STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056485	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Gardens Care Center	3688 Nye Avenue Riverside, CA 92505

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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 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 provide care and treatment according to professional standards of practice for three of 19 residents (Residents 123, 5, and 126) when:1. For Resident 123, a bottle of open, unlabeled Equate (equivalent to Afrin) nasal spray (medication used to relieve stuffiness from colds, allergies, and sinus pressure (feeling of fullness, pain, or tightness in the face) was found at bedside without a physician's order.This failure had the potential for Resident 123 to receive ineffective treatment that could lead to serious health problems.2. For Resident 5, one open, unlabeled box of Salonpas medication pads (topical pain relievers used to provide temporary relief to minor muscle aches, joint pain, back aches, strains, and sprains) was found at the bedside with no physician's order for administration. In addition, Resident 5 did not have a self-administration assessment.This failure had the potential for Resident 5 to receive pain medication without a physician's order which could interact with the other pain medication already administered.3. For Resident 126, there was no reassessment and physician notification when Resident 126's blood pressure was low as per facility's policy and procedure.This failure had the potential for Resident 126 to experience unidentified hypotension (low blood pressure) and unrecognized change in condition which could lead to a deterioration in health and safety.Findings: 1. During a concurrent observation and interview on January 5, 2026, at 9:52 a.m., with Resident 123, Resident 123 was observed lying in bed, awake and alert. A used and unlabeled bottle of Equate nasal spray was observed on top of Resident 123's bedside table. She stated she was using the Equate nasal spray for her allergy symptoms and the nurses were aware of it. On January 6, 2026, at 8:02 a.m., Resident 123 was observed lying in bed. A used and unlabeled bottle of Equate nasal spray was observed on top of Resident 123's bedside table. On January 6, 2026, at 3:39 p.m., Licensed Vocational Nurse (LVN) 5 was observed entering Resident 123's room. A used and unlabeled bottle of Equate nasal spray was observed on top of Resident 123's bedside table. LVN 5 asked Resident 123 if the Equate nasal spray was her own medication. Resident 123 stated the used and unlabeled bottle of Equate nasal spray was her own medication and would give herself two (2) squirts on the right nares every morning. LVN 5 informed Resident 123 that she will call the physician about the Equate nasal spray and ask for a physician's order. On January 6, 2026, at 3:50 p.m., in a concurrent interview and record review with LVN 5, she stated Resident 123 did not have an order for the Equate nasal spray to be administered. She stated medications should have a physician's order and the resident should have a physician's order for medication self-administration. She also stated Resident 123 did not have an assessment for medication self-administration and she did not have one. On January 6, 2026, at 4:25 p.m., during a concurrent interview and record review with the Director of (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON), she stated Resident 123 did not have a physician's order for the Equate nasal spray and did not have an order to self-administer the nasal spray. She also stated Resident 123 did not have an assessment for medication self-administration for the Equate nasal spray. On January 6, 2026, Resident 123's record was reviewed. Resident 123 was admitted to the facility on [DATE], with diagnoses which included asthma (a chronic lung condition causing inflamed, narrowed airways). There was no physician's order for the Equate nasal spray and there was no assessment for self-administration of medication for Resident 123. 2. On January 6, 2026, at 9:21 a.m. an observation and interview was conducted with Resident 5. Resident 5 was alert and sitting upright in bed. Observed one opened box of Salonpas on the bedside table. Resident 5 stated she did receive an order for a Lidocaine patch (pain relieve patch) but did not like how it felt so she would request for the nurses to apply the Salonpas on various occasions. Resident 5 stated the doctor said I could use them. On January 6, 2026, at 10:10 a.m., an observation, interview and record review was conducted with LVN 8. LVN 8 was asked if Resident 5 had orders to receive any pain relieve patches. LVN 8 stated Resident 5 had orders for Lidocaine patch to be applied to the affected area for pain management. LVN 8 stated Resident 5 did not have any other orders for pain patches. LVN 8 was asked to identify an opened box of Salonpas on the bedside table of Resident 5. LVN 8 stated they should not be at the bedside; I will need to keep them in my cart. LVN 8 was asked if there was an order for Salonpas to be applied for pain management. LVN 8 stated there is no order and I will need to call the doctor to approve the administration of them. LVN 8 was asked if Resident 5 had orders for self-administration of medications. LVN 8 stated Resident 5 did not have orders to self-administer any medications. After LVN 8 asked Resident 5 if she or any other nurse applied the Salonpas to her Resident 5 denied having one applied. LVN 8 stated there should be an order for all medications and not left at the bedside. A review of Resident 5's Medication Administration Record (MAR) for December 2025 and January 2025 was conducted with LVN 8. LVN 8 indicated the lidocaine physician ordered patch was administered per physician order and that the pain was monitored and managed which was confirmed to be within the accepted parameters according to the physician orders. LVN 8 stated there was no documented administration of a Salonpas patch. 3. On January 8, 2025, Resident 126 was admitted to the facility on [DATE], and discharged [DATE], with a diagnoses which included, wedge compression fracture of first lumber vertebra, subsequent encounter for fracture with routine healing (broken back bone). The History and Physical Examination, dated November 4, 2025, indicated Resident 125 had the capacity to understand and make decisions. A review of the Nurse Vital Signs Trend log dated November 6, 2025, indicated, .Vital signs.blood pressure.94/54 mmHg (a unit of measurement).pulse.74. A review of the progress notes from November 6, 2025 to November 7, 2025 indicated no communication with the nursing staff, physician, administration or representative party that a low blood pressure reading was identified. A review of the care plan titled, Hypertension, indicated, .resident is at risk for.decreased blood (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure.interventions.monitor blood pressure as ordered.observe for signs and symptoms of abnormal blood pressure and complications r/t (related to) hypertension (increased blood pressure), and notify physician as needed. There was no evidence in the nursing documentation that any additional blood pressure was taken to verify a low blood pressure or that the physician was made aware of the low blood pressure reading. On January 8, 2026, at 2:39 p.m. an interview was conducted with Certified Nursing Assistant (CNA 1). CNA 1 was asked to explain the protocols for obtaining vital signs for residents. CNA 1 stated all nursing aides would take vital signs once a shift or at more frequency depending on the required monitoring. Regarding blood pressure (BP), if a BP was high, it would be above 160 and a low would be 90 or below and all vitals should always be reported to the nurses. CNA 1 stated the nurses would record and report the vital signs and nurses would determine if additional interventions and reports were needed if a change in condition was identified. CNA 1 stated she was educated on how to obtain vitals during orientation and asked to demonstrate during annual competencies. On January 8, 2026, at 2:42 p.m. an interview was conducted with LVN 8. LVN 8 was