| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 05A360 | A. Building<br>B. Wing | 11/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Penn Mar Healthcare Center | 3938 Cogswell Road<br>El Monte, CA 91732 |

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

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|---|---|
| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on interview and record review, the facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, seven days a week from 11/1/2025 through 11/19/2025 for six out of 19 days. This deficient practice had the potential to affect the quality of nursing care provided to the residents.Findings: During a concurrent interview and record review on 11/19/2025 at 2:28 pm with the Director of Staff Development (DSD), the Nurse Staffing Sign-in Sheet for the month of November 2025 was reviewed. The Nurse Staffing Sign-in Sheet dated 11/1/2025 through 11/19/2025 did not indicate an RN was on duty for 6 days. The DSD stated the facility had no full time RN who worked eight hours per day, seven days a week since August 2025. The DSD stated a full time RN was important to oversee Licensed Vocational Nurses (LVNs) and Certified Nurse Assistants (CNAs) and to conduct residents' assessment and care in the facility daily. During a review of the facility's Assignment/Sign-In Sheet for all shifts, dated 11/1/2025, 11/2/2025, 11/8/2025, 11/9/2025, 11/15/2025 and 11/16/2025, the Sign-In Sheets indicated, there was no RN coverage for these six days. During an interview on 11/19/2025 at 3:12 pm with the Director of Nursing (DON), the DON stated there was no RN working on the weekends from 11/1/2025 up to date (11/19/2025). The DON stated the facility needed RN coverage for 8 consecutive hours for 7 days/week since the RN was responsible for overseeing the LVN's and CNA's in compliance with state regulations. The DON stated resident's initial assessment should be done by an RN. During a review of the facility's Policy and Procedure (P&P) titled, Nursing Department-Staffing, Scheduling & Postings, revised 10/1/2023, the P&P indicated To ensure an adequate number of nursing personnel are available to meet resident needs. The facility will employ sufficient Nursing Staff on a 24-hour basis that meets the appropriate competencies, skill set and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident. |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain written informed consent for two of five sampled residents (Residents 6 and 9) by failing to:a. Obtain a written informed consent for the use of Lithium Carbonate (mood stabilizing medication to treat bipolar disorder [mental disorder characterized by periods of depression and of elevated mood]) for Resident 9.b. Ensure Resident 6 had written informed consents for the use of Clozapine (medication used to treat schizophrenia [mental disorder characterized by abnormal social behavior and failure to understand what is real]) and Fluvoxamine Maleate (medication used to treat depression [persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities]) before use. These deficient practices had the potential for the residents not to receive adequate or sufficient information regarding psychotropic medications (medication to treat mental disorders) necessary to make an informed health care decision.Findings:<br><br>a. During a review of Resident 9's admission Record (AR), the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included anxiety (emotion characterized by an unpleasant state of inner turmoil) and schizophrenia (a mental illness characterized by disturbances in thought).<br><br>During a record review of Resident 9's Order Summary Report (OSR), dated 6/19/2025, the OSR indicated for licensed staff to administer Lithium Carbonate Oral Capsule 300 milligram (mg), two (2) capsules by mouth in the evening related to schizophrenia.<br><br>During a review of Resident 9's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 9/22/2025, the MDS indicated Resident 9 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 9 was independent for eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene.<br><br>During a concurrent interview and record review on 11/18/2025 at 1:27 pm with the Medical Records (MR) staff, of Resident 9's medical records (PointClickCare - PCC, a cloud-based software), the MR stated there was no informed consent obtained prior to administering Lithium Carbonate medication to Resident 9.<br><br>During an interview on 11/18/2025 at 1:30 pm with Responsible Party 1 (RP 1), RP1 stated, I have not received a call from the facility when Resident 9 was admitted getting a consent for Lithium Carbonate use. No, I have not talked to the facility to give consent since Resident 9's admission. It's ok fwith me for the facility to call me.<br><br>During a concurrent interview on 11/18/2025 at 1:45 pm with the facility's Director of Nursing (DON) and record review of Resident 9's PCC, the DON stated consent was not obtained prior to the use of Lithium Carbonate for Resident 9. The DON stated it was important to obtain informed consent for residents receiving psychotropic medications for the responsible party and residents to be aware of the risks and benefits as discussed by the physician and validated by Licensed Nurses.<br><br>During a record review of the facility's Policy and Procedure (P&P) titled, Psychotherapeutic Drug Management, dated 10/1/2023, the P&P indicated, When obtaining consent for use of psychotherapeutic drugs, the resident will be informed of the risks and benefits for the use of these<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | medications. When admitted with orders for psychotherapeutic drugs, licensed staff will verify with the resident that the risk and benefits have been explained to them prior to consent or use. The consent will remain in place until medication is discontinued or until consent is revoked by resident/responsible party. The P&P indicated, Licensed Nurse will not administer the psychotherapeutic medication until an informed consent form has been obtained and documented by the Attending Physician/Licensed Health Practitioner from the resident and/or surrogate decision maker unless it is an emergency situation.<br><br>b. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included schizophrenia.<br><br>During a review of Resident 6's History & Physical (H&P), dated 7/18/2025, the H&P indicated the resident had fluctuating capacity to make medical decisions.<br><br>During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 was cognitively intact.<br><br>During a review of Resident 6's OSR active as of 11/20/2025, the OSR indicated Resident 6 had active orders for:<br><br>1. Clozapine oral tablet 400 milligrams (mg- unit of measurement) to be given by mouth in the evening for thought disorganization related to schizophrenia, ordered on 7/17/2025.<br><br>2. Fluvoxamine Maleate oral tablet 25 mg to be given by mouth in the evening to augment Clozapine, ordered on 7/17/2025.<br><br>During a review of Resident 6's Medication Administration Record (MAR) dated 11/1/2025 to 11/30/2025, the MAR indicated Resident 6 had been receiving Clozapine 400 mg and Fluvoxamine Maleate 25 mg in the evening from 11/1/2025 to 11/17/2025.