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	06/13/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents had access to the weekly menu and list of alternative choices to the weekly menu, by posting them outside the kitchen, excluding access to residents who are bed or chair bound affecting two of three sampled residents (Resident 12 and Resident 36). The deficient practice of failing to provide menus to residents limited their choice of food due to their physical limitations. Findings: During a review of Resident 12's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), cardiac arrhythmia (a condition where the heart beats too fast, too slow, or irregularly), and hyperkalemia (a condition where there is too much potassium [an essential mineral vital for numerous bodily functions] in the blood). During a review of Resident 12's History and Physical Examination (H&P) dated 3/26/2025, the H&P indicated Resident 12 had the ability to understand and make decisions. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool) dated 3/25/2025, the MDS indicated, for eating and oral hygiene, Resident 12 requires setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity). During a review of Resident 12's Order Summary Report, a diet order dated 5/6/2025, indicated Resident 12 was on a carbohydrate controlled diet (each meal contains fairly equal amount of carbohydrates - a nutrient the body uses for energy) soft and bite sized texture, thin consistency, double protein (a nutrient the body uses to build and maintain muscle and support bone health among other benefits) portions at breakfast. During a review of Resident 36's admission Record, the admission record indicated Resident 36 was admitted to facility on 2/4/2025 with diagnoses including heart failure, difficulty in walking, and muscle weakness. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 36's H&P dated 2/14/2025, the H&P indicated Resident 36 has decision-making capacity. During a review of Resident 36's MDS dated [DATE], the MDS indicated, for eating and oral hygiene, Resident 36 is dependent upon a helper to do all the effort. During a review of Resident 36's Order Summary Report, a diet order dated 5/15/2025, indicated Resident 36 was on a regular diet, regular texture, thin consistency. During an interview with Resident 12 on 6/12/2025 at 9:06 am, Resident 12 stated he did not know there was a menu, or an alternative menu and he has not seen one since admission. Resident 12 stated he has not been offered food choices and eats what they bring him. Resident 12 stated he would like to get something different sometimes. During an interview with Resident 36 on 6/12/2025 at 9:10 am, Resident 36 stated he was not aware of a food menu or that he could choose something other than what was served. Resident 36 said it would be nice to know in advance in case he does not like something that is being served. Resident 36 stated he sometimes eats food he would not choose. During an interview on 6/12/2025 at 12:15 pm with Dietary District Manager (DDM), the DDM stated residents can check the menus on the wall outside the kitchen before meals, and put in requests for alternate choices at least two hours before meal times. When asked about residents with physical limitations who are unable to see the menus due to placement, the DDM stated the Certified Nursing Assistants (CNA's) could bring the residents menus if requested. During a review of the facility's Policy & Procedures (P&P) titled Resident Rights revised December 2021, the P&P indicated residents have the right to communication with and access to people and services, both inside and outside the facility. During a review of the facility's P&P titled Menus revised October 2017, the P&P indicated menus are developed and prepared to meet resident choices including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one out of five residents (Resident 22) call light was within reach. This failure had the potential for Resident 22 needs not being met. Findings: During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 22 diagnoses included dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a chronic mental illness that affects a person's thinking, behavior, and perception of reality), and gastro-esophageal reflux disease([GERD]- stomach acids flow back up into esophagus and causes heartburn). During a review of Resident 22's History and Physical (H&P), dated 7/8/2024, the H&P indicated Resident 22 did not have the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set ([MDS]- a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 22's cognition (ability to learn, reason, remember, understand, and make decisions) had severe cognitive impairment. The MDS indicated Resident 22 required substantial/maximal assistance (helper does [NAME] than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) from staff for showering, toileting hygiene, and dressing. During an observation on 6/11/2025 at 9:43 a.m. Resident 22's call light was not within reach. The call light was hanging behind the residents' bed. During a concurrent observation and interview on 6/12/25 at 8:47 a.m. with Licensed Vocational Nurse (LVN) 2, a picture taken on 6/11/2025 of Resident 22's call light not within reach was reviewed. LVN 2 stated the call light was not within reach and this was unacceptable. LVN 2 stated it was important to have the call light within reach for Resident 22 to communicate his needs. LVN 2 stated if the call light is not within reach the resident could be in distress and the situation could go from small manner to a significant emergent manner. During a concurrent observation and interview on 6/12/2025 at 1:16 p.m. with Certified Nursing Assistant (CNA) 2, a picture taken on 6/11/2025 of Resident 22's call light not within reach was reviewed. CNA 2 stated I am to place the call light within reach. CNA 2 stated it was important for the call light to be within reach so Resident 22 could call for help. CNA 2 stated having the call light within reach will stop the resident from trying to get up out of the bed and prevent him from falling. During a review of the facility's policy and procedures (P&P) titled, Answering the Call Light, dated 10/2024, the P&P indicated the purpose of this procedure is to ensure timely responses to the resident's requests and needs. The P&P indicated to ensure that the call light is accessible to the resident when in bed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one out of three sampled residents (Resident 58): 1. Resident 58 was free from mental abuse. 