STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Playa Del Rey Center	7716 Manchester Avenue Playa Del Rey, CA 90293

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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 0655 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 create a baseline care plan (initial instructions that addresses resident-specific health and safety concerns immediately upon admission, including needs for supervision, behavioral interventions, and assistance with activities of daily living) within 48 hours of admission, for one of four residents (Resident 1), as indicated in the facility's policy and procedure (P&P) titled Care Plan - Baseline. This failure had the potential to result in Resident 1's care team not aware of Resident 1's needs and placed the resident at risk for not receiving the necessary care and services safely. Findings:During a record review of Resident 1's Inter-Facility Transfer Report (essential documentation accompanying a patient being transferred from one healthcare facility to another to receive a different level of care), dated 11/11/2025, the Inter-Facility Transfer Report indicated Resident 1 had left hip hemiarthroplasty (partial joint replacement surgery) on 11/9/2025. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE], with diagnoses including history of left femur (leg bone) fracture (broken bone) and for aftercare following joint replacement surgery. During a review of Resident 1's History and Physical (H&P), dated 11/12/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's care plan titled, Baseline Care Plan: Resident is newly admitted to the facility, dated 11/16/2025, the care plan interventions indicated to assist Resident 1 to acclimatize (become accustomed) with her new environment, assist with transfers and ambulation as needed, and provide assistance with activities of daily living as needed. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 1 was cognitively intact and did not reject care. The MDS indicated Resident 1 was dependent (helper does all of the effort) for toileting hygiene (the ability to maintain perineal hygiene, adjust clothing before and after). The MDS indicated Resident 1 required maximum (helper foes more than half the effort) to shower/bathe herself. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) to roll left and right on the bed (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), moving from sitting to lying (the ability to move from sitting on side of bed to lying flat on the bed), and move from a sitting to standing (the ability to come to a standing position from sitting). During a review of Resident 1's Medication Administration Record (MAR - daily documentation by a licensed nurse for medications given to a resident), from 11/12/2025 through 11/14/2025, the MAR indicated Resident 1 was monitored for pain every shift, anticoagulant (blood thinner) medication monitoring every shift, and episodes of depression every shift.During a concurrent interview and record review on 12/2/2025 at 2:25 p.m., with the Treatment Nurse (TN), Resident 1's care plan titled Baseline Care Plan: ., dated 11/16/2025, was reviewed. TN stated the baseline care plans should have been created and implemented within 48 hours of admission (on 11/14/2025). The TN stated Resident 1's baseline care plans were created over 48 hours after admission (on 11/16/2025). The TN stated Resident 1 did not have baseline care plans to address her activities of daily living and her medications, conditions, and pain monitoring within 48 hours of admission. The TN stated that there was a risk of Resident 1's nursing staff being unaware of Resident 1's needs, which could result in those needs not being met.During a concurrent interview and record review on 12/4/2025 at 3:53 p.m., with Registered Nurse 1 (RN 1), Resident 1's MDS, dated [DATE], was reviewed. RN 1 stated Resident 1 needed moderate to maximal assistance with toileting, bathing, and moving from a sitting to standing position. RN 1 stated Resident 1's care and level of assistance should have been care planned to inform the care team about Resident 1's needs and provide appropriate care.During a review of the facility's P&P titled Care Plan - Baseline, dated 8/25/2021, the P&P indicated a baseline care plan that included instructions needed to provide effective and person-centered care of the resident should be developed for each resident by the Interdisciplinary Team ([IDT] group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents) within 48 hours of a resident's admission.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 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 ensure care was provided in accordance with professional standards of practice and the resident's comprehensive person-centered care plan for one of three residents (Resident 1) who was admitted to the facility with a left hip surgical incision/wound received treatment. The facility failed to ensure:1). Resident 1's left hip surgical site/ wound was monitored for signs of infections like pustules (a small blister or pimple on the skin containing pus) and inflammation (a condition in which a part of the body becomes reddened, swollen, hot, and often painful, especially as a reaction to injury or infection) as indicated in Resident 1's care plan titled, Resident has skin breakdown related to surgical site.2). The Baseline Care Plan (a care plan developed within 48 hours of admission, which would address resident-specific health and safety concerns and instructions to prevent decline) was created timely, to ensure staff received the necessary interventions and instructions in the care and assessment of Resident 1's left hip surgical site. 3). Resident 1's follow up appointment to the surgeon (the doctor who performed surgery) was scheduled timely, as ordered on 11/13/2025. 