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	08/22/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 8/19/2025 when food items listed on the resident menu were not available and were replaced by alternative menu without the Registered Dietician's (RD) approval for 21 of 21 residents who did not receive the roasted cauliflower listed in the menu item in the residents meal trays during lunch. This deficient practice had the potential to result in residents dissatisfaction with the meal, not receiving the basic nutritional needs and/or receiving food preferences. Findings: During a review of the facility's P&P titled Menus, revised on 10,2022, the P&P indicated Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with the established national guidelines. Menus will be developed to meet the criteria through the use of an approved planning guide. During a review of the facility lunch menu for 8/19/2025, the following food items would be served. Regular diet: baked ziti/meat sauce, roasted cauliflower, garlic bread (one each), iced brownie (one each), milk 2%(percent) (four fluid oz [ounce]). During an observation of the tray line service (a system of food preparation, in which trays move along an assembly line) for lunch, on 8/19/2025, at 12:51 PM, the cook (Cook 1) served steamed cauliflower instead of roasted cauliflower for six (6) resident meal trays. At 1:08 PM [NAME] 1 served steamed sliced carrots instead of roasted cauliflower for 15 resident meal trays. During an interview with [NAME] 1 on 8/19/2025 at 1:26 PM, [NAME] 1 stated he ran out roasted cauliflowers to serve all the residents. During an interview with the Dietary Supervisor (DS) on 8/19/2025 at 1:35 PM, the DS stated he did not know why the facility ran out of roasted cauliflowers and had to serve a number of residents with the alternative lunch vegetables. The DS stated they had used this recipe before and had never run out of vegetables. The DS stated the replacement was unexpected and they were unable to inform or notify the residents beforehand or contact the RD before changing the menu. The DS stated the residents could be dissatisfied if they were expecting to be served with the regular roasted cauliflowers but were actually served with the alternative vegetables without being informed beforehand. During an interview on 2/26/2025 at 3:49 PM with Resident 39, Resident 39 stated the facility had done this before, putting one thing on the menu and serving something different without asking or informing the residents. Resident 39 stated he did not eat the carrots he was sent. During an interview on 8/19/2025 at 4:09 PM with Resident 124, Resident 124 stated he was not informed the facility had run out of roasted cauliflower before he was served lunch. Resident 124 stated he wished he had chance to pick alternative veggies before the tray was delivered. Resident 124 stated would still rather receive roasted cauliflowers as listed on the paper sent with tray.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and monitor three of four sampled residents (Resident 84, 27, 26 and 103) with indwelling catheter (foley catheter, a thin, flexible tube that goes into the bladder to drain urine into a collection bag outside of the body) for sediments (free floating solid particles in the urine) in the drainage tubing and drainage bag as indicated in the resident's plan of care, the physician's order and the facility's policy and procedures. In addition, for Resident 26 and Resident 103 with suprapubic catheter drainage bag (a medical device, typically a bag with a tube, that collects urine) the facility failed to ensure the catheter bag was kept below the level of the residents bladder. These failures had the potential for the residents not to receive necessary care timely and for the supra pubic and indwelling catheter becoming occluded with sediment which may lead to a urinary leakage, bladder distention, urinary tract infection (UTI, an infection in the bladder/urinary tract), kidney infection, and possible septicemia (a serious bloodstream infection). 1.During a review of the facility's P&P titled, UTI (Catheter Associated) Guidelines for Prevention, dated 2021 indicated to prevent of catheter associated UTIs (CAUTIs), the staff must be able to identify, document and report the clinical signs and symptoms of a UTI to the physician or provider. During a review of Resident 27's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 Diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood) and benign prostatic hyperplasia (BPH; a condition in which the prostate gland [A gland in the male reproductive system] grows larger than normal) During a review of Resident 27's History and Physical (H&P) dated 1/15/2025, the H&P indicated that Resident 27 has fluctuating capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS, a care assessment and screening tool) dated 8/1/2025, the MDS indicated the resident was assessed to have intact cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and was dependent (helper does all of the effort) for toileting hygiene, showering. The MDS's bowel and bladder assessment indicated Resident 27 required an indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine). During a review of Resident 27's Order Summary Report (OSR) dated 8/12/2024, the OSR indicated that Resident 108 had an order for suprapubic catheter (flexible tube inserted above the pelvis into the bladder [organ where urine is stored] to drain urine). The OSR also indicated that the suprapubic catheter needed to be flushed with 50 milliliters (ml; a measuring unit for liquids) of normal saline (a saltwater solution) every shift. During a review of Resident 27's Care Plan (CP) titled The resident has Suprapubic Catheter dated 8/13/2024, the CP indicated to ensure the resident will not have signs or symptoms (s/s) of UTI (signs and symptoms of UTI include: frequent urination, pain or burning during urination, cloudy or foul-smelling urine, and blood in the urine) through review date, Resident 27's urine will be monitored for sedimentation (sediments; particles in liquid). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/18/2025 at 1:21 PM, Resident 27's indwelling catheter was observed with sediment in the urine in the urinary tubing. During a concurrent interview and record review on 8/19/2025 at 8:54 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated there was no documented evidence that a CoC was completed on 8/18/2025 to address Resident 27's sediments in the urine. LVN 3 stated that sediments in urine could indicate UTI and a CoC needs to be done. LVN 3 stated Resident 27's doctor needs to be notified as well so that the appropriate UTI treatment can be ordered. During a concurrent record review and interview with the DON on 8/21/2025 at 9:47 AM, the DON stated that presence of sediments in the urine is a possible s/s of UTI, and the facility's policy for UTI stated that the doctor must be notified for signs and symptoms of infection and it must be documented. 2. During a review of the facility's policy and procedures (P&P) titled Urinary Tract Infections/Bacteriuria – Clinical Protocol, dated April 2018, the P&P indicated nurses should observe, document, and report signs and symptoms in detail. During a review of Resident 84's admission Records (AR), the facility admitted Resident 84 on 2/1/2023 and readmitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (DM, having high blood sugar and difficulty in blood sugar control) and poor wound healing), Fournier Gangrene (a rapidly progressing and life threatening infection of the soft tissues in the genitals or perineum area that results in tissue death), and urethral fistula (an abnormal opening that connects the urethra [tube that carries urine out of the body] to a new unintended part of the body, which may cause frequent infections). During a review of Resident 84's care plan (CP), dated 3/15/2023, the CP indicated Resident 84 required an indwelling catheter due to Fournier Gangrene. The CP's interventions included to monitor urine for sediment, cloudy, odor, blood, and amount and to report to the physician promptly if the urine contains any sediment, or blood, is cloudy, or odorous, or if the resident has a fever. During a review of Resident 84's History and Physical (HP), dated 5/28/2025, the HP indicated Resident 84 had the capacity to understand and make decisions. During a review of Resident 84's Order Summary Report (a physician's order), dated 5/31/2025, the order indicated Resident 84 had an indwelling catheter for straight drainage for diagnoses and history of Fournier Gangrene. During a review of Resident 84's Order Summary Report, dated 5/31/2025, the order indicated to monitor Resident 84's indwelling catheter for the color, hematuria (blood in urine), odor, and sediments every shift. During a review of Resident 84's Treatment Administration Record (TAR), dated June 2025, the TAR indicated on 6/2 to 6/6, 6/9 to 6/14, 6/16 to 6/22, and 6/27 had incomplete documentation to monitor Resident 84's indwelling catheter for color, hematuria, odor, and sediment every shift. During a review of Resident 84's Minimum Data Set (MDS, a resident assessment), dated 7/7/2025, the MDs indicated Resident 84's cognition (a person's mental process of thinking, learning, remembering, and using judgement) was moderately impaired. The MDS indicated Resident 84 was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependent (helper does all the effort) for toileting hygiene. The MDS indicated Resident 84 had an indwelling catheter. The MDS indicated Resident 84 had End Stage Renal Disease (ESRD, irreversible kidney failure). During a review of Resident 84's TAR, dated July 2025, the TAR indicated 7/4, 7/10 to 7/12, 7/14-7/17, 7/21-7/23, and 7/30 had incomplete documentation to monitor Resident 84's indwelling catheter for color, hematuria, odor, and sediment every shift. During a review of Resident 84's TAR, dated August 2025, the TAR indicated 8/3, 8/14, 8/17 to 8/18 had incomplete documentation to monitor Resident 84's indwelling catheter for color, hematuria, odor, and sediment every shift. During an observation on 8/18/2025 at 10:15 AM in Resident 84's room, Resident 84's indwelling catheter drainage bag and tubing were observed with small amounts of sediments. During a concurrent observation and interview on 8/20/2025 at 12:55 PM with the MDS 2 in Resident 84's room, Resident 84's indwelling catheter drainage tubing and indwelling catheter bag was observed. The MDS 2 stated, there was some urine sediment in Resident 84's drainage tubing. During a concurrent interview and record review on 8/20/2025 at 2:35 PM with MDS 1, Resident 84's TAR for August 2025 was reviewed. The MDS 1 stated, for 8/3, 8/14, and 8/16-8/17, there was incomplete documentation monitoring Resident 84's indwelling catheter for color, hematuria, odor, and sediment. During a concurrent interview and record review on 8/20/2025 at 2:40 PM with the MDS 1, Resident 84's TAR for August was reviewed. The MDS coordinator stated, it was difficult to identify when the sediment began because the TAR indicated Resident 84's urine was yellow and did not indicate any presence of sediment. During an interview on 8/22/2025 at 3:44 PM with the Director of Nursing (DON), the DON stated, if there was incomplete documentation monitoring Resident 84's indwelling catheter, it means Resident 84's indwelling catheter was not monitored for color, odor, and sediment. The DON stated, sediment in the indwelling catheter does not automatically indicate a UTI, however, it could indicate a change in Resident 84's condition. 3.During a review of the facility's Policy and Procedure (P&P) and guidelines for preventing Urinary tract infections (catheter-associated) dated 2001, the P&P indicated to prevent catheter-associated urinary tract infection (CAUTIS) the facility will maintain unobstructed urine flow, keep drainage bag below the level of the bladder at all times and do not place drainage bag on the floor. During a review of Resident 26's admission Record (AR), The AR indicated Resident 26 was admitted to the facility on [DATE] with a diagnosis that included Urinary tract infection (UTI, an infection in any part of the urinary system such as the urethra, ureters, bladder and kidneys), benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate gland that causes difficulty urinating, frequent or urgent need to urinate, and incomplete bladder emptying). During a review of Resident 26's History & Physical (H&P) dated 4/10/2025, the H&P indicated Resident 26 has the capacity to understand and make decisions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool) dated 6/10/2025 indicated Resident 26 has an indwelling catheter. During a review of Resident 26's care plan, dated 5/26/2025, indicated the resident was at risk for infection related to complications of burning sensation during urination, The care plan intervention indicated to keep collection bag below the resident's bladder level to reduce risk of contamination. During an observation on 8/18/2025 at 10:40 AM in Resident 26's room, Resident 26's suprapubic catheter drainage bag hanging from Resident 26's bed frame on the upper handrails next to Resident 26's head. During a subsequent observation and interview on 8/18/2025 at 10:50 AM of Resident 26's Room with Licensed vocational nurse (LVN 3), LVN 3 stated Resident 26's suprapubic catheter drainage bag should not be hanging on Resident 26's bed frame next to his head. LVN 3 stated Resident 26's suprapubic catheter drainage bag should be placed below Resident 26's waist level to prevent any urine from flowing back to the urinary tract. 4. During a review of Resident 103's admission Record (AR), The AR indicated Resident 103 was initially admitted to the facility on [DATE] and recently readmitted on [DATE], with a diagnosis including sepsis (a life-threatening condition that occurs when the body's immune system responds excessively to an infection) and UTI. During a review of Resident 103's History & Physical (H&P) dated 1/08/2025, the H&P indicated Resident 103 does not have the capacity to understand and make decisions. During a review of Resident 103's Minimum Data Set (MDS, a resident assessment tool) dated 5/13/2025, indicated Resident 103 has an indwelling catheter. During a review of Resident 103's care plan, dated 5/08/2025, indicated Resident 103 requires indwelling foley catheter due to neurogenic bladder (a condition where the bladder muscles and nerves do not function properly). The care plan goal was to have no signs and symptoms of urinary tract infections for 90 days and the interventions included to provide catheter care twice a day and as needed. During a observation on 8/18/2025 at 9:46 AM of Resident 103's room, Resident 103's suprapubic catheter drainage bag was observed hanging from Resident 103's bed frame upper handrails next to Resident 103's head. During a subsequent observation and interview on 8/18/2025 at 10:12 AM of Resident 103's Room with LVN 4, LVN 4 stated Resident 103's suprapubic catheter drainage bag should not be hanging on above Resident 103's waist level next to his head. LVN 4 stated Resident 103's suprapubic catheter drainage bag should. During a interview and concurrent record review on 8/22/2025 at 2:55 PM, with the DON, the DON stated that Resident 26's and Resident 103's suprapubic catheter drainage bag needs to be maintained at a level below the Residents waist to prevent any urine backflow back to the Resident's bladder that can cause an infection.