<br><br>During a concurrent interview and record review on 11/18/25 at 3:03 pm with Licensed Vocational Nurse 3 (LVN 3), Resident 6's medical record was reviewed. The medical record indicated there was no informed consent for Clozapine 400 mg and Fluvoxamine maleate 25 mg. LVN 3 stated, informed consents were needed for these psychotropic medications. LVN 3 stated the informed consent had to be completed to educate and inform the residents of the side effects and why they were taking the medication. LVN 3 stated the medications should not have been started before the facility received consent from the conservator and acknowledgment from the doctor.<br><br>During an interview on 11/20/2025 at 10:13 am with the Director of Nursing (DON), the DON stated the licensed nurse needed to verify the informed consent was complete before administering the medication to the resident. The DON stated informed consents were done because the medications had long term side effects and to ensure the resident's quality of life.<br><br>During a review of the facility's P&P titled, Informed Consent, dated 10/1/2023, the P&P indicated the purpose was to ensure that the facility respected the resident's rights to make an informed decision prior to deciding to undergo certain medical therapies and procedures. The P&P indicated the facility would have the Attending Physician/Licensed Healthcare Practitioner (LHP) determine when circumstances have changed so that an informed consent was required from the resident before providing treatment. The P&P indicated informed consent should be obtained from the resident or<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | authorized representative before administration of a therapy or procedure that requires an informed consent. The P&P indicated informed consent should be done for psychotherapeutic drugs and should be documented and placed in the resident's medical record. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a copy of the Advance Directive (AD- a written statement of a person's wishes regarding medical treatment, made to ensure those wishes are carried out should the person be unable to communicate them) was not incomplete nor missing the conservator's signature, and readily available in the residents' medical chart for three of five sampled residents (Residents 5, 8 and 21) in accordance with the facility's Policy and Procedure (P&P) titled Advance Directives. These failures had the potential for the facility staff not knowing Residents 5, 8 and 21's specific wishes to follow and provide medical treatment and services against the will of the residents. Findings:<br><br>a. During a review of Resident 5's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental condition that causes both a loss of contact with reality [psychosis] and mood problems) and major depressive disorder (persistent feeling of sadness and loss of interest).<br><br>During a review of Resident 5's Order Summary Report (OSR) dated 6/26/2025, the OSR indicated, Legal Status: Conservatorship.<br><br>During a review of Resident 5's History and Physical Examination (H&P), dated 6/29/2025, the H&P indicated Resident 5 did not have the capacity to understand and make decisions and currently under a temporary conservatorship (a legal arrangement where the court appoints a responsible person to manage the personal and/or financial affairs of another adult who was deemed unable to do so themselves). The H&P also indicated, Unable to obtain consent from patient, as patient lacks decision-making capacity.<br><br>During a review of Resident 5's Minimum Data Set (MDS – a federally mandated resident assessment care screening tool) dated 10/6/2025, the MDS indicated Resident 5 was independent (resident completes the activity by themselves with no assistance from a helper) for eating, oral, toileting and personal hygiene.<br><br>During a review of Resident 5's Advance Directive Acknowledgement (ADA) dated 6/30/2025, the ADA was signed by Resident 5 and a facility representative but was not signed by Resident 5's Responsible Party (RP) or Conservator.<br><br>During an interview with the Minimum Data Set Coordinator (MDSC) on 11/20/2025 at 9:55 AM, the MDSC stated all consents including the AD should be filled out completely with name and date to confirm understanding between the conservator or the resident on what the facility offers and needs consent for resident treatments.<br><br>During concurrent interview and record review with MDSC on 11/20/2025 at 10:00 AM, the MDSC stated Resident 5's AD should have been signed by Resident 5's conservator not the patient if the patient lacked decision making capacity. Per MDS, the AD was incomplete if it was missing a signature, date or the conservator or doctor's signature and if incomplete, the document was invalid. The MDSC stated it was very important for the forms to be completed and filled out by the right person and if the resident cannot provide a consent, it should be the conservator.<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Advance Directives dated 10/1/2023 indicated, the P&P indicated To provide residents with the opportunity to make decisions regarding their health care. If a resident is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she executed an Advance Directive, the facility may give Advance Directive information to the resident's representative in accordance with state law.<br><br>During a review of the facility's P&P titled, Informed Consent dated 10/1/2023, the P&P indicated, To ensure that the facility respects the resident's right to make an informed decision prior to deciding to undergo certain medical therapies and procedures.<br><br>B. The resident or representative must sign an informed consent prior to administration of treatment/procedure.<br><br>Record Keeping:<br><br>A. The facility will maintain documentation of verification of informed consent/Notice in the resident's medical record.<br><br>b. During a review of Resident 8's AR, the AR indicated Resident 8 was admitted on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought) and depression (a mood disorder that may cause persistent sadness or loss of interest in activities).<br><br>During a review of Resident 8's H&P dated 7/10/2025, the H&P indicated Resident 8 was unable to communicate and make decisions.<br><br>During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 was cognitively intact (ability to think).<br><br>During a review of Resident 8's ADA dated 7/9/2025, the ADA did not indicate acknowledgement from the resident or responsible party (RP) of the following: being given written material and informed about rights to accept or refuse medical treatments, information of rights to formulate an AD, no obligation to formulate an AD, and if any AD was executed and it would be followed by the facility staff and it's attending physician. The ADA did not have the responsible party's (RP)/agent's signature.<br><br>During an interview on 11/18/2025 at 10:32 am with Medical Records staff (MR), MR stated the ADA should be completed on admission. MR stated the ADA should be filled out and explained to the resident/responsible party and all consents should be completed on admission or within 72 hours of the resident's admission.<br><br>During a concurrent interview and record review on 11/20/2025 at 9:38 am with MDSC, Resident 8's ADA dated 7/9/2025 was reviewed. The ADA did not have acknowledgments and responsible party's signature. The MDSC stated, Resident 8's ADA was an incomplete form. The MDS C stated the RP or conservator had the right to be informed.