STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555010	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Post Acute	1201 Walnut Avenue Long Beach, CA 90813

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an informed consent was obtained prior to administering amphetamine-dextroamphetamine ([Adderall] a psychotropic [any drug that affects a person's mental state, emotions, thoughts, or behavior] medication used to treat attention-deficit hyperactivity disorder [ADHD - a condition that makes it difficult to focus, stay organized and control restlessness) for one of four sampled residents (Resident 1).This failure resulted in Resident 1 receiving Adderall without documented informed consent, and without being informed of the medication's purpose, dose, risks, benefits and alternatives prior to administration. This failure had the potential for Resident 1 to receive unnecessary medications. Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including generalized anxiety disorder (extreme worry), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), recurrent, severe (serious depression that comes back repeatedly and significantly affects daily functioning) with psychotic symptoms (hearing or seeing things that are not there or having strong false beliefs), and ADHD.During a review of Resident 1's History and Physical (H&P), dated 3/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and required supervision or touching assistance (helper provides verbal cues, steadying and/or contact guard assistance as resident completes activity) from staff for eating, oral hygiene, toileting, bathing, upper/lower body dressing and personal hygiene. During a review of Resident 1's Initial Psychiatric Evaluation, dated 3/20/2026, the Initial Psychiatric Evaluation indicated Resident 1 had a diagnosis of ADHD. The Initial Psychiatric Evaluation further indicated Resident 1 was currently receiving Adderall 20 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) daily as a psychotropic medication and the plan was to continue the Adderall 20 mg daily.During a review of Resident 1?s Order Summary Report (Physician' s Orders) dated 3/31/2026, the Physician' s Order indicated an order was placed for Resident 1 to receive Adderall 20 mg by mouth one time a day for ADHD ordered on 3/21/2026. 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), dated 3/2026, the MAR indicated Adderall was administered to Resident 1 every day from 3/21/2026 through 3/31/2026.During a review of Resident 1's MAR dated 4/2026, the MAR indicated Adderall was administered to Resident 1 every day from 4/1/2026 through 4/30/2026.During a review of Resident 1's MAR dated 5/2026, the MAR indicated Adderall as administered to Resident 1 every day from 5/1/2026 through 5/5/2026.During a review of Resident 1's Interdisciplinary Team (IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) Conference Note, dated 3/25/2026, the IDT Conference Note indicated Resident 1 inquired about the next psychiatric visit to discuss the Adderall dosing with the medical doctor. The IDT Conference Note indicated Resident 1 would be notified once (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility was aware of the next psychiatric visit date. During an interview on 4/28/2026 at 11:17 a.m., Resident 1 stated she took Adderall 20 mg three times a day prior to her admission to the facility. Resident 1 stated the facility administered Adderall 20 mg to her once a day. Resident 1 stated she had not been informed why the Adderall dose was changed and requested to speak with the psychiatrist (a medical doctor who diagnoses and treats mental health conditions) regarding the Adderall dose change.During a concurrent interview and record review on 5/4/2026 at 3:53 p.m., with the Registered Nurse Supervisor (RNS) 1, Resident 1's Medical Records was reviewed. RNS 1 stated there was no informed consent for Adderall and stated she was not sure if Adderall was considered a psychotropic medication. RNS 1 stated if Adderall was considered a psychotropic medication, then there should have been an informed consent completed prior to Resident 1 receiving Adderall. RNS 1 stated an informed consent for psychotropic medications was important because the informed consent acknowledged the resident knew the medication, route, potential side effects, and non-pharmacological interventions. RNS 1 stated the informed consent reduced residents' questions about medications because residents knew what they were taking and what to expect from the medication.During an interview on 5/5/2026 at 11 a.m., Resident 1 stated she never signed an informed consent for Adderall or reviewed the Adderall medication dose with a doctor. Resident 1 stated the facility record indicated a diagnosis of stimulant abuse, but the facility prescribed Adderall which was a stimulant. Resident 1 stated she wanted provider clarification regarding the stimulant abuse diagnosis and why she was ordered a stimulant if she was diagnosed with a stimulant abuse. During a review of Resident 1's email, dated 5/5/2026 at 3:05 p.m., the email indicated staff presented Resident 1 with an informed consent form related to stimulant medication. The email indicated Resident 1 did not sign the informed consent form because the medical record contained disputed stimulant-related language while the facility prescribed and administered stimulant medication. The email indicated Resident 1 requested direct provider clarification regarding who ordered the medication and why the current dose and schedule differed from Resident 1's prior prescribed dose and schedule.During a review of the facility's policy and procedure (P&P) titled, Informed Consent, revised 4/2017, the P&P indicated if the attending physician, Physician Assistant (PA), or Nurse Practitioner (NP) prescribed, ordered, or increased an order for a psychotherapeutic medication, the Physician, PA, or NP shall obtain informed consent from the resident. The P&P indicated the facility shall verify informed consent prior to the administration of a psychotherapeutic medication. The P&P indicated the facility could have the licensed healthcare practitioner who ordered the therapy obtain informed consent from the resident or obtain a copy of the current informed consent from the facility where the therapy was started. The P&P indicated it was the responsibility of the physician, PA, or NP who ordered the therapy to obtain informed consent prior to initiation of therapy. The P&P indicated the physician, PA, or NP could not delegate the responsibility to the nurse to obtain consent. The P&P indicated information material to a decision concerning administration of a psychotherapeutic drug included the reason for treatment, nature of the treatment, nature, degree, duration, and probability of side effects and significant risks, reasonable alternative treatments and risks, why the treatment was recommended, and the resident's right to accept or refuse the proposed treatment.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the grievance process was followed for one of four sampled residents (Resident 1).This failure resulted in Resident 1's grievance regarding food preferences being marked resolved without the identified problem being corrected, without the responsible department being notified, and without follow-up to verify resolution. This failure resulted in Resident 1 continuing to receive unwanted processed deli meats after the grievance was filed and had the potential to negatively impact Resident 1's health and well-being. Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including attention-deficit hyperactivity disorder ([ADHD] a condition that makes it difficult to focus, stay organized and control restlessness), functional dyspepsia (ongoing stomach discomfort such as fullness, bloating, or mild pain without a clear medical cause), and constipation (difficulty having bowel movements or having fewer bowel movements than usual).During a review of Resident 1's History and Physical (H&P), dated 3/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and required supervision or touching assistance (helper provides verbal cues, steadying and/or contact guard assistance as resident completes activity) from staff for eating, oral hygiene, toileting, bathing, upper/lower body dressing and personal hygiene. The MDS indicated Resident 1 felt it was very important to have snacks available between meals. During a review of the facility's Grievance/Concern Log dated 3/2026, the Grievance/Concern Log indicated Resident 1 had one grievance reported on 3/24/2026. The Grievance/Concern Log indicated the grievance was reported by Resident 1, the incident took place on 3/24/2026, the result was noted as resolved, and the resolution date was 3/25/2026.During a review of Resident 1's Grievance/Concern Form, dated 3/24/2026, the Grievance/Concern Form indicated Resident 1 reported ongoing dietary concerns. The Grievance/Concern Form indicated Resident 1 reported she was served food items she did not request, and Resident 1 had already discussed meal preferences with staff. The Grievance/Concern Form indicated the concern was reported to the Business Development Director and the department addressing the concern was Social Services. The Grievance/Concern Form indicated Resident 1's dietary preferences were reviewed in detail and updated. The Grievance/Concern Form indicated nursing staff were reminded to reinforce and communicate updated dietary preferences to the dietary department promptly. The Grievance/Concern Form indicated the concern