4). The physician, physician assistant (PA) and licensed nurses, assessed Resident 1's left hip surgical site, for any signs of wound complications (such as redness, pain, discharges, and dehiscence) after admission to the facility on [DATE].5). Resident 1 was assessed thoroughly, when the resident presented pain on 11/16/2025, 11/17/2025, 11/20/2025, 11/21/2025, 11/22/2025, and 11/23/2025.These failures had the potential to result in delayed assessment for signs of infections and in providing the care and services necessary to promote wound healing. Findings:During a record review of Resident 1's Inter-Facility Transfer Report (essential documentation accompanying a patient being transferred from one healthcare facility to another to receive a different level of care), dated 11/11/2025, the Inter-Facility Transfer Report indicated Resident 1 had left hip hemiarthroplasty (partial joint replacement surgery) on 11/9/2025.During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE], with diagnoses including history of left femur (leg bone) fracture (broken bone) and for aftercare following joint replacement surgery.During a review of Resident 1's History and Physical (H&P), dated 11/12/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Body Check, dated 11/12/2025, the Body Check indicated Resident 1 had a left trochanter (hip) surgical site (the specific location where an incision (cut) was made to perform an operation), measuring 15 centimeters (cm- a metric unit of length) with 23 staples (wound closure devices). Resident 1's Body Check indicated the left trochanter surgical site had some hematuria (bloody urine), no signs or symptoms of infection, and no dehiscence (a surgical incision or wound split open).During a review of Resident 1's care plan titled Resident has skin breakdown related to surgical site., dated 11/12/2025, the goal indicated the facility would manage wound odor (smell) and exudate (discharge). The interventions indicated to observe for signs and symptoms (s/s) of skin breakdown such as redness, cracking (split on the skin's surface), blistering (small bubbles on the skin filled with serum [fluid] and caused by friction, burning, or other damage), and skin that does not blanche (turn white when pressed) easily and to evaluate for localized skin problems such as dryness, redness, pustules, and inflammation. During a review of Resident 1's Physician Orders, dated 11/13/2025, the Physician Orders indicated staff to monitor Resident 1's left trochanter surgical site for skin breakdown every dayshift (7:00 a.m.- 3:00 p.m.). The Physician Orders indicated to schedule Resident 1's follow-up appointment with Medical Doctor 2 (MD 2- Surgeon).During a review of Resident 1's care plan titled, Baseline Care Plan: Resident is newly admitted to the facility, dated 11/16/2025, the care plan interventions indicated, alteration in skin integrity (skin's overall health) (Actual or Potential): monitor skin and report red/ discolored or broken skin; alteration in skin integrity: skin assessment per protocol; at risk for orthopedic complications: observe for s/s of infection at surgical site; at risk for pain/ discomfort: assess pain level as needed, give meds as ordered and observe for pain and provide comfort measures as needed.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 1 was cognitively intact and did not reject care. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) to roll left and right on the bed (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), moving from sitting to lying (the ability to move from sitting on side of bed to lying flat on the bed), and move from a sitting to standing (the ability to come to a standing position from sitting). The MDS indicated Resident 1 had a surgical wound and a history of surgery During a review of Resident 1's

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 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 an interview and record review, the facility failed to implement the physician's order for pain management for one of four sampled residents (Resident 1).This failure had the potential to result in Resident 1 becoming dependent on pain medication.This failure had the potential for Resident 1 to reduce her capacity to manage and cope with her pain.Findings:During a review of Resident 1's Resident 1's Inter-Facility Transfer Report, dated 11/11/2025, the Inter-Facility Transfer Report indicated Resident 1 had left hip hemiarthroplasty (partial joint replacement surgery) on 11/9/2025.During a review of Resident 1's admission Record, Resident 1 was admitted on [DATE]. The admission Record indicated that Resident 1 had a history of fracture of left femur (leg bone), generalized anxiety (a mental condition