<br><br>During a concurrent interview and record review on 11/20/2025 at 10:22 am with the Director of Nursing (DON), Resident 8's ADA dated 7/9/2025 was reviewed. The ADA did not have acknowledgments and responsible party's signature. The DON stated Resident 8's ADA was<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | incomplete because it was missing the responsible party's signature and any checks or initials for the acknowledgment portion of the form. The DON stated the ADA was used to protect the residents' rights and verify if they had made an AD or not.<br><br>During a review of the facility's P&P titled, Advance Directives, dated 10/1/2023, the P&P indicated, its purpose was to provide residents with the opportunity to make decisions regarding their health care. The P&P indicated, at the time of admission, admission staff or designee would inquire about the existence of an AD and the admission staff would inform and provide written information to residents concerning the right to accept or refuse medical treatment. The P&P indicated, upon admission, admission staff or designee would inform the resident of their right to execute an AD Form, if one does not already exist. The P&P indicated, if the resident was incapacitated at the time of admission and was unable to receive information or articulate whether or not he or she had executed an AD, the Facility may give AD information to the resident's representative in accordance with state law. The P&P indicated, each resident was informed that it was his/her choice to complete the AD.<br><br>c. During a review of Resident 21's AR, the AR indicated the resident was initially admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought).<br><br>During a review of Resident 21's H&P dated 9/4/2025, the H&P indicated Resident 21 has the capacity to make medical decisions.<br><br>During a record review on 11/18/2025 at 10:15 a.m. of Resident 21's chart, the ADA form was blank. The elements missing from the document were the resident's identification, treatment preferences, signature, date signed and witness signatures.<br><br>During a concurrent interview and record review on 11/18/2025 at 10:30 a.m. with Medical Records (MR), the MR stated the Advance Directive Acknowledgment form was blank and should have been completed upon admission or within 72 hours. The MR stated an Advance Directive Acknowledgement form was signed by residents to show that the facility informed the residents about their rights to make decisions about their care.<br><br>During a concurrent interview and record review on 11/19/2025 at 1:30 p.m. with [NAME] President of Clinical (VPC), Resident 21's medical record was reviewed. The VPC stated there was no Advance Directive Acknowledgement form. The VPC stated an Advance Directive Acknowledgement form offers as a guide for the care and wishes of Resident 21 and a blank form was an issue as the facility was unable to acknowledge Resident 21's preferences.<br><br>During a review of the facility's policy and procedure titled Advance Directives, dated October 1, 2023, indicated, Upon admission, admission Staff or designee will inform the resident of their right to execute an Advance Directive form, if one does not already exist.Each resident is informed that it is his/her choice to complete the Advance Directive. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement an individualized/person-centered care plan (CP) for two of two sampled residents (Residents 9 and 31) in accordance with facility's Policy and Procedure (P&P) titled Care Planning. These deficient practices had the potential for Residents 9 and 31 to not receive necessary treatment and specific care services. Findings: a. During a review of Resident 9's admission Record (AR), the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included anxiety (emotion characterized by an unpleasant state of inner turmoil) and schizophrenia (a mental illness characterized by disturbances in thought). During a record review of Resident 9's Order Summary Report (OSR), dated 6/19/2025, the OSR indicated for licensed staff to administer Lithium Carbonate Oral Capsule 300 milligram (mg), two (2) capsules by mouth in the evening related to schizophrenia. During a review of Resident 9's OSR dated 6/19/2025, the OSR indicated for licensed staff to administer Benztropine Mesylate Oral Tablet one milligram (mg-unit of measurement) one tablet by mouth, two times a day related to schizophrenia. During a review of Resident 9's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/22/2025, the MDS indicated Resident 9 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 9 was independent for eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During an interview and concurrent record review on 11/19/2025 at 8:53 am with Licensed Vocational Nurse 1 (LVN 1) of Resident 9's medical records (PointClickCare - PCC, a cloud-based software), LVN 1 stated there was no clinical documentation that a CP was initiated/implemented for the management of Resident 9's use of Benztropine Mesylate Oral Tablet and Lithium Carbonate Oral Capsule. LVN 1 stated a person-centered CP should have been initiated and implemented for Resident 9's use of Benztropine Mesylate Oral Tablet and Lithium Carbonate Oral Capsule to guide the nurses on how to provide proper care and treatment to Resident 9. During an interview on 11/20/2025 at 11:14 am with the facility's Director of Nursing (DON), the DON stated a CP should have been initiated and implemented for Resident 9's use of Benztropine Mesylate Oral Tablet and Lithium Carbonate Oral Capsule. The DON stated the purpose of the CP was to provide staff guidance on how to provide care and treatment to the residents. b. During a review of Resident 31's AR, the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included anxiety and schizophrenia. During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31 had intact cognition for daily decision making. The MDS indicated Resident 31 was independent for eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent interview and record review on 11/20/2025 at 11:15 am with the Minimum Data Set Coordinator (MDS C), Resident 31's PCC was reviewed. The MDSC stated the CP for Seroquel use was not initiated and implemented for Resident 31 upon receiving the order from the physician. The MDSC stated the facility should have initiated the CP for Resident 31's use of Seroquel upon admission for staff to determine what were the specific interventions on how to take care of Resident 31. During a review of the facility's P&P titled, Care Planning, revised 10/2023, the P&P indicated to ensure that a comprehensive person-centered CP is developed for each resident based on their individual assessed needs. The P&P indicated the CP will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. The P&P indicated the comprehensive CP must be completed within 7 days after completion of the Comprehensive admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on interview and record review, the facility failed to conduct competencies (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully) for two of five staff (Licensed Vocational Nurse 2 [LVN 2] and Registered Nurse 1 [RN 1]). This deficient practice had the potential for residents not to receive appropriate nursing care and services. Findings: During a concurrent record review and interview on 11/20/2025 at 10:16 am with the Director of Staff and Development (DSD), LVN 2's employee file was reviewed. The DSD stated LVN 2 worked fulltime in the facility since 3/21/2025. The DSD stated the DON was the one conducting staff competency for all licensed nurses. During a concurrent record review and interview on 11/20/2025 at 10:27 am with the Bookkeeper (BK), RN 1's