STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor Resident 3's right to exercise choice and autonomy when staff did not provide the resident with a shower on her regularly scheduled shower date (1/13/2026). This failure interfered with Resident 3's ability to participate in decisions about her daily routine and preferences and resulted in the resident expressing feelings of neglect and sadness. Findings: A review of the facility's policy and procedure titled Activities of Daily Living (ADLs), Supporting, undated, indicated: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. A review of Resident 3's admission Record (AR) indicated that Resident 3 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection) and type 2 diabetes mellitus (high blood sugar). A review of Resident 3's History and Physical (H&P) dated 12/30/2025 indicated that Resident 3 had the capacity to understand and make decisions. A review of Resident 3's Minimum Data Set (MDS), a resident assessment tool, dated 1/02/2026 indicated Resident 3 was cognitively intact (normal thinking and memory). The MDS further indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort, lifts or holds trunk or limbs, and provides more than half the effort) with oral hygiene, toileting, shower/bath, lower body dressing, lying to sitting, chair-to-bed transfer, and toilet transfer. A review of Resident 3's Care Plan (CP) for ADL (Activities of Daily Living) Self-Care, initiated on 11/05/2025, indicated interventions for bathing: Resident 3 requires partial/moderate assistance from staff to provide a bath as necessary. A review of Resident 3's CP indicated that While in the facility, Resident 3 states that it is important that she has the opportunity to engage in daily routines that are meaningful relative to her preference, initiated on 11/02/2025, the CP indicated the goal: Resident 3 will express satisfaction that her daily routines and preferences are accommodated by staff. Interventions included: It is important for Resident 3 to choose between a tub bath, shower, bed bath, or sponge bath. A review of the facility-provided document for Resident 3's bathing task indicated the following entries dated 1/13/2026: Bathing self-performance (ability to bathe self, including washing, rinsing, and drying self, excluding washing of back and hair): Not applicable. Type of bath: Not applicable. Were there any reddened areas observed on skin that did not go away: Not applicable. During an interview on 1/13/2026 at 4:00 PM, Resident 3 stated she had not received a shower that day, which was her regularly scheduled shower day. Resident 3 stated there are many times the nurses do not help her shower even though she asks multiple times, and that makes her feel depressed and useless because she depends on staff for assistance. Resident 3 stated she has her own personal shampoo, conditioner, and (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soap and does not understand why staff would not help her shower. Resident 3 stated when she asked for a shower earlier that day, her Certified Nurse Assistant (CNA) told her she would get to it when she had time but never returned. During an interview on 1/14/2026 at 10:30 AM, CNA 3 stated she was assigned to Resident 3 on 1/13/2026 and 1/14/2026. CNA 3 stated Resident 3's regular shower days are Tuesdays and Thursdays. CNA 3 stated she did not assist Resident 3 with a shower on 1/13/2026 because she was busy. CNA 3 stated she initially went to Resident 3's bedside in the morning to take her to the shower, but Resident 3 said not right now because she was in pain. CNA 3 stated she did not return later to ask Resident 3 if she wanted a shower because she was busy with other residents. CNA 3 stated she did not notify anyone else that Resident 3 had not received her shower because she was busy and forgot. During an interview with the Director of Nursing (DON) on 1/14/2026 at 9:30 AM, the DON stated Resident 3 should be showered on her scheduled shower days and can also receive additional showers on non-scheduled days if requested. The DON stated if assigned CNAs cannot provide a shower on a scheduled day, they should notify the charge nurse so another staff member can assist the resident.

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to monitor and establish a system to implement the facility's policy and procedure (P&P) titled Visitation which indicated that visitation may be subject to reasonable clinical and safety restrictions to protect residents, including denying or limiting access to individuals suspected of bringing illegal substances into the facility for one of three sampled residents (Resident 1), who has a history of alcohol and substance abuse (harmful or hazardous use of psychoactive substances [any chemical that changes brain function, affecting mood, perception, consciousness, and behavior]). The facility failed to increase supervision and reassess visitation access for Resident 1's family member (FM 2) or other visitors of Resident 1, despite previous incidents of visitor-introduced contraband on 7/15/2025, 11/27/2025, and 1/4/2026. Despite this, the facility continued to allow Resident 1's visitor (FM 2) unsupervised and unrestricted visits during another visitation on 1/11/2026, after Resident 1 returned from the GACH on 1/5/2026 due to alcohol intoxication. FM 2, who had previously been witnessed by facility staff providing Resident 1 with alcohol, marijuana, and other unknown smoking materials, continued to visit Resident 1 unsupervised, placing Resident 1 at risk for harm, including accidental overdose, fire hazards, and other safety risks. Cross Referenced to F689 Findings: During a review of the facility's P&P titled, Visitation, dated 11/2025, the P&P indicated some visitation may be subject to reasonable clinical and safety restrictions to protect the health, safety, security, and/or rights of the facility's residents by denying access or providing limited and supervised access to an individual found to be abusing, coercing or exploiting a resident, and limiting visitation to individuals who have a history of bringing illegal substances into the facility and/or had been found to have committed criminal act. During a review of the facility's policy and procedure (P&P) titled, Substance Use Disorder, dated 4/2025, the P&P indicated Residents who are admitted to the facility with substance use disorder will receive the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being, provided by the facility and the in accordance with the comprehensive assessment and care plan. During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 11/27/2023 and readmitted on [DATE] with diagnoses that include psychoactive substance abuse and paraplegia (inability to voluntarily move the lower parts of the body). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 10/10/2025, indicated Resident 1's had no cognitive impairment (ability to understand and make decisions). The MDS indicated Resident 1 required partial/moderate assistance with eating, oral hygiene, personal hygiene, and was dependent on staff with transfers and impaired mobility on both upper and lower extremities. During a review of Resident 1's Care Plan (CP) for substance use (alcohol/drugs) related to a history of addiction and fentanyl overdose, dated 12/6/2023 and updated on 8/5/2025, to observe for signs/symptoms of withdrawal for detoxification (a medical or supervised process of removing alcohol or drugs from the body, managing symptoms, and addressing physical dependence), reassess resident to determine if substance use can be effectively managed in the current setting, and evaluate need for psych/behavioral health consult. During a review of Resident 1's Progress Notes (PN), dated 5/15/2025, the PN indicated Resident 1's Family Member (FM) 2 was staying almost every night in Resident 1's room. The PN also indicated that the Director of Nursing (DON) was notified, and police were notified due to suspicious behavior. During a review of Resident 1's Care Plan for substance abuse, dated 6/9/2025, indicated to monitor the resident for signs and symptoms of substance use and abuse such as confusion, drowsiness, outburst of anger, (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and changes in mood. There was no documented evidence, during a review of Resident 1's records from 6/9/2025 to the present, indicating that the facility monitored Resident 1 for signs and symptoms of substance use or abuse-such as confusion, drowsiness, outbursts of anger, and mood changes-as outlined in the care plan to prevent substance use and abuse. During a review of Resident 1's PN, dated 7/15/2025 timed at 9:16 AM, the Director of Social Service (DSS) documented on 7/15/2025, that nursing staff (LVN1) witnessed Resident 1 with a vape, then DSS came into room with the Director of Staff Development (DSD), and the DSD took vape from Resident 1. During a review of Resident 1's PN, dated 7/15/2025 timed at 9:05 PM, LVN 1 documented Resident 1 was found smoking a vape and had certain pills. During a review of Resident 1's PN, dated 7/16/2025, documented by SSD indicated during the Interdisciplinary Care Conference (IDT), a nursing staff observed Resident 1 in possession of a vape in his room and taken away a [NAME] vape, a [NAME] Kawali Live Resin vape(a portable, battery-powered device used to heat substances-nicotine liquids, cannabis [weed and marijuana, a mind-altering substance] oils, concentrates or dry herbs-into an inhalable vapor without combustion), and blue chew (a chewable tablets that treat erectile dysfunction [the consistent inability to achieve or maintain a firm erection for sexual intercourse] male enhancement tablets. The PN indicated these items were removed due to safety concerns and the potential for adverse interactions with the resident's current medications. During a review of Resident 1's PN, a late entry note dated 7/17/25 timed at 9:52 AM Director of Nursing (DON) 2 documented that on 7/15/2025 during the 3 to 11 shift, an LVN found Resident 1 in possession of a vape in his room and male enhancement pill. The note indicated the facility had removed a [NAME] vape, [NAME] Kawali Live Resin vape, and Blue Chew male enhancement tablets due to safety concerns and potential interference with Resident 6's medications and was given to FM 1. DON 2 documented in Resident 1's records that due to Resident 6's history of substance-related behaviors, ongoing monitoring was recommended. There was no documented evidence, during a review of Resident 1's records from 7/17/2025 to the present, indicating that the facility supervised, monitored for any suspicious behaviors due to history of substance related behaviors, signs and symptoms of substance use and abuse as outlined in the DON 2's late entry note on 7/17/2025 to prevent Resident 1 from substance abuse and use. During a review of Resident 1's PN, dated 10/8/2025, the PN indicated Resident 1 was educated on facility policy that no marijuana was to be used in the facility due to complaints of Resident 1's room smelling like weed, and Resident 1 was noted to be with a visitor. The PN further indicated Resident 1, and the visitor were educated on facility policy. The PN did not indicate who Resident 1's visitor that was mentioned in Resident 1's progress note. There was no documented evidence, during a review of Resident 1's records, that the Care Plan for risk of substance use related to a history of addiction-developed on 12/6/2023 and revised on 11/3/2025-included new nursing interventions such as re-education of Resident 1 and the resident's visitor regarding the smell of weed in the room, as documented in Resident 1's progress notes on 10/8/2025. No new interventions were added on 11/3/2025, despite the care plan indicating a revision on that date. There was no documented evidence that the care plan on substance abuse, developed on 6/9/2025 was revised to add interventions after Resident 1 and an unknown visitor was educated on the facility policy that no marijuana was to be used in the facility. During a review of Resident 1's PN, dated 11/27/2025, Resident 1 was observed by Restorative Nursing Assistant (RNA) 1 outside at the front of the facility