-esteem and feeling depressed. The IPN stated a resident that was left in “soiled conditions” for extended periods of time could have serious infection risks, skin breakdown and bedsores. The IPN stated the combination of moisture and bacteria from urine and feces would create an environment that can quickly lead to skin breakdown, infection and other health complications. During an interview with the DON (DON) on 8/22/2025 at 9:10 AM, the DON stated it was not acceptable for a resident to be in bed soiled for hours. The DON stated, as soon as a staff identify the resident needed to be changed, the resident needed to be cleaned immediately. During an interview with the Treatment Nurse (TN1) on 8/22/2025 at 1:33 PM, TN1 stated ADLs and timely peri-care must be provided to all residents. TN 1 stated, when residents were at risk of skin breakdown or have wounds, it was extremely important to prevent infections. TN 1 stated it was not acceptable for a resident to be soiled from 7:00 AM to 11:00 AM. TN1 stated, if a resident was left for long periods of time soiled or not being cleaned, it would make the resident feel uncomfortable, embarrassed and neglected. During a review of the facility’s Policy and Procedures (P&Ps) titled, “Activities of Daily Living (ADL), Supporting” revised March 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 activities of daily living (ADLs). The P&P indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During a review of the facility’s P&P titled, “Perineal Care”, revised February 2018, the P&P indicated, “The purpose of this procedure was to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident’s skin conditions.” During a review of the facility’s P&P titled, “Residents Rights”, revised December 2016, the P&P indicated, “Employees shall treat all residents with kindness, respect and dignity.” During a review of the facility’s P&P titled, “Quality of Life-Dignity”, revised February 2020, the P&P indicated, “Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem.” The P&P indicated demeaning practices and standards of care that compromise dignity is prohibited. Staff are expected to promote dignity and assist residents. For example, promptly responding to a resident’s request for toileting assistance.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to:a. Administer medications in a timely manner for three of four sampled residents (Residents 218, 209 and 89). This failure had the potential to result in the effectiveness of the medication affecting the residents' wellbeing.b. Ensure during a medication pass observation on 8/21/2025 at 8:33 am, Licensed Vocational Nurse 8 (LVN 8) did not attempt to administer 2 tablets of Tylenol Oral Tablet 325 mg to Resident 34.c. Ensure an accurate account of the use of a controlled medication (medications that the use and possession of are controlled by the federal government), Pregabalin (a controlled medication used for pain and seizures) for Resident 47 when the licensed nurse did not document its usage on the controlled drug record.These deficient practices had the potential to result in adverse consequences for the residents. Findings: a. A review of Resident 218’s admission Record (AR), dated 10/19/2024, the AR indicated that Resident 218 has iron deficiency anemia due to chronic blood loss, a Stage IV Pressure (a localized area of skin damage that develops due to prolonged pressure on an area of the body) Ulcer of Sacral Region, Type 2 diabetes, and intractable epilepsy. A review of Resident 218’s Care Plan Report (CP), dated 10/19/2024, the CP indicated that Resident 218 should have medications administered as ordered and be monitored for side effects of those medications for diabetes, anemia, seizures, a pressure ulcer and report those side effects to the physician. A review of Resident 89’s admission Record (AR), dated 4/21/2025, the AR indicated Resident 89 has end stage renal (Kidney) disease, anemia, and hyperlipidemia (high levels of cholesterol in the blood). A review of Resident 89’s Care Plan Report (CP), dated 4/22/2025, the CP indicated that Resident 89’s anemia (not having enough red blood cells) medication should be given as ordered and the goal for Resident 89 was to remain free of complications related to hyperlipidemia and administer fenofibrate tab 145 mg tablet and ezetimibe tab 10mg one time a day. A review of Resident 218’s Minimum Data Set Assessment (MDS), dated [DATE], the MDS indicated that Resident 218 has a problem remembering the past and Resident 218’s skills for daily decision making are severely impaired. A review of Resident 209’s admission Record (AR), dated 7/10/2025, the AR indicated that Resident 209 had a Stage 2 pressure ulcer, epilepsy, and hereditary and idiopathic neuropathy. A review of Resident 209’s Care Plan Report (CP), dated 7/10/2025, the CP indicated that Resident 209’s pain medications should be given as order by the physician. A review of Resident 209’s Minimum Data Set Assessment (MDS), dated [DATE], the MDS indicated Resident 209 is absent of spoken words, is rarely understood, and is severely impaired at making decisions. During an interview on 8/22/2025 at 9:54 a.m., with LVN 13, LVN 13 stated medications are late if (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	given two hours after the assigned time. Residents can experience side effects from not having the medication on time. We notify the families when the medications are late. During an interview on 8/22/2025 at 9:58 a.m., with RN 1, RN 1 stated medications are late if given one hour after the medication is due and the Physician or Nurse Practitioner are notified. If medications are given late the resident’s blood pressure or heart rate could be affected. Also, the medication levels in the blood are affected. A review of Resident 218’s Medication Administration Audit Report (MAAR), dated 8/22/2025, the MAAR indicated that the following medications were administered greater than one hour after the prescribed administration time: 1.SF Prostat 30cc PO Daily for 3 months – Healing Support in the morning until 9/19/2025 at 23:59, prescribed for 9 a.m., every day, was administered more than one hour after the prescribed administration time on the following dates: 8/4/2025 administered at 10:22 a.m.; 8/5/2025 administered at 10:58 a.m.; and on 8/9/2025 administered at 10:46 a.m. 2.Levetiracetam oral solution 100mg. Give 5 mL enterally every 12 hours for seizure (uncontrollable jerking body movement) disorder, prescribed for 9 a.m. was administered more than one hour after the prescribed administration time on the following dates: 8/4/2025 at 10:22 a.m.; on 8/5/2025 at 10:58 a.m.; and on 8/6/2025 at 11:41 a.m. 3.Ferrous Sulfate Elixir 220 mg solution; give 7.5 cc enterally one time a day for anemia, prescribed for 9 a.m. was administered more than one hour after the prescribed administration time on the following dates: 8/4/2025 at 10:22 a.m.; on 8/5/2025 at 10:58 a.m.; and on 8/6/2025 at 11:41 a.m. A review of Resident 209’s Medication Administration Audit Report (MAAR), dated 8/22/2025, the MAAR indicated that the following medications were administered greater than one hour after the prescribed administration time: 1.Gabapentin Oral Tablet 100 mg; give one capsule via G-tube three times a day for neuropathy, were more than one hour past the prescribed medication time for two morning doses, due at 9 a.m., and one afternoon dose, due at 1 p.m. The following dates and times are: 8/1/2025 at 3:20 p.m., 8/2/2025 at 3:38 p.m., and at 8/4/2025 at 10:20 a.m. 2. Levetiracetam Oral Tablet 500mg; give 1 tablet via G-Tube two times a day for seizures, were more than one hour past the prescribed medication time of 9:00 a.m. for three doses on the following dates and times are: 8/3/2025 at 11:05 a.m.; 8/5/2025 at 10:57 a.m., and 8/6/2025 at 11:41 a.m. 3. Zinc Sulfate Oral Tablet 66mg. Give one tablet via G-Tube one time a day for healing support was more than one hour past the prescribed medication time of 9 a.m. for three doses on the following dates and time: 8/5/2025 at 10:55 a.m.; 8/6/2025 at 11:41; and 8/9/2025 at 10:48 a.m. A review of Resident 89’s Medication Administration Audit Report (MAAR), dated 8/22/2025, the MAAR indicated that the following medications were administered greater than one hour after the prescribed administration time: 1.B-Complex w/ C & Folic Acid Tablet 0.8 mg. Give 1 tablet by mouth one time a day for supplement prescribed for administration at 11 a.m. was administered more than one hour after the prescribed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration time on 8/3/2025, 8/4/2025, and 8/6/2025. 2. Fenofibrate tablet 145 mg. Give 1 tablet by mouth one time a day for hyperlipidemia prescribed for administration at 11 a.m. was administered more than one hour after the prescribed administration time on 8/3/2025, 8/4/2025, and 8/5/2025. 3. Ezetimibe tablet 10 mg. Give one tablet by mouth one time a day for hypercholesterolemia was administered more than one hour after the prescribed administration time on 8/4/2025, 8/5/2025, and 8/6/2025. A review of the facility’s policy and procedure titled, Administering Medications, dated April 2019, the policy indicated medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). b. During a review of Resident 34’s admission Record (AR), the AR indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure (condition characterized by a gradual loss of kidney function over time) and heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs). During a review of Resident 34's Order Summary Report (OSR), dated 6/30/2025, the OSR indicated to administer Tylenol (Acetaminophen, medicine that relieves mild to moderate pain and reduces fever) Oral Tablet 325 milligrams (mg, unit of measurement), two (2) tablet by mouth in the morning for pain. Give 30 minutes prior (before) to wound care, not to exceed (NTE) three (3) grams (gr, unit of measurement) in 24 hours. During a review of Resident 34’s Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 7/15/2025, the MDS indicated Resident 34 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 34 was dependent (helper does all of the effort) to staff for toileting hygiene and shower. The MDS indicated Resident 34 needed maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) to staff for upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a medication pass observation on 8/21/2025 at 8:33 am, Licensed Vocational Nurse 8 (LVN 8) attempted to administer 2 tablets of Tylenol Oral Tablet 325 mg prior to wound care to Resident 34. During an interview on 8/21/2025 at 8:34 am, Resident 34 stated “I don’t have any wound. I don’t want to take Tylenol.” During an interview on 8/21/2025 at 9:30 am, with LVN 8, the LVN 8 stated, “Tylenol was discontinued now (8/21/2022) because patient (resident) doesn’t have any wound. Patient’s wound was resolved.” During an interview with the facility’s Director of Nursing (DON) on 8/21/2025 at 10:08 am, the facility DON stated, Resident 34 did not need Tylenol Oral Tablet routinely because Resident 34’s wound treatment was resolved. The DON stated Tylenol Oral Tablet was ordered to administer prior to wound care and Resident 34 did not