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the licensed nursing staff and physician failed to act upon the Pharmacist's recommendations documented in the Medication Regimen Review (MRR)-a comprehensive evaluation of a resident's medication regimen intended to promote positive outcomes and minimize adverse effects-for four of seven sampled residents (Residents 4, 7, 8, and 100) reviewed for MRR. The facility failed to: 1.Follow the pharmacist's recommendation to include the manifested behavior related to the use of Escitalopram (a type of antidepressant medication, used to treat depression and anxiety) for Resident 100. 2.Follow the pharmacist's recommendation to monitor orthostatic hypotension (a sudden drop in blood pressure that occurred when one stood up from lying or sitting, causing symptoms like lightheadedness or dizziness) for Resident 4 in relation to Risperdal use. 3. Follow the pharmacist's recommendation for Resident 8's Neurontin (gabapentin - medication that calmed overactive nerves in the body) to mix contents with water prior to administration. 4. Follow the pharmacist's recommendation for Resident 8's Protonix (pantoprazole - medication that reduced the amount of acid produced in the stomach) to be mixed with apple juice only, and not with any other liquid or food, including water. 5. Follow the pharmacists' recommendation for Resident 8's cholecalciferol (Vitamin D3, a nutrient your body needs to absorb calcium and build strong, healthy bones) to change from a daily dose to a weekly dose. 6. Follow the pharmacist's recommendation to monitor orthostatic hypotension for Resident 7 in relation to Risperdal use. These deficient practices had the potential for delayed identification of clinical changes, ineffective medication administration, and adverse effects that could lead to acute medical events requiring emergency care or hospitalization. Findings: During a review of the facility's P&P titled, Medication Utilization and Prescribing – Clinical Protocol dated April 2018, the P&P indicated that facility staff and the consultant pharmacist must identify factors affecting medication effectiveness and risks. The P&P indicated that the consultant pharmacist is expected to review medication use patterns, conduct thorough interim and monthly regimen reviews, and address issues like drug interactions, medication-related problems, and unsupported medication use. 1. During a review of Resident 100's admission Record indicated an admission to the facility on 8/25/2023 with diagnoses that included end stage renal disease (irreversible kidney failure), depression (consistent feeling of sadness and hopelessness), and anxiety disorder (feelings of worry of fear of the unknown that interfere with one's daily activities). During a review of Resident 100's History and Physical assessment dated [DATE] indicated Resident 100 had fluctuating capacity to understand and make decisions. During a review of Resident 100's Order Summary Report (a physician's order) dated 1/17/2025, indicated to administer Escitalopram Oxalate Oral Tablet 10 mg to Resident 100 mg one tablet by mouth one time a day for depression. During a review of the facility's Medication Regimen Review (MRR) indicated on 6/2025 and 7/2025 the pharmacist recommended that the physician include the manifested behavior related to the use of Escitalopram in the physician's order and ensure it was recorded in the Medication Administration (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record (MAR). During a review of Resident 100's Medication Administration Record (MAR) dated June 1, 2025, to August 21, 2025, indicated that Escitalopram was administered as ordered. The MAR showed that 0 or no behavior was documented as being monitored for the use of Escitalopram every shift from June to August 2025. During a telephone interview with the Pharmacist (Pharm) 1 on 8/21/2025, at 3:15 PM, the pharmacist stated that she recommended the physician to include monitoring manifested behavior related to the use of Escitalopram because it was unclear what the medication was being used to treat. The pharmacist stated she noted that Resident 100's MAR did not include the instruction to specify behavior manifestation for the use of Escitalopram. Pharm 1 explained that if staff were not monitoring Resident 100's behavior, they would not be able to determine whether the medication was effective or if a dosage adjustment—either an increase or decrease—was necessary. During a concurrent interview and record review of Resident 100's MAR dated 8/2025, conducted with LVN 5 on 8/22/2025, at 1:23 PM, LVN 5 stated that she could not find documented evidence in the MAR from 8/1/2025 to 8/21/2025, indicating that licensed nurses monitored Resident 100 for a specific behavior indicated for the use of Escitalopram. LVN 5 stated identifying a specific behavior was important so that staff can determine whether administration of Escitalopram was necessary or if a dosage adjustment was warranted. LVN 5 explained that the specific behavior is what staff should be monitoring, but the MAR did not specify what behavior to observe. LVN 5 further stated that monitoring the use of Escitalopram helps determine the medication's effectiveness and whether the physician should be notified. When monitoring Resident 100's behavior, she reported asking certified nursing assistants (CNAs) whether the resident had crying periods or had refused to eat or be changed. During a concurrent interview and record review of the facility's Monthly Review Reports (MRR) for 6/2025 and 7/2025, conducted with the DON on 8/22/2025, at 2:52 PM, the DON confirmed that the pharmacist had recommended to include what behavior to monitor for the use of Escitalopram for Resident 100. The DON stated that the pharmacist's recommendation should have been implemented to ensure Resident 100's safety and to monitor for any potential adverse effects of the medication. The DON stated staff should that have been monitoring a specific behavior associated with the use of Escitalopram to evaluate its effectiveness. During a concurrent interview and record review of Resident 100's Order Summary dated 1/17/2025 with the Director of Nursing (DON) on 8/22/2025 at 2:56 PM, the DON confirmed that Resident 100's order for Escitalopram did not include a specific behavior or manifestation to monitor. The DON stated that it is important to include a specific behavior or manifestation in the order to determine whether the medication was effective for the resident. The DON further explained that without monitoring, staff would not be able to assess whether the medication is working or if adjustments to the treatment plan are needed. During a concurrent interview and record review of Resident 100's Medication Administration Record (MAR) dated 6/1/2025 to 8/21/2025, conducted with the DON on 8/22/2025, at 3:23 PM, the DON stated that he could not find documented evidence in the MARs indicating that staff were monitoring for a specific behavior. The DON stated that monitoring a specific behavior related to the use of Escitalopram is important to determine whether the medication is effective for the resident. He further stated that if behavior is not monitored, the resident could be receiving unnecessary (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication. 2. During a review of Resident 4's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental illness that was characterized by disturbances in though), bipolar disorder (a mental health condition) and periods of deep sadness [depression]), and syncope (a temporary loss of consciousness, commonly known as fainting. During a review of Resident 4's History and Physical (H&P) dated 11/22/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/12/2025, the MDS indicated Resident 4 was receiving an antipsychotic medication. During a review of Resident 4's Consultant Pharmacist's MRR dated 6/1/2025 to 6/18/2025, the pharmacist recommended weekly orthostatic hypotension monitoring due to Risperdal use. The recommendation specified monitoring BP in both lying and sitting positions, with both BP readings collected on the same day. During a review of Resident 4's Risperdal Care Plan dated on 6/2/2025, the Care Plan indicated a goal that the resident would receive the smallest, most effective dose of Risperdal without side effects. The care plan interventions included monitoring for changes in mental status and functional level with reporting to the physician, monitoring for side effects with consultation to the physician or pharmacist as needed, and implementing gradual dose reduction (GDR) as ordered. However, the Care Plan did not include monitoring for orthostatic hypotension, despite prior pharmacist recommendations. During a review of Resident 4's Physician's Order dated 7/3/2025, the order indicated Risperdal oral tablet 1 mg, to be administered by mouth twice daily for the treatment of schizophrenia and schizoaffective disorder, bipolar type (mental disorders). The order indicated Resident 4's diagnoses was characterized by rapid mood cycling, evidenced by sudden shifts in mood from pleasant to extreme anger, including episodes of yelling and screaming. During another review of the Consultant Pharmacist's MRR dated 7/1/2025 to 7/28/2025, the pharmacist included a similar recommendation for weekly orthostatic hypotension monitoring due to Resident 4's continued Risperdal use. The recommendation specified monitoring BP in both lying and sitting positions, with both BP readings collected on the same day. During another review of Resident 4's Consultant Pharmacist's MRR dated 8/1/2025 to 8/18/2025, the pharmacist indicated similar recommendations made from June 2025 and July 2025 for weekly orthostatic hypotension monitoring due to Resident 4's continued Risperdal use. The recommendations specified monitoring Resident 4's BP in both lying and sitting positions, with both BP readings collected on the same day. During a review of Resident 4's BP Summaries for 6/1/2025 to 6/30/2025, 7/1/2025 to 7/31/2025, and 8/1/2025 to 8/31/2025, the BP Summaries showed inconsistent documentation of the resident's position during BP measurements—recorded as lying, sitting, or other. The BP Summary had no indication that orthostatic hypotension monitoring was performed. The BP Summary indicated Resident 4's BP was collected daily and taken at different times of the day. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, during a review of Resident 4's MARs dated 6/1/2025 to 6/30/2025, 7/1/2025 to 7/31/2025, and 8/1/2025 to 8/31/2025, the MARs did not reflect that orthostatic hypotension monitoring had been conducted. During a concurrent interview and record review of Resident 4's MRR on 8/21/2025 at 3:13 PM, the Pharmacist stated that for residents receiving antipsychotic medications, monitoring for side effects such as orthostatic hypotension should have been conducted. The Pharmacist stated that if the facility was not monitoring Resident 4 for orthostatic hypotension, the resident could experience dizziness, which could increase the risk of a fall. During a concurrent interview and record review of Resident 4's MRR on 8/22/2025 at 2:55 PM, the DON stated that orthostatic hypotension monitoring was not conducted for Resident 4 but acknowledged that the facility staff should have monitored as recommended by the pharmacist. The DON further stated that failure to follow the Pharmacist's recommendations posed a potential risk of harm, particularly if the resident became hypotensive, as this could lead to dizziness and an increased risk of falls. During a review of the Manufacturer's Label for Risperdal dated 1/2025, the Manufacturer's Label indicated under, Warnings and Precautions that orthostatic hypotension is a known risk. 3. During a review of Resident 8's AR, the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included hemiplegia (total paralysis or inability to move one side of the body) and hemiparesis (partial weakness on one side of the body), and Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's History and Physical (H&P) dated 9/14/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 8's Physician's Order dated 6/29/2025, the order indicated gabapentin oral capsule, give 300 milligrams (mg) was to be administered via gastrostomy tube (G-tube - a feeding tube inserted directly into the stomach through the abdominal wall) three times daily for neuropathic pain related to hemiplegia and hemiparesis. During a review of Resident 8's Physician's Order dated 6/29/2025, the order indicated Cholecalciferol tablet 50,000 units to be given orally once daily as a supplement. During a review of Resident 8's Physician's Order dated 7/7/2025, the order indicated Protonix 40 mg oral packet was to be administered via G-tube each morning for heartburn (a burning chest pain caused by stomach acid flowing back into the esophagus due to a faulty valve). During a review of Resident 8's Consultant Pharmacist's MRR dated 6/1/2025 to 6/18/2025, the MRR included a recommendation for Neurontin capsules to be mixed with water prior to administration. During a review of Resident 8's Consultant Pharmacist's MRR dated 7/1/2025 to 7/28/2025, the MRR included the following pharmacist recommendations: A similar recommendation for Neurontin (gabapentin) capsules: Mix contents with water prior to administration. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For Protonix (pantoprazole) packets: Mix granules with apple juice only; do not use other liquids or foods, including water. For cholecalciferol (Vitamin D3) 50,000 units daily: Pharmacist noted to consult the primary care provider (PCP) to change the dose from daily to weekly. During a review of Resident 8's Medication Administration Records (MARs) dated 6/1/2025 to 6/30/2025, 7/1/2025 to 7/31/2025, and 8/1/2025 to 8/31/2025, the MARs showed an order for gabapentin 300 mg oral capsule to be given via G-tube three times daily for neuropathic pain. The MARs did not include instructions to mix the gabapentin capsule contents with water, as recommended by the pharmacist. The MARs also indicated to administer Cholecalciferol tablet 50,000 units given orally once daily for supplement. The MARs indicated Resident 8's Cholecalciferol tablet 50,000 units frequency was not changed from daily to weekly, as recommended by the pharmacist. The MARs further indicated an order for Protonix 40 mg oral packet to be given via G-tube each morning for heartburn. The MARs did not indicate that the medication should be mixed with apple juice only or that other liquids or foods, including water, should be avoided, as recommended by the pharmacist. During an interview on 8/21/2025 at 3:19 PM, the pharmacist stated that Neurontin and Protonix required specific mixing instructions to ensure proper absorption and effectiveness, and that unclear directions could lead to confusion and reduced efficacy. In the same interview, on 8/21/2025 at 3:19 PM, the pharmacist further stated that cholecalciferol 50,000 units is typically a weekly dose, and the recommendation to change from daily to weekly was made to prevent potential toxicity. During a concurrent interview and record review of Resident 8's MRR, the Director of Nursing (DON) stated the pharmacist's recommendations for June, July, and August were not implemented. The DON acknowledged that cholecalciferol should have been administered weekly, and that daily dosing could lead to toxicity, posing a risk of harm or serious injury to Resident 8. 