STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555027	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachside Nursing Center	7781 Garfield Avenue Huntington Beach, CA 92648

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility P&P review, the facility failed to ensure food safety guidelines related to food storage were followed in the kitchen. * The facility failed to ensure the food items past the use by date were discarded. This failure increased the risk for food borne illness for 56 residents who received food prepared in the facility's kitchen.Findings: Review of the facility's P&P titled Labeling and Dating of Foods dated 2023 showed all food items in the storeroom, refrigerator, and freezer need to be labeled and dated for either food safety or product rotation. The use by date will be the absolute date in which the food must be consumed or discarded by the facility. On 2/22/26 at 0801 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the Diet Lead. The following were observed:a. The Reach-in Refrigerator 1 by the dry storage area had a container with four packs of sliced cheese was observed with a use by date of 2/20/26. The Diet Lead verified the findings and removed the sliced cheese from the refrigerator;b. The dry storage area had a can of instant mashed potatoes with a date of 9/19/25 on the can and a delivery date of 12/2/25. The Diet Lead verified the findings and removed can of instant mashed potatoes from the dry storage area;c. The Reach-in Refrigerator 2 by the handwashing station had the following:- a large bin of celery with a use by date of 2/20/26,- a large bin containing ten red bell peppers and one cabbage with a use by date of 2/20/26, and- a small container of an open sliced ham package with a used by date of 2/20/26. The Diet Lead verified the findings and removed the items from the refrigerator. On 2/24/26 at 0902 hours, an interview was conducted with the RD. The RD was informed and acknowledged the above findings.

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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(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 interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was complete and accurately maintained for two of 15 final sampled residents (Residents 1 and 33) and two of three residents (Residents 78 and 90) reviewed for closed records. * The facility failed to document in the medical record all the observations, assessments, vital signs, interventions, and change in condition, when Resident 78 expired in the facility. In addition, the facility failed to document the names and titles of the facility staff who conducted these observations and assessments and performed the interventions. * The facility failed to ensure the physician's orders for the route of medication administration for Resident 1 were accurate. The medication route was ordered for oral administration instead of via GT. * The facility failed to ensure Resident 33's wound treatment and monitoring was documented according to the facility's policy. * The facility failed to ensure resident's IDT Care Plan Review was complete and accurate according to the facility's policy. Additionally, the facility failed to ensure Resident 90's vital signs at the time of discharge were documented in the resident's medical record according to the facility's policy. These failures had the potential for the residents' care needs not being met as the medical record was incomplete.Review of the facility's P&P titled Charting and Documentation revised 4/2008 showed all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. All observations, medications administered, and services performed must be documented in the resident's clinical records. All incidents, accidents, or changes in the resident's condition must be recorded. Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: the date and time the procedure/treatment was provided; the name and title of the individual who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment; notification of the family and physician; and the signature and title of the individual documenting. 1. Closed medical record review for Resident 78 was initiated on [DATE]. Resident 78 was admitted to the facility on [DATE], and expired at the facility on [DATE]. Review of Resident 78's POLST dated [DATE], showed not to attempt resuscitation (if Resident 78 found pulseless and not breathing). Review of Resident 78's progress note dated [DATE] at 0637 hours, showed Resident 78 was pronounced deceased at 0630 hours. Resident 78's death was confirmed by two licensed nurses. The resident's family and administration were notified. Review of Resident 78's progress noted dated [DATE] at 0928 hours, showed Resident 78 expired on [DATE] at 0630 hours, the resident's code status was DNR, the medical doctor pronounced the death, family was notified, and postmortem care was completed. However, further review of Resident 78's medical record failed to show documentation specific to the events surrounding Resident 78's death. Resident 78's medical record failed to show documentation specific to all observations conducted, assessments conducted, vital signs obtained, interventions performed, and changes in condition. Additionally, the medical record failed to show documentation of the names and titles of the facility staff who conducted observations and assessments and performed interventions. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 0930 hours, a telephone interview was conducted with LVN 6. LVN 6 verified she was assigned to care for Resident 78 at the time of her death on [DATE]. LVN 6 stated she observed Resident 78 alive and at her baseline physical and mental status, on the morning of [DATE] at approximately 0500 hours. LVN 6 stated after she completed her morning medication administration (sometime before 0700 hours), the CNA assigned to care for Resident 73 informed LVN 6 that Resident 78 was observed unresponsive and was not moving. LVN 6 stated she then entered Resident 78's room and performed an assessment of Resident 78. LVN 6 stated she checked Resident 78's carotid artery for a pulse but stated she could not feel Resident 78's carotid pulse. LVN 6 stated she did not observe Resident 78 breathing, as evidenced by a lack of chest rise and fall. LVN 6 stated she attempted to obtain Resident 78's oxygen saturation, however, she was unable to obtain a reading. LVN 6 stated Resident 78 had a DNR order, therefore, she did not perform CPR. LVN 6 verified all observations, assessments, vital signs, interventions, changes in condition, and the names and titles of the facility staff who conducted observations, conducted assessments, and performed interventions, should have been documented in Resident 78's medical record. On [DATE] at 0951 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified the findings and stated all observations, assessments, vital signs, interventions, changes in condition, and the names and titles of the facility staff who conducted observations, conducted assessments, and performed interventions, surrounding Resident 78's death, should have been documented in Resident 78's medical record, to ensure an accurate and complete account of Resident 78's condition. 2. Review of the facility's P&P titled Medication Administration (undated) showed medications are administered in accordance with the written orders of the attending physician. Medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated [DATE], showed Resident 1 had a GT and medical diagnosis of dysphagia (difficulty swallowing). Review of Resident 1's Order Summary Report, showed the following physician's orders: - dated [DATE], a diet order of NPO (nothing by mouth), - dated [DATE], to administer famotidine (medication that helps reduce stomach acid) 40 mg one tablet by mouth one time a day for supplement, - dated [DATE], to administer ferrous sulfate (supplement) 325 mg one tablet by mouth one time a day for supplement, and- dated [DATE], to administer acetaminophen (pain reliever) 500 mg tablet by mouth every eight hours for pain, not to exceed 3 grams in 24 hours. Review of Resident 1's MAR for February 2026 showed Resident 1 was administered the following medications and signed for by the licensed nurse as administered via oral route: - on [DATE] at 0900 hours and from 2/19 to [DATE] at 0600 hours, Resident 1 was administered with the famotidine and ferrous sulfate medications; and - on [DATE] at 1400 and 2200 hours, [DATE] at 0600 and 2200 hours, and [DATE] at 0600 hours, Resident 1 was administered with the acetaminophen medication. On [DATE] at 1423 hours, an interview and concurrent medical record review for Resident 1 was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted with LVN 5. LVN 5 stated Resident 1 was NPO and received all her medications via GT. LVN 5 verified the above findings. LVN 5 stated the ordered route for the above medications should be change to accurately reflect the care that the resident was receiving, which was to receive the medications via GT. On [DATE] at 1029 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 1. 