was completed on 3/25/2026. The Grievance/Concern Form indicated the dietary department was informed in person on 3/24/2026. The Grievance/Concern Form indicated correct meals were provided to Resident 1, Resident 1 was informed of corrective actions taken and expressed understanding, and the facility would continue to monitor meal accuracy to ensure compliance with Resident 1's preferences.During an interview on 4/28/2026 at 11:17 a.m., Resident 1 stated she was unable to eat the food served by the facility because the facility did not consistently provide food according to her preferences. Resident 1 stated she requested salads with chicken only, but the facility continued to serve salads with processed deli meat. Resident 1 stated she removed the processed deli meat from the salads and returned the processed deli meat to the kitchen. Resident 1 stated she had complained several times, but the kitchen continued to serve processed deli meat on meals after the grievance was filed. Resident 1 stated she understood grievances were filed by sending concerns directly to the Administrator (ADM). Resident 1 stated she sent concerns regarding food, privacy, medications, and dental care directly to the ADM by email.During a concurrent observation and interview on 4/28/2026 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:40 p.m., in Resident 1's room, Resident 1's lunch tray was observed with a salad. The salad included cheese, cucumbers, tomatoes, lettuce, carrots, and processed deli meat. Resident 1 stated the processed deli meat on the salad was the same meat she had repeatedly requested not be served.During an interview on 4/29/2026 at 3:30 p.m., with the Social Services Director (SSD), the SSD stated residents could file a grievance by completing a Grievance Form located outside the Social Services office. The SSD stated the facility investigated grievances, developed solutions, and referred grievances to the appropriate department for follow-up. The SSD stated grievances were reported to the Administrator (ADM), who participated in the grievance process. The SSD stated she was informed of Resident 1's dietary grievance and spoke with Resident 1 regarding the grievance. The SSD stated Resident 1 had an Interdisciplinary Team (IDT) meeting with nursing and dietary staff, and the IDT addressed Resident 1's food preferences, including what Resident 1 wanted and did not want in the salad. The SSD stated she followed up with Resident 1 the day after the grievance was filed. The SSD stated Resident 1 was upset and stated she still was not receiving the salad. The SSD stated she checked Resident 1's meal that day, and Resident 1 had received a salad. The SSD stated she did not remember Resident 1 stating she did not want processed meat on the salad.During a concurrent interview and record review on 4/30/2026 at 9:40 a.m., with the Registered Dietitian (RD), Resident 1's Grievance/Concern Form, dated 3/24/2026, was reviewed. The RD stated she was unaware of Resident 1's grievance regarding food preferences. The RD stated Resident 1's food preferences were documented on the Nutrition Services Progress Note, provided to the kitchen, and posted in the kitchen.During a concurrent interview and record review on 4/30/2026 at 11:40 a.m., with the Dietary Supervisor (DS), Resident 1's Grievance/Concern Form, dated 3/24/2026, was reviewed. The DS stated if a grievance involved the dietary department, the DS should receive the Grievance/Concern Form. The DS stated he did not receive Resident 1's Grievance/Concern Form and was not aware Resident 1 had filed a grievance regarding food preferences. The DS stated if he had known Resident 1 filed a grievance regarding food preferences, he would have followed up with Resident 1 to ensure Resident 1's food preferences were followed.During a review of a forwarded email from Resident 1, dated 5/5/2026 and timed at 2:59 p.m., the email included a photo of a plate card (meal ticket) showing chef salads for lunch and dinner with extra meat, chicken only, and no eggs or processed meats in salads. The email indicated there was additional photographs showing facility-served meals and salads with chopped processed/deli-style meat despite the plate card instruction. During a concurrent interview and record review on 5/5/2026 at 4:04 p.m., with the ADM, the facility's Grievance Procedure policy and procedure (P&P) was reviewed. The ADM stated the SSD was the grievance official and responsible for grievances. The ADM stated grievances involving the dietary department were referred to dietary, and dietary followed up with the resident. The ADM stated the RD and DS knew about Resident 1's grievance regarding food preferences. The ADM stated the facility completed the grievance process for Resident 1's grievance but did not provide documentation of the completed grievance process. The ADM stated the facility did not complete the regular grievance process because the facility could not complete an IDT meeting with Resident 1. The ADM stated Resident 1 wanted the grievance by email, and the facility could not complete the grievance process as indicated in the facility's Grievance Procedure P&P.During a review of the facility's policy and procedure (P&P) titled, Grievance Procedure, revised 1/2017, the P&P indicated the resident had the right to and the facility must make prompt efforts to resolve grievances the resident, responsible party, other family members, or advocates may have. The P&P indicated any resident, responsible party, family member, or advocate may file a grievance or complaint concerning the resident's treatment, medical care, behavior of other residents or staff members, without fear of discrimination or reprisal in any form. The P&P indicated grievances should be submitted in writing but may include verbal complaints. The P&P indicated the Grievance Official for the facility was the ADM, who was responsible for overseeing the grievance process. The P&P indicated the resident or person filing the grievance on behalf of the resident would be informed of the findings of the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation and actions to correct any identified problems, unless the grievance was filed anonymously. The P&P indicated the results of the grievance would be reported within ten working days of filing the grievance or complaint with the facility and would include the date the grievance was received, the summary of steps taken to investigate it, a summary of the resolution with a statement whether the grievance was confirmed or not, and any corrective action taken. The P&P indicated the ADM was responsible for taking appropriate corrective action in accordance with state law if the violation of resident rights was substantiated and would maintain evidence demonstrating the resolution for at least three years. The P&P indicated grievances filed and the resulting investigations by the facility would be reviewed monthly during the monthly Quality Assurance Performance Improvement ([QAPI] a data driven proactive approach to improvement used to ensure services are meeting quality standards) meeting to ensure appropriate measures were taken to investigate the grievance.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set ([MDS] - a resident assessment tool) accurately reflected the active diagnoses of one of four sampled residents (Resident 1). This failure resulted in inaccurate diagnoses, incomplete nutritional assessments, and Care Plans that did not reflect Resident 1's gastric sleeve surgery (a surgery which permanently reduces stomach size and affects how much and what types of food the resident can tolerate), loose teeth, autism diagnosis (a developmental condition that affects how the resident understands information, communicates, interacts with others, and responds to sensory input), history of eating disorders, chewing problems, or food intolerances. These failures had the potential to negatively affect Resident 1's nutritional management, dietary tolerance, and individualized plan of care. Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses generalized anxiety disorder (ongoing excessive worry or nervousness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) , insomnia (trouble falling asleep or staying asleep), nightmare disorder (repeated bad dreams that disturb sleep), attention-deficit hyperactivity disorder (ADHD - a condition that makes it difficult to focus, stay organized and control restlessness), functional dyspepsia (ongoing stomach discomfort such as fullness, bloating, or mild pain without a clear medical cause), and constipation (difficulty having bowel movements or having fewer bowel movements than usual). During a review of Resident 1's History and Physical (H&P), dated 3/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and required supervision or touching assistance (helper provides verbal cues, steadying and/or contact guard assistance as resident completes activity) from staff for eating, oral hygiene, toileting, bathing, upper/lower body dressing and personal hygiene. The MDS indicated Resident 1 felt it was very important to have snacks available between meals. The MDS did not include Resident 1's autism, eating disorder, gastric sleeve surgery, or dental concerns. During a review of Resident 1's General Acute Care Hospital (GACH) Psychiatric Evaluation, dated 2/23/2026, the Psychiatric Evaluation indicated Resident 1 was diagnosed with autism and had eating disorders in the past. During a review of Resident 1's GACH History and Physical (H&P), dated 2/24/2026, the H&P