4. During a review of Resident 7's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included schizophrenia. During a review of Resident 7's H&P dated 9/14/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 7's Physician's Order dated 8/28/2024, the order indicated to monitor orthostatic blood pressure (BP that drops significantly upon standing, potentially causing dizziness or lightheadedness]) while the resident is lying, sitting, and standing, every shift, due to administration of Risperdal (risperidone) 0.5 mg daily. The order specified BP monitoring in both sitting and lying positions. The order indicated the order was discontinued on 9/13/2024. During a review of a subsequent Physician's Order dated 9/14/2024, the order indicated that risperidone (Risperdal) 0.5 mg oral tablet was to be administered to Resident 7, once daily via gastrostomy tube (G-tube [a feeding tube surgically placed through the abdomen directly into the stomach]), due to symptoms manifested by sudden mood shifts from pleasant to anger, including yelling, associated with schizophrenia. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Consultant Pharmacist's Medication Regimen Review (MRR) dated 6/1/2025 to 6/18/2025, the pharmacist recommended weekly orthostatic hypotension monitoring for Resident 7, due to Risperdal use. The recommendation specified monitoring BP in both lying and sitting positions, with both BP readings collected on the same day. During a review of Resident 7's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During another review of the Consultant Pharmacist's MRR dated 7/1/2025 to 7/28/2025, the MRR included a similar recommendation for weekly orthostatic hypotension monitoring for Resident 7, due to Risperdal use. The pharmacist specified that two blood pressure (BP) readings were required—one while the resident was lying down and another while sitting up. The recommendation also stated that the physician should be notified if the systolic BP (top number) differed by 20 millimeters of mercury (mmHg) or more, or if the diastolic BP (bottom number) differed by 10 mmHg or more between positions. Additionally, during a review of Resident 7's MARs dated 6/1/2025 to 6/30/2025, 7/1/2025 to 7/31/2025 and 8/1/2025 to 8/31/2025, the MARs did not reflect that orthostatic hypotension monitoring had been conducted. During a review of Resident 7's BP Summaries for 6/1/2025 to 6/30/2025, 7/1/2025 to 7/31/2025 and 8/1/2025 to 8/31/2025, the BP Summary showed inconsistent documentation of the resident's position during BP measurements—recorded as lying, sitting, or other. The BP Summary had no indication that orthostatic hypotension monitoring was performed. The BP Summary indicated Resident 7's BP was collected daily and taken at different times of the day. During a review of Resident 7's Risperdal Care Plan, revised on 8/14/2025, the Care Plan goal indicated that the resident would receive the smallest, most effective dose of Risperdal without side effects. The care plan interventions included monitoring for changes in mental status and functional level with reporting to the physician, monitoring for side effects with consultation to the physician or pharmacist as needed, and implementing gradual dose reduction (GDR) as ordered. However, the Care Plan did not include monitoring for orthostatic hypotension, despite prior pharmacist recommendations. During a concurrent interview and record review of Resident 7's MRR on 8/21/2025 at 2:52 PM, the Pharmacist stated orthostatic hypotension monitoring was necessary because the resident was on Risperdal and should have been monitored weekly. The Pharmacist stated the facility should have implemented the recommendations within one to two weeks. The Pharmacist further stated that failure to do so could result in the resident experiencing orthostatic hypotension, dizziness, and potentially experience a fall. During a concurrent interview and record review of Resident 7's MRR on 8/22/2025 at 2:45 PM, the Director of Nursing (DON) stated the Pharmacist's recommendations were not followed but should have been implemented to ensure the resident's safety and monitored for any adverse effects. The DON stated that failure to follow the recommendations posed a potential risk of harm to Resident 7, particularly if the resident became hypotensive, which could lead to a fall-related accident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview and record review the facility failed to ensure food are stored properly for one of one of the facility's kitchen, in accordance with the facility's policy and procedure titled Food Storage- Cold Foods, by failing to label the ice cream with an open and used by date and storing onions properly to prevent mold growth and fruit flies. This deficient practice had the potential to cause food stored past safe storage time/ period, and place residents who consume this food at risk for foodborne illness (food poisoning or food illness due to pathogens [harmful organisms that cause illness such as bacteria, viruses, or parasites] and toxins that contaminate food). Findings: During a review of the facility's policy and procedures (P&P) titled Food Storage- Cold Foods revised 2/2023, the P&P indicated the following: All Time/ Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with the guidelines of the FDA (Food and Drug Administration- An agency in the U.S. federal government who protects public health by making sure that food, cosmetics, and nutritional supplements are safe to use and truthfully labeled.) Food Code (a model for best practices to ensure the safe handling of food). All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. During a review of the facility's P&P titled Food Receiving and Storage undated, the P&P indicated the following: Food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times. Non-refrigerated foods, disposable dishware and napkins are stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. During an observation and concurrent interview on 8/18/2025 at 8:39 AM, a bin of onions was observed stored under food preparation desk in the kitchen. When onions were taken out from the bin for inspection, a group of fruit flies were observed. Two onions out of 12 in the same bin were observed with molds on them. The Dietary Supervisor (DS) stated the cook was responsible for checking all produces even if it's not used, and the dietary staff should have done inspection of current stored produces on the day of receiving new ordered items. The DS stated the onions are not safe to use and should have been disposed. During an observation and concurrent interview on 8/18/2025 at 8:59 AM, a ton (one-third gallon [unit of measurement for volume]) of vanilla ice cream in the walk-in freezer was observed not labeled with date opened or Use by date. The DS stated he did not see labels of Use by date or date opened anywhere on the package of this ice cream. The DS stated any kitchen staff that opened the ice cream was responsible for labeling the food at the time he or she put it in the freezer for food safety.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the facility obtained an informed consent (a written document signed by the physician or designee that indicated the resident/responsible party was informed about the risk and benefit of the proposed treatment) with the use of psychotropic medications (medications that affects mood and behavior), from two of two sampled residents (Resident 8 and 100) reviewed for the use of psychotropic medications by failing to: 1.Obtain a consent from Resident 8 or the resident's responsible party prior to administration of Mirtazapine (a medication used to treat depression or an antidepressant). 2. Obtain a consent from the Resident 100 or the responsible party prior to administration of Ativan (a medication used to treat anxiety [the fear of the unknown that interfere with one's daily activities}). This deficient practice violated the residents right to make an informed decision regarding the use of psychotropic medications (Ativan and Mirtazapine). During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use dated June 2021, the P&P indicated, When a Physician/Prescriber orders a psychotropic medication for a resident the facility should ensure that Physician/Prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacologic medication is necessary. The P&P indicated, It is the responsibility of the attending health care practitioner to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulation. The informed consent will be obtained by the Prescriber prior to initiation of the psychotropic medication. The Facility shall verify informed consent prior to the administration of a psychotropic medication for a resident. 1.During a review of Resident 8's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included hemiplegia (total paralysis or inability to move one side of the body) and hemiparesis (partial weakness on one side of the body), During a review of Resident 8's History and Physical (H&P) dated 9/14/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/28/2025, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). During a review of Resident 8's Physician's Order dated 6/30/2025 at 5:04 PM, the Physician's Order indicated mirtazapine oral tablet 7.5 milligrams (mg, unit of measurement), give one tablet via gastrostomy tube (g-tube, a feeding tube that goes directly through a small surgical opening in the abdomen into the stomach) at bedtime for depression manifested by verbalization of sadness related to depression, unspecified, consent obtained from RP. During a review of Resident 8's undated Psychotropic Medication Administration Disclosure Form, the Form indicated the physician ordered mirtazapine 7.5 mg daily at bedtime for depression via g-tube. and the form was not signed by the physicians. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 8's Mirtazapine Care Plan dated 8/13/2025, the Care Plan indicated a goal for the resident to have the smallest most effective dose without side effects for 90 days. The Care Plan intervention included monitoring changes in mental status, functional level, and report to MD, monitor for side effects and consult the physician/pharmacist as needed, and providing informed consent to resident or healthcare decision maker. During a concurrent interview and record review of Resident 8's Psychotropic Medication Administration Disclosure Form on 8/22/2025 at 1:52 PM, the Registered Nurse (RN) 2 stated the Form was not complete because the Form was missing the physician's signature and the date the consent was obtained. RN 2 stated if all the information was not on the Psychotropic Medication Administration Disclosure Form Resident 8, should not have been getting the medication. During a concurrent interview and record review of Resident 8's Psychotropic Medication Administration Disclosure Form on 8/22/2025 at 3:59 PM, the Director of Nursing (DON) stated the form was not complete and did not include information if the risk and benefit of the drug was discussed with the RP, the physician's signature, and there was no date when the consent was obtained . The DON stated if all the information was not documented the facility could be giving unnecessary medication to Resident 8. 2.During a review of Resident 100's admission Record indicated a readmission to the facility on 6/17/2024 with diagnoses that included depression (mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily life), and anxiety disorder (the fear of the unknown that interfere with one's daily activities). During a review of Resident 100's History and Physical assessment dated [DATE] indicated Resident 100 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 100's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/5/2025 indicated resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 100 had no symptoms present of the following behaviors: little interest or pleasure in doing things, feeling or appearing down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, indicating that they feel bad about self, are a failure, or have let self or family down. During a review of Resident 100's Order Summary Report (a physician's order) dated 5/20/2025 indicated to give Ativan Oral Tablet 1 MG (Lorazepam) by mouth one time a day every Tuesday, Thursday, Saturday for anxiety 30 minutes before hemodialysis (a process of filtering the blood of a person whose kidneys are not working normally). During a review of Resident 100's Psychotropic Medication Administration Disclosure (Anti-Anxiety) (PMAD, a document providing specific information to a patient or their guardian to obtain informed consent before administering a psychotropic medication) for the use of Ativan dated 6/19/2025 indicated no Resident/Resident Representative signature was obtained. The disclosure indicated no counter signature was obtained by second licensed nurse for verification. During a concurrent interview and record review of Resident 100's Psychotropic Medication Administration Disclosure (Anti-Anxiety) dated 6/19/2025 with the Director of Nursing (DON) on 8/22/2025 at 3:53 PM, the DON stated the resident representative signature and counter signature by another licensed nurse was missing. The DON stated this was a legal document and it should have been verified to make sure it was valid and accurate.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's needs were accommodated by the facility staff according to resident's needs and preferences for one out of 9 sampled residents (Resident108) reviewed for accommodation of needs, by failing to ensure Resident 108's call light was in reach while in bed for for call light observation, in accordance with the facility's policies and procedures (P&P) titled Answering the Call Light. This deficient practice had the potential to prevent Resident 108 from receiving personal and medical assistance when needed. Findings: A review of the facility's P&P titled, Answering the Call Light dated 10/24/2024 indicated to ensure timely responses to the resident's requests and needs, the call lights are accessible to the resident when in bed. During a review of Resident 108's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 Diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood), and cerebral infarction (loss of blood flow to a part of the brain) affecting his left side. During a review of Resident 108's History and Physical (H&P) dated 9/25/2024, the H&P indicated that Resident 108 does not have the capacity to understand and make decisions. During a review of Resident 108's Minimum Data Set (MDS, a care assessment and screening tool) dated 7/24/2025, the MDS indicated the resident was assessed to have severely impaired cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) skills and was dependent (helper does all of the effort) for oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 108 was dependent on rolling left and right, bed to chair transfer and shower transfer. During an observation on 8/20/2025 at 6:12 AM, Resident 108's call light was observed behind Resident 108's bed. During a concurrent interview and observation on 8/20/2025 at 6:14 AM with Certified Nursing Assistant (CNA) 1, Resident 108's call light was observed behind Resident 108's bed (hanging behind the bed). CNA 1 stated that the call light was behind Resident 108's bed and it needs to be within Resident 108's reach so they may call for help when necessary. CNA 1 stated that Resident 108 will not be able to get help when needed or if he has a medical problem if the call light is not within reach. During a concurrent interview and record review on 8/21/2025 at 9:50 AM with the Director of Nursing (DON), the facility's P&P titled, Answering the Call Light dated 10/24/2024 was reviewed, the DON stated that call lights must be in reach while a resident is in bed to ensure residents' needs are not delayed.