3. Medical record review for Resident 33 was initiated on [DATE]. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 33's H&P examination dated [DATE], showed the resident had no capacity to understand and make decisions. Review of Resident 33's Order Summary Report dated [DATE], showed the following physician's orders: - dated [DATE], to monitor low air loss mattress function and placement according to weight and comfort every shift; and - dated [DATE], to apply antifungal cream 2% to perineal for skin management every shift. Review of Resident 33's TAR showed the following: - a wound treatment ordered on [DATE], to apply antifungal cream 2 % to the perineal for skin management every shift was blank with no licensed nurse initial to indicate if the wound treatment was completed or any code why the wound treatment was not completed on the PM shift (1500 to 2300 hours) on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. - a monitoring ordered on [DATE], to monitor low air loss mattress function and placement according to weight and comfort every shift was blank with no licensed nurse initial to indicate if monitoring was completed or any code to indicate why the monitoring was not completed on the PM shift on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] at 0857 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 8. LVN 8 verified the above findings. On [DATE] at 0952 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 4. Review of the facility's P&P titled Comprehensive Resident Centered Care Plan revised 4/2025 showed the interdisciplinary team will develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meets the professional standards of quality of care. The facility team will provide a written summary of the baseline care plan to the resident and their representative that includes the initial goals of the resident, a summary of medications and dietary instructions, and any services and treatments to be administered. This summary will be in a language and conveyed in a manner the resident and/or their representative can understand. This summary will be provided by the time of the completion of the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive care plan. Review of the facility's P&P titled Discharge Summary and Plan revised [DATE] showed when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The content of the discharge summary section showed in part, the discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's: Medical status measurement (objective measurements of a resident's physical and mental abilities including, but not limited to, information on vital signs, clinical laboratory values, or diagnostic tests). The content of post discharge summary showed the post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will contain, as a minimum: a. A description of the resident's and family's preferences for care; b. A description of how the resident and family will access such services; c. A description of how the care should be coordinated if continuing treatment involves multiple caregivers; d. The identity of specific resident needs after discharge (example: personal care, sterile dressings, physical therapy); and e. A description of how the resident and family need to prepare for the discharge. Closed medical record review for Resident 90 was initiated on [DATE]. Resident 90 was admitted to the facility on [DATE], and was discharged on [DATE] Review of Resident 90's H&P examination dated [DATE], showed the resident had the capacity to understand and make decisions. Review of Resident 90's Order Summary Report dated [DATE], showed the following physician's order: - dated [DATE], to admit Resident 90 to the facility; and - dated [DATE], for the last covered day on [DATE], discharge on [DATE] with home health for PT and RN. a. Review of Resident 90's IDT Care Plan Review dated [DATE], showed the following: - IDT conference conducted secondary to initial review. - Section II, section 2b: to show if the resident participated in development and review of his/ her plan of care was not marked. - Section II, section 2bb: The area for explanation for not able to participate in the development and review of his/ her plan of care was blank. - Section III, section 3d: The name of social services was blank. - Section III, section 3e: The name of activity person was blank. - Section III, section 3g: The name of attending physician was blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Section IV, section 4a: The resident information on the admission record (face sheet) was verified with the resident and/ or resident representative was blank. - Section V, section 5a: The advance directive had no mark for the antibiotic therapy, cardiopulmonary, intravenous infusion, intubation, life support, resuscitation, and other directive. - Section V, section 5b: the additional comments section was blank. - Section VII, section 7i: The social services plan of care (cognitive patterns, mood and behavior) was blank. - Section VIII, section 8a: The summary of discharge plan was blank. - Section IX. 9a: to show if the resident and/ or resident representative have been notified of their right was not marked. - Section IX. 9b: to show if the resident and/or resident representative agreed with established plan of care was not marked, and no reason was specified. - Section X. 10 : to show if the physician/healthcare practitioner participated in the care plan review and agreed with established plan of care was not marked, and no reason was specified. On [DATE] at 1410 hours, an interview and concurrent closed medical record review for Resident 90 was conducted with the SSD. The SSD stated the IDT met for Resident 90's baseline care plan meeting; however, she could not remember the resident's IDT care conference. The SSD verified the IDT Care Plan Review dated [DATE], showed missing information as listed above. On [DATE] at 0918 hours, an interview and concurrent closed medical record review for Resident 90 was conducted with the DON. The DON stated she attended Resident 90's IDT baseline care plan meeting; however, she did not remember where it occurred. The DON verified the IDT Care Plan Review dated [DATE], showed missing information as listed above. On [DATE] at 1005 hours, an interview was conducted with the Administrator and DON was conducted. The Administrator and DON were informed and acknowledged the above findings. b. Review of Resident 90's Weights and Vital Signs Summary showed the following vital signs: - Resident 90's blood pressure was 122/ 80 mmHg on [DATE] at 0928 hours; - Resident 90's temperature was 97.6 degrees Fahrenheit on [DATE] at 0035 hours; - Resident 90's pulse was 94 beats per minute on [DATE] at 0035 hours; and - Resident 90's respiration was 17 breaths per minute on [DATE] at 0253 hours. Review of Resident 90's MAR for 1/1 – [DATE] showed the following: - Resident 90's blood pressure was 122/80 mmHg on [DATE] at 0900 hours; and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 90's pulse was 94 beats per minute on [DATE] at 0900 hours. Review of Resident 90's Discharge Summary and Post-Discharge Plan of Care dated [DATE], showed the resident's pain level was zero on [DATE] at 2304 hours. Review of Resident 90's Discharge Note dated [DATE] at 1521 hours, showed the resident was discharged with a family member with stable vital signs. However, further review of Resident 90's medical record failed to show a measurement of the resident's vital signs prior discharge, to indicate resident's medical status measurement at the time of discharge. On [DATE] at 1338 hours, an interview and concurrent closed medical record review for Resident 90 was conducted with RN 1. RN 1 verified Resident 90's vital signs measurements from the Weights and Vital Signs Summary, and Resident 90's MAR for 1/1 – [DATE] as listed above. RN 1 stated Resident 90's vital signs should have been obtained at the time of the resident's discharge, to assess if the resident was stable. On [DATE] at 0919 hours, an interview was conducted with the DON. The DON stated the expectation was for the licensed nurses to obtain the resident's vital sign measurements just prior to the time of the resident's discharge. On [DATE] at 1005 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the findings as above.