asked to explain obtaining vital signs and reporting protocols. LVN 8 stated vital signs should be taken in the morning and per shift by the CNA and all readings would be reported and recorded by the LVN on that shift. LVN 8 stated any abnormal pulse anything less than 60 bpm (beats per minute – a unit of measurement) any BP systolic (top number reading) over 160 and under 110 should be reported. LVN 8 stated if nursing determined blood pressure was low or high then it should be rechecked and the recheck should be noted in the medical record. If the resident was symptomatic then appropriate change of condition notifications and interventions should be done per facility policy. LVN 8 further stated she was provided education upon hire and during annual competency regarding obtaining and reporting vital signs. On January 8, 2026, at 2:48 p.m. a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON was asked to explain the facilities policy regarding reporting high or low blood pressures. The DON indicated if blood pressure was low a resident should be rechecked and that recheck should be in the medical record, and the nurses should conduct assessments to document any changes in condition and that the physician was made aware. A review of Resident 125's medical record was conducted with the DON. The DON stated that the LVN should have rechecked the low blood pressure to verify if that was a correct reading and then documented both the initial and the rechecked blood pressure in the medical record. The DON stated if a nurse finds that the blood pressure was still low after a recheck then they should also notify the physician, formulate a change of condition, and conduct assessments. The DON further stated if there was no blood pressure rechecked then there would be no way to know what the condition of the resident was in and the physician should have been notified of the low blood pressure. A review of the facility policy and procedure titled, Administering medication, revised April 2019, indicated, .Medications are administered in a safe and timely manner and as prescribed.Medications are administered in accordance with prescriber orders.Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team (a group of healthcare professionals from different specialties), has determined that they have the decision-making capacity to do so safely. A review of the facility policy and procedure titled, Self-Administration of Medications, revised (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 2021, indicated, .Any medication found at bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. A review of the facility policy and procedure titled, Blood pressure, measuring, dated September 2010, indicated, .the blood pressure is generally defined as Normal when the systolic pressure is in the range of 101 to 129 mm/Hg and the diastolic pressure (bottom number reading) is in the range of 61 to 84 mm/Hg .Hypotension is defined as blood pressure less than 100/60/Hg (sic) .reporting .report other information in accordance with facility policy and professional standards of practice . A review of the facility policy and procedure titled, Charting and Documentation, dated July 2017, indicated, .the following information is to be documented in the resident medical record .changes in the resident's condition .the assessment data and/or any unusual findings obtained during the procedure .notification of family, physician, or other staff .

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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 ensure accurate accountability of controlled medications (controlled substances, those with high potential for abuse and addiction) when:The Controlled Substance Records (CSR, accountability records) for two of four randomly selected residents (Residents 4 and 108) did not reconcile with the Medication Administration Records (MAR, daily documentation record used by a licensed nurse to document medications and treatments given to a resident),The CSR did not match the narcotic (controlled substances used to treat pain) medication contents for one of four randomly selected residents (Resident 123) in Medication Cart 1, andThe facility did not implement appropriate disposal of fentanyl (narcotic pain medication that is 100 times more potent than morphine) patches for one of one randomly selected residents (Resident 123).These failures resulted in inaccurate accountability of controlled medications and the potential for duplicate doses and possible abuse or diversion of controlled medications.1a. Resident 4 had a physician's order, dated [DATE], for oxycodone with acetaminophen (a controlled medication for pain, generic for Percocet) 5-325 milligrams (mg), Give 12.5 mg tablet by mouth every 8 hours as needed for Pain moderate to severe.During a concurrent interview and record review on [DATE], at 11:03 a.m. with the Infection Preventionist (IP), Resident 4's Percocet 5-325 mg Medication Count Sheet (also known as controlled substance record, CSR), dated [DATE], and [DATE] MAR were reviewed. The CSR indicated the nursing staff signed out one tablet on [DATE], at 9:00 p.m., but did not document the administration on the MAR. The IP verified the CSR indicated a dose of Percocet was removed but not documented as administered to Resident 4. 1b. Resident 108 had a physician's order, dated [DATE], for hydrocodone with acetaminophen (a controlled medication for pain, generic for Norco) 10-325 mg, Give 1 tablet by mouth every 6 hours as needed for Moderate to Severe pain.During a concurrent interview and record review on [DATE], at 11:03 a.m. with the IP, Resident 108's Norco 10-325 mg Medication Count Sheet (CSR), dated [DATE], and [DATE] MAR were reviewed. The CSR indicated the nursing staff signed out one tablet on [DATE], at 10:00 a.m., but did not document the administration on the MAR. The IP verified the CSR indicated a dose of Norco was removed but not documented as administered to Resident 108. During an interview on [DATE], at 11:03 a.m., the IP stated if a dose was not documented as administered on the MAR, it meant the dose was not given. During an interview on [DATE], at 3:20 p.m., the Director of Nursing (DON) stated the expectation was nurses documented on the CSR and the MAR when administering narcotic medications. The DON stated the CSR and the MAR should match. During a telephone interview on [DATE], at 8:33 a.m., the Consultant Pharmacist (CP) stated narcotic medication administration needed to be charted accurately. The CP stated nurses would not know when the last dose was given unless they chart in the CSR and the MAR. The CP stated nurses were supposed to document the administration when they gave a medication. A review of the facility's policies and procedures (P&P), titled, Administering Medications, dated [DATE], indicated: .the individual administering the medication records in the resident's medical record.the date and time the medication was administered.the dosage. 2. During a concurrent observation, interview, and record review on [DATE], at 3:50 p.m. with LVN 5, Medication Cart 1 was reviewed. The medication cart contained one box of fentanyl 25 micrograms (mcg, a unit of measurement) per hour (mcg/hr, rate of medication release) transdermal (onto the skin) patches for Resident 123. The box contained four fentanyl patches individually sealed in foil packets and one opened foil packet containing a used fentanyl patch. Resident 123's fentanyl patch Medication Count Sheet (CSR, controlled substance record), dated [DATE], was reviewed. The CSR indicated Resident 123's fentanyl 25 mcg/hr patches were filled on [DATE] with orders to Apply 1 patch to skin every 72 hours for pain (remove old patch before applying new one. Rotate site). The CSR further indicated a quantity received of five fentanyl (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patches. LVN 5 stated the CSR indicated there should be four fentanyl 25 mcg/hr patches in the cart. During an interview on [DATE], at 3:10 p.m., Registered Nurse 1 (RN 1) stated used fentanyl patches were kept in the medication cart until the DON was available. During an interview on [DATE], at 3:33 p.m., the DON stated the nurses brought used fentanyl patches to her for destruction. The DON stated the fentanyl patch contained medication after removal from the resident. The DON stated the nurses kept the used fentanyl patches in the medication cart until the fentanyl box was empty. The DON acknowledged the risk of diversion for used fentanyl patches when stored in the medication cart. During a telephone interview on [DATE], at 8:33 a.m., the CP stated the CSR should account for used fentanyl patches with matching quantities. The CP stated a nurse who took a used fentanyl patch would never be caught without proper documentation. During an interview on [DATE], at 10:54 a.m., the DON stated nurses reviewed the medication cart's narcotic inventory at each shift change for accountability. The DON stated this accountability review for used fentanyl patches was not documented. A review of the facility's P&P, titled, Controlled Substances, dated [DATE], indicated: .an individual resident controlled substance record is made for each resident.This record contains.quantity received.number on hand.Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.The system of reconciling the receipt, dispensing and disposition of controlled substances includes.Records of personnel access and usage.Medication administration records.Declining inventory records.Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count.The nurse coming on duty and the nurse going off duty make the count together and document. 3. During a concurrent observation and interview on [DATE], at 3:40 p.m. with LVN 5, Medication Cart 1 was reviewed. The medication cart contained one box of fentanyl 25 mcg/hr patches for Resident 123. The box contained one opened foil packet containing a used fentanyl patch. The patch was stuck onto the inside of the foil packet. LVN 5 stated the nurses put used fentanyl patches into the opened foil packets like this and stored in the medication cart. LVN 5 stated the used patch was labeled 0800 [DATE] which meant the patch was placed at 8:00 a.m. on [DATE]. During a concurrent interview and record review on [DATE], at 3:57 p.m. with LVN 5, Resident 123's fentanyl administration record, dated [DATE], to [DATE], was reviewed. The record indicated LVN 1 placed a fentanyl patch on Resident 123 at 8:08 a.m. on [DATE]. The record further indicated the fentanyl patch was removed by LVN 7 at 8:15 a.m. on [DATE]. LVN 5 stated the used fentanyl patches were given to the Director of Nursing (DON) for destruction when all five patches in the box were used. During an interview on [DATE], at 3:10 p.m., RN 1 stated all narcotics were given to the DON for destruction. RN 1 stated used fentanyl patches were stuck to the foil packet before giving to the DON. During a telephone interview on [DATE], at 8:33 a.m., the CP stated incorrect disposal of fentanyl patches could cause death. The CP stated used fentanyl patches contained between 25% and 30% of the fentanyl dose after removal. The CP stated there was a risk drug addicts could unfold a folded fentanyl patch or remove a fentanyl patch stuck to foil. During an interview on [DATE], at 10:54 a.m., the DON stated nurses were supposed to fold used fentanyl patches in half after removing from the resident. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for fentanyl patches, dated [DATE], retrieved from DailyMed, indicated: .Proper handling of fentanyl transdermal system is necessary in order to prevent serious adverse outcomes, including death, associated with accidental secondary exposure to fentanyl transdermal system.Instruct patients to dispose of used patches immediately upon removal by folding the adhesive side of the patch to itself.Expired, unwanted, or unused fentanyl transdermal systems should be disposed of by folding the patch so that the adhesive side of the patch adheres to itself. A review of the facility's P&P, titled, Controlled Substances, dated [DATE], indicated: .Disposal methods are used to prevent diversion and/or accidental exposure to controlled or hazardous substances. Fentanyl patches are disposed of in one of the following ways.By folding in half, sticky sides together and flushing down the toilet.Using approved drug disposal products specifically for fentanyl patches.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a medication error rate of 8.82% when three medication errors occurred out of 34 opportunities during the medication administration observation for three out of five residents (Residents 36, 111, and 69). These failures resulted in medications not given according to the physician's orders and had the potential for residents to experience side effects such as nausea, upset stomach, and gastric irritation (inflammation of the stomach lining).1. During a medication pass observation on January 5, 2026, at 9:07 a.m., Licensed Vocational Nurse 1 (LVN 1) was observed administering four medications to Resident 36. The medications included one tablet of metformin (medication to treat diabetes) 1000 milligrams (mg). LVN 1 asked Resident 36 if he had eaten breakfast yet. Resident 36 stated he did not eat breakfast and would eat a banana later. Resident 36 had a physician's order, dated November 5, 2025, for metformin 1000 mg, Give 1 tablet by mouth two times a day for DM type II [diabetes mellitus type 2, disorder characterized by difficulty in blood sugar control] give with food. During an interview on January 5, 2026, at 12:45 p.m., LVN 1 stated Resident 36's metformin was not given with food. 2. During a medication pass observation on January 5, 2026, at 9:20 a.m., LVN 1 was observed administering eight medications to Resident 111. The medications included one tablet of potassium chloride (medication to treat low potassium levels) extended release (ER) 10 milliequivalents (mEq, a unit of measurement). Resident 111 had physician's orders, dated November 14, 2025, for potassium chloride ER 10 mEq Give 1 tablet by mouth two times a day for hypokalemia [low potassium levels] Give with meals. During an interview on January 5, 2026, at 12:45 p.m., LVN 1 stated Resident 111's potassium chloride orders indicated to give with a meal. LVN 1 stated the potassium tablet was given to Resident 111 after a meal. 3. During a medication pass observation on January 5, 2026 at 9:47 a.m., LVN 1 was observed administering 11 medications to Resident 69. The medications included one tablet of potassium chloride ER 10mEq. Resident 69 had physician's orders, dated November 3, 2025, for potassium chloride ER 10 mEq Give 10 mEq by mouth one time a day for Hypokalemia Give with food. During an interview on January 5, 2026, at 12:40 p.m., LVN 1 stated Resident 69's potassium chloride was administered after Resident 69 ate breakfast. LVN 1 stated the physician's orders to give the medication with food were not followed. During a telephone interview on January 8, 2026, at 8:33 a.m., the Consultant Pharmacist (CP) stated giving medications after eating was not following the physician's orders to give with food. The CP stated potassium chloride was given with food to prevent stomach upset. The CP stated nurses should offer residents food with the medication to follow the physician's orders to take with food. During an interview on January 8, 2026, at 10:47 a.m., the Director of Nursing (DON) stated if the physician's orders indicated to give a medication with food, the nurse needed to give the medication with food. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for metformin tablets, dated September 6, 2012, retrieved from DailyMed, indicated: .Metformin.should be given in divided doses with meals. and .Common side effects of Metformin.include diarrhea, nausea, and upset stomach.Taking your medicine with meals can help reduce these side effects. A review of the PI for potassium chloride ER tablets, dated November 18, 2025, retrieved from DailyMed, indicated: .Take potassium chloride extended-release tablets with meals and with a glass of water or other liquid. Do not take on an empty stomach because of its potential for gastric irritation. A review of the facility's policies and procedures (P&P), titled, Administering Medications, dated April 2019, indicated: .Medications are administered in accordance with prescriber's orders.