have any wounds. During a concurrent review of Resident 34’s Skin Observation Tool (SOT) dated 8/15/2025, and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview with the Registered Nurse 2 on 8/21/2025 at 2:05 pm, the SOT indicated Resident 34 was seen and evaluated by the wound consultant and had an order to discontinue treatment to the left anterior (front) lower leg wound. RN 2 stated the wound treatment was discontinued by the wound consultant on 8/15/2025. RN 2 stated Resident 34’s wound was resolved. During a concurrent review of Resident 34's Medication Administration Record (MAR) dated from 8/1/2025 to 8/31/2025, and interview with RN 2 on 8/21/2025 at 2:07 pm, the MAR indicated Resident 34 received Tylenol Oral tablet 325 mg, 2 tablet by mouth in the morning for pain and give 30 minutes prior to wound care from 8/16/2025 to 8/20/2025. The MAR indicated on 8/21/2025 Resident 34 refused to take Tylenol oral tablet. RN 2 stated Tylenol Oral tablet 325 mg should have not administered since 8/16/2025 because the wound was resolved on 8/15/2025. RN 2 stated Resident 34 was receiving unnecessary medication for there was no existing wound or treatment to be done. During a review of the facility’s policy and procedure (P&P) titled, “Administering Medication, revised 12/2012, the P&P indicated medications shall be administered in a safe and timely manner, and as prescribed. The P&P indicated medications must be administered in accordance with the orders, including any required time frame. c. During a review of Resident 47’s admission Record (AR), the admission Record indicated Resident 47 was admitted on [DATE] with diagnoses that included alcoholic cirrhosis (chronic liver disease from excessive alcohol consumption), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and insomnia (trouble falling asleep or staying asleep). During a review of Resident 47’s History & Physical (H&P), dated 1/31/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 47’s Minimum Data Set assessment (MDS – a federally mandated resident assessment tool), dated 7/5/2025, the MDS indicated Resident 47 had intact cognition (ability to think). During a review of Resident 47’s Order Summary Report, dated 8/22/2025, the Order Summary indicated Resident 47 had an order for Lyrica (generic medication – Pregabalin) oral capsule 100 milligrams (mg) to be given three times a day for pain, ordered on 7/23/2025. During a review of Resident 47’s Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 8/1/2025 through 8/31/2025, the MAR indicated Resident 47 received Pregabalin oral capsule 100 mg on 8/21/2025 at 9 am and 1 pm. During a review of Resident 47’s Record of Controlled Substances (a controlled drug record/accountability record of medications that are considered to have a strong potential for abuse) for Pregabalin 100 mg caps, dated 8/3 and ending on 8/20, the record indicated there was no documentation for the doses given on 8/21/2025 at 9 am and 1 pm. During an interview on 8/21/2025 at 3:25 pm with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated Resident 47 was given Pregabalin 100 mg by her at 8:40 am and 1 pm, but did not document on the Record of Controlled Substances because she was too busy. LVN 7 stated she was supposed to (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	document the administration on the Record of Controlled Substances after Resident 47 took it to prevent any mistakes from happening. LVN 7 stated the medication was an opioid (a class of drug used to reduce moderate to severe pain that can be addictive) for pain and could pose a danger to the resident. During an interview on 8/22/2025 at 11:58 am with the Director of Nursing (DON), the DON stated when giving a controlled drug the nurse should document it on the MAR and they must sign the controlled drug record to keep count of the quantity remaining and reflect the date/time of when the drug was given. The DON stated, once the medication is removed from the medication blister pack it should be documented timely to avoid it being forgotten. The DON stated signing off on the record was important so every medication that was used had a record and the next shift would know when it was utilized. During a review of the facility’s policy and procedure (P&P) titled, “Controlled Substances,” last revised 11/2022, the P&P indicated the facility complied with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976). The P&P indicated controlled substance inventory were monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. The P&P indicated the system of reconciling the receipt, dispensing and disposition of controlled substances included medication administration records.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide safe storage of medications by failing to:a. Ensure Resident 15's eye drop bottle was labeled with the resident's name.b. Ensure Resident 71's eye drop bottle and box were labeled with the resident's name. c. Ensure the medication cart was not left open and unattended and outside of view of staff in nursing station 1.These deficient practices had the potential to result in unintentional medication administration to the wrong resident and could have also resulted in missing medications from the medication cart. Findings: a. During a review of Resident 15’s admission Record (AR), the admission Record indicated Resident 15 was admitted on [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction caused by diseases or toxins in the body) and sepsis (a life-threatening blood infection). During a review of Resident 15’s History & Physical (H&P), dated 6/26/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 15’s Minimum Data Set assessment (MDS – a federally mandated resident assessment tool), dated 7/26/2025, the MDS indicated Resident 15 had moderately impaired cognition (ability to think). During a review of Resident 15’s Order Summary Report, dated 8/22/2025, the Order Summary indicated Resident 15 had an order for to instill artificial tears ophthalmic solution 1.4% (polyvinyl alcohol) with one drop in both eyes twice a day for dry eyes, ordered on 6/25/2025. During a review of Resident 15’s Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 8/1/2025 through 8/31/2025, the MAR indicated Resident 15’s received artificial tears ophthalmic solution 1.4% (polyvinyl alcohol) from 8/1/2025 to 8/20/2025 at 9 am and 6 pm and on 8/21/2025 at 9 am. During a concurrent observation and interview during a medication cart inspection on 8/19/2025 at 3 pm with Licensed Vocational Nurse 7 (LVN 7), an open box of Polyvinyl alcohol 1.4% lubricating eye drops had Resident 15’s medication label on the box and the eye drop bottle lacked any resident identifying information. LVN 7 stated, the eye drop medication should be labeled by the nurse with the resident’s name to prevent giving the medication to another resident. During an interview on 8/22/2025 at 11:54 am with the Director of Nursing (DON), the DON stated eye drops should be labeled upon opening with the date to allow nurses to know when to replenish it. The DON stated it must be labeled with the resident’s name and the room number on the bottle and the box, but must be labeled on the bottle to prevent another resident from being given the medication. During a review of the facility’s policy and procedure (P&P) titled, “Medication Labeling and Storage,” last revised 2/2023, the P&P indicated the labeling of medications and biologicals dispensed by the pharmacy were consistent with applicable federal and state requirements and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	currently accepted pharmaceutical practices. The P&P indicated the medication label included at a minimum the resident’s name. b. During a review of Resident 71’s admission Record (AR), the admission Record indicated Resident 71 was admitted on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and sepsis (a life-threatening blood infection). During a review of Resident 71’s Minimum Data Set assessment (MDS – a federally mandated resident assessment tool), dated 7/26/2025, the MDS indicated Resident 71 had moderately impaired cognition (ability to think). During a review of Resident 71’s History & Physical (H&P), dated 7/31/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 71’s Order Summary Report, dated 8/22/2025, the Order Summary indicated Resident 15 had an order for Tetrahydrozoline HCl ophthalmic solution with one drop instilled in both eyes twice a day for redness/itching, ordered on 8/20/2025. During a concurrent observation and interview during a medication care inspection on 8/19/2025 at 3 pm with Licensed Vocational Nurse 7 (LVN 7), an open box of Care All redness reliever eye drops were labeled with “606A” on the top and side of the box with the bottle inside unlabeled with no date of opening. LVN 7 stated, the medication should be labeled by the nurse and eye drops were labeled with the open date and resident’s name on the bottle. LVN 7 stated they don't label the medication with a room number because the resident may change rooms, and they could give the medication to the wrong resident. During an interview on 8/22/2025 at 11:54 am with the Director of Nursing (DON), the DON stated eye drops should be labeled upon opening with the date to allow nurses to know when to replenish it. The DON stated it must be labeled with the resident’s name and the room number on the bottle and the box but must be labeled on the bottle to prevent another resident from being given the medication. During a review of the facility’s policy and procedure (P&P) titled, “Medication Labeling and Storage,” last revised 2/2023, the P&P indicated the labeling of medications and biologicals dispensed by the pharmacy were consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The P&P indicated, the medication label included, at a minimum the resident’s name. c. During a medication Pass Observation on 8/21/2025 at 9:30 am with Licensed Vocational Nurse 8 (LVN 8) on Station 1, LVN 1 left the medication cart (MedCart) in the hallway unlocked and out of view where the residents and staff passed by. During an interview on 8/21/2025 at 9:32 am, with LVN 8 on Station 1, LVN 8 stated “I did not lock my MedCart. I was nervous and I forgot to lock it. Someone might open the MedCart and might take medications that could cause harmful effect.” During an interview on 5/16/2025 at 3:28 pm with the facility’s Director of Nursing (DON), the DON stated the MedCart needed to be locked if it was outside of the Licensed Nurse's view. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the facility’s Director of Nursing (DON) on 8/21/2025 at 10:08 am, the facility DON stated, the MedCart should be locked every time if it was outside the view of licensed nurses for safety. During a review of the facility’s undated Policy and Procedure titled, “Storage of Medications,” the P&P indicated, “Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended”