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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, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services for the use psychotropic medications were provided for one of five final sampled residents (Resident 80) reviewed for unnecessary psychotropic medications. * The facility failed to ensure Resident 80 was informed and the informed consent included the indication and manifested behaviors for the use sertraline (antidepressant medication) and Abilify (antipsychotic medication) as ordered by the physician. In addition, the facility failed to ensure the informed consent had the prescriber's signature. These failures had the potential for the Resident 80 to be unaware of the risks and potential side effects associated with the use psychotropic medications.Findings: Review of the facility's P&P titled Informed Consent revised 5/2019 showed it is the policy of this facility that resident rights are not violated and a copy of these rights and pertinent policies are made available to the resident and to any representative of the resident. The P&P further showed the following:1. Among these rights under this section are:a. The right to receive in advance all information that is material to a decision to accept or refuse treatment, andb. To consent to or to refuse any treatment or procedure; and2. Physician's orders related to the use of psychotherapeutic drug and physical restraints should not be initiated until an informed consent is obtained. Medical record review for Resident 80 was initiated on 2/22/26. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's H&P examination dated 2/14/26, showed the resident had the capacity to understand and make decisions Review of Resident 80's Order Summary Report dated 2/23/26, showed the following physician's order dated 2/22/26:- to administer Abilify 5 mg tablet, give 2.5 mg by mouth at bedtime for depression as manifested by verbalizations of feeling hopeless; and- to administer sertraline hydrochloride 100 mg tablet by mouth in the afternoon for depression as manifested by verbalizations of feeling sad with dinner. Review of Resident 80's MAR for February 2026 showed Resident 80 was administered the following medications:- dated 2/22/26 at 2100 hours, the Abilify 5 mg tablet, give 2.5 mg by mouth at bedtime for depression as manifested verbalizations of feeling hopeless; and- dated 2/22/26 at 1700 hours, the sertraline hydrochloride 100 mg tablet by mouth for depression manifested by verbalizations of feeling sad with dinner. Review of Resident 80's Psychotherapeutic Drug Informed Consent Form for Abilify medication showed Resident 80 signed the form on 2/13/26. However, further review of the form showed the indication for Abilify medication was for anxiety. The form also failed to show the behavior manifestations for the use of Abilify medication and the prescriber's signature. Review of Resident 80's Psychotherapeutic Drug Informed Consent Form for sertraline hydrochloride medication showed Resident 80 signed the form on 2/13/26. However, further review of the form showed the indication for the medication was for anxiety. The form also failed to show the behavior manifestations for the use of sertraline hydrochloride medication and the prescriber's signature. On 2/23/26 at 1503 hours, an interview and concurrent record review for Resident 80 was conducted with RN 1. RN 1 verified there were no informed consents to administer Abilify 5 mg tablet, to give 2.5 mg by mouth at bedtime for depression as manifested by verbalizations of feeling hopeless, and sertraline hydrochloride 100 mg tablet by mouth in the afternoon for depression as manifested by verbalizations of feeling sad with dinner as ordered by the physician on 2/22/26. RN 1 verified and acknowledged the above findings. On 2/23/26 at 1520 hours, an interview was conducted with Resident 80. Resident 80 stated she had been taking the Abilify and sertraline medications for anxiety as prescribed by her private psychiatrist prior to her admission to the facility. Resident 80 further stated she was not aware and the facility did not explain the Abilify and sertraline medications were being administered to her for treatment of depression. On 2/25/26 at 1005 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure privacy was provided for one nonsampled residents (Resident 4) during the medication administration. * The facility failed to ensure Resident 4's privacy was observed when the licensed nurse administered the resident's medications in the hallway. This failure had the potential to negatively affect the dignity of the resident and violate the resident's rights to privacy. Findings: Review of the facility's P&P titled Resident's Rights: Dignity and Privacy dated 11/2021 showed it is the policy of this facility that all residents be treated with kindness, dignity and respect. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by. Medical record review for Resident 4 was initiated on 2/22/26. Resident 4 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 4's MDS annual assessment dated [DATE], showed Resident 4 had a BIMS score of 10, which meant moderately impaired cognition. On 2/24/26 at 1325 hours, a medication administration observation was conducted for Resident 4 with LVN 5. Resident 4 was observed sitting in her wheelchair in the hallway, in front of Room A. LVN 5 prepared and administered the following medications to Resident 4:- one tablet of carbidopa-levodopa (medication to treat Parkinson's disease) 100 mg; and- three tablets of sodium chloride (supplement medication) 1 gram.LVN 5 was observed administering the medications to Resident 4 in the hallway, when other residents and facility staff members were observed passing. On 2/24/26 at 1351 hours, an interview was conducted with LVN 5. LVN 5 verified Resident 4 was not provided privacy during the medication administration observation. On 2/24/26 at 1402 hours, an interview was conducted with Resident 4. When asked, Resident 4 stated she preferred her medications to be administered inside her room. On 2/25/26 at 0857 hours, an interview was conducted with the DON. The DON was informed of the above findings. The DON stated the licensed nurse needed to provide privacy when administering the medications to the residents. On 2/25/26 at 1008 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to maintain a safe and homelike environment for one of 15 final sampled residents (Resident 86). * Resident 86's nightstand was not in good repair and safe condition. This failure had the potential to negatively impact on Resident 86's' quality of life and safety. Findings: On 2/22/26 at 0830 hours, during the initial tour of the facility, Resident 86's nightstand was observed by the resident's bed. A bedside commode was placed in front of the nightstand. Resident 86's nightstand was observed with the bottom drawer sticking out and unable to fully close. The right side of the nightstand that was positioned close to the resident's bed was observed with the lower part of the wood warped. Medical record review for Resident 86 was initiated on 2/22/26. Resident 86 was admitted to the facility on [DATE]. Review of Resident 86's H&P examination dated 2/22/26, showed the resident had the capacity to understand and make decisions. On 2/22/26 at 1130 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 86 used the bedside commode. On 2/22/26 at 1134 hours, an interview was conducted with Resident 86. Resident 86 stated she would like the facility to fix or change the nightstand because she could tear her skin or bump her head with the broken furniture. On 2/22/26 at 1140 hours, an interview was conducted with Family Member 1. Family Member 1 stated the residents tend to lean towards the edge of the bed when sleeping. Family Member 1 further stated he was concerned the resident might get injured with the broken nightstand. On 2/22/26 at 1149 hours, an observation of Resident 86's nightstand and concurrent interview was conducted with RN 1. RN 1 verified Resident 86's nightstand's bottom drawer was sticking out and did not fully close, and the right side of the nightstand that was positioned close to the resident's bed was observed with the lower part of the wood warped. RN 1 stated he would inform the maintenance staff to fix or change the nightstand. On 2/25/26 at 0948 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care were revised to reflect the residents' current care needs and interventions for two of 15 final sampled residents (Residents 17 and 75) reviewed for care plans. * Resident 17's care plan addressing the resident's nutrition was not revised to address Resident 17's significant unplanned weight loss on 1/21/26. In addition, the care plan interventions did not reflect Resident 17's current physician's orders. * The facility failed to ensure Resident 75's care plan addressing the resident's activity was revised to reflect the resident's contact isolation precaution. These failures posed the risk of not providing the resident with individualized and person-centered care. Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 4/2025 showed the facility IDT will develop and implement a comprehensive person-centered and culturally competent care plan for each resident and will include each resident's needs identified in the comprehensive assessment. Review of the facility's P&P titled Change in Condition revised 4/2025 showed if a staff member recognized the condition or care needs of the resident have changed, such as changes in weight, the IDT shall collaborate with the attending physician, resident, and/or resident representative to review the risk indicators and the plan of care. 1. Medical record review for Resident 17 was initiated on 2/22/26. Resident 17 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 17's H&P examination dated 1/7/26, showed Resident 17 had the capacity to understand and make her own medication decisions. Review of Resident 17's Order Summary Report, showed a physician's order dated 2/17/26, to provide a fortified diet (added vitamins and minerals to food to increase the nutritional value), easy to chew with level 7 texture (consists of soft, tender, and moist foods that are easy to bite) and thin liquids. Review of Resident 17's Weights and Vitals Summary, showed the following weights in January and February 2026: - dated 1/8/26, a weight of 131 lbs., - dated 1/14/26, a weight of 130 lbs.,- dated 1/21/26, a weight of 125 lbs.,- dated 1/28/26, a weight of 111 lbs.,- dated 2/4/26, a weight of 112 lbs., - dated 2/11/26, a weight of 110 lbs., and - dated 2/18/26, a weight of 110 lbs. Resident 17 had a significant unplanned weight loss of six lbs. (4.58 %) from 1/8 to 1/21/26, and 14 lbs. (11.2 %) from 1/21 to 1/28/26. In total, Resident 17 has a weight loss of 21 lbs. (16 %) from 1/8 to 2/18/26. Review of Resident 17's plan of care showed a care plan problem initiated on 1/7/26, and revised 2/17/26, addressing Resident 17's nutritional problem. The care plan showed on 1/7/26, Resident 17 was considered malnourished per the mini nutritional assessment, and on 2/11/26, Resident 17 lost (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	20 lbs. (15.3 %) in one month. The interventions showed to provide Resident 17 a regular diet, easy to chew – level 7 texture and thin liquids. Further review of Resident 17's plan of care did not show a care plan revision for Resident 17's significant unplanned weight loss of 6 lbs. (4.58 %) on 1/21/26. On 2/25/26 at 1029 hours, an interview and concurrent medical record review for Resident 17 was conducted with the DON. The DON stated the residents' care plans should be revised when there was a change in the residents' care. For Resident 17, there should have been a care plan addressing her weight loss on 1/21/26. The DON reviewed Resident 17's medical record and verified Resident 17 did not have a change in condition assessment and a care plan addressing Resident 17's weight loss on 1/21/26. The DON acknowledged the above findings for Resident 17. 2. Medical record review for Resident 75 was initiated on 2/22/26. Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's H&P examination dated 2/9/26, showed Resident 75 had the capacity to understand and make decisions. Review of Resident 75's plan of care showed a care plan dated 2/16/26, addressing Resident 75's activity. The interventions included to invite the resident to scheduled activities and explain that may leave activities at any time and is not required to stay for entire activity. Review of Resident 75's Order Summary Report, showed the following physician's orders: - dated 2/20/26, for contact isolation for a diagnosis of Shingles (viral infection that causes painful rash). - dated 2/20/26, for room placement: single room isolation (all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.) for Shingles. On 2/22/26 at 0805 hours, during the initial tour of the facility, Resident 75's room was observed with a sign outside the door for contact isolation precaution. Resident 75 was observed sitting in her wheelchair and stated she was on contact isolation for Shingles. Resident 75 stated she was in the room by herself and felt lonely. On 2/23/26 at 1223 hours, a follow up interview was conducted with Resident 75. Resident 75 stated she never went out to attend activities in the facility, and no facility staff came and offered her room activities. On 2/23/26 at 1413 hours, an interview and concurrent medical record review was conducted with Activity Director. The Activity Director verified Resident 75's care plan for activity was not revised nor modified when Resident 75 was diagnosed with Shingles and was unable to leave her room due to contact isolation precaution. The Activity Director failed to show a documentation if the facility offered room activities to Resident 75. On 2/25/26 at 0857 hours, an interview was conducted with the DON. The DON was informed of the above findings. The DON stated Resident 75's activity care plan should have been updated with Resident 75's new order for contact isolation precaution. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/26 at 1008 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services status post fall for one of 15 final sampled residents (Resident 82) and dietary services for one non-sampled resident (Resident 40) in accordance to the facility's P&P. * The facility failed to complete the physical assessment, obtain the vital signs and perform the neuro checks post fall incident for Resident 82. In addition, the facility failed to monitor Resident 82's blood pressure and heart rate prior to the administration of sacubitril-valsartan (a medication used to treat chronic heart failure) and complete a fall risk assessment correctly. * The facility failed to provide Magic Cup (a nutritional supplement) to Resident 40 as ordered by the physician. These failures posed a risk for the residents to not receive the appropriate care and could negatively affect the residents' health and well-being and potentially contributed to Resident 82's death. Findings: 1. Review of the facility's P&P titled Fall Management System revised 4/2025 showed it is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The Procedure section included when a resident sustains a fall, a physical assessment will be completed by a licensed nurse, with results documented in the medical record.a. The attending physician and resident representative shall be notified of the fall and the resident status. b. Follow-up documentation will be completed for a minimum of 72 hours following the incident.c. A Fall Risk Evaluation will be completed post fall incident. Review of the facility's P&P titled Acute Changes in Condition - Clinical Protocol revised October 2010 showed the following:- As a part of the initial assessment, the physician will help identify individuals with a significant risk for having acute changes of condition during their stay; In addition, the nurse shall assess and document/report the following baseline information: a. Vital signs; b. Neurological status; c. Current level of pain, and any recent changes in pain level; d. Level of consciousness; e. Cognitive and emotional status; f. Resident's age and sex; g. Onset, duration, severity; h. Recent labs; i. History of psychiatric disturbances, mental illness, depression, etc.; J. All active diagnoses; and k. All current medications; - Before contacting a physician about someone with an acute change of condition, the nursing staff will make pertinent observations and collect appropriate information to report to the physician.phone calls to attending physician should be made by adequately prepared nurse who has collected pertinent information, including the resident's current symptoms and status;- The nursing staff will contact the Physician based on the urgency of the situation; and- The nurse and physician will discuss the situation and the physician should ask questions to clarify the situation; for example, vital signs, physical findings, and description of symptoms. Review of the facility's P&P titled Neurological Assessment revised October 2010, showed neurological assessment are indicated: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition. When assessing the neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure (ICP), and any change in vital signs or /neurological status in a previously stable resident should be reported to the physician immediately. The Neurological Assessment P&P further showed the Steps in the Procedure included to take the temperature, pulse, respirations and blood pressure and the Documentation section showed the following information should be recorded in the resident's medical record:1. The date and time the procedure was performed; 2. The name and title of the individual(s) who performed the procedure;3. All assessment data obtained during the procedure;4. How the resident tolerated the procedure;5. If the resident refused the procedure, the reason(s) why and the intervention taken; and6. The signature and title of the person recording the data. Review of the facility's P&P titled Charting and Documentation revised 4/2008 showed all services provided to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record; all observations, medication administered, services performed, etc. must be documented in the resident's clinical records; and all incidents, accidents, or changes in the resident's condition must be recorded. Medical record review for Resident 82 was initiated on 2/22/26. Resident 82 was admitted to the facility on [DATE]. Review of Resident 82's H&P examination dated 2/22/25, showed the resident lacks the capacity to make decisions. Review of Resident 82's Order Summary Report dated 2/22/25, showed the following physician's orders:* dated 2/21/26, to administer the following:- apixaban (a blood thinner) 5 mg tablet by mouth two times a day;- empagliflozin (used to lower blood sugar) 10 mg tablet by mouth one time a day;- furosemide (a diuretic) 40 mg tablet by mouth one time a day;- memantine hydrochloride (decreases abnormal activity in the brain) 5 mg tablet every 12 hours, discontinued on 1/23/26;- carvedilol (an antihypertensive) 6.25 mg tablet by mouth two times a day;- quetiapine fumarate (an antipsychotic medication) 25 mg tablet by mouth at bedtime, discontinued on 1/23/26;- sacubitril-valsartan (a medication used to treat chronic heart failure) 24-25 mg tablet by mouth every 12 hours, to hold if the systolic blood pressure is less than 110 mmHg and heart rate less than 60 beats per minute; and- spironolactone (a diuretic) 25 mg tablet, give half tablet by mouth one time a day, to hold if the systolic blood pressure is less than 110 mmHg and heart rate less than 60 beats per minute .