STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A109	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center	2335 S. Mountain Ave Duarte, CA 91010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide comfortable and safe water temperature between 105 and 125 degrees Fahrenheit (F) accordance with the facility's policy and procedure for nine of 11 sampled residents (Resident 92, 39, 144, 76, 66, 52, 71, 76, and 81) in the following locations: 1. room [ROOM NUMBER] and 22, room [ROOM NUMBER] and 26, room [ROOM NUMBER] and 30, and room [ROOM NUMBER] and room [ROOM NUMBER] sinks in the residents' restrooms shared by Resident 92, 39, 144, 76, and 66. 2. Women's Shower Room (WSR) S1, S3, S4, and S5 shared by residents Resident 52, 71, 76, and 81). These deficient practices had resulted in the residents not receiving comfortable hot water when showering and maintain personal hygiene effectively that can negatively impact the resident's physical and psychosocial wellbeing and quality of life. Findings: a. During a review of Resident 92's admission Record (AR), the AR indicated the facility originally admitted Resident 92 on 5/10/2012 and readmitted on [DATE] with diagnoses that included schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and diabetes mellitus (a group of diseases that result in too much sugar in the blood). During a review of Resident 92's Minimum Data Set (MDS, a resident assessment tool), dated 7/1/2025, the MDS indicated Resident 92 had moderately impaired memory and cognition (ability to think and reasonably). The MDS indicated Resident 92 was independent with oral hygiene, toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, shower/bathe self and personal hygiene. b. During a review of Resident 39's AR, the AR indicated the facility originally admitted Resident 39 on 3/9/2012 and readmitted on [DATE] with diagnoses that included schizophrenia and anxiety disorder (a 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 39's MDS, dated [DATE], the MDS indicated Resident 39 had moderately impaired memory and cognition. The MDS indicated Resident 39 was independent with toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, oral hygiene, shower/bathe self and personal hygiene. c. During a review of Resident 144's AR, the AR indicated the facility admitted Resident 144 on 5/17/2017 with diagnoses that included schizophrenia and seborrheic dermatitis (A skin condition that causes scaly patches and red skin, mainly on the scalp). During a review of Resident 144's MDS, dated [DATE], the MDS indicated Resident 144 had moderately impaired memory and cognition. The MDS indicated Resident 144 was independent with toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, oral hygiene, shower/bathe self and personal hygiene. d. During a review of Resident 76's AR, the AR indicated the facility admitted Resident 76 on 10/11/2023 with diagnoses that included schizophrenia and constipation (when a person passes less than three bowel movements a week or has difficult bowel movements). During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 had moderately impaired memory and cognition. The MDS indicated Resident 76 was independent with toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, oral hygiene, shower/bathe self and personal hygiene. e. During a review of Resident 66's AR, the AR indicated the facility admitted Resident 66 on 9/21/2022 with diagnoses that included schizoaffective disorder (a mental health condition characterized by a combination of schizophrenia symptoms and mood disorder symptoms) and dermatitis (a general term for inflamed skin, characterized by redness and itching). During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had moderately impaired memory and cognition. The MDS indicated Resident 76 was independent with oral hygiene, toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, shower/bathe self and personal hygiene. f. During a review of Resident 52's AR, the AR indicated the facility admitted Resident 52 on 5/16/2024 with diagnoses that included schizophrenia and constipation. During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52 had intact memory and cognition. The MDS indicated Resident 52 was independent with toileting hygiene and chair/bed-to-chair transfer, and required supervision or touching assistance with eating, oral hygiene, shower/bathe self and personal hygiene. g. During a review of Resident 71's AR, the AR indicated the facility admitted Resident 71 on 6/3/2025 with diagnoses that included schizophrenia and anxiety disorder. During a review of Resident 71's MDS, dated [DATE], the MDS indicated Resident 71 had intact memory and cognition. The MDS indicated Resident 71 was independent with toileting hygiene and