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 70 and 244) received food that was palatable, attractive, and according to food preference according to the facility's Policy and Procedure (P&P) titled, Food and Nutrition Services, revised October 2017.These failures had the potential for Residents 70 and 244 to be at risk of unplanned weight loss, a consequence of poor food intake. Findings: a. During a review of Resident 244's admission Record (AR), the AR indicated the facility admitted Resident 244 on 6/8/2022 and readmitted on [DATE] with diagnoses including respiratory failure (when the lungs can't get enough oxygen into the blood), dependence on respiratory ventilator (a type of breathing apparatus that moves air into and out of the lungs), and dependence on renal dialysis (the process of removing excess water and toxins from the blood in people whose kidneys can no longer perform these functions naturally). During a review of Resident 244's Minimum Data Set (MDS, a resident assessment tool) dated 5/27/2025, the MDS indicated Resident 244 had intact cognition (ability to understand). The MDS indicated Resident 244 was dependent (helper does all the effort) on staff for bathing, lower body dressing, and toileting and hygiene. During a review of Resident 244’s History and Physical (H&P) dated 1/25/2025, the H&P indicated Resident 244 had the capacity to understand and make medical decisions. During an interview on 8/21/2025 at 1:00 PM with Resident 244, Resident 244 stated the food served at the facility was “awful.” Resident 244 stated that the food the facility served did not look appetizing. During a concurrent observation and interview on 8/21/2025 at 1:00 PM with Resident 244, Resident 244’s lunch tray included a plate of food containing a piece of meat. The surveyor and Resident 244 were not able to identify what kind of meat it was. The piece of meat looked unappetizing. Resident 244 stated Resident 244 did not want to eat lunch because the food did not look appetizing. During a concurrent observation and interview on 8/21/2025 at 1:11 PM with Dietary Aid 1 (DA 1), DA 1 stated the piece of meat was baked chicken. DA 1 stated the chicken looked overcooked. b. During a review of Resident 70’s AR, the AR indicated Resident 70 was admitted to the facility on [DATE] with diagnoses including unspecified severe protein-calorie malnutrition, dysphagia (difficulty swallowing) oropharyngeal (middle part of the throat located behind the mouth) phase, and muscle wasting and atrophy (partial or complete wasting away of a part of the body). During a review of Resident 70’s Order Summary Report (OSR) dated 4/30/2025, the OSR indicated Regular Diet, Regular texture, Regular/Thin consistency, IDDSI (International Dysphagia Diet Standardization Initiative – an international collaboration of professionals who developed a standardized framework for labeling texture-modified foods and thickened liquids) Level 7 (foods are soft, tender, and easy to chew) for Resident 70. During a review of Resident 70’s H&P dated 6/12/2025, the H&P indicated, Resident 70 had the capacity to understand and make decisions. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 70’s MDS dated [DATE], the MDS indicated Resident 70 had intact cognition (ability to understand). The MDS indicated Resident 70 was independent (resident completes the activity by themselves with no assistance from a helper) for eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). During an interview on 8/20/2025 at 9:45 AM with Resident 70, Resident 70 stated, the facility did not have enough food variety. Resident 70 stated, Resident 70 requested no fish but Resident 70 was served fish. Resident 70 stated, Resident 70 would return the food served and food was of bad quality. During a concurrent observation and interview on 8/21/2025 at 1:20 PM with Resident 70, Resident 70’s meal tray had chopped steamed spinach, grains, a lemon wedge and a light brown irregular shaped piece of meat with bubbled and crater-like texture and pinkish-red tinge colored section in the center part of the meat. Resident 70 stated, Resident 70 did not know what the piece of meat was on the meal tray. Resident 70 stated, the piece of meat did not look like a ground beef patty. During a concurrent observation and interview on 8/21/2025 at 1:29 PM with Resident 70 and the Dietary Supervisor (DS), Resident 70’s meal tray had chopped steamed spinach, grains, a lemon wedge and a light brown irregular shaped piece of meat with bubbled and crater-like texture and pinkish-red tinge colored section in the center part of the meat. The DS stated the piece of meat was a ground beef patty. The DS stated, the DS would taste the ground beef patty on the ends and not the pink area. The DS stated the ground beef patty was pink when cooked. The DS stated, the ground beef patty did not “look like that when we get it.” During a review of the facility’s Policy and Procedure (P&P) titled, “Resident Food Preferences,” revised 7/2017, the P&P indicated, the food service department would offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. During a review of the facility’s P&P titled, “Food and Nutrition Services,” revised 10/2017, the P&P indicated, each resident was provided with nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The P&P indicated, the food and nutrition services staff would inspect food trays to ensure that the correct meal was provided to each resident, the food appeared palatable and attractive. If an incorrect meal was provided to a resident, or a meal did not appear palatable, nursing staff would report it to the food service manager so that a new food tray could be issued.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure each kitchen sanitization bucket (used to sanitize surfaces in the facility kitchen) and the sink sanitization compartment used to sanitize tray line preparation area, was maintained at the required concentration for effective sanitization by failing to:Ensure two red buckets and the sink sanitization compartment (third compartment of the sink) used in the kitchen for sanitation of kitchen surfaces and in food preparation areas, were maintained at the correct concentration to maintain effectiveness to prevent cross contamination.Findings:During a concurrent observation and interview, on 8/19/25, at 9:56 a.m., with the Dietary Supervisor (DS), two of four red sanitization buckets and the sanitization compartment of the kitchen sink were tested for efficacy (ability to produce a desired or intended result). Two of the red bucket sanitizations and third sink compartment concentrations were observed at 50 parts per million (ppm). The DS stated the red buckets are filled from the third sink compartment. The DS stated red bucket concentration should be between 200-400ppm.During an interview, on 8/19/25, at 10 a.m., with the Registered Dietitian (RD), the RD stated it is important for the red bucket efficacy concentration to be maintained because of the safety and health issues of our patients, cross contamination, and we have sick people with compromised immune systems. During a concurrent interview, the DS stated it is important because patients can get sick.During an interview, on 8/21/25, at 9:35 a.m., with the DS, the DS stated the problem with the red sanitization buckets was that the test strips they were using to test had expired.During a record review of the manufacturer's guidelines, titled, Individual Sanitizer Testing Procedure, indicated the sanitization testing range should be 150-400ppm.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its infection control policy for five of seven sampled residents (Residents 168, 175, 218, 1 and 105) by failing to ensure:a. The urine drainage bag was not touching the floor for Resident 168b. Resident 175 oxygen tubing was not touching the floor.c. Staff performed hand hygiene before and after taking care of Residents 218 and 1d. Resident 105's IV tubing was not looped at the end of the same administration set and the IV ports were not left uncovered.These deficient practices had the potential to result in infection for Residents 168, 175, 218, 1 and 105. a. During a review of Resident 168’s admission Record (AR), the AR indicated Resident 168 was admitted to the facility on [DATE] with diagnoses that included but not limited to fracture of neck, injury of head, quadriplegia (a form of paralysis that affects all four limbs, plus the torso), anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), depression (mood disorder that causes a persistent feeling of sadness and loss of interest). During a record review of Resident 168’s History and Physical (H&P), dated 7/18/2025, the H&P indicated Resident 168 has the capacity to understand and make decisions. During a review of Resident 168’s Minimum Date Set (MDS – a resident assessment tool), dated 7/23/2025, the MDS indicated Resident 168 required dependent care (helper does all of the effort, the resident does none of the effort to complete the activity) from staff for eating, oral, personal and toileting hygiene, shower/bathing self, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 168’s Order Summary (OS) dated 7/18/2025 at 4:24 PM, the OS indicated, “(Treatment) condom catheter: Monitor placement and patency (allow for free flow) every shift. Condom Catheter (a non-invasive urinary drainage device used primarily in males)-Medium size, May change PRN if leakage, blockage, dislodgement (removed) or soiled for Neurogenic bladder (a condition where the bladder muscles and nerves do not function properly due to damage) as needed.” During an initial observation and interview of Resident 168 on 8/19/2025 at 10:53 AM, Resident 168 was observed to be resting in bed watching tv. Resident 168’s condom catheters drainage bag (a medical device, usually made of plastic, that collects urine) was hanging from the right side of the bed, not covered with privacy bag and touching the floor. The privacy bag was observed hanging next to the drainage bag. During an interview with the Infection Preventionist Nurse (IPN) on 8/21/2025 at 3:02 PM, the IPN stated that a urine drainage bag should not be touching the floor because the floor has bacteria and that can cause an infection leading to more complications with the residents health. During an interview with the Director of Nursing (DON) on 8/22/2025 at 9:07 AM, the DON stated the urine drainage bag should not be touching the floor. Per the DON, the facilities infection control policies indicate that if a urine drainage bag touches the floor, germs can enter the system, leading to a urinary tract infection (UTI-infection in the bladder). The bag should always be kept below the level of the bladder to prevent urine backflow and contamination, and the drainage spout or any part of the open system must not touch the floor or other surfaces. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facilities Policies & Procedures (P&Ps) titled, “Policies and Practices-Infection Control”, revised October 2018, the P&P indicated “This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.” b. During a review of Resident 175's admission Record (AR), the AR indicated the facility readmitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (paralysis on one side of the body), urinary tract infection (illness in urinary tract {system/organs that makes urine}), and hemorrhage of cerebrum (bleeding inside the brain). During a review of Resident 175's Minimum Data Set (MDS, a resident assessment tool), dated 5/22/25, the MDS indicated Resident 175 was moderately cognitively (ability to understand and process thoughts) impaired, required substantial/maximal assistance with activities of daily living (ADLs), and mobility. During a review of Resident 175’s History & Physical (H&P), dated 8/8/25, the H&P indicated Resident 175 did not have the capacity to make medical decisions. During a review of Resident 175’s Physician Recapitulation Orders (PO), dated 8/21/25, the OSR indicated Resident 175 received 2-4 liters (L) of oxygen (O2) as needed (prn) for shortness of breath (SOB) and to keep the oxygen saturation (percentage of oxygen carried by red blood cells) above 92%. During an observation, 8/20/25, at 9 a.m., Resident 175 was observed receiving 2L O2 via nasal cannula (flexible tube with two prongs that fit into the nostrils to deliver supplemental oxygen). Resident 175’s oxygen tubing was observed on the side of Resident 175’s bed and touching the floor. During a concurrent observation and interview, on 8/20/25, at 9:11 a.m., with Licensed Vocational Nurse (LVN 13), Resident 175’s oxygen tubing was observed on the floor. LVN 13 stated Resident 175’s oxygen tubing touching the floor is an infection control issue and can cause an infection for sure. During an interview, on 8/22/25, at 10:23 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated the oxygen tubing should definitely not be on the floor. The IPN stated this can cause germs on the tubing to the nose and it should be changed. During a review of the facility’s Policy and Procedure (P&P), titled, “Infection Prevention and Control,” dated 2001, the policy indicated the facility's adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. c). During a review of Resident 1’s admission Record (AR), the AR indicated the facility admitted Resident 1 on 7/2/2025 with diagnoses of toxic encephalopathy, acute respiratory failure with hypoxia, urinary tract infection, and resistance to vancomycin. A review of Resident 1’s Care Plan Report (CP) dated 7/2/2025, the CP indicated staff were to perform proper hand hygiene prior to oral care to decrease Resident 1’s risk for developing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ventilator-Associated Pneumonia ([NAME]). A review of Resident 1’s Minimum Data Set (MDS- a resident assessment tool) dated 7/8/2025, the MDS indicated Resident 1’s cognition (ability to understand) as rarely understood, there was a memory problem, skills for daily decision making were severely impaired, Resident 1’s arms and legs were severely impaired and that Resident 1 was totally dependent on staff for self-care. A review of Resident 218’s admission Record (AR) dated 10/19/2024, the AR indicated Resident 218 has a diagnosis of Candidiasis (a yeast infection), unspecified (unable to determine the location). A review of Resident 218’s Order Summary Report, dated 10/19/2024, the order summary report indicated Resident 218 has an active order, dated 2/19/2025, for enhanced barrier precautions, for five infectious (a germ) organisms. During an observation on 8/20/2025 at 2:35 p.m., while at the door of Resident 218, LVN 9, did not perform hand hygiene before putting on gloves to assess Resident 218’s abdomen. LVN 9 did not perform hand hygiene after removing gloves, and LVN 9 did not perform hand hygiene before putting on another pair of gloves. During an observation on 8/22/2025 at 8:59 a.m., while at the door of Resident 1’s room, RT 1, did not perform hand hygiene before putting on gloves to assess Resident 1’s ventilator (a machine to replace breathing of a person) machine, and did not cleanse hands after removing gloves and leaving Resident 1’s room. During an interview on 8/20/2025 at 2:35 p.m., with LVN 9, LVN 9 stated staff should use soap or hand sanitizer before putting on gloves and after removing gloves. During an Interview on 8/20/2025 at 3:18 p.m., with RN 1, RN 1 stated staff should perform hand hygiene with an alcohol based cleaner before touching residents. The process is to cleanse with an alcohol-based cleanser and put on a pair of clean gloves. After giving care, staff should remove gloves, dispose of them, then cleanse hands with the alcohol-based cleanser. An interview on 8/22/2025 at 9:05 a.m., while outside Resident 1’s room, RT 1 stated if hand hygiene is not performed properly, germs can be spread from one resident to another. A review of Handwashing/Hand Hygiene policy, dated revised April 2019, the Handwashing/Hand Hygiene policy indicated personnel should use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before and after direct contact with residents. d. During a review of Resident 105’s admission Record (AR), the AR indicated Resident 105 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), osteomyelitis (inflammation of bone or bone marrow, usually due to infection), and cellulitis (a skin infection that causes swelling and redness). During a review of Resident 105’s Order Summary Report (OSR), dated 7/29/2025, the OSR (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident 105 had an order for Zosyn (combination antibiotic used to treat a wide range of bacterial infections) Intravenous (IV, administered into a vein) Solution every six (6) hours for right heel osteomyelitis for 6 weeks. During a review of Resident 105’s Minimum Data Set (MDS, a resident assessment tool), dated 8/2/2025, the MDS indicated Resident 105 had an intact cognition (ability to understand and process information). The MDS indicated Resident 105 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity) oral and toileting hygiene. The MDS indicated Resident 105 required substantial/maximal assistance (helper did more than half the effort) with shower, and lower body dressing. During a concurrent observation while inside Resident 105’s room and interview on 8/19/2025 at 8:58 am with Certified Nurse Assistant 3 (CNA 3), Resident 105 was in bed on Resident 105’s back. Resident 105 had a right upper arm peripherally inserted central catheter (PICC, a thin flexible tube inserted into a vein in the upper arm and advanced into a larger vein in the chest near the heart) line with two (2) uncovered ports. CNA 3 stated Resident 105’s IV tubing was looped and tucked into another port of the same administration set. During an interview on 8/21/2025 at 11:21 am with Registered Nurse Supervisor 1 (RN 1), RN 1 stated all PICC line ports and IV line tubing should be covered with IV [NAME] lock (a standard, threaded medical connector that provides a secure, twist-on, leak-proof connection for IV administration sets, syringes, and catheters) cap when not in use to prevent contamination and infection. During an interview on 8/21/2025 at 11:38 am with the Assistant Director of Nursing (ADON), the ADON stated PICC line ports and IV-line tubing should not be left uncovered when not in use and loop at the end of the same administration set for infection control. During a review of the facility’s policy and procedures (P&P) titled, “Administration Set/Tubing Changes,” revised February 2023, the P&P indicated, “Place a sterile end cap on the primary and/or secondary intermittent tubing when it is disconnected from the catheter. The sterile end cap is discarded when tubing is reconnected to the catheter. Do not attach (loop) the male [NAME] end of the administration set to a port of the same administration set. During a review of the facility’s P&P titled, “Central Venous Catheter Care and Dressing Changes,” revised March 2022, the policy indicated its purpose is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings.”

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain written informed consent for one of five sampled residents (Resident 7) for the use of Buspirone (an antianxiety medication use to treat anxiety [emotion characterized by feelings of tension, worried thoughts and physical changes]. This deficient practice had the potential to result in Resident 7 not receiving adequate or sufficient information regarding Buspirone to make an informed health care decision.Findings:During a review of Resident 7's admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included anxiety (emotion characterized by an unpleasant state of inner turmoil), depression (a feeling of severe sadness or hopelessness) and bipolar disorder (mental disorder with periods of depression and periods of elevated mood). During a review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/5/2025 the MDS indicated Resident 7 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 7 needed maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) to staff for lower body dressing. The MDS indicated Resident 7 needed moderate assistance (helper did less than half the effort) from staff for toileting hygiene, shower, upper body dressing and putting on/taking off footwear. During a review of Resident 7's Order Summary Report (OSR), dated 7/24/2025, the OSR indicated to administer Buspirone Hydrochloride (HCL) tablet 7.5 milligrams (mg) one tablet by mouth three (3) times a day for anxiety manifested by inability to physically rest/stay still causing distress. During a concurrent record review and interview on 8/19/2025 at 10:48 am with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated physician documentation of the Informed Consent for Resident 7's Buspirone used was not documented. LVN 4 stated the physician needed to inform Resident 7 to obtain informed consent for the use of any psychotropic medication. LVN 4 stated there was no other clinical documentation that consent was obtained for Resident 7 who received Buspirone. LVN 4 stated it was important to have an informed consent for residents receiving psychotropic medications and for the physician to discuss the risks and benefits and adverse effects (unwanted or undesirable effect) with Resident 7. During a concurrent interview on 8/19/2025 at 10:48 am with the Director of Nursing (DON) and record review of Resident 7's medical record (chart), the DON stated consent was not obtained prior to use of Buspirone. The DON stated it was important to have an informed consent for residents receiving psychotropic medications for the responsible party and residents to be aware of the risks and benefits and their needs to be discussed with residents or resident's responsible party by the physician. The DON stated psychotropic medications can have a harmful effect on the residents. During a record review of the facility's policy and procedure (P&P) titled, Psychoactive medication Informed Consent, dated 3/2024, the P&P indicated an informed consent for the specific medication will be obtained by the physician and verified by the nurse. The P&P indicated a signed consent form will be obtained as acknowledgement at the time of obtaining the informed consent by an ordering physician and/or mid-level practitioner. The P&P indicated a signed consent form will be obtained as acknowledgment at the time of verifying informed consent by the facility staff. If a signed consent cannot be obtained a telephone verification of the informed consent will be documented on the consent form by the facility staff.