characterized by excessive or a mental condition characterized by excessive worry) disorder, and polyneuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). The admission Record indicated Resident 1 was admitted for aftercare following joint replacement surgery.During a review of Resident 1's History and Physical (H&P), dated 11/12/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. The H&P indicated Resident 1 had a diagnosis including [NAME] Syndrome (painful inflammatory condition causing swelling and tenderness in the cartilage where ribs meet the breastbone). During a review of Resident 1's Body Check, dated 11/12/2025, the Body Check indicated Resident 1 had a left trochanter (hip) surgical site (the specific location where an incision (cut) was made to perform an operation) measuring 15 centimeters (cm- a metric unit of length) with 23 staples (wound closure devices). Resident 1's Body Check indicated the left trochanter surgical site had some hematuria (bloody urine), no signs or symptoms of infection, and no dehiscence (a surgical incision or wound split open).During a review of Resident 1's Physician Orders, dated 11/12/2025, the Physician Orders indicated staff must document non-pharmacological interventions such as heat, repositioning, relaxation breathing, flood/fluid, massage, exercise, immobilization of joint, and other as needed and to document the results. The orders indicated Tramadol (a synthetic [man-made] opioid medication to treat pain) 50 milligrams (mg- a unit of measurement), two tablets, by mouth every six hours as needed for moderate to severe pain rated five (5) to 10 out of 10.During a review of Resident 1's Progress Notes, dated 11/12/2025, the notes indicated Resident 1 was alert with periods of confusion.During a review of Resident 1's care plan titled Baseline Care Plan: Resident is newly admitted to the facility, dated 11/16/2025, the care plan indicated an intervention of at risk for pain or discomfort: observed for pain and provide comfort measures as needed and At risk for pain or discomfort: give pain meds as ordered.During a review of Resident 1's Physician Orders, dated 11/17/2025, the Physician Orders indicated an order placed on11/12/2025 for pain monitoring every shift and to document non-pharmacological interventions(s) such as heat, repositioning, relaxation, breathing, food/fluid, massage, exercise, immobilization of join. The physician's orders indicated to write in progress notes as needed and document results of non-pharmacological interventions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 1 was cognitively intact and did not reject care. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) in rolling left and right, moving from sitting to lying position, and to a standing position from sitting. The MDS indicated Resident 1 had a surgical wound and a history of surgery. The MDS indicated Resident 1 occasionally experienced moderate pain and did not receive non-medication interventions for pain within the past five days.During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), for the month of 11/2025, the MAR did not indicate Resident 1 was offered or provided any non-pharmacological interventions on the following dates as indicated in the physician's orders:1). For 8/10 pain on 11/16/2025 at 4:46 p.m.2). For 7/10 pain on 11/21/2025 at 7:39 p.m.3). For 7/10 pain on 11/22/2025 at 10:52 a.m.4). For 7/10 pain on 11/23/2025 at 3:29 a.m.5). For 8/10 pain on 11/23/2025 at 9:57 a.m. The MAR indicated Resident 1 received Tramadol 50 mg 2 tablets for the following:1). 0/10 pain on 11/18/2025 at 1:14 pm.2). 0/10 pain on 11/21/2025 at 1:54 p.m.3). 0/10 pain on 11/26/2025 at 12:31 p.m. During a concurrent interview and record review on 12/4/2025 at 9:22 a.m. with Registered Nurse 15 (RN 15), Resident 1's MAR, for the month of 11/2025, and Progress Notes, for the month of 11/2025, were reviewed. RN 15 stated Resident 1 should have been offered non-pharmacological pain management interventions on 11/16/2025, 11/21/2025, 11/22/2025 and 11/23/2025 when she

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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F 0803 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 provide pork sausage patty in the breakfast tray, for two of four sampled residents (Residents 2 and 3), as indicated on the menu and meal tickets (the diet order that matched the dietitian approved menu, honoring resident food preferences).This failure resulted in Resident 2 and Resident 3 not receiving the adequate protein and calories, potentially worsening their protein and calorie malnutrition (undernutrition).Findings:1.) During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included generalized muscle weakness, anemia (a condition where the body does not have enough healthy red blood cells), and chronic kidney disease (long-term impaired kidney function).During a review of Resident 2's History and Physical (H&P), dated 10/28/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's Dietary Profile, dated 10/28/2025, the Dietary Profile indicated Resident 2 did not have any religious or cultural preferences and did not dislike any meat products.