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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 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 interviews and record review, the facility failed to carry out the physician's order to obtain monthly Clozaril (brand name for clozapine, a class of medications used to treat treatment-resistant schizophrenia, a chronic and severe mental disorder that affects how a person thinks, feels, and behaves) serum (liquid component of blood) level (concentration of certain substances) for one of 4 sampled residents (Resident 5). The facility did not carry out the order to obtain Resident 5's monthly Clozaril level in 2 of the past 5 months (May 2025 and June 2025). This deficient practice led to inadequate monitoring of Clozaril that may lead to insufficient or too much level of Clozaril that can affect the well-being of the resident. Findings: During a review of Resident 5's admission record, the admission record indicated Resident 5 was admitted on [DATE] with the diagnoses including schizoaffective disorder (a mental health condition characterized by a blend of psychotic symptoms like hallucinations (sensory experiences that seem real but are not) and delusions (false beliefs that persist despite contradictory of mental health conditions) along with significant mood episodes) and post-traumatic stress disorder. During a review of Resident 5's physician orders, there was an order for Clozaril 400 milligrams (mg) by mouth at bedtime for auditory hallucination manifested by responding to internal stimulus causing stress, dated 3/10/2025 at 11:01 AM. During an interview on 7/24/2025 at 10:15 AM, and a concurrent review of Resident 5's physician orders, the director of nursing (DON) stated there was an order to obtain Clozaril (blood, or serum) level every month, dated 3/10/2025 at 10:55 AM. During an interview on 7/24/2025 at 2:18 PM, DON stated the facility did not have the lab result of the Clozaril blood levels in May and June 2025 for Resident's 5. During the review of the facility policy, titled Antipsychotic Medications, dated July 2023, the policy did not indicate the monitoring Clozaril serum level, nor denote the process of adequate monitoring or antipsychotic usage.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's policy and procedure titled Discharge Summary and Plan, to ensure one of two sampled residents (Resident 146) had a physician's order to be discharged and complete the discharge summary note when the resident was discharged to the General Acute Care Hospital (GACH) on 6/11/2025. The deficient practice had the potential to negatively affect the continuity of care for Resident 146. Findings: During a review of Resident 146's admission Record (AR), the AR indicated the facility originally admitted Resident 146 on 9/7/2022 and readmitted on [DATE] with diagnoses that included schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and anxiety disorder (a 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 146's Minimum Data Set (MDS, a resident assessment tool), dated 6/11/2025, the MDS indicated Resident 146 was discharged to inpatient psychiatric facility (psychiatric hospital or unit) on 6/11/2025. During a review of an email message from the Case Manager (CM) of the Nursing Home Program titled, Resident 146 Hospitalization, dated 6/12/2025 at 9:13 AM, the email message indicated due to the nature of Resident 146's hospitalization and the fact that he would not be stabilized within seven days, the facility would not provide a bed hold (to hold the resident's bed for new admission while the resident is in the hospital) for the resident to return to the facility after his hospitalization. During a concurrent interview and record review on 7/24/2025 at 9:04 AM, with the Social Services Assistant (SSA), Resident 146's Discharge Notification record, dated 6/11/2025, indicated Resident 146 was transferred to the hospital on 6/11/2025 due to physical aggression. SSA stated she had 24 hours to initiate the bed hold notice to the resident and his responsible party. The SSA stated bed hold notice was not initiated because she received an email message from Resident 146's CM of the Nursing Home Program that indicated the facility would discharge Resident 146 on 6/12/2025 at 9:28 AM. The SSA stated there was no DC order and no DC summary in Resident 146's medical records. During a concurrent interview and record review on 7/24/2025 at 9:14 AM with Licensed Vocational Nurse Supervisor (LVNS), Resident 146's medical records were reviewed, The LVNS stated there was no DC order to DC the resident on 6/11/2025 and there was no DC summary in the resident's medical records. LVNS stated she sent Resident 146 to transfer for psychiatric evaluation on 6/11/2025 and the seven days bed hold should be provided to the resident within 24 hours of the transfer, but she did not know the resident was discharged from the facility on 6/11/2025. LVNS stated she did not know the communication between the SSA and the CM to discharge the resident from the facility on 6/12/25. During an interview on 7/24/2025 at 9:40 AM with the Administrator (ADM), the ADM stated there was no bed hold notice for Resident 146's transfer to the hospital on 6/11/2025 since the resident was DC from the facility on 6/11/25. The ADM stated the outside facility Nursing Home Program CM had worked with the resident for a long time, and on 6/12/2025, the CM informed the facility would not be an appropriate placement for the residents due to the resident's behavior of having multiple physical aggression incidents towards others recently. The AMD stated there was no DC order from the physician and no DC summary regarding the discharge to GACH on 6/11/2025. The AMD stated the nurse should obtain a DC order from the physician and complete the DC summary to ensure the resident was properly and safely DC from the facility. During an interview on 7/24/2025 