employee file was reviewed. BK stated RN 1 worked per diem in the facility since 12/10/2002. BK stated the DON was the one conducting staff competency for RNs. During an interview on 11/20/2025 at 10:47 am with the facility's DON, the DON stated she was the one responsible for doing skills competency for all Licensed Nurses. The DON stated she did not get to complete LVN 2's competency and did not get her to sign the skills competency. During an interview on 11/20/2025 at 10:56 am with the facility's DON, the DON stated there was no clinical documentation that competency was done for RN 1. The importance of competency was to make sure that licensed staff was providing proper care and treatment to the residents. The DON stated, I will get back to you with the policy and procedure for staffing competency. During an interview on 11/20/2025 at 1:34 pm with LVN 2, LVN 2 stated that she has not done with her skills competency. The LVN 2 stated, That would be good if they will do a skills competency for me, to show that there is a room for improvement. Since I started here (facility), they did not do my skills competency. During a review of the facility's policy and procedure (P&P), titled Nursing Department - Staffing, Scheduling, and Postings, dated 10/1/2023, the P&P indicated to ensure an adequate number of nursing personnel are available to meet residents needs, the facility will employ sufficient Nursing staff on a 24-hour basis that meets the appropriate competencies, skills set, and required qualifications to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for each resident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 05A360 | A. Building<br>B. Wing | 11/21/2025 |

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| Penn Mar Healthcare Center | 3938 Cogswell Road<br>El Monte, CA 91732 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to follow proper food storage handling practices by failing to label and discard expired food items stored in two of two facility's refrigerators. Facility failed to ensure: 1. Two (2) Caesar salad containers, one (1) fruit salad container, four (4) ham sandwiches, and three (3) peanut butter and jelly sandwiches from the kitchen refrigerator had use by date.2. Four (4) meat sandwiches observed inside the refrigerator located in the nursing station, had use by date and the date when the sandwiches were made. These deficient practices have the potential to result in pathogen (germ) exposure to residents and place residents at risk for developing foodborne illness (food poisoning) which can lead to hospitalization.During initial kitchen observation and interview with the Dietary Supervisor (DS) on 11/18/2025 at 8:00 AM, observed a total of three (3) Caesar salads and one (1) fruit salad inside the kitchen refrigerator. One (1) Caesar salad was labeled with a date of 11/17/2025. Two Caesar salads were not labeled. DS stated the salads were from yesterday, but confirmed that two (2) Cesar salads and one (1) fruit salad were not labeled with a date of when they were made or best by date. DS stated if there's no label indicating the use by date or best by date, the food item should be tossed to make sure it's safe to eat and to make sure it's not expired. DS stated, This way staff will know when food items are expiring and when not to serve to the residents. Per DS, residents could get sick and could have stomach issues such as vomiting or diarrhea if given expired food, which could harm the residents. During the same kitchen observation and interview with the DS on 11/18/2025 at 8:09 AM, observed a container of four (4) ham and cheese sandwiches and a container of three (3) peanut butter and jelly sandwiches with a label indicating made date of 11/15/2025 and use by date of 11/17/2025. DS stated that according to the labels on the containers, the food items were expired and should have been thrown away. Per DS, expired items should be tossed to make sure they're not given to the residents by accident causing them to get sick. During an observation inside the nursing station on 11/20/2025 at 9:09 AM, a small refrigerator was observed containing a plastic bag with 4 (four) meat sandwiches that did not have the resident's name, room number, and the date of when the sandwiches were made or use by date. During an interview inside the nursing station with License Vocational Nurse (LVN1) on 11/20/2025 at 9:10 AM, LVN1 stated the refrigerator contained snacks for residents. LVN1 stated the plastic bag containing four meat sandwiches inside the refrigerator, did not have a use by date or date when the sandwiches were made. LVN1 stated, I don't know when they were made, they should be individually labeled in the bag. We do hand them out to the patients, but I shouldn't because they are not dated. I don't know if they are expired and if the sandwiches are given to the patients, it can make them sick. During an interview with LVN2 inside the nursing station on 11/20/2025 at 9:26 AM, LVN2 stated, The sandwiches inside the refrigerator are not dated, they are given to the residents, but the sandwiches should have a use by date or at least a date of when the sandwich was made. If the sandwiches are expired or past the use by date and the resident eats them, it can make them sick and give them a stomachache. These sandwiches should not be given to the residents; it is not safe. It can cause residents to have vomiting and diarrhea. During a concurrent kitchen observation and interview with the [NAME] (CK1) on 11/20/2025 at 11:45 AM, CK1 stated, Food items in the kitchen must be labeled indicating the date of when the food is made because everyone needs to know when the food item expires. We can't use expired food, it's not good for the residents, they can get sick. During a concurrent kitchen interview with DS on 11/20/25 at 12:09 PM, DS stated, Labels are used to identify when food is not to be used or is expired. It is very important not to give expired food to the residents since it can make them sick, causing stomach issues like stomach cramping, nausea, and vomiting. If there is food that is not labeled or expired inside the refrigerator, it should be tossed immediately. DS stated the sandwiches inside the refrigerator in the nursing station area should have a date. Per DS, if the sandwiches are not dated, then they should be<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | thrown out and not given to the patients. DS further stated if there is no date on the sandwiches, then there is no way to know how long these sandwiches have been there and they might be expired. During an interview with the Activity Director (AD) on 11/21/2025 at 7:46 AM, AD stated there were no sandwiches or food from the kitchen in the Activity room for the patients. AD stated the snacks provided for the patients in the activity room are usually sealed and have an expiration or used by date. AD stated the snacks provided to the patients are cookies and coffee. Per AD, the kitchen staff makes the sandwiches for the residents and leave them in the nursing station with the nurses. AD stated all food items provided to the patients need to be labeled with a use by or expiration date because if residents eat expired food, it can make them sick. During a review of the facility's Policy and Procedures (P&P), titled Food Storage, implemented on October 1, 2023, the P&P indicated the purpose of this policy is to establish guidelines for storing, thawing, and preparing food. Storage Guidelines indicated to Label and date storage products. During a review of the facility's undated P&P, titled Labeling/Date Marking and Safe Storage of Refrigerated & Frozen Foods, the P&P's Guidelines section indicated, Foods held in refrigerated or other storage areas shall be covered. Liquids and food which are prepared and not served shall be tightly covered, stored appropriately, clearly labeled, and dated. A written procedure shall be established and followed for the safe use of leftover foods. Spoiled or contaminated food shall not be served. The P&P indicated, Practices to maintain safe refrigerated storage include labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) or discarded. The P&P further indicated any foods removed from original container will be properly labeled as follows: - - The name of the food item being stored and the date the food was removed from its original container and stored. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:a. Maintain clinical records in accordance with accepted professional standards and practices for one of one sampled resident (Resident 1) by failing to accurately document the monitoring of side effects from antipsychotic medications.b. Ensure medical records were accessible to staff for two of two sampled residents (Residents 26 and 33).These deficient practices had the potential to result in inappropriate care planning, unrecognized service needs, and failure to follow resident's treatment needs.Findings:<br><br>a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and insomnia (trouble falling asleep or staying asleep).<br><br>During a review of Resident 1's History and Physical (H&P), dated 9/25/2025, the H&P indicated the resident did not have the capacity to make medical decisions.<br><br>During a review of Resident 1's Minimum Data Set (MDS – a federally mandated resident assessment tool) assessment, dated 9/8/2025, the MDS indicated Resident 1 was cognitively intact (ability to think).<br><br>During a review of Resident 1's Order Summary Report (OS), dated 11/20/2025, the OS indicated Resident 1 had an active order to: Monitor side effects of antipsychotic agent every shift. Chart 0 for None or use 1st letters: TCAP, T=Tardive Dyskinesia (facial tongue movement); C=Cognitive Impairment (decreased mental status); A=Akathisia (Inability to sit still); P=Parkinsonism (tremors, drooling, rigidity) with an order date of 4/23/2025.<br><br>During a review of Resident 1's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/1/2025 through 11/30/2025, the MAR indicated the Resident 1's order to monitor the side effects of the antipsychotic agent every shift was documented incorrectly on November 1, 2, 3, 4, 5, 7, 8, 9, 10, 14, 15, 16, 17, 18, and 19 across various (day, evening, and night) shifts with a dash in place of a zero or letter.<br><br>During a concurrent interview and record review on 11/20/2025 9:13 am with Licensed Vocational Nurse 1 (LVN 1), Resident 1's antipsychotic side effect monitoring order in the November MAR was reviewed. LVN 1 stated Resident 1 was on multiple antipsychotics, and the monitoring was documented incorrectly. LVN 1 stated it should be charted zero or the letter indicated for the symptom, T-C-A-P (T - Tardive Dyskinesia, C - Cognitive Impairment, A- Akathisia, P - Parkinsonism). LVN 1 stated it was important to chart properly so staff would know if Resident 1 was experiencing any symptoms and if she was, they could contact the psychologist for treatment modifications.<br><br>During a concurrent interview and record review on 11/20/2025 at 10:21 am with the Director of Nursing (DON), Resident 1's antipsychotic side effect monitoring order in the November MAR was reviewed. DON stated it was charted incorrectly and the nurses should follow the order's instructions. DON stated this was done for accurate charting and monitoring of the resident.<br><br>During a review of the facility's policy and procedure (P&P), titled Documentation-Nursing, dated<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10/1/2023, the P&P indicated nursing documentation would be concise, clear, pertinent, and accurate. The P&P indicated checklists, flow charts, and other documentation would be used as appropriate. The P&P indicated medication administration records and treatment administration records are completed with each medication or treatment completed.<br><br>b. During a review of Resident 26's admission Records, the admission Records indicated Resident 26 was admitted on [DATE] to the facility with diagnoses of Schizophrenia (a mental illness that is characterized by disturbances in thoughts); other long term(current) drug therapy.<br><br>During a review of Resident 26's Minimum Data Set [MDS) - a resident assessment tool) dated 11/3/25 revealed that the resident is able to make himself understood and is able to understand others. Resident 26 is independent (completes the activities by himself with no assistance from a helper) with eating, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear.<br><br>During a review of Resident 33's admission Records, the admission Records indicated Resident 33 was admitted on [DATE] to the facility with diagnoses of schizophrenia, other stimulant abuse, uncomplicated; essential (primary) hypertension (high blood pressure with no specific medical cause).<br><br>During a review of Resident 33's MDS dated [DATE] indicated the resident has the ability to make himself understood and to understand others. Resident 33 is independent (completes the activities by himself with no assistance from a helper) with eating, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear.<br><br>During a concurrent interview and record review for Resident 26 on 11/19/25 at 3:10 pm with [NAME] President of Clinic (VP of Clinic). She stated everyone is a level II in facility. VP of Clinic stated that for Resident 26, (PASRR) level I and referral letter were found in chart but PASRR level II was not found in the chart. VP of Clinic stated that PASRR is important because it identifies needed services, and without it, required care may be missed.<br><br>During a concurrent interview and record review for Resident 33's physical chart on 11/18/2025 at10:40 am with Medical Records (MR), MR stated all the consents for this resident were not signed including advance directive.<br><br>During a concurrent interview and record review of Resident 33's physical chart on 11/18/25 at 3:00pm with Minimum Data Set Coordinator (MDSC), MDSC stated she does not see advance directive in the chart. She also stated it is Important to have an advanced directive, so they know what to do, how to treat resident, and resident's wishes. The advance directive still needs to be done even if they are full code.<br><br>During a Concurrent interview and record review of Resident 33's Physical chart on 11/19/25 at 11:43am with Medical Social Worker (MSW), she stated she had some advance directives in a separate folder and Resident 33's advance directive was there.<br><br>During a review of the facility's policy and procedure (P&P) titled, Pre-admission Screening and Resident Review (PASRR), dated 10/1/2023, the P&P indicated, The PASRR results are maintained in the resident's medical record.<br><br>During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10/1/2023, the P&P indicated, upon admission, admission Staff or designee will inform the resident of their right to execute an Advance Directive Form, if one does not already exist. The P&P indicated if the resident has an Advance Directive, admission Staff or designee will place a copy of the Advance Directive in the resident's medical record and will notify the Director of Social Services of the existence of the Advance Directive. |