indicated Resident 1 had gastric sleeve surgery in 2017 and had a loose right front tooth (a dental condition that can affect chewing and food intake). During a review of Resident 1's admission Diagnosis List, dated 3/11/2026, the admission Diagnosis List did not include autism, history of eating disorders, gastric sleeve surgery in 2017, a loose right front tooth, toothache, or chewing problems. During a review of Resident 1's Nutrition Risk Assessment, dated 3/11/2026, the Nutrition Risk Assessment indicated Resident 1 had teeth or dentures in good condition and Resident 1 had good food intake. The Nutrition Risk Assessment did not indicate Resident 1 had loose teeth, toothache, gastric sleeve surgery, autism, eating disorder history, food intolerances, chewing problems, or swallowing problems. During a review of Resident 1's Gastrointestinal (GI) Distress Care Plan, dated 3/11/2026, the Care Plan indicated Resident 1 had dyspepsia. The Care Plan did not include Resident 1's gastric sleeve history or intolerance to certain foods related to the gastric sleeve. During a review of Resident 1's Oral/Dental Care Plan, dated 3/11/2026, the Care Plan indicated Resident 1 had loss of appetite, refusal to eat and behavior. The Care Plan's goals indicated Resident 1 will not complain of mouth pain and dental pain related to poor teeth condition. The Care Plan did not include Resident 1's loose teeth, chewing difficulty, or the need for modified textures due to dental status. During a review of Resident 1's admission Diagnosis List, dated 3/12/2026, the Admissions Diagnosis List did not include Resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated one important function of the MDS assessment was to generate an updated, accurate picture of the resident's current health status. The RAI Manual indicated active diseases and infections drove the current plan of care. The RAI Manual indicated medical record sources for diagnoses included progress notes, the most recent H&P, transfer documents, discharge summaries, diagnosis/problem list, and other available resources. The RAI Manual indicated active diagnoses had a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, or nursing monitoring. The RAI Manual indicated diseases coded in the categories were not limited to the diseases listed as examples, and if a disease or condition was not specifically listed, the diagnosis was entered in Additional Active Diagnoses.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered Care Plan for Resident 1's autism (a developmental condition that affects how the resident understands information, communicates, interacts with others, and responds to sensory input) and bathing preferences/barriers for one of four sampled residents (Resident 1). This failure resulted in Resident 1's Care Plans not reflecting individualized interventions for cognitive, behavioral, hygiene, and physical care needs. This failure had the potential to negatively affect Resident 1's individualized care, hygiene, and overall well-being.Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses generalized anxiety disorder (ongoing excessive worry or nervousness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) , insomnia (trouble falling asleep or staying asleep), nightmare disorder (repeated bad dreams that disturb sleep) and attention-deficit hyperactivity disorder (ADHD - a condition that makes it difficult to focus, stay organized and control restlessness). During a review of Resident 1's History and Physical (H&P), dated 3/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 3/17/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and required supervision or touching assistance (helper provides verbal cues, steadying and/or contact guard assistance as resident completes activity) from staff for eating, oral hygiene, toileting, bathing, upper/lower body dressing and personal hygiene. The MDS indicated Resident 1's preference to choose between a tub bath, shower, bed bath, or sponge bath and to have snacks available between meals were very important. During a review of Resident 1's General Acute Care Hospital (GACH) Psychiatric Evaluation, dated 2/23/2026, the Psychiatric Evaluation indicated Resident 1 was diagnosed with autism (a developmental condition that affects communication, social interaction, learning, and sensory processing) and had eating disorders in the past.During a review of a forwarded email from Resident 1 to the facility's Administrator (ADM) and Social Services Director (SSD), date sent 4/30/2026 at 12:43 p.m., the email indicated Resident 1 requested the facility include autism in Resident 1's record and identify care approaches related to Resident 1's autism. The email indicated Resident 1 requested advance notice, scheduled therapy times, a clear therapy plan before each session, staff identification by name and role, communication in writing, when possible, a private setting for sensitive discussions, and assignment to therapy staff Resident 1 could work safely and calmly.During an interview on 4/30/2026 at 3 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 1 refused her shower. CNA 2 stated CNA 2 did not know why Resident 1 refused her shower. CNA 2 stated CNA 2 asked Resident 1 every couple of hours, and if Resident 1 continued to refuse, CNA 2 reported the refusal to the charge nurse. CNA 2 stated Resident 1's showers were scheduled on Tuesdays and Saturdays, but Resident 1 could get a shower any day, and CNA 2 offered showers to residents every day. CNA 2 stated Resident 1 always refused showers when CNA 2 was assigned to Resident 1. CNA 2 stated when CNA 2 told the charge nurse Resident 1 still did not go take a shower, the charge nurse talked to Resident 1, but Resident 1 still refused.During a concurrent interview and record review on 5/4/2026 at 3:53 p.m., with Registered Nurse (RN) 1, Supervisor, Resident 1's Interdisciplinary Team (IDT) Notes, Care Plans, hospital discharge records, and psychiatric evaluation were reviewed. RN 1 stated Resident 1 declined showers and preferred to complete personal hygiene in Resident 1's room. RN 1 stated Resident 1's showers were not documented as refusals because completing personal hygiene in Resident 1's room was Resident 1's preference. RN 1 stated RN 1 did not know why Resident 1 declined showers. RN 1 stated if Resident (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Post Acute	1201 Walnut Avenue Long Beach, CA 90813

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 refused showers, the care team should have been notified, and the shower refusals should have been addressed in Resident 1's Care Plan. RN 1 stated Resident 1's Care Plans did not include shower refusals. RN 1 stated RN 1 did not know Resident 1 was uncomfortable taking showers or if discomfort was the reason Resident 1 declined showers. RN 1 stated a care plan should have been developed for Resident 1's showers, and staff should have attempted other approaches to get Resident 1 to shower. RN 1 stated, from a nursing perspective, staff needed to ensure Resident 1 had good skin care and prevent potential skin breakdown and infection. RN 1 stated staff should have followed up to ensure Resident 1 provided good hygiene for herself. RN 1 stated if Resident 1 was uncomfortable with a certain staff member, staff could have provided a staff member Resident 1 was more comfortable with. RN 1 stated if Resident 1 refused showers, staff should have attempted to educate Resident 1 regarding the importance of showers and determined why Resident 1 refused showers. RN 1 stated the refusal needed to be addressed to resolve the refusal. RN 1 stated before the investigation, RN 1 was unaware of Resident 1's diagnosis of autism. RN 1 stated Resident 1 did not have a care plan for autism. RN 1 stated the diagnosis for autism should have been completed by the admitting nurses. RN 1 stated if RN 1 had known Resident 1 had autism, staff might have had a different approach to Resident 1's care, and autism should have been care planned. RN 1 stated not knowing a resident's diagnosis could definitely impact the resident's care regarding specific food preferences and concerns being addressed. RN 1 stated Resident 1's care plans were important because care plans guided Resident 1's care. RN 1 stated if Resident 1 had autism, there should have been a different approach to Resident 1's care. RN 1 stated knowing Resident 1 had autism would change how RN 1 related to Resident 1, and RN 1 would add a care plan for the diagnosis.During a concurrent interview and record review on 5/5/2026 at 8:33 a.m., with the MDS Nurse (MDSN), Resident 1's Medical Records, GACH hospital discharge records, and Care Plans were reviewed. The MDSN stated he was responsible for adding diagnoses to Resident 1's medical diagnosis list in the EHR. The MDSN stated he did not add autism or gastric sleeve surgery to Resident 1's medical diagnosis list because the physician did not add the diagnoses to the physician's notes. The MDSN stated autism and gastric sleeve surgery would have been under Resident 1's diagnoses if they had been captured. The MDSN stated if the diagnoses had been captured, the diagnoses would have been care planned with interventions. The MDSN stated leaving diagnoses off the diagnosis list affected Resident 1's care, especially for residents with autism, because there would be a care plan for autism. The MDSN stated Resident 1 had autism and needed a different type of care, and Resident 1's care needed to be tailored to Resident 1, not just in general. The MDSN stated the IDT