* dated 2/22/26, to administer the following:- clonidine hydrochloride (an antihypertensive) 0.1 mg tablet by mouth one time a day;- clonidine hydrochloride (an antihypertensive) 0.1 mg tablet by mouth every 8 hours as needed for a systolic blood pressure greater than 150 mmHg; and- trazadone hydrochloride (an antidepressant) 25 mg by mouth every 24 hours as needed for inability to sleep. a. Review of Resident 82's eInteract SBAR Communication Notes dated 2/23/26 at 2010 hours, showed the resident had a fall. The documented vital signs were blood pressure = 157/86 mmHg, pulse rate = 65 beats per minute, respiration rate = 18 breaths per minute, and temperature = 97.2 degrees Fahrenheit. The evaluation for Resident 82's behavior, respiratory, cardiovascular, abdominal or gastrointestinal, genitourinary, skin evaluation, pain and neurological evaluations were marked not clinically applicable to the change in condition being reported. The notes further showed the physician was notified with no new orders. Review of Resident 82's Weight and Vitals Summary showed the following documented vital sign:- dated 2/23/26 at 1802 hours, the blood pressure was 157/85 mmHg;- dated 2/23/26 at 2003 hours, the temperature was 97.2 degrees Fahrenheit;- dated 2/23/26 at 1802 hours, the pulse rate was 65 beats per minute; and- dated 2/23/26 at 0825 hours, the respiration rate was 18 breaths per minute. Further review of the Weights and Vitals Summary failed to show the vital signs were obtained on 2/23/26 after Resident 82 had a fall incident. Review of Resident 82's Nursing Progress Notes showed the following:- dated 2/23/26 at 2011 hours, the resident was found sitting on the floor mat next to his bed.- dated 2/23/26 at 2213 hours, at around 2140 hours, Resident 82 was found unresponsive, the code status was checked, the resident was DNR, and the vital signs were checked and were non-recordable. The note further showed another nurse assess the vital signs and were still non-recordable.- dated 2/23/26 at 2218 hours, the post mortem care was rendered, and Resident 82's responsible party was informed of the resident's passing. Further review of Resident 82's Progress Notes failed to show Resident 82 was monitored after the fall. In addition, review of Resident 82's medical records failed to show a physician's order and documentation for the neuro-check monitoring after the fall. On 2/24/26 at 1111 hours, an interview and a concurrent record review for Resident 82 was conducted with RN 1. RN 1 reviewed Resident 82's eInteract SBAR Notes dated 2/23/26 at 2010 hours and verified those vital signs were taken prior to Resident 82's fall. RN 1 stated the vital signs should have been taken after the resident's unwitnessed fall. RN 1 acknowledge the body system assessments in SBAR should have been completed after the resident's unwitnessed fall to determine if there was an injury or changes in the resident's condition. In addition, RN 1 stated for the residents with unwitnessed fall the facility would start the neuro-checks. RN 1 stated the neuro-check form would be in the chart. However, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 1's paper chart failed to show the neuro-check form. On 2/24/26 at 1141 hours, a telephone interview was conducted with LVN 1. LVN 1 stated on 2/23/26 around 2000 hours, he saw resident sitting up next to his bed. LVN 1 stated he took the vital signs and documented the readings on the fall precaution sheet which was given to the nurse on the next shift. LVN 1 stated he did not assess for pain although the resident did not complain of any pain. When asked if he performed an assessment of Resident 82 after the fall, LVN 1 responded he checked the resident's hand grips. LVN 1 stated he notified the physician of Resident 82's fall and the physician responded with no new order. LVN 1 stated he did not discuss with the physician the medications Resident 82 was taking. On 2/24/26 at 1517 hours, a follow-up interview and concurrent record review for Resident 82 was conducted with LVN 1. LVN 1 stated he does not remember the last time he saw the resident prior to the incident of fall. LVN 1 stated he wrote the resident's vital signs in the neuro-check form. Review of the narcotic book where the neuro-check forms were located was conducted with LVN 1. LVN 1 checked the narcotic book; however, failed to locate a neuro-check form for Resident 82. On 2/24/26 at 1532 hours, an interview was conducted with LVN 2. LVN 2 stated she assisted LVN 1 to put Resident 82 back to bed after the fall. LVN 2 stated he did not ask if Resident 82 had any pain. LVN 2 further stated she did not assess the resident. LVN 2 stated she left Resident 82 and LVN 1 in the room after Resident 82 was put back to bed. On 2/24/26 at 1545 hours, an interview and concurrent record review for Resident 82 was conducted with LVN 3. LVN 3 stated LVN 1 reported Resident 82 fell; however, LVN 3 stated he did not assess Resident 82 as the resident was already back in bed. LVN 3 stated the vital signs after the fall should have been reflected on the resident's eInteract SBAR. LVN 3 stated for the residents on anticoagulant medication who had an unwitnessed fall, the facility would usually call the paramedics. On 2/25/26 at 0928 hours an interview and concurrent record review for Resident 82 was conducted with the DON. The DON verified Resident 82's vital signs in the SBAR form were not taken after the resident had a fall. The DON acknowledged the vital signs should have been taken and documented after the resident's fall. DON verified Resident 82's evaluation section for Behavior, Respiratory, Cardiovascular, Abdominal or Gastrointestinal, Genitourinary, Skin Evaluation, Pain and Neurological evaluations were marked as not clinically applicable to the change in condition being reported. The DON stated she will discuss the documentation with LVN 1. When asked if the facility conducted a neuro-check on Resident 82, the DON stated there was a neuro-check completed for Resident 82. The DON called the Medical Records Assistant over the speaker phone to obtain the resident's neuro-check form. The Medical Records Assistant responded she gave the form to LVN 1, for LVN 1 to complete; however, the form was not returned to her. The DON verified there was no neuro-check for Resident 82. On 2/25/26 at 1007 hours, an interview was conducted with the Administrator and the DON. The Administrator and the DON was informed of the findings as above. b. Review of the facility's P&P titled Medication Administration (undated) showed the medications will be administered as prescribed by the physician and will only by persons lawfully authorized to do so. Medications are administered in accordance with the written orders of the attending physician. Review of Resident 82's Order Summary Report showed a physician's orders dated 2/21/26, to administer sacubitril-valsartann24-25 mg tablet by mouth every 12 hours, and to hold if the systolic blood pressure was less than 110 mmHg and heart rate was less than 60 beats per minute. Review of Resident 82's MAR for February 2026 showed the sacubitril-valsartan 24-25 mg medication was administered on 2/22/26 at 2100 hours, and 2/23/26 at 2100 hours. However, the MAR failed to show if Resident 82's blood pressure and heart rate reading was obtained prior to the administration of the sacubitril-valsartan medication. Further review of Resident 82's medical records failed to show a blood pressure and heart rate was obtained prior to the administration of sacubitril-valsartan medication on 2/2/26 and 2/23/26. On 2/25/26 at 0856 hours, an interview and a concurrent record review for Resident 82 was conducted with RN 1. RN 1 verified the physician's orders dated 2/21/26, showed to administer