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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. Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for four of nineteen residents reviewed for infection control practices (Residents 125, 36, 111, and 69) when:1. For Resident 125, the nasal cannula tubing was not changed according to facility policy.2. For Residents 36, 111, and 69, shared equipment was not disinfected with the appropriate disinfectant between residents. These failures had the potential to expose residents to infection and compromise residents' health and safety in the facility. Findings: 1.On January 6, 2026, at 8:42 a.m., Resident 125, was observed in bed alert and interviewable, receiving two liters (unit of measurement) per minute of oxygen through a nasal cannula tubing (thin tubing with two prongs that goes into each nostril to deliver oxygen) dated December 29, 2025. On January 6, 2025, at 10:01 a.m., a concurrent observation and interview was conducted with the Licensed Vocational Nurse (LVN 9). LVN 9 stated she was the assigned LVN for Resident 125. LVN 9 stated Resident 125's nasal cannula tubing was dated December 29, 2025. LVN 9 stated Resident 125's nasal cannula tubing should have been changed every Sunday. Resident 125's medical records were reviewed. Resident 125 was admitted into the facility on December 28, 2025, with diagnoses which included joint replacement surgery left hip (removing damaged joint and replacing it with a prosthetic part made of metal, plastic, or ceramic). The history and physical dated December 29, 2025, indicated Resident 125 had the capacity to make decisions. The physician order dated December 29, 2025, indicated .initiate O2 (oxygen) 2 Lpm (LPM-liter per minute) via Nasal cannula continuous related to Left artificial hip + symptoms of severe SOB (shortness of breath) at NOC (night) and QHOS (every hour of sleep + daytime sleepiness) to keep SpO2 (peripheral oxygen saturation-measured by a medical device that indicates percentage of oxygen in blood) greater than 90% per MD (medical doctor) . On January 7, 2026, at 10:42 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility process was to change respiratory tubing weekly every Sunday. The DON stated Resident 125's tubing should have been changed Sunday (January 4, 2025). A review of the facility policy and procedure titled Prevention of Infection Respiratory Equipment, dated November 2011, indicated .the purpose of this procedure is to guide prevention of infection associated with respiratory therapy task and equipment among residents and staff .obtain equipment .oxygen tubing .change the oxygen cannula and tubing every seven days or as needed 2a. During an observation on January 5, 2026, at 9:14 a.m., LVN 1 was observed checking Resident 36's blood sugar with an Assure Platinum (brand name) glucometer (handheld device used to check blood sugar). LVN 1 was observed placing the used glucometer on top of the medication cart. LVN 1 did not clean or disinfect the glucometer after use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on January 5, 2026, at 10:03 a.m., LVN 1 stated he did not wipe the glucometer after checking Resident 36's blood sugar. LVN 1 stated he wiped the glucometer with an alcohol wipe from the green top container before checking Resident 36's blood sugar. LVN 1 further stated he was supposed to wipe the glucometer with the blue top wipes (Micro-Kill Bleach) before use on each resident, not the alcohol wipes. During an interview on January 5, 2026, at 10:19 a.m., LVN 1 stated he checked Resident 103's blood sugar with the glucometer, wiped with an alcohol wipe from the green top container, then checked Resident 36's blood sugar with the same glucometer. During a concurrent interview and record review on January 7, 2026, at 4:12 p.m. with the DON, the Assure Platinum Blood Glucose (sugar) Monitoring System (glucometer) reference manual, revised December 2019, was reviewed. The manual indicated: .To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed as recommended in the instructions below. .The meter should be cleaned and disinfected after use on each patient. .Clean the outside of the blood glucose meter with a lint-free cloth dampened with soapy water or isopropyl alcohol (70-80%). Disinfect the meter.[with] bleach. The DON stated the glucometer was supposed to be disinfected with bleach wipes between residents. A review of the facility's policies and procedures (P&P), titled, Obtaining a Fingerstick Glucose Level, dated October 2011, indicated: .Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between residents. and .Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. 2b. During an observation on January 5, 2026, at 9:08 a.m., LVN 1 was observed checking Resident 36's blood pressure (BP) with a shared BP cuff. During an observation on January 5, 2026, at 9:19 a.m., LVN 1 was observed checking Resident 111's BP with the same shared BP cuff. LVN 1 used an alcohol wipe from the green top container to wipe off the BP cuff before use on Resident 111. During an observation on January 5, 2026, at 9:37 a.m., LVN 1 was observed checking Resident 69's BP with the same shared BP cuff. LVN 1 used an alcohol wipe from the green top container to wipe off the BP cuff before use on Resident 69. During an interview on January 5, 2026, at 10:01 a.m., LVN 1 stated he used the alcohol wipes from the green top container to wipe the BP cuff between residents. LVN 1 stated he should have used the blue top wipes with bleach for the BP cuff. During an interview on January 5, 2026, at 10:52 a.m., LVN 3 stated the bleach wipes were supposed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be used to wipe the glucometer and the BP cuff between residents. During an interview on January 5, 2026, at 4:21 p.m., LVN 6 stated the bleach wipes were supposed to be used to wipe the glucometer and the BP cuff between residents. During an interview on January 6, 2026, at 11:41 a.m., the Infection Preventionist (IP) stated shared equipment such as the BP cuff and the glucometer needed to be wiped with bleach wipes before and after use on each resident. During an interview on January 6, 2026, at 11:54 a.m., the IP verified it was not appropriate to use alcohol wipes to sanitize shared equipment, such as the BP cuffs and glucometers, between residents. During a concurrent interview and record review on January 8, 2026, at 9:54 a.m. with the IP, the facility's P&P, titled, Cleaning and Disinfection of Environmental Surfaces, dated June 2009, was reviewed. The IP stated the following policy excerpt indicated BP cuffs needed to be wiped with bleach between uses: .Manufacturers' instructions will be followed for proper use of disinfecting (or detergent) products.