would be a way to catch diagnoses missed on admission. The MDSN stated when diagnoses were missed, the missed diagnoses affected the care of the resident, and correct diagnoses would change the care of the resident.During a review of the facility's policy and procedure (P&P) titled, Policy for the Interdisciplinary Team, revised 8/2016, the P&P indicated it was the policy of the facility that the Interdisciplinary Team (IDT) was responsible for the development of an individualized comprehensive care plan for each resident. The P&P indicated a comprehensive care plan for each resident shall be started on admission and completed within seven days of completion of the resident assessment. The P&P indicated the care plan was based on the resident's needs and the resident's comprehensive assessment and was developed by a Care Planning/IDT which included, but was not necessarily limited to, the resident's attending physician, the registered nurse who had responsibility for the resident, the dietary manager/dietitian, social services personnel responsible for the resident, the activity director/coordinator, therapists, consultants, the director of nursing, the charge nurse responsible for resident care, nursing assistants responsible for the resident's care, and others as appropriate or necessary to meet the needs of the resident. The P&P indicated the resident, the resident's family, and/or the resident's legal representative/guardian or surrogate were encouraged to participate in the development and revisions to the resident's care plan. The P&P indicated every effort would be made to schedule care plan meetings at the best time of the day for the resident and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's family. The P&P indicated the mechanics of how the IDT met its responsibilities in the development of the interdisciplinary care plan, including face-to-face, teleconference, written communication, etc., was at the discretion of the Care Planning Committee.During a review of the facility's P&P titled, Resident Rights, revised 9/2017, the P&P indicated residents had the right to participate in the development and implementation of the person-centered plan of care, including goals and outcomes, to be informed in advance of changes to the plan of care, to request meetings or revisions to the care plan, and to see the care plan and sign after any significant changes to it.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff consistently identified, documented, and addressed the reasons for one of four sampled residents (Resident 1) repeated refusals of scheduled showers, and implement alternative approaches to provide adequate bathing and hygiene care. This failure resulted in Resident 1 not receiving showers for an extended period and had the potential to affect Resident 1's dignity and increase the risk for poor hygiene, skin breakdown, and infection.Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnosis including muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (a decrease in size or wasting away of a body part or tissue), abnormalities of gait and mobility (difficulty walking or moving in a normal, safe, or steady way), generalized anxiety disorder (ongoing excessive worry or nervousness), and attention-deficit hyperactivity disorder (ADHD - a condition that makes it difficult to focus, stay organized and control restlessness). During a review of Resident 1's History and Physical (H&P), dated 3/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's History and Physical (H&P), dated 4/21/2026, the H&P indicated Resident 1 had mobility and ADL dysfunction related to muscle wasting and atrophy and abnormal gait/mobility. The H&P indicated Resident 1's medical rehabilitation goal included activities of daily living ([ADLs) activities such as bathing, dressing and toileting a person performs daily) supervision.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and required supervision or touching assistance (helper provides verbal cues, steadying and or contact guard assistance as resident completes activity) from staff for eating, oral hygiene, toileting, bathing, upper/lower body dressing and personal hygiene. The MDS indicated Resident 1's preference to choose between a tub bath, shower, bed bath, or sponge bath was very important. During an interview on 4/28/2026 at 11:17 a.m., with Resident 1, Resident 1 stated she did not take showers because there was no privacy in the shower room and men could be in the shower room with women. Resident 1 stated the shower room was nasty, the shower had multiple showers with curtains which did not close all the way, and dirty linen was kept inside the shower room. Resident 1 stated when she had to take a shower, there was a tall male staff member who watched while residents took showers, and this made Resident 1 feel very uncomfortable. Resident 1 stated the curtains did not provide complete privacy, and the male staff member stared while Resident 1 took a shower. Resident 1 stated she told staff she did not take showers because there was no privacy and she did not want men walking in unannounced. Resident 1 stated when she complained to the facility about the shower situation, staff did not do anything. Resident 1 stated since staff did not do anything about the shower situation, Resident 1 washed up in the bathroom in Resident 1's room with baby wipes. Resident 1 stated when Resident 1 told staff about Resident 1's shower concerns, Resident 1 was told, You can take a shower if you want.During an interview on 4/30/2026 at 3 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 1 refused her shower. CNA 2 stated CNA 2 did not know why Resident 1 refused her shower. CNA 2 stated CNA 2 asked Resident 1 every couple of hours, and if Resident 1 continued to refuse, CNA 2 reported the refusal to the charge nurse. CNA 2 stated Resident 1's showers were scheduled on Tuesdays and Saturdays, but Resident 1 could receive a shower any day, and CNA 2 offered showers to residents every day. CNA 2 stated Resident 1 always refused showers when CNA 2 was assigned to Resident 1. CNA 2 stated when CNA 2 told the charge nurse Resident 1 still did not go take a shower, the charge nurse talked to Resident 1, but Resident 1 still refused.During a concurrent interview and record review on 5/4/2026 at 3:53 p.m., with RN 1, Resident 1's Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who work together to help a resident achieve their goals) Notes and Care Plans were reviewed. RN 1 stated Resident 1 declined showers and completed personal hygiene in her room. RN 1 stated the showers were not documented as refusals because staff considered the personal hygiene in her room to be her preference. RN 1 acknowledged Resident 1's IDT notes did not indicate shower refusals were addressed. RN 1 acknowledged Resident 1's care plans did not address shower refusals. RN 1 stated she did not know why Resident 1 declined showers. RN 1 stated she did not know Resident 1 was uncomfortable taking showers or if discomfort was the reason she declined showers. RN 1 stated, from a nursing perspective, staff needed to ensure good skin care and prevent potential skin breakdown and infection. RN 1 stated staff should have followed up to ensure Resident 1 provided good hygiene for herself. RN 1 stated if Resident 1 was uncomfortable with a certain staff member, staff could have provided a staff member she was more comfortable with. RN 1 stated if Resident 1 refused showers, staff should have attempted to educate her regarding the importance of showers and determined why she refused. RN 1 stated the refusal needed to be addressed to resolve the refusal.During a review of the facility's policy and procedure (P&P) titled, Certified Nursing Assistant Documentation, revised 10/2015, the P&P indicated it was the policy of the facility that certified nursing assistants document per shift, accurately and consistently. The P&P indicated certified nursing assistants were required to have daily documentation. The P&P indicated activities of daily living included personal hygiene, including how the resident maintained personal hygiene, combing hair, brushing teeth, and shaving. The P&P indicated activities of daily living included bathing, including how the resident took a full-body bath/shower, sponge/bed bath, and transfer. The P&P indicated activities of daily living required a performance code. The P&P indicated additional information required on the 7-3, 3-11, and 11-7 shifts included a check of the resident's skin, which was to be initialed when done, and the signature of the certified nursing assistant to verify delivery of service.During a review of the facility's P&P titled, Resident Rights - Refusal of Care, revised 4/2017, the P&P indicated it was the policy of the facility to implement approaches with a resident who refused care. The P&P indicated the facility had to respect the resident's right to refuse care and/or treatment. The P&P indicated if a resident was resistant to care or refused care, the facility would implement approaches. The P&P indicated if a resident refused care or was agitated, the staff member would leave the resident's room and attempt to gain the resident's cooperation in 10-15-minute increments times three. The P&P indicated if the resident was refusing care from a certified nursing assistant, the licensed nurse would be notified of the resident's refusal. The P&P indicated if a resident refused care or treatment, medications, or food, the resident's attending physician would be notified within a 72-hour time frame.