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| F 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>Based on interview and record review, the Quality Assurance Performance Improvement (QA/QAPI - Quality Assurance/Quality Assurance and Performance Improvement, a data driven proactive approach to improvement used to ensure services are meeting quality standards) committee did not fulfill the requirement to have the Medical Director (MD) participate in the QAPI Committee meetings. This failure had the potential to negatively impact resident care coordination and ensure that resident care policies were implemented appropriately.Findings:During a review of the QAPI committee information, undated, the committee information indicated the MD was a member who attended the monthly and quarterly QA meetings. During a review of the Quality Assurance/Risk Management Plan, undated, the plan indicated the Medical Director would have a joint responsibility with the Administrator for the operation of the QA/Risk Management Program. During a concurrent interview and record review on 11/21/2025 at 10:54 am with the Director of Nursing (DON), the QAPI meeting sign-in sheets from January 2025 to October 2025 were reviewed. The QAPI sign-in sheets indicated the MD was not in attendance at any of the meetings. DON verified they were not signed by the MD and stated that QAPI meetings were conducted monthly and quarterly. DON further stated the MD should be involved in the meetings and during her employment at the facility, the DON had not seen the MD in attendance during their QAPI committee meetings. During a review of the facility's policy and procedure (P&P), titled QAPI Program, dated 10/1/2023, the P&P indicated its purpose was to ensure all services provided by the facility to residents met quality standards and the facility implemented and maintained an ongoing, facility-wide Quality Assurance and Performance Improvement (QAA) Program designed to monitor and evaluate the quality of resident care, pursue methods to improve care quality, and resolve identified problems. The P&P indicated the governing body of the facility should be ultimately responsible for the QAPI Program. The P&P indicated the QAA committee met at least quarterly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 9)'s target behavior was monitored for the use of Lithium Carbonate Oral Capsule (medication that treats bipolar disorder (mental disorder with periods of depression and periods of elevated mood) and the indication for use of Benztropine Mesylate Oral Tablet (Cogentin, medication used to treat symptoms of Parkinson's disease, such as tremors and stiffness, as well as involuntary movements caused by certain antipsychotic drugs [antipsychotic medication - drugs that are used to treat symptoms of psychosis]) was accurate for one of five sampled residents (Resident 9) as indicated in the facility's Policy and Procedure (P&P) titled Psychotherapeutic Drug Management. This deficient practice had the potential to result in the use of unnecessary psychotropic drug, which may result in significant adverse (harmful) consequences to Resident 9.Findings: During a review of Resident 9's admission Record (AR), the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included anxiety (emotion characterized by an unpleasant state of inner turmoil) and schizophrenia (a mental illness characterized by disturbances in thought). During a record review of Resident 9's Order Summary Report (OSR), dated 6/19/2025, the OSR indicated for licensed staff to administer Lithium Carbonate Oral Capsule 300 milligram (mg), two (2) capsules by mouth in the evening related to schizophrenia. During a review of Resident 9's OSR dated 6/19/2025, the OSR indicated for licensed staff to administer Benztropine Mesylate Oral Tablet one milligram (mg-unit of measurement) one tablet by mouth, two times a day related to schizophrenia. During a review of Resident 9's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/22/2025, the MDS indicated Resident 9 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 9 was independent for eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent interview and record review on 11/19/2025 at 8:40 am with Licensed Vocational Nurse 1 (LVN 1) of Resident 9's medical records (PointClickCare - PCC, a cloud-based software), the OSR did not indicate the specific target behavior and there was no documented monitoring for Resident 9's target behavior for the use of Lithium Carbonate since 6/19/2025. LVN 1 stated it was important to monitor the target behavior of the residents every shift to determine if the medication was effective or not. During a concurrent interview and record review on 11/19/2025 at 8:46 am with LVN 1 of Resident 9's PCC, LVN 1 stated the indication for the use of Benztropine Mesylate Oral Tablet was not accurate. LVN 1 stated We don't give Cogentin for schizophrenia. It (Cogentin) should be administered to manage the side effects caused by antipsychotic medications. During a concurrent interview and record review on 11/20/2025 at 11:14 am with the facility's Director of Nursing (DON) of Resident 9's PCC records, the DON stated the target behavior should have been indicated in the physician's order for any psychotropic medications. The DON stated, per regulation, psychotropic medications were administered to a correct/accurate diagnosis and specific behaviors. The DON stated staff needed to monitor the target behavior every shift to monitor how the residents responded to the medication therapy and to avoid unnecessary use of the medication. During a review of the facility's P&P titled, Psychotherapeutic Drug Management, dated 10/2023, the P&P indicated, The psychotherapeutic medication order will include the following information: Diagnosis for the medication, indications and manifestations of the disorder treated. The P&P indicated, Nursing Responsibility: Will monitor the presence of target behaviors on a daily basis charting by exception (i.e., charting only when the behaviors are present). |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident's (Resident 6) Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment related to medications was accurately documented to reflect the resident's use of an antidepressant (medication used to treat depression). This failure had the potential to negatively affect Resident 6's plan of care and delivery of necessary care and services.Findings: During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 6's History and Physical (H&P), dated 7/18/2025, the H&P indicated the resident had fluctuating capacity to make medical decisions. During a review of Resident 6's Minimum Data Set assessment, dated 10/22/2025, the MDS indicated Resident 6 was cognitively intact (ability to think) and was taking an antipsychotic medication (a type of medicine used to help manage symptoms of certain mental health conditions, such as schizophrenia), no antidepressants were indicated in use. During a review of Resident 6's Order Summary Report (OS), dated 11/20/2025, the OS indicated Resident 6 had an active order for fluvoxamine maleate (antidepressant medication) oral tablet 25 milligrams (mg, a unit of mass ) to be given by mouth in the evening to augment clozapine (an antipsychotic medication), ordered on 7/17/2025. During a review of Resident 6's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/1/2025 