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 2 was cognitively intact, was able to understand others and express ideas and wants.During a review of Resident 2's Nutrition Assessment, dated 12/4/2025, the assessment indicated Resident 2 weighed 126.6 pounds (in low normal range for Resident 2's height and age). The assessment indicated Resident 2 received supplementation for her iron deficiency. The assessment indicated a goal for Resident 2 to maintain optimal oral intake to avoid significant weight change.During a review of Resident 2's Breakfast Meal Ticket, dated 12/4/2025, Resident 2's Meal Ticket indicated a regular texture, regular diet. The Meal Ticket indicated Resident 2's breakfast tray should include one sausage patty.During a concurrent observation and interview on 12/4/2025 at 8:11 a.m., with Resident 2 in Resident 2's room, Resident 2's breakfast tray did not have a sausage patty. Resident 2 stated she was saddened by the lack of sausage patty.During a concurrent interview and record review on 12/4/2025 at 10:20 a.m., with the Dietary District Manager (DDM), Resident 2's Meal Ticket, dated 12/4/2025, was reviewed. The DDM stated Resident 2 did not have an allergy or dislike to pork or sausage or sodium intake restriction. The DDM stated the kitchen cooks, dietary aides, and nursing staff check each tray composition to ensure residents receive the correct diet and food items according to their meal tickets. The DDM stated Resident 2 should have received every item listed on the Meal Ticket, including the sausage patty. The DDM stated the cooks, aides, and nursing staff should have noticed Resident 2's tray did not include each item from the menu and meal ticket, returned the tray to the kitchen, and added the sausage patty to the tray before Resident 2 received the tray.During a concurrent interview and record review on 12/4/2025 at 3:15 p.m., with the Registered Dietitian (RD 1), Resident 2's Meal Ticket, dated 12/4/2025, Resident 2's Nutrition Assessment, dated 12/4/2025, the facility's menu, dated 12/4/2025, and the facility's recipe titled Sausage Patty, dated Fall 2025, were reviewed. RD 1 stated the menu, recipe, and Resident 2's Meal Ticket indicated Resident 2 should have one sausage patty with breakfast. RD 1 stated this failure had the potential to result in Resident 2 experiencing weight loss, worsened iron deficiency, and compromised protein intake. 2.) During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 3 had diagnoses including muscle weakness, acute (short-term) and chronic (long-term) respiratory failure (impairment of the lungs), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 3's H&P, dated 8/20/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions.During a review of Resident 3's Interdisciplinary Care Conference ([IDT] group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents), dated 8/21/2025, the conference indicated admission goals to improve nutritional status and tolerate a high protein diet. During a review of Resident 3's care plan titled At risk for malnutrition related to inadequate protein-calorie intake , dated 8/22/2025, the care plan indicated staff must provide diet as ordered.During a review of Resident 3's Dietary Profile, dated 11/21/2025, the profile indicated Resident 3 liked all meats, had no food allergies or intolerances, and tolerated her regular texture diet.During a review of Resident 3's Nutrition Assessment, dated 12/4/2025, the Nutrition Assessment indicated Resident 3's needs were not met because a regular diet may not be enough calories and protein to meet Resident 3's needs

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 2) was not served in her breakfast tray, orange juice and hot cereal as indicated in the resident's meal ticket.This failure resulted in a violation in Resident 2's rights, which caused her to feel angry and distressed.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included generalized muscle weakness, anemia (a condition where the body does not have enough healthy red blood cells), and chronic kidney disease (long-term impaired kidney function).During a review of Resident 2's history and physical (H&P), dated 10/28/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 2 was cognitively intact, understood others and was able to express her ideas and wants.During a review of Resident 2's physician orders, dated 12/12/2025, the physician's order indicated a regular texture, regular diet.During a review of Resident 2's Dietary Profile, dated 10/28/2025, the Dietary Profile indicated Resident 2 disliked orange juice, hot cereal, tomatoes, and bell peppers.During a concurrent observation and interview on 12/4/2025 at 8:11 a.m., with Resident 2 in Resident 2's room, Resident 2's breakfast tray included orange juice and hot cereal. Resident 2 stated she did not like orange juice and hot cereal. Resident 2's Meal Ticket indicated Resident 2 disliked orange juice and hot cereal.During an observation on 12/4/2025 at 8:18 a.m., Certified Nursing Assistant (CNA) 10 was in Resident 2's room. Resident 2 informed CNA 10 about the presence of her disliked food (orange juice and hot cereal) on her breakfast tray. CNA 10 removed the orange juice and told Resident 2 that she should not have received her disliked food items. CNA 10 left the hot cereal on Resident 2's tray. During a concurrent observation and interview on 12/4/2025 at 8:29 a.m., with the Dietary