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility's policy and procedure (P&P) titled Notification of Change in Condition to notify the physician for one of five sampled residents (Resident 84) with significant change of condition related swelling on bilateral lower extremities (edema) and presence of urine sediment (solid particles like crystals, cells, or debris, which can be caused by dehydration, a urinary tract infection (UTI), kidney stones, or other underlying health conditions). This deficient practice had the potential for Resident 84 not to receive care and services needed for the significant change in condition and for the representative party to be unaware of the significant change of condition. Findings: During a review of the facility's policies and procedures (P&P) titled Change in Condition: Notification of, dated 8/25/2025, indicated the facility must immediately inform the resident, consult the resident's physician and/or nurse practitioner, and notify, consistent with his/her authority, resident representative where there is. a change in the resident's physical, mental, or psychosocial status. During a review of Resident 84's admission Records (AR), the facility admitted Resident 84 on 2/1/2023 and readmitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), Fournier Gangrene (a rapidly progressing and life threatening infection of the soft tissues in the genitals or perineum area that results in tissue death), and urethral fistula (an abnormal opening that connects the urethra [tube that carries urine out of the body] to a new unintended part of the body, which may cause frequent infections). During a review of Resident 84's Care Plan (CP), dated 3/15/2023, indicated Resident 84 required an indwelling catheter due to Fournier Gangrene. The CP's interventions included to monitor urine for sediment, cloudy, odor, blood, and amount, and to report to the physician promptly if the urine contains any sediment, or blood, is cloudy, or odorous, or if the resident has a fever. During a review of Resident 84's CP, dated 2/22/2025, the CP indicated Resident 84 exhibited or at risk of fluid volume excess as evidence by edema to bilateral lower extremities. The CP's interventions included to notify physician if edema continues or increases. During a review of Resident 84's History and Physical (HP), dated 5/28/2025, the HP indicated Resident 84 had the capacity to understand and make decisions. During a review of Resident 84's Minimum Data Set (MDS, a resident assessment), dated 7/7/2025, the MDs indicated Resident 84's cognition (a person's mental process of thinking, learning, remembering, and using judgement) was moderately impaired. The MDS indicated Resident 84 was dependent (helper does all the effort) for toileting hygiene. The MDS indicated Resident 84 had an indwelling catheter and End Stage Renal Disease (ESRD, irreversible kidney failure. During an observation on 8/18/2025 at 10:15 AM in Resident 84's room, Resident 84 was observed with edema in his bilateral lower extremities and small amounts of sediment in the urine draining in the indwelling catheter drainage tubing. During an observation and interview on 8/18/2025 at 10:20 AM in Resident 84's room with Treatment Nurse (TXN) 1, Resident 84's bilateral lower extremities were observed. Treatment Nurse stated, she was unaware of Resident 84's bilateral feet swelling. During an interview on 8/18/2025 at 2:50 PM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, the previous shift's LVN 4 did not endorse Resident 84's bilateral lower extremity swelling to her upon report. LVN 4 stated, she did not assess Resident 84's feet in the morning and did not notify the physician. LVN 4 stated, she will call the physician now. During a concurrent interview and record review on 8/20/2025 at 2:42 PM with MDS 1, Resident 84's Change in Condition (CoC) evaluations were reviewed. MDS 1 stated, there was no CoC evaluation completed for Resident 84's bilateral lower extremity swelling and presence of sediment in the urine draining in the indwelling catheter drainage tubing on 8/18/25 prior to the observation of the surveyor. During an interview on 8/20/2025 at 2:45 PM with the MDS 1, the MDS 1 stated, the physician must be notified of Resident 84's bilateral lower extremities edema and presence of (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sediment in the urine draining in the indwelling catheter drainage tubing because these are considered a change in Resident 84's condition and need to be monitored. During an interview on 8/22/2025 at 3:50 PM with the Director of Nursing (DON), the DON stated, the physician was not notified of Resident 84's bilateral lower extremity swelling and presence of sediment in the urine until it was brought to our attention. The DON stated, it was important to create a CoC to monitor and to notify a resident's change of condition.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the proper documentation, tracking, and safeguarding of residents' personal property for one (1) of two (2) sampled residents (Resident 71) reviewed for concerns related to personal property. Specifically, the facility failed to ensure that residents' personal belongings were properly documented and safeguarded in accordance with facility policy and Procedure (P&P) titled Resident's Personal Property. For Resident 71, the facility failed to update the Inventory of Personal Effects form to include personal belongings brought into the facility after admission by failing to ensure that Resident 1's hearing aids (electronic devices designed to amplify sound for individuals with hearing loss) were properly accounted for and replaced in a timely manner. These failures resulted in unaccounted-for loss or theft of personal property for Resident 71 and reflected a systemic breakdown in the facility's responsibility to maintain accurate inventory records and oversight that compromises the facility's ability to protect residents' belongings and ensure staff awareness of residents' personal belongings. These failures placed other residents at risk for loss of essential personal items, which may negatively impact their quality of life and dignity. Findings: During a review of the facility's P&P titled Resident's Personal Property, dated 8/25/2021, the policy indicated, The purpose of the policy is to protect the resident's right to retain his/her personal belongings and preserve the resident's individuality and dignity. The same P&P further indicated that all items brought into the facility must be listed on the Inventory of Personal Effects form and kept in the resident's clinical chart. It also stated that any additional items brought into the facility after admission must be added to this list. Furthermore, the policy indicated that the facility would make reasonable efforts to safeguard resident property and would reimburse or replace stolen or lost property at its current value. During a review of Resident 71's admission Record (AR), the AR indicated that Resident 71 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood) and hypertension (blood pressure that is higher than normal). During a review of Resident 71's History & Physical (H&P) dated 1/21/2025, the H&P indicated that Resident 71 has fluctuating capacity to understand and make decisions. During a review of Resident 71's Inventory of Personal Effects, dated 1/23/2025, showed that only a hospital nightgown was listed under the Articles section. Under the section titled Items Acquired After Original Entry, the handwritten note stated no belongings. The Inventory of Personal Effects form included instructions at the top, which read: Instructions: Upon admission, identify the patient's belongings by indicating the quantity of those items listed. Use the space allowed to write additional items as necessary. Update as necessary throughout the patient's stay by using the space provided. During an initial facility tour observation on 8/18/2025, at 11:15 AM, Resident 71 was observed sitting in bed, in his room. When the surveyor attempted to interview the resident, Resident 71 stated that he could not hear well and asked the surveyor to speak loudly and close to his ears, as he is hard of hearing in both ears. During an interview and observation conducted on 8/18/2025, at 11:22 AM in Resident 71's room, in the presence of Licensed Vocational Nurse (LVN) 3, LVN 3 stated that the Social Services Department (SSD) is responsible for updating all residents' inventory lists. LVN 3 stated that she had previously seen Resident 71 wearing hearing aids during visits from family members (resident representative). LVN 3 stated that Resident 71 is hard of hearing and that staff typically needs to speak loudly and in close proximity to his ears to communicate effectively with Resident 71. During the same observation, Resident 71 was seen retrieving his hearing aids from his bedside drawer and requested assistance from LVN 3 to put the hearing aids on. LVN 3 stated that she was not aware that Resident 71 had hearing aids stored at his bedside. During a telephone interview on 8/20/2025, at 9:32 AM with Resident 71's family member (Resident Representative [RP] 1), RP 1 stated that she was present (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Resident 71 upon his admission to the facility from the acute hospital in January 2025, at which time he had hearing aids in his possession. RP 1 stated that Resident 1's hearing aids were lost at the facility around March 2025. RP 1 stated she informed the facility's nursing staff, who told her they would follow up and search for the missing devices. RP 1 stated that, after multiple unsuccessful attempts to locate the hearing aids, the family decided to purchase a new set of hearing aids, which are currently kept at Resident 71's bedside. During an interview and record review of Resident 71's current Inventory of Personal Effects list on 8/21/2025, at 9:45 AM, Social Services Assistant 2 (SSA 2) stated that when a resident is admitted to the facility, the admitting nurse is responsible for completing the initial inventory list and placing it in the resident's medical record. SSA 2 explained that if facility staff observe that a resident has brought in personal belongings not listed on the inventory, the list should be updated accordingly to ensure all resident belongings are properly accounted for while the resident is in the facility. SSA 2 further stated that Resident 71's inventory list had not been updated since his admission in January 2025 to reflect the personal belongings currently at his bedside.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of seven sampled residents reviewed for unnecessary medications are free from unnecessary use of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) by failing to: 1.Ensure that PRN (as needed) orders for psychotropic medications were limited to a duration of 14 days, for Resident 80 who was receiving psychotropic medications, specifically an active order of Ativan (lorazepam- a medication used to treat anxiety) initiated on 7/27/2025, with no documented stop date or evidence of physician re-evaluation to justify continued use beyond 14 days. 2. Ensure a specific behavior was assessed and documented for Resident 100, who had a diagnosis of depression (mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily life). 3. Ensure to monitor and document the side effects and effectiveness of Escitalopram (a psychotropic medication) prescribed to Resident 100. These deficient practices placed Resident 100 and Residents 80, and other residents receiving psychotropic medications, at risk for undetected drug adverse effects, continued use of medications without a clear clinical indication, and potential harm due to lack of monitoring for efficacy and side effects. Findings: During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 6/2021, the P&P indicated psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric cause of behavioral symptoms. The P&P indicated all medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired effect. The P&P indicated all residents receiving medications used to treat behaviors should be monitored for efficacy, risks, benefits, harm or adverse consequences. The P&P indicated facility staff should monitor behavioral triggers, episodes and symptoms. During the same policy review, the P&P indicated residents shall not receive psychotropic drugs pursuant to a PRN order unless the medication is necessary to treat a diagnosed, specific condition that is documented in the clinical record. PRN orders for psychotropic drugs are limited to 14 days. The P&P indicated that for PRN psychotropic medications, excluding antipsychotics, if the attending physician or prescribing practitioner believes it is appropriate to extend the PRN order beyond 14 days, they must document the rationale in the resident's medical record and indicate the duration of the PRN order. 1.During a review of Resident 80's admission Record (AR), the AR indicated that Resident 80 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including paranoid schizophrenia (mental health condition that affects how people think, feel and behave), unspecified asthma (airways in the lungs become narrowed and swollen, making it difficult to breathe). During a review of Resident 80's Minimum Data Set (MDS, a resident assessment tool) dated 7/02/2025, the MDS indicated Resident 80 was severely impaired in cognitive skills (thought process). During a review of Resident 80's Order Summary Report for August 2025, the Report indicated a (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician order for Ativan oral tablet 2 milligrams (mg-a unit of measurement) dated 7/27/2025, was to be administered orally, once daily every 8 hours as needed for anxiety related to generalized anxiety disorder. During an interview and concurrent record review of Resident 80's medical records on 8/21/2025 at 10:22 AM, with the Director of Nursing (DON), the DON stated that Resident 80's PRN order for Ativan 2 mg, dated 7/27/2025, did not include a stop date or a documented rationale from the prescribing physician explaining why the medication should be continued beyond the 14-day limit. The DON further stated that Ativan, like other PRN psychotropic medications, must be renewed every 14 days and that the resident must be seen and evaluated by their attending physician prior to the renewal of any PRN psychotropic medication. 