smoking (unknown smoking material) in the presence of FM 2. The PN indicated Resident 1 was approached by Licensed Vocational Nurse (LVN) 2 and the Administrator (ADM) and was educated on the facility smoking and safety precautions. The PN indicated that the Registered Nurse (RN), Responsible Party and Nurse Practitioner (NP) were made aware, with new order to closely monitor Resident 1 for any (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes in altered level of consciousness (ALOC). The PN indicated supervisor and the ADM were notified. There was no documented evidence, during a review of Resident 1's records from 11/27/2025 to the present, that a reassessment of Resident 1's level of consciousness-including monitoring for signs and symptoms of substance use or abuse-was performed following observations on 11/27/2025 by RNA 1, LVN 2, and the Administrator that Resident 1 was smoking an unknown smoking material, in the presence of FM 2, in front of the facility. During a review of Resident 1's PN- Situation, Background, Assessment, and Recommendation (SBAR- a documentation process to facilitate concise, clear, focused communication) Summary, dated 1/4/2026 timed at 4:40 PM, indicated Resident 1 was found vomiting, with foaming in his mouth and FM 2 was by his side. The SBAR indicated the environment smelled like alcohol and FM 2 admitted he gave Resident 1 alcohol. The SBAR also indicated that the RN contacted the doctor and called 911 and was sent to emergency room (ER). During a review of Resident 1's PN, dated 1/4/2026 timed at 5:57 PM, the PN indicated the charge nurse went into the resident's room with Certified Nursing Assistant (CNA) and found Resident 1 vomiting and kept dropping his head. The PN indicated a smell of smoking noted. The PN indicated FM 2 admitted giving Resident 1 alcohol. The PN indicated MD was notified and 911 was called, and Resident 1 was transferred to the hospital. During a review of Resident 1's General Acute Care Hospital (GACH) indicated Resident 1 was admitted in the Emergency Department Reports on 1/4/2026 at 4:48 PM and was discharged on 1/5/2026 with diagnosis of alcohol intoxication and alcohol abuse, and the laboratory results of ethanol/alcohol level blood of 126. During a review of Resident 1's PN indicated the resident arrived at the facility on 1/5/2026 at 2:19 AM without pain. The PN did not have any documentation that supervision and monitoring were to be provided to Resident 1 and to FM 2 when the resident returned to the facility. During a review of the facility's Visitor Sign in Sheet, dated 1/11/2026 at 11:43 AM, indicated FM 2 visited Resident 1 in the facility and on 1/5/2026, 1/6/2026, 1/12/2026. Resident 1's friends visited. During an interview on 1/13/2026 at 11:42 AM with the Administrator (ADM), the ADM stated on 7/15/2025, Resident 1 was found with vape pens and Blue Chew pills inside Resident 1's personal belongings at the bedside. The ADM explained Resident 1 and FM 1 who were interviewed did not want to say where the resident obtained the vape and the blue pills. The ADM stated the facility did not investigate to determine the source of the vape pens and blue Chew pills that the resident possess. The ADM stated the items found at Resident 1's bedside was given to FAM 1. During an interview on 1/13/2026 at 11:55 AM, inside Resident 1's room FM 1 stated, FM 2 gave Resident 1 juice, but FM 2 was not aware that there was alcohol in it on 1/4/2026. FM 1 stated Resident 1 took a sip and made him sick because he had never had it before. During a concurrent interview and record review on 1/13/2026 at 5PM with DON 1, Resident 1's Care Plan was reviewed. DON 1 stated the facility had not developed a care plan to address Resident 1's alcohol use in the facility that occurred on 1/4/2026 because they were waiting for the involvement of family members in the IDT meeting and care planning. DON 1 stated the facility did not deny and continued to allow FM 2 and FM 1 and friends of Resident 1 with visits without restrictions or supervision during the visitation. During an interview on 1/14/2026 at 12:22 PM with RNA 1, RNA 1 stated on 11/27/2026 while she was walking in the front of the facility, she saw FM 2 smoking a small thing (unknown smoking material) and then he leaned over to Resident 1 who was facing him and put the smoking material to Resident 1's mouth. RNA 1 stated she saw Resident 1 smoked, but she does not know what type of smoking material Resident 1 and FM 2 smoked because she did not approach Resident 1 and FM 2. RNA 1 stated, she immediately reported the incident to LVN 2 because she was concerned for Resident 1's health. RNA 1 stated she did not know if Resident 1 could be smoking with FM 2. During a concurrent interview and record review on 1/14/26 at 4:42 PM with MDS Nurse (MDSN), (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's medical record was reviewed. The MDSN stated there was no documented evidence the facility processed an SBAR or conduced an IDT meeting with Resident 1, FM 1 and FM 2 and the resident's primary care physician to discuss the incidents of suspicious behavior when FM 2 stayed almost every night in Resident 1's room documented in NP on 5/15/2025, smoking and vaping what smelled like marijuana in the room, possession of vaping pens and blue chews on 7/15/2025. The MDSN stated there was no documented evidence that the facility supervised, monitored for behavior and signs and symptoms of substance use and abuse as indicated in the care plan to prevent Resident 1 from substance abuse and use. During a concurrent interview and record review on 1/14/2026 at 5:30 PM with the ADM, Resident 1's medical record was reviewed. The ADM stated was not aware of this incident 5/15/2025 regarding the suspicious behavior because she was not the ADM at the facility at that time. The ADM stated on 7/15/2025, Resident 1 did not want to tell her and other staffs where he obtained the vape and the blue pills for male enhancement. The ADM stated on 11/27/2025, the facility staff reported to her that Resident 1 was smoking with FM 2. the police department and state agency were not informed, and the facility does not have an investigation into the case. On 1/4/2026, the facility staff attempted to do investigation, but Resident 1 refused and FM 1 declined to attend. The ADM stated the facility did not inform the staff of what specific behavior Resident 1 should monitor for. During an interview on 1/14/2026 at 5:40 PM with the ADM, the ADM stated the facility did not restrict or deny visitation or supervise FM 2 when he visited Resident 1. The ADM stated when FM 2 and Resident 1 were not supervised or monitored for drug use because the IDT wanted to meet with Resident 1, FM 1 and FM 2 first to discuss possible interventions to prevent the incident from happening again. During an interview on 1/14/2026 at 6:51 PM with RN 1, RN 1 started on 1/4/2026 during the evening shift, she heard an overhead page and was informed by LVN 1 to check Resident 1 in the room. RN 1 stated when she entered the room, she observed Resident 1 not looking good and throwing up with head down, looking weak and could not communicate. RN 1 stated she smelled alcohol when she approached Resident 1 and saw a white foam coming out from the resident's mouth. RN 1 stated she asked the staff for call FM 2 (who was previously in the room). RN 1 stated when FM 2, who was crying, was asked what he gave Resident 1, FM2 told her he gave Resident 1 alcohol. RN 1 further stated she was not familiar of Resident 1 and was not aware of any specific monitoring or supervision that the resident required for substance abuse or alcohol use. During a concurrent interview and record review of Resident 1's medical record on 1/15/2026 at 10:11 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, on 11/27/2025, RNA 1 reported that she observed Resident 1 smoking outside in front of the facility, so she and the administrator (ADM) went outside and saw Resident 1 with FM 2. LVN 2 stated she notified the Nurse Practitioner (NP) 1 and she received order to closely monitor Resident 1 for any changes in ALOC, but the NP did not order to closely supervise and monitor Resident 1 and FM 2 or other visitors during visitation. LVN 2 stated she was not aware that Resident 1 had history of smoking in the room or history of substance abuse. LVN 2 stated she was not aware of any specific monitoring and supervision recommended or ordered by the physician for Resident 1 during the time of visitation by FM 2. During a telephone interview on 1/15/2026 at 10:38 AM with LVN 1, LVN 1 stated on 7/15/202, while he was checking Resident 4 who was coughing and had been coughing for over a week. LVN 1 stated while he was in the room, he saw a big cloud of smoke on the ceiling coming from Resident 1's bedside and he saw Resident 1 holding a vape pen, put it in his mouth and vaping in the room, which Resident 1 quickly put in his left pocket when he saw LVN 1. LVN 1 stated the smoke had a distinct smell like marijuana. LVN 1 stated he reported the incident to the RN supervisor that evening. During a telephone interview on 1/15/2026 at 10:40 AM with LVN 1, LVN 1 stated on the next day on July 15, 2025, the day (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/15/2026 at 6:58 PM with the Director of Staff Development (DSD), the DSD stated in 7/2025, one of the CNA reported to her Resident 1 was taking pills and Resident 1 would have an erection and saying inappropriate things while she provided urinal to him. DSD stated LVN 1 reported the staff found wrappers of Blue Chew in Resident 1's room and He had walked into Resident 1's room and smelled Marijuana-like smoke in the room and outside the hallway. The DSD stated LVN 1 had reported to the ADM that he saw Resident 1 smoking the marijuana pen in the room. The DSD stated she reported to the ADM about the inappropriateness. The DSD stated the ADM told her not document anything. The DSD stated she and the Social Service Director (SSD) followed the ADM's instruction to confiscated Resident 1's fanny bag and they found vape pens, marijuana vape pens and multiple blue packets. The DSD stated after the incident in 7/2025, there was SBAR was documented for Resident 1's smoking and possession of substance and drugs. The DSD stated there was no order for monitoring Resident 1's use of substance and drugs and no order to monitor Resident 1's visitations. During an interview on 1/20/2026 at 11:43 AM with RN 3, RN 3 stated she completed Resident 1's Smoking Evaluation on 11/27/2026 and documented Resident 1 could smoke but require supervision during smoking because of the resident's right to smoke. RN 3 stated she was aware the legal age to buy and possess tobacco product was [AGE] years old and Resident 1 was under [AGE] years old, but she was more concerned about the resident's right to smoke than the legal age issue when she completed the Smoke Evaluation. During an interview on 1/20/2026 at 4:45 PM with LVN 4, LVN 4 stated, during the 3 PM-11PM shift on 1/4/2026 and worked until 7 AM on 1/5/2026 and he was assigned to Resident 1. LVN 4 stated on the evening of 1/4/2026, CNA (unidentified) called him to check on Resident 1, when he entered the room with the CNA, he saw Resident 1 was sitting on his wheelchair vomiting and unable to keep his head up but able to say his name and date of birth . LVN 4 stated he smelled the resident and room with a distinct smell in the room, like weed it is not the smell of cigarette. LVN 4 stated he asked to check on Resident 1 and when RN 1 came out of Resident 1's room she talked to FM 2. Then LVN 4 was informed by RN 1 that the resident will be transferred to the hospital. LVN 4 stated Resident 1 returned after midnight on 1/5/2026. LVN 4 stated a care plan was not developed after the incident and there was no specific monitoring ordered by the physician when the resident returned to the facility. LVN 4 stated before and after the incident occurred on 1/4/2026, there was no restriction or specific supervision of Resident 1 or his visitors. LVN 4 stated there was no specific monitoring on Resident 1 for sign and symptoms of substance abuse, smoking, and substance seeking behaviors before this incident.

