STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056487	A. Building B. Wing	05/15/2026

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the continuity of care for one of 2 sampled residents (Resident 1) during their admission to the facility transitioning from a general acute care hospital (GACH) by failing to reconcile Resident 1's admission orders as evidenced to include vancomycin (an antibiotic or medication used to treat infection). This failure led to a break in course of therapy for Resident 1 and a delay of more than 24 hours to administer vancomycin (an antibiotic to treat Clostridioides difficile, also known as C. diff or C. difficile, which is a highly contagious bacterium that infects the large intestine, causing severe inflammation and watery diarrhea) that had a potential to worsen resident's infection and health condition.During a review of Resident 1's admission record, the record indicated Resident 1 was originally admitted to the facility on [DATE] and last readmitted on [DATE], with diagnoses that included: Chronic Obstructive Pulmonary Disease (COPD, is a progressive, inflammatory lung disease that restricts airflow and causes breathing difficulties), dysphasia (a language disorder caused by brain damage that impairs your ability to produce, understand, or process spoken and written language) following cerebral infarction (a medical emergency that occurs when blood flow to an area of the brain is blocked or significantly reduced), and need for assistance with personal care. During a review of Resident 1's Minimum Data Set (MDS, a mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 3/2/2026, MDS indicated Resident 1 had no speech (absence of spoken words), rarely or never able to express ideas and wants, rarely or never understood others. Resident 1 had short- and long- term memory problems, and severely impaired cognitive skills for daily decision making. Resident 1 was dependent (helper does all of the effort) on others for self-care and mobility. During an interview on 5/15/2026 at 11 AM, the Director of Nursing (DON) reviewed Resident 1's census list and stated Resident 1 was readmitted to the facility from GACH on 4/24/2026 at 6:12 PM. During a concurrent interview and record review of the Physician's Order on 5/15/2026 at 11 AM with the DON, the DON stated Resident 1's Physician's Orders on 4/25/2026 at 2:24 PM to be given vancomycin orally (by mouth) in suspension (a liquid medication where solid particles of the drug do not dissolve completely) 50 milligrams (mg, unit to measure mass) per (/) milliliter (ml, unit to measure volume) to give 2.5 ml via G-Tube (a soft, flexible medical device surgically inserted into the abdomen to the stomach and used to deliver nutrition, hydration, and medications) every 6 hours. During a concurrent review of the pharmacy delivery receipt, the receipt indicated the facility received Resident 1's vancomycin on 4/25/2026 at 6:38 PM. During an interview on 5/15/2026 at 12:24 PM, and a concurrent review of Resident 1's medication administration record (MAR) for April 2026, DON stated Resident 1 received the first dose of vancomycin at the facility on 4/25/2026 around 6 PM. DON was not sure why there was a delay on Resident 1's vancomycin that was ordered on 4/25/2026 and not on 4/24/2026 during the admission at the facility. DON also stated the admitting nurse was responsible to reconcile and verify medication orders on admission which was not done. During an interview on 5/15/2026 at 1:01 PM, the Registered Nurse (RN) 1 stated, the RN on duty usually conducts the admission assessment and reconcile the physicians orders from the GACH to the facility. RN 1 stated new antibiotic order usually takes 2 - 4 hours for the pharmacy to deliver, and the (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility has automated dispensing cabinet (ADC, a computerized medication storage system) for first doses and emergency use. However, RN 1 stated Resident 1's vancomycin oral suspension was not stocked in the facility's ADC. RN 1 did not remember why Resident 1's vancomycin order was entered a day after resident's admission. During an interview on 5/15/2026 at 2:50 PM, DON stated there was no documentation explaining why Resident 1's vancomycin oral suspension order was not ordered on 4/24/2026 but delayed until 4/25/2026 at 2:14 PM, while Resident 1's other medications were ordered shortly after the admission on [DATE]. DON acknowledged that the admitting nurse missed Resident 1's antibiotic order. During a review of the facility's policy, admission Assessment and Follow Up: Role of the Nurse (revised September 2012), the policy indicated upon admission, the nurse should conduct an admission assessment, including contacting the attending physician to obtain admission orders and record in the resident's medical record of orders obtained from the physician.

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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 0689 Level of Harm - 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, interviews, and record reviews, the facility failed to ensure one of three sampled residents (Resident 1), who was totally dependent with care of daily living, abnormal posture with a left knee contracture (a permanent tightening or shortening of muscles, tendons, or skin that causes a joint to become stiff and locks it into a bent position), non-verbal, and had an altered mental status, was free from fall and injury in accordance Resident 1's care plan (CP), titled Resident utilizes LALM for Wound/Skin Management, dated 1/31/2026, and the facility procedure, titled Repositioning, revised 2013 and Fall Management, dated 5/26/2021 by failing to: 1. Ensure Certified Nurse Assistant (CNA) 1 requested for staff assistance before repositioning Resident 1 to the side during linen change while the resident was on a Low Air Loss Mattress (LALM, mattress that operates using a blower-based pump that was designed to circulate a constant flow of air) on 5/7/2026 at 4:30 AM. 2. Ensure CNA 1 did not transfer Resident 1 back to bed, prior to LVN 2 observing, checking and assessing Resident 1's injuries in accordance with the facility's Policy and Procedure (P&P) titled, Fall Management, dated 5/26/2021. 