Services Supervisor (DSS) in Resident 2's room, Resident 2's breakfast tray that included hot cereal was observed. The DSS stated Resident 2's tray should not have included any items on her dislike list (orange juice and hot cereal). During a concurrent interview and record review on 12/4/2025 at 3:15 p.m., with the Registered Dietitian (RD 1), Resident 2's Meal Ticket, dated 12/4/2025, and the facility's policy and procedure (P&P) titled Dining and Food Preferences, dated 9/2017, were reviewed. RD 1 stated Resident 2's Meal Ticket indicated Resident 2 should not have orange juice and hot cereal. RD 1 stated the P&P was not followed because Resident 2 should not have received any food that she disliked. RD 1 stated this failure had the potential to result in Resident 2 experiencing weight loss, losing her sense of control, and feeling dissatisfied. RD 1 stated residents had the potential to be exposed to allergens and could develop allergic reactions because dietary and nursing staff did not ensure residents' food trays match the foods listed on their Meal Tickets.During a review of the facility's P&P titled Dining and Food Preferences, dated 9/2017, the P&P indicated that upon meal service, any resident with expressed refusal of food and/or beverage should be offered an alternate selection of comparable nutritive value.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate documentation was maintained for one of four resident's (Resident 1).This failure had the potential for miscommunication and inaccurate clinical decision-making and could result in delayed identification of condition changes and providing care. Findings:During a record review of Resident 1's Inter-Facility Transfer Report (essential documentation accompanying a patient being transferred from one healthcare facility to another to receive a different level of care), dated 11/11/2025, the Inter-Facility Transfer Report indicated Resident 1 had left hip hemiarthroplasty (partial joint replacement surgery) on 11/9/2025.During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE], with diagnoses including history of left femur (leg bone) fracture (broken bone) and for aftercare following joint replacement surgery.During a review of Resident 1's History and Physical (H&P), dated 11/12/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Body Check, dated 11/12/2025, the Body Check indicated Resident 1 had a left trochanter (hip) surgical site (the specific location where an incision (cut) was made to perform an operation), measuring 15 centimeters (cm- a metric unit of length) with 23 staples (wound closure devices). Resident 1's Body Check indicated the left trochanter surgical site had some hematuria (bloody urine), no signs or symptoms of infection, and no dehiscence (a surgical incision or wound split open).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 1 was cognitively intact and did not reject care. The MDS indicated Resident 1 had a surgical wound and a history of surgery.During a review of Resident 1's Change of Condition (COC- a communication tool used by healthcare workers when there is a clinical deviation from a resident's baseline), dated 11/26/2025 at 3:45 p.m., the COC indicated Resident 1's left trochanter surgical incision had 2 cm. of wound dehiscence (split open skin). The COC indicated Resident 1's left trochanter surgical incision had some (unspecified) drainage and moisture. The COC indicated Resident 1's wound dehiscence started in the morning (time not specified). During a review of Resident 1's Daily Body Check, dated 11/26/2025 for the 3:00 p.m. to 11:30 p.m. shift, the body check indicated Resident 1 had skin treatment on the right hip. During a concurrent interview and record review on 12/2/2025 at 2:25 p.m., with the Treatment Nurse (TN), Resident 1's Body Check, dated 11/12/2025, was reviewed. The TN stated Resident 1's Body Check indicated Resident 1 was admitted on [DATE], with a surgical site on the left hip with some hematuria on the left hip surgical site. The TN stated she incorrectly believed hematuria meant bloody discharge. The TN stated the wound assessment was incorrect because hematuria, which is of the urine, and was not coming out of Resident 1's lift hip wound. During a concurrent interview and record review on 12/12/2025 at 11:30 a.m., with the Director of Nursing (DON), Resident 1's Body Check, dated 11/12/2025, and Daily Body Check, dated 11/26/2025, were reviewed. The DON stated Resident 1 had a surgical incision and wound treatment on her left hip, not the right hip as indicated in the Daily Body Check dated 11/26/2025 for the 3:00 p.m. to 11:30 p.m. shift.During a concurrent interview and record review on 12/12/2025 at 11:45 a.m., with the TN, Resident 1's COC, dated 11/26/2025, was reviewed. The TN stated Resident 1's wound dehiscence indicated in the COC was identified on 11/26/2025, in the afternoon (time not specified), not in the morning. The TN stated the documentation of her assessment was incorrect because Resident 1's wound dehiscence was not discovered in the morning.During a review of the facility's policy and procedure (P&P) titled Nursing Documentation, dated 6/27/2022, the P&P indicated nursing documentation should be accurate and based on the resident's condition to communicate a resident's status.