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NAME OF PROVIDER OR SUPPLIER Rio Hondo Subacute & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 273 E Beverly Boulevard Montebello, CA 90640	

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve a grievance for one of two sampled residents (Resident 3) reviewed for resident's rights under the grievance process. Furthermore, the facility failed to keep Resident 3 informed of progress toward resolution of the grievance from 12/22/2025 and provide a written resolution within 72 hours, in accordance with the facility's policy and procedure titled Grievance/Concern. This deficient practice violated the resident's right to be informed of the resolution of a grievance filed by the resident and had the potential to negatively impact Resident 3's psychosocial well-being and quality of life. Findings: During a review of the facility's policy and procedure (P&P) titled Grievances/Concerns, dated 8/25/2021, the P&P indicated: Upon receipt of the grievance/concern, the grievance/concern form will be initiated by the staff member receiving the concern and documented on the Grievance/Concern Log. The policy further stated: The department manager will notify the person filing the grievance of resolution and/or status within 72 hours. During a review of Resident 3's admission Record (AR), the AR indicated that Resident 3 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection) and type 2 diabetes mellitus (high blood sugar). During a review of Resident 3's History and Physical (H&P) dated 12/30/2025, the H&P indicated that Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS), a resident assessment tool, dated 1/02/2026, the MDS indicated Resident 3 was cognitively intact (normal thinking and memory). During a review of Resident 3's Dialysis Center document provided by the dialysis center social worker (DSW), titled Dialysis Social Worker Evaluation - Progress Notes Report, dated 12/22/2025 and written by the Dialysis Social Worker (DSW), the report indicated the DSW followed up a concern with Resident 3. The document indicated Resident 3 reported that when she asked for assistance at the nursing facility where she resides, staff did not respond. Resident 3 stated this had been occurring since she began residing at the facility approximately two months ago. Resident 3 reported that staff at the nursing facility had been behaving in an unprofessional manner (cursing while at work). The DSW documented that she contacted the facility's Social Services Director (SSD) by phone regarding Resident 3's concerns on 12/22/2025. The document indicated that the facility SSD informed the DSW that she would follow up the concerns with Resident 3 once the resident returned to the facility from the dialysis center that day. During another review of Resident 3's Dialysis Center document titled Dialysis Social Worker Evaluation - Progress Notes Report, dated 1/12/2026 and written by the DSW, the report indicated the DSW attempted to contact the facility SSD but did not receive a response. The DSW documented that she left a voicemail message with her contact information. During a review of the facility's Resident Grievance/Complaint Log for December 2025, there were no grievances documented for Resident 3. During a review of Resident 3's progress notes dated from 12/22/2025 to 1/13/2026, there were no documentation regarding the DSW's conversation with the SSD about Resident 3's concerns or allegations about facility staff response and how facility staff was behaving in an unprofessional manner. During an interview on 1/12/2026 at 3:30 PM with the Dialysis Social Worker (DSW), the DSW stated she called the facility Social Services Director (SSD) on 12/22/2025 and spoke to her on the phone with Resident 3 present. The DSW stated the SSD told them she would look into the issues raised by Resident 3 and follow up with her. The DSW stated she followed up with Resident 3 on 1/05/2026 to ask if the facility SSD had addressed her concerns, but Resident 3 reported that no one from the facility had (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed up. The DSW stated she called the facility again on 1/12/2026 and left another voicemail message to find out why no one had addressed the concerns discussed during the 12/22/2025 phone conversation but did not receive a response. During an interview on 1/13/2026 at 4:00 PM with Resident 3, Resident 3 stated that as of this day, no one from the facility had addressed the concerns she communicated to the facility's SSD on 12/22/2025. Resident 3 stated she told the DSW because she had previously voiced her concerns to facility staff, but no one addressed them or followed up, and she hoped by informing the DSW, someone from the facility would respond. During an interview and concurrent record review on 1/14/2026 at 12:30 PM of the facility's Grievance/Complaint Binder with the SSD, the SSD stated she did not have any documented grievances for Resident 3 for December 2025 or January 2026. The SSD stated the facility's grievance process is that if a resident, family member, or responsible party specifically requests to fill out a grievance/complaint form, she would provide one. The SSD stated if the person does not specifically ask for the grievance form, she would not initiate to offer the grievance form to complete, when someone just verbally expresses a complaint or concern. The SSD stated she does not document verbal concerns or issues brought up to her attention because there are too many residents in the facility to document every verbal concern. The SSD stated there was no grievance resolution provided to Resident 3 because there was no documentation of the concerns raised by Resident 3 and the Dialysis Social Worker (DSW). The SSD stated she could not recall the issues brought to her attention and could not confirm whether the concerns were filed as a grievance.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify, investigate, report to appropriate agencies, and initiate protective measures for an allegation of abuse for one of two sampled residents (Resident 2) reviewed for abuse, in accordance with the facility's policy and procedure titled Abuse Prohibition Policy and Procedures. On 1/11/2026, Resident 2's family member (FM 4) reported to Licensed Vocational Nurse (LVN 5) that Certified Nursing Assistant (CNA 2) had handled Resident 2 roughly during care and requested that CNA 2 not be reassigned to Resident 2. The facility did not identify the allegation as potential abuse, failed to initiate protective measures, and reassigned CNA 2 to care for Resident 2 the next day, on 1/12/2026, before completing an investigation. These failures placed Resident 2 at risk for further abuse, retaliation, and psychosocial harm. Cross Referenced to F609 Findings: During a review of the facility's policy and procedures (P&P) titled Abuse Prohibition Policy and Procedure dated 2/23/2021, the P&P indicated the facility would ensure that facility staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown sources, misappropriation of property for all patients. The P&P indicated the facility would implement the Abuse Prohibition Program through the following: Screening of potential hires Training of employees Prevention of occurrences Identification of possible incidents or allegations which needs investigation Investigation of incidents and allegations Protection of patients during investigations Reporting of incidents, investigation and response to the results of their investigations Furthermore, the facility P&P information included but not limited to the following: Staff would identify events that may constitute abuse. The employee to have committed the act of abuse will be immediately removed from duty pending investigation. Upon receiving information concerning a report of suspected or alleged abuse . the designee would report allegations involving abuse not later than two hours after the allegation is made, notify local law enforcement, ombudsman, licensing district office, licensing boards, registries and other agencies as required. Additionally, initiate an investigation within two hours of an allegation of abuse that included documentation of witness interviews and protect patients from further harm during an investigation. During a review of Resident 2's admission Record (AR), the AR indicated that Resident 2 was originally admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (the weakness of one entire side of the body) following cerebral infarction (when the blood supply to part of the brain is blocked or reduced) affecting left dominant side, essential hypertension ([NAME] the pressure in your blood vessels is too high) During a review of Resident 2's History and Physical (H&P) dated 11/08/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS), a resident assessment tool, dated 11/13/2025 indicated Resident 2 was cognitively intact (normal thinking and memory). During a review of Nursing Staffing Assignment and Sign in Sheet dated 1/10/2026 for 11 PM to 7 AM shift, the assignment sheet indicated CNA 2 was assigned to care for Resident 2 on 1/10/2026. During a review of Nursing Staffing Assignment and Sign in Sheet dated 1/11/2026 for 7 AM to 3 PM shift, the assignment sheet indicated CNA 2 was assigned to care for Resident 2 on 1/11/2026. During a review of Resident 2's Change in Condition Evaluation dated 1/11/2026 time stamped at 10 AM written by LVN 5, Patient [Resident 2] claims CNA [CNA 2] assigned this AM was rough while turning him [Resident 2]. Assessed patient [Resident 2] no c/o [complained of] pain at this time. Supervisor made aware, reassigned CNA. During a review of Nursing Staffing Assignment and Sign in Sheet dated 1/12/2026 for 11 PM to 7 AM indicated CNA 2 was assigned to care again for Resident 2 on 1/12/2026. During an interview on 1/13/2026 at 1:30 PM with FM 4, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	FM 4 stated that on Sunday morning (1/11/2026), she visited Resident 2, who told her that CNA 2 had hurt him. FM 4 reported that CNA 2 was rough and hurt Resident 2's left arm. FM 4 stated she asked Resident 2's roommate, Resident 10, who is alert, and Resident 10 confirmed that he heard Resident 2 scream while CNA 2 was changing his briefs that morning (1/11/2026). FM 4 stated she reported the incident to LVN 5 and the Registered Nurse (RN 3) and requested that CNA 2 not be assigned to Resident 2 again. FM 4 further stated that on the morning of 1/13/2026, when she arrived at the facility around 9:00 AM, Resident 2 informed her that no one had checked on him or changed his diaper during the night shift of 1/12/2026. FM 4 said she touched the top part of the diaper and the area toward Resident 2's back, and it was soaking wet. Resident 2 told FM 4 that the CNA assigned to him was CNA 2-the same CNA she had asked the facility not to assign to Resident 2 due to the previous incident involving rough handling. FM 4 expressed that she did not understand why the facility would assign CNA 2 to Resident 2 again after her request following the reported incident on 1/11/2026. During an interview on 1/13/2026 at 3:02 PM with LVN 5, LVN 5 stated on Sunday around 10 AM resident 2's FM 4 approached her and complained that CNA 2 had been rough towards Resident 2 while changing his incontinence briefs in bed. LVN 