3. Ensure the Director of Nursing (DON) and the Administrator (ADM) thoroughly investigate the root cause of the fall and injury by interviewing CNA 1 who witnessed the fall and to update care plan to reflect new interventions to prevent recurrent fall. These deficient practices resulted in Resident 1 sliding off the bed and fall on the floor striking Resident 1's head on the nightstand on 5/7/2026 at 4:30 AM. Resident 1 sustained a wound measuring 0.5 x (times) 0.1 x 0.1 centimeter (cm, unit of length) with scratch, swelling, bruising on the right outer eye with active bleeding, and complete bilateral anterior jaw dislocation with superior migration (a severe medical emergency when both sides of the lower jaw have popped entirely out of their sockets, moved forward in front of the joint ridge, and shifted forcefully). Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis that included hemiplegia (paralysis that affects only one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (occurs as a result of disrupted blood flow to the brain), dementia (a progressive state of decline in mental abilities), left knee contracture, abnormal posture, and muscle weakness. During a review of Resident 1's CP, titled Resident utilizes LALM for Wound/Skin Management, dated 1/31/2026, the CP indicated Resident 1 utilized LALM for wound/skin management. The goal was for Resident 1 to have no complications with the use of LALM. The CP interventions included providing Resident 1 with two-person physical assistance during transfers and bed mobility. During a review of Resident 1's Physician's Order (PO), dated 2/3/2026, the PO indicated Resident 1 was using LALM every shift for wound management. During a review of Resident 1's Minimum Data Set (MDS- a required standardized assessment and care planning tool) dated 2/6/2026, the MDS indicated Resident 1's cognitive skills (ability to think and process information) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 was non-verbal and unable to understand others. The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required to complete the activity) on toileting, hygiene and rolling left and right (the ability to roll from lying back to left and right side and return to lying on back on the bed). During a review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR, a standardized communication framework used in nursing homes to concisely convey critical resident information among providers), dated 5/7/2026, documented by LVN 1, the SBAR indicated Resident 1 had a scratch with bleeding and slight purple discoloration on the right outer eye area. The SBAR indicated Resident 1 was agitated, moving her arm up and down and grabbing/scratching her gown. The SBAR indicated Resident 1 was in bed while Rehabilitation Nurse Aide (RNA) 1 reported to LVN 1 that Resident 1 was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bleeding on the right outer eye area and slight amount of blood was on Resident 1's pillowcase. The SBAR indicated LVN 1 assessed Resident 1 and noted scratches with small amount of bleeding and slight purple-green discoloration on Resident 1's right outer corner of the right eye. The SBAR indicated Resident 1's Primary Care Clinician (NP 1) was made aware on 5/7/2026 at 9 AM, and NP 1 recommended to monitor Resident 1 for any vision issues and to start treatment by Treatment Nurse (TXN) 1. During a review of Resident 1's Body check, dated 5/7/2026, documented by TXN 1, the assessment indicated Resident 1 had a right outer eye scratch 0.5 x 0.1 x 0.1 cm with scant sanguineous drainage (the leakage of fresh blood from an open wound) with no odor, 100 % pink. During a review of Resident 1's Nurses Progress Note (NPN), dated 5/8/2026 timed at 8:43 AM, the NPN indicated Resident [1] noted with swelling/bruising to the orbital region (the bony eye socket and everything inside it) during assessment. Initial image (picture) obtained yesterday (5/7/2026) with follow-up image obtained early this morning (5/8/2026) showing worsening appearance/swelling to the affected [right eye] area. Charge nurse previously followed up with MD (MD 1), who advised monitoring for any vision impairment or obscured vision The NPN indicated, Resident [1] is not alert/oriented at baseline and unable to appropriately verbalize symptoms or participate in a reliable vision assessment. No identifiable or witnessed fall reported at this time. Follow-up communication completed with the NP (Nurse Practitioner 1) regarding worsening condition and updated images were provided for review. The NPN indicated Resident [1] also noted to be on aspirin therapy, increasing concern for possible underlying injury/bleeding. Orders subsequently received to transfer resident to the hospital for further evaluation of head trauma and for CT imaging (Computed Tomography scan, is a noninvasive medical imaging test that combines a series of X-rays [a painless medical imaging test] taken from different angles of the bones, organs and soft tissues) of the head/brain. EMS (Emergency Medical Services, a system that responds to emergencies in need of highly skilled pre-hospital clinicians) activated and resident transferred out to hospital in stable condition for further workup and management. Responsible party (Resident 1's responsible party) notified. Continued monitoring including