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Registered Dietician (RD) and Dietary Supervisor (DS) completed a comprehensive and accurate nutritional assessment for one of four sampled residents (Resident 1) to meet their individualized needs and dietary preferences. This failure resulted in Resident 1 receiving meals which did not align with her stated food preferences and nutritional needs. This failure had the potential to negatively affect Resident 1's nutritional status and dietary management due to autism (a developmental condition that affects how the resident understands information, communicates, interacts with others, and responds to sensory input), gastric sleeve surgery (a procedure which permanently reduces stomach size and affects how much and what types of food the resident can tolerate), loose teeth, history of eating disorders, and documented food preferences.Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 was admitted to the facility with diagnoses including attention-deficit hyperactivity disorder (ADHD - a condition that makes it difficult to focus, stay organized and control restlessness), overweight (body weight higher than what is considered health for height), functional dyspepsia (ongoing stomach discomfort such as fullness, bloating, or mild pain without a clear medical cause), and constipation (difficulty having bowel movements or having fewer bowel movements than usual).During a review of Resident 1's History and Physical (H&P), dated 3/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and required supervision or touching assistance (helper provides verbal cues, steadying and/or contact guard assistance as resident completes activity) from staff for eating, oral hygiene, toileting, bathing, upper/lower body dressing and personal hygiene. The MDS indicated Resident 1's preference to have snacks available between meals was very important. During a review of Resident 1's General Acute Care Hospital (GACH) Psychiatric Evaluation, dated 2/23/2026, the GACH Psychiatric Evaluation indicated Resident 1 was on disability since 2018 due to depression, autism (a developmental condition that affects how a person communicates, interacts with others, learns, and experiences the world around them), anxiety (extreme worry), and ADHD. The GACH psychiatric evaluation indicated Resident 1 had eating disorders in the past.During a review of Resident 1's GACH H&P, dated 2/24/2026, the GACH H&P indicated Resident 1 had gastric sleeve surgery in 2017. The GACH H&P indicated Resident 1 complained of a recent fall which caused a loose right front tooth. The GACH H&P indicated Resident 1 had not seen a dentist and requested a recommendation for treatment after discharge. The GACH H&P indicated Resident 1 had prediabetes (when blood sugar is higher than normal, but not high enough to be diagnosed as diabetes [a disorder characterized by difficulty in blood sugar control and poor wound healing]).During a review of Resident 1's admission Diagnosis List, dated 3/11/2026, the admission Diagnosis List did not indicate Resident 1 had autism, eating disorders in the past, gastric sleeve in 2017, a loose right front tooth, toothache, or chewing problems.During a review of Resident 1's Nutrition Risk Assessment, dated 3/11/2026, the Nutrition Risk Assessment indicated Resident 1 was lethargic and disoriented. The Nutrition Risk Assessment indicated Resident 1 fed herself, had stable weight within the last three months, had teeth or dentures in good condition, had good food intake, took snacks and supplements as offered, had few food dislikes, and had two to three predisposing conditions. The Nutrition Risk Assessment did not indicate Resident 1 had loose teeth, toothache, gastric sleeve in 2017, autism, eating disorders in the past, many food dislikes or complaints, food-related intolerances, or chewing problems.During a review of Resident 1's Gastrointestinal (GI) Distress Care (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan, dated 3/11/2026, the Care Plan indicated Resident 1 had dyspepsia. The Care Plan's interventions included give diet per physician order, avoid irritants in diet such as coffee, spicy food, and alcohol, administer anti-acid or gas medication per physician order, monitor for signs and symptoms of GI distress (stomach or intestinal discomfort) such as abdominal pain, blood in stool, weakness, and diarrhea, and assess for abdominal distention, bowel sounds, and tenderness. During a review of Resident 1's Oral/Dental Care Plan, dated 3/11/2026, the Care Plan indicated Resident 1 had loss of appetite, refusal to eat, and behavior. The Care Plan's goals indicated mouth, and teeth would be cleaned daily, Resident 1 would not complain of mouth pain, Resident 1 would not have any choking episode daily, and Resident 1 would not complain of dental pain related to poor teeth condition. The Care Plan's interventions included diet as ordered, monitor tolerance of texture of food, monitor appetite and weights and report significant weight loss, monitor percentage of food consumption for each meal, dental consult and follow-up as ordered and needed, follow up dental treatment as needed, encourage Resident 1 to report difficulty chewing food, and staff to monitor for signs and symptoms of chewing difficulty, including taking longer to chew or longer time when eating.During a review of Resident 1's Nutrition Care Plan, dated 3/12/2026, the Care Plan indicated Resident 1 was at risk for malnutrition related to anxiety (extreme worry), depression (mood disorder that causes a persistent feeling of sadness and loss of interest in activities), chronic pain, insomnia (difficulty sleeping), alcohol abuse, and overweight. The Care Plan's interventions indicated Resident 1's diet was regular diet, regular texture, thin liquids, nutritional shake three times a day as needed, honor Resident 1's reasonable food preferences, RD to evaluate and make nutrition recommendations as needed, monitor for and document signs and symptoms of dysphagia (difficulty swallowing), offer meal replacement if Resident 1 consumed less than 50 percent, and provide assistance during meals as needed.During a review of Resident 1's Physician Note, dated 3/13/2026, the Physician Note indicated Resident 1 had gastric sleeve in 2017. The Physician Note indicated Resident 1 stated, I cannot eat and my system does not accept. The Physician Note indicated Resident 1 requested Ensure. During a review of Resident 1's admission Nutritional Assessment, dated 3/16/2026, the admission Nutritional Assessment did not indicate Resident 1 had autism, eating disorders in the past, gastric sleeve in 2017, a loose right front tooth, toothache, or chewing problems.During a review of Resident 1's Order Summary Report (Physician's Orders), dated 3/31/2026, the Physician's Order indicated and order was placed for Resident 1 to receive a regular diet, regular texture, and thin liquids. The Physician's Orders indicated Resident 1 had an order for nutritional shakes three times a day. During a review of Resident 1's Physician Note, dated 4/17/2026, the Physician Note indicated Resident 1 had gastric sleeve in 2017. The physician note indicated Resident 1 stated, My teeth still hurt. I need a dentist. The Physician Note indicated Resident 1 had a toothache. The Physician Note indicated the plan included a dental consult. The Physician Note indicated acute care hospital, skilled nursing facility, and therapy records were reviewed personally.During a concurrent observation and interview on 4/28/2026 at 11:17 a.m., Resident 1 stated she had difficulty eating food served by the facility. Resident 1 stated she requested salads because salads were something she could eat. Resident 1 stated she requested chicken only on her salads, but the facility served salads with diced deli meat. Resident 1 stated she did not want diced deli meat on her salads because the diced deli meat upset her stomach and became stuck in her loose teeth. Resident 1 stated she had gastric sleeve surgery and could not tolerate certain foods. Resident 1 stated the facility had prepared salads according to her preference before, but the facility did not consistently prepare salads according to her preference. Resident 1 stated no matter how often she complained, the kitchen continued to serve diced deli meat. Resident 1 stated some days the kitchen put chicken on her salads and then served diced deli meat again. Resident 1 stated the facility did not adhere to her preferences and did not consider her gastric sleeve. Resident 1 showed photographs of salads served with diced deli meat. Resident 1 showed a photograph of diced deli meat removed from a salad and wrapped in plastic to return to the kitchen. Resident 1 moved both upper front teeth back and forth with her finger. Resident (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's upper front teeth appeared visibly loose when Resident 1 moved the teeth back and forth.During a review of a forwarded email from Resident 1, dated 4/29/2026 at 1:01 p.m., the forwarded email included photographs of meals Resident 1 received at the facility. The photographs showed several salads with diced processed meat.During a concurrent interview and record review on 4/30/2026 at 9:40 a.m., with the Registered Dietitian (RD), Resident 1's admission Record (Face Sheet), admission Diagnosis List, Physician's Order, hospital discharge notes, physician notes, Nutrition Services Progress Note, and admission Nutritional Assessment were reviewed. The RD stated she used Resident 1's Face Sheet, admission Diagnosis