2. During a review of Resident 100's admission Record indicated a readmission to the facility on 6/17/2024 with diagnoses that included end stage renal disease (irreversible kidney failure), depression, and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 100's History and Physical assessment dated [DATE], the Assessment indicated Resident 100 had fluctuating capacity to understand and make decisions. During a review of Resident 100's Order Summary Report (OSR), the following physician orders indicated: Dated 1/17/2025: Escitalopram Oxalate Oral Tablet, 10 milligrams (mg). Administer one tablet by mouth once daily for depression. Dated 1/17/2025: Antidepressant monitoring order: Monitor episodes related to escitalopram use (specify behavioral manifestations) every shift. Document non-drug interventions used, including: Removed resident from the environment Redirected resident by engaging in an alternative activity Listened to the resident and attempted to calm them; familiarized resident with belongings and surroundings Toileted the resident Ambulated the resident (if able) Provided the resident with food or drink Document the result of the intervention every shift, indicating + if effective. During a review of the facility's Medication Regimen Review (MRR), pharmacist recommendations were noted regarding the use of escitalopram for Resident 100. In June 2025, the facility's pharmacist consultant recommended that the facility monitor Resident 100's manifested behavior on the Medication Administration Record (MAR) and include the specific behavior as part of the physician's order. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the continued review of the facility's MRR, a similar pharmacist recommendation was made again in July 2025, emphasizing the need to document the behavioral manifestations associated with escitalopram use and to ensure that this information was reflected both in Resident 100's MAR and in the physician's order. During a review of Resident 100's MAR dated 6/1/2025 to 8/21/2025, the MAR indicated escitalopram was administered as ordered. However, there was no documentation indicating that the resident's behavior was monitored or recorded every shift during this period, as required by the physician's order and facility policy. During a concurrent interview and record review of Resident 100's MAR for August 2025, conducted with Licensed Vocational Nurse (LVN) 5 on 8/22/2025, at 1:23 PM, LVN 5 stated that she could not find any documented evidence in the MAR from 8/1/2025 to 08/21/2025, indicating that licensed nurses had monitored Resident 100 for a specific behavior related to the use of escitalopram. LVN 5 stated that identifying a specific behavior is important so that staff can determine whether the administration of the medication is necessary or if the dosage needs to be adjusted. LVN 5 further stated that the MAR did not specify which behavior should be monitored. LVN 5 emphasized that monitoring the resident's behavior in relation to escitalopram use is essential to evaluate the medication's effectiveness and to determine whether the physician should be notified. LVN 5 added that, in practice, when monitoring Resident 100's behavior, she would ask certified nursing assistants (CNAs) whether the resident had exhibited signs such as abruptly crying or refusing to eat or be changed. During a concurrent interview and record review of Resident 100's Order Summary dated 1/17/2025, with the Director of Nursing (DON) on 8/22/2025, at 2:56 PM, the DON stated that Resident 100's order for escitalopram did not include a specific behavior or manifestation to monitor. The DON stated that it is important to include a specific behavior and manifestation in the order to determine whether the medication is effective for the resident. The DON further stated that without proper monitoring, facility staff would not be able to assess whether the medication is working or if adjustments to the dosage or treatment plan are necessary. During a concurrent interview and record review of Resident 100's MAR, dated 6/1/2025 to 8/21/2025, with the DON on 8/22/2025, at 3:23 PM, the DON stated that he could not find documented evidence in the MARs indicating that staff had monitored Resident 100 for a specific behavior for escitalopram use. The DON stated that monitoring a specific behavior related to the use of escitalopram is important to determine whether the medication is effective for the resident. The DON further stated that without such monitoring, the resident could be receiving unnecessary medication.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Pre admission Screening and Resident Review II (PASARR 11- a follow up assessment that ensures residents with mental disabilities receive appropriate care) after the PASARR I (initial PASARR assessment) was completed for one (1) out of three (3) sampled residents (Resident 27) reviewed for PASARR completion. This deficient practice had the potential to put Resident 27 at risk of not receiving appropriate mental health care and placement to appropriate facility.Findings: During a review of the facility's P&P titled, PASARR Completion Policy dated 9/30/2024 indicated the facility will make sure that all admissions have the appropriate PASARR completed; the ADM is accountable for monitoring the process of completing the necessary paperwork for admissions and; the facility will follow the State's specific guidelines for completion. During a review of Resident 27's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) . During a review of Resident 27's History and Physical (H&P) dated 1/15/2025, the H&P indicated that Resident 27 had fluctuating capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS, a care assessment and screening tool) dated 8/1/2025, the MDS indicated the resident was assessed to have intact cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life. During a concurrent interview and record review on 8/20/2025 at 9:52 AM with the administrator (ADM), Resident 27's PASARR I, dated 8/20/2025, indicated that Resident 27 was admitted on [DATE] and required a PASARR II. The ADM stated that Resident 27 was admitted last August 2024 and did not have a PASARR II completed yet which was indicated in the PASARR I report. The ADM stated that Resident 27 should have received a PASARR II last year shortly after admitted to the facility. During an interview on 8/21/2025 at 9:51 AM, the DON stated that the PASARR was an assessment completed to ensure residents were provided correct care for residents with mental disabilities and if it was not completed the residents may not receive appropriate care and placement to appropriate facility. The DON stated that the facility's P&P indicated all residents must have the appropriate PASARR completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that two of two sampled residents (Resident 71 and 84) reviewed for comprehensive, person-centered care planning had their medical, nursing, mental, and psychosocial needs appropriately identified, assessed, and addressed through individualized care plans. 1.For Resident 71, the facility failed to develop and implement a comprehensive care plan to address the resident's hearing impairment. Resident 71 used bilateral hearing aids but was unable to independently insert or manage them and the facility had no interventions to address the need of the resident. As a result of this deficient practice Resident 71 had difficulty communicating with staff his needs that could lead to not receiving the needed care and assistance. In addition, the resident had increased dependence on family members for basic communication support. 2. For Resident 84, the facility failed to implement the resident's care plan interventions related to Fournier Gangrene (a life-threatening soft tissue infection) and bilateral lower limb swelling. The care plan included interventions such as monitoring for edema or swelling and monitoring for sediments in the urine, but staff interviews and observations revealed inconsistent implementation. This failure placed the resident at risk for worsening infection, delayed healing, and increased discomfort, violating the requirement to implement care plans that address identified medical needs. Findings: During a review of the facility's Policy and Procedure (P&P) titled Care Plan – Comprehensive, dated 8/25/2021, the P&P indicated that the facility's interdisciplinary team, in coordination with the resident and/or the resident's family or representative, must develop and implement a comprehensive, person-centered care plan for each resident. The care plan must include measurable objectives and timeframes to address the resident's medical, physical, mental, and psychosocial needs as identified in the comprehensive assessment. The P&P further indicated Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the residents. that require careful data gathering, proper sequencing of events and systematic clinical decision making. 1. During a review of Resident 71's admission Record (AR), the AR indicated that Resident 71 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including acute kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood) and hypertension (blood pressure that is higher than normal). During a review of Resident 71's History & Physical (H&P) dated 1/21/2025, the H&P indicated that Resident 71 has fluctuating capacity to understand and make decisions. During an initial facility tour observation on 8/18/2025, at 11:15 AM, Resident 71 was observed sitting in bed in his room. When the surveyor attempted to interview the resident, Resident 71 stated that he could not hear well and requested that the surveyor speak loudly and close to his ears, as he is hard of hearing in both ears. Resident 71 further stated that he would like to use his hearing aids during the day but is unable to do so because he does not know how to turn them on, and facility staff do not assist him. Resident 71 stated he must wait until his family visits the facility to be able to use his hearing aids. During a subsequent observation and interview on 8/18/2025, at 11:22 AM, conducted in Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	71's room in the presence of Licensed Vocational Nurse (LVN 3), LVN 3 stated that she had previously seen Resident 71 wearing hearing aids during visits from his family (resident representative). LVN 3 stated that Resident 71 is hard of hearing and that staff typically needs to speak loudly and in close proximity to his ears to communicate effectively with Resident 71. During the same observation on 8/18/2025 at 11:22 AM, Resident 71 was seen retrieving his hearing aids from his bedside drawer and requested assistance from LVN 3 to put them on. LVN 3 stated that she was not aware Resident 71 had hearing aids stored at his bedside and added that she could not assist him with using the devices because she did not know how to properly place the hearing aids on the resident. During an interview and concurrent record review of Resident 71's medical records, on 8/19/2025 at 12:08 PM, the Director of Nursing (DON) stated that there was no care plan in place addressing Resident 71's hearing loss and need for assistance in applying the hearing aids. The DON stated absence of such a care plan failed to identify goals or interventions for facility staff to support the resident's communication needs. During a telephone interview on 8/20/2025, at 9:32 AM with Resident 71's family member (Resident Representative [RP] 1), RP 1 stated that the family purchased a new set of hearing aids for the resident, which are currently kept at Resident 71's bedside. RP 1 further stated that Resident 71 required assistance in effectively communicating his needs due to both a language barrier and hearing impairment. RP 1 explained that Resident 71 sometimes struggles to communicate appropriately with staff, particularly when he is not wearing his hearing aids, as he cannot hear well. 2. During a concurrent observation and interview on 8/18/2025, at 10:15 AM in Resident 84's room, in the presence of Treatment Nurse (TXN) 1, Resident 84 was observed with edema in both lower extremities and small amounts of sediment in the indwelling catheter drainage tubing. TXN 1 stated Resident 84 did not have any treatment and was not on her list of residents to monitor. TXN 1 stated that she was unaware of the resident's bilateral lower extremity swelling. During a follow-up interview on 8/18/2025, at 2:50 PM—approximately 4 hours and 35 minutes later—with Resident 84's assigned charge nurse, Licensed Vocational Nurse (LVN) 4, LVN 4 stated that the previous shift's licensed nurses did not report Resident 84's bilateral lower extremity swelling (edema) during shift change. LVN 4 further stated that she had not assessed the resident's lower extremities that morning. LVN 4 concluded the interview by stating, I will call the physician now. During a review of Resident 84's admission Records (AR), the AR indicated the facility admitted Resident 84 on 2/1/2023 and readmitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and Fournier Gangrene (a rapidly progressing and life threatening infection of the soft tissues in the genitals or perineum area that results in tissue death), and bilateral lower limb localized swelling . During a review of Resident 84's History and Physical (H&P), dated 5/28/2025, the H&P indicated Resident 84 had the capacity to understand and make decisions. During a review of Resident 84's Weekly Summary Documentation form, dated 5/31/2025, 6/14/2025, 7/6/2025, 7/12/2025, 7/19/2025, 7/26/2025, 8/2/2025, and 8/9/2025, the form indicated Resident 84 did not have any skin issues. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 84's care plans developed since admission on [DATE], and readmission on [DATE], revealed the following: -A care plan dated 3/15/2023, documented that Resident 84 required an indwelling catheter due to Fournier's Gangrene. The care plan interventions included: Monitor for sediment, cloudy, odor, blood, and amount, and report to the physician promptly if the urine contains any sediment or blood, is cloudy or odorous, or if the resident has a fever. -A care plan dated 8/9/2023, indicated that Resident 84 had experienced a weight gain of 19 pounds over a three-month period. One of the listed care plan interventions was to Monitor for any edema or swelling developing and report to the physician. -A care plan dated 2/22/2025, identified that Resident 84 exhibited or was at risk for fluid volume excess, as evidenced by edema in the bilateral lower extremities. The care plan interventions included: Notify physician if edema continues or increases. -A care plan last revised on 6/13/2025, indicated that Resident 84 exhibited or was at risk for impaired renal function related to acute kidney injury. The care plan interventions included monitoring for signs and symptoms of fluid overload, such as increased shortness of breath, increased fatigue, significant weight gain, and edema, and to notify the physician of any significant changes. During a review of Resident 84's Minimum Data Set (MDS, a resident assessment), dated 7/7/2025, the MDs indicated Resident 84's cognition (a person's mental process of thinking, learning, remembering, and using judgement) was moderately impaired. The MDS indicated Resident 84 had an indwelling catheter. The MDS indicated Resident 84 had End Stage Renal Disease (ESRD, irreversible kidney failure). During a concurrent observation and interview on 8/20/2025 at 12:50 PM in Resident 84's room with Resident 84, Resident 84's bilateral lower extremity edema was observed graded as 2+ to 3+ pitting edema (+2 means [a light dent between 3 to 4 mm deep that disappears within 15 seconds and +3 means [a noticeably deep pit between 5 to 6 mm deep that takes longer than 15 seconds but less than 60 seconds to rebound) that extended from the resident's feet up to the shins (the front part of the leg between the knee and the ankle). Resident 84 stated, he found out today that his feet were swollen. Resident 84 reported that his lower extremities hurt when pressure is applied. During an interview on 8/20/2025 at 2:15 PM with MDS 1, MDS 1 stated, care plans are important to provide the highest level of care for the residents. MDS 1 stated, care plans are used to identify any problem or focus area needed to provide the residents with high quality of care. MDS 1 stated, care plans are like guidelines for the facility staff to provide person-centered care to residents. During a concurrent interview and record review on 8/20/2025 at 2:18 PM with MDS 1, Resident 84's Change in Condition (CoC) evaluation records were reviewed. MDS 1 stated, there was no documented evidence of the facility monitoring Resident 84's indwelling catheter drainage for sediment, cloudy, odor, blood, and amount of urine as indicated in the car plan. MDS 1 stated, there was no documented evidence of the facility's licensed nurses monitored Resident 84's edema in his bilateral lower extremities. During an interview on 8/20/2025 at 3:50 PM with the Director of Nursing (DON), the DON stated, Resident 84 must have a history of chronic bilateral lower extremity swelling if there was a care plan (continued on next page)

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	056487	A. Building B. Wing	08/22/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	already in place to monitor his swelling. The DON stated, Resident 84's care plan was not followed because there was no documented evidence the licensed nurses were monitoring his edema, swelling of lower extremities, and/or sediments in the urine daily as indicated in the care plans. The DON stated, it was important to follow the resident's care plans because the care plans provide guidelines and directions set by the interdisciplinary team to provide quality of care to meet the resident's medical, physical, mental, and psychosocial needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that licensed nursing staff followed the facility's own Policy and Procedure (P&P) titled Blood Pressure, Monitoring and the professional standard of practice when measuring blood pressure for one of four sampled residents (Resident 1) observed during medication pass. This failure placed Resident 1 at risk for inaccurate blood pressure readings, which could result in inappropriate medication administration, discomfort, or potential harm. Findings: During a review of the facility's undated Policy and Procedure (P&P) titled, Blood Pressure, Measuring dated 9/2010 indicated, the purpose of this procedure is to measure the pressure exerted by the circulating volume of blood on the walls of the arteries, veins and chambers of the heart and the procedure to take the blood pressure are: 1. Wrap the blood pressure cuff evenly around the upper arm, approximately one (1) inch from the elbow. (Note: The cuff should fit snugly, but not so tightly that the resident is uncomfortable. If the cuff is placed too loosely, you will get a false .blood pressure reading.) 2. With your second and third finger of one hand, locate the brachial pulse at the bend in the elbow. 3. When you locate the pulsation, place the diaphragm of the stethoscope firmly against the skin. Hold the diaphragm in place with your hand. During a review of Resident 1's admission record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, hemiplegia (severe or complete loss of strength or paralysis on one side of the body), hemiparesis (a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (also known as stroke-a medical emergency when blood flow to the brain is stopped or blocked) affecting right dominant side, acute on chronic diastolic congestive heart failure (acute on chronic diastolic congestive heart failure [CHF] a sudden worsening of symptoms in a person with pre-existing, long-term diastolic heart failure [the heart muscle is unable to relax properly, leading to reduced blood filling]), and hypertension (HTN, high blood pressure). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/20/2025, the MDS indicated Resident 1s cognition (ability to learn reason, remember, understand, and make decisions) was severely impaired. During a review of Resident 1's Physician Order Summary, the Order Summary included an order dated 8/1/2025, to administer Furosemide (diuretic or water pill that increases urination) 20 milligrams (mg, unit of measure by weight), one tablet by mouth one time a day for CHF hold if systolic blood pressure (SBP, measures the pressure in the arteries when the heart beats) is less than 100 millimeters of mercury (mmHg, unit of measurement). During a review of Resident 1's care plan, dated 12/18/2024 and revised 5/28/2025 indicated Resident 1 exhibited or was at risk for cardiovascular symptoms or complications related to admission diagnosis.HTN.Stroke. Resident 1's care plan intervention indicated to assess and monitor vital signs as ordered and report abnormalities to physicians. During a concurrent medication pass observation and interview on 8/20/2025 at 8:42 AM with Licensed Vocational Nurse (LVN) 2 inside of Resident 1's room, LVN 2 was observed placing a blood pressure cuff on Resident 1's upper left arm. LVN 2 placed the diaphragm of the stethoscope (a medical instrument for detecting sounds produced in the body that are conveyed to the ears of the listener) completely under the blood pressure (BP) cuff then pumped up the BP cuff. Resident 1 made a wincing sound and the resident's skin appeared a little red on the upper part of the arm once the BP cuff was removed. LVN 2 pointed to the area on Resident 1's upper arm that was a little red and stated that is where she placed the diaphragm of the stethoscope, usually under the BP cuff. During an interview on 8/20/2025 at 11:27 AM, with the Director of Nursing (DON), the DON stated the diaphragm of the stethoscope should be placed on the resident's skin where you can feel the brachial pulse (is the palpable beat of the brachial artery, a major blood vessel located on the inner side of the upper arm at the bend of the elbow). DON stated the diaphragm of the stethoscope should not be under the BP cuff, because the nurse could not see if the diaphragm is in the correct location to hear the resident's brachial pulse. DON stated the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diaphragm of the stethoscope being placed completely under the BP cuff could give an inaccurate BP reading and could cause pain and discomfort to the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the provision of care and services in accordance with professional standards of practice for one of one sampled resident, reviewed for physical restraints (Resident 80). Resident 80 was found to have a Wanderguard device applied to his wrist without a physician's order, a documented risk assessment, or an individualized care plan to justify its use. The absence of clinical justification and interdisciplinary care planning for the use of a device that may potentially restrict freedom of movement failed to meet professional standards of practice and placed the resident at risk for unnecessary restriction, and psychosocial harm Findings: During a review of the facility's Policy and Procedure (P&P) Tab Alarms, Bed alarms, Wander guard System, with a revision date of 12/12/2024, the P&P indicated nursing assessment of each resident must be done on admission and change in status to evaluate if he/she is at risk for falls or elopement. The P&P indicated a plan of care must be formulated with the interdisciplinary team to determine the need for tab, bed alarm or wander guard bracelet and documented in the care plan. During a review of Resident 80's admission Record (AR), the AR indicated that Resident 80 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including paranoid schizophrenia (mental health condition that affects how people think, feel and behave), unspecified asthma (airways in the lungs become narrowed and swollen, making it difficult to breathe). During a review of Resident 80's Minimum Data Set (MDS, a resident assessment tool) dated 7/02/2025, the MDS indicated Resident 80 was severely impaired in cognitive skills (thought process). The MDS indicated Resident 80 did not use devices such as Wanderguard. During a review of Resident 80's Elopement Evaluation (EA) dated 5/23/2025, the EA indicated Resident 80 did not have a history of elopement or attempting to leave the facility without informing the staff. The Evaluation indicated Resident 80 did not verbally express the desire to go home, pack belongings to go home or stay near an exit door. The Evaluation indicated Resident 80 wanders, but the wandering behavior was not goal directed (specific destination in mind, going home). During a review of Resident 80's Order Summary Report, dated 8/01/2025, the Report did not indicate an order for wander guard placement or monitoring for Resident 80. During a review of Resident 80's medical record from 5/23/2025 to 8/19/2025, did not indicate an Interdisciplinary team conference was conducted to assess Resident 80's need for wander guard placement. During an initial facility tour interview and observation on 8/18/2025 at 9:57 AM with Resident 80, Resident 80 was observed lying on the floor mat next to his bed. Wander guard was observed on Resident 80's right wrist. Resident 80 stated a facility staff member had placed the Wanderguard bracelet on him, but he does not like it and wants the nurses to take it off. During an interview and observation on 8/20/2025 at 11:46 AM, conducted in Resident 80's room in the presence of Licensed Vocational Nurse (LVN) 6 and the Director of Nursing (DON), LVN 6 and DON stated they were unaware Resident 80 had a wander guard device in place. The DON stated Resident 80 was not an elopement risk and and, therefore, should not have had a Wanderguard applied. During a concurrent interview and record review on 8/20/2025 at 11:59 AM with LVN 6 regarding Resident 80's medical record, LVN 6 stated that Resident 80 did not have a current physician's order for a Wanderguard device. LVN 6 further stated that Resident 80 likes wheeling himself throughout the facility, was not considered an elopement risk, and they were unaware of who applied the WanderGuard or why it had been placed. During an interview on 8/22/2025 at 2:50 with the DON, the DON stated the admitting nurse should have conducted an assessment and obtained a physician's order for the use of a wander guard for Resident 80. The DON stated the wander guard restricts Resident 80' from moving freely in and out of the facility.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to adequately assess one of two sampled residents (Resident 8) reviewed for Restorative Nurse Assistant (RNA - help patients recover after an illness or injury by working to restore their physical abilities and independence) Services, in accordance with the physician's order, by not evaluating and documenting the resident's tolerance and wear time (in hours) during the provision of RNA services. This deficient practice had the potential to negatively impact Resident 8's plan of care, interventions, that included increased risk of injury or fatigue, unnoticed pain or discomfort, and/or incomplete resident's records that could compromise interdisciplinary communication and decision making. Findings: During a review of the facility's policy and procedure titled, Restorative Nursing Services dated July 2017, the P&P indicated, Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. During a review of Resident 8's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included hemiplegia (total paralysis or inability to move one side of the body) and hemiparesis (partial weakness on one side of the body), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and lack of coordination (not able to move different parts of the body together well or easily). During a review of Resident 8's History and Physical (H&P) dated 9/14/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 8's MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). During a review of Resident 8's Physician's Order dated 7/9/2025 at 5:42 PM, the Physician's Order indicated Restorative Nurse Assistant for passive range of motion (PROM) to bilateral upper extremities (BUEs) five times a week or as tolerated every day shift. During a review of Resident 8's Physician's Order dated 7/9/2025 at 5:43 PM, the Physician's Order indicated RNA to apply hand carrot splints to bilateral hands (soft, cushioned hand splint shaped like a carrot that was used to gently position severely curled or clenched hands), five times a week up to four hours as tolerated with skin check every day shift. During a review of Resident 8's Physician's Order dated 7/10/2025 at 10:13 AM, the Physician's Order indicated RNA for PROM to bilateral lower extremities, five times a week as tolerated every day shift for rehabilitation. During a review of Resident 8's Restorative Administration Record (RAR) dated 7/1/2025 to 7/31/2025, the RAR indicated that the RNA was to apply hand carrot splints to both hands five times a week, for up to four hours as tolerated, with a skin check to be performed every day shift. The RAR included a section to document the resident's tolerance using the following codes: G = Good, F = Fair, P = Poor, along with the wear time (in hours). However, there was no documentation indicating the resident's tolerance or wear time during this period. During a continued review of Resident 8's RAR dated 7/1/2025 to 7/31/2025, the RAR indicated RNA for PROM to bilateral lower extremities (BLE), five times a week as tolerated every day shift for rehabilitation. The RAR included a section to document the resident's tolerance using the following codes: G = Good, F = Fair, P = Poor, along with the wear time (in hours). However, there was no documentation indicating the resident's tolerance or wear time during this period. During a continued review of Resident 8's RAR dated 7/1/2025 to 7/31/2025, the RAR indicated RNA for PROM to bilateral upper extremities (BUEs) five times a week or as tolerated every day shift. The RAR included a section to document the resident's tolerance using the following