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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 one of one sampled residents' (Resident 11) doctor of Resident 11's complaint of burning when urinating on 8/19/2025. This failure resulted in Resident 1 continuing to feel burning pain when urinating on 8/20/2025. (Cross Reference F550 and F684) Findings:During a review of Resident 11's admission Record (AR), the AR indicated Resident 11 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and bipolar disorder (a mental illness that causes unusual shifts in a person's mood).During a review of Resident 11's History and Physical (H&P), dated 6/7/2025, the H&P indicated, Resident 11 had the mental capacity to understand and make medical decisions.During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 8/5/2025, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 11 was dependent (helper does all the effort) on staff for bathing, dressing, and toileting hygiene. During a review of Resident 11's care plan titled Risk for Impaired Urinary Elimination., dated 7/29/2025, the care plan indicated facility staff were to notify Resident 11's healthcare provider immediately if Resident 11 had any voiding (urinating) abnormalities.During an interview on 8/19/2025 at 1:35 PM with Resident 11, Resident 11 stated Resident 11 had been recently treated for a urinary tract infection (UTI, an infection in any part of the urinary system, including the kidneys, bladder, or urethra). Resident 11 stated Resident 11 currently had another UTI because Resident 11 felt a burning pain when Resident 11 urinated. Resident 11 stated Resident 11 had told multiple nurses (unidentified) about Resident 11's burning pain with urination, but the unidentified nurses told Resident 11 that Resident 11 was fine.During an interview on 8/19/2025 at 2:00 PM with Licensed Vocational Nurse (LVN) 9, the surveyor informed LVN 9 that Resident 11 complained of feeling burning pain when Resident 11 urinated. LVN 9 stated LVN 9 would go and evaluate Resident 11.During an interview on 8/20/2025 at 10:06 AM with Resident 11, Resident 11 stated Resident 11 still felt burning pain when Resident 11 urinated. Resident 11 stated Resident 11 had complained to multiple staff (unidentified) about the pain on 8/19/2025 but that no one did anything about Resident 11's complaint.During an interview on 8/20/2025 at 10:09 AM with LVN 9, LVN 9 confirmed Resident 11 had complained to LVN 9 that Resident 11 experienced burning pain when Resident 11 urinated. LVN 9 stated LVN 9 did not notify Resident 11's doctor of Resident's complaint of burning when urinating. LVN 9 stated LVN 9 notified Registered Nurse (RN) 4 about Resident 11's complaint of burning when urinating.During an interview on 8/20/2025 at 10:15 PM with RN 4, RN 4 stated burning when urinating is a symptom of a UTI. RN 4 stated if a resident (in general) complained of burning when urinating, the staff should call the resident's (in general) doctor. RN 4 stated RN 4 did not notify Resident 11's doctor of Resident 11's complaint of feeling burning pain when urinating.During a concurrent interview and record review on 8/21/2025 at 9:06 AM with RN 1, Resident 1's lab report (LR) titled, Urinalysis, collected 8/20/2025 was reviewed. The LR indicated Resident 11's urine showed a large amount of Leukocyte esterase (an enzyme test that detects the presence of white blood cells [WBCs] or their enzymes in the urine, which often signals a UTI) and positive for nitrite (can indicate a bacterial UTI). RN 4 stated Resident 11's LR indicated Resident 11 had a UTI. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status revised 11/2015, the P&P indicated, Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The P&P indicated, The Nurse Supervisor/Charge Nurse will notify the resident's (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attending Physician or On-Call Physician when there has been.A significant change in the resident's physical/emotional/mental condition.A need to alter the resident's medical treatment significantly.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to maintain a clean and stain-free floors of Resident 86's room and in Station 4 shower rooms.This failure resulted in an unsanitary appearance and did not maintain a homelike environment for the residents. Findings:During a review of Resident 86's admission Record (AR), the AR indicated the facility admitted Resident 86 on 5/27/23 with diagnoses that included Type 2 diabetes mellitus (elevated blood sugar level) and acute kidney failure (kidneys are not able to filter waste).During a review of Resident 86's History & Physical (H&P) dated 5/30/25, the H&P indicated Resident 86 had the capacity to make medical decisions.During a review of Resident 86's Minimum Data Set (MDS, a resident assessment tool) dated 8/16/25, the MDS indicated Resident 86 was independent for shower/bathing self.During a concurrent observation and interview on 8/22/25, at 3:30 p.m., with the Maintenance Supervisor (MS), Resident 86's floor had black stains. The MS stated the MS and the MS's staff check each resident's room weekly and there was no log kept. The MS stated the black stains observed on Resident 86's floor were dirt. During a concurrent observation and interview with the MS, two Station 4 shower rooms were observed. A black colored substance was observed on the floor and grout of the showers. The MS stated it could be cleaner and there was no log kept. The MS stated it was important for the floor areas to be cleaned because it has to be like a house and their home.During a review of the facility's Policy and Procedure (P&P), titled, Quality of Life-Homelike Environment, revised May 2017, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.

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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 a plan of care for one of one sampled resident (Resident 7), who sustained a fall on 8/15/2025, as indicated in the facility's policy Care Plans, Comprehensive Person Centered. This deficient practice had the potential to place Resident 7 at risk for recurrent falls.Findings: During a review of Resident 7's admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included anxiety (emotion characterized by an unpleasant state of inner turmoil), depression (a feeling of severe sadness or hopelessness) and bipolar disorder (mental disorder with periods of depression and periods of elevated mood). During a review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/5/2025, the MDS indicated Resident 7 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 7 needed maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) to staff for lower body dressing. The MDS indicated Resident 7 needed moderate assistance (helper did less than half the effort) to staff for toileting hygiene, shower, upper body dressing and putting on/taking off footwear. During a review of Resident 7's Care Plan titled, Fall, initiated on 7/8/2025, the care plan did not indicate that Resident 7 had a fall on 8/15/2025. The care plan interventions indicated for nursing staff to keep the resident's bed in its lowest position and to place bilateral floor mats. During a review of Resident 7's Fall Risk Evaluation (FRE- method of assessing a patient's likelihood of falling), dated 8/15/2025, the FRE indicated Resident 7 was assessed as having had 3 or more falls in the past 3 months, had balance problem while standing, and while walking and required use of assistive devices and had a risk for falls. During a review of the interdisciplinary team (IDT) conference record dated 8/18/2025, the IDT record indicated Resident 7 had a syncopal (temporary loss of consciousness usually related to insufficient blood flow to the brain) episode and laid down on the floor. The IDT record indicated the interventions provided to Resident 7 for fall management were short term and long-term care plan for care plan for fall was updated. During an interview and concurrent record review on 8/19/2025 at 3:48 pm, with Licensed Vocational Nurse 5 (LVN 5) of Resident 7's medical records (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities and chart), LVN 5 stated Resident 7 had a fall on 8/15/2025 and the care plan for falls was not revised. LVN 5 stated Resident 7's CP for falls needed to be revised to determine if nursing interventions for the fall was effective or not. During an interview on 8/22/2025 at 9:52 am, with the facility Director of Nursing (ADON), the DON stated the care plan for falls needed to be revised to address nursing interventions for Resident 7 after a fall on 8/15/2025. The DON stated Resident's 7's care plan needed to be revised to determine if fall interventions were effective or not to prevent future falls. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person - Centered, revised 3/2022, the P&P indicated the assessment of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The P&P indicated the interdisciplinary team reviews and updates the care plan when there has been a significant change in the residents' condition, when the desired outcome is not met, when a resident has been readmitted to the facility from a hospital stay.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff members failed to provide peri-care (the cleaning and maintenance of the perineum, the area between the anus and the genitals) for two of two sampled residents, (Resident 136 and Resident 27), who required physical assistance with toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement). This deficient practice had the potential to place Resident 136 and Resident 27 at risk for increased risk for infection, skin breakdown and further potential health complications.Findings:a). During a review of Resident 136's admission Record (AR), the AR indicated Resident 136 was admitted to the facility on [DATE] with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD- is a common lung disease causing restricted airflow and breathing problems), type 2 diabetes (elevated sugar in the blood), pneumonia (is an infection that inflames the air sacs in one or both lungs), morbid obesity (a person's body has a lot of extra weight) with alveolar hypoventilation (is a breathing disorder that affects some people who have obesity). During a record review of Resident 136's History and Physical (H&P), dated 7/17/2025, the H&P indicated Resident 136 does has the capacity to understand and make decisions. During a review of Resident 136's Minimum Date Set (MDS - a resident assessment tool), dated 7/22/2025, indicated Resident 136 required dependent care (helper does all of the effort, the resident does none of the effort to complete the activity) from staff for toileting hygiene, shower/bathing self and putting on/taking off footwear. During a review of Resident 136's Skin Check (SC) dated 7/17/2025 at 2:49 PM, the SC indicated Resident 136 with a new skin issue the middle are of the sacrum (a triangular bone at the base of the lower back) that was present on admission considered a pressure ulcer/injury (damage to the skin caused by continuous pressure) Stage 3 full-thickness skin loss (a bedsore where the skin is destroyed and extending into deeper tissue and fat) and surrounding tissue to be fragile with skin that is at risk for breakdown. Additional care areas indicated incontinence management and mattress with pump. During a review of Resident 136's untitled Care Plan Report (CP) dated 7/17/2025, the CP indicated Resident has problems with Activities of Daily Living (ADL- referring