List, and Physician's Order to complete Resident 1's admission Nutritional Assessment. The RD stated she routinely used the Face Sheet, admission Diagnosis List, and Physician's Order to complete nutritional assessments. The RD stated the Face Sheet, admission Diagnosis List, and Physician's Order were sufficient to complete Resident 1's admission Nutritional Assessment. The RD stated she did not use Resident 1's hospital discharge notes to complete Resident 1's admission Nutritional Assessment and was unfamiliar of how to obtain these records in Resident 1's electronic health record (EHR). The RD stated she did not assess Resident 1 for chewing or swallowing difficulties because speech therapy (a service that helps residents improve or maintain their ability to speak, understand language, swallow safely, and communicate their needs) assessed residents for chewing and swallowing. The RD stated she did not know Resident 1 had loose teeth, gastric sleeve surgery, autism, or eating disorders in the past when she completed Resident 1's admission Nutritional Assessment. The RD stated she did not reference Resident 1's loose teeth, gastric sleeve surgery, autism, or eating disorders in the past in the admission Nutritional Assessment. Upon review of Resident 1's physician notes, dated 3/13/2026 and 4/17/2026, the RD acknowledged Resident 1 had gastric sleeve surgery in 2017. The RD stated Resident 1 should have told the RD Resident 1 had gastric sleeve surgery. The RD stated she should not rely totally on Resident 1 for Resident 1's medical history. The RD stated she was surprised she did not mention Resident 1's gastric sleeve surgery. The RD stated she was blown away and frustrated because she did not know Resident 1 had gastric sleeve surgery. The RD stated if she had known Resident 1 had gastric sleeve surgery, she would have asked Resident 1 more questions. The RD stated she should look at more information to ensure she was getting accurate information about Resident 1. The RD stated she should have reviewed Resident 1's hospital discharge records upon admission to ensure Resident 1's information was accurate, but she did not know how to access the records in the electronic health record (EHR). The RD stated after she reviewed Resident 1's hospital records, the Face Sheet and admission Diagnosis List were not complete and did not include gastric sleeve surgery or autism. The RD stated knowing Resident 1 had gastric sleeve surgery would have made a difference. The RD stated she did not think autism affected Resident 1's eating or food preferences because Resident 1 was an adult who could name her food preferences. The RD stated autism could be an issue for a child or teenager because children and teenagers with autism could have food aversions and food preferences, but not adult autistic residents. The RD stated Resident 1 had very specific food likes and dislikes. The RD stated Resident 1's food preferences were documented on the Nutrition Services Progress Note and provided to the kitchen on 3/16/2026. The RD stated she was not aware Resident 1 had filed a grievance regarding food preferences or Resident 1's preference to not have processed meat with meals.During a concurrent interview and record review on 4/30/2026 at 11:48 a.m., with the Dietary Supervisor (DS), Resident 1's admission Nutritional Assessment and Nutrition Services Progress Note were reviewed. The DS stated when a resident was admitted , the DS went to the resident to determine if the resident had chewing difficulty, swallowing difficulty, or food preferences. The DS stated the information was documented on an admission nutritional assessment screening form and transferred to a diet card ([plate card] - a small card or label placed on a resident's meal tray that tells dietary staff exactly how the resident's food should be prepared and served). The DS stated the plate cards were kept in the dietary department and used to identify special requests or resident-specific meal preferences. The DS (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if a resident wanted to speak with the DS regarding meals, preferences, or food issues, nursing staff notified the DS. The DS stated he spoke with the resident and added changes to the plate card. The DS stated he referred issues to the RD, but the plate card was the only place where the information was documented. The DS stated he did not write a note when he referred a resident to the RD and only told the RD verbally. The DS stated he reviewed residents every three months and wrote a progress note. The DS stated he did not complete Resident 1's admission Nutritional Assessment and the RD completed it. The DS stated the dental status section of Resident 1's admission Nutritional Assessment was not completed but should have been completed. The DS stated if Resident 1 had a chewing or swallowing problem, the chewing or swallowing problem should have been circled on the admission Nutritional Assessment. The DS stated there was no circled chewing or swallowing problem on Resident 1's admission Nutritional Assessment, which indicated Resident 1 did not have a chewing or swallowing problem. The DS stated he completed a Nutrition Services Progress Note for Resident 1, dated 3/12/2026, and the Nutrition Services Progress Note indicated Resident 1 did not have complaints of chewing or swallowing difficulties. The DS stated he remembered the Social Services Director (SSD) coming into the kitchen with Resident 1. The DS stated Resident 1 did not mention processed meat and only stated she wanted a salad with extra meat but did not state what type of meat. The DS stated Resident 1 stated she did not want eggs on her salad. The DS stated if he had known Resident 1 wanted regular chicken and did not want processed meat, it would not have been a problem because the request could have been done. The DS stated he did not know Resident 1 filed a grievance regarding dietary preferences and stated if the grievance involved dietary preferences, he should have received a copy of the grievance. The DS stated if he had known there was a grievance regarding Resident 1's food preferences, he would have followed up with Resident 1 to ensure Resident 1's preferences were followed.During a review of a forwarded email from Resident 1 to the facility's Administrator (ADM) and Social Services Director (SSD), date sent 4/30/2026 at 12:43 p.m., the email indicated Resident 1's dietary concern was not a general food preference and involved gastric sleeve history, functional dyspepsia, loose teeth, dental pain, difficulty eating safely, muscle wasting/atrophy, gait/mobility issues, and the need for a consistent tolerable protein/dietary plan.During a concurrent observation and interview on 5/4/2026 at 9:11 a.m., with the Dietary Supervisor (DS), while in the kitchen, a handwritten dietary preference note was observed posted for Resident 1. The note indicated Resident 1 wanted chef's salad for lunch and dinner every day, no egg, extra meats, and chicken only. The note included a handwritten date of 3/20/2026. The words chicken only appeared to be written in black marker and appeared consistent with the handwriting and marker style used for the other dietary preference information on the note. The words chicken only were circled in black ink pen, and a handwritten date of 4/30/2026 appeared in black ink pen next to the circled words. The DS stated the 4/30/2026 date was written because he added chicken only to the posted dietary preference note on 4/30/2026. The DS stated Resident 1's original plate card with preferences was discarded and was not available for review.During a concurrent interview and record review on 5/4/2026 at 3:53 p.m., with RN 1, Resident 1's Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) Notes and Care Plans were reviewed. RN 1 stated she knew Resident 1 had an IDT meeting on 3/26/2026 regarding specific food preferences for breakfast, lunch, and dinner. RN 1 stated the RD was part of the IDT meeting on 3/26/2026 and documented Resident 1's food preferences for breakfast, lunch, and dinner. RN 1 stated she was not aware Resident 1 had a grievance regarding food preferences, which was resolved on 3/25/2026. RN 1 stated this was the first time RN 1 heard about processed meats. RN 1 stated Resident 1 mentioned in the IDT meeting what she would like to eat, as opposed to what she did not want. RN 1 stated with a grievance, staff needed to follow up and reassess to make sure the grievance was resolved. RN 1 stated staff should have checked with Resident 1 to ensure the grievance preferences were addressed. RN 1 stated before the investigation, RN 1 was unaware Resident 1 had diagnoses of (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	autism and gastric sleeve. RN 1 stated if staff knew about autism, staff may have had a different approach to Resident 1's care. RN 1 stated not knowing the diagnoses could affect Resident 1's care regarding Resident 1's specific food preferences and concerns being addressed.During an interview on 5/5/2026 at 8:33 a.m., with the MDS Nurse (MDSN), the MDSN stated he was responsible for entering the diagnoses for all residents upon admission. The MDSN stated he reviewed Resident 1's hospital discharge records upon admission and entered her diagnoses. The MDSN stated he did not enter Resident 1's gastric sleeve surgery, autism, or loose tooth from the hospital discharge record because those diagnoses were not being monitored. The MDSN acknowledged those diagnoses had been captured, the diagnoses would have been care planned