neuro checks and documentation completed throughout shift before transfer. During a review of Resident 1's PO, dated 5/8/2026, the order indicated for staff to transfer Resident 1 to GACH 1 for CTA (Computed Tomography Angiography, an X-ray that uses contrast materials to examine blood flow in blood vessels) of head/brain. During a review of Resident 1's GACH 1 ED (Emergency Department) Note, dated 5/8/2026 timed at 11:16 AM, the ED Note indicated Resident 1 arrived at the ED via ambulance for evaluation of wounds, bruising and swelling to the right eye area with unknown cause. The ED Note indicated there was no report of the residents falling to the ground. The ED Note indicated Resident 1 was found with a small scratch to the right side of the face just above her right eye as well as a small area of bruising immediately adjacent to the right eye, ecchymosis to the right orbit (a black eye or a bruise around the eye socket). The ED Note indicated there had been no reports of trauma. The ED Note indicated Resident 1's diagnosis that included bilateral anterior jaw dislocation, and right orbit ecchymosis. The ED note indicated Resident 1 would require transfer to a higher level of care for OMFS consultation. During a review of GACH 1's CT scan result, dated 5/8/2026, the CT scan result indicated complete bilateral anterior jaw dislocation with superior migration. During a review of GACH 2's History & Physical - Adult (H&P), dated 5/9/2026, the H&P indicated Resident 1 presented with right-sided deficits, contractures of the lower extremities (legs), baseline nonverbal and non-ambulatory (not able to walk without assistance or at all). The H&P indicated Resident 1 was brought to GACH 1 from SNF 1 for multiple bruises and facial fractures. The H&P indicated SNF 1 stated no reported trauma and the wound was self-inflicted. During an observation on 5/12/2026 at 9 AM in Resident 1's room, Resident 1 was not in the room. Resident 1's bed has a LALM, and a three-drawers nightstand was on the left side of Resident 1's bed. During an interview on 5/12/2026 at 9:30 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, on 5/7/2026, at 8:30 AM, RNA 1 called LVN 1 into Resident 1's room and reported that RNA 1 saw blood on the resident's right outer eye. LVN 1 stated LVN 1 noticed fresh blood on the Resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1's pillowcase, approximately the size of a small egg and Resident 1 was also bleeding above the corner of Resident 1's right eye. LVN 1 stated, LVN 1 called MD 1'office but spoke to NP 1 and received an order from NP 1 to monitor Resident 1's right eye wound and assess Resident 1 for any vision changes. LVN 1 stated, LVN 1 took care of Resident 1 again on 5/8/2026, at 7 AM (morning shift) and noticed the wound on Resident 1's right eye got bigger and the bruise was more purple in color. LVN 1 stated LVN 1 reported her finding to Registered Nurse (RN) 1 who contacted NP 1 again. LVN 1 stated NP 1 ordered to send Resident 1 to GACH 1 for further evaluation due to a concern for trauma. During an interview on 5/12/2026 at 9:45 AM with RNA 1, RNA 1 stated on 5/7/2026, at around 8 or 8:30 AM when RNA 1 put on Resident 1's splint (a device that hold bones and joints in place so they can heal after a fracture, injury or surgery), RNA 1 saw small amount of fresh blood on Resident's pillowcase and on Resident 1's right eye. RNA 1 stated RNA 1 called LVN 1 right away to let LVN 1 know about Resident 1's condition (bleeding on the right eye). During a phone interview on 5/12/2026 at 1:45 PM with CNA 1, CNA 1 stated on 5/6/2026, CNA 1 worked from 11PM-7AM shift (night shift) and took care of Resident 1. CNA 1 stated, at around 4:30 AM in the morning of 5/7/2026, CNA 1 changed Resident 1's adult incontinence brief by herself without staff assistance. CNA 1 stated, CNA 1 was standing on the right side of Resident 1's bed when Resident 1 was laying on the resident's right side. CNA 1 stated, CNA 1 turned Resident 1 over to Resident 1's left side to clean the resident's bottom by turning the resident's right leg. CNA 1 stated the LALM was slippery and Resident 1's right leg was contracted and stiff, which caused Resident 1 to be pulled downward, the resident slid out of bed and landed on the floor. CNA 1 stated, Resident 1 landed on Resident 1's bottom and Resident 1's head hit the nightstand, which was on the left side of Resident 1's bed. CNA 1 stated, Resident 1 ended up on the floor while leaning on the nightstand. CNA 1 stated, CNA 1 could not catch Resident 1 because Resident 1 was falling to the other side of the bed (the left side of the bed). CNA 1 stated I asked if the resident (Resident 1) was ok, but the resident did not respond so I (CNA 1) thought the resident was fine. CNA 1 stated, CNA 1 saw some blood around Resident 1's right eye area so CNA 1 wiped the blood and pulled Resident 1 back to bed alone without asking a staff for assistance. CNA 1 stated, CNA 1 did not report the incident to CNA 1's supervisor (LVN 2) or tell anyone regarding Resident 1's fall (on 5/7/2026, at 4:30 AM) because CNA 1 had to attend to other residents. CNA 1 further stated, nobody from the facility has asked CNA 1 anything related to Resident 1's fall. CNA 1 stated you are the first person to ask me about the resident's (Resident 1's) fall [the fall on 5/7/2026, at 4:30 AM]. During a review of CNA 1's handwritten letter provided by the facility, dated 5/12/2026, (untimed), the letter indicated CNA 1 worked night shift (11PM-7AM) on 5/6/2026 and took care of Resident 1. The letter indicated on 5/7/2026, at 4:30 AM, during the morning care, CNA 1 turned Resident 1 to Resident 1's left side and reached for the protective chuck (incontinent pad). Resident 1's right leg pulled Resident 1's body down and Resident 