2. To follow facility's policy and procedure (P&P) titled, Abuse Prohibition Policy and Procedure, dated 2/2021, the P&P indicated mental abuse were prohibited threats verbal or nonverbal conduct which can cause or had the potential for the patient to experience intimidation or fear. This deficient practice of not preventing mental abuse for Resident 58 had the potential for Resident 58 to feel unsafe and uncomfortable. Findings: a. During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 18 diagnoses included anxiety (a feeling of worry, nervousness, or unease), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and post-traumatic stress disorder ([PTSD] - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). During a review of Resident 18's History and Physical (H&P), dated 12/12/2025, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a review of Resident 18's Minimum Data Set ([MDS]- a resident assessment tool), dated 5/14/20205, the MDS indicated Resident 18's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 18 had exhibited verbal behavioral symptoms (threatening, screaming, and cursing) towards others one to three days. The MDS indicated Resident 18 had psychiatric and mood disorder which included anxiety, depression, bipolar disorder, and PTSD. During a review of Resident 18's Situation Background Assessment Recommendation (SBAR), dated 4/10/2025, the SBAR indicated Resident 18 had behavioral symptoms (agitation) on 4/10/2025. During a review of Resident 18's care plan titled, Resident 18 had tendencies to become verbally abusive toward nurses/staff and had demonstrated verbal abusive behavior related to poor anger management/poor impulse control, dated 4/10/2025. The care plan indicated monitor behavior such as aggression, agitation, and compulsive behavior. During a review of Resident 18's care plan titled, Resident 18 had strong discussion with roommate on 5/7/2025, dated 5/7/2025, the care plan indicated to monitor for further occurrences involving strong discussion with roommate. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 18's Interdisciplinary Care Conference ([IDT]- healthcare professionals from various disciplines who collaborate to prove comprehensive and coordinated care to patients), dated 5/22/2025, the IDT indicated the non-pharmacological (any therapeutic or preventive measures that do not involve the use of medication) intervention staff will continue to monitor the resident for changes in mood, behavior, and response to interventions. The IDT indicated the staff were to analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. b. During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was admitted to the facility on [DATE]. Resident 58 diagnoses included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder. During a review of Resident 58's History and Physical (H&P), date unknown, the H&P indicated Resident 58 had the capacity to understand and make decisions. During a review of Resident 58's MDS dated the MDS indicated Resident 58's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 58 did not exhibit physical and verbal behavioral symptoms. The MDS indicated Resident 58 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, showering, and dressing. During a review of Resident 58's care plan titled, Resident 58 had strong discussion with roommate on 5/7/2025, dated 5/7/2025, the care plan indicated to monitor for further occurrences involving strong discussion with roommate. During a review of Resident 58's Change of Condition (COC), dated 5/7/2025, the COC indicated there was a verbal exchange between two residents. The COC indicated Resident 58 reported, Resident 18 was speaking loudly while he was trying to sleep and told Resident to lower his voice. The COC indicated this led to a verbal exchange. During a review of Resident 58's Interdisciplinary Care Conference (IDT), dated 5/7/2025, the IDT indicated during the verbal exchange Resident 18 had called Resident 58 a name and Resident 18 refused to change rooms. During a review of Resident 58's Change of Condition (COC), dated 5/24/2025, the COC indicated there was a verbal disagreement with resident (Resident 18). The COC indicated Resident 58 reported, Resident 18 placed his hand on his right shoulder and took a butter knife off his plate and held it in the air. During a review of Resident 58's IDT, dated 5/27/2025, the IDT indicated, Resident 58 had reported Resident 18 placed his hand on his right shoulder, then picked up a butter knife off his plate and held it in the air. The IDT indicated Resident 58 reported that Resident 18 told him to shut up. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2025 at 2:00 p.m. with Resident 58, Resident 58 stated Resident 18 had walked over to his bed and started yelling. Resident 58 had put his hand on my shoulder and picked up my butter knife and held it in the air. Resident 58 stated Resident 18 would frequently yell (speak loudly) throughout the day. Resident 58 stated they had an argument a few weeks ago (5/7/2025) with Resident 18 and the staff was in the room with Resident 18. Resident 58 stated the CNA had stepped out of the room during the time of the incident. Resident 58 stated when Resident 18 touched his shoulder and picked up the knife from his lunch tray. Resident 18 stated he felt uncomfortable and I went ahead and did a room change. During an interview on 6/13/2025 at 8:15 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 18 had mood swings he had verbal outburst and using profanity (words or expressions that are considered offensive). CNA 1 stated Resident 18 had a prior encounter of verbal outburst with Resident 58 on 5/7/2025. CNA 1 stated the staff was to monitor Resident 18's whereabouts and that he was one to one supervision. CNA 1 stated I was to monitor to prevent harm and maintain the other resident's safety. During an interview on 6/13/2025 at 11:00 a.m. with Treatment Nurse (TN) 1, the TN 1 stated the staff was told to monitor Resident 18's behavior and was placed on one-to-one supervision for the last month (month of May). TN 1 stated the assigned CNA was to follow Resident 18 keep track of his whereabouts, report agitation, and loud outburst. TN 1 stated the actions of Resident 18 would create a hostile environment (a situation where living conditions are made intolerable due to unwelcome conduct or harassment, impacting the victim's ability to comfortably and safely use or enjoy their dwelling) for Resident 58. During an interview on 6/13/2025 at 12:37 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 18 was verbally abusive towards Resident 58 on 5/7/2025. LVN 1 stated both residents refused to do a room change and the resolution Resident 18 was to have one to one supervision. LVN 1 stated Resident 18 had one to one supervision including staff was to be in the room with the resident. LVN 1 stated on 5/24/2025 Resident 58 had reported Resident 18 had gone to his side of the room, touched his shoulder, and grabbed a knife from the meal tray and threatened Resident 58. LVN 1 stated CNA 3 was assigned to Resident 18 for one-to-one supervision. LVN 1 stated Resident 58 had experienced mental abuse per abuse policy which could potentially leave him to feel afraid. During a concurrent interview and record review on 6/13/2025 at 1:55 p.m. with Registered Nurse (RN) 1, Resident 18's IDT, dated 5/22/2025 was reviewed. The IDT indicated the non-pharmacological intervention staff will continue to monitor the resident for changes in mood, behavior, and response to interventions. The IDT indicated the staff were to analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document. RN 1 stated Resident 18 had aggressive behavior. RN 1 stated Resident 18 required one to one supervision and at all times. RN 1 stated the staff were to align with Resident 18, know his whereabouts at all times, and document his behavior. During a concurrent interview and record review on 6/13/2025 at 2:05 p.m. with RN 1, the P&P titled, Abuse Prohibition Policy and Procedure, dated 2/2021 was reviewed. The P&P indicated mental abuse were prohibited threats verbal or nonverbal conduct which can cause or had the potential for the patient to experience intimidation or fear. RN 1 stated Resident 58 had touched Resident 18 shoulder and grabbed a knife. RN 1 stated this was considered mental abuse per P&P and could make Resident 18 scared and make him feel uncomfortable. RN 1 stated it would make me scared too. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/2025 at 3:59 p.m. with CNA 3, CNA 3 stated Resident 18 was on one-to-one supervision for at least a month. CNA 3 stated there was an altercation between Resident 18 and Resident 58. CNA 3 stated he had stepped away and was no longer in the line of sight of the Resident 18 to pass meal trays for breakfast and lunch on 5/24/2025 the day of the incident. CNA 3 stated I was to be with Resident 18 at all times, CNA 3 stated when, I stepped away Resident 18 was not monitored. CNA 3 stated had the potential for Resident 18 to argue, threaten, and fight with Resident 58 During an interview on 6/13/2025 at 4:10 p.m. with Administrator (ADM), The ADM stated Resident 18 and Resident 58 had an altercation. The ADM stated CNA 3 stepped away and did not have Resident 58 in the line of sight. The ADM stated when CNA 3 stepped anyway an altercation occurred and that's why we reported the incident. During a review of the facility's P&P titled, Abuse Prohibition Policy and Procedure, dated 2/2021, the P&P indicated healthcare centers prohibit abuse, mistreatment, and neglect for all residents. The P&P indicated abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury or mental anguish. The P&P indicated mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report a femur (thigh bone) fracture of an unknown origin to the California Department of Public Health (CDPH) for one of one sampled residents (Resident 57). This failure resulted in a delay of an investigation by the CDPH. Findings: During a review of Resident 57's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 57 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hip, end stage renal disease (ESRD -irreversible kidney failure), and dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 57's Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 5/7/2025, the MDS indicated Resident 57 was cognitively intact (ability to reason, understand, remember, judge, and learn) and had impairments of the lower extremities (related to the legs). During a review of Resident 57's Situation, Background, Assessment, and Recommendation form (SBAR -a communication tool used by healthcare workers when there was a change of condition among the residents) dated 5/28/2025, the SBAR indicated Resident 57 had severe pain in her lower back, bilateral hips and down her lower extremities with the right side more than the left side and has limited movement on the right lower extremity. The SBAR further indicated the doctor was notified and an order for an x-ray of the right thigh and hips were ordered. During a review of Resident 57's SBAR dated 5/29/2025, the SBAR indicated Resident 57's results came back and resulted in a right femur (the thigh bone) fracture and the family and doctor was notified. During a review of Resident 57's Radiology (using imaging to diagnose and treat diseases and or conditions) Results Report of the right femur, dated 5/30/2025, the Radiology Results Report indicated there was likely acute horizontal fracture through the base of the right femoral neck (the narrow part of the femur (thigh bone) that connects the femoral head [ball] to the femoral shaft [long bone]) with cortical bone irregularity (an abnormal or uneven appearance of the outer layer of a bone) at the fracture margins (cannot rule out an underlying lytic bone lesion [an area of bone tissue that has been destroyed or weakened] with a pathological fracture[a fracture that occurs in a bone weakened by an underlying disease, such as a tumor, infection, or metabolic disorder, rather than by a direct injury]). During a review of Resident 57's Radiology Results Report of the right hip, dated 5/30/2025, the Radiology Results Report indicated there was severe diffuse osteopenia (a widespread and significant reduction in bone density across the body) (presumed osteoporosis [(weak and brittle bones due to lack of calcium and Vitamin D]). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 57's History & Physical (H&P), dated 6/6/2025, the H&P indicated Resident 57 had the capacity to make decisions and had a good understanding of their health condition. During an interview on 6/10/2025 at 10:49 a.m. with Resident 57 in her room, Resident 57 was lying in bed awake. Resident 57 was asked about her fractured femur to which she stated she had no idea how she got the fracture and denied staff handling her roughly, denied falling, abuse or accidentally hitting her leg on something. Resident 57 stated she woke up one day and it just started hurting more than usual. During an interview on 6/12/2025 at 1:47 p.m. with Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 3, RN 1 stated they ordered an x-ray for Resident 57 was done because she was complaining of increased pain especially on the right leg. When the x-ray results came back, RN 1 stated the staff notified her doctor and received an order to transfer her to the hospital. LVN 3 stated after she received Resident 57's x-ray report and found out about the femur fracture, she spoke with Resident 57 and asked her if she could have possibly fallen on the bed, if she hit her leg on something, or if a staff might have handled her roughly. LVN 3 stated Resident 57 denied all of that happening and stated she did not know where the fracture came from. RN 1 and LVN 3 stated the Director of Nursing and the Administrator was made aware of the situation. During an interview on 6/13/2025 at 10:58 a.m. with the Administrator (ADMN), the ADMN stated she was made aware of Resident 57's fractured femur and went to speak with Resident 57. Resident 57 told her she was not handled roughly by staff, she did not fall or hit her leg anywhere, and no abuse. The ADMN stated Resident 57 was awake and alert and able to have conversations with her and she could recall past events, and there was no reason to not believe what she was telling her. The ADMN stated this incidence was not reported to the state agency as an unusual occurrence or an injury of unknown origin because it didn't fit that description. The ADMN stated her doctor had determined and told her that Resident 57's fractured femur was a pathological fracture due to her being a long-term dialysis resident. The ADMN stated with Resident 57 denying abuse, fall, or mishandling and the doctor's determination that it was a pathological fracture, they know exactly what caused the fracture and it was not considered an unusual occurrence or an injury or unknown origin since they know where the fracture came from. The ADMN further stated she was content in her decision of not reporting this incident. During a review of the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting, dated 8/27/2021, the P&P indicated the facility would follow all applicable state and federal laws and regulations regarding the reporting of unusual occurrences. The P&P further indicated unusual occurrences are reported to the appropriate state agency within 24 hours.