with interventions. The MDS Nurse stated it was important for nursing staff and clinicians to review the hospital records themselves and should not rely only on the diagnoses entered by the MDSN. The MDSN stated gastric sleeve history mattered because there could be eating and dietary concerns, absorption issues, need for added vitamins, and food intolerances. The MDSN stated leaving diagnoses off the diagnosis list affected Resident 1's care.During an interview on 5/5/2026 at 1:07 p.m., Resident 2 stated she was Resident 1's roommate. Resident 2 stated she was present when facility staff brought Resident 1's meals into the room. Resident 2 stated she observed facility staff bring Resident 1 salads with chopped meat, and Resident 1 told facility staff she did not want chopped meat. Resident 2 stated Resident 1 refused the chopped meat and facility staff continued to bring chopped meat to Resident 1. Resident 2 stated Resident 1 asked for chicken constantly and Resident 2 observed chopped meat on Resident 1's meals. Resident 2 stated Resident 1's salads looked different each time they were served but always included chopped meat. Resident 2 stated Resident 1 only received chicken on her salad when chicken was on the facility's menu. Resident 2 stated she was present when Resident 1 offered to buy her own chicken for her meals.During a review of a forwarded email from Resident 1, dated 5/5/2026 at 2:59 p.m., the attachment to the email included a photograph of Resident 1's plate card, which indicated Resident 1's lunch and dinner preference was chef salads for lunch and dinner with extra meat, chicken only, and no eggs or processed meats in salads. The attachment also included a photograph of a chef salad dated with an orange label marked 5/2/2026 and served with diced processed/deli-style meat.During a review of the facility's policy and procedure (P&P) titled, Policy for the Interdisciplinary Team, revised 8/2016, the P&P indicated the Interdisciplinary Team (IDT) was responsible for the development of an individualized comprehensive care plan for each resident. The P&P indicated a comprehensive care plan for each resident would be started on admission and completed within seven days of completion of the resident assessment. The P&P indicated the care plan was based on the resident's needs and comprehensive assessment. The P&P indicated the IDT included the resident's attending physician, registered nurse responsible for the resident, dietary manager or dietitian, social services staff, therapists, director of nursing, charge nurse, nursing assistants, and others as appropriate or necessary to meet the needs of the resident.During a review of the facility's P&P titled, Dietary - Menus, Food and Drink, reviewed 1/2017, the P&P indicated the facility's policy was to meet the nutritional needs of residents in accordance with established national guidelines. The P&P indicated the facility would provide food and drink that was palatable, attractive, and at a safe and appetizing temperature. The P&P indicated menus would be prepared in advance and the facility would make reasonable efforts to reflect the religious, cultural, and ethnic needs of the residents. The P&P indicated menus would be reviewed by a registered dietitian (RD) for nutritional adequacy and updated periodically. The P&P indicated the facility would respect the resident's right to make personal dietary choices. The P&P indicated food would be prepared to accommodate resident allergies, intolerances, and preferences. The P&P indicated if a resident refused the meal served or requested a different meal, appealing options of similar nutritive value would be offered. The P&P indicated drinks would be served consistent with the resident's needs and preferences, sufficient to maintain resident hydration.During a review of the facility's P&P titled, Food and Nutrition Preparation and Service, reviewed 1/2017, the P&P indicated the facility's policy was to (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide each resident with a nourishing, palatable, well-balanced diet that met the daily nutritional and dietary needs of the resident. The P&P indicated each resident would be provided a nourishing, palatable, well-balanced diet that met daily nutritional and dietary needs while taking into account the preferences of the resident. The P&P indicated the resident-centered care plan would identify preferences of the resident, as well as the resident's religious, cultural, and ethnic needs, if applicable. The P&P indicated the facility would make reasonable efforts to offer meals and snacks to residents outside scheduled or non-traditional times.During a review of the facility's P&P titled, Nutritional Screening/Assessments/Resident Care Planning, dated 2023, the P&P indicated the resident's nutritional status and nutritional needs would be assessed. The P&P indicated a nutritional program specific to the resident's needs would be planned and implemented and reassessed periodically for progress. The P&P indicated information recorded would come from a variety of sources and vary with each resident, including direct resident interview, contact with family and friends, the medical record, direct observation, and resident care conference. The P&P indicated change in eating habits, difference in eating pattern, eating problems, weight, and other problems would be recorded in dietary progress notes and the resident care plan. The P&P indicated the Food and Nutrition Services Director and/or Facility Registered Dietitian would participate in resident care planning to contribute pertinent nutritional information to the medical and nursing team.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff accurately documented when a resident (Resident 1) refused therapy and when Resident 1 was notified that her therapy services were discontinued for one of four sampled residents (Resident 1). This deficient practice resulted in an incomplete clinical record and had the potential to negatively affect Resident 1's continuity of care, care planning, skilled coverage decision-making, and the facility's ability to evaluate the appropriateness of therapy discontinuation.Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (a decrease in size or wasting away of a body part or tissue), abnormalities of gait and mobility (difficulty walking or moving in a normal, safe, or steady way), pain in right leg, chronic pain, muscle spasm (sudden tightening and cramping of a muscle) and attention-deficit hyperactivity disorder (ADHD - a condition that makes it difficult to focus, stay organized and control restlessness).During a review of Resident 1's History and Physical (H&P), dated 3/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's History and Physical (H&P), dated 4/21/2026, the H&P indicated Resident 1 had mobility and activities of daily living ([ADL] activities such as bathing, dressing and toileting a person performs daily) dysfunction related to muscle wasting and atrophy and abnormal gait/mobility. The H&P indicated physical therapy/occupational therapy (PT/OT) was requested from 3/12/2026 through 4/9/2026 for muscle wasting and atrophy and abnormal gait/mobility. The H&P indicated to continue PT/OT from 4/7/2026 through 5/5/2026. The H&P indicated Resident 1 had a high risk for functional impairment without therapy.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding though thought, experience, and the senses) was intact and required supervision or touching assistance (helper provides verbal cues, steadying and or contact guard assistance as resident completes activity) from staff for eating, oral hygiene, toileting, bathing, upper/lower body dressing and personal hygiene.During a review of Resident 1's Subjective, Objective, Assessment, Plan ([SOAP] a common format used by healthcare workers to write notes about a resident's condition and care) Note, dated 4/6/2026, the SOAP Note indicated Resident 1 continued PT/OT. The SOAP Note indicated Resident 1 had musculoskeletal hypomobility, muscle wasting and atrophy, and abnormalities of gait and mobility. The SOAP Note indicated the plan included PT/OT exercises and skilled needs for PT/OT.During a review of Resident 1's Licensed Nurses' Notes, dated 4/7/2026, the Licensed Nurses' Notes indicated a telephone order was received from the physician to continue skilled physical therapy (PT) and occupational therapy (OT) treatment.During a review of Resident 1's Licensed Nurses' Notes, dated 4/16/2026, the Licensed Nurses' Notes indicated a telephone order was received from the physician to discontinue skilled OT intervention after that day. The Licensed Nurses' Notes indicated the order was noted and carried out. The Licensed Nurses' Notes did not indicate Resident 1 was notified of the discontinuation of OT services.During a review of Resident 1's History and Physical (H&P), dated 4/21/2026, the H&P indicated Resident 1 had mobility and activities of daily living (ADL) dysfunction related to muscle wasting and atrophy and abnormal gait/mobility. The H&P indicated Resident 1 had a high risk for functional impairment without therapy and adequate pain control. The H&P indicated Resident 1 had a high risk of developing contractures, pressure ulcers, poor healing, or falls if Resident 1 did not receive adequate therapy and pain control. The H&P indicated to continue PT/OT from 4/7/2026 through 5/5/2026.During a review of Resident 1's Physical Therapy (PT) Notes, dated 3/2026 through 5/2026, there was no documentation indicating Resident 1 was notified of documented