1 ended up sliding on the floor on her bottom in a sitting position and hitting her head on the nightstand. The letter indicated The Resident (Resident1) didn't make any sound, just opened her eyes. The letter indicated CNA 1 asked if Resident 1 was ok but no sound or responds and the resident didn't appear to be in pain. The letter indicated CNA 1 picked up the resident (Resident 1) and put her back in bed in a sitting position. During an interview on 5/12/2026 at 3:50 PM with the Assistant Director of Nursing (ADON), the ADON stated CNA 1 should have reported the fall incident to the licensed nursing staff (LVN 2) immediately after Resident 1's fall (on 5/7/2026, at 4:30 AM), and should not handle the situation (Resident 1's fall with injuries) by herself. The ADON stated, after Resident 1's fall, the Registered Nurse (RN) should have assessed Resident 1 to make sure the resident was safe and reported the fall to the doctor (MD 1) right away for treatment and monitoring orders. The ADON stated, It's important to know if the resident (Resident 1) had a fall and hit her (Resident 1's) head because the doctor needs to know regarding Resident 1's fall right away so Resident 1 could receive immediate and correct treatment to prevent any complication from the injuries due to the Fall. During an interview on 5/12/2026 at 4:47 PM with the DON, the DON stated, the DON did not interview CNA 1 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	when the DON investigated the root cause of Resident 1's fall/injuries. The DON stated, CNA 1 told the DON that CNA 1 was overwhelmed so CNA 1 did not inform any staff member from the facility about Resident 1's fall. During a concurrent interview and record review on 5/13/2026 at 12:45 PM with the Director of Staffing Development (DSD), the facility's competency skills check titled, Positioning/Transferring, Changing Resident in Low Air Loss Mattress, undated, was reviewed. The competency skills check indicated all positioning/transferring/changing of a resident on a LALM must always use two-person assist/technique for safety; CNA/Nurse position themselves on one side, the other CNA/nurse on the opposite side of bed. The DSD stated that the competency skills check is part of the facility's policy. The DSD stated, LALM is one of the risk factors that contribute to the residents' fall because of the air distribution in the mattress, which can make one side of the bed raised higher than the other side of bed and increase the fall risk for all residents. During a concurrent observation and interview on 5/13/2026 at 1 PM with the DSD in Resident 1's room, the DSD stated that Resident 1's mattress was a LALM. The DSD sat on the right side of Resident 1's bed, the mattress immediately sank on the right side and raised on the opposite side, the unbalanced surface making it easier to slide and fall off bed. The DSD stated that two-person assistance is required to make sure the resident (in general) will not slide out of bed. During a current interview and record review on 5/13/2026 at 1:30 PM conducted with the DSD, CNA 1's competency skills set and the policy and procedure titled, Positioning/Transferring, Changing Resident in Low Air Loss Mattress, dated 8/25/2025, was reviewed. The DSD stated that CNA CNA1 received training on the procedure for positioning/transferring, changing resident in LALM on 8/25/2026. The DSD stated she expected CNA 1 to follow the facility's policy and procedure to ensure the resident's safety during repositioning, transferring and changing the resident in LALM. During a concurrent interview and record review on 5/13/2026 at 1:40 PM conducted with TXN 1, Resident 1's care plan with the focus of Resident utilizes LALM for wound/skin management, dated 1/31/2026, was reviewed. TXN 1 stated, Resident 1's care plan interventions indicated to provide 2-person physical assistance with transfers and bed mobility. TXN 1 stated, bed mobility included repositioning, transferring resident in and out of bed, turning while changing. TXN 1 stated, because the LALM can move due to alternate pressure, Resident 1 would be at higher risk for fall while CNA 1 repositioning and changing the resident so 2-person assist is required. During an interview on 5/13/2026 at 3:30 PM with the ADON, the ADON stated Resident 1 should have 2-person physical assistance because Resident 1 was on LALM. ADON added, the LALM has air filled in it and the pressure can shift so patients are at higher risk of sliding from the bed to a lower surface. The ADON stated, CNA 1 needed to ask or wait for someone (another available staff member) to help CNA 1 with turning and cleaning Resident 1 because the resident was on LALM. The ADON stated, when Resident 1 slid out of bed, CNA 1 needed to report the incident right away so appropriate interventions could have been implemented immediately to prevent a delay in complications from the injuries due to the fall. The ADON stated that immediate prevention should have been provided such as Register Nurse (RN in general) who could have done neuro check (checks how different parts of your nervous system are working), perform comprehensive assessment (complete and through assessment). The ADON stated that facility staff could have transferred Resident 1 immediately to the hospital for CT scan due to trauma to Resident 1's head from a witnessed fall. During an observation and attempt to interview Resident 1 on 5/15/2026 at 10 AM, Resident 1 had purple discoloration around Resident 1's right eye area, and Resident 1's lower lip had scabs, and medical wires were in the resident's mouth. Resident 1 was awake and not able to make any sound or answer any questions. During an interview on 5/15/2026 at 2 PM with NP 1, NP 1 stated on 5/7/2026 NP 1 was informed that Resident 1 had a skin