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one out of five sampled residents (Resident 29) had a revised care plan for medication administration to be taken by mouth. The deficient practice had the potential for repeat occurrences. Findings: During a review of Resident 29's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 29 diagnoses gastronomy ([g-tube]- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), gastro-esophageal reflux disease ([GERD]- stomach acids flow back up into esophagus and causes heartburn), and dysphagia (difficulty or discomfort in swallowing). During a review of Resident 29's History and Physical (H&P), dated 4/18/2025, the H&P indicated Resident 29 had the capacity to understand and make decisions. During a review of Resident 29's Minimum Data Set ([MDS]- a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 29's cognition (ability to learn, reason, remember, understand, and make decisions) was moderate cognitive impaired. The MDS indicated Resident 29 required substantial/maximal assistance (helper does [NAME] than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) from staff for showering, toileting hygiene, and dressing. The MDS indicated Resident 29 had a swallowing disorder due to coughing or choking during meals or when swallowing medications. The MDS indicated Resident 29 nutritional approaches were to have a mechanical altered diet (require change in texture of food or liquids). During a record review of Resident 29's physician orders titled, Order Summary Report, dated 4/15/2025, the physician orders indicated to flush g-tube with 15 cubic centimeters ([cc] - a unit of volume used to measure liquid medication dosages and other fluid volumes in patient care) of water post completion of medication administration every shift. During a record review of Resident 29's care plan titled, Resident exhibits or is at risk for impaired swallowing related to Parkinson's disease, dated 9/8/2023, the care plan interventions indicated to for Resident 29 to be in an upright position when swallowing food or drinks and encourage small sips/bites. The care plan was not revised when the physician authorized for the resident medications to taken by mouth. During a record review of Resident 29's care plan titled, Patient with treatment diagnosis of dysphagia, dated 4/14/2025, the care plan interventions indicated speech therapy three times per week for four weeks. The care plan was not revised to indicate what interventions were needed when the physician authorized for the resident medications to taken by mouth. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 29's physician orders titled, Order Summary Report, dated 5/23/2025, the physician orders indicated Resident 29 had a regular diet with soft and bite-sized texture and mildly thick consistency. During a telephone interview on 6/12/2025 11:27 a.m. with Medical Doctor (MD), the MD stated she had telephoned vis text that it was okay to allow Resident 29 to take medications by mouth on 4/26/2025. The MD stated, not having the orders and interventions clear it could cause confusion for the staff and myself. During a concurrent interview and record review on 6/13/25 at 1:09 p.m. with Registered Nurse (RN) 1, Resident 29's physician orders titled, Order Summary Report, dated 5/23/2025, the physician orders indicated Resident 29 had a regular diet with soft and bite-sized texture and mildly thick consistency. RN 1 stated the therapeutic diet Resident 29 was for him to easily chew and swallow his food to prevent choking. During a concurrent interview and record review on 6/13/2025 at 1:19 p.m. with RN 1, Resident 29's care plan titled, Patient with treatment diagnosis of dysphagia, dated 4/14/2025 was reviewed. The care plan interventions indicated speech therapy three times per week for four weeks. Resident 29's care plan titled, Resident exhibits or is at risk for impaired swallowing related to Parkinson's disease, dated 9/8/2023 was reviewed, the care plan interventions indicated to for Resident 29 to be in an upright position when swallowing food or drinks and encourage small sips/bites. RN 1 stated when there were changes from the resident using the g-tube for medications to being able to orally take the medications the care plan interventions needed to be revised. RN 1 stated Resident 29 still needed to be monitored when taken the medications since he was at risk for dysphagia. RN 1 stated the staff would monitor Resident 29 for coughing or choking when taken the medications. RN 1 stated if Resident 29 were to have distress the care plan would indicate to notify the physician. During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/2021, the P&P indicated care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. The P&P indicated the facility was to develop a comprehensive care plan that incorporates identified problem areas, incorporate risk and contributing factors associated with identified problems, reflect treatment goals, timetables, and objectives in measurable outcomes. During a review of the facility's policy and procedure there were no policy for revised care plan once the triggers (events, situations, or stimuli that initiate a specific response or action, often related to patient care or safety) were identified and/or changed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to follow the physician's orders to not give losartan (a medication used to control blood pressure) for one out of one resident (Resident 84) when the systolic blood pressure (SBP- the top number of a blood pressure reading) was less than 110 millimeters of mercury (mmHg- unit of measurement). This deficient practice had the potential for Resident 84 to experience adverse effects related to receiving losartan when her blood pressure was too low and could result in dizziness and falls. Findings: During a review of Resident 84's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 84 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included syncope (fainting or passing out), and hypertension (high blood pressure). During a review of Resident 84's Minimum Data Set (MDS - a resident assessment tool) dated 4/7/2025, the MDS indicated Resident 84 was cognitively intact (ability to reason, understand, remember, judge, and learn) and did not have impairments of the lower extremities (related to the legs). During a review of Resident 84's Order Summary Report, the Order Summary Report indicated Resident 84 had an order to receive losartan 25 milligrams (mg) one time a day for hypertension and to hold for SBP less than 110 mmHg. During a review of Resident 84's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), Resident 84's blood pressure was 105/70 on 6/1/2025, 100/60 on 6/6/2025 and losartan was given on both those dates. During a concurrent interview and record review on 6/13/2025 at 8:29 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 84's June 2025 MAR for losartan was reviewed. LVN 3 stated the losartan should not have been given on 6/1/2025 and 6/6/2025 because her SBP was too low, and the order indicated to not give the losartan if it was below 110. LVN 3 stated by giving the losartan when the SBP was low, it could cause the resident to be dizzy, pass out, fall and hit her head. During a review of the facility's policy and procedure (P&P) titled Medication Administration- General Guidelines, dated 10/2017, the P&P indicated medications are administered in accordance with written orders of the physician.