STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056438	A. Building B. Wing	04/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flower Villa, Inc	1480 S. LA Cienega Bl Los Angeles, CA 90035

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of one sampled resident (Resident 9) was free from unnecessary physical restraint (any manual method, physical or mechanical device, material, or equipment attached to a patient's body that restricts freedom of movement or normal access to their body, which they cannot easily remove), by failing to 1. Justify medical indications for applying mittens (padded, glove-like medical device considered a form of physical restraint) on Resident 9. 2. Obtain a doctor's order prior to application of physical restraints on Resident 9. These deficient practices had the potential for significant negative implications including delirium, pressure injuries, and psychological trauma and had the potential to compromise patient dignity, autonomy, and quality of care by causing severe physical deconditioning, reduced dignity and increase the risk mortality for Resident 9. Findings: A review of Resident 9's admission record indicated the resident was originally admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included weakness, neuropathy (damage to or dysfunction of the peripheral nerves), gastrostomy status (surgically created opening (stoma) in the stomach wall used for long-term feeding, hydration, or medication administration,), displaced fracture of shaft of right clavicle (a broken collarbone where the bone ends are out of alignment), dysphagia (difficulty swallowing,), dementia (a decline in mental function-specifically memory, reasoning, and communication-severe enough to disrupt daily life) and schizophrenia (severe mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions). A review of Resident 9's History and Physical (H&P) dated 1/28/2026 indicated Resident 9 did not have the capacity to understand and make decisions. A review of Resident 9's Minimum Data Set (MDS-a resident assessment tool), dated, 3/25/2026, indicated Resident 9's cognitive (mental ability to make decisions for daily living) was severely impaired, Resident 9 was totally dependent for oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, putting on/taking off footwear and was non-ambulatory. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 2 on 4/12/2026 at 8:24, LVN 2 stated she did not know why Resident 9 had mittens restraints placed bilaterally on Resident 9's left and right hands. During an on 4/12/2026 at 12:15pm, (Minimum Data Set Coordinator- (MDSC) stated Resident 9 is not supposed to have restraints because there were no indications justifying use and/or doctor's orders to restrain Resident 9. During an interview on 4/12/2026 at 7:13 pm, Director of Nursing (DON) stated applying physical restraints on a resident without indications for use and a doctor's order is a violation of the Residents rights and Residents dignity. DON stated the physical restraints could cause physical injuries and harm to the Resident. A review of facility policy and procedures (P&P) titled Use of Restraints undated, indicated, Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to:1. Treat the medical symptom.2. Protect the resident's safety; and 3. Help the resident attain the highest level of his/her physical or psychological well-being.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 accurately code the Minimum Data Set (MDS - a resident assessment tool) to reflect the Level II (two) Preadmission Screening and Resident Review (PASRR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) for two of five sampled residents (Resident 2 and Resident 7) according to the facility's the facility's policy and procedures (P&P) titled, Minimum Data Set 3.0 Assessment Completion, Transmission and Validation, dated 1/2026. This deficient practice had the potential to incorrectly reflect the residents' plan of care and care and services received by the residents. Findings: a. A review of Resident 2's admission Record indicated the facility originally admitted the resident on 2/3/2023 and readmitted on [DATE] with diagnoses including but not limited to major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 2's State Health Care Services Department Notice of PASRR Level I Screening results letter, dated 1/24/2025, indicated Resident 2 had a serious SMI and a level II Mental health evaluation was required. A review of Resident 2's State Health Care Services Department Notice of Individual Determination letter dated 1/28/2025 indicated the resident had a serious mental illness and required specialized add - on services which included mental health rehabilitation activities, activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) training, psychotherapy/counseling and behavior monitors. b. A review of Resident 7's admission Record indicated the facility originally admitted the resident on 11/20/2018 and re-admitted the resident on 12/20/2025 with diagnoses that included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), anxiety disorder (a mental health condition with feeling of worry, anxiety, or fear interfering with one`s daily activities) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). A review of Resident 7's State Health Care Services Department Notice of PASRR Level I Screening form, dated 9/9/2024, indicated Resident 7 had a serious SMI and a level II Mental health evaluation was required. A review of Resident 7's State Health Care Services Department Notice of Individual Determination letter dated 9/11/2024 indicated the resident had a serious mental illness and required specialized add - on services which included medication education and training, activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) training, neuropsychology consultation and safety monitors. A review of Resident 7's Annual MDS, dated [DATE], indicated the resident's cognition was moderately impaired. The MDS also indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. During a concurrent interview and record review on 4/12/2026 at 12:36 PM, Resident 2 and Resident 7's most recent Annual MDS assessments were reviewed with the Minimum Data Set Coordinator (MDSC). The MDSC stated