scratch on the side of Resident 1's right eye, so NP 1 ordered nursing staff (LNV 1) to monitor Resident for visual changes and provide wound care. NP 1 stated NP 1 asked LVN 1 if Resident 1 had a fall because it was significant to know, especially if Resident 1 hit the head with injuries. NP 1 stated if Resident 1 had a fall and hit the resident head Resident 1 should be transferred to the hospital right away for (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	higher level of care and evaluation. NP 1 stated if NP 1 knew Resident 1 had fallen and struck Resident 1's head on the nightstand, NP 1 would have ordered for LVN 1 to call 911 (emergency telephone number) so Resident 1 could be transferred to the acute hospital immediately as head trauma requires prompt assessment and imaging to prevent delays in necessary care and treatment. NP 1 stated that neuro checks alone might not be sufficient given Resident 1's condition (dementia and nonverbal), Resident 1 would not be able to communicate Resident 1's feeling and what had happened to Resident 1. During an interview on 5/15/2026 at 2:10 PM with the DON, the DON stated that for residents (in general) on a LALM, the DON expected CNAs (all CNAs) to follow the facility's policy and procedure that required a two-person assist to ensure resident safety. The DON stated that because the alternating pressure of the LALM increased the risk of falls, two-person physical assistance is required when turning or repositioning the resident (any resident) for peri care per facility's policy. During an interview on 5/15/2026 at 3:15 PM with Resident 1's family member (FAM) 1, FAM 1 stated, FAM 1 was very upset and disappointed with the care provided by the facility. During a review of the facility's policy and procedures (P&P) titled, Repositioning, revised 2013, the P&P indicated, the procedure for repositioning the resident in bed included to check the care plan to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to reposition the resident. During a review of the facility's P&P titled, Positioning/Transfer and Changing Resident with Low Air Loss Mattress, revised 10/24/2024, the P&P indicated the policy establishes techniques, responsibilities, and protocols for transferring, repositioning and changing of residents on an Air Loss Mattress to ensure safety of the resident and employee; Positioning, repositioning, transferring and changing a resident is a primary responsibility of nursing assistants. During a review of the facility's P&P titled, Bed, Special - Low Air Loss Therapy, revised 11/2012, the P&P indicated: It is the policy of the facility to utilize low air loss therapy under the direction of a physician's order. Facility staff working directly with the low air loss therapy unit will have training in its use by company representatives or a trained facility staff member. During a review of the facility's P&P titled, Fall Management, dated 5/26/2021, the P&P indicated: patients experiencing a fall will receive appropriate care and investigation of the case. If the patient falls: observe/check for injury, document accident/incident in the clinical record, update care plan to reflect new intervention, notify physician and responsible party, interdisciplinary to review post fall.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure one of one sampled resident (Resident 1) who was nonverbal (unable to talk) and unable to report pain was accurately assessed and provided pain management in accordance with the facility's policy and procedure titled Pain Management and resident's care plan by failing to: 1.Resident 1, who had dementia (the loss of cognitive functioning [thinking, remembering, and reasoning] to such an extent that it interferes with a person's daily life and activities), nonˆverbal, and with altered mental status, was assessed using the numerical pain scale, instead of Pain Assessment in Advanced Dementia (PAINAD a 5-item observational tool used to evaluate pain in patients with severe cognitive impairment or dementia) after sustaining jaw dislocation with a scratch, swelling, bruising to the right outer eye, and active bleeding after sliding and falling from the bed, striking her head on the nightstand, and landing on the floor when Certified Nurse Assistant (CNA) 1 repositioned the resident in bed. 2. LVN 1 did not provide pain management to Resident 1 when resident was found actively bleeding on right outer eye on 5/7/2026 at 8:30 AM and showed agitation by moving her arm up and down and clutching at her gown. As a result of these failures, Resident 1 experienced unrelieved pain from 5/7/2026 at 4:30 AM. On 5/8/2026 at 10 AM (after 29.5 hours from Resident 1's fall on 5/7/2026, at 4:30 AM), Resident 1 was transferred to General Acute Care Hospital (GACH) 1 for evaluation of head trauma. Later that same day (on 5/8/2026), Resident 1 was transferred to GACH 2 -Trauma Center for an Oral and Maxillofacial Surgery (OMFS, operations on the mouth, jaws, neck or face) consultation and operation of the dislocated jaw on 5/11/2026. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis that included hemiplegia (paralysis that affects only one side of the body) and hemiparesis (one-sided muscle weakness), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting right dominant side, facial weakness, Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), dementia, left knee contracture (the shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), abnormal posture, and muscle weakness. During a review of Resident 1's Care Plan (CP), dated 2/20/2025, the CP indicated Resident 1 exhibits or is at risk for alterations in comfort related to Alzheimer's disease, hemiplegia, and muscle weakness and the goal was that the resident will achieve acceptable level of pain control. The interventions included medicating resident as ordered for pain, monitor for effectiveness, medicate as needed prior to treatment or therapy, monitor for non-verbal signs/symptoms of pain and medicate as ordered, and monitor for nonverbal signs of pain such as increase in agitation, grimace, resistance to care. During a review of Resident 1's Order Summary Report (OSR) for January to May 2026, the OSR indicated the following physician orders:On 1/24/2026 the physician ordered to document pain level for treatments before, during, and after treatment. On 1/24/2026 the physician ordered to document non-pharmacological interventions that included heat application, repositioning, relaxation breathing, massage, exercise, immobilization of joint and write in progress note as needed. Document results (-) ineffective (+) effective. On 3/29/2026 the physician ordered for Acetaminophen tablet 325 mg, give 2 tablets via G-Tube (gastrointestinal tube surgically inserted into the stomach to deliver fluid, formulas and medications) every 4 hours as needed for mild pain 1-4. During a review of Resident 1's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 1's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 was non-verbal and unable to understand others and make self-understood. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity on toileting hygiene (the (continued on next page)

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	056487	A. Building B. Wing	05/15/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ability to maintain perineal hygiene), shower/bathe self (the ability to bathe self, including washing, rinsing, and drying self) and personal hygiene. The MDS indicated Resident 1 was dependent on rolling left and right (the ability to roll from lying back to left and right side and return to lying on back on the bed). During a review of Resident 1's SBAR Summary Form and Progress Note for RNs/LPN/LVNs dated 5/7/2026, documented by LVN 1, the SBAR indicated Resident 1 was observed to have right outer eye scratch and bleeding was noted with slight purple discoloration on the right outer eye area. The SBAR indicated that Resident 1's behavioral evaluation was agitated moving her arm up and down and grabbing/scratching her gown. The SBAR indicated pain evaluation was not clinically applicable to the change in condition being reported, and the answer for question Does the resident show non-verbal signs of pain (for residents with dementia)? was left blank. During a review of Resident 1's Body check, dated 5/7/2026, documented by TXN 1, the assessment indicated Resident 1 had a right outer eye scratch 0.5 x 0.1 x 0.1 cm scant sanguineous drainage (the leakage of fresh blood from an open wound). During a review of Resident 1's Nurses Progress Note (NPN), dated 5/8/2026 timed at 8:43 AM, the NPN indicated Resident [1] noted with swelling/bruising to the orbital region (the bony eye socket and everything inside it) during assessment. Initial image obtained yesterday with follow-up image obtained early this morning showing worsening appearance/swelling to the affected [right eye] area. Charge nurse previously followed up with MD (medical doctor), who advised monitoring for any vision impairment or obscured vision The NPN further indicated, Resident [1] is not alert/oriented at baseline and unable to appropriately verbalize symptoms or participate in a reliable vision assessment. No identifiable or witnessed fall reported at this time. Follow-up communication completed with the NP (Nurse Practitioner) regarding worsening condition and updated images were provided for review. The NPN also indicated Resident [1] also noted to be on Aspirin (medication that prevent blood clot to form therapy, increasing concern for possible underlying injury/bleeding), therapy, physician orders subsequently received to transfer resident to the hospital for further evaluation of head trauma and for CT imaging of the head/brain. EMS (Emergency Medical Services, a system that responds to emergencies in need of highly skilled pre-hospital clinicians) activated and resident transferred out to hospital in stable condition for further workup and management. During a review of Resident 1's GACH 1 ED (Emergency Department) Note, dated 5/8/2026 timed at 11:16 AM, the ED Note indicated that Resident 1 arrived at the ED via ambulance for evaluation of wound, bruising and swelling to the right eye with unknown cause. The ED Note further indicated Resident 1 was found with a small scratch to the right side of the face just above her right eye as well as a small area of bruising immediately adjacent to the right eye, ecchymosis to the right orbit (a black eye or a bruise around the eye socket). GACH 1 ED Note indicated Resident 1's diagnosis that included bilateral anterior jaw dislocation (both sides of the lower jawbone slide too far forward and get locked out of their sockets), bilateral mandibular condyle (the round ends of the lower jaw) fracture-dislocation (a double-trouble injury that happens when a bone breaks [fracture] and pops out of its normal joint position [dislocation] at the same time), and right orbit ecchymosis . The ED note indicated Resident 1 would require transfer to a higher level of care for OMFS consultation. During a review of GACH 1's CT scan result, dated 5/8/2026, the CT scan result indicated complete bilateral anterior jaw dislocation with superior migration (means the condyles have shifted upward from their normal position, often due to high-energy trauma and associated fractures - distinct from the more common simple anterior dislocation). There are also fractures dislocating bilateral head of mandibular condyles (fractures with displacement of both condylar heads from their sockets). Oral maxillofacial consult. During a