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to ensure one out of five sampled residents (Resident 77) was allowed to eat meals out of her bed. This deficient practice of not taking Resident 77 out of bed during mealtimes had the potential for the resident to decline in mobility (a patient's ability to move and change body positions, encompassing the physical capacity to perform functional movements and the independence to carry out daily activities) during activities of daily living ([ADL] -routine tasks/activities to perform daily care for themselves). Findings: During a review of Resident 77's admission Record, the admission Record indicated Resident 77 was admitted to the facility on [DATE]. Resident 77 diagnoses included epilepsy (a neurological disorder characterized by recurring, unprovoked seizures due to abnormal electrical activity in the brain), cerebral infraction (the death of brain tissue due to a lack of blood flow), dysarthria (motor speech disorder), and diabetes mellitus([DM] -a disorder characterized by difficulty in blood sugar control and poo wound healing). During a review of Resident 77's History and Physical (H&P), dated 11/20/2024, the H&P indicated Resident 77 had no decision-making capacity. During a review of Resident 77's Minimum Data Set ([MDS]- a resident assessment tool), dated 4/21/2025, the MDS indicated Resident 77's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 77 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) on staff for eating, showering, toileting hygiene, and dressing. The MDS indicated Resident 77 had functional limited range of motion to upper extremities (shoulder, elbow, wrist, and hands) and lower extremities (hip, knee, ankle, and foot). During an observation Resident 77 was in her bed eating and was not taken out of the bed during mealtimes on 6/10/2025 to 6/12/2025 at 8:15 a.m. and 12:30 p.m. during breakfast and lunchtime. During a review of Resident 77's physician orders titled, Order Summary Report, dated 12/2/2024, the physician orders indicated Resident 77 was to be taken out of the bed daily during mealtimes. During a review of Resident77's care plan titled, Resident is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, related to limited mobility, dated 11/18/2024, the care plan interventions did not include removing Resident 77 from the bed during mealtimes. During a concurrent observation and interview on 6/12/2025 at 8:15 a.m. with Resident 77, in her room, Resident 77 was lying in the bed eating breakfast. Resident 77 stated the staff did take her out of the bed during mealtimes. Resident 77 stated she would like to get out of the bed to eat, if the staff would help her to get out of the bed. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/12/2025 at 8:40 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 77's physician orders titled, Order Summary Report, dated 12/2/2024 was reviewed. The physician orders indicated Resident 77 was to be taken out of the bed daily during mealtimes. LVN 2 stated I have not seen Resident 77 out of bed during mealtimes. LVN 2 stated the staff should asked and put the resident out of bed to chair during mealtimes. LVN 2 stated it was important for Resident 77 to out of bed to chair to improve the resident circulation (the continuous flow of blood throughout the body) to prevent pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and mobility. LVN 2 stated taken Resident 77 out of bed during mealtimes could help with mental health (the state of well-being where individuals can cope with life stresses and realize their abilities) just being in a new position. During an interview on 6/12/2025 at 2:40 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she passes the meal trays to Resident 77 and set up the meal trays to eat while the resident was in bed. CNA 4 stated she was not aware that Resident 77 was to be taken out of the meal during mealtimes. CNA stated taken Resident 77 out of bed would keep her motivated, improve on her body movements, and prevent the decline in her ability to move her body. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, dated 3/2018, the P&P indicated Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The P&P indicated appropriate care, and services will be provided included mobility (transfer and ambulation, including walking), dining, and care and services to prevent or minimize functional decline.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure certified nurse assistant (CNA) 5 placed the low air loss mattress ([LALM]- an air mattress used to prevent pressure sores) on static mode (mattress setting that provides a firm, even surface for the user by inflating all air cells) and provide two-person assistance when changing Resident 97 on a LALM. This deficient practiced resulted in Resident 97 rolling off the bed while being changed by CNA 5. Findings: During a review of Resident 97's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 97 was admitted on [DATE] with diagnoses that included muscle weakness, and encephalopathy (a broad range of conditions that cause brain dysfunction). During a review of Resident 97's Order Summary Report, the Order Summary Report indicated Resident 97 had an order placed on 5/2/2025 for the use of a LALM for skin management. During a review of Resident 97's Minimum Data Set (MDS - a resident assessment tool) dated 5/2/2025, the MDS indicated Resident 97 had moderately impaired cognition (ability to reason, understand, remember, judge, and learn) and was dependent on staff for all forms of mobility. During a review of Resident 97's Progress Notes on 6/4/2025 at 7:33 a.m., the Progress Note indicated Resident 97 fell out of bed during patient care at approximately 5:30 a.m During an interview on 6/12/2025 at 7:15 a.m. with CNA 5, CNA 5 stated she was changing Resident 97 around 5:30a.m.- 6:00a.m. when Resident 97 rolled over and fell on the right side of the bed. CNA 5 stated she was standing on the left side of the bed with Resident 97 facing the left side when she walked over to the right side of the bed and Resident 97 rolled over and fell to the floor. CNA 5 stated she did not know how Resident 97 fell but was told later that when changing someone on a LALM they had to put the setting of the LALM on static and have two-person assist when changing a resident on a LALM. During an interview on 6/12/2025 at 2:28 p.m. with Registered Nurse (RN) 1, RN 1 stated when a resident is on a LALM and needs to be changed, the LALM must be in the static mode and not the usual alternating mode meaning the air in the LALM would alternate in different areas of the mattress and shifts around. RN 1 further stated there would need to be two staff members to change a resident on a LALM to prevent them from sliding. RN 1 sated if it is in the alternating mode, the resident could roll off so the LALM needs to be on static. During a review of the In-Service Lesson Plan, titled Low Air Loss Mattress Lesson Plan (2 persons assist), undated, the In-service Lesson Plan indicated the course content included the purpose and features of a LALM and when and why a two-person assist is needed along with safety considerations. It further indicated a two-person assist is needed when the resident is immobile, has medical equipment attached, or needs repositioning on a LALM.