codes: G = Good, F = Fair, P = Poor, along with the wear time (in hours). However, there was no documentation indicating the resident's tolerance or wear time during this period. During a review of Resident 8's RAR dated (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/1/2025 to 8/31/2025, the RAR indicated RNA to apply: hand carrot splints to both hands, five times a week, for up to four hours as tolerated, with skin check to be performed every day shift. The RAR included a section to document the resident's tolerance using the following codes: G = Good, F = Fair, P = Poor, along with the wear time (in hours). However, there was no documentation indicating the resident's tolerance or wear time during this period. During a continued review of Resident 8's RAR dated 8/1/2025 to 8/31/2025, the RAR indicated RNA for PROM to BLE, five times a week as tolerated every day shift for rehabilitation. The RAR included a section to document the resident's tolerance using the following codes: G = Good, F = Fair, P = Poor, along with the wear time (in hours). However, there was no documentation indicating the resident's tolerance or wear time during this period. During a continued review of Resident 8's RAR dated 8/1/2025 to 8/31/2025, the RAR indicated RNA for PROM to BUE five times a week or as tolerated every day shift. The RAR included a section to document the resident's tolerance using the following codes: G = Good, F = Fair, P = Poor, along with the wear time (in hours). However, there was no documentation indicating the resident's tolerance or wear time during this period. During a review of Resident 8's Decline in ROM of BLE Care Plan dated 8/13/2025, the Care Plan indicated a goal to maintain current ROM of BLE and prevent further contractures from developing. The Care Plan interventions included RNA for PROM to BLE every three times a week as tolerated to maintain lower extremity ROM and strength. During a review of Resident 8's Restorative ROM Care Plan dated 8/13/2025, the Care Plan indicated a goal for the resident to maintain BUE ROM. The Care Plan interventions included RNA for PROM to BUE five times a week or as tolerated and RNA to apply hand carrot splints to bilateral hands five times a week up to four hours as tolerated with a skin check. During a concurrent interview and record review on 8/20/2025 at 10 AM, RNA 1 stated the RNAs did not assess and document Resident 8's tolerance of RNA services as ordered by the physician, to show if there was a decline in ROM or a change in condition. RNA 1 stated if the facility was not documenting Resident 8's PROM and hand carrot splints tolerance, the facility would not know what was going on with the resident, if something were wrong, and if the resident has a decline in ROM. During a concurrent interview and record review on 8/20/2025 at 1:33 PM, the Case Manager (CM) stated there was no documentation that the RNAS assessed Resident 8's tolerance and wear time of RNA services. The CM stated the RNAs should have assessed Resident 8's tolerance to RNA services as ordered, to see if the resident was in any pain/discomfort, if there were any restrictions, and to see if RNA services should be continued.

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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 provide a hazard free environment and implement the facility's policy and procedure titled Falling Star Program Protocol (a measure used by the facility to identify residents at risk for fall with the use of star) and implement documented interventions by placing a floor mat next to the resident's bed for one of two sampled residents (Resident 31) reviewed for accident and supervision due to being identified as high risk and with history of falls. This deficient practice had the potential to cause a repeat fall and safety risks for Resident 31. Findings: During a review of the facility's policy and procedure (P&P) titled Fall Management dated 5/26/2021 indicated to reduce risk for falls and minimize the actual occurrence of falls the facility will address injury and provide care for a fall and develop or update a care plan to reflect new interventions. During a review of the facility's undated policy and procedure titled Falling Star Program Protocol, the Protocol indicated criteria to include residents in the Falling Star Program included a resident who fell in the last 30 days with or without injury. The Protocol indicated residents would have a Falling Star sign placed on the door name, and department heads would complete person-centered room rounds to check interventions were in place for high fall risk residents including the availability of star symbol on the door name. During a review of Resident 31's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included history of falling, aphasia (difficulty speaking, expressing need and understanding of language), and hypertension (HTN, high blood pressure). During a review of Resident 31's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/3/2025, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated the resident did not have any falls since admission/entry, reentry or the prior MDS assessment. During a review of Resident 31's Nursing Documentation Evaluation dated 4/12/2024 at 10:36 PM, the Nursing Documentation Evaluation indicated Resident 31's fall risk factors including poor safety judgement, impaired balance, and an unsteady gait. During a review of Resident 31's Change in Condition Evaluation dated 8/10/2025, at 9:45 PM, indicated the resident was found on the floor mat on the right side of the bed with knees bent. During a review of Resident 31's Unwitnessed Fall Care Plan developed on 8/10/2025, the Care Plan indicated to place the resident on Falling Star Program. During a review of Resident 31's Interdisciplinary Care Conference (ICC) notes dated 8/11/2025 at 11:51 AM, the ICC notes indicated the resident sustained a fall and recommended to reassess resident's mental status and a comprehensive assessment conducted by a mental health professional to evaluate an individual's mental health and cognitive abilities) follow up for evaluation. During a concurrent observation and interview in Resident 31's Room on 8/18/2025 at 10:33 AM, a star sticker was not placed on the door next to the resident's name. Resident 31 was in bed with the bed low to the ground and the resident's floor mat was observed leaning against the wall instead of next to the resident's bed. Resident 31 stated, the floor mat was usually next to me when I'm in bed in case I fall. During a concurrent observation and interview in Resident 31's Room on 8/18/2025 at 10:37 AM, Certified Nursing Assistant (CNA) 1 stated the resident should have had the floor mat next to the resident's bed because Resident 31 was a fall risk and if the resident fell, the resident could get hurt. During a concurrent observation and interview in Resident 31's Room on 8/18/2025 at 10:53 AM, the Licensed Vocational Nurse (LVN) 1 stated the resident should have had a floor mat next to the resident's bed because if Resident 31 fell the resident could have a major injury like a fracture (a break or crack in a bone). During a concurrent interview and record review of the facility's Falling Star Program on 8/21/2025 at 12:07 PM, the Director of Nursing (DON) stated Resident 31 was not included in the list (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of residents in the Falling Star Program, but she should have been included in the list of residents who have fallen and should have had a star next to the door name. The DON stated the facility was not following the Falling Star Program protocol which could result in another fall causing harm and injury to Resident 31.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to failed to promote resident safety in administering oxygen for two (2) of 2 sampled residents (Resident 103 and 133) reviewed for oxygen therapy, in accordance with the facility's policy and procedure by failing to: Ensure the oxygen tubing (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient's ears) was changed every 7 days per Physician's order for Resident 100. 2. Ensure Resident 103's nebulizer mask was stored in a plastic bag with residents name and dated with open date, in accordance with facility policy titled Administering Medications through a Small Volume(Handheld) Nebulizer. This deficient practice had the potential for Resident 103 and 133 to contract infection when receiving oxygen therapy which could increase the risk of the spread of infection to the residents, staff, and other visitors in the facility. Findings: During a review of the facility's Policy and Procedure (P&P) Administering Medications through a Small Volume(Handheld) Nebulizer, dated with a revision date of October 2010, the P&P indicated The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The policy further indicated Steps of procedure . 29.When equipment is completely dry, store in a plastic bag with the resident's name and the date on it, 30. Change equipment and tubing every seven days, or according to facility protocol. 1. During a review of Resident 103's admission Record (AR), The AR indicated Resident 103 was initially admitted to the facility on [DATE] and recently readmitted on [DATE], with a diagnosis that included Sepsis (a life-threatening condition that occurs when the body's immune system responds excessively to an infection),Chronic respiratory failure (a condition where the lungs cannot adequately oxygenate the blood over an extended period). During a review of Resident 103's History & Physical (H&P) dated 1/08/2025, the H&P indicated Resident 103 does not have the capacity to understand and make decisions. During a review of Resident 103's Order summary report, dated 6/2025 indicated an order for Ipratropium-Albuterol solution a medication used to help control the symptoms of lung diseases) 0.5-2.5 milligrams/3 milliliters (a unit of measurement) inhale orally every 6 hours as needed for shortness of breath or wheezing with a start date of 6/16/2025. During an observation on 8/18/2025 at 10:10 AM of Resident 103's room, Resident 103's open mask and plastic tubing was on top or Resident 103's bedside drawer. A clear undated plastic bag was observed hanging from Resident 103's bedside drawer. During a concurrent observation and interview with Licensed Vocational Nurse (LVN 3) on 8/18/2025 at 10:12 AM, LVN 3 stated Resident 103's nebulizer mask should not be laying opened on Resident 103's bedside drawer. LVN 3 stated per facility policy the opened nebulizer mask should be kept in a bag with the date and residents name written on the bag so that the facility staff can identify who the mask belongs to and when it was opened. During an interview on 8/21/2025 at 4:00 PM with Director of Nursing (DON), DON stated per facility policy all respiratory equipment including nebulizer mask should be stored in a plastic bag with the (continued on next page)

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	056487	A. Building B. Wing	08/22/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date opened so that facility nurses can identify when to change per facility policy to prevent any contamination and risk for infection to Resident 103. 2. During a review of the facility's policy and procedure (P&P) titled Oxygen Administration dated 1/31/2023 indicated to provide guidelines for safe oxygen administration. The P&P indicated to review the physician's orders or facility protocol prior to oxygen administration. During a review of Resident 133's admission record indicated the resident was admitted on [DATE] with diagnoses that included hypo-osmolality (condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low blood sodium), sepsis (life threatening condition that occurs when the body's immune system overreacts to an infection), and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty breathing). During a review of Resident 133's History and Physical (H&P), dated 7/9/2025, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 133's Order Summary Report indicated the following orders: Dated 7/6/2025, a physician order to administer Oxygen at 1 to 2 liters (L) per minute via nasal cannula (medical device to provide supplemental oxygen therapy) every shift. Dated 7/9/2025, a physician order for oxygen tubing change weekly one time a day every Wednesday. During a concurrent observation and interview in Resident 133's room on 8/18/2025 at 9:55 AM, Resident 133's oxygen tubing label was observed with the date 8/6/2025. Licensed Vocational Nurse (LVN) 1 confirmed oxygen tubing date was 8/6/2025 and was not changed. LVN 1 stated the oxygen tubing should be changed every 7 days as ordered. Resident 133 stated she was still using the same oxygen tubing yesterday. During an interview with the Director of Nursing (DON) on 8/22/2025 at 3:24 PM, the DON stated it was important for oxygen tubing to be changed per physician's order because of infection control, and the integrity of the tubing was not good. The DON stated staff should make sure the oxygen tube is intact. The DON stated if oxygen equipment was not intact, resident would not receive oxygen as ordered.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 24) observed during medication pass was administered Carvedilol (medication used to treat high blood pressure) with food, as ordered by the physician. In addition, the facility failed to have systems ensuring records of disposition of drugs in sufficient detail to enable an accurate reconciliation in accordance with the facility's policy and procedure for Medication Destruction. This failure increased the risk of Resident 24 experiencing side effects (undesirable effect of a drug or medical treatment) from Carvedilol, that include sudden drop in blood pressure (orthostatic hypotension) which may lead to dizziness, light-headedness, fatigue (tiredness) and fainting. Findings: During a review of the facility's undated Policy and Procedure (P&P) titled, Administering Medications, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame. Medications administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: Enhancing optimal therapeutic effect of the medication. During a review of another facility's P&P titled, Oral Medication Administration, dated 2/2016, the P&P indicated, Refer to medication reference text for guidelines if additional information is needed. During a review of Resident 24's admission record (AR, a document containing diagnostic and demographic information), the AR indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses includingˆOther Sequelae of a Cerebral Infarction (long-term or lasting medical, physical, and emotional problems that occur as a consequence of a stroke), Hypertensive Heart Disease (heart conditions caused by long-term high blood pressure [hypertension]) with Heart Failure (the heart muscle cannot pump enough blood and oxygen to the body's organs), Chronic systolic congestive heart failure (is a long-term condition where the heart's main pumping chamber, the left ventricle, is unable to pump blood forcefully enough to meet the body's needs), and Paroxysmal atrial fibrillation ([Afib] is a type of irregular heartbeat). During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool), dated 6/10/2025, the MDS indicated Resident 24s cognition (ability to learn reason, remember, understand, and make decisions) was intact.