she incorrectly coded Resident 2 and Resident 7's annual MDS assessments and did not accurately reflect that the resident's had positive Level II PASSRs. The MDSC stated the MDS was an overall assessment of the resident and should accurately reflect what the care the resident was receiving. During an interview on 4/12/2026 at 2:59 PM, the Director of Nursing (DON) stated the MDS was a comprehensive assessment of the resident. The DON further stated the MDS should reflect the care the resident is receiving. The DON also stated that incorrect coding of the MDS may result in the wrong assessment and reflection of care. A review of the facility's policy and procedures (P&P) titled, Minimum Data Set 3.0 Assessment Completion, Transmission and Validation, dated 1/2026, indicated that, the purpose was:1. to establish that the facility uses an interdisciplinary approach to complete a (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive standardized assessment of each resident's functional capacity as required by OBRA (Omnibus Budget Reconciliation Act) 2. to develop and modify the resident's plan of care based on the residence status. A review of the facility's MDS/RAI Coordinator Job Description, undated, indicated the MDS/RAI Coordinator major duties and responsibilities included coordination of the facilities Resident Assessment Instrument (RAI) process in accordance with state and federal regulations and the accurate completion of all MDS assessments and any supporting assessments or clinical documentation.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility's policy and procedures (P&P) titled Enteral feeding- Safety Precautions dated 01/2026 for three of three sampled residents (Residents 4, 9, and 12), by failing to ensure: Resident 12 received the correct amount of gastrostomy tube (G-tube) feeding (a medical device inserted through the abdominal wall directly into the stomach to deliver nutrition, fluids, and medications, bypassing the mouth and esophagus [throat]). The facility nursing staff changed Residents 4 and 9 feeding tube every 24 hours. These deficient practices had the potential to cause infection and/or possible hospitalization, unintended weight loss manifested by malnutrition and dehydration, and the potential to result in severe nutrient deficiencies, weakened immunity, and electrolyte imbalances for the residents. Findings: A. A review of Resident 12's admission record indicated the Resident was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included inguinal hernia without obstruction (non-emergency bulge in the groin caused by tissue pushing through the abdominal wall), gastrostomy status (an artificial opening (stoma) in the stomach wall, generally created to allow a feeding tube (G-tube) to be inserted directly into the stomach), hyperlipidemia (abnormally high levels of lipids (fats), in the blood), psychosis (profound loss of contact with reality, where a person cannot distinguish what is real from what is not), anxiety disorder (excessive, persistent, and uncontrollable worry or fear that interferes with daily functioning), schizophrenia (disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and bipolar disorder (intense, extreme mood swings, ranging from high-energy mania to low-energy depression). A review of Resident 12's Minimum Data Set (MDS-a resident assessment tool), dated, 3/13/2026 indicated Resident 12's cognitive (mental ability to make decisions for daily living) was severely impaired, Resident 12 was totally dependent for oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, putting on/taking off footwear and was non-ambulatory. A review of Resident 12's physician's order, dated 4/1/2026, indicated to provide Jevity 1.5 calories (a calorically dense [1.5 Cal/mL-unit of measurement], high-protein, fiber-fortified enteral nutrition formula designed for tube feeding, providing complete, balanced nutrition) via enteral pump (a medical device used to deliver liquid nutrients, formula, or medication directly into a patient's gastrointestinal (GI - stomach and intestine) tract at a controlled, steady rate) to run at 50 (rate) cubic centimeters (cc-unit of measure) every hour to yield 1000cc to 1500 cc calories in 20 hours (hrs.) or until dose is completed. Start feeding infusion between 2 to 3 pm. During an initial tour of the facility on 4/11/2026, at 8:57 am, Resident 9 was observed lying asleep in bed. At the resident's beside, was 1500 cc bottle of Jevity 1.5 calories that was attached to the resident's g-tube was turned off. The 1500cc bottle of Jevity 1.5 calories was connected to a feeding pump on a pole. The Jevity 1.5 calories bottle had a residual (remaining/left) of 900 cc of Jevity formula. The g-tube feeding bottle was labeled as started on 4/10/2026 at 2 pm and was to infuse (deliver/run) rate of 50cc/hr. attached to Resident 9's g-tube at bedside. During an interview on 4/11/2026 at 9:03am, Licensed Vocational Nurse (LVN) 1 stated Resident 9's g-tube feeding is usually infused continuously from 2 pm to 10 am the following day for a period (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	totaling 20hrs. LVN1 was unable to state why Resident 9's g-tube feeding bottle had a residual of 900cc left in the bottle. During an interview on 4/12/2026 at 7:39 pm, Director of Nursing (DON) stated, indication for g-tube feedings is nutritional support when the gastrointestinal (GI) tract is functional but oral intake is insufficient, unsafe, or impossible. DON stated, failure to provide adequate g-tube feeding could cause unintended weight loss malnutrition and dehydration, resulting in severe nutrient deficiencies, weakened immunity, poor wound healing, and electrolyte imbalances and hypoglycemia. A review of the facility's policy and procedures (P&P) titled enteral feeding- Safety Precautions dated 01/2026 indicated, Feeding pumps must . ensure that the pump delivers the prescribed volume within 10 per cent accuracy. B. A review of Resident 4's admission Record indicated the facility admitted Resident 4 on 4/5/2018, and readmitted resident 4 on 3/5/2025 with diagnoses including dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and schizophrenia (a mental illness that is characterized by disturbances in thought). A