5 stated FM 4 told her she did not want CNA 2 to be assigned to Resident 2 again. LVN 5 stated she immediately reported the incident to RN 3 and reassigned CNA 2 to a different resident for the remainder of the shift on 1/11/2026. LVN 5 stated she did not report the incident to the DON or Administrator because she assumed RN 3 would report it to the Administrator who is the facility's abuse coordinator. During an interview on 1/13/2026 at 3:35 PM with Resident 2, Resident 2 stated that on Sunday (1/11/2025) CNA 2 came to his bedside and said, I'm going to change you. Resident 2 stated CNA 2 then proceeded to pull him from his left arm and he screamed and told CNA 2 that the way she was pulling him from his left arm hurts. Resident 2 stated CNA 2 did not stop and continued changing him and did not say anything even though he was screaming because he was hurt. During an interview on 1/13/2026 at 3:50 PM with Resident 10 (Resident 2's roommate), Resident 10 stated that on 1/11/2026, two days ago, he heard Resident 2 scream and say you hurt me while CNA 2 was changing Resident 2 and CNA 2 did not stop. Resident 10 stated CNA 2 kept going and seemed like CNA 2 was in a hurry and just wanted to finish. Resident 10 also stated that CNA 2 was assigned back to both him and Resident 2 the next night (1/12/2026). During an interview on 1/13/2026 at 4:30 PM with the ADM, the ADM stated she was not aware of FM 4's complaint to facility staff regarding CNA 2's rough handling against Resident 2 on 1/11/2026. The ADM stated if she was made aware by facility staff she would have suspended CNA 2 and start an investigation that would include suspending CNA 2, interviewing Resident 2, FM 4 and other facility staff involved and do necessary reporting as per facility's Abuse Prevention Policy. The ADM stated CNA 2 should not have been reassigned to Resident 2 on 1/12/2026 pending investigation. During an interview on 1/16/2026 at 8:40 AM with CNA 2, CNA 2 stated that Resident 2 speaks in a different language that she does not understand. CNA 4 stated she observed Resident 2 talking to his left hand and assumed he [Resident 2] was not 100% there (confused). CNA 2 stated that when she or other CNAs provide care to Resident 2, he begins talking a lot and appears afraid of everyone. CNA 2 stated she could not recall much about what happened when she changed Resident 2 on 1/11/2026 but remembered leaning over the resident to reach the other side of the bed while changing him. CNA 2 stated that on 1/11/2026, she was informed by licensed nurses that FM 4 had complained about her, saying something was wrong during care, and then she was reassigned to a different resident that same day. CNA 2 stated she returned to work on the night of 1/12/2026 and was reassigned back to Resident 2. CNA 2 stated no one from the facility interviewed her or explained why she was reassigned on 1/11/2026.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to report an allegation of abuse within two hours after the allegation was made for two of two sampled residents (Resident 2), as required by the facility's policy and procedure (P&P) titled Abuse Prohibition Policy and Procedures. The allegation should have been reported to the California Department of Public Health (CDPH) and other state agencies (local law enforcement, Ombudsman). On 1/11/2026 at 10:00 AM, Resident 2 and Resident 2's family member (FM 4) reported to Licensed Vocational Nurse (LVN) 5 that Certified Nurse Assistant (CNA) 2 was rough during care and hurt Resident 2. LVN 5 failed to report the allegation of abuse to CDPH and other state agencies as required by the facility's P&P. This deficient practice resulted in the facility underreporting allegations of abuse and Resident 2 being reassigned to CNA 2 after FM 4 had reported rough handling by CNA 2 and requested that CNA 2 not be assigned to care for Resident 2 again. Cross Referenced to F607 Findings: During a review of the facility's policy and procedures (P&P) titled Abuse Prohibition Policy and Procedure dated 2/23/2021, the P&P indicated upon receiving information concerning a report of suspected or alleged abuse . the designee would report allegations involving abuse not later than two hours after the allegation is made, notify local law enforcement, ombudsman, licensing district office, licensing boards, registries and other agencies as required. Additionally, initiate an investigation within two hours of an allegation of abuse that included documentation of witness interviews and protect patients from further harm during an investigation. During a review of Resident 2's admission Record (AR), the AR indicated that Resident 2 was originally admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (the weakness of one entire side of the body) following cerebral infarction (when the blood supply to part of the brain is blocked or reduced) affecting left dominant side, essential hypertension ([NAME] the pressure in your blood vessels is too high) During a review of Resident 2's History and Physical (H&P) dated 11/08/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS), a resident assessment tool, dated 11/13/2025 indicated Resident 2 was cognitively intact (normal thinking and memory). During a review of Nursing Staffing Assignment and Sign in Sheet dated 1/11/2026 for 7 AM to 3 PM shift, the assignment sheet indicated CNA 2 was assigned to care for Resident 2 on 1/11/2026. During a review of Resident 2's Change in Condition Evaluation dated 1/11/2026 time stamped at 10 AM written by LVN 5, Patient [Resident 2] claims CNA [CNA 2] assigned this AM was rough while turning him [Resident 2]. Assessed patient [Resident 2] no c/o [complained of] pain at this time. Supervisor made aware, reassigned CNA. During a review of Nursing Staffing Assignment and Sign in Sheet dated 1/12/2026 for 11 PM to 7 AM indicated CNA 2 was assigned to care again for Resident 2 on 1/12/2026. During an interview on 1/13/2026 at 1:30 PM with FM 4, FM 4 stated that on Sunday morning (1/11/2026), she visited Resident 2, who told her that CNA 2 had hurt him. FM 4 reported that CNA 2 was rough and hurt Resident 2's left arm. FM 4 stated she asked Resident 2's roommate, Resident 10, who is alert, and Resident 10 confirmed that he heard Resident 2 scream while CNA 2 was changing his briefs that morning (1/11/2026). FM 4 stated she reported the incident to LVN 5 and the Registered Nurse (RN 3) and requested that CNA 2 not be assigned to Resident 2 again. FM 4 further stated that on the morning of 1/13/2026, when she arrived at the facility around 9:00 AM, Resident 2 informed her that no one had checked on him or changed his diaper during the night shift of 1/12/2026. FM 4 said she touched the top part of the diaper and the area toward Resident 2's back, and it was soaking wet. Resident 2 told FM 4 that the CNA assigned to him was CNA 2-the same CNA she had asked the facility not to assign to Resident 2 due to the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	previous incident involving rough handling. FM 4 expressed that she did not understand why the facility would assign CNA 2 to Resident 2 again after her request following the reported incident on 1/11/2026. During an interview on 1/13/2026 at 3:02 PM with LVN 5, LVN 5 stated on Sunday around 10 AM resident 2's FM 4 approached her and complained that CNA 2 had been rough towards Resident 2 while changing his incontinence briefs in bed. LVN 5 stated FM 4 told her she did not want CNA 2 to be assigned to Resident 2 again. LVN 5 stated she immediately reported the incident to Registered Nurse (RN) 3 and reassigned CNA 2 to a different resident for the remainder of the shift on 1/11/2026. LVN 5 stated she did not report the incident to the DON or Administrator because she assumed RN 3 would report it to the Administrator who is the facility's abuse coordinator. During an interview on 1/13/2026 at 4:30 PM with the ADM, the ADM stated she was not aware of FM 4's complaint to facility staff (LVN 5 and RN 3) regarding CNA 2's rough handling against Resident 2 on 1/11/2026. The ADM stated if she was made aware by facility staff (LVN 5 and RN 3) she would have suspended CNA 2 and start an investigation that would include suspending CNA 2, interviewing Resident 2, FM 4 and other facility staff involved and do the necessary reporting to all required state agencies as per facility's Abuse Prevention Policy. On 1/14/2026 at 9:30 AM and 2:15 PM multiple attempts to call RN 3 for an interview was made with no answer or return callback.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 3 sampled residents reviewed with pressure ulcers (Resident 6) and admitted without a pressure ulcer (skin damage due to prolonged unrelieved pressure and skin friction) received treatment and services to protect skin integrity (the state of skin being intact, healthy, and free from damage), promote healing, and prevent the development and worsening of pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to: 1. Conduct a skin assessment and risk evaluation upon admission and weekly during the first month after admission on [DATE] to determine the treatment and services Resident 6 required to prevent the development of pressure ulcers in accordance with the facility's policy and procedure titled, Skin Integrity Management, effective 5/26/2021. 2. Develop a comprehensive care plan (CP) with specific interventions to prevent the development of pressure ulcers for Resident 6 from admission 1/7/2026 through 1/16/2026. 3. Ensure LVN 3 measured Resident 6's pressure ulcer upon initial identification on 1/13/2026 to facilitate appropriate treatment orders. 4. Provide necessary wound treatments on 1/13/2026 and 1/14/2026 upon identification of a Stage 3 pressure ulcer (a serious, full-thickness skin injury appearing as a deep crater, extending through the skin into subcutaneous fat, but not exposing muscle, tendon, or bone) and deep tissue injury (DTI- a serious form of pressure ulcer/sore involving damage to underlying soft tissue, often presented as purple or maroon localized, intact skin) on Resident 6's sacrococcyx (tail bone) as ordered by the physician. As a result of these deficient practices, Resident 6 developed a deep tissue injury and Stage 3 pressure ulcer on the sacrococcyx, characterized by purple discoloration and measuring 5 cm in length, 7 cm in width, and 0.2 cm in depth, with a light amount of serosanguineous drainage (thin, watery, pink to light red fluid from a wound). The wound required surgical debridement (removal of damaged tissue or foreign objects). In addition, these deficient practices placed Resident 6 at risk for infection, discomfort, and pain at the pressure ulcer site Findings: During a review of the facility's policy and procedure (P&P) titled, Skin Integrity Management, effective 5/26/2021, the P&P indicated the following: The facility is to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. Complete comprehensive evaluation of the [resident] upon admission/re-admission to the center. Complete risk evaluation on admission/readmission, weekly for the first month, quarterly, and with significant change in condition. Perform wound observations and measurements upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. Implement pressure ulcer prevention for identified risk factors. Determine the need for support surface