ˆ During a review of Resident 24's Physician Order Summary, the Order Summary included an orderˆdated 7/21/2025, to administerˆCarvedilol 25 milligrams (mg, unit of measure by weight), one tablet by mouth two times a day for hypertension (HTN), hold if systolic blood pressure (SBP, measures the pressure in the arteries when the heart beats) is less than 120 millimeters of mercury (mmHg, unit of measurement), heart rate (HR) is less than 65 beats per minute (bpm) and notify MD (physician), give with food. During a review of Resident 24 care plan dated 2/9/2022 and revised 6/17/2025 indicated resident exhibits or is at risk for cardiovascular symptoms or complications related to diagnosis of acute endocarditis (a life-threatening, rapid-onset infection of the heart's inner lining), hemiplegia (severe or complete loss of strength or paralysis on one side of the body), hemiparesis (a mild or partial weakness or loss of strength on one side of the body) with cerebral infarction (stroke) right side weakness, and hypertension.Resident 24's care plan interventions indicated, administer medications as ordered and assess for effectiveness and side effects and report abnormalities to physician. During a review of Resident 24's care plan dated 2/9/2022 and revised 5/28/2025 indicated resident is at risk for falls related to admission diagnosis, acute endocarditis.cerebral infarction.hypertension.Resident 24's care plan interventions indicated, medication evaluation as needed.monitor vital signs including orthostatic blood pressure as needed and report to MD as indicated. During a medication pass observation on 8/20/2025 between 9:49 AM to 10:20 AM with Licensed Vocational Nurse (LVN) 1, LVN 1ˆwas observed preparing and administering the following medications for Resident 24: 1.ˆˆˆˆ Amlodipine (used to treat high blood pressure) 10 mg, one tablet 2.ˆˆˆˆ Carvedilol 25 mg, one tablet 3.ˆˆˆˆ (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Losartan (treat high blood pressure) 50 mg, one tablet 4. Eliquis (apixaban, prevent blood clots), 5 mg, one tablet 5. Vitamin D (supplement) 25 micrograms (mcg, unit of measurement by weight), one tablet 6. Rena Vite (supplement), one tablet During an observation on 8/20/2025 at 10:20 AM, Resident 24 was observed not taking medications with food. During an interview on 8/20/2025 at 10:21 AM, LVN 1 was asked about the physician's order to administer Carvedilol with food. LVN 1 stated that the Resident 24 was not administered his Carvedilol with food. During a follow-up interview on 8/20/2025 at 10:38 AM, LVN 1 stated she reviewed and understand that Carvedilol needs to be given with food to improve the effectiveness of the medication and prevent side effects that may cause Resident 24's blood pressure to drop too low. During an interview on 8/21/2025 at 10:51 AM with the Dietary Supervisor (DS), DS stated that breakfast cart to Station 2 where Resident 24 is delivered between 7:15 AM to 7:20 AM daily. DS stated that Resident 24 is on the list to receive morning snacks daily at 10 AM, but do not have a record to indicate if residents receive their snacks. During a review of the facility's dietary snack list provided by DS for Resident 24 indicated that Resident 24 was scheduled on 8/20/2025 and 8/21/2025 to receive a snack at 10 AM that consisted of [NAME] Crackers 1-SERV to be served at the Front Dining Room. During an interview on 8/21/20 25 at 11:07 AM with the Director of Nursing (DON), the DON reviewed the manufacturer's labeling for Carvedilol and stated that Carvedilol is to be given with food to improve absorption and reduce the risk of dizziness and hypotension (low blood pressure). The DON stated that Carvedilol should be given to Resident 24 with at least a sandwich. According to DailyMed (the official provider of the U.S. Food and Drug Administration [FDA] label information (package inserts), updated 10/2024, indicated, Carvedilol tablets should be taken with food to slow the rate of absorption and reduce the incidence of orthostatic effects.Most common adverse events.dizziness, fatigue, hypotension. bradycardia (slow heart rate, defined as a resting heart rate below 60 beats bpm) . When administered with food, the rate of absorption is slowed, as evidenced by a delay in the time to reach peak plasma levels, with no significant difference in extent of bioavailability. Taking carvedilol with food should minimize the risk of orthostatic hypotension. 2. During a review of the facility's policy and procedures (P&P) titled, Medication Destruction, dated 10/2017, the P&P indicated, Discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed. Non-controlled medication destruction occurs in the presence of two licensed nurses. During a concurrent medication storage inspection and interview on 8/20/2025 at 10:56 AM with Registered Nurse (RN) 1 on Station 1 Medication Room, a review of the non-controlled medication disposal logs documentation between 8/11/2025 through 8/18/2025 indicated one licensed nurse's initials were on the form. RN 1 stated Station 1 Medication Room was used by all four nursing stations. RN 1 stated there was one nurse's initial for non-controlled medication disposal on the non-controlled disposal log and there was no witness documented with the disposal of medication. RN 1 stated, I have never done drug disposal and do not know if a witness is needed for non-controlled drug disposal. During an interview with the Director of Nursing (DON) on 8/20/2025 at 11:24 AM, the DON stated the RN Supervisor can oversee the process for non-controlled destruction. DON stated that he was not sure if non-controlled medication disposal needed to be done with a witness. During another interview with the DON on 8/20/2025 at 12:10 PM, the DON provided a copy of the facility's Medication Destruction policy and stated the non-controlled medication disposal must be witnessed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document complete and accurate information on the informed consent (a process in which a healthcare professional educates a patient about the risks, benefits, and alternatives of a given procedure or intervention) form about psychotropic medications (medications that affects mood and behavior), in accordance with accepted professional standard of practice for four of four sampled residents (Residents 7, 57, 83, and 100) reviewed for resident's rights by failing to ensure: Resident 100's, informed consent for the use of Escitalopram (medication used to treat depression [feeling of severe sadness and hopelessness and anxiety [the fear of the unknow] was signed by the healthcare practitioner who discussed the risks and benefits of the medication with the resident or responsible party. 2. Resident 57 and Resident 83's, informed consent for the use of Duloxetine (medications used to treat depression and anxiety) was signed by heath practitioner that obtained and discussed the consent to the resident or responsible party. 3. Resident 7's informed consent for a psychotropic medication was accurately documented in the resident's record by failing to obtain the resident's physician (Medical Doctor [MD] 1) signature. These deficient practices resulted to violating Residents 100, 57, 83 and 7's rights to be informed and participate in care decisions. A review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 6/2021 indicated the attending health care practitioner was responsible to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulation. The P&P indicated the informed consent will be obtained by the Prescriber prior to initiation of the psychotropic medication and shall verify informed consent prior to the administration of psychotropic medication for a resident. 1. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use dated June 2021, the P&P indicated It is the responsibility of the attending health care practitioner to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy and applicable state regulation. The informed consent will be obtained by the Prescriber prior to initiation of psychotropic medication. The P&P indicated The facility shall verify informed consent prior to the administration of a psychotropic medication for a resident. During a review of Resident 7's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental illness that was characterized by disturbances in though), dementia (a progressive state of decline in mental abilities), and Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 7's History and Physical (H&P) dated 9/14/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 7's Physician's Order, dated 9/14/2024 timed at 3:01 AM, the Physician's Order indicated to give Risperidone (also named Risperdal, medication used to treat schizophrenia oral (by mouth) tablet 0.5 milligram (mg, unit of measurement), give one tablet via gastrostomy tube (g-tube, a feeding tube surgically placed through the abdomen directly into the stomach) one time a day for sudden shift of mood from pleasant to anger by yelling. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's Psychotropic Medication Administration Disclosure Form dated 5/19/2025, the form indicated MD 1 ordered Resident 7 to receive Risperidone 0.5 mg, give one tablet via g-tube one time a day for schizophrenia manifested by sudden shift of mood. The Form showed another Physician's name written out and a signature that was not MD 1's signature. During a review of Resident 7's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/24/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 7's Care Plan reviewed on 8/14/2025, the Care Plan indicated the informed consent was obtained by MD 1 from the resident who informed the resident about the risk and benefits of Risperdal. The goal indicated Resident 7 would have the smallest most effective dose without side effects for 90 days and interventions included to monitor for side effects, changes in mental status/functional level, report changes to the MD, and consult the physician or pharmacist as needed. During an observation in Resident 7's room on 8/18/2025 at 9:54 AM, Resident 7 was lying down on the bed and did not respond or look up when spoken to. During an interview on 8/22/2025 at 1:21 PM, the Registered Nurse (RN) 3 stated Resident 7's was non-verbal and did not have capacity to make healthcare decisions. During a concurrent interview and record review of Resident 7's Risperdal Consent Form on 8/22/2025 at 5:08 PM, the DON indicated the physician's signature on the form was not MD 1's signature, but was MD 1's designee the Nurse Practitioner (NP, an RN with advanced education and training who could perform many of the same tasks as a doctor) 1. The DON stated NP 1 should have been writing his name out next to his signature so that the form did not look like NP 1 was signing as MD 1. The DON stated in doing so, the form was falsifying the MD signature and could be considered an unnecessary medication which could harm the resident and overmedicate Resident 7. 2. During a review of Resident 100's admission Record (AR) indicated the resident was readmitted to the facility on [DATE] with diagnoses that included depression, and anxiety disorder During a review of Resident 100's History and Physical assessment dated [DATE] indicated Resident 100 had fluctuating capacity to understand and make decisions. During a review of Resident 100's Order Summary Report (a physician's order) dated 5/20/2025 indicated to give Escitalopram Oxalate Oral Tablet 10 MG (Escitalopram Oxalate) to by mouth one time a day for depression. During a review of Resident 100's Psychotropic (psychoactive drug that alters psychological functioning by modulating central nervous system activity) Medication Administration Disclosures (Anti-Anxiety) (PMAD a document providing specific information to a patient or their guardian to obtain informed consent before administering a psychotropic medication): The PMAD dated 1/17/2025 indicated Medical Doctor (MD) 2 provided informed consent for the use of Escitalopram to Resident 100's representative and was signed by Nurse Practitioner (NP) 1. The PMAD dated 6/19/2025 for Ativan (medication used to treat anxiety disorders) indicated NP 1 provided informed consent to Resident 100's representative and was signed by NP 2. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 100's PMA Disclosures (Anti-Anxiety) with the Director of Nursing (DON) on 8/22/2025 at 5: PM, the DON stated Resident 100's PMA Disclosure for Escitalopram dated 1/17/2025 and PMA Disclosure for Ativan dated 6/19/2025 were ordered by 2 different providers. The DON stated the problem with Resident 100's PMAD was that NP 1 should have indicated his/her name when signing the PMAD on behalf of the NP 2 or MD 1, otherwise it would be falsification of document. The DON stated this was an issue because these are consents for resident's medications. 3. During a review of Resident 57's admission Record indicated an admission to the facility on 7/28/2023 with diagnoses that included depression. During a review of Resident 57's History and Physical assessment dated [DATE] did not indicate Resident 57's decision making capabilities. During a review of Resident 57's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/3/2025 indicated resident's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. During a review of Resident 57's Order Summary Report dated 8/21/2025 indicated to give Duloxetine Hydrochloride Oral Capsule Delayed Release Sprinkle 30 mg (Duloxetine Hcl) 30 mg by mouth at bedtime for depression. During a review of Resident 57's PMAD (Anti-Anxiety) dated 5/29/2025 for Duloxetine indicated MD 3 provided informed consent to Resident 57 and was singed by NP 1. During a concurrent interview and record review of Resident 57's PMAD dated 5/29/2025 with the DON on 8/22/2025 at 5:43 PM, the DON stated Resident 57's PMAD was ordered by MD 3. The DON stated and confirmed the signature on Resident 57's PMA was by NP 1 instead of MD 3. 4. During a review of Resident 83's admission Record indicated an admission to the facility on 6/18/2024 with diagnoses that included pain in thoracic spine, type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (high blood pressure). During a review of Resident 83's History and Physical assessment dated [DATE] indicated Resident 83 had the capacity to understand and make decisions. During a review of Resident 83's MDS dated [DATE] indicated resident's cognition was intact. During a review of Resident 83's Order Summary Report dated 8/18/2025 indicated to give Duloxetine Hydrochloride Oral Capsule Delayed Release Sprinkle 30 mg by mouth one time a day for lumbar spondylosis (an age-related degeneration of the vertebrae and disks of the lower back). During a review of Resident 83's PMAD (Anti-Anxiety) dated 5/3/2025 for Duloxetine indicated MD 4 provided informed consent to Resident 83 that was signed by NP 1. During a concurrent interview and record review of Resident 83's PMAD dated 5/3/2025 with the DON on 8/22/2025 at 5:45 PM, the DON stated Resident 83's PMAD Disclosure was provided by MD 4. The DON stated and confirmed the signature on Resident 83's PMAD was by NP 1 and not MD 4.