review of Resident 4's MDS dated [DATE], indicated Resident 4 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 4 was dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. A review of Resident 4's physician order dated 3/5/2025 indicated enteral feed order, every night shift change/spike administration set every day on 11PM to 7 AM shift. A review of Resident 4's physician order dated 10/15/2025 indicated enteral feed order, every night Glucerna 1.2 via pump at 50cubic centimeter (CC -unit of measure) to yield 1000 CC/per 1200 calories (Cal -unit of measure) in 20 hours or until dose is completed start feeding infusion between 2PM and 3 PM. During an observation on 4/11/2026, at 8:16 A.M., in Resident 4's room, the tube feeding formular Glucerna 1.2 cal was connected to resident 4 and running at 50cc/hr via a tube feeding tube that was labelled/dated 4/8/2026. During a concurrent observation and interview on 4/11/2026, at 8:25 A.M., with Licensed Vocation Nurse 1 (LVN 1) in Resident 4's room, the tube feeding formular was connected to Resident 4 and running at 50cc/hr via a tube feeding tube that was labelled/dated 4/8/2026. LVN 1 stated that tube feeding tubing is changed whenever a new bottle is hung. LVN 1 stated that resident 4's tube feeding formular Glucerna according to the label on the bottle was hung on 4/10/2026 at 2PM, however, the tube feeding tubing was dated 4/8/2026 and should have been changed at the time the new feeding formular was hung to prevent infection control. LVN 1 stated that not changing the tubing can lead to bacteria in the bottle that may go into the stomach causing diarrhea. LVN 1 stated the tubing should have been changed at the same time as the feeding formular. A review of Resident 9's admission Record indicated the facility admitted Resident 9 on 4/15/2025, and readmitted resident 4 on 1/28/2026 with diagnoses including dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of emotional highs). A review of Resident 9's Minimum Data Set (MDS – resident assessment tool) dated 3/25/2026, indicated Resident 9 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 9 was dependent on staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. A review of Resident 9's physician order dated 1/28/2026 indicated, enteral feed order, every night shift change/spike administration set every day on 11PM to 7 AM shift. A review of Resident 9's physician order dated 3/5/2026 indicated enteral feed order, every night Jevity 1.5 via enteral pump at 65milliliters (ML -unit of measure) per hour to yield 1300 ML/per 1950 calories (Cal -unit of measure) in 20 hours or until dose is completed start feeding infusion between 2PM and 3 PM. During an observation on 4/11/2026, at 9:25 A.M., in Resident 9's room, the tube feeding formular Jevity 1.5 was connected to resident 9 and running at 70ml/hr(m per hour) with a tube feeding label on the formular dated 4/12/2026. During a concurrent observation and interview on 4/11/2026, at 9:37 A.M., with Infection Preventionist (IP) in Resident 9's room, the tube feeding formular was connected to Resident 9 and running at 70ml/hr with a tube feeding label on the formular dated 4/12/2026. IP stated that the tube feeding formular was dated 4/12/2026 and should have instead been dated 4/11/2026, it is an error. IP stated that the date on the feeding tube formular should reflect the accurate date, so the next nurse knows when the feeding formular bottle needs to be changed. The IP stated that the resident is already vulnerable, and we should not add more things to them, they can have stomach pains. IP stated that tube feeding tubing needs to be changed every 24 hours to prevent possible stomach pain, as a result of infection. During an interview, on 4/12/2026, at 7:20 P.M., with the Director of Nursing (DON), the DON stated that tubing for the feeding tube should be changed every 24 hours, the DON stated that if the tubing is dated 4/8/2026 and the tube feeding formular was hang at 2PM, it should have been changed the next day on 4/9/2026 at 2PM. The DON stated if the tubing for the tube feeding is not changed, it can lead to infection causing abdominal distention, pain and diarrhea. The DON stated that tube feeding formular labels should reflect the time it was changed or hung. The DON label indicating 4/12/2026, on 4/11/2026 is wrong and may pose a risk for infection to the resident such as diarrhea, dyspepsia, stomach upset if the next nurse comes in and does not change it due to the inaccurate date on the label. A review of the facility's P&P, titled Enteral Feeding -Safety Precautions, dated 1/2026, indicated, Purpose: To ensure the safe administration of enteral nutrition. Preparation: 1. All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The facility will remain current in and follow accepted best practices in enteral nutrition. General Guidelines: Preventing contamination 1. Maintain strict aseptic technique at all times when working with enteral nutrition systems and formulas. 6. Administration set changes: a. Change administration sets for open-system enteral feedings at least every 24 hours. b. Change administration sets for closed-system enteral feedings according to manufacturer's instructions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when:1. A container with fresh garlic gloves with use by date of 4/3/2026 was stored in the refrigerator past its use by date.2. Tuna salad with use by date of 4/8/2026 was stored in the refrigerator past its use by date.3. The dry storage room did not contain a dented can section. 4. An ice scoop did not have a date that the facility cleaned it or any documentation that the facility cleaned the ice scoop. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 32 out of 35 residents who received food from the facility.Findings: During an observation in the kitchen on 4/11/2026 at 6:30AM, the following were observed were made:A container with fresh garlic gloves with use by date of 4/3/2026 which was past use by date in the facility's refrigerator. 2. A container with tuna salad with use by date of 4/8/2026 which was past use by date in the facility's refrigerator. 