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for two of five sampled residents (Residents 5 and 19) on psychotropic (affecting brain activities associated with mental processes and behavior) medications. This failure had the potential for residents or their representatives to not be fully informed of the risks and benefits of psychotropic medications before receiving treatment. 1. Resident 5 had a physician's order, dated March 19, 2025, for buspirone (generic for Buspar, a medication to treat anxiety) 5 milligrams (mg), Give 1 tablet by mouth three times a day for anxiety, restlessness. A review of Resident 5's medication administration record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated March 2025, indicated Resident 5 received buspirone three times per day from March 20, 2025, to March 28, 2025. During a concurrent interview and record review on January 7, 2026, at 1:10 p.m. with the Director of Nursing (DON), Resident 5's informed consents were reviewed. The DON stated there was no informed consent for Resident 5's buspirone started on March 19, 2025. 2. Resident 19 had a physician's order, dated December 16, 2025, for trazodone (a medication to treat depression) 50 mg, Give 50 mg by mouth one time a day for Depression m/b [manifested by] unable to fall asleep. A review of Resident 19's MAR, dated December 2025, indicated Resident 19 received trazodone from December 17, 2025, to December 31, 2025. During a concurrent interview and record review on January 8, 2026, at 10:05 a.m. with the DON, Resident 19's informed consents were reviewed. The record indicated informed consent was obtained for trazodone on January 1, 2026. The DON stated there was no informed consent for Resident 19's trazodone started on December 16, 2025. The DON verified there should be an informed consent on file from December 16, 2025. During an interview on January 7, 2026, at 12:28 p.m., the DON stated the facility obtained informed consent from the resident or representative when they received orders for psychotropic medications. The DON stated informed consent was needed for the initial order or an increased dose of a psychotropic medication. A review of the facility's policies and procedures (P&P), titled, Psychoactive/Psychotropic Medication Use, undated, indicated: .Informed Consent.The resident or resident representative has the right to be informed in advance.of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.Prior to administration of a Psychotropic medication, the prescribing clinician will obtain informed consent from the resident (or, as appropriate, the resident representative), and document the consent in the medical record.The facility must verify the presence of written informed consent in the resident's medical record before initiating treatment with psychotropic medication.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to meet professional standards when one of five sampled residents (Resident 19) did not have documentation to support a diagnosis of schizophrenia (a mental illness characterized by disturbances in thought). This failure had the potential for unnecessary and inappropriate use of antipsychotic (medications to treat mental illness like schizophrenia) medications.A review of Resident 19's admission Record, printed on January 8, 2026, indicated the resident was admitted to the facility from the hospital on December 10, 2025, with diagnoses including dementia (a progressive state of decline in mental abilities). The record also indicated Resident 19 had a previous admission to the facility on December 30, 2024. Resident 19 had physician's orders, dated December 10, 2025, for the following medications: - Quetiapine (generic for Seroquel, an antipsychotic medication to treat mental illness) 25 milligrams (mg), Give 1 tablet by mouth at bedtime for schizophrenia m/b [manifested by] hallucinations - Quetiapine Give 12.5 mg by mouth two times a day for schizophrenia m/b hallucinations A review of Resident 19's medication administration record (MAR, daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated December 2025, indicated Resident 19 received doses of quetiapine from December 11, 2025, to December 16, 2025. The December 2025 MAR further indicated both orders for quetiapine were discontinued on December 16, 2025. A review of Resident 19's MAR, dated December 2025, indicated to Monitor Episodes Of schizophrenia AEB [as evidenced by]: hallucinations.every shift, from December 10, 2025, to December 16, 2025. The December 2025 MAR indicated Resident 19 did not exhibit any episodes of hallucinations. During a concurrent interview and record review on January 8, 2026, at 10:05 a.m. with the Director of Nursing (DON), Resident 19's admission record, dated December 10, 2025, was reviewed. The DON stated Resident 19's schizophrenia diagnosis was added to his medical record on December 10, 2025. Resident 19's hospital discharge records, dated December 10, 2025, were reviewed. The DON stated there was no history of schizophrenia before admission to the facility. The DON stated Resident 19's Comprehensive Psychiatric Evaluation, dated December 16, 2025, and completed by a psychiatrist, did not include a diagnosis of schizophrenia. The DON stated Resident 19's Physician Progress Notes, dated December 15, 2025, to January 5, 2026, indicated a diagnosis of schizophrenia and to continue quetiapine. The DON stated Resident 19's medical records did not include documentation to support the schizophrenia diagnosis. During a concurrent interview and record review on January 8, 2026, at 11:26 a.m. with the MDS (minimum data set, a resident assessment tool) Coordinator 1 (MDSC 1), Resident 19's medical record was reviewed. MDSC 1 verified Resident 19 did not have a schizophrenia diagnosis prior to admission to the facility. MDSC 1 stated the facility's physician diagnosed Resident 19 with schizophrenia upon admission to the facility. MDSC 1 stated schizophrenia was an active diagnosis for Resident 19. Resident 19's MDS Section I - Active Diagnoses, dated December 16, 2025, indicated schizophrenia under Active Diagnoses in the last 7 days. MDSC 1 stated a schizophrenia diagnosis was documented in the MDS Section I because the physician included schizophrenia in the physician's orders for quetiapine, dated December 10, 2025. During a concurrent interview and record review on January 8, 2026, at 11:38 a.m. with MDSC 1, Resident 19's 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] Level 1 Screening, dated December 11, 2025, was reviewed. The PASRR indicated No in response to the question, Diagnosed Serious Mental Illness. Does the individual have a serious diagnoses mental disorder such as.Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? MDSC 1 stated the PASSR was completed by the hospital prior to admission to the facility. MDSC 1 stated Resident 19's schizophrenia diagnosis came from the facility's physician, not the hospital. During an interview on January 8, 2026, at 11:48 a.m., the DON stated the facility's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician indicated Resident 19's schizophrenia diagnosis in the quetiapine medication orders and the physician progress notes. The DON stated this was the only evidence she could provide regarding the initial schizophrenia diagnosis for Resident 19. The DON stated there was no other documentation addressing Resident 19's new diagnosis of schizophrenia upon admission to the facility. A review of Resident 19's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated December 30, 2024, and completed by the DON, indicated No in response to the question, Diagnosed Serious Mental Illness. Does the individual have a serious diagnoses mental disorder such as.Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? A review of Resident 19's psychiatric consultation notes, dated January 21, 2025, indicated .No evidence of hallucinations or delusional thoughts. The notes did not indicate a diagnosis of schizophrenia. A review of Resident 19's psychiatric consultation notes, dated February 11, 2025, indicated .patient has no behavior problems at this time.No evidence of hallucinations or delusional thoughts. The notes did not indicate a diagnosis of schizophrenia. A review of Resident 19's hospital Discharge Summary, dated December 10, 2025, indicated discharge diagnoses including Delirium [serious disturbance in mental abilities that results in a decreased awareness of one's environment and confused thinking] with baseline dementia - improving. The record did not include a diagnosis of schizophrenia. A review of Resident 19's Physician History and Physical, dated December 12, 2025, completed by the facility's physician, indicated: .Patient seems to be in no acute distress, reports is doing well, and there are no recent events per nursing staff reports. and Assessment and Plan.Schizophrenia m/b hallucinations.Continue quetiapine. A review of Resident 19's Comprehensive Psychiatric Evaluation, dated December 16, 2025, indicated .Taking Seroquel for agitation associated with dementia. The record further indicated dementia with agitation and depression under psychiatric history. The Assessment section indicated a checkmark next to Dementia with agitation and did not indicate a checkmark next to schizophrenia. The record indicated to discontinue both quetiapine orders. A review of the facility's policies and procedures (P&P), titled, Psychotropic / Anti-Psychotic Medication Use / PASRR, dated December 2016, indicated: .Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident.Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders.Schizophrenia.Psychosis [severe mental condition in which thought and emotions are so affected that contact is lost with reality] in the absence of dementia . A review of the facility's clinical protocol, titled, Schizophrenia and Related Disorders, dated 2001, indicated: .The physician/practitioner and staff will identify and document individuals who have a history of schizophrenia.The practitioner will not newly diagnose a resident with a serious mental illness without evidence-based criteria that are documented in the resident's medical record.The rationale for the diagnosis will be based on a comprehensive assessment of the resident's physical, behavioral, mental status, psychosocial status, and comorbid conditions. Documentation will include.the findings from the comprehensive assessment.the presence and duration of symptoms, behaviors, and disturbances consistent with current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for schizophrenia.that the symptoms, behaviors, and disturbances are not attributable to substances, medications, or other conditions .the effect the disturbance is having on the resident's function, self-care, or interpersonal relationships, in comparison to before the onset of the disturbance .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an observation, interview, and record review, the facility failed to follow its established smoking policy for one of one residents reviewed (Resident 20) when smoking materials were not stored in a locked container as required by the facility's policy.This failure had the potential to create environmental risk, hazards and accidents such as fire and/or burn injuries.Findings:On January 6, 2026, at 9:08 a.m., Resident 20 was observed in the smoking patio area unsupervised. Resident 20 stated he was an independent smoker and did not require supervision. Resident 20 stated he was allowed to keep his smoking materials since he was an independent smoker.On January 7, 2025, at 9:19 a.m., an observation of Resident 20's room was conducted. Resident 20 shared a room with a resident who was on oxygen. The sign on the outside of Resident 20's room indicated oxygen in use no smoking.On January 6, 2026, at 2:01 p.m., a concurrent interview and record review was conducted with the Social Service Director (SSD). The SSD stated the facility process for smokers was to perform a smoking assessment to determine if the resident was an independent smoker or dependent smoker. If the resident was an independent smoker the resident would be allowed to keep their smoking material with them in a locked box and could smoke unsupervised. The SSD stated Resident 20 was an independent smoker. The SSD stated Resident 20 kept his smoking materials with him. The SSD stated Resident 20 did not have a locked box for his smoking materials and the locked boxes were scheduled to arrive at the facility tomorrow (January 7, 2026). The SSD further stated Resident 20 should have had a locked box for his smoking materials prior to allowing him to smoke independently.Resident 20's medical records were reviewed.Resident 20 was admitted to the facility on [DATE], with diagnoses which included spinal stenosis cervical (narrowing of the spinal canal in the neck).The history and physical completed on October 21, 2025, indicated Resident 20 had the capacity to make decisions.The smoking assessment dated [DATE], indicated .smoking cigarettes .no impairment .level of assistance .independent .On January 7, 2026, at 10:42 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility policy for smoking was for a smoking assessment to be conducted by the SSD with the resident, inform the residents of the smoking policy which included the times and designated smoking area. The DON stated the smoking assessment indicated Resident 20 was an independent smoker. The DON stated independent residents were allowed to keep their smoking materials with them in a locked box. The DON stated the facility did not currently have lock boxes available.A review of the facility policy and procedures titled Smoking Policy-Residents, undated indicated .upon admission, residents shall be informed about any limitations on smoking designated smoking areas .The staff shall consult with attending physician and Interdisciplinary Team (IDT) to determine any restrictions on a resident smoking privileges as needed Smoking articles for residents with smoking privileges: .Residents who have smoking privileges shall not be permitted to keep cigarettes, pipes, tobacco, or other smoking articles in their possession or at the bedside unless assessed as independent by the IDT .Patient will be provided a lock box .Smoking articles will be kept secured at the nursing station provided to the residents as requested and/ or needed .