sacubitril-valsartan 24-25 mg tablet by mouth every 12 hours, and to hold if the systolic blood pressure was less than 110 mmHg (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and if the heart rate was less than 60 beats per minute. RN 1 verified Resident 82's medical record failed to show the blood pressure and heart rate were obtained prior to the administration of sacubitril-valsartan 24-25 mg tablet on 2/22/26 at 2100 hours, and 2/22/26 at 2100 hours. On 2/25/26 at 1008 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was informed and acknowledged the above findings. c. Review of Resident 82's Fall Risk Evaluation date 2/21/26, the section for Medications showed to respond based on the following types of medications such as anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/ hypnotics. The medication section indicated Resident 86 was taking 1-2 of those medications. On 2/24/26 at 1111 hours, an interview and a concurrent record review for Resident 82 was conducted with RN 1. RN 1 verified Resident 18's Order Summary Report showed the resident was taking eight medications listed in the Fall Risk Evaluation. However, the medication section of Resident 89's Fall Risk Evaluation dated 2/21/26, indicated Resident 82 was only taking 1-2 of those medications. On 2/25/26 at 0928 hours an interview and concurrent record review for Resident 82 was conducted with the DON. The DON verified Resident 89's Fall Risk Evaluation dated 2/21/26, the Medication section indicated Resident 82 was taking 1-2 of the medications; however, Resident 82 was taking eight medications based on the classification listed. 2. Review of facility's P&P titled Diet Orders (undated) showed the diet orders as prescribed by the physician will be provided by the Food & Nutrition Services Department. The Procedure section showed any discrepancy in the diet slip will be clarified by the Food & Nutrition Services Department Director or cook in charge with Nursing. Medical record review for Resident 40 was initiated on 2/22/26. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's H&P examination dated 5/2/25, showed the resident did not have the capacity to make decisions. Review of Resident 40's Order Summary Report dated 2/23/25, showed a physician's order dated 7/10/25, to give Magic Cup 4 ounces per serving three times a day with meals for supplement. Review of Resident 40's Care Plan Report showed a focus problem initiated on 5/1/25 to address Resident 40's nutritional problem or potential nutritional problem. The intervention included to provide supplements as ordered, and Magic Cup three times a day. On 2/22/26 at 1248 hours, a dining observation was conducted with Resident 40 in her bedroom. Resident 40's Lunch Meal Ticket dated 2/22/26, showed Magic Cup. However, Resident 40's lunch tray was observed without a Magic Cup. On 2/22/26 at 1249 hours, a follow-up observation of Resident 40's lunch tray and concurrent interview was conducted with CNA 5. CNA 5 verified Resident 40's meal ticket indicated for Resident 40 to have a Magic Cup. CNA 5 also verified Resident 40's meal tray did not have the Magic Cup. CNA 5 stated she would go to the kitchen to request the Magic Cup. On 2/22/26 at 1250 hours, a follow-up interview was conducted with CNA 5. CNA 5 returned from the kitchen and stated the kitchen ran out of the Magic Cup. When asked what the facility's protocol was when a food item was missing in the resident's tray, CNA 5 stated she would ask the kitchen if they could provide an alternative. On 2/22/26 at 1252 hours, an interview and concurrent review of Resident 40's meal ticket was conducted with the RD. The RD verified Resident 40's meal ticket dated 2/22/26 showed Magic Cup. The RD stated the kitchen currently had no Magic Cup available. On 2/22/25 at 1003 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was informed and acknowledged the above findings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services for one of one final sampled residents (Resident 5) reviewed for indwelling urinary catheter (flexible tube inserted into the bladder to continuously drain urine into an external collection bag). * The facility failed to monitor Resident 5's urinary output per the resident's plan of care. This failure had the potential for the resident to develop indwelling urinary catheter related complications. Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 4/2025 showed the facility IDT will develop and implement a comprehensive person-centered and culturally competent care plan for each resident and will include each resident's needs identified in the comprehensive assessment. Medical record review for Resident 5 was initiated on 2/22/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 12/30/25, showed Resident 5 had the capacity to understand and make his own medical decisions. Review of Resident 5's Order Summary Report showed a physician's order dated 12/30/25, for an indwelling urinary catheter size #16 Fr to gravity drainage bag for obstructive uropathy (blockage in the urinary tract that prevents urine flow) related to urinary retention (unable to empty the bladder). Review of Resident 5's plan of care showed a care plan problem dated 2/10/26 and revised 2/23/26, addressing Resident 5's indwelling urinary catheter use. The interventions included to monitor the intake and output of the indwelling urinary catheter. However, further review of Resident 5's medical record failed to show the fluid output was monitored and documented for Resident 5. On 2/24/26 at 0850 hours, an interview for Resident 5 was conducted with CNA 2. CNA 2 stated she would empty Resident 5's urinary drainage bag and report the color and amount of urine collected from the drainage bag to the LVN. CNA 2 further stated she did not document the resident's fluid output because the LVN would chart the fluid output of the resident. On 2/24/26 at 1410 hours, an interview and concurrent observation was conducted with Resident 5. Resident 5 was observed lying in bed and the indwelling urinary catheter drainage bag was hanging on the right side of the bed. Resident 5 stated he had an indwelling urinary catheter because his enlarged prostate caused urinary retention. On 2/24/26 at 1423 hours, an interview and concurrent medical record review for Resident 5 was conducted with LVN 5. LVN 5 stated monitoring for the fluid intake and output was not necessary unless there was a physician's order. When asked what should be monitored for the residents with an indwelling urinary catheter, LVN 5 stated she would check for any leakage, clarity of the urine, and patency by checking if there was urine in the drainage bag. When asked if the CNAs would report the fluid output to the LVN, LVN 5 stated yes, but stated the LVNs did not have to document the fluid output. On 2/24/26 at 1622 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 1. RN 1 stated Resident 5 had an indwelling urinary catheter for urinary retention. When asked what should be monitored for the residents with an indwelling urinary catheter, RN 1 stated the treatment nurse would check for inflammation at the insertion point, clarity of the urine, and the resident should be producing 30 ml an hour of urine. When asked if the facility monitored the fluid intake and output for the residents with an indwelling catheter, RN 1 stated no and that monitoring for the luid intake and output was done in the acute care hospital setting. RN 1 stated the facility staff members monitored for urinary retention by using the bladder scanner (a non-invasive portable ultrasound device used to measure bladder volume). However, RN 1 stated the residents' care plans should be followed. RN 1 reviewed Resident 5's care plan for the use of an indwelling urinary catheter and stated the intervention for monitoring intake and output was entered inappropriately because the facility staff members did not monitor the fluid output. On 2/24/26 at 1638 hours, an interview and concurrent medical record review for Resident 5 was conducted with the DON. The DON was asked if the facility monitored the fluid intake and output, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON stated yes, but the facility would just document if the resident urinated. When asked where it was documented, the DON stated the fluid output should be documented under the Tasks - Fluid Output or Tasks - Bladder Continence in Resident 5's medical record. The DON reviewed the tasks summaries in Resident 5's medical record, however, the resident's medical record failed to show if the fluid output was monitored and documented for Resident 5. The DON verified there was no fluid output being monitored and documented for Resident 5. On 2/25/26 at 1029 hours, a follow up interview was conducted for Resident 5 with the DON. The DON stated Resident 5 had an indwelling urinary catheter due to urinary retention. The DON stated the fluid output should be monitored to ensure the resident was not retaining urine.