3. A dented can section in the dry storage room. 4. A ice scoop did not have a date on it when it was cleaned or documentation that the ice scoop was cleaned. During an interview on 4/11/2026, at 10:19 A.M., with the Dietary Supervisor (DS), the DS stated that the facility process for food labeling is that the food labels are labeled with the date the food came from the supplier, date of receipt, when the food item was opened and the date when it should be used by. The DS stated that if a food item is beyond its use by date, it needs to be discarded to prevent food borne illnesses, and cross contamination. During a concurrent observation and interview on 4/11/2026, at 10:19 A.M., with the DS, in the dry storage room, there was no dented can section. The DS stated that the facility did not have a dented can area sectioned off and labeled as such. The DS stated that dented cand needed to have a separated and/or have a designated area in the dry storage room from the rest of the cans, so the facility staff know which can's not to use. The DS stated that the dented cans may have a hole in them that can cause food borne illnesses and that is why they need to be separated. The DS stated I will make a label and have an area set aside for the dented cans. During an interview on 4/11/2026, at 10:19 A.M., with the DS, the DS stated that the ice scoop is washed as needed and that there is no documentation to show when the ice scoop was cleaned. The DS stated that that if the ice scoop is not cleaned, it can lead to foodborne illnesses such as vomiting, diarrhea, and fever. The DS stated that the facility does not have and has never had any documentation to show that the ice scoop was cleaned, it is the first times I am hearing about it. The DS stating moving forward, he will have a log to show when the ice scoop has been cleaned. During an interview, on 4/12/2026, at 7:31 P.M., with the Director of Nursing (DON), the DON stated that food items beyond their use by date should not be in the refrigerator, they need to be thrown away, right away because if consumed they may lead to vomiting, diarrhea and Escherichia (E.Coli - bacteria commonly found in the intestines of humans and animals). The DON stated that dented cans in the kitchen need to be separated and have a designated area labeled as such to prevent possible infection if they happen to be open. The DON stated that the ice scoop in the kitchen needs to be cleaned daily, documentation needs to be done to show that the ice scoop was cleaned, that the job was done. The DON stated if there is no documentation showing that the ice scoop was cleaned, whether it was done or not. If the ice scoop is not cleaned, it can spread infection such as diarrhea, nausea, vomiting, stomach upset, causing cross contamination and infection. A review of the facility's policy and procedures (P&P), titled Date Marking for Food Safety dated 1/2026 indicated, Policy:The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food.Policy Explanation and Compliance Guidelines for Staffing:2. The food, including fruits and vegetables, shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared.4. The marking (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded.5. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day I. (For example, food prepared on Tuesday shall be discarded on or by Friday.)6. The Head Cook, or designee, shall be responsible for checking daily food items that are expiring, and shall discard accordingly.7. The Dietary Manager, or designee, shall spot check refrigerators weekly for compliance, anddocument accordingly. Corrective action shall be taken as needed.8. Note: prepared foods that are delivered to the nursing units shall be discarded within two hours, if not consumed. These items shall not be refrigerated as the time/temperature controls cannot be verified. A review of the facility's P&P, titled Food Safety Requirements dated 1/2026 indicated:Policy:It is the policy of this facility to procure food from sources approved or considered satisfactory byfederal, state and local authorities. Food will also be stored, prepared and served in accordance with professional standards for food service safety.Definitions:Food service safety refers to handling, preparing, and storing food in ways that prevent foodbome illness.Foodborne illness refers to an illness caused by the ingestion of contaminated food or beverages.Contamination means the unintended presence of potentially harmful substances including, but not limited to microorganisms, chemicals, or physical objects.Policy Explanation and Compliance Guidelines:1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following:a. Procurement (obtaining) of food from sources approved or considered satisfactory by federal, state, and local authorities.b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms.c. Preparation of food, including thawing, cooking, cooling, holding, and reheating.d. Distribution of food to the resident, including transportation, set up, and assistance.e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food.f. Employee hygienic practices. A review of the facility's P&P, titled Food Storage -Dented Cans dated 1/2026 indicated:POLICY: Food in unlabeled, rusty, leaking, broken containers or cans with side-seam dents, rim dents or swells shall not be retained or used by the facility.PROCEDURE: Any dented cans found to include rusty cans are immediately separated from the remaining stock and placed in a specified labeled area for return to vendor for refund or immediately removed from the facility. All leaking cans are to be disposed of immediately. A review of the facility's P&P, titled Ice Machine and Ice Storage Chests dated 1/2026 indicated:Policy StatementIce machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice.Policy Interpretation and Implementation1.Ice-making machines, ice storage chests/containers, and ice can all become contaminated by:a. Unsanitary manipulation by employees, residents, and visitors;b. Waterborne microorganisms naturally occurring in the water source;c. Colonization by microorganisms; and/ord. Improper storage or handling of ice.2. To help prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow these precautions: During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At any time when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold.