at 1:20 PM with the SSA, the SSA stated after she completed the DC notification, she put the DC document in an envelope and dropped it off to the nursing station, the nurses were responsible to contact the MD to obtain the DC order and complete the DC summary. During an interview on 7/24/2025 at 1:29 PM with the LVNS, the LVNS state she missed the DC notification for Resident 146 because she was busy to arrange the psychiatrist visits for other residents on 6/12/2025. The LVNS did not call the physician to obtain the DC order and did not complete the DC summary. The LVNS stated she should have checked the DC notification from the SSA, obtain an DC order, and complete the DC summary, so they would know the status of the resident after the transfer to ensure the resident received the continuation of care. During a review of the facility's policy and procedure (P&P) titled, Discharge Summary and Plan, dated 10/2022, the P&P indicated When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and/or implement an individualized person-centered plan of care with measurable objectives, timeframe, and interventions to meet the resident's needs for 1 of 3 sampled residents (Resident 56) by failing to: Update and implement Resident 56 care plan goals for mood swings related to schizoaffective disorder (mental illness can combines disorganized thinking and inappropriate behavior) manifested by going from calm and cooperative to physical/verbal aggression then leading to property destruction by kicking a hole in wall. These deficient practices had the potential to negatively affect the delivery of necessary care and services for Resident 56's medical and physical needs. Findings: A Review of Resident 56's admission Record [AR] indicated Resident 56 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder and bipolar type (a condition that involves impulsive and aggressive outburst). A Review of Resident 56's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the Patient's health status) signed by the attending physician on 10/28/2024, the HPE indicated Resident 56 had a mental illness. A Review of Resident 56's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 4/26/2025, the MDS indicated that Resident 56 had moderately impaired cognition (ability to think and reason or thought process) and had behavioral symptoms such as hitting and screaming. A Review of Resident 56's care plans titled Mood swing related to schizoaffective disorder indicated Resident 56 had multiple physical aggression episodes with property destruction from 10/18/2022 to 7/14/2025. The care plan goal indicated that Resident 56 will reduce episodes of mood instability to 5 times per week in 3 months which was initiated on 10/26/2021 with a target date of 10/21/2025. A Review of Resident 56 care plan titled Resident broke overhead light over in his bedroom indicated under goals Resident 56 will have no further episodes of property destruction in the facility. A Review of Resident 56's Nursing Progress Notes date 7/20/2025 at 1:36PM, indicated that staff reported to the charge nurse at 11:15AM that Resident 56 was experiencing physical aggression with property destruction. The progress note indicated Resident 56 had a broken the light cover over his bed banging it multiple times with a closed fist. During a concurrent interview and observation on 7/21/2025 at 10:08AM, with the Program Director (PD) inside Resident 56 bedroom. PD stated that there were 6 areas boarded-up with plywood in Resident 56's room were areas in which Resident 56 kicked and punched a hole in the wall and was boarded-up with plywood. PD stated that she observed that Resident 56 had no injuries to his hands or feet. PD stated Resident 56 had the potential to cause others or he can sustain physical injury related to his physical aggression when he gets upset. During an interview on 7/24/2025 at 9:47AM, Certified Nursing Assistant (CNA 2) stated that when Resident 56 becomes upset he had exhibited aggressive behavior, such as kicking and punching the walls in his room. CNA 2 stated when Resident 56 was unable to speak with his family that it would trigger his aggressive behavior; Resident 56 would get angry and start punching and kicking the walls inside his room. During a concurrent interview and record review on 7/24/2025 at 10:16AM with the Licensed Vocational Nurse (LVN 1), Residents 56's Care Plans were reviewed. LVN 1 stated that Resident 56's care plan titled Mood swings related to schizoaffective disorder indicated the mood swings were manifested by going from calm and cooperative to physical /verbal aggression, LVN 1 stated that the care plan goals had not been updated despite the target date 10/21/2025 due to multiple episodes of Resident 56 physical aggression with property destruction, particularly on 6/2025 and 7/2025. LVN 1 stated the care plan indicated that Resident 56 had 7 instances of kicking a hole in the wall and damaged a property in June, and 5 similar incidents in July. LVN 1 stated that Resident 56's care plan did not have interventions addressing the root cause and triggers that caused his anger to escalate that resulted in property damage. LVN 1 stated that Resident 56 exhibited episodes of aggressive behavior, including punching and kicking the walls in his room, resulting in property damage such as holes in the wall. LVN 1 stated that multiple areas in Resident 56 room had been patched with boards due to previous damage. LVN 1 stated had the care plan been updated to address Resident 56 underlying triggers, it might have helped prevent his anger escalation thereby reducing physical aggression and property damage in his room. During a concurrent interview and record review on 7/24/2025 at 11AM with the Assistant Director of Nursing (ADON), Resident 56's Care Plans were reviewed. ADON stated that Resident 56's care plan titled Mood swings related to schizoaffective disorder which indicated the mood swings were manifested by going