for bed and chair. During a review o/f the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, effective 8/25/2021, the P&P indicated the following: An individualized comprehensive care plan that includes measurable objectives and timetables to [NAME] the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. The facility's Interdisciplinary Team (IDT) must develop and implement a comprehensive person-centered care plan for each resident. Each resident's comprehensive care plan is designed to incorporate risk and contributing factors associated with identified problems, aid in preventing or reducing declines in the resident's functional status and/or functional levels, and reflect currently recognized professional standards of practice for problem areas and conditions. The comprehensive care plan includes services that are to be furnished to attain or maintained the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing, and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	care plans are reviewed and revised as information about the resident and the resident's condition change. The IDT is responsible for evaluation and updating of care plans when there has been a significant change in the resident's condition. During a review of Resident 6's admission Record (AR) indicated the resident was admitted on [DATE] with diagnoses that included muscle weakness, lack of coordination, and paraplegia (paralysis of the legs and lower body). The AR did not indicate presence of pressure ulcers. During a review of Resident 6's History and Physical (H&P), dated 1/8/2026 indicated the resident does not have the capacity to understand and make decisions. The H&P indicated Resident 6 had no pressure ulcer. During a review of Resident 6's Physical Therapy Evaluation note (a comprehensive initial assessment where a therapist gathers your medical history, strength assessment, flexibility, balance, and function), dated 1/7/2026, the evaluation indicated that Resident 6 required maximal assistance (the helped does more than half the effort) to roll left and right in bed. During a review of Resident 6's Occupational Therapy Evaluation note (an assessment of an individual's abilities and challenges in daily activities to identify strengths and barriers, leading to a personalized treatment plan to improve function and independence), dated 1/10/2026, indicated that Resident 6 required maximal assistance in activities and personal hygiene. During a review of Resident 6's skin assessment note titled, Braden Scale for Predicting Pressure Ulcer Risk (BSP, an assessment tool used to determine a resident's risk factors for developing pressure ulcers), dated 1/7/2026 and timed at 4:41 PM, indicate the facility did not complete the BSP to indicate the resident's risk for developing pressure ulcer. The BSP also did not have a signature of a facility staff who initiated the assessment. During a review of Resident 6's care plans developed from 1/7/2026 to 1/16/2026 indicated there was no documented evidence a care plan was developed for pressure ulcers that address interventions to prevent the development and worsening of pressure ulcers, including providing maximal assistance to roll left and right in bed. During the review of Resident 6's Interdisciplinary (IDT) Care Conference (a conference conducted by a group of facility staff, the resident and responsible party to discuss the individualized care plan for the residents) held on 1/9/2026, the team did not document or address that Resident 6 had a pressure ulcer. During a review of Resident 6's Body Check from 1/7/2026-1/13/2026 indicated no documented evidence that Resident 6 was identified having skin breakdown, pressure ulcers, or open wounds. During a review of Resident 6's Change in Condition (CIC) Evaluation, dated 1/13/2026, timed at 4:48 PM, and documented by LVN 3, the CIC indicated that Resident 6 had a DTI on the left buttock and a Stage 3 pressure ulcer with surrounding DTI on the sacrococcyx. The CIC indicated that Resident 6's physician was notified on 1/13/2026 at 3:09 PM with recommendations for a wound consultation and treatment order. During a review of Resident 6's medical records revealed no documented evidence of physician orders for wound treatment for the newly developed Stage 3 pressure ulcer on Resident 6's sacrococcyx, despite LVN 3 informing the physician about the ulcer on 1/13/2026. During a review of Resident 6's physician's orders dated 1/14/2026 (obtained one day after the pressure ulcer was identified), new treatment orders were issued for Resident 6 which included the following: Cleanse sacrococcyx (area of the buttocks) Stage 3 with NS (normal saline, a sterile cleaning solution), pat dry and apply medi-honey (a medication to treat wounds) with barrier cream to surrounding skin and cover with foam dressing [one time] now Cleanse left buttocks DTI with NS, pat dry and apply zinc oxide (a cream that helps treat or prevent skin irritation like cuts, burns or diaper rash) and leave open to air (uncovered) one time. During a review of Resident 6's Medication Administration Records (MAR) and Treatment Administration Records (TAR) for January 2026 indicated that Resident 6 did not receive any initial wound or skin treatments, including treatment for pressure ulcers, on 1/13/2026-after LVN 3 identified a Stage 3 pressure ulcer on Resident 6 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Hondo Subacute & Nursing Center	273 E Beverly Boulevard Montebello, CA 90640

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F 0686 Level of Harm - Actual harm Residents Affected - Few	and documented it in a CIC note at 4:48 PM on the same day. Furthermore, the MAR and/or TAR did not contain documented evidence that wound treatments were performed on 1/14/2026, despite the physician's orders for Stage 3 wound treatments, including the application of Medi-Honey and zinc oxide to Resident 6's sacrococcyx and left buttocks, as ordered on 1/14/2026. During a review of Resident 6's BSP after the identification of the Stage 3 pressure ulcer, dated 1/16/2026, timed at 2:26 PM, the BSP indicated that Resident 6 was at moderate risk of developing a pressure ulcer. During an observation on 1/13/2026 at 2:48 PM, Resident 6 was lying bed supine (lying on the back) without a low air loss mattress. During an interview on 1/13/2026 at 2:49 PM with Family Member (FM) 3, FM 3 stated that Resident 6 was admitted to the facility on [DATE] without skin breakdown, redness and pressure ulcer. FM 3 stated, while assisting a nurse (Certified Nursing Assistant (CNA) 1) with changing Resident 6's soiled incontinent brief at approximately 11:43 AM today, she observed redness on the resident's buttock that was not previously present. FM 3 stated she did not know how long the resident had been soiled and confirmed that Resident 6 had been lying on a regular mattress and not on a Low Air Loss mattress since admission to the facility. FM 3 showed the surveyor a picture that she took of Resident 6's buttocks that showed an open skin. During an interview on 1/13/2026 at 3:13 PM, CNA 1 stated that she offered to change Resident 6's incontinence brief around 9:00 AM, but Resident 6 refused. CNA 1 further stated that at approximately 11:45 AM, she assisted FM 3 in changing Resident 6's incontinent brief, which contained a small amount of stool. CNA 1 reported that she did not know how long Resident 6 had been wearing the soiled brief. CNA 1 stated that FM 3 cleaned and wiped Resident 6's buttock/sacrococcyx area while she held the resident. CNA 1 explained that because she was assisting with holding Resident 6, she did not observe the skin on the buttock area during the change and was unaware that Resident 6 had an open wound. During an interview on 1/13/2026 at 3:07 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated FM 3 reported to her that Resident 1 had skin redness on his buttock area about an hour ago today. LVN 3 stated she had not assessed Resident 1's skin, but the picture that FM 3 showed her looked like Resident 1's skin was broken. LVN 3 stated she had not notified the doctor about Resident 6's skin condition (Stage 3) at this time yet. During another interview on 1/13/2026 at 3:20 PM with LVN 3, LVN 3 stated upon skin assessment on 1/13/2026 Resident 6 was observed with skin breakdown on the buttocks that the facility had not identified before. LVN 3 stated she informed the doctor at 3:09 PM and is currently awaiting a response. On 1/14/2026, during a review of Resident 6's medical records, the records did not indicate documented evidence that Resident 6's pressure ulcer on the buttocks was assessed for size and appearance such as presence of drainage if any, color of the pressure from 1/13/2026 and 1/14/2026. During a review of the Wound Assessment, dated 1/15/2026, signed by the Physician Assistant (PA), the PA documented that Resident 6 had a Stage 3 pressure ulcer on the sacrococcyx with purple discoloration, measuring 5 centimeter (cm) in length, 7 cm in width, and 0.2 cm in depth. The ulcer had a light amount of serosanguineous drainage. The intervention included applying Medi Honey with dry dressing and continuation of pressure reduction and offloading. The Note also indicated that a surgical debridement (removal of damaged tissue or foreign objects from a wound) was performed on the resident. During a concurrent observation and interview on 1/16/2026 at 12:40 PM with TN 1 inside Resident 6's room, Resident 6 was observed lying in bed without the LAL mattress. TN 1 stated Resident 6 should be on a LAL mattress. During a concurrent interview and record review on 1/16/2026 at 12:42 PM with TN 1, Resident 6's CIC, dated 1/13/2026 and timed at 4:48 PM was reviewed. TN 1 stated according to the CIC Resident 6 was found to have a pressure ulcer on 1/13/2026 which did not include the measurements of the wound and initial wound treatments. TN 1 added that measurements of the wound is part of the nurse's assessment (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	and wounds must be measured so they can track if the wound is getting better or worsening. During the same concurrent interview and record review on 1/16/2026 at 12:42 PM with TN 1, Resident 6's records were reviewed. TN 1 stated a care plan was not developed for Resident 6 that indicates interventions to prevent the development of pressure ulcers when the resident was admitted on [DATE] and a CP to prevent worsened pressure ulcer that was identified on 1/13/2026. TN 1 added that a care plan to prevent pressure ulcer should include interventions such as repositioning the resident at least every two hours and using LAL mattress and keeping the resident clean and dry by changing the incontinent brief immediately when soiled. During another concurrent interview and record review of Resident 6's Wound Assessment, dated 1/15/2026 on 1/16/2026 at 1:02 PM with TN 1. TN 1 stated that the wound assessment indicated that Resident 6's sacrococcyx wound was a Stage 3 pressure ulcer. TN 1 stated that Resident 6 should be on a low air loss mattress as a pressure reduction to prevent further worsening of the wound. During a concurrent interview and record review on 1/16/2026 at 1:54 PM with RN 2, RN 2 stated Resident 6's BSP was not completed since the resident was admitted to the facility on [DATE]. RN 2 stated the BSP was incomplete