through 11/30/2025, the MAR indicated Resident 6 received fluvoxamine maleate from 11/1/2025 to 11/19/2025 each evening. During a concurrent interview and record review on 11/20/2025 9:47 am with Minimum Data Set Coordinator (MDSC), Resident 6's MDS dated [DATE] was reviewed. MDS did not indicate Resident 6 was on an antidepressant. MDSC stated it was an error that it was not documented and it was important to document accurately for each resident's individual needs. MDSC stated MDS was used to provide care and services for the residents and when submitted to The Centers for Medicare and Medicaid Services (CMS), it should be coded as accurately as possible. During an interview on 11/20/2025 at 10:10 am with the Director of Nursing (DON), DON stated MDS was used for continuity of care to allow the resident's care to be reflected through their MDS. DON stated it needed to be coded accurately to reflect that resident's care in the facility. During a review of the facility's policy and procedure (P&P), titled Documentation-Nursing, dated 10/1/2023, the P&P indicated nursing documentation would be concise, clear, pertinent, and accurate. The P&P indicated MDS completion as per CMS and Medicare guidelines. |

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| Penn Mar Healthcare Center | 3938 Cogswell Road<br>El Monte, CA 91732 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that medication regimen review (MRR, a comprehensive evaluation of a resident's medications by a pharmacist to ensure the drugs are appropriate, effective, and safe) irregularity identified by the facility's Pharmacy Consultant was acted upon for one of five sampled resident (Resident 31). This deficient practice had the potential for resident harm due to the missed opportunity by the physician and the licensed staff to act upon the reported irregularities. Findings: During a review of Resident 31's admission Record (AR), the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included anxiety and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 31's History and Physical (H&P), dated 7/24/2025, the H&P indicated the resident had fluctuating capacity to make medical decisions. During a review of Resident 31's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/28/2025, the MDS indicated Resident 31 had intact cognition for daily decision making. The MDS indicated Resident 31 was independent for eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 31's Order Summary Report (OSR), dated 11/19/2025, the OSR indicated to administer Gabapentin Oral Capsule (used primarily to calm overactive nerves to treat certain types of nerve pain and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) 600 milligram (mg, a unit of mass) one tablet by mouth three (3) times a day for anxiety/restlessness related to Schizophrenia with an order date of 9/24/2025. During a review of a facility document, titled Note to Attending Physician/Prescriber, dated 9/17/2025, completed by the facility's Pharmacy Consultant, the note indicated The resident (Resident 31) has Gabapentin 600 mg three times a day for schizophrenia, which is a non-FDA (Food and Drug Administration, a public health protector by ensuring that a wide range of products are safe and effective for public use) labeled use of this medication for this particular indication. According to CMS guidelines, this can be considered duplicate, unnecessary therapy. Please evaluate the risks/benefits of this medication for this resident to keep the facility in compliance with regulations. During an interview on 11/20/2025 at 11:18 am, with the facility's Director of Nursing (DON), the DON stated the MRR was a monthly recommendation that licensed nurses supposed to carry out once received from the pharmacy. The DON stated there was no other clinical documentation that the monthly recommendation for Resident 31 from the pharmacist dated 9/17/2025 was carried out. The DON stated the purpose of MRR was for the pharmacy to review if residents were receiving proper medications and to avoid unnecessary drug use. During a review of the facility's Policy and Procedure (P&P), titled Drug Regimen Review, dated 10/1/2023, the P&P indicated The pharmacist will review each resident's medication regimen at least once a month to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. The consulting Pharmacist will report any irregularities such as unnecessary drugs (which include but are not limited to excessive dosage, excessive duration, inadequate monitoring, inadequate indications for use or adverse consequences of use) to the Facility's Medical Director, Director of Nursing, and the Attending Physician. The report will be submitted within 3 business days if review unless the irregularity is an emergent issue requiring immediate action if the irregularity is emergent, the Attending Physician will be contacted as soon as practicable from the time the irregularity is identified. |

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| F 0881<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Implement a program that monitors antibiotic use.<br><br>Based on observation, interview, and record review, the facility failed to ensure an active, ongoing antibiotic stewardship program (ASP - promote appropriate use of antibiotics while optimizing the treatment of infections, and reduce possible adverse events associated with antibiotic use) with monitoring, tracking, reviewing antibiotic use, and implementing interventions to promote appropriate antibiotic prescribing for the 13 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 8, Resident 9, Resident 21, Resident 26, Resident 31, Resident 33, Resident 36, and Resident 37).This failure has the potential to result in residents receiving unnecessary or inappropriate antibiotics, delayed identification of antimicrobial resistance (bacteria stop responding to medicine), avoidable drug reactions, and compromised resident health outcomes.Findings:During an interview on 11/19/2025 at 9:09 a.m. with Director of Staff Development (DSD), the DSD stated the facility does not have an ASP. The DSD was unable to identify any antibiotics screening used to treat infections for residents. During an interview on 11/19/2025 at 1:20 p.m. with [NAME] President of Clinical (VPC), the VPC stated the facility does not have an ASP in place. During a review of the facility's Quality Assurance / Risk Management Committee (QAC) minutes for August 2025, September 2025, and October 2025, the QAC minutes did not include the facility's ASP as indicated by Medication Monitoring with no documentation. During a record review on 11/19/2025 of the facility's policy and procedure titled Antibiotic Stewardship, dated October 1, 2023, indicated The Facility's leadership team will identify and Infection Preventionist (IP) who will collaborate with the Medical Director to oversee the ASP (Antibiotic Stewardship Program) for the facility.The IP and Medical Director will set standards for the use of antibiotics after reviewing antibiotic trends from the previous quarter and outcome reports.The IP reports ICC recommendations to the QAC during monthly/quarterly QAC meetings. |