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F 0756 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure the Medication Regimen Review (MRR- a review of medications to identify problems/errors) for one of two sampled residents (Resident 24) was reviewed by the doctor to approve or not approve the pharmacist's recommendation for the month of May. This failure had the potential to result in side effects that could go undetected by licensed staff and delay for the physician to act upon irregularities. Findings: During a review of Resident 24's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 24 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included atrial fibrillation (a heart condition where the heart's upper chambers beat irregularly and rapidly, disrupting blood flow), and heart failure (heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 24's Order Summary Report, the Order Summary Report indicated Resident 24 had an order for amiodarone (a medication used to treat irregular heart rhythm) 100 milligrams (mg) to be taken twice a day and to hold the medication if the heart rate is less than 60,and carvedilol 12.5 mg to be taken twice a day and to hold the medication if the heart rate is less than 60. During a review of Resident 24's Care Plan, dated 5/9/2025, the Care Plan indicated Resident 24 was at risk for cardiovascular (refers to the heart and blood vessels) symptoms or complications related to atrial fibrillation and heart failure. Interventions included to administer medications as ordered and to assess for side effects and report abnormalities to the doctor. During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool) dated 5/12/2025, the MDS indicated Resident 24 was cognitively intact (ability to reason, understand, remember, judge, and learn) and had impairments of the upper extremities (related to the arms). During a review of the MRR dated 5/27/2025, the MRR indicated the pharmacist recommended that because Resident 24 was on both amiodarone and carvedilol; based on manufacturer recommendation, administering both medications may enhance the beta blocking (a class of medications that cause the heart to beat more slowly and with less force) properties of carvedilol where monitoring of signs of bradycardia is recommended. There were no indications on the MRR that indicated a physician had reviewed the MRR and agreed or disagreed with the pharmacists' recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/13/2025 at 9:00am with Registered Nurse (RN) 1, Resident 24's MRR was reviewed. RN 1 stated the MRR is usually reviewed by the DON and kept in the DON's office and if requested by the DON, the RN would review it as well. RN 1 stated they would speak with the doctor and inform them of the pharmacist's recommendation and see if they agree or disagree with the recommendation and place an additional order if the doctor agrees. RN 1 reviewed Resident 24's MRR for the month of May and stated there was no documentation on the form to show the physician reviewed this recommendation. RN 1 further stated she was not asked by anyone to review the MRR for the month of May and the DON has since resigned. RN 1 stated it was important to have the doctor review the MRR, if not the medications prescribed would not be followed up on and changes would not be made for the resident. During a review of the facility's policy and procedure (P&P) titled Consultant Pharmacist Reports, dated 6/2021, the P&P indicated recommendations are acted upon and documented by facility staff and or the prescriber. The physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication error by failing to administer clonidine (a medicine used to treat high blood pressure) within the administration parameters (instructions in the medication order to give the medication if the blood pressure reading is high) a total of 33 times between 3/19/2025 and 6/11/2025 affecting one of three residents sampled for unnecessary medications (Resident 12.) The deficient practice of failing to administer clonidine as ordered had a potential to place Resident 12 at risk for adverse effects of uncontrolled high blood pressure such as heart attack, stroke, vision loss or other serious complications. Findings: During a review of Resident 12's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), cardiac arrhythmia (a condition where the heart beats too fast, too slow, or irregularly), and hyperkalemia (a condition where there is too much potassium [an essential mineral vital for numerous bodily functions] in the blood). During a review of Resident 12's Order Summary Report dated 6/12/2025, the order summary report indicated an order dated 3/18/2025 for the medicine clonidine HCL 0.1 mg (milligrams - a metric unit of measurement, used for medication dosage), by mouth every six hours as needed for SBP (systolic blood pressure - the top number in a blood pressure reading) greater than 150. During a review of Resident 12's History and Physical Examination (H&P), the H&P indicated Resident 12 has the ability to understand and make decisions. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), the MDS indicated Resident 12 has the ability to make self understood and to understand others. The MDS also indicated Resident 12 required substantial/maximal assistance (helper does more than half the effort) for bathing, toileting, and dressing. During an interview on 6/12/2025 at 9:06 am with Resident 12, Resident 12 stated he does not remember all the medications he takes and would not know if clonidine was given to him. Resident 12 also stated he does not ask questions about his blood pressure and would trust that the nurses give him his medication when they are supposed to. During a concurrent interview and record review on 6/12/2025 at 9:21 am with Licensed Vocational Nurse (LVN) 4, Resident 12's MAR (Medication Administration Record) for March, April, May, and June 2025 were reviewed. LVN 4 stated the parameters for giving the clonidine are there for lowering the Residents' blood pressure if the top number is above 150. LVN 4 stated the MAR indicates the blood pressure was checked every six hours as ordered but none of the MAR's show the clonidine was given due to the blank spaces under the dates where the nurse would initial after administration. LVN 4 stated, not giving the clonidine could have resulted in Resident 12 having a stroke or something worse such as death from his uncontrolled blood pressure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy & Procedures (P&P) titled Medication Administration - General Guidelines dated October 2017, the P&P indicated medications are administered in accordance with written orders of the attending physician. The P&P also indicated the resident's MAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the safe provision of pharmacy services for two of three sampled residents (Resident 94 and 17) when: 1. Resident 94 ' s supplements were not labeled with resident ' s name and date of birth . 