to fundamental personal care tasks such as bathing, dressing, eating, transferring, toileting, and managing continence) decline by decline in functional mobility skills and potential for skin break down. The goal is to prevent skin breakdown but there are no ADL maintenance or repositioning included or documented in any other CP in Resident 136's medical record (MR). During a review of Resident 136's Wound Evaluation & Treatment Progress Note (WETPN) dated 8/14/2025, the WETPN indicated Resident 136's skin exam indicated the sacrococcyx (the tail bone located at the base of the spine), and sacral region (lower back) wound closed. The listed recommendations indicated aggressive offloading (refers to the practice of relieving or redistributing pressure from a specific area of a patient's body to prevent and treat wounds, especially pressure ulcers) recommended every two (2) hours turning; no sitting beyond two hours; frequent diaper checks and changes; Additional recommendations indicated to turn patient every two hours and to keep skin clean and dry.b). During a review of Resident 27's AR, the AR indicated Resident 27 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included end stage renal disease (a severe and irreversible condition where the kidneys have lost most of their function and can no longer adequately filter waste products from the blood), cutaneous abscess (a collection of pus under the skin) of the groin (the area between the abdomen and the thigh), laceration with foreign body of right buttock, necrotizing fasciitis (a bacterial infection that enters the body, most commonly through a break in the skin such as a cut, scrape, or burn), morbid (severe) obesity due to excess calories, type 2 diabetes (sugar in the blood) and inflammation of the vagina and vulva.During a review of Resident 27's untitled CP dated 7/23/2025, the CP indicated Potential for infection related to surgical incision on right groin extended to right buttock. Interventions indicated to keep area clean and dry.During a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 27's MDS dated [DATE], the MDS indicated Resident 27 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene and upper body dressing. Resident 27 was dependent on staff assistance for shower/bathing self and putting on/taking off footwear and lower body dressing.During a record review of Resident 27's H&P, dated 8/17/2025, the H&P indicated Resident 27 does has the capacity to understand and make decisions.During a review of Resident 27's untitled CP dated 8/17/2025, the CP indicated Resident has problems with ADL decline, by a decline in functional mobility skills and potential for skin break down. The goal is to prevent skin breakdown but there was no ADL maintenance or repositioning included or documented in any other CP in Resident 27's MR.During initial observation and interview with Resident 27 on 8/19/2025 at 10:04 AM, Resident 27 was observed sitting at the side of the bed. Resident 27 stated, I want to get clean. When they do peri-care, I don't feel clean. The staff do it for me. I'm all dirty. It makes me feel mad and sad at the same time. I'm a very clean person; it makes me feel staff is not listening to me. During an initial observation and interview with Resident 136 on 8/19/2025 at 11:03 AM, Resident 136 was observed to be sitting up in bed watching television (TV). Resident 136 stated, I've had a bowel movement (BM) since 7:30 AM. I've been calling them all morning. It's 11:07 AM now and I'm still waiting. I'm afraid my wounds will come back. I am very upset and embarrassed. Sometimes I wait up to three (3) hours to get cleaned up. I call and they don't come. During an interview with License Vocational Nurse (LVN9) on 8/19/2025 at 11:11 AM, LVN9 stated Resident 136 should not have been waiting since 7:30 AM to be cleaned up by staff especially if Resident 136 had a bowel movement. LVN9 stated it was not sanitary, and it must be uncomfortable for Resident 136 to be soiled for such a long period of time. LVN9 stated she would go look for Certified Nursing Assistant (CNA4) to have Resident 136 cleaned up. LVN9 stated that CNA4 was assigned to Resident 136 but CNA4 was busy with another resident and that CNA4 would clean up Resident 136 when there was a chance. During an interview with CNA4 on 8/19/2025 at 11:14 AM, CNA4 stated there were 10 residents on his assignment for the day and someone might have answered the call light earlier and not communicated to CNA4 that Resident 136 was soiled. CNA4 stated he was busy earlier because there was a room change. CNA4 stated that the Cnas can feel overworked and burned out at times and feel like they don't have time to change all the residents in their assignments in a timely manner. During a concurrent interview with CNA4 on 8/20/2025 at 11:39 AM, CNA4 stated, I do find some of the alert residents that have been waiting for a long period of time tell me the previous shift staff answered the call light but never provided the care they were requesting. Sometimes when I check a resident to clean them up, they are very soiled. They have gone urine or poo once or twice in the same diaper. Per CNA4, the LVNs or Charge Nurses (CN) are supposed to help, and they can also do the job. During a concurrent interview with Resident 27 on 8/20/2025 at 11:54 AM, Resident 27 stated that the day before, after dinner she had a BM and felt dirty, and her vaginal area was itchy. Resident 27 stated she asked the night shift Cna to clean her. Resident 27 stated that when the night shift Cna cleaned her vaginal area, the Cna showed Resident 27 the towel she used to clean her and showed Resident 27 that she still had poop in her vagina. Per Resident 27 the day shift cna (CNA4) had not cleaned her properly. During an interview with LVN10 on 8/20/2025 at 11:56 AM, LVN10 stated The residents should get showers and peri-care often for hygiene and to prevent infections or skin problems. It is not acceptable to have a resident sitting in their own filth for long periods of time. This can make them feel terrible, helpless, neglected, sad and depressed. Feeling this way puts them at risk for depression or anxiety withdrawal. During an interview with Infection Prevention Nurse (IPN) on 8/21/2025 at 3:10 PM, the IPN stated residents need to be provided with hygiene and peri-care as needed. The IPN stated that it's not acceptable to leave a resident for long periods of time if they are soiled. Per IPN, a resident that is left in soiled conditions for extended periods of time can have serious infection risks like skin tears, skin inflammation and bedsores. IPN stated, The combination of moisture and bacteria from urine and feces creates an environment that can quickly lead to skin breakdown, and other health (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complications. Also, it would make the resident feel uncomfortable, embarrassed and neglected, and their self-esteem would go down making them feel depressed. During an interview with the DON (DON) on 8/22/2025 at 9:10 AM, the DON stated that it is not acceptable for a resident to be in bed soiled for hours. The DON stated, As soon as a staff identify the resident needs to be changed, the resident still needs to be cleaned. Anyone can do it, including an LVN or RN. This is part of the supervision and mentoring the license nurses must provide to the cna. Per the DON if the resident does not receive proper ADLs including peri-care, the resident will be uncomfortable causing them discomfort and possibly suffering from irritating skin. During an interview with the Treatment Nurse (TN1) on 8/22/2025 at 1:33 PM, TN1 stated that ADLs and timely peri-care must be provided to all residents. TN1 stated that especially when residents are at risk of skin breakdown or have wounds it's extremely important to prevent infections. Per TN1, the main thing is to prevent infections and provide comfort. TN1 stated, It's not acceptable for a resident to be soiled and just have the resident sit there from 7 AM to 11:30 AM. The residents with wounds need to be repositioned as well. Even if the staff is busy, under no circumstances should the resident go for a long period of time without being changed. Per TN1, if a resident is left for long periods of time soiled or not being cleaned completely, it would make the resident feel uncomfortable, embarrassed and neglected. During a review of the facilities Policy and Procedures (P&Ps) titled, Activities of Daily Living (ADL), Supporting revised March 2018 indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During a review of the facilities P&P titled, Perineal Care, revised February 2018 indicated, The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin conditions. During a review of the facilities P&P titled, Residents Rights, revised December 2016 indicated Employees shall treat all residents with kindness, respect and dignity. During a review of the facilities P&P titled, Quality of Life-Dignity, revised February 2020 indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. For example, promptly responding to a resident's request for toileting assistance.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure bilateral (both sides) hand rolls (a cylindrical device used to support and position the hand) were maintained in correct position for one of one sampled resident (Resident 125).This failure had the potential for a decline in range of motion (ROM, measure of joint flexibility and functionality), stiffness, and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) for Resident 125. Findings:During a review of Resident 125's admission Record (AR), the AR indicated Resident 125 was admitted to the facility on [DATE] with diagnoses that included traumatic subarachnoid hemorrhage (a collection of blood that accumulates between the inner layer of the skull and the surface of the brain after a head injury), surgery on the nervous system (a complex network of organs, tissues, and cells that controls and coordinates all bodily functions), and benign prostatic hyperplasia (BPH, enlarged prostate gland).During a review of Resident 125's Minimum Data Set (MDS, a resident assessment tool), dated 7/29/2025, the MDS indicated Resident 125 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 125 was dependent (helper did all the effort) to staff with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.During a review of Resident 125's Order Summary Report (OSR), dated 7/29/2025, the OSR indicated Resident 125 had an order for Restorative Nurse Assistant (RNA, a specialized role for certified nursing assistants that involves training in rehabilitation skills) to apply bilateral hand rolls for up to six (6) hours, five (5) times a week and for RNA to monitor skin integrity, pain and discomfort during or after splint (an external device used to support, protect, and immobilize an injured body part by preventing further damage and movement) application.During a concurrent observation inside Resident 125's room and interview on 8/19/2025 at 10:37 am with Licensed Vocational Nurse 1 (LVN 1), Resident 125 was awake, lying in bed with a hand roll on Resident 125's left hand. LVN 1 stated Resident 125's right hand roll was on the bed and not in Resident 125's right hand. LVN 1 stated the RNA should ensure the hand rolls were in place and kept in Resident 125's right hand throughout the duration of the treatment to provide effective treatment and prevent further contractures.During an interview on 8/20/2025 at 3:58 pm with RNA, the RNA stated residents on RNA