review of GACH 2's History & Physical - Adult (H&P), dated 5/9/2026, the H&P indicated Resident 1 presented with right-sided deficits, contractures of the lower extremities, baseline nonverbal and non-ambulatory (not able to walk without assistance or at all). The H&P indicated Resident 1 was brought to GACH 1 from SNF 1 for multiple bruises and facial fractures. The H&P indicated SNF 1 stated no reported trauma and the wound was self-inflicted. During a review of GACH 2's Operative Note, dated 5/11/2026, the note indicated on 5/10/2026 at (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6:15 PM, Resident 1 was taken to the operating room for closed treatment of bilateral mandibular condylar fracture, and maxillomandibular fixation with hybrid arch bars. During a review of CNA 1's handwritten letter provided by the facility, dated 5/12/2026, the letter indicated CNA 1 was working night shift (11PM-7AM) on 5/6/2026 and took care of Resident 1. The letter indicated on 5/7/2026 at 4:30 AM, during the morning shift change, CNA 1 put Resident 1 on her left side and CNA 1 reached over to the other side for the protective chuck (a pad placed on top of the bed for incontinent residents to prevent stools or urine to penetrate the mattress). Resident 1's right leg pulled her body down and Resident 1 ended up sliding on the floor on her bottom in a sitting position and hitting her head on the nightstand. The letter indicated Resident 1 didn't make any sound, just opened her eyes. CNA 1 asked if Resident 1 was ok but no sound or response and the resident didn't appear to be in pain. CNA 1 picked up the resident and put her back in bed in a sitting position. During an interview on 5/12/2026 at 9:30 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, on 5/7/2026 at 8:30 AM, she her rounds and found Resident 1 was lying in bed on her right side. LVN 1 stated when she entered Resident's room, she found Resident 1 lying flat with her face upward and noticed fresh blood on the resident's pillowcase, approximately the size of a small egg. Resident 1 was actively bleeding above the corner of the right eye. LVN 1 stated Resident 1 was agitated, moving her arms around, clutching at her gown. LVN 1 stated, LVN 1 thought Resident 1 was itching rather than experiencing pain, so LVN 1 did not perform a complete pain assessment that included assessing the source of pain and location of pain. LVN 1 further stated, Resident 1 was non-verbal and cannot make any conversation, and unable to tell anyone if she has pain. LVN 1 stated that for nonverbal residents with dementia, agitation and restlessness are indicators of pain. A review of the Medication Administration Record (MAR) for May 2026, indicated Resident 1 did not receive any pain medication to relieve pain. During an interview on 5/12/2026 at 9:45 AM with RNA 1, RNA 1 stated on 5/7/2026, around 8 or 8:30 AM when she came to provide RNA therapy to Resident 1, the resident was lying on her right side of bed. When RNA 1 turned Resident 1 to lay flat on her back before putting on the resident's splint (a device that hold bones and joints in place so they can heal after a fracture, injury or surgery), RNA 1 saw small amount of fresh blood on the resident's pillowcase and on the right eye toward the side of her face. RNA 1 stated, Resident 1 cannot tell if in pain because the resident is non-verbal. RNA 1 stated, Resident 1 looked irritated and her arms were moving around. During a phone interview on 5/12/2026 at 1:45 PM with CNA 1, CNA 1 stated CNA 1 on 5/6/2026, CNA 1 worked from 11PM-7AM shift (night shift). CNA 1 stated, at around 4:30 AM on 5/7/2026, CNA 1 changed Resident 1's adult incontinence brief. CNA 1 stated, CNA 1 turned Resident 1 over to Resident 1's left side to clean the resident's bottom by turning the resident's right leg over the left leg. CNA 1 stated the LALM was slippery and Resident 1's right leg was contracted and stiff, which caused the resident to slide downward out of bed and landed on the floor. CNA 1 stated, Resident 1 landed on Resident 1's bottom and Resident 1's head hit the nightstand, which was on the left side of the resident's bed. CNA 1 stated, Resident 1 ended up on the floor while leaning on the nightstand. CNA 1 added, CNA 1 could not catch Resident 1 because Resident 1 was falling to the other side of bed (the left side). During a concurrent interview and record review on 5/13/2026 with Registered Nurse (RN) 1, Resident 1's SBAR, dated 5/7/2026 and Pain Evaluation, dated 5/7/2026 timed at 8:15 AM, were reviewed. RN 1 stated, the SBAR indicated pain assessment was not provided. RN 1 stated, according to Resident 1's clinical record, the pain evaluation was partially completed, and a Numerical Pain scale was used on 5/7/2026 to 5/8/2026 by the licensed staff to document the pain level of Resident ,1 which was inaccurate because the resident was nonverbal. RN 1 added, Resident 1's pain assessment should had been completed by the licensed nurses using the PAINAD scale. It scores physical and behavioral cues from 0 to 2 for a total possible score of 10, with a score of 2 or higher acting as a clinical trigger for pain treatment). During an observation and attempt to interview Resident 1 on 5/15/2026 at 10 AM, Resident 1 was lying in bed on her left side with purple discoloration around the right eye area and the lower lip had scabs with the medical wires in the resident's mouth. Resident 1 was awake (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and not able to make any sound or answer any questions. During an interview on 5/15/2026 at 2 PM with NP 1, NP 1 stated given the resident's condition, she would not be able to communicate what happened and was not oriented. NP 1 stated, he would expect the licensed nurse to assess Resident 1 for pain per