2. Resident 17 ' s box of morphine medication was labeled with another resident ' s medication label This failure had the potential to result in medication errors. Findings: During a review of Resident 94 ' s admission Record (Face sheet), the admission Record indicated the facility admitted Resident 94 on 2/22/2025 and was readmitted on [DATE] with diagnosis including intraspinal abscess and granuloma (pus inside or around the spinal cord and collection of immune cells that form in response to infection), sepsis (a life-threatening blood infection), anemia (a condition where the body does not have enough healthy red blood cells), opioid dependence with withdrawal (body has become used to having pain killers and stopping them causes pain), and spinal stenosis (spaces within the spine narrow and cause pain). During a review of Resident 94 ' s History and Physical (H&P) dated 3/2/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 94 ' s Minimum Data Set (MDS- a resident assessment tool) dated 4/14/2025, the MDS indicated the Resident 94 had intact cognition (ability to think and reason) and required substantial/maximal assistance (helper does more than half the effort) from the staff with upper body dressing, toileting hygiene, bathing/shower self, and sit to standing. During on observation on 6/11/2025 at 3:48 p.m., Resident 94 ' s multivitamin supplements were stored in the facility ' s medication cart without the resident ' s name and date of birth . The supplements were only marked with the resident ' s room number. During an interview on 6/11/2025, at 3:55 p.m. with Registered Nurse (RN) 2 stated, the vitamin bottles should have the Resident 94 ' s name on it. RN 2 stated the facility writes the resident ' s name and date of birth as resident identifiers. RN 2 stated if the supplement was only labeled with the room number, if the resident was moved to another room, the supplements could have been given to the wrong resident. During an interview on 6/12/2025, at 9:43 a.m. with Licensed Vocational Nurse (LVN) 3 stated, medications including over the counter vitamins should have a label with Resident 94 ' s name. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 17 ' s admission Record, the admission Record indicated the facility admitted Resident 17 on 10/06/2023 and was readmitted on [DATE] with diagnosis including Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), osteoporosis (weak and brittle bones), pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), spinal stenosis(spaces within the spine that narrow and cause pain), chronic pain (pain that lasts longer than three months) and polyosteoarthritis (generalized osteoarthritis). During a review of Resident 17 ' s Minimum Data Set (MDS- a resident assessment tool) dated 4/10/2025, the MDS indicated the Resident 17 had severe cognitive (ability to think and reason) impairment and was dependent (helper does all of the effort) from the staff for personal hygiene, oral hygiene, eating, toileting hygiene, shower/bathing, upper and lower body dressing, sit to lying and chair/bed to chair transfer. During on observation on 6/11/2025 at 3:10 p.m., Resident 17 ' s medication box containing Morphine Sulfate Solution (narcotic pain medication) that was stored in the medication cart had another resident ' s medication label affixed the on the box. During an interview on 6/11/2025, at 3:12 p.m. with Licensed Vocational Nurse (LVN) 3 stated, having another resident ' s medication label on Resident 17 ' s medication box can cause a medication error. LVN 3 stated the label was from a resident who was no longer in the facility. During a review of the facility ' s policy and procedure (P&P) titled, Medication Labels dated 4/20, the P&P indicated, the resident name, at least, must be maintained directly on the actual product container . Nonprescription medications not labeled by pharmacy are kept in the manufacturer ' s original container and identified with the resident ' s name. Medication containers having soiled, damaged, incomplete, illegible, confusing labels are returned to the dispensing pharmacy for relabeling or destroyed in accordance with the medication destruction policy. Improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to: 1. Ensure one of five sampled residents (Resident 29) physician orders were updated when the Licensed staff received a telephone order. This deficient practice of not updating physician orders had the potential to cause the Licensed staff to administer the medication the incorrect route. 2. Complete an initial Body Check for one of three sampled residents (Resident 88), by not documenting the status of her skin upon admission. This deficient practice of failing to do an initial skin assessment, caused Resident 88's medical records to be incomplete. Findings: 1. During a review of Resident 29's admission Record, the admission Record indicated Resident 22 was admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 29 diagnoses gastronomy ([g-tube]- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), gastro-esophageal reflux disease([GERD]- stomach acids flow back up into esophagus and causes heartburn), and dysphagia (difficulty or discomfort in swallowing). During a review of Resident 29's History and Physical (H&P), dated 4/18/2025, the H&P indicated Resident 29 had the capacity to understand and make decisions. During a review of Resident 29's Minimum Data Set ([MDS]- a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 29's cognition (ability to learn, reason, remember, understand, and make decisions) was moderate cognitive impaired. The MDS indicated Resident 29 required substantial/maximal assistance (helper does [NAME] than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) from staff for showering, toileting hygiene, and dressing. The MDS indicated Resident 29 had a swallowing disorder due to coughing or choking during meals or when swallowing medications. The MDS indicated Resident 29 nutritional approaches were to have a mechanical altered diet (require change in texture of food or liquids). During a record review of Resident 29's physician orders titled, Order Summary Report, dated 4/15/2025, the physician orders indicated to flush g-tube with 15 cubic centimeters ([cc] - a unit of volume used to measure liquid medication dosages and other fluid volumes in patient care) of water post completion of medication administration every shift. There were no physician orders on the Order Summary Report to give the medications by mouth. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/12/2025 at 9:56 a.m. with Licensed Vocational Nurse (LVN) 2, the physician orders were reviewed. Resident 29's physician orders titled, Order Summary Report, dated 4/15/2025, the physician orders indicated to flush g-tube with 15 cubic centimeters ([cc] - a unit of volume used to measure liquid medication dosages and other fluid volumes in patient care) of water post completion of medication administration every shift. LVN 2 stated there were no physician orders on the Order Summary Report to give the medications by mouth. LVN 2 stated there was a physician order given for Resident 29 to swallow his medications but could not remember when the order was given. LVN 2 stated it was important to update and transcribe the orders once the physician change the route of the medication. LVN 2 stated clarification withy the physician was needed to verify the correct route of the medication to avoid Resident 29 from aspirating (the process where food, liquid, salvia, vomit enters the lungs instead of the stomach various factors, including impaired swallowing). During a telephone interview on 6/12/2025 11:27 a.m. with Medical Doctor (MD), the MD stated she had telephoned vis text that it was okay to allow Resident 29 to take medications by mouth on 4/26/2025. The MD stated, not having the orders and interventions clear it could cause confusion for the staff and myself. During a concurrent interview and record review on 6/12/2025 at 9:56 a.m. with Registered Nurse (RN) 1, the physician orders were reviewed. Resident 29's physician orders titled, Order Summary Report, dated 4/15/2025, the physician orders indicated to flush g-tube with 15 cubic centimeters ([cc] - a unit of volume used to measure liquid medication dosages and other fluid volumes in patient care) of water post completion of medication administration every shift. RN 1 stated the process is to review the physician orders first before administering the medications to Resident 29. RN 1 stated an order was to be placed and documented in the physician orders for Resident 29 to have the pills by mouth. RN 1 stated once the physician order was received it was to be placed in the physician order right away. RN 1 stated it was important to get clarification for the staff to administer the medications safely to prevent choking. During a review of the facility's policy and procedure (P&P) titled, Nursing Documentation, dated 6/2022, the P&P indicated nursing documentation will follow the guidelines of good communication be concise, clear, pertinent, and accurate based on the resident's condition, situation, and complexity. The P&P indicated a timely entry of documentation must occur as soon as possible after the provision of care. 2. During a review of Resident 88's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission record indicated Resident 88 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness, diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood as well as they should.) During a review of Resident 88's Surgical Consult dated 11/21/2024, the surgical consult indicated Resident 88 had a wound located on the inter gluteal fold (the vertical groove located between the buttocks). During a review of Resident 88's History and Physical Examination (H&P) dated 5/5/2025, the H&P indicated Resident 88 had fluctuating capacity to understand and make decisions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 88's Minimum Data Set (MDS - a resident assessment tool) dated 5/15/2025, the MDS indicated Resident 88 was at risk of developing pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence - area where bone is physically projecting out.) The MDS also indicated Resident 88 had one deep tissue injury (pressure injury with damage to underlying soft tissue.) During a concurrent interview and record review on 6/13/2025 at 2:00 pm, with Registered Nurse (RN) 1, Resident 88's document titled Body Check dated 11/19/2025, was reviewed as incomplete. RN 1 stated she was unsure why it was not done the day Resident 88 was admitted . RN 1 stated it was important to have the skin assessment done to determine what skin issues Resident 88 had upon admission and to establish a baseline. During a review of the facility's Policy & Procedure (P&P) titled Nursing Documentation dated 6/27/2022, the P&P indicated the purpose of nursing documentation is to communicate the resident's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. During a review of the facility's P&P titled Pressure Ulcers/Skin Breakdown - Clinical Protocol undated, the P&P indicated The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure staff disposed of a used protective personal equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) inside the resident ' s room instead of the hallway. This failure had the potential to increase the chances of acquiring infections and for germs to be transmitted in between residents. Findings: During an observation on 6/10/2025 at 9:17 a.m. Licensed Vocational Nurse (LVN) 4 came out of Resident 4 and Resident 93 ' s room with a used PPE gown still on and proceeded to remove it and throw the gown away in a linen hamper located outside the resident ' s room and in the facility hallway. During an interview on 6/10/2025, at 1:50 p.m., LVN 4 stated, the gown should have been thrown away inside the resident ' s room. Doffing (putting on) outside the room can cause cross contamination and spread of infections. During an interview on 6/12/2025, at 2:07 p.m. with the Infectious Prevention Nurse (IPN) stated, if PPE was disposed outside of the residents ' rooms, this can cause the spread of germs and other residents can get sick. The IPN stated used PPE needs to be disposed of prior to exiting a resident ' s room. During an interview on 6/13/2025, at 11:32 a.m. with the Interim Director of Nursing (IDON) stated, throwing away PPE in the hallway and not in the resident's room, will be a break in infection control practice and causes cross contamination. During a review of the facility ' s policy and procedure (P&P) titled, Personal Protective Equipment Gowns . Infection Control revised on 12/2023, the P&P indicated, When gowns are used, they must be used only once and discarded into appropriate receptacles located in the room . Soiled gowns must be removed prior to leaving the work area and discarded into the appropriate receptacle located in the work area.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility failed to ensure 23 of 36 resident's rooms (rooms 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 22, 23, 24, 28, 29, 30, 31, 32, 33, 34, 35, 36) met the requirement of 80 square feet (sq. ft.) per resident in a multiple resident room. This deficient practice had the potential for inadequate space for resident care and personal property and the inability to move around the room easily. Findings: During a facility tour and observation on 6/10/24 at 4:02 PM, residents in rooms 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 22, 23, 24, 28, 29, 30, 31, 32, 33, 34, 35, 36 were able to move in and out of their rooms and had space for their personal property. During a review of the facility's Client Accommodations Analysis form, completed by the Maintenance Director (MS) indicated 23 resident rooms did not meet the space requirement in a multiple resident room. During an interview on 6/13/2025 at 9:32 AM, the Administrator (ADM) stated resident care was not affected due to the room sizes being out of compliance. The waiver request for bedroom to measure at least 80 sq. ft. letter dated 6/13/2024, submitted by the administrator for 23 resident rooms was reviewed. The waiver request letter indicated there was adequate space for resident care, and the health and safety of residents occupying the rooms are not in jeopardy. The waiver request letter indicated the following rooms did not meet the 80 sq. ft. requirement: Rooms Number of beds Square Feet 2 3 228 3 3 228 4 (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3 228 5 3 228 7 3 228 8 3 228 9 3 228 10 3 228 11 3 228 12 3 228 13 (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3 228 22 3 228 23 3 228 24 3 228 28 3 228 29 3 228 30 3 228 31 3 228 32 (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3 228 33 3 228 34 3 228 35 3 228 36 3 228