services like hand rolls and/or splints should be monitored to ensure the hand rolls were properly applied and maintained throughout the duration of the application to prevent further contracture and decrease in mobility.During the interview on 8/21/2025 at 11:51 am with the Director of Nursing (DON), the DON stated the RNA should ensure splints and hand rolls were applied properly and kept in place throughout the duration of the application to prevent further contracture and decrease in range of motion.During a review of the facility's policy and procedures (P&P) titled, Resident Mobility and Range of Motion, revised July 2017, the P&P indicated, Resident with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Foley catheter (FC, a thin, flexible, rubber or plastic tube used to drain urine from the bladder) was secured on the resident's thigh in accordance with the facility's Policy and Procedure (P&P) Catheter Care, Urinary) for one of four sampled residents (Resident 131).This failure had the potential for Resident 131 to result in catheter-related complications.Findings:During a review of Resident 131's admission Record (AR), the AR indicated Resident 131 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body affecting the face, arm, or leg), acute kidney failure (a condition where the kidneys suddenly lose their ability to function properly) and urinary tract infection (UTI, an infection in the bladder/urinary tract).During a review of Resident 131's Order Summary Report (OSR), dated 8/9/2025, the OSR indicated Resident 131 had an order for a FC to gravity drainage every day shift.During a review of Resident 131's Minimum Data Set (MDS, a resident assessment tool), dated 8/12/2025, the MDS indicated Resident 131 had an intact cognition (ability to understand and process information). The MDS indicated Resident 131 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, required substantial/maximal assistance (helper did more than half the effort) from staff with toileting, upper and lower body dressing and dependent (helper did all the effort) from staff with shower.During a concurrent observation inside Resident 131's room and interview on 8/19/2025 at 9:38 am with Certified Nurse Assistant 1 (CNA 1), Resident 131 was in bed with FC hanging on the right metal frame of the bed. CNA 1 stated Resident 131's FC tubing did not have a securement device and was not secured on Resident 131's thigh. CNA 1 stated the FC tubing should be secured properly on the resident's thigh to prevent pulling during Resident 131's movement. During an interview on 8/21/2025 at 11:44 am with the Director of Nursing (DON), the DON stated all residents with indwelling catheters should have a securement device and tubing secured on the resident's thigh to hold the catheter in place and to prevent pulling and cause injury or trauma to the resident during mobility and transfers.During a review of the facility's Policy and Procedure (P&P) titled, Catheter Care, Urinary, revised August 2022, the P&P indicated, Ensure the catheter remains secured with a securement device to reduce friction and movement at the insertion site.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for a resident with gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) for one of two sampled residents (Resident 75) by failing to:a. Ensure Resident 75's GT site dressing was changed consistently with the physician's order.b. Ensure an individualized and comprehensive GT site plan of care was developed for Resident 75.These failures had the potential for complications related to tube feedings for Resident 75.Findings:a. During a review of Resident 75's admission Record (AR), the AR indicated Resident 75 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included respiratory failure (a medical condition where the lungs are unable to adequately exchange oxygen and carbon dioxide between the body and the environment), dysphagia (difficulty swallowing), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach).During a review of Resident 75's Order Summary Report (OSR), dated 2/9/2025, the OSR indicated Resident 75 had a treatment order for licensed staff to clean the mid-abdomen GT site with normal saline (NS), pat dry and cover with dry dressing daily, every day shift.During a review of Resident 75's Minimum Data Set (MDS, a resident assessment tool) dated 5/28/2025, the MDS indicated Resident 75 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 75 was dependent (helper did all the effort) to staff with eating, oral hygiene, toileting, shower, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 75 had a feeding tube for nutrition.During a review of Resident 75's Treatment Administration Record (TAR), dated August 2025, the TAR indicated Resident 75's GT site dressing treatment was not completed on 8/20/2025 and 8/21/2025.During a concurrent observation inside Resident 75's room and interview on 8/19/2025 at 10:03 am with Certified Nurse Assistant 1 (CNA 1), Resident 75 was in bed, and lying on Resident 75's back. CNA 1 stated Resident 75's GT site dressing was wet and soaked in yellow-colored liquid. CNA 1 stated CNA 1 did not know when the GT site dressing was changed.During an interview on 8/19/2025 at 10:37 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated GT site should be changed daily and as needed to keep the GT site clean and dry all the time to prevent skin irritation and skin breakdown and cause infection on the GT site.b. During a concurrent interview and record review of Resident 75's Care Plans on 8/20/2025 at 3:52 pm with Registered Nurse Supervisor 3 (RN 3), RN 3 stated Resident 75 did not have a care plan developed to address Resident 75's GT site care. RN 3 stated a care plan specific and centered on Resident 75's needs and treatment should have been developed to ensure necessary and appropriate interventions were provided for Resident 75.During an interview on 8/21/2025 at 11:48 am with the Director of Nursing (DON), the DON stated, the GT site needed to be kept clean, dry, covered, and secured to prevent skin irritation on the surrounding area around the GT site for infection prevention. The DON stated all residents with GT site should have a care plan to address the needs of the resident and assist and guide the staff on how to provide care and treatment to the residents with GT.During a review of the facility's policy and procedures (P&P) tiled, Gastrostomy/Jejunostomy Site Care, revised October 2011, the P&P indicated, To promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection. Review the residents' care plan and provide for any special needs of the resident. Assess the stoma site for signs of redness, pain or soreness, swelling or drainage. If the stoma has signs of irritation or infection, clean the area several times a day.During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person - Centered, revised 3/2022, the P&P indicated the comprehensive, person-centered care plan is develop within seven days of the completion of the required MDS assessment (Admission, Annual, or significant change in status), and no more than 21 days after admission.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to manage urinary tract infection (UTI- bacteria enter the urinary tract) symptoms and urinary pain for one of four sampled residents (Resident 58).This deficient practice resulted in Resident 58 experiencing unrelieved pain which caused physical and emotional distress and did not maintain the resident's highest practical physical and mental well-being. (Cross Reference F684) Findings:During a review of Resident 58's admission Record (AR), the AR indicated Resident 58 was admitted to the facility on [DATE] with diagnoses that included pericardial effusion (buildup of fluid in the membrane that surrounds the heart), Type 2 diabetes mellitus (elevated blood sugar levels) with chronic kidney disease (kidneys unable to filter waste), and chronic obstructive pulmonary disease (blocked airflow making it difficult to breathe). During a review of Resident 58's Physician's Order (PO) dated 9/7/24, the PO indicated for licensed staff to administer Acetaminophen Oral Tablet 325 milligrams (mg-unit of measurement), 2 tablets by mouth, every four hours as needed for pain management, mild pain (1-3). During a review of Resident 58's PO dated 9/7/24, the PO indicated for licensed staff to administer Acetaminophen-Codeine Oral tablet 300-60 mg, one tablet by mouth, every four hours as needed for pain management for moderate to severe pain.During a review of Resident 58's History & Physical (H&P) dated 9/9/24, the H&P indicated Resident 58 had the capacity to make medical decisions.During a review of Resident 58's Physician Orders (PO) dated 11/10/24, the PO indicated pain assessment every shift: 0-No Pain, 1-3 mild pain,4-6 moderate pian, 7-10 severe pain.During a review of Resident 58's Minimum Data Set (MDS, a resident assessment tool) dated 6/6/25, the MDS indicated Resident 58 was cognitively intact (ability to understand and process thoughts), and required substantial/maximal assistance with toileting and personal hygiene.During a review of Resident 58's short term care plan dated 7/21/25 for pain when urinating, the CP indicated for nursing staff to notify Resident 58's physician (MD) of any changes.During a review of Resident 58's Progress Note (PN) dated 8/18/25 at 3:40 p.m., the PN indicated Resident 58 complained of dysuria (discomfort when urinating), was treated with antibiotics last month and will check the resident's urine again.During an interview on 8/20/25 at 8:34 a.m., Resident 58 stated Resident 58 had pain when urinating for three weeks. Resident 58 stated Resident 58 had taken two antibiotics but Resident 58 had no relief. Resident 58 stated Resident 58 told everybody in the facility that Resident 58 still had urinary pain, but the facility staff did not address her complaint of pain. During an interview on 8/20/25 at 3:45 p.m., Resident 58 stated Resident 58 had radiating 10/10 back pain when urinating, based on the pain scale (0= no pain, 10=worst pain). During a concurrent interview and record review on 8/20/25 at 4:30 p.m. with Licensed Vocational Nurse (LVN 3) of Resident 58's Progress Notes (PN) dated 8/18/25, the PN indicated Urine Analysis (UA) and Culture and Sensitivity (C&S- used to identify the specific bacteria causing infection). LVN 3 stated the UA and C&S were not carried out. LVN 3 stated licensed staff needed to check the physician (MD)/ Family Nurse Practitioner (FNP) Progress Note following a physician's assessment. During a review of Resident 58's Electronic Medical Record (EMR) with LVN 3, the EMR did not indicate a Situation, Background, Assessment, and Recommendation (SBAR- helps team share information) for Resident 58's complaint of dysuria noted in the MD progress note dated 8/18/25.During an interview on 8/20/25 at 4:38 p.m. with LVN 3, LVN 3 stated the FNP stated FNP forgot to tell the licensed staff to do UA with CS. During an interview on 8/20/25 at 5:00 p.m. with LVN 3, LVN 3 stated Certified Nurse Assistants (CNA) should communicate to licensed staff any foul smell or any complaints of pain reported by a resident to the licensed staff.During an interview on 8/20/25 at 5:20 p.m. at Resident's 58's bedside, Resident 58 stated Resident 58 had pain when urinating.During a phone interview on 8/22/25, at 8:55 a.m. with the FNP, the FNP stated the plan for a UA and CS was communicated to the nursing staff on 8/18/25 after FNP assessed Resident 58 but the FNP stated the FNP did not know the