therapy (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusals, that Resident 1 was educated regarding the effect of therapy refusals on continued skilled services. There was no documentation indicating Resident 1 was notified that PT services would be discontinued before the Notice of Medicare Non-Coverage ([NOMNC] a Medicare notice used to inform a beneficiary of the planned end of Medicare-covered skilled services) was issued.During a review of Resident 1's Occupational Therapy (OT) Notes, dated 3/2026 through 5/2026, there was no documentation indicating Resident 1 was notified of documented therapy refusals, that Resident 1 was educated regarding the effect of therapy refusals on continued skilled services. There was no documentation indicating Resident 1 was notified OT services would be discontinued before OT services were discontinued on 4/16/2026.During a review of Resident 1's Clinical Record, dated 3/2026 through 5/2026, there was no documentation indicating an Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) meeting related to Resident 1's therapy refusals was held before OT services were discontinued on 4/16/2026. There was also no documentation indicating an IDT meeting was held related to Resident 1's therapy refusals before the NOMNC was issued.During a review of Resident 1's Licensed Nurses' Notes, dated 4/28/2026, the Licensed Nurses' Notes indicated Resident 1's last covered day (LCD) was 5/1/2026 and Resident 1 was changed to custodial care on 5/2/2026. The Licensed Nurses' Notes indicated this was noted and communicated. The Licensed Nurses' Notes did not indicate who was notified or whether Resident 1 was notified.During a review of Resident 1's Advance Beneficiary Notice of Non-Coverage ([ABN] a notice used to inform a beneficiary Medicare may not pay for listed services), dated 4/28/2026, the ABN indicated Medicare may not pay for physical therapy (PT), occupational therapy (OT), speech therapy (ST), and daily skilled nursing care. The ABN indicated the reason Medicare may not pay was Skilled no longer needed. Goals met. The ABN indicated Resident 1's last covered day was 5/1/2026, and custodial care would begin on 5/2/2026. The ABN did not indicate Resident 1 was notified of documented therapy refusals, educated regarding how therapy refusals affected continued skilled services, or informed of the basis for discontinuation of PT/OT services before the ABN was issued. There was no documentation indicating Resident 1 or Resident 1's Responsible Party (RP) selected an option, signed, or dated the ABN.During a review of Resident 1's NOMNC, the NOMNC indicated Medicare coverage of Resident 1's current skilled nursing services would end on 5/1/2026. The NOMNC indicated, under Additional Information, Skilled is no longer needed. Goals met. There was no documentation indicating Resident 1 was notified of documented therapy refusals, educated regarding how therapy refusals affected continued skilled services, or informed of the basis for discontinuation of physical therapy/occupational therapy (PT/OT) services before the NOMNC was issued. The NOMNC was not signed or dated by Resident 1 or her RP. During an interview on 4/30/2026 at 1:18 p.m., with Occupational Therapist (OT) 1, OT 1 stated Resident 1 received occupational therapy services for activities of daily living (ADLs), therapeutic exercises, and therapeutic activities. OT 1 stated Resident 1's OT services were initiated on 3/12/2026. OT 1 stated Resident 1's goals were self-care, increased independence and strength, and functional reach. OT 1 stated she made the decision to discontinue Resident 1's OT services and informed the physician. OT 1 stated the decision to discontinue therapy was based on Resident 1's participation, level of function, improvement, refusals, and goals being met. OT 1 stated Resident 1's last day of OT was 4/16/2026, according to the physician's order in the chart. OT 1 stated she was not involved in an Interdisciplinary Team (IDT) meeting before Resident 1's OT services were discontinued. OT 1 stated she informed Resident 1 she would be discontinued from OT but did not document the conversation. OT 1 stated the discussion was a conversation in passing. OT 1 stated when she informed Resident 1 she would be discontinued from therapy, Resident 1 said, Okay. OT 1 stated she did not know if Resident 1 was aware therapy was required for continued skilled services. OT 1 stated she did not inform Resident 1 that therapy was required for continued skilled services. OT 1 stated she was not involved in whether Resident 1's discontinuation of therapy affected her skilled level of care because she did not know all of Resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's skilled levels and was not involved in the insurance part.During a telephone interview on 5/4/2026 at 9:24 a.m., with the Physical Therapist/Director of Rehabilitation (PT/DOR), the PT/DOR stated Resident 1 was discharged from therapy because Resident 1 had reached her goals. The PT/DOR stated reasons for therapy discharge included a resident achieving goals or being non-compliant. The PT/DOR stated if a resident had three refusals, therapy staff explained to the resident why therapy services were being discontinued and documented the refusal or no treatment on the service log matrix. The PT/DOR stated Resident 1 had no complaints related to certain staff members and stated Resident 1 was busy doing something else when she refused therapy. The PT/DOR stated therapy staff did not complete an interdisciplinary team (IDT) meeting for refusals and did not complete an IDT meeting related to Resident 1 before discontinuing therapy. The PT/DOR stated therapy staff let Resident 1 know before discharge the therapy was ending. The PT/DOR stated Resident 1 was informed through NOMNC when Resident 1's therapy services were being discharged . The PT/DOR stated if Resident 1 wanted to appeal, Resident 1 could appeal the decision. The PT/DOR stated Resident 1 appealed, and the appeal did not reinstate Resident 1's Medicare coverage. The PT/DOR stated therapy services were to continue until the NOMNC end date of 5/1/2026.During a concurrent interview and record review on 4/29/2026 at 2:48 p.m., with the Business Office Manager (BOM) and Resident 1, Resident 1's NOMNC was reviewed. The BOM stated the NOMNC meant the physician reviewed Resident 1's therapy notes and concluded Resident 1 no longer required skilled nursing services. The BOM stated the NOMNC meant Medicare would no longer be billed after the date listed on the NOMNC. The BOM stated Resident 1's Medicare coverage ended on 5/1/2026. The BOM stated Resident 1 had Medi-Cal eligibility as of April 2026. The BOM stated the Advance Beneficiary Notice of Non-Coverage ([ABN] - a notice used to inform a beneficiary of services Medicare may not cover) indicated Resident 1's last covered day was 5/1/2026, and custodial care would begin on 5/2/2026. The BOM stated Resident 1 could remain in custodial care and receive assistance with medications. The BOM stated Resident 1 wanted to go to another facility and wanted her Medicare coverage. The BOM stated the Medicare denial was only for the facility and not for all facilities. Resident 1 stated she did not agree with the assessment to end physical therapy/occupational therapy (PT/OT) services. Resident 1 stated she did not agree with the physician discontinuing PT/OT services. Resident 1 stated the only reason PT/OT services were discontinued was because she refused to be seen by a certain staff member from the therapy department. Resident 1 stated she did not refuse therapy services and only did not want the specific staff member. Resident 1 stated she communicated to the therapy department because she did not want to work with the specific staff member, but her request was not honored. Resident 1 stated she wrote an email to the Administrator on 4/24/2026 regarding this concern.During a review of Resident 1's email titled, Rehab/Skilled-Care Dispute, dated 5/4/2026, the email indicated Resident 1 disputed any record indicating or implying Resident 1 refused rehabilitation, refused skilled care, no longer required skilled care, met all goals, or accepted custodial/lower-level care. The email indicated Resident 1 requested an accommodation not to work with a specific therapy staff member due to prior interactions and communication concerns. The email indicated Resident 1 identified the request as an accommodation/safety request, not a refusal of rehabilitation.During a review of the facility's undated policy and procedure (P&P) titled, Medicare Part A Eligibility for Rehabilitation Services, the P&P indicated the resident must require daily skilled nursing or rehabilitation services. The P&P indicated the treatment modalities, frequency, and duration must be specifically ordered by the physician. The P&P indicated the resident must have potential to reach rehabilitative goals in a reasonable and predictable period. The P&P indicated there must be a change in function and medical condition to support the need for skilled therapy.During a continued review of the facility's undated P&P titled, Medicare Part A Eligibility for Rehabilitation Services, the P&P indicated it was important to have physician documentation of changes in the resident's functional and medical condition to support the need for skilled therapy to restore the resident to the resident's prior level of function. The P&P indicated discontinuation of Medicare Part A (continued on next page)

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