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	056438	A. Building B. Wing	04/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flower Villa, Inc	1480 S. LA Cienega Bl Los Angeles, CA 90035

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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 ensure facility verify informed consent (a principle in medical ethics and medical law that a patient should have sufficient information before making their own free decisions about their medical care) form was given to the physician prior to administering Ativan (a psychotropic medication [a substance that act on the central nervous system to affect brain function, resulting in changes to mood, perception, consciousness, and behavior] medication that is potentially life-threatening medication that treats psychosis) for one of five sampled residents (Resident 19). This deficient practice had the potential for Resident 19 to not be able to exercise his right to know what medications the facility is administering to the resident. Findings: A review of Resident 19's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety disorder (a mental health condition with feeling of worry, anxiety, or fear interfering with one`s daily activities) and encephalopathy (brain damage that causes severe confusion and forgetfulness). A review of Resident 19's Physician's Orders, dated 3/29/2026, indicated Resident 19 was to receive Ativan 1 milligram (mg) by mouth every 6 hours as needed for the inability to relax. A review of Resident 19's October 2025 Medication Administration Record indicated the resident received Ativan 1mg on 10/20/2025, 10/23/2025, 10/25/2025, 10/26/2025, 10/27/2025, 10/28/2025 and 10/30/2025. A review of Resident 19's Minimum Data Set (MDS, a resident assessment tool) dated 2/20/2026, indicated the resident's cognition (the ability to think, understand, reason, and make decisions) was moderately impaired. The MDS indicated Resident 19 had active diagnoses of anxiety disorder, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a concurrent interview and record review on 4/12/2026 at 8:39 AM, Resident 19's Verification of Informed Consent form were reviewed. MDSC stated there was no Verification Form for Ativan in the resident's chart and nurses are to verify informed consent prior to administering psychotropic medication. MDSC stated not verifying informed consents violates the resident's rights. During an interview and concurrent record review on 4/12/2026 at 2:58 PM, the Director of Nursing (DON) stated they are receiving MDSC stated staff are to verify with the resident that the risk and benefits of the psychotropic medication was explained and the resident agreed with receiving the medication. During an interview on 4/12/2026 at 5:50 PM Resident 19 stated he has received Ativan in the past but doesn't know what it is used for. A review of the facility's policy and procedures (P&P) titled, Nursing Standards of Practice Subject: Consent - Informed, revised 1/2026, indicated informed consent is a decision made freely by the patient/resident or a legally authorized representative after he/ she has full knowledge and understanding of the risks, benefits, and available options about off tomorrow the various treatment alternatives. The P&P further indicated Nurses are responsible for explaining human responses to treatment or procedures:A. Disclosure1. Reinforce information presented and provide supplemental explanations and educational materials2. Notify physician if it is ascertained that the patient/resident's comprehension is poor.3. Inform physician of the possible medication administration that may interfere with comprehension4. Confirm documentation of informed consent on the medical record. And The patient/resident or legal guardian signs and dates prior to treatment/procedure beingperformed.6. The completed consent form is placed in the resident's medical record.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a copy of the residents notice of transfer for medical reason was sent to the office of the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) as soon as practicable according to the facility's Policy & Procedure (P&P) titled Transfer and Discharge (Including AMA) dated 1/2026 for two of two sampled residents, (Resident 5 and Resident 38).This deficient practice resulted in the ombudsman's office not being aware of Residents 5 and 38's whereabouts for safety reasons during their emergency medical reason transfer to general acute care hospital (GACH). Findings: A review of Resident 5's admission Record indicated the facility admitted Resident 5 on 4/4/2025 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and chronic obstructive pulmonary disease (COPD - chronic lung disease causing difficulty in breathing). A review of Resident 5's Minimum Data Set (MDS - a resident assessment tool) dated 1/16/2026, indicated Resident 5 is cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 5 required supervision or touch assistance from staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. A review of resident 5's Notice of proposed Transfer/discharge date d 3/2/2026, at 3:17 P.M., indicated notification date 3/11/2026. Transfer/Discharge location: GACH. reason for discharge . 1. The transfer/discharge is necessary for your welfare, and your needs cannot be met in the facility A review of the facility's fax cover sheet indicated to: Ombudsman. Regarding: Resident 5, dated: 3/11/2026. During an interview, on 4/12/2026, at 11:44 A.M., with the Medical Records Director (MRD), the MDR stated that the notice of proposed transfer is supposed to be sent to the Ombudsman's office the next day. The MRD stated Resident 5's notice of proposed transfer should have been faxed to the ombudsman's office 3/3/2026 instead of 3/11/2026 when it was faxed. The transfer notification to the Ombudsman office is done to ensure that the Ombudsman's office is aware of where the residents is. A review of Resident 38's admission Record indicated the facility admitted Resident 38 on 5/6/2025, and readmitted Resident 38 on 3/3/2026 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and dementia (a progressive state of decline in mental abilities). A review of Resident 38's MDS dated [DATE], indicated Resident 38 was cognitively intact. The MDS indicated Resident 38 is dependent on assistance from staff with ADL (activities such as bathing, dressing and toileting a person performs daily) care. A review of Resident 38's Notice of proposed Transfer/discharge date d 3/6/2026, at 2:18 P.M., indicated notification date 3/6/2026. Transfer/Discharge location: GACH. reason for discharge . 