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nutritional care and services were provided for one of two residents reviewed for nutrition (Resident 92), when the physicians order to stop fluid restriction was not observed by the nursing and kitchen staff timely. This failure had the potential for Resident 92 to not have her preferences honored, and/or lead to weight loss and compromised nutritional status.Findings: On January 5, 2026, at 10:09 a.m. a concurrent observation and interview was conducted with Resident 92. Resident 92 indicated she was not made aware as to why she was on a fluid restriction. One 800 ml (milliliters -a unit of measure) clear bottle was on the bedside table. The meal ticket on the bedside table indicated 240ml fluid restriction. Resident 92 stated she should not be on a fluid restriction and that she was unsure about what the fluid restriction included. A review of Resident 92's medical record was conducted. Resident 92 was admitted to the facility on [DATE], with readmission date of December 19, 2025, with a diagnoses of edema (swelling of the body under the skin), heart failure, and pneumonia (lung infection). The Minimum Data Set (MDS - an assessment tool), dated November 22, 2025, indicated Resident 92 had a BIMS (Brief Interview for Mental Status) score of 12 (cognitively intact). A review of the Order Summary indicated the following physicians diet orders: Order date: December 19, 2025, .CCHO (Consistent/Controlled Carbohydrate Diet), NAS ((No Added Salt) diet.regular texture.thin consistency, Fluid restriction 1.5 L/day (liters per day - a unit of measurement) dietary = 720 ml/day (Breakfast/Lunch/Dinner: 240 ml); Nursing =780 ml/day (AM 360ml, PM 240ml, NOC. 180ml) (a unit of measurement).Discontinue January 2, 2026.increase nutrient need. Order date: January 3, 2025, .Fortified, CCHO, NAS diet.Regular texture.Thin consistency. A review of the Meal Ticket Diet Order for Resident 92 dated January 7, 2026, indicated, .Diet order: Regular, CCHO, Fortified, Thin, NAS.notes.Fluid Restriction 240 ml's. A review of the Nursing Progress Note, dated January 5, 2026, at 3:55 p.m., indicated, .Physician left orders to remove patient off of fluid restriction per patient request. Orders are initiated and dc (discontinued).There was no indication an order for a fluid restriction was continued from January 2, 2026, to January 5, 2026, or that the restriction was communicated with the kitchen and the nursing staff. On January 7, 2026, at 10:43 a.m. a concurrent observation and interview and record review was conducted with Licensed Vocational Nurse (LVN 8). LVN 8 indicated Resident 92 was not on a fluid restriction and that she did not have an active order for fluid restriction. LVN 8 stated she could not recall seeing a measured fluid water container that required nursing to record the amount of fluid that would normally be used to record the fluid intake for residents on fluid restriction. There was no clear container with measurable portions observed at the bedside for Resident 92. On January 7, 2026, at 10:55 a.m., a concurrent interview and record review was conducted with the Dietary Supervisor (DS). The DS was asked to provide the current diet order for Resident 92. The DS indicated Resident 92 had the following diet order; Fortified, CCHO, NAS diet.regular texture.thin consistency. The DS was asked to review the current meal ticket for Resident 92. The DS reviewed the meal ticket and stated in the notations section Resident 92 had a Fluid Restriction 240 ml. The DS stated, I don't see an order for the fluid restriction, the order was from December 19, 2025, to January 2, 2026, and it was discontinued on January 2, 2026, so that order should have been removed. The DS stated that it was the responsibility of the nursing staff to communicate orders for diet changes and that the RD (Registered Dietitian) should update the orders and the nurses would provide a printed copy of the orders to her so that she could update the dietary meal ticket processing system. The DS further stated the diet orders should be followed in order to honor the resident preferences and according to the physicians' orders. On January 7, 2026, at 12:02 p.m. concurrent interview and record review was conducted with the Director of Nursing (DON). The DON was asked about the protocols for dietary orders. The DON stated the expectation was that the RD consultant would change the orders for diets according to the physicians orders and the nurses would confirm the orders, document the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change and communicate with the kitchen. A review of the medical record was conducted with the DON. The DON stated the current diet order on the meal ticket for Resident 92 did not reflect the current diet order. The DON further stated there was a possibility the resident could become upset if the facility did not honor the diet preferences and follow the physician orders. On January 7, 2026, at 3:34 p.m. an interview was conducted with the Registered Dietitian (RD). The RD stated Resident 92 was admitted [DATE], with an order for a fluid restriction which ended on January 2, 2026. The RD further stated that the nursing staff or the kitchen supervisor should have communicated with her the discontinuation of the fluid restriction and updated the resident's diet order. A review of the facility policy and procedures titled, Physicians Orders, Accepting, Transcribing and Implementing (noting), dated January 2017, indicated, .Licensed nursing personnel will ensure that written (noting), telephone, and verbal orders will be recorded and implemented. All physician orders are to be complete and clearly defined to ensure that accurate implementation.licensed nursing shall verify each order for completeness, clarity and appropriateness.record order changes in nursing notes.