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain acceptable parameters of nutritional status for 1 of 3 sampled residents (Resident 11) by failing to address Resident 11 weight loss by failing to: 1. The IDT (Interdisciplinary Team- a group of facility staff that develops a plan of care for the residents) did not conduce a comprehensive assessment to determine the resident's that refusal of dental treatment and tooth ache contributed to the weight loss. 2. Dietary Supervisor (DS) did not directly communicate to the Registered Dietician (RD) that Resident 1's dental issues were likely contributing to his weight loss. This deficient practice had the potential for the resident to continue to have increased weight loss. Findings: A Review of Resident 11's admission Record [AR] indicated Resident 11 was admitted to the facility on [DATE], with diagnoses that included schizoaffective disorder (psychotic symptoms, such as hallucinations [an experience involving the apparent perception of something not present] and delusions [false beliefs that are held with strong conviction]) and bipolar type (a condition that involves impulsive and aggressive outburst). A Review of Resident 11's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the Patient's health status) dated on 8/7/2024, the HPE indicated Resident 11 had a mental illness. A Review of Resident 11's Minimum Data Set (MDS, a resident assessment tool) dated 5/14/2025, the MDS indicated that Resident 11 had a moderately impaired cognition (thought process) and had a weight loss 5% or more in the last month. A Review of Resident 11's Weights and Vitals Summary dated 7/23/2025, indicated the following: Resident 11 weight 197lbs. on 9/3/2024. Resident 11 weight 167lbs. on 3/13/2025. Resident 11 weight loss of 28lbs or 14.2%, over 180 days/6 months. A Review of Resident 11's Health Status Note, dated 7/18/2025, indicated the interdisciplinary (a group of facility staffs that develops the care plan for the residents) team bi-monthly (twice a month) weight variance indicated Resident 11 weight was 156lbs. (indicating a weight loss of 41 lbs. or 20. 8 % weight loss) in 10 months. During a dining observation on 7/22/2025 at 12PM, Resident 11 was served double portions for lunch and ate independently. Resident 11 ate 50% of his meal with occasional food spillage from his mouth. Resident 11 was served with cauliflower and spaghetti that the resident was able to chew. During an interview on 7/23/2025 at 1:50PM, Resident 11 stated that he had occasional dental pain and he did receive medication for pain. Resident 11 stated that sometime when he has dental pain he doesn't feel like eating too much food. Resident 11 stated he did not have any tooth pain while eating his meal today and was provided snacks. During an interview on 7/23/2025 at 2:04PM, Certified Nursing Assistant (CNA 3) stated that Resident 11 usually eat about 50% of his meals. CNA 3 stated that Resident 11 had trouble with chewing his food because of his missing teeth. During an interview on 7/23/2025 at 2:14PM, Licensed Vocational Nurse (LVN 1) stated that Resident 11 had received double portions for all his meals and typically consuming about 50%. LVN 1 stated that Resident 11 experienced tooth pain 2 to 3 times a week and was given Tylenol for relief. LVN 1 stated that Tylenol would alleviate the tooth pain and was under the care of a dentist. LVN 1 stated that Resident 11 would frequently refuse dental treatment, but a care plan was not developed to address the refusal to dental care. LVN 1 stated he has observed Resident 11 losing weight and appeared [NAME] in the upper body. During a review of the Dental Notes dated 6/11/2025, indicated Resident 11 reported his tooth bothers him and wished to have the tooth removed. During a concurrent interview and record review on 7/23/2025 at 3:21PM with Registered Dietitian (RD 1), Resident 11 Weight Variance from 9/6/2024 to 7/1/2025 was reviewed. RD 1 stated that RD 2 was managing Resident 11 weight loss from 9/2024 to 6/2025. RD 1 stated she took over the care of Resident 11 on 7/2025. RD 1 stated that Resident 11 Weight Variance report indicated from 9/6/2024 to 3/14/2025, Resident 11 had a weight loss of 14.2% (28lb) within a 6-month period. RD 1 stated that Resident 11 had achieved the target weight goal of 150 to 160 lbs. but still a potential for weight loss. RD 1 stated that despite receiving double portions at meals and supplemental snacks throughout the day, Resident 11 continued to lose weight. RD 1 stated that Resident 11 dental issues could have been contributing to his weight loss. During an interview on 07/23/2025 at 4:10 PM, DS stated that she was aware that Resident 11 had ongoing weight loss, noting a significant weight loss of 14% as of 3/14/2025. DS stated that RD 2 had implemented dietary adjustments, including double portions for every meal with additional supplemental snacks that the resident eats. DS stated that Resident 11 was on a mechanical soft diet because of his dental issues related to missing teeth and dental pain. DS stated she did not directly communicate but she documented Resident 11