because it lacked markings, score, and category to indicate the Resident 6's risk for pressure ulcer. RN 2 explained the BSP is a tool used by the facility to determine interventions to prevent pressure injuries and emphasized that Resident 6's paraplegia the resident at higher risk. RN 2 added that not having proper interventions could lead to pressure injuries, such as the stage 3 ulcer that developed on Resident 6's sacrococcyx. During an interview on 1/16/2026 at 1:54 PM, during an interview and record review with RN 2, Resident 6's medical records were reviewed, including the MAR, TAR and a CIC dated 1/13/2026 timed at 4:48 PM. RN 2 stated Resident 6's TAR indicated facility staff did not perform wound treatments on Resident 6's buttocks pressure ulcer on 1/13/2026 and 1/14/2026 (two days). RN 2 stated that not conducting wound treatment for two days could indicate a delay in care, potentially worsening the pressure ulcer. During a concurrent wound treatment observation and interview on 1/16/2026 at 2:31 PM, with TN 1 and CNA 1 in Resident 6's room, Resident 6 wound was observed dark purplish, located in the middle of the sacrococcyx, measuring approximately 5 cm in length and 7 cm in width, with two circular open areas bordered by peeled skin. TN 1 stated Resident 6's had a DTI with openings classified as Stage 3 pressure ulcer. During a concurrent interview and record review on 1/16/2026 at 2:42 PM with LVN 3, LVN 3 stated she received a telephone physician order for Resident 6's Stage 3 pressure ulcer treatment on 1/13/2026 but she did not transcribe the physician's order in the TAR and MAR and the physician order. LVN 3 explained that she did not know how to enter the physician orders in the electronic MAR/TAR and was waiting on the Treatment Nurses (TN 1 or TN 2) to put the initial treatment orders for Resident 1's Stage 3 pressure ulcer. LVN 3 stated she did not perform initial wound treatments to Resident 6's newly identified Stage 3 pressure ulcer to the sacrococcyx and buttocks because it was already the end of her shift and assumed the facility's treatment nurses would perform the initial wound treatments after the specific wound treatments was clarified with a wound physician. During an interview on 1/16/2026 at 3:39 PM with Physical Therapist (PT) 1, PT 1 stated that Resident 6 requires the help of 2 people to turn and reposition in bed. During a concurrent wound treatment observation and interview on 1/20/2026 at 1:35 PM with TN 2, TN 2 removed Resident 6's wound dressing at the sacrococcyx and observed an open wound. TN 2 stated Resident 6 had Stage 3 pressure ulcer at sacrococcyx with red and moist wound bed and slough (a yellowish, soft, and often stringy material that forms in wounds as a result of dead or dying tissue, protein buildup, and bacterial contamination). During an interview on 1/20/2026 at 4:35 PM with TN 2, TN 2 stated the interventions to prevent a resident who was admitted to the facility without a pressure ulcer could be turning and repositioning, maintaining (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	clean and dry skin, changing the resident more often for urine and feces, and providing good intake and hydration. During an interview on 1/20/2026 at 5:04 PM with the Director of Nursing (DON) 1, the DON 1 stated BSP was part of the admission assessment, and it should be completed within 24 hours. The DON stated it was important to complete [NAME] Scale, which the facility staff assessed the possibility of a resident's skin issue depending on the resident's mobility, activity, and nutrition, to prevent any skin breakdown. The DON 1 stated to ensure a resident, who was admitted into the facility without a pressure ulcer, not to develop a pressure ulcer in the facility, the facility staff were doing weekly body check, repositioning, and using low air loss mattress based on the assessment. The DON 1 stated a Care Plan for the pressure ulcer for Resident 6 should be developed when the change of condition was created and the interventions should be implemented timely to ensure proper wound healing. During an interview on 1/20/2026 at 5:04 PM with the Director of Nursing (DON) 1, the DON 1 stated BSP was part of the admission assessment, and it should be completed within 24 hours. The DON stated it was important to complete [NAME] Scale, which the facility staff assessed the possibility of a resident's skin issue depending on the resident's mobility, activity, and nutrition, to prevent any skin breakdown. The DON 1 stated to ensure a resident, who was admitted into the facility without a pressure ulcer, not to develop a pressure ulcer in the facility, the facility staff were doing weekly body check, repositioning, and using low air loss mattress based on the assessment. DON 1 stated a Care Plan for the pressure ulcer for Resident 6 should be developed when the change of condition was created and the interventions should be implemented timely to ensure proper wound healing.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the resident environment was as free of accident hazards as possible and that residents received adequate supervision and assistance. This failure affected one of 15 residents (Resident 1) reviewed for accidents. Resident 1 was admitted to the facility on [DATE] with a history of alcohol abuse and fentanyl overdose (an excessive amount of a potent drug that could lead to death). The facility did not identify potential hazards, implement interventions to provide supervision and increased monitoring, or establish a system to limit and supervise access to an individual (Family Member [FM] 2) with a history of bringing illegal substances into the facility. These failures placed Resident 1 at risk for accidental illegal substance use and alcohol intoxication while in the facility. Additionally, the facility failed to: 1. Ensure Resident 1 was assessed for continued substance use and abuse as required by the facility's policy and procedure (P&P) titled Visitation and the resident's care plan on history of substance abuse and fentanyl overdose. On 5/15/2025, facility staff observed Resident 1's visitor, FM 2, staying almost every night in Resident 1's room. Facility staff noted suspicious behavior without detailing the specific actions or activities involved; however, this observation prompted facility staff to contact local police. Staff interviews and record reviews revealed that no investigation was conducted by the facility, and no reassessment for substance use or abuse was performed on Resident 1 following the documented staff observations of FM 2 and Resident 1 exhibiting unspecified suspicious behavior to maintain adequate supervision and safety for Resident 1 during visitations. This deficient practice of failure to assess and address potential substance use or abuse posed an immediate risk to Resident 1 for potential illegal substance use, which could lead to overdose, impaired judgment, accidents, and/or death involving Resident 1 and his visitor (FM 2), despite documented unspecified suspicious behavior and police involvement, thereby placing Resident 1 and possibly other residents at risk for serious harm, injury, or death. 2. Address and investigate an incident involving Resident 1, who was observed by Licensed Vocational Nurse (LVN) 1 vaping a substance that smelled like marijuana inside his room and possessing non-prescribed pills known as Blue Chew (a sexual enhancement pill) on 7/15/2025. LVN 1 also observed Resident 1's roommate (Resident 4) coughing due to secondhand smoke and reported the incident to Registered Nurse (RN) 1 on 7/15/2025. The Director of Staff Development (DSD 1), who was informed of the incident by LVN 1 on 7/16/2025, reported it to the Administrator (ADM) on 7/16/2025. The facility failed to determine whether additional interventions and increased supervision were needed to prevent medical emergencies, accidental overdose, and ensure resident safety after illegal substances, including vaping marijuana and non-prescribed sexual enhancement pills, were observed in Resident 1's possession. This deficient practice of failure to address, investigate, and establish a system to limit and supervise access to visitors who may bring illegal substances into the facility-posed an immediate health risk and potential medical emergencies for Resident 1, including accidental overdose or adverse reactions from ingesting non-prescribed pills (e.g., Blue Chew) and/or using marijuana. Furthermore, secondhand smoke exposure, as observed when Resident 4 was coughing, can cause respiratory distress and created a safety hazard by exposing other residents to illegal substances or the risk of obtaining them. 3. Intervene and implement Resident 1's smoking assessment and enforce the facility's Smoking P&P and Visitation P&P when Restorative Nursing Attendant (RNA) 1 observed FM 2 on 11/27/2025 placing an unknown smoking material in Resident 1's mouth and observed Resident 1 smoking outside, in front of the facility. Resident 1's care plan indicated that he should not be allowed to smoke due to being under the legal smoking age ([AGE] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	years old) and being unable to hold a cigarette safely. The facility failed to take appropriate action to prevent unsafe behaviors and ensure compliance with its Smoking and Visitation P&P. This deficient practice of failure of the facility to take appropriate action regarding Resident 1's visitor (FM 2) introducing unknown smoking materials to Resident 1 increased the risk of contraband substances entering the facility and exposed Resident 1, who had a documented inability to safely hold a cigarette, to potential burn injuries, fire hazards, inhalation injuries, and/or other medical emergencies. 4. Provide supervision and monitoring on 1/4/2026 for Resident 1 and FM 2, despite FM 2's history of multiple unspecified suspicious behaviors, including documented police involvement on 7/15/2025 and introducing unknown smoking materials to Resident 1 on 11/27/2025. On 1/4/2026, FM 2 visited Resident 1 and summoned Certified Nursing Assistant (CNA) 1 into Resident 1's room, which smelled of smoke, marijuana, and alcohol. Resident 1 was observed dropping his head, vomiting, and foaming at the mouth, and was unable to hold his head upright. FM 2 admitted to providing Resident 1 with alcohol. As a result, Resident 1 was transferred to the General Acute Care Hospital (GACH) Emergency Department (ED) on 1/4/2026 via 911 (an emergency services), where records confirmed acute alcohol intoxication on 1/4/2026 with a blood alcohol level of 126 mg/dL. Resident 1 was readmitted back to the facility the next day 1/5/2026 after nine (9) hours. 