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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. Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 123) was free of unnecessary medications when side effects were not monitored with the administration of an anticoagulant (blood thinner). This failure had the potential for undetected bleeding and harm to residents.Resident 123 had a physician's order, dated December 27, 2025, for heparin (an anticoagulant medication), to Inject 5000 unit subcutaneously [under the skin] every 8 hours for DVT [deep vein thrombosis, type of blood clot] prophylaxis [prevention]. During an interview on January 7, 2026, at 12:40 p.m., the Director of Nursing (DON) stated all residents on anticoagulants, including heparin, were monitored for bleeding and bruising. During a concurrent interview and record review on January 7, 2026, at 1:18 p.m. with the DON, Resident 123's physician's orders were reviewed. The physician's order, dated January 2, 2026, indicated to Monitor for S/S [signs and symptoms] of bleeding q [every] SHIFT e.g. Epistaxis [nosebleed], Blood Stool, Bruising, Notify MD [physician] for any of the above changes. Resident 123's December 2025 and January 2026 Medication Administration Records (MAR, daily documentation record used by a licensed nurse to document medications and treatments given to a resident) were also reviewed. Resident 123's MARs indicated Resident 123 received at least one dose of heparin per day from December 28, 2025, to January 1, 2026. The record did not indicate the facility monitored Resident 123 for signs and symptoms of bleeding on these dates. The DON stated Resident 123 started heparin on December 27, 2025, and the monitoring for bleeding started on January 2, 2026. The DON stated the facility's protocol was to have orders to monitor bleeding for all residents on anticoagulants. A review of Resident 123's care plans, dated December 28, 2025, indicated a care plan for anticoagulant medication. The care plan indicated: .Assess for signs signifying blood loss (e.g., petechiae [tiny bleeding spots under the skin], bruises, dark-colored stools, etc.) . and .Monitor for bruising or bleeding . A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for heparin injection, dated April 15, 2025, retrieved from DailyMed, indicated: .Fatal hemorrhages [excessive bleeding] have occurred.Hemorrhage is the chief complication that may result from heparin therapy. Bleeding can occur at any site. A review of the facility's clinical protocol, titled, Anticoagulation - Clinical Protocol, dated 2001, indicated: .The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056485	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Gardens Care Center	3688 Nye Avenue Riverside, CA 92505

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medications according to the facility policy and procedures (P&P) and manufacturer's specifications when:1. One room temperature medication was inappropriately stored in the refrigerator in one of one reviewed medication rooms (Medication room [ROOM NUMBER]),2. One expired medication was stored in one of one reviewed medication rooms (Medication room [ROOM NUMBER]), and3. One inhaler was not labeled with an open date in one of two reviewed medication carts (Medication Cart 1).These deficient practices had the potential for inadequate medication monitoring, which could lead to the use of unsafe and ineffective medications for the residents. 1. During a concurrent observation and interview on [DATE], at 3:05 p.m. with Licensed Vocational Nurse 2 (LVN 2), Medication room [ROOM NUMBER] was toured. The medication fridge contained one box of epinephrine (a medication to treat medical emergencies) 0.3 milligram (mg) auto-injector (medical device to inject a premeasured medication dose) labeled for Resident 92. LVN 2 stated the epinephrine auto-injector pens were not supposed to be stored in the refrigerator. 2. During a concurrent observation and interview on [DATE], at 3:05 p.m. with LVN 2, Medication room [ROOM NUMBER] was toured. LVN 2 stated Resident 92's epinephrine auto-injector expired on [DATE], and the medication was not good. During an interview on [DATE], at 3:52 p.m., the Director of Nursing (DON) stated expired medication needed to be discarded. The DON acknowledged Resident 92's epinephrine auto-injector was expired and inappropriately stored in the refrigerator. Resident 92 had a physician's order, dated [DATE], for EPINEPHrine Injection Solution Auto-injector 0.3 MG/0.3ML [milliliters] Inject 0.3 ml intramuscularly [into the muscle] as needed for Anaphylaxis [sudden and severe allergic reaction]. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for epinephrine auto-injector, dated February 15, 2023, retrieved from DailyMed, indicated: .Store at 20 C to 25 C (68 F to 77 F). and .Do not refrigerate. and .Properly dispose all used, unwanted or expired epinephrine.auto-injectors. A review of the facility's P&P, titled, Storage of Medications, dated [DATE], indicated: .Drugs.are stored.under proper temperature.controls. and .Discontinued, outdated, or deteriorated drugs.are returned to the dispensing pharmacy or destroyed. 3. During a concurrent observation and interview on [DATE], at 3:50 p.m. with LVN 5, Medication Cart 1 was reviewed. The medication cart contained an opened pouch with a Symbicort (medication used for chronic obstructive pulmonary disease [COPD], a lung disease causing breathing problems) 80-4.5 micrograms (mcg, a unit of measurement) inhaler for Resident 127. LVN 5 stated nurses were supposed to label all inhalers with an open date immediately after opening. LVN 5 stated Resident 127's Symbicort inhaler wasn't labeled and it should have been. During an interview on [DATE], at 3:52 p.m., the DON stated Resident 127's Symbicort inhaler was supposed to be labeled with the date it was opened. Resident 127 had a physician's order, dated [DATE], for Symbicort 80-4.5 mcg, 2 puff inhale orally [by mouth] two times a day for COPD. A review of the PI for Symbicort, dated [DATE], retrieved from DailyMed, indicated: .The inhaler should be discarded when the labeled number of inhalations have been used or within 3 months after removal from the foil pouch. A review of the facility's P&P, titled, Administering Medications, dated [DATE], indicated: .When opening a multi-dose container, the date opened is recorded on the container.

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	056485	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Gardens Care Center	3688 Nye Avenue Riverside, CA 92505

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 store, prepare, and distribute food in accordance with professional standards for food safety when one unopened carton of 237 ml (milliliter - a unit of measurement) Boost (nutritional supplement) with an expiration date of September 24, 2025, was found stored in residents' refrigerator # (number) 1 located in nurse's station 1.This failure had the potential to cause foodborne illnesses when consumed by a medically vulnerable resident.Findings:On January 7, 2026, at 10:38 a.m., an inspection of Residents' refrigerator #1 located in Nurse's Station 1 was conducted with Licensed Vocational Nurse (LVN) 9. One unopened carton of 237ml Boost with an expiration date of September 24, 2025, was found stored in Residents' refrigerator #1 and readily available for consumption. LVN 9 stated the expired Boost should have been discarded since it had an expiration date of September 24, 2025. LVN 9 stated she was not sure why the expired Boost was still in the refrigerator when the residents' refrigerator was inspected daily by the staff.During an interview on January 7, 2026, at 2:25 p.m., with the Director of Nursing (DON), she stated the facility did not have Boost for nutritional supplements. She stated the facility staff should check for expiration dates when receiving food brought from home and should be labeled and dated. She also stated there should be no expired food in the residents' refrigerator.During an interview on January 7, 2026, at 11:20 a.m., with the Dietary Supervisor (DS), she stated there should be no expired food in the refrigerator including the residents' refrigerator.During an interview on January 9, 2026, at 12:28 p.m., with the Registered Dietician (RD), she stated food brought from home should be dated and labeled. She stated the nurses should check for the expiration date. She stated there should be no expired food in the refrigerator. The RD stated expired food when consumed could cause the resident to get sick.The facility policy and procedure titled, FOOD FOR RESIDENTS FROM OUTSIDE SOURCES, revised July 18. 2023, indicated, .Food items are inspected for safety.before they are stored and/or served in accordance with food safety standards.Perishable food that requires refrigeration, can be stored for the resident in the refrigerator.If unopened, refrigerated/frozen items will be disposed of by the expiration date on the container.The facility policy and procedure titled, Foods Brought by Family/Visitors, dated May 28, 2025, indicated, .The nursing staff will discard perishable foods on or before the use by date.