1. The transfer/discharge is necessary for your welfare, and your needs cannot be met in the facility. During an interview, on 4/12/2026, at 12:21 P.M., with the MRD, the MDR stated that the notice of proposed transfer notification to the Ombudsman's office for Resident 38 was not done. The MRD stated that the notice of proposed transfer needs to be faxed to the Ombudsman office the next day after the residents have been transferred to the hospital so the Ombudsman can know that the resident is not in the facility. The MRD stated that the notification is done per facility policy and to follow federal regulations. During an interview, on 4/12/2026, at 7:10 P.M., with the Director of Nursing (DON), the DON stated that the notice of proposed transfer is a form that the facility uses to report that the resident has gone to the hospital, to another facility -any facility. The DON stated that the facility process for a notice of prosed transfer is that medical records faxed the notification to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ombudsman's office as soon as possible, on the day of the transfer. The DON stated that Practicable means as soon as the transfer is completed. The DON stated that the Ombudsman needs to know where the patient is. A review of the facility's P&P titled Transfer and Discharge (Including AMA) dated 1/2026, indicated,Policy This facility complies with federal regulations to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the service provided by the facility;3. The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident;4. The health of individuals in the facility would otherwise be endangered;5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; or6. The facility ceases to operate.Policy Explanation and Compliance Guidelines:Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.a. Transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.b. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.7. Emergency Transfers/Discharges -for medical reasons, or for the immediate safety and welfare of aresident, initiated by the facility (nursing responsibilities unless otherwise specified).j. Provide transfer notice as soon as practicable to resident and representative.k. Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview and record review the facility failed to implement one of one sampled resident's (Resident 7) communication care plan interventions by not providing/applying Resident 7 his hearing aid (a device worn in or behind the ear designed to amplify sound for individuals who have difficulty hearing) daily according to the facility's policy and procedures titled, Care of Hearing Aid, dated 1/2026. Resident 7 had decreased hearing. This deficient practice had the potential to result in a delay in communication for Resident 7. Findings: A review of Resident 7's admission Record indicated the facility originally admitted the resident on 11/20/2018 and re-admitted the resident on 12/20/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic [ongoing] lung disease causing difficulty in breathing), heart disease and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 7's Communication Care Plan, initiated 12/20/2025, indicated the resident had hearing loss. The care plan goal was for the resident to have increased participation in conversations with staff and peers. The care plan interventions included to apply/check placement /monitor placement of hearing aid(s) daily. A review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2026, indicated the resident had moderately difficult hearing and possessed a hearing aid. The MDS also indicated the resident could make himself understood and usually understood others. The MDS further indicated the resident required partial assistance with toileting hygiene, showering, dressing and personal hygiene. A review of the Social Services Note, dated 6/16/2025 indicated the Social Services Director (SSD) received Resident 7's hearing aids and the SSD educated Resident 7 on how hot properly use them and that nursing staff will help Resident 7 to place the hearing aids on. A review of Resident & Ear Nose Throat (ENT) Consultation Form, dated 9/17/2025, indicated the resident had decreased hearing and had a history of ear infections. The Consultation Form also indicated that the physician recommended the resident to have a hearing aids for his right and left ear. During a concurrent interview and observation on 4/11/2026 at 8:32 AM, Resident 7 was observed sitting in a wheelchair in the resident's room. Resident 7 stated he could not hear and he needs a hearing aid. While attempting to interview the resident, the resident became very frustrated with not being able to hear and stopped the interview. Resident 7 was observed not wearing hearing aids. During a concurrent interview and observation on 4/12/2026 at 9:34 AM, Certified Nursing Assistant (CNA) 1 stated you have to speak loudly for Resident 7 to hear. Sometimes when you speak to Resident 7 he doesn't respond. CNA 1 stated she was not sure but she believed Resident 7's hearing aids are located at the front desk. CNA 1 stated she never gave Resident 7 his hearing aids. During a concurrent observation of Resident 7 sitting on the smoking patio, CNA 1 stated Resident 7 was not wearing his hearing aids and she had not offered them to him. During an interview on 4/12/2026 at 11:39 AM, the SSD stated Resident 7's hearing aids are to be offered to him in the morning by the morning shift CNA and then taken off at night. The SSD stated there is no log of when the hearing aids are offered to Resident 7. SSD stated it would be hard for Resident 7 to express his needs if he doesn't have his hearing aids. During an observation on 4/12/2026 at 12:05 PM, Resident 7 was ambulating in the wheelchair in the hallway going to the resident's room. The resident was not wearing hearing aids. During a concurrent interview, Resident 7 stated he doesn't have any hearing aids. During an interview on 4/12/2026 at 2:56 PM, the Director of Nursing (DON) stated charge nurses have a list of residents who have hearing aids and they are to offer the hearing aids to the residents daily. The DON further stated nursing staff are not documenting when the resident is offered their hearing aid. A review of the facility's policy and procedures, Care of Hearing Aid, dated 1/2026, indicated the purpose of caring for a hearing aid is to maintain the resident's hearing at the highest attainable level. The P&P also indicated, the following information should be recorded in the resident's medical record:1. The date and time the hearing aid was checked and/or battery was (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	replaced.2. The name and title of the individual(s) who checked the hearing aid and changed the battery.3. If the resident refused the procedure, the reason(s) why and the intervention taken.4. The signature and title of the person recording the data.