protocol. NP 1 stated, after the fall and hitting her head on the nightstand, a nonverbal resident with behaviors of agitation and moving her arms up and down could be indicators for pain. During an interview on 5/15/2026 at 2:10 PM with the DON, the DON stated, LVN 1 should have assessed Resident 1 for using PAINAD scale for pain when LVN 1 found Resident 1 with blood and purple discoloration around the right eye area. DON added, Resident 1 could be in a lot of pain because any person with head injury would be in pain. The DON PAINAD pain scale was used to assess residents with dementia and not able to verbalize pain. The DON added, numerical scale was not appropriate pain scale to use because Resident 1 was unable to verbalize pain level. The DON stated that agitation with moving arms around is restlessness, which can be indicator for pain. During an interview on 5/15/2026 at 3:15 PM with Resident 1's family member (FAM) 1, FAM1 stated, FAM1 was very upset and disappointed with the care provided by the facility. FAM1 stated Resident 1 was able to chew food before the G-tube placement a few months prior to this incident. FAM 1 added that Resident 1 must be in a lot of pain. During a review of the facility's policy and procedure dated 8/25/2021, titled Pain Management the facility will maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain as part of the nursing assessment process for the presence of pain upon admission/re- admission, quarterly, with change in condition or change in pain status, and as required by the state thereafter. Pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the Resident's goals and preferences is provided to Residents who require such services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to order from the pharmacy and administer an antibiotic (medication to treat infection) as ordered by the physician for one (1) of one resident (Resident 1) in a timely manner. As a result of this failure Resident 1 had delayed and missed four (4) doses of vancomycin (an antibiotic that treats certain infections) oral suspension for more than 24 hours that could lead to worsened infection and a decline in resident's health condition. Findings: During a review of Resident 1's admission record, the record indicated Resident 1 was originally admitted on [DATE] and last readmitted on [DATE], with diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease (COPD, is a progressive, inflammatory lung disease that restricts airflow and causes breathing difficulties), dysphasia (a language disorder caused by brain damage that impairs your ability to produce, understand, or process spoken and written language) following cerebral infarction (a medical emergency that occurs when blood flow to an area of the brain is blocked or significantly reduced), and need for assistance with personal care. During a review of Resident 1's Minimum Data Set (MDS, a Federally-mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 3/2/2026, MDS indicated Resident 1 had no speech (absence of spoken words), rarely or never able to express ideas and wants, rarely or never understood others. Resident 1 had short- and long- term memory problems, and severely impaired cognitive skills for daily decision making. Resident 1 was dependent (helper does all of the effort) on others for self-care and mobility. During an interview on 5/15/2026 at 11 AM, the director of nursing (DON) reviewed Resident 1's census list and stated Resident 1 was readmitted to the facility from a general acute care hospital (GACH) on 4/24/2026 at 6:12 PM. During a review of Resident 1's medication order dated 4/25/2026 at 2:24 PM, the order indicated vancomycin (an antibiotic to treat Clostridioides difficile, also known as C. diff or C. difficile, which is a highly contagious bacterium that infects the large intestine, causing severe inflammation and watery diarrhea) oral suspension 50 milligrams (mg, unit to measure mass) per (/) milliliter (ml, unit to measure volume) to give 2.5 ml via G-Tube (a soft, flexible medical device inserted directly through the abdomen into the stomach used to deliver nutrition, hydration, and medications to individuals who cannot eat, drink, or swallow safely) every 6 hours. During a record review and concurrent interview on 5/15/2026 at 12:30 PM with the DON, the DON reviewed Resident 1's discharge medication list from the GACH dated 4/24/2026. stated Resident 1 received the last dose of vancomycin at the GACH on 4/24/2026 at 1:37 PM. DON stated the facility received Resident 1's first dose of vancomycin on 4/25/2026 at 6:38 PM. During a concurrent review of the Medication Administration Record (MAR) history indicated the vancomycin was administered to Resident 1 on 4/25/2026 at 6:45 PM. DON acknowledged there was approximately 29 hours between Resident 1's last vancomycin dose received in the GACH on 4/24/2026 at 1:37 PM and the first dose received at the facility on 4/25/2026 at 6:45 PM; during this 29-hours period, there was 1 dose missed on 4/24/2026 and 3 doses missed on 4/25/2026. DON confirmed there was no documentation on 4/24/2026 regarding medication reconciliation on admission and no documented reason for the delay in entering Resident 1's vancomycin order. During a review of Resident 1's MAR for April 2026, there was no administration record of vancomycin on 4/24/2026. The MAR also indicated the doses were scheduled at 12 midnight, 6 AM, 12 noon, and 6 PM. Resident 1 received the first dose of vancomycin on 4/25/2026 around 6 PM. During a review of the facility's policy, admission Assessment and Follow Up: Role of the Nurse (revised September 2012), the policy indicated upon admission, the nurse should reconcile resident's medications, the discharge orders from the previous institution, and obtain orders from the physician.