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews and record review, the facility failed to ensure non-controlled medications (medications that do not carry a significant risk of abuse or dependence) dispositions were performed by two licensed nurses as per policy, for the past nineteen months. This deficient practice led to inaccurate accountability and/or misuse of medications. Findings: During a record review and a concurrent interview with the director of nursing (DON) on 7/22/2025 at 2:58 PM, DON presented a binder of narcotic (also known as controlled substances, medications regulated by the government due to the high risk for abuse or addiction) drugs disposition logs and a binder of non-controlled medication disposition record logs. The non-controlled medication disposition record log sheet, each line has a sticker indicating a prescription number and the name of the medication. Also, for each line, there were columns to fill in the quantity to be disposed, date of disposition, and a signature. There were signatures of a registered nurse under the column titled Disposed by. However, the next column titled Witnessed by . were blank. During an interview on 7/22/2025 at 3:04 PM, DON stated non-controlled medication disposition were done at least on a monthly basis. DON stated the most recent medication dispositions were completed on 7/22/2025 which included 25 residents' non-controlled medications as shown on the log. DON stated the dispositions of non-controlled medications had been performed by one nurse instead of two nurses. During an interview with the DON and concurrent review of the facility policy and procedures, Medication Destruction (dated 10/2017), on 7/22/2025 at 3:04 PM, the policy indicated . Non-controlled medication destruction occurs in the presence of two licensed nurses. DON acknowledged the facility's current practice did not match the facility policy. After reviewing the older logs in the same binder, DON confirmed the policy had not been implemented since January 2024.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure one (1) of 8 medication carts was locked when it was unattended in Nursing Station 1. The Nursing Station 1 medication room can be accessed by other non nursing staff in the facility. This deficient practice had the potential to allow unauthorized access to drugs and result in medication misuse or loss of medications prescribed for the residents. Findings: During an observation on 7/22/2025 at 3:15 PM with the Director of Nursing (DON), there was an unattended medication cart (labeled AM med cart) parked outside of the medication room in Nursing Station 1. During a concurrent interview, on 7/22/2025 at 3:15 PM, the DON confirmed the aforementioned medication cart was not locked. DON stated Certified Nursing Assistants (CNAs) and other non-nursing staff had key access to enter the Nursing Stations. DON stated the medication cart should be locked. the Medication rooms, carts, and medication supplies should be locked or attended by persons with authorized access. During a review of the facility policy and procedures, titled, Storage of Medications (revised [DATE]), the policy indicated Medications. are stored safely, securely, and properly, . The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A109	A. Building B. Wing	07/24/2025

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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 follow its policy and procedure on food storage, preparation, distribution and serving food in accordance with professional standards for food service safety by failing to seal and label a bag of dehydrated milk (powder formed milk) stored in the dry food storge area with the date of when the food was prepared and when to be consumed by the residents. This deficient practice had the potential to result in food contamination, growth of microorganisms (disease causing organism) that could cause 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 an initial kitchen observation of the dry food storage area conducted with the Dietary Supervisor (DS) on 7/21/2025 at 9:14 AM, an opened plastic container was found containing an unsealed bag of dehydrated milk. The bag had no visible label or dates indicating when it was opened or its expiration date. In a concurrent interview the DS confirmed the presence of the unsealed, unlabeled and undated bag. DS stated that the bag of dehydrated milk needed to be thrown away because of the risk of being contaminated and the residents would get sick from the contaminated milk products. DS stated that all food products needed to be labeled, sealed and dated with opened or its expiration to prevent contamination and spoilage. During a review of the facility's policy and procedures (P&P) titled, Food Receiving and Storage revised 11/2022, dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use. The P&P indicated dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date).