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a care plan (a document outlining a detailed approach to care customized to an individual resident's need) with measurable goals and interventions to address care and treatment of a resident with dementia (a progressive state of decline in mental abilities) for one of one sampled residents (Resident 19). This deficient practice had the potential to negatively affect the delivery of services.Findings: A review of Resident 19's admission record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included anxiety disorder (a mental health condition with feeling of worry, anxiety, or fear interfering with one`s daily activities) and encephalopathy (brain damage that causes severe confusion and forgetfulness). A review of Resident 19's Physician Orders, dated 10/16/2025 indicated the facility was to administer to the resident:- Aricept (medication for dementia) 10 milligrams (mg - unit dose measurement) at bedtime for dementia- Wellbutrin (medication for depression) 75 mg in the evening for depression manifested by verbalization of hopelessness- Haldol (medication for schizophrenia) 5 mg by mouth two times a day for schizophrenia manifested by striking out at staff without provocation. A review of Resident 19's interdisciplinary team (IDT - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] that provide care for the residents) Meeting/Care Conference, dated 1/23/2026, indicated the resident ambulated with an unsteady gait and requires assistance with activities of daily living, including personal hygiene and proper hand hygiene. The resident has been refusing select ADLs, such as bathing, hygiene care, and changing soiled clothing. The IDT Meeting/Care Conference further indicated no discharge planning is indicated, and the resident will continue in long-term care at the skilled nursing facility. The interdisciplinary team will maintain ongoing monitoring, assessments, and care planning to support his medical, psychiatric, and emotional needs. A review of Resident 19's Annual Minimum Data Set (MDS, a resident assessment tool) dated 2/20/2026, indicated the resident's cognition (the ability to think, understand, reason, and make decisions) was moderately impaired. The MDS indicated Resident 19 had active diagnoses of anxiety disorder, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and Non-Alzheimer's Dementia. During an observation on 4/11/2026 at 8:54 AM, Resident 3 was standing in the hallway alone. Resident 3's both hands were observed to be shaking. Resident 3 declines offer from staff to go to Activity room. A review of Resident 19's Care Plans on 10/17/2024 at 9:00AM, indicated there was no individualized person-centered care plan for the resident's dementia care or a care plan that addressed the resident's cognitive status. During a concurrent interview and record review on 4/12/2026 at 8:39 AM , Resident 19's care plans were reviewed with the Minimum Data Set Coordinator (MDSC) . MDSC stated Resident 19's diagnoses included anxiety disorder and dementia. MDSC further stated Resident 19 did not have any care plan with measurable goals and interventions that addressed the resident's diagnosis of dementia or cognitive skills. MDSC was unable to provide documented evidence the licensed nursing staff identified and/or assessed specific behaviors or episodes. During an interview on 4/12/2026 at 2:58 PM, the Director of Nursing (DON) stated nursing staff did not develop a care plan with measurable goals and interventions to address the care and services needed by Resident 19. The DON further stated a dementia care plan needed to be in place in order to address the care the resident receives. The DON stated the care plan would include the behavioral interventions one would implement in caring for a resident with dementia. A possible outcome of not having a dementia care would be the resident would not receive the care needed. A review of the facility's policy and procedures (P&P), Dementia Care, dated 1/2026, indicated, It was the facility's policy provide the appropriate treatment and services to every resident who displays (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs of, or is diagnosed with, dementia to meet his or her highest practicable physical, mental, and psychosocial well-being. The P&P further indicated:1. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible.2. The care plan goals will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals.3. The care plan interventions will be related to each resident's individual symptomology and rate of dementia (or related disease) progression with the end result being noted improvement or maintained of the expected stable rate of decline associated with dementia and dementia-like illnesses.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to provide appropriate monitoring for the targeted behavior of Ativan (an anti-anxiety medication) for one of five sampled residents (Resident 19) according to the facility's policy and procedures titled, Behavior Assessment and Monitoring, dated 1/2026, indicated. This deficient practice had the potential to result in delayed provision of necessary care and services. Findings; A review of Resident 19's admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety disorder (a mental health condition with feeling of worry, anxiety, or fear interfering with one`s daily activities) and encephalopathy (brain damage that causes severe confusion and forgetfulness). A review of Resident 19's Physician's Orders, dated 3/29/2026, indicated Resident 19 was to receive Ativan 1 milligram (mg- unit dose measurement) by mouth every 6 hours as needed for the inability to relax. A review of Resident 19's Minimum Data Set (MDS, a resident assessment tool) dated 2/20/2026, indicated the resident's cognition (the ability to think, understand, reason, and make decisions) was moderately impaired. The MDS indicated Resident 19 had active