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| F 0887<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>Based on observation, interview, and record review, the facility failed to:a. Ensure education was provided about the benefits and risks of the COVID-19 (an illness caused by the coronavirus and affects the lungs and breathing, and can make other parts of the body sick) vaccine, maintain documentation of vaccine education, refusals, or acceptance, and follow their policy for ongoing COVID-19 immunization review for 13 of 13 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 8, Resident 9, Resident 21, Resident 26, Resident 31, Resident 33, Resident 36, and Resident 37). b. Ensure staff documentation contained complete information demonstrating each staff member had been screened, provided with COVID-19 vaccine education, was offered the vaccine and had their current vaccination status recorded.This failure had the potential to result in residents and staff remaining unprotected against COVID-19, increased risk of serious illness, delayed identification of vaccine status, and missed opportunities to prevent the spread of infection within the facility.Findings:a. During an interview on 11/19/2025 at 9:09 a.m. with the Director of Staff Development (DSD), the DSD stated the facility has not offered COVID-19 immunizations and has not offered education on COVID-19 immunization to residents since January 2025 based on a decision by the Quality Assurance / Risk Management Committee (QAC). The DSD stated the facility has not tracked COVID-19 immunizations given to residents by the facility since January 2025. The DSD stated she was one of two Infection Preventionists (IP- a nurse whose main job is to maintain and oversee infection control policies and procedures in a nursing home, hospital, or clinic) for the facility. During an interview on 11/19/2025 at 1:20 p.m. with [NAME] President of Clinical (VPC), the VPC stated the facility has not immunized residents with the COVID-19 vaccine based on a decision by the QAC. The VPC stated the decision was not based from the guidance of All Facility Letter (AFL- message by state health department to give important updates, rules or instructions), Quality, Safety, and Oversight [QSO- message from Centers for Medicare & Medicaid Services (CMS- government agency sets the rules and for nursing homes and healthcare facilities are safely providing care to patients) informing nursing homes the federal rules, new guidance, or changes in how surveys are done], or Health Officer Order (HOO- an official order from the County or State Health Officer that facilities must follow, usually during outbreaks, emergencies, or public health issues). The VPC stated the facility has not offered education and has not tracked COVID-19 immunizations since January 2025. During a record review on 11/19/2025 at 4:00 p.m. of Quality Assurance / Risk Management Committee (QAC) minutes for August 2025, September 2025, and October 2025, the QAC minutes did not include the tracking and administration of COVID-19 immunization in the minutes. During a record review on 11/19/2025 the facility's policy and procedure titled COVID-19 Vaccination, dated June 15, 2021, indicated, When the COVID-19 vaccine is available, the facility will offer each resident.the COVID-19 vaccine unless it is medically contraindicated, or the individual has already been fully vaccinated.The facility will provide education to .residents or resident representatives.on the risks, benefits and potential side effects of the COVID-19 vaccine.The Infection Preventionist, or designee, will ensure that the resident's medical record includes documentation that at a minimum, the resident and/or resident representative was provided education regarding the vaccine they were offered if they accepted and received the vaccine or the reason for refusal.b. During an interview on 11/19/2025 at 9:09 a.m. with the Director of Staff Development (DSD), the DSD stated the facility has not offered COVID-19 immunizations to staff and has not offered education on COVID-19 immunization to staff since January 2025 based on a decision by the Quality Assurance / Risk Management Committee (QAC). The DSD stated the facility has not tracked COVID-19 immunizations given to staff by the facility since January 2025. During a record review on 11/19/2025 at 4:00 p.m. of Quality Assurance / Risk Management Committee (QAC) minutes for<br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | August 2025, September 2025, and October 2025, the QAC minutes did not include the tracking and administration of COVID-19 immunization in the minutes. During a record review on 11/19/2025 of Centers for Disease Control and Prevention (CDC -the nation's leading science-based, data-driven, service organization that protects the public's health) CDC.gov website indicated, CDC recommends everyone ages 65 years and older, including people who live and work in LTC settings, get 2 doses of an updated COVID-19 vaccine 6 months apart.During a record review on 11/19/2025 the facility's policy and procedure titled COVID-19 Vaccination, dated June 15, 2021, indicated, When the COVID-19 vaccine is available, the facility will offer each staff.the COVID-19 vaccine unless it is medically contraindicated, or the individual has already been fully vaccinated.The facility will provide education to staff on the risks, benefits and potential side effects of the COVID-19 vaccine .Facility staff will complete COVID-19 Vaccine-Staff Consent/Declination.The Facility will maintain consent/declination forms in the medical record in the personnel file for facility staff. |

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| F 0911<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.<br><br>Based on observation, interview, and record review, the facility failed to ensure five out of 11 resident bedrooms accommodated no more than four residents in Rooms 25, 27, 29, 31, and 33. This deficient practice had the potential to result in inadequate space for residents' mobility and staff provision of care to the residents in these rooms.Findings: During a review of the facility's Client Accommodation Analysis (CAA) form, dated 11/19/2025, the CAA form indicated that Rooms 25, 27, 29, 31, and 33 were occupied by five ambulatory residents to be used as a bedroom. During a review of the facility's letter for the room waiver request, dated 11/19/2025, the letter indicated the facility was requesting a room waiver for rooms 25, 27, 29, 31, and 33. The letter indicated all the rooms had the same measurement of 464.96 square feet and had five beds in each room. The letter further indicated that each of these rooms had ample space to accommodate wheelchairs and other medical equipment, as well as space for mobility and movement of ambulatory residents. The letter indicated that there was adequate space for nursing care, and the health and safety of residents occupying these rooms were not in jeopardy. During an observation on 11/20/2025 at 11:14 am, the five resident bedrooms for which a waiver was requested (Rooms 25, 27, 29, 31, and 33) had adequate space available for the residents' use and movement. There were no adverse effects as to the adequacy of the spaces for nursing care, comfort, and privacy to the residents. There were no residents who expressed any concerns about the room sizes. During an interview on 11/20/2025 1:25 pm with Administrator (ADM), ADM verified that Rooms 25, 27, 29, 31, and 33 were occupied by five residents in each room. ADM stated, these rooms had adequate space to provide care for each resident and will not adversely affect the residents' health and safety. During a review of the facility's policy and procedure (P&P), titled Resident Rooms and Environment, dated 10/1/2023, the P&P indicated the facility must ensure resident rooms do not accommodate more than four residents. |