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	05A109	A. Building B. Wing	07/24/2025

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility failed to ensure resident's bedroom measured at least 80 square feet (sq. ft.-a unit of measurement) per resident for ten out of 62 resident rooms (Rooms B4, C13, D1, D2, D3, D4, D5, D6, D7, D8). The ten resident rooms consisted of two beds in each room. This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents.Findings: During an interview with the Administrator (ADM) on 7/21/2025 at 8:45 AM, the ADM did not submit room waiver application and declined room variances.During a review of the Facility's Client Accommodations Analysis (CAA- a form used to identify the room sizes and number of beds in the room) form undated, indicated the facility had ten rooms that measured less than the required 80 square footages per resident. The following resident bedrooms were: Room # # of beds # of residents Sq. Ft Sq. Ft. /residentRm B4 2 beds 1 resident 144 72Rm C13 2 beds 2 residents 132 66Rm D1 2 beds 1 resident 144 72Rm D2 2 beds 1 resident 144 72Rm D3 2 beds 2 residents 144 72Rm D4 2 beds 2 residents 144 72Rm D5 2 beds 2 residents 144 72Rm D6 2 beds 1 resident 144 72Rm D7 2 beds 2 residents 144 72Rm D8 2 beds 2 residents 144 72 During the recertification survey from 7/21/2025 to 7/24/2025, the rooms were observed, and no issues were identified due to the room size. During a Resident Council meeting on 7/22/2025 at 10:30 AM, no concerns or issues of room space were brought up by residents.During the re-certification survey between 7/21/2025 and 7/24/2025, the above listed rooms had sufficient space for the residents' freedom of movement. The rooms had adequate space to provide nursing care, privacy during care, and the ability to maneuver resident care equipment with the room. The room size did not have any adverse effect on the residents' personal space, nursing care, and comfort.The facility's Room Waver and Variance request, dated 8/7/2025, indicated granting the room waver and variance the facility will be able to provide necessary services without adversely affecting the residents' health and safety.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain a safe and functional environment for one of three sampled residents (Resident 64) by failing to provide a dead bolt (a lock bolt to keep door closed that is moved by turning a knob or key in order to open) in good working condition in Resident 64's cabinet to keep the cabinet fully closed inside the shared residents' rooms of Resident 64. This deficient practice had the potential to have resident's belongings misplaced and inability of the resident to have a safe space and storage to keep their personal belongings. Findings: During an observation of Resident 64's room on 7/21/2025 at 9:00 AM, in the presence of the Infection Prevention Nurse (IPN), the cabinet on the left side with letter C in the shared room which belonged to Resident 64 was opened. Upon closer inspection of the cabinet, the dead bolt to keep the cabinet closed was missing. During a concurrent interview, the IPN stated all cabinets must have locks and the locks must work for the residents to have a safe space to keep their personal belongings in the shared rooms. The IPN stated all facility staffs are responsible to report to the Maintenance Department if something in a resident's room is not working properly once it is found. The IPN stated she would notify the maintenance department to fix the lock on the cabinet door. During an interview and observation on 7/21/2025 at 9:01 AM of Resident 64's room with Counselor 1, the cabinet on the left with letter C of the shared room which belonged to Resident 64 was observed open. The dead bolt used to maintain the cabinet closed was observed missing. During a concurrent interview, Counselor 1 stated he had verbally reported to Maintenance Department a few weeks ago that the cabinet lock was missing, but that Maintenance Supervisor who he reported about the lock no longer working in the facility. Counselor 1 stated he was not aware to put in the maintenance log any problem, rather when he was hired at the facility he was instructed if he saw a problem to verbally report to the maintenance staff. Counselor 1 stated he did not follow up with Maintenance Supervisor after reporting. During an interview on 7/24/2025 at 9:30 AM, with Administrator (ADM), ADM stated the maintenance staffs should be conducting daily facility checks, and room rounds. ADM stated, the Department heads also have assigned rooms that they check daily, and to ensure everything is safe and working correctly in the room. ADM stated the lock in Resident 64 room should have been fixed on 7/21/2025 or when it was reported to Maintenance Department. During a review of the facility's policies and procedures (P&P) titled, Maintenance Service, dated 12/2009, the P&P indicated the maintenance service is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times.