diagnoses of anxiety disorder (a mental health condition with feeling of worry, anxiety, or fear interfering with one`s daily activities) and encephalopathy (a disease that damages the functions of the brain). A review of the April 2026 Medication Administration Record (MAR), indicated no documented evidence the licensed nurses monitored for the targeted behavior of the inability to relax. A review of the history of current anxiety problems care plan initiated 10/16/2025 indicated Resident 19 had episodes of repetitive physical movement manifested by wringing of hands and the inability to relax. The care plan indicated the goal was for episodes of mood to be limited to 10 minutes daily. The care plan interventions included to implement behavior management techniques, administer medications per physician order and observe for side effects and to document behavior in the medication book. During an concurrent interview and record review on 4/12/2026 at 8:39 AM, the Minimum Data Set Coordinator (MDSC) stated on 3/4/2026 the physician ordered Resident 19 to receive Ativan 1mg every six hours as needed for the inability to relax. The MDSC further stated there was no documentation for the monitoring for the targeted behavior. The MDSC also stated not monitoring for the targeted behavior could lead to Resident 19 not receiving an effective dosage of medication. During an interview with the Director of Nursing (DON) on 4/12/2026 at 3 PM, the DON stated for all psychotropic medications, staff are to monitor for the targeted behavior and the behaviors are tallied monthly. The DON further stated monitoring for the behavior allows us to assess if the resident's behavior is managed or if changes need to be implemented. A review of the facility's policy and procedures titled, Behavior Assessment and Monitoring, dated 1/2026, indicated, The staff will document (either in progress notes, behavior assessment forms, or other comparable approaches) the following information about specific problem behaviors:a. Number and frequency of episodes;b. Preceding or precipitating factors;c. Interventions attempted (if psychoactive drug is used as an intervention, institute appropriate psychoactive drug monitoring); andd. Outcomes associated with interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056438	A. Building B. Wing	04/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Flower Villa, Inc	1480 S. LA Cienega Bl Los Angeles, CA 90035

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure a safe, sanitary, compliant environment with properly maintained and disposed of garbage according to their facility's policy and procedures (P&P) tiled, Kitchen Garbage and Trash, dated 1/2026, when one of four trash bins in the kitchen did not have a lid on it. This deficient practice had the potential to attract insects and rodents in the kitchen. Findings: During an observation on 4/11/2026, at 6:32 A.M., in the kitchen, there was an open trash can without a lid by the handwashing sink. During an interview on 4/11/2026, at 10:19 A.M., with the Dietary Supervisor (DS), the DS stated that trash cans in the kitchen need to have a lid on them to prevent the spread of infection and cross contamination. A review of the facility's P&P tiled, Kitchen Garbage and Trash, dated 1/2026 indicated, Policy:To ensure a safe, sanitary, and compliant environment, trash containers with properly maintained and regularly emptied.Policy Explanation and Compliance Guidelines:1.Trash containers in the kitchen must be durable, easily cleanable, non-absorbent, leak-proof, and designed to prevent contamination and to ensure pest prevention.2. Trash containers shall have tight-fitting lids or covers. Lids or covers shall remain closed on trash containers when not in use.3. Trash containers shall be lined with appropriately sized, durable plastic bags to facilitate easy and sanitary removal of waste.4. At least one trash container shall be placed near food preparation or dish-washing area.5. Trash containers shall be emptied frequently and as needed to prevent overflow.6. Trash containers shall be inspected regularly during the day to ensure cleanliness (e.g., remove visible debris) and proper function.7. Trash containers shall be properly cleaned and sanitized at least daily.8. Trash containers will be replaced as needed. A review of Food and Drug Administration (FDA) Food Code 2022 dated 1/18/2023, code number 5-501.113 titled Covering receptacles, indicated, receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated, under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable indicated refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review the facility failed to ensure 18 of 21 resident rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 14, 15, 16, 18, 19, 21, 23 and 25) met the are footage requirements of 80 square feet (sq ft) per resident. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for 31 Residents. Findings: On 4/11/2026, the Administrator provided a copy of the Client Accommodation Analysis, dated 4/11/2026 and the facility letter requesting for continuation of room waiver. A review of the Client Accommodation Analysis indicated that 18 of 21 rooms did not have at least 80 square feet per resident. The room waiver request and Client Accommodation Analysis showed the following: Room # No. of Beds Total Square Footage Square footage per bed 1 2 144.72 72.36 2 2 144.72 72.36 3 2 144.72 72.36 4 2 147.4 73.7 5 2 147.4 73.7 6 2 144.72 72.36 7 2 152.76 76.38 9 2 144.72 72.36 10 2 147.4 73.7 11 2 144.72 72.36 14 2 134 67 15 2 144.72 72.36 16 2 144.72 72.36 18 2 144.72 72.36 19 2 144.72 72.36 21 2 144.72 72.36 23 2 144.72 72.36 25 2 144.72 72.36 During the initial tour on 4/11/2026, at 8:18 AM, the evaluators inspected the aforementioned rooms and observed that nursing staff had enough space to provide care to the residents; there were curtains to provide privacy for each resident and the rooms had direct access to the corridors. During multiple observations made from 4/11/2026 to 4/12/2026, both residents and staff had enough space to move about freely inside the rooms. The nursing staff had enough space to safely provide care to the residents with space for beds, side tables, dressers and resident care equipment. A review of the facility's policy and procedures titled, Resident Rooms, dated 1/2026, indicated Resident bedrooms will measure at least 80 square feet per resident and multiple resident bedrooms and at least 100 square feet and single resident bedrooms.