5. Establish and implement a system to increase supervision and reassess visitation access for FM 2 or other visitors of Resident 1, despite previous incidents of visitor-introduced contraband on 7/15/2025, 11/27/2025, and 1/4/2026. The facility continued to allow FM 2 unsupervised and unrestricted visits during another visitation on 1/11/2026, after Resident 1 returned from the GACH on 1/5/2026 due to alcohol intoxication. FM 2, who had previously been witnessed by facility staff providing Resident 1 with alcohol, marijuana, and other unknown smoking materials, continued to visit Resident 1 unsupervised, placing Resident 1 at risk for harm, including accidental overdose, fire hazards, and other safety risks. As a result of these deficient practices, Resident 1 and other residents in the facility were exposed to illegal substances or faced the risk of obtaining contraband. Resident 1 who has a history of alcohol abuse and fentanyl overdose, along with other residents, were placed at risk for repeated exposure to illegal substances and alcohol use, which could lead to overdose, impaired judgment, accidents, and/or death. Cross referenced to F563 Findings: During a review of the facility's P&P titled, Visitation, dated 11/2025, the P&P indicated some visitation may be subject to reasonable clinical and safety restrictions to protect the health, safety, security, and/or rights of the facility's residents by denying access or providing limited and supervised access to an individual found to be abusing, coercing or exploiting a resident, and limiting visitation to individuals who have a history of bringing illegal substances into the facility and/or had been found to have committed criminal act. During a review of the facility's policy and procedure (P&P) titled, Substance Use Disorder, dated 4/2025, the P&P indicated Residents who are admitted to the facility with substance use disorder will receive the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being, provided by the facility and the in accordance with the comprehensive assessment and care plan. During a review of the facility's P&P titled, Smoke, dated 8/9/2022, the P&P indicated the facility to provide a safe environment for residents, staff and visitors. During a review of the facility's P&P titled, Change in Condition: Notification of, dated 8/25/2021, the P&P indicated the facility staff to ensure .physicians are informed of changes in the resident's condition. During a review of the facility's P&P titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pills. During a review of Resident 1's PN, dated 7/16/2025, documented by SSD indicated during the Interdisciplinary Care Conference (IDT), a nursing staff observed Resident 1 in possession of a vape in his room and taken away a [NAME] vape, a [NAME] Kawali Live Resin vape(a portable, battery-powered device used to heat substances-nicotine liquids, cannabis [weed and marijuana, a mind-altering substance] oils, concentrates or dry herbs-into an inhalable vapor without combustion), and blue chew (a chewable tablets that treat erectile dysfunction [the consistent inability to achieve or maintain a firm erection for sexual intercourse] male enhancement tablets The PN indicated these items were removed due to safety concerns and the potential for adverse interactions with the resident's current medications. During a review of Resident 1's Care Plan for with erecting enhancers and vapes, developed on 7/16/2025, the care plan indicated Resident 1 would be monitored for any changes or abnormalities from non-prescribed medications. There was no documented evidence, during a review of Resident 1's records from 7/16/2025 to the present, that the facility monitored Resident 1 for the use of any non-prescribed medications or for changes or abnormalities related to such use, as indicated in the care plan addressing erectile enhancers and vaping products. During a review of Resident 1's PN, a late entry note dated 7/17/25 timed at 9:52 AM Director of Nursing (DON) 2 documented that on 7/15/2025 during the 3 to 11 shift, an LVN found Resident 1 in possession of a vape in his room and male enhancement pill. The note indicated the facility had removed a [NAME] vape, [NAME] Kawali Live Resin vape, and Blue Chew male enhancement tablets due to safety concerns and potential interference with Resident 6's medications and was given to FM 1. DON 2 documented in Resident 1's records that due to Resident 6's history of substance-related behaviors, ongoing monitoring was recommended. There was no documented evidence, during a review of Resident 1's records from 7/17/2025 to the present, indicating that the facility supervised, monitored for any suspicious behaviors due to history of substance related behaviors, signs and symptoms of substance use and abuse as outlined in the DON 2's late entry note on 7/17/2025 to prevent Resident 1 from substance abuse and use. During a review of Resident 1's PN, dated 10/8/2025, the PN indicated Resident 1 was educated on facility policy that no marijuana was to be used in the facility due to complaints of Resident 1's room smelling like weed, and Resident 1 was noted to be with a visitor. The PN further indicated Resident 1, and the visitor was educated on facility policy. The PN did not indicate who Resident 1's visitor was mentioned in Resident 1's progress note. There was no documented evidence, during a review of Resident 1's records, that the Care Plan for risk of substance use related to a history of addiction-developed on 12/6/2023 and revised on 11/3/2025-included new nursing interventions such as re-education of Resident 1 and the resident's visitor regarding the smell of weed in the room, as documented in Resident 1's progress notes on 10/8/2025. No new interventions were added on 11/3/2025, despite the care plan indicating a revision on that date. There was no documented evidence that the care plan on substance abuse, developed on 6/9/2025 was revised to add interventions after Resident 1 and an unknown visitor was educated on the facility policy that no marijuana was to be used in the facility. During a review of Resident 1's psychiatrist consultation, dated 11/11/2025, the record indicated Resident 1 reported history of Fentanyl, Benzodiazepine (a medication that slow down activity in the brain), marijuana and alcohol abuse and the psychiatrist indicated to continue monitoring and follow up with the resident closely. There was no documented evidence, during a review of Resident 1's records from 11/11/2025 to the present, indicating that the facility conducted appropriate monitoring of suspicious behaviors or followed up with the resident, including monitoring for signs and symptoms of substance use or abuse related to a history of substance-related behaviors, as outlined in the psychiatrist's consultation on 11/11/2025. During a review of Resident 1's PN, dated 11/27/2025, Resident 1 was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed by Restorative Nursing Assistant (RNA) 1 outside at the front of the facility smoking (unknown smoking material) in the presence of FM 2. The PN indicated Resident 1 was approached by Licensed Vocational Nurse (LVN) 2 and the Administrator (ADM) and was educated on the facility smoking and safety precautions. The PN indicated that the Registered Nurse (RN), Responsible Party and Nurse Practitioner (NP) were made aware, with new order to closely monitor Resident 1 for any changes in altered level of consciousness (ALOC). The PN indicated supervisor and the ADM were notified. There was no documented evidence, during a review of Resident 1's records from 11/27/2025 to the present, that a reassessment of Resident 1's level of consciousness-including monitoring for signs and symptoms of substance use or abuse-was performed following observations on 11/27/2025 by RNA 1, LVN 2, and the Administrator that Resident 1 was smoking an unknown smoking material, in the presence of FM 2, in front of the facility. During a review of Resident 1's PN- Situation, Background, Assessment, and Recommendation (SBAR- a documentation process to facilitate concise, clear, focused communication) Summary, dated 1/4/2026 timed at 4:40 PM, indicated Resident 1 was found vomiting, with foaming in his mouth and FM 2 was by his side. The SBAR indicated the environment smelled like alcohol and FM 2 admitted he gave Resident 1 alcohol. The SBAR also indicated that the RN contacted the doctor and called 911 and was sent to emergency room (ER). During a review of Resident 1's PN, dated 1/4/2026 timed at 5:57 PM, the PN indicated the charge nurse went into the resident's room with Certified Nursing Assistant (CNA) and found Resident 1 vomiting and kept dropping his head. The PN indicated a smell of smoking noted. The PN indicated FM 2 admitted giving Resident 1 alcohol. The PN indicated MD was notified and 911 was called, and Resident 1 was transferred to the hospital. During a review of Resident 1's General Acute Care Hospital (GACH) indicated Resident 1 was admitted in the Emergency Department Reports on 1/4/2026 at 4:48 PM and was discharged on 1/5/2026 with diagnosis of alcohol intoxication and alcohol abuse, and the laboratory results of ethanol/alcohol level blood of 126. During a review of Resident 1's PN indicated the resident arrived at the facility on 1/5/2026 at 2:19 AM without pain. The PN did not have any documentation that supervision and monitoring were to be provided to Resident 1 and to FM 2 when the resident returned to the facility. During a review of the facility's Visitor Sign in Sheet, dated 1/11/2026 at 11:43 AM, indicated FM 2 visited Resident 1 in the facility and on 1/5/2026, 1/6/2026, 1/12/2026. Resident 1's friends visited. During an interview on 1/13/2026 at 11:42 AM with the Administrator (ADM), the ADM stated on 7/15/2025, Resident 1 was found with vape pens and Blue Chew pills inside Resident 1's personal belongings at the bedside. The ADM explained Resident 1 and FM 1 who were interviewed did not want to say where the resident obtained the vape and the blue pills. The ADM stated the facility did not investigate to determine the source of the vape pens and blue Chew pills that the resident possess. The ADM stated the items found at Resident 1's bedside were given to FAM 1. During an interview on 1/13/2026 at 11:55 AM, inside Resident 1's room FM 1 stated, FM 2 gave Resident 1 juice, but FM 2 was not aware that there was alcohol in it on 1/4/2026. FM 1 stated Resident 1 took a sip and made him sick because he had never had it before. During a concurrent interview and record review on 1/13/2026 at 5PM with DON 1, Resident 1's Care Plan was reviewed. DON 1 stated the facility had not developed a care plan to address Resident 1's alcohol use in the facility that occurred on 1/4/2026 because they were waiting for the involvement of family members in the IDT meeting and care planning. DON 1 stated the facility did not deny and continued to allow FM 2 and FM 1 and friends of Resident 1 with visits without restrictions or supervision during the visitation. During an interview on 1/14/2026 at 12:22 PM with RNA 1, RNA 1 stated on 11/27/2026 while she was walking in the front of the facility, she saw FM 2 smoking a small thing (unknown smoking material) and then he (FM 2) leaned over to Resident 1 who was facing him and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the room, he saw a big cloud of smoke on the ceiling coming from Resident 1's bedside and he saw Resident 1 holding a vape pen, put it in his mouth and vaping in the room, which Resident 1 quickly put in his left pocket when he saw LVN 1. LVN 1 stated the smoke had a distinct smell like marijuana. LVN 1 stated he reported the incident to the RN supervisor that evening. During a telephone interview on 1/15/2026 at 10:40 AM with LVN 1, LVN 1 stated on the next day on July 15, 2025, the day after Resident 1 was observed vaping, LVN 1 stated no investigation or intervention implemented to identify concern about Resident 1 vaping in the room. LVN 1 stated he reported the incident again to the ADM in the presence of the DSD and SSD, then the DSD went into Resident 1's room and took Resident 1's fanny bag containing one or two wax pens with cartridges for marijuana, a big vape pen and 30 labeled as blue chew pills. LVN 1 stated the ADM knew about Resident 1 vaping in the room and the blue pills inside his fanny bag. LVN 1 stated after the incident, there was no interventions in place for Resident 1's use of vape, marijuana and alcohol in the facility, and the nurses were not told to monitor Resident 1 for substance abuse behavior and use. LVN 1 stated all Resident 1's visitors would still come to visit Resident 1 anytime 24 hours a day and 7 days a week without supervision or monitoring. During a review of Resident 4's AR (Resident 1's roommate), the AR indicated the facility admitted Resident 4 on 5/25/2022 with diagnoses that include type II diabetes mellitus (a medical condition that high sugar level in the blood) and hemiplegia (inability to voluntarily move one side of the body). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had no cognitive impairment. During a concurrent interview and record review on 1/15/2026 at 12:35 PM with MD 1, MD 1 stated he was not aware of Resident 1's suspicious behavior on 5/15/2025 or that the resident had been vaping and in possession of pills, the vaping device and the [NAME] vape, [NAME] Kawali Live Resin vape, and Blue Chew male enhancement tablets that was taken by the facility from the resident on 7/15/2025. MD 1 stated there was no documentation indicating the facility informed the MD about these two incidents. MD 1 stated Resident 1 had a history of substance abuse and overdose which resulted in his current health state. MD 1 stated if he had been aware of the incidents on 5/15/2025, 7/15/2025 and 11/27/2025, he and the facility staff could have monitored Resident 1's substance abuse behavior and monitored or supervised or denied FM2 during visitation because FM2's visitation had put Resident 1 at risk for substance overdose and alcohol intoxication. MD 1 stated other interventions that the facility could have placed to prevent Resident 1's incident on 1/4/2026 included supervision of visitors who could potentially bringing illegal substance inside the facility, close monitor his substance abuse behavior, and provide frequent psychiatrist (a physician specialized in treatment of mental health issues) visits, and altering medication as needed to avoid behavior issues. During an interview with FM 1 and Resident 1 about the incidents on 1/15/2026 at 12:55 PM, FM 1 and Resident 1 were asked about the incident regarding the vaping, smoking, alcohol intoxication and the blue pills that the facility found in the resident's possessions on 7/15/2026. FM 1 and Resident 1 denied the incident occurred and stated, I don't remember. During an interview on 1/15/2026 at 1:10 PM with Resident 4, Resident 4 stated on numerous he smelled strong smoke from Resident 1 bedside stated he overheard one incident that Resident 1 was mad and was on the phone with someone saying that his vape pens were taken away. Resident 4 stated he was worried about his own health because he was exposed to secondhand smoke. During a concurrent interview on 1/15/2026 at 1:55 PM with RN 4, Resident 1's Smoking Evaluation, dated 11/27/2025, was reviewed. The Smoking Evaluation indicated Resident 1 required supervision for smoking. RN 4 stated based on this document, Resident 1 was allowed to smoke under supervision. RN 4 stated she was not sure of the legal age for smoking, and she thought the legal age was 18. RN 4 reviewed California Tobacco 21 Law and stated the legal age to purchase (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and possess tobacco product was [AGE] years old. RN 4 stated Resident 1 was at age of 20 and he should not be allowed to smoke During an interview on 1/15/2026 at 4:38 PM with Receptionist 1, Receptionist 1 stated there were no restrictions of Resident 1's visitors or to supervise Resident 1 while he received visitors. Receptionist 1 stated she was not instructed to inform visitors what contraband were not allowed to bring to the residents in the facility. During an interview on 1/15/2026 at 6:58 PM with the Director of Staff Development (DSD), the DSD stated in 7/2025, one of the CNA reported to her Resident 1 was taking pills and Resident 1 would have an erection and saying inappropriate things while she provided urinal to him. DSD stated LVN 1 reported the staff found wrappers of Blue Chew in Resident 1's room and He had walked into Resident 1's room and smelled Marijuana-like smoke in the room and outside the hallway. The DSD stated LVN 1 had reported to the ADM that he saw Resident 1 smoking the marijuana pen in the room. The DSD stated she reported to the ADM about the inappropriateness. The DSD stated the ADM told her not document anything. The DSD stated she and the Social Service Director (SSD) followed the ADM's instruction to confiscated Resident 1's fanny bag and they found vape pens, marijuana vape pens and multiple blue packets. The DSD stated after the incident in 7/2025, there was SBAR was documented for Resident 1's smoking and possession of substance and drugs. The DSD stated there was no order for monitoring Resident 1's use of substance and drugs and no order to monitor Resident 1's visitations. During an interview on 1/20/2026 at 11:43 AM with RN 3, RN 3 stated she completed Resident 1's Smoking Evaluation on 11/27/2026 and documented Resident 1 could smoke but require supervision during smok[TRUNCATED]

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide medically related social services support to one of three sampled residents (Resident 1), a paraplegic resident who requested and had a physician order for an electric wheelchair to maintain or improve resident mobility. The facility's failure to obtain and provide the prescribed electric wheelchair limited Resident?1's freedom of movement, increasing risk of isolation and compromising his right to functional mobility Findings: During a review of the facility's policy and procedure (P&P) titled Social Services dated September 2021, the P&P indicated that medically related social services are provided to maintain or improve each resident's ability to meet everyday physical needs, including equipment for ambulation. During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 11/27/2023, and readmitted on [DATE] with diagnoses including paraplegia (inability to voluntarily move the lower parts of the body) and psychoactive substance abuse (harmful or hazardous use of substances that alter brain function, affecting mood, perception, consciousness, and behavior). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 10/10/2025, the MDS indicated Resident 1 had intact cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 1 required partial/moderate assistance with eating, oral hygiene, personal hygiene, and was dependent on chair/bed-to-chair transfer, toileting hygiene and shower/bathe self. During a review of Resident 1's Physician Order, dated 7/14/2025, the order indicated the physician ordered an electric wheelchair for Resident 1. The order indicated the facility's case manager to request authorization [for the electric wheelchair]. During a review of Resident 1's Interdisciplinary Care Conference record dated 9/26/2025, the record indicated the facility's interdisciplinary team (IDT) composed of the resident's family member (FM 1), the facility's Social Services Director (SSD), Social Services Assistant (SSA), Director of Rehabilitation (DOR) and the Director of Staffing and Development (DSD) conducted an IDT meeting to review Resident 1's request for electric wheelchair. The record indicated that facility's IDT determination for the requested electric wheelchair was not appropriate during that time due to Resident 1's documented history of substance use disorder with prior fentanyl use, and recent incidents involving contraband items that included marijuana vape products and non-prescribed supplements. The record indicated the IDT believed that if Resident 1 had access to an electric wheelchair, the potential for self-harm resulting from drug-seeking behavior outweighs the potential benefits. The record further indicated that Resident 1 was currently utilizing a manual wheelchair for his mobility needs with staff and family assistance and able to navigate throughout the facility and outings with family with support. During an interview on 1/13/2026 at 11:56 AM with Resident 1's family member (Family Member [FM] 1), FM 1 stated Resident 1 could not walk, and had requested an electric wheelchair from the facility since July of 2025 but had not received the electric wheelchair. FM 1 stated Resident 1 had been experiencing isolation and loneliness from his current condition. During a concurrent observation and interview on 1/13/2026 at 12:05 PM inside Resident 1's room, Resident 1 stated he was using a manual wheelchair at this time, but he could not safely wheel himself alone and required assistance from others to wheel him around the facility or places he wanted to go. Resident 1 stated he felt his mobility was limited and his right to move freely in his environment was restricted. During the observation, Resident 1 attempted to wheel himself in a straight line, but veered to the right, striking the bedside table and the wall in his room. During an interview on 1/13/2026 at 3:53 PM with Physical Therapist (PT) 1, PT 1 stated Resident 1 could not propel himself using a manual wheelchair due (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to poor coordination. During an interview on 1/15/2026 at 5:39 PM with the facility's Case Manager (CM), the CM stated she was not employed in the facility in July 2025 when Resident 1's electric wheelchair was ordered by the physician. The CM stated she was not aware of Resident 1's electric wheelchair request. The CM stated there was no documentation or endorsement regarding this request. During an interview on 1/15/2026 at 6:03 PM with the Social Services Director (SSD), the SSD stated that an electric wheelchair is Durable Medical Equipment (DME - refers to medical devices and equipment that can withstand repeated use [durable].and primarily and used for a medical purpose) and that Resident 1 was a custodial resident (someone who primarily needs assistance with daily living activities (ADLs) rather than skilled medical care) in the facility. The SSD stated Social Services were only responsible for arranging DME for residents who were going to be discharge. The SSD stated she did not know what happened to Resident 1's initial order for an electric wheelchair in July 2025. During an interview on 1/15/2026 at 6:30 PM with the Director of Nursing (DON), the DON stated Social Services was responsible for following up and arranging DME supplies for custodial residents. During an interview on 1/15/2026 at 7:50 PM with the Administrator (ADM), the ADM stated Resident 1's physician ordered an electric wheelchair on 7/14/2025, but there was no documentation of follow up on this order until 9/26/2025. The ADM stated the decision not to provide the motorized electric wheelchair was due to the concern of Resident 1's safety due to history of behaviors involving the use of illegal substances