licensed nurse's name to whom the plan was (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicated. The FNP stated the UA & CS for Resident 58 was missed. The FNP stated, the FNP would communicate orders verbally after resident assessments during on site to the nursing staff and a telephone order was written. The FNP stated Pyridium (a urinary analgesic that relieves pain) administration for pain upon urination was delayed. The FNP stated the FNP would refer residents to Urology (medical specialty that focuses on diagnosis and treatment of disorders related to the urinary tract system) but Resident 58 was not referred to Urology.During an interview on 8/22/25 at 10:34 a.m., with LVN 15, LVN 15 stated Resident 58 had a history of UTI. LVN 15 stated the care plan to address pain upon urination was not revised. LVN 15 stated the care plan was important because the care plan had interventions to manage the problem and track actions being taken to prevent further symptoms on the resident.During a review of the facility's Policy and Procedure (P&P), titled, Pain Assessment and Management, revised April 2018, the P&P indicated the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an informed consent (voluntary agreement to accept treatment and/or procedure after receiving education regarding the risks, benefits and alternatives offered) was obtained before the installation of bilateral (both sides) upper half siderails (adjustable metal or rigid plastic bars attached to the bed) for one of one sampled resident (Resident 8).This failure placed Resident 8 at risk for entrapment (an event in which a resident was caught, trapped, or entangled in the tight spaced around the bed) and injury from the use of siderails. Findings:During the review of Resident 8's admission Record (AR), the AR indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and osteoporosis (weak and brittle bones, due to lack of calcium and vitamin D).During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 7/26/2025, the MDS indicated Resident 8 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 8 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.During a concurrent observation while inside Resident 8's room and interview on 8/19/2025 at 9:35 am with Certified Nurse Assistant 2 (CNA 2), Resident 8 was lying in bed, on Resident 8's back with upper half side rails up on both sides of the bed. CNA 2 stated Resident 8 had bilateral arms and hands contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). CNA 2 stated Resident 8 was dependent in all activities of daily living (ADLs) and did not have the ability to hold on to the side rails during positioning and bed mobility.During a concurrent interview and record review on 8/20/2025 at 10 am with Licensed Vocational Nurse 1 (LVN 1), Resident 8's OSR and medical record (chart) were reviewed. LVN 1 stated the OSR did not indicate Resident 8 had an order for bilateral upper half side rails use. LVN 1 stated there was no record that an informed consent was obtained before the installation of bilateral upper half side rails. LVN 1 stated side rails should not be installed without a doctor's order and a signed informed consent for the safety of the residents.During an interview on 8/21/2025 at 11:48 am with the Director of Nursing (DON), the DON stated all residents on side rail use need to have a doctor's order and a signed informed consent obtained before the installation of side rails to make sure that resident and/or responsible party were informed, and risks and benefits of side rail use were explained to prevent injury to the resident and restrict the resident's bed mobility.During a review of the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, revised August 2022, the P&P indicated, The use of bed rails or side rails (including temporarily raising the side rails, for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.

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	08/22/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observation, interview and record review, the facility failed ensure one of five sampled resident (Resident 34) was free from unnecessary drugs as indicated in the facility's policy and procedure titled, Administering Medication. This deficient practice had the potential to result in unnecessary use of Tylenol (Acetaminophen, medicine that relieves mild to moderate pain and reduces fever). Findings:During a review of Resident 34's admission Record (AR), the AR indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure (condition characterized by a gradual loss of kidney function over time) and heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs).During a review of Resident 34's Order Summary Report (OSR), dated 6/30/2025, indicated to administer Tylenol Oral Tablet 325 milligrams (mg, unit of measurement), give two (2) tablet by mouth in the morning for pain. Give 30 minutes prior (before) to wound care, not to exceed (NTE) three (3) grams (gr, unit of measurement) in 24 hours. During a review of Resident 34's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/15/2025, the MDS indicated Resident 34 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 34 was dependent (helper does all of the effort) to staff for toileting hygiene and shower. The MDS indicated Resident 34 needed maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) to staff for upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a medication pass observation on 8/21/2025 at 8:33 am, Licensed Vocational Nurse 8 (LVN 8) attempted to administer 2 tablets of Tylenol Oral Tablet 325 mg prior to wound care to Resident 34. During an interview on 8/21/2025 at 8:34 am, Resident 34 stated I don't have any wound. I don't want to take Tylenol.During an interview on 8/21/2025 at 9:30 am, with LVN 8, the LVN 8 stated, Tylenol was discontinued now (8/21/2022) because patient (resident) doesn't have any wound. Patient's wound was resolved.During an interview with the facility's Director of Nursing (DON) on 8/21/2025 at 10:08 am, the facility DON stated, Resident 34 did not need Tylenol Oral Tablet routinely because Resident 34's wound treatment was resolved. The DON stated Tylenol Oral Tablet was ordered to administer prior to wound care and Resident 34 did not have any wound. The facility DON stated it was unnecessary for Resident 34 to take Tylenol Oral Tablet for resident did not have wound or did not need wound treatment. During a concurrent review of Resident 34's Skin Observation Tool (SOT) dated 8/15/2025, and an interview with Registered Nurse 2 on 8/21/2025 at 2:05 pm, the SOT indicated Resident 34 was seen and evaluated by the wound consultant and had an order to discontinue treatment to the left anterior (front) lower leg wound. RN 2 stated the wound treatment was discontinued by the wound consultant on 8/15/2025. RN 2 stated Resident 34's wound was resolved.During a concurrent review of Resident 34's Medication Administration Record (MAR) dated from 8/1/2025 to 8/31/2025, and an interview with RN 2 on 8/21/2025 at 2:07 pm, the MAR indicated Resident 34 received Tylenol Oral tablet 325 mg, 2 tablets by mouth in the morning for pain, give 30 minutes prior to wound care from 8/16/2025 to 8/20/2025. The MAR indicated on 8/21/2025 Resident 34 refused to take Tylenol oral tablet. RN 2 stated Tylenol Oral tablet 325 mg should not have been administered since 8/16/2025 because the wound was resolved on 8/15/2025. RN 2 stated Resident 34 was receiving unnecessary medication because there was no existing wound or treatment to be done. During a review of the facility's policy and procedure (P&P) titled, Administering Medication, revised 12/2012, the P&P indicated medications shall be administered in a safe and timely manner, and as prescribed. The P&P indicated medications must be administered in accordance with the orders, including any required time frame.

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	08/22/2025

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

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

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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 four sampled residents (Resident 118), received and was provided food that accommodated Resident 118's food preferences.This deficient practice had the potential for Resident 118 to develop further weight loss. Findings:During a review of Resident 118's admission Record (AR), the AR indicated Resident 118 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM II - adult onset disorder characterized by difficulty in blood sugar control), anemia (a condition where the body does not have enough healthy red blood cells) and muscle wasting and atrophy (partial or complete wasting away of a part of the body).During a review of Resident 118's Order Summary Report (OSR) dated 3/31/2025, the OSR indicated CCHO (consistent controlled carbohydrate) regular texture, regular/thin consistency IDDSI (International Dysphagia Diet Standardization Initiative - an international collaboration of professionals who developed a standardized framework for labeling texture-modified foods and thickened liquids) Level 7 (foods are soft, tender, and easy to chew) diet for Resident 118.During a review of Resident 118's Minimum Data Set (MDS - a resident assessment tool) dated 7/7/2025, the MDS indicated, Resident 118 had intact cognition (ability to understand). The MDS indicated Resident 118 was independent (resident completes the activity by themselves with no assistance from a helper) for eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). The MDS indicated Resident 118 had no signs and symptoms of possible swallowing disorder and was on a therapeutic diet (specifically designed meal plan used to treat or manage a specific health condition).During an interview on 8/20/2025 at 9:40 AM with Resident 118, Resident 118 stated, the food at the facility was terrible. Resident 118 stated, Resident 118 had lost eighty pounds since 3/31/2025 because Resident 118 did not eat the food at the facility. Resident 118 stated, Resident 118 needed to lose weight. Resident 118 stated, Resident 118's preference was no bread and no rice, but Resident 118 was served with bread and rice every meal.During a concurrent observation, interview, and record review on 8/21/2025 at 1:00 PM with Resident 118 and the Dietary Supervisor (DS), at Resident 118's bedside, Resident 118's tray card (a card used to identify a person's dietary needs and other important information for meal service, such as a patient's diet, allergies, and dislikes placed on a resident's meal tray) was reviewed. The tray card indicated no bread and liked green salad with tomatoes. Resident 118's meal tray had a bread roll and a small bowl of cut up lettuce only. Resident 118 stated, Resident 118 did not like bread and requested for no bread and the small bowl of cut up lettuce, was not a salad. During a review of the facility's Policy and Procedure (P&P) titled, Resident Food Preferences, revised 7/2017, the P&P indicated the food service department would offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. During a review of the facility's P&P titled, Food and Nutrition Services, revised 10/2017, the P&P indicated, each resident was provided with nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The P&P indicated, reasonable efforts would be made to accommodate resident choices and preferences. The P&P indicated, Food and Nutrition staff would inspect food trays to ensure that the correct meal was provided to each resident.