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility P&P review, the facility failed to provide the necessary care and services related to weight loss for one of four residents (Resident 17) reviewed for nutrition. * The facility failed to ensure the physician was notified when Resident 17 had a weight loss. In addition, the facility failed to conduct an IDT meeting and carried out an RD recommendation related to Resident 17's weight loss. These failures had the potential for the resident to not receive the necessary care and nutritional interventions and could contribute to resident's further weight loss.Findings: Review of the facility's P&P titled Food and Nutrition Services - Nutrition Care Management dated 2/9/26 showed the facility shall ensure all residents maintain acceptable parameters of nutritional status such as usual body weight (UBW) or desirable body weight (DBW) and electrolyte balance, unless the resident's clinical condition or resident preference demonstrates that it is not possible. The section for Definitions for Weight Loss showed significant weight loss is a loss of 5% in one month, 7.5 % in three (3) months, or 10% in six months or unplanned weight loss that occurs over time. In addition, the physician will be notified by the licensed nurse of significant unplanned weight change percentages over time, the care plan shall be updated and revised as appropriate, and significant monthly weight changes will be reviewed by the facility IDT. Significant weight loss of 5% in one month, 7.5% in three months, or 10% in six months. Review of the facility's P&P titled Change in Condition revised 4/2025 showed if a staff member recognized the condition or care needs of the resident have changed, such as changes in weight, the licensed nurse shall be made aware to perform an assessment of the resident, identify needs for additional interventions, or communicate with the resident's physician using SBAR (Situation, Background, Assessment, Recommendation - a communication framework to ensure concise information exchange). The nurse will communicate the change to other departments as appropriate and the IDT shall collaborate with the attending physician, resident, and/or resident representative to review risk indicators and the plan of care. Medical record review for Resident 17 was initiated on 2/22/26. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 17's H&P examination dated 1/7/26, showed Resident 17 had the capacity to understand and make her own medication decisions. Review of Resident 17's Weights and Vitals Summary, showed Resident 17's weights on the following dates:- dated 1/14/26, a weight of 130 lbs.,- dated 1/21/26, a weight of 125 lbs.,- dated 1/28/26, a weight of 111 lbs.,- dated 2/11/26, a weight of 110 lbs., and- dated 2/18/26, a weight of 110 lbs. Review of Resident 17's Nutrition Evaluation and RDN Review 1/12/26, showed Resident 17's UBW was 131 lbs. and her DBW range was between 126 to 136 lbs. Resident 17's food preferences showed Resident 17 liked most food and disliked creamy soups. The nutritional plan of care for Resident 17 included to provide a Med Pass 2.0 (high protein, high calorie oral nutritional supplement) twice a day and to monitor her weight. The goal for Resident 17 was for her meal intake to be greater than 50% and to not have significant weight changes greater than 5%. Review of Resident 17's Order Summary Report, showed the following physician's orders:-dated 1/6/26, to provide Med Pass 2.0 five ounces per serving two times a day for the resident's risk of malnutrition, and-dated 1/14/26, to provide a health shake one time a day for nutritional supplement. 1. Review of Resident 17's Weights and Vitals Summary showed Resident 17 weighed 130 lbs. on 1/14/26, then weighed 125 lbs. on 1/21/26 (a weight loss of 5 lbs./3.8% in one week).Review of Resident 17's medical record failed to show if the physician was made aware of Resident 17's weight loss of 5 lbs. from 1/14 to 1/21/26. On 2/24/26 at 1206 hours, an interview and concurrent medical record review for Resident 17 was conducted with RNA 1. RNA 1 stated he obtained Resident 17's weights weekly; furthermore, RNA 1 stated the electronic medical record would alert the licensed nursing staff if a resident lost more than 5 lbs. in a week and he also would verbally notify the licensed nursing staff. When asked if he notified the licensed nursing staff regarding Resident 17's 6 lbs. weight loss on 1/21/26, RNA 1 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he did make a licensed nurse aware. On 2/24/26 at 1423 hours, an interview and concurrent medical record review for Resident 17 was conducted with LVN 5. LVN 5 stated weight loss of 5 lbs. or more was reported to the RD and physician. When asked if the physician was made aware of Resident 17's weight loss of 5 lbs. from 1/14 to 1/21/26, LVN 5 stated she did not see any documentation in Resident 17's medical record. 2. Review of Resident 17's eINTERACT Change in Condition Evaluation - V 5.1 dated 1/28/26, showed Resident 17 had 14 lbs. weight loss in one week and the physician and Resident 17's responsible party was made aware. Review of Resident 17's Weights and Vitals Summary showed Resident 17 weighed 125 lbs. on 1/21/26, then weight 111 lbs. on 1/28/26 (a weight loss of 14 lbs./11.2% in one week). Review of Resident 17's Progress Note - Weight Change Note by the RD dated 1/30/26, showed Resident 17's weight was 111 lbs. and the resident was noted with significant weight loss. The note further showed see nutrition IDT update note. However, Review of Resident 17's LN - Nutrition Interdisciplinary Team Update dated 1/30/26, showed the status of the document was in progress. The documentation only included Resident 17's weight of 111 lbs. 3. Review of Resident 17's Progress Note - Weight Change Note dated 2/13/26, showed a late entry from the RD discussing Resident 17's weight change. The RD note further showed Resident 17 might benefit from a fortified diet related to weight variance. Review of Resident 17's Order Summary Report showed a physician's order dated 2/17/26, to provide a fortified diet, easy to chew with level 7 texture (consists of soft, tender, and moist foods that are easy to bite) and thin liquids. Further review of Resident 17's medical record showed Resident 17 went below her DBW of 126 lbs. Resident 17's medical record failed to show any new interventions to be implemented or if the IDT was conducted to address Resident 17's weight loss of 14 lbs. in one week. In addition, Resident 17's diet was changed on 2/17/26, 20 days after the identified weight loss of 14 lbs. on 1/28/26. Review of Resident 5's LN - Nutrition Interdisciplinary Team Update dated 2/17/26, showed Resident 17's current weight was 110 lbs. and the resident now had a significant weight loss of 20 lbs. (15.3%) in one month. On 2/24/26 at 0902 hours, an interview and concurrent medical record review for Resident 17 was conducted with the RD. The RD stated when a resident had a weight loss triggered on the electronic medical record, the RD would review the resident's medical record and determine if the resident was experiencing a significant weight loss. If there was significant weight loss, the RD would notify the licensed nursing staff to complete a change of condition form, the RD would meet with the resident and discuss the change of condition during the IDT meeting. The RD stated Resident 17's 15% weight loss was a significant weight loss. When asked if there were any interventions or IDT meetings for Resident 17's weight loss on 1/28/26, the RD acknowledged the LN - Nutrition Interdisciplinary Team Update dated 1/30/26 was not completed. The RD further stated he spoke with Resident 17 on 2/13/26 and on 2/17/26 there was an IDT meeting regarding Resident 17's weight loss. When asked how often an IDT meeting should be conducted for Resident 17's weight loss, the RD stated it should have been done weekly. On 2/24/26 at 1622 hours, an interview and concurrent medical record review for Resident 17 was conducted with RN 1. RN 1 stated if a resident lost more than 2 lbs. a week, the process was to alert the physician and the RD. RN 1 further stated a weight loss greater than 5 lbs. was considered a change in condition and the dietitian and electronic medical record should have alerted the physician. On 2/25/26 at 1029 hours, an interview and concurrent medical record review for Resident 17 was conducted with the DON. If a resident had a significant weight loss the licensed nurse should contact the physician. Furthermore, the DON stated when a significant weight loss was reported, there should be an IDT meeting regarding the resident's weight. The DON verified there was no IDT meeting or change in condition document regarding Resident 17's weight loss on 1/21/26. The DON stated the 5 lb. weight loss should have been addressed. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for one of one final sampled resident (Resident 86) and two non-sampled residents (Residents 16 and 51) reviewed for the respiratory care. * The facility failed to ensure Resident 86 had a physician's order for the use of oxygen therapy. Furthermore, when Resident 86 had an order for oxygen, Resident 86 was provided with oxygen greater than what was ordered by the physician. In addition, Resident 86's nebulizer mask and tubing were not labeled and stored properly when not in use. * The facility failed to ensure the nebulizer mask and tubing at Resident 16's bedside was labeled and stored in a bag. In addition, the facility failed to ensure the nebulizer mask and tubing at Resident 16's nightstand belonged to the resident. * The facility failed to ensure Resident 51's nebulizer mask was stored in a set-up bag when not in use. These failures had the potential for the residents not to receive the appropriate respiratory care and could negatively affect the residents' health and well-being.Findings: Review of the facility's P&P titled Oxygen Administration revised October 2010, showed the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review of the facility's P&P titled Administering Medications through a Small Volume Handheld Nebulizer revised October 2010 showed the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The steps in the Procedure section showed (in part) 23. administer therapy until medication is gone; 27. Rinse and disinfect the nebulizer equipment according to the facility protocol, or a. wash pieces with warm soapy water, b. Rinse with hot water; c. Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. d. Rinse all pieces with sterile water (not tap, bottled, or distilled); and e. Allow to air dry on a paper towel; 29. When equipment is completely dry, store in a plastic bag with resident's name and the date on it; and 30. Change equipment and tubing every seven days, or according to facility protocol. 1. Medical record review for Resident 86 was initiated on 2/22/26. Resident 86 was admitted to the facility on [DATE]. Review of Resident 86's H&P Examination dated 2/22/26, showed resident had the capacity to understand and make decisions. a. On 2/22/26 at 0758 hours, during the initial tour of the facility, Resident 86's was observed lying in bed. Resident 86 was observed using the oxygen via nasal cannula and the oxygen concentrator was set at a rate of three liters per minute. On 2/22/26 at 1148 hours, an observation for Resident 86 and concurrent interview was conducted with RN 1. RN 1 verified Resident 86 was using oxygen and the oxygen concentrator was set at three liters per minute. On 2/22/26 at 1152 hours, an interview and concurrent record review for Resident 86 was conducted with RN 1. RN 1 verified Resident 86's medical record failed to show a physician's order for the use of oxygen. RN 1 further stated resident's use of oxygen would require a physician's order. b. Review of Resident 86's Order Summary Report showed a physician's order dated 2/22/26, to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer continuous oxygen at a rate of two liters per minute via nasal cannula or mask to keep the oxygen saturation above 90% every shift for shortness of breath. On 2/23/26 at 1013 hours, Resident 86 was observed in her bedroom sitting in the wheelchair using oxygen via nasal cannula. The oxygen concentrator was set at a rate of three liters per minute. On 2/23/2026 at 1200 hours, an observation of Resident 86 and concurrent interview was conducted with RN 1. RN 1 verified resident was provided with oxygen via nasal cannula at a rate of three per minute via oxygen concentrator. On 2/23/26 at 1207 hours, an interview and a concurrent record review for Resident 86 was conducted with RN 1. RN 1 verified Resident 86's medical record showed a physicians order dated 2/22/26 to administer continuous oxygen at a rate of two liters per minute via nasal cannula or mask to keep oxygen saturation above 90% every shift for shortness of breath. RN 1 stated he will decrease resident's oxygen to follow the physician's order. On 2/25/26 at 0951 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was informed and acknowledged the above findings. c. Review of Resident 86's Order Summary Report dated 2/25/26, showed a physician's order dated 2/21/26, to administer albuterol sulfate (a bronchodilator, works by opening airways to make breathing easier) inhalation nebulization solution 2.5 mg/ 0.5 ml give 3 ml, inhale orally via nebulizer every four hours for shortness of breath. Review of Resident 86's MAR for February 2026 showed the albuterol sulfate inhalation nebulization solution was administered to the resident on 2/21/26 at 2000 hours, and on 2/22/26 at 0000 hours. On 2/22/26 at 0758 hours, during the initial tour of the facility, Resident 86's was observed lying in bed. Resident 86's nebulizer mask and tubing was observed on top of a plastic bag inside the opened top drawer of the nightstand. On 2/22/26 at 0837 hours, a follow-up observation of Resident 86's nebulizer mask and tubing and concurrent interview was conducted with the MDS Nurse. The MDS Nurse verified Resident 86's nebulizer mask was observed with some fluid in the receptacle, the mask was placed on top of the unlabeled plastic bag, and the nebulizer and tubing had no label of the resident's name and date. The MDS nurse stated the nebulizer mask should have been emptied and stored in a bag labeled with the resident's name and date. On 2/25/26 at 0952 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was informed and acknowledged the above findings. 2. On 2/22/26 at 0945 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 16. Resident 16 was observed lying in her bed. A nebulizer mask and tubing attached to a nebulizer machine was observed on top of Resident 16's nightstand and exposed to air. Resident 16 stated the nebulizer mask and tubing does not belong to her. Resident 16 further stated the equipment had been there. On 2/22/26 at 0946 hours, an observation and concurrent interview was conducted with LVN 4 on Resident 16' room. LVN 4 verified the nebulizer mask and tubing was exposed to air and was not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inside a labeled bag with the resident's name and date. LVN 4 stated the nebulizer masks and tubing should have been stored in a bag labeled with the resident's name and date. Medical record review for Resident 16 was initiated on 2/22/26. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 1/31/26, showed the resident had the capacity to understand and make decisions. Further review of Resident 16's medical records failed to show a physician's order to administer inhalation solution via nebulizer to the resident. On 2/22/26 at 0950 hours, an interview and concurrent record review was conducted with LVN 4. LVN 4 verified Resident 16's medical record failed to show a physician's order to administer solution via nebulizer to the resident. LVN 4 stated he was not sure who the nebulizer machine and the nebulizer mask belonged to. LVN 4 acknowledged the respiratory supplied should not be at Resident 16's nightstand. LVN was observed removing the nebulizer machine and mask from resident's nightstand. On 2/25/26 at 0952 hours, an interview was conducted with the Administrator and DON. The administrator and DON was informed and acknowledged the above findings. 3. On 2/22/26 at 0829 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with LVN 4. Resident 51's nebulizer mask was observed on top of the Resident 51 bedside table and not stored in a set up bag. LVN 4 verified Resident 51's nebulizer mask was not stored in the bag. LVN 4 stated the nebulizer mask needed to be inside a set up bag when not in use to prevent infection. Review of Resident 51's medical record was initiated on 2/22/26. Resident 51 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of the Resident 51's admission MDS assessment dated [DATE], showed Resident 51 had a BIMS score of 14 (meaning cognitively intact). Review of Resident 51's Order Summary Report dated 2/23/26, showed the following physician's order: - dated 2/3/26, for Pulmicort Suspension (a bronchodilator) 0.5 mg/2ml to give 0.5 mg nebulizer every 12 hours for COPD; and - dated 2/11/26, for levalbuterol inhalation solution (a bronchodilator) 0.31mg/3ml to give 3 ml via nebulizer every 12 hours for wheezing shortness of breath, and levalbuterol inhalation solution (a bronchodilator) 0.31mg/3ml to give 3 ml via 3 ml inhale orally via nebulizer every 6 hours as needed for wheezing shortness of breath. On 2/25/26 at 0857 hours, an interview was conducted with the DON. The DON acknowledged the above findings. The DON stated the nebulizer tubing should have been stored in a bag to keep it clean, sanitary and for infection control. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/26 at 1008 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services for one final sampled resident (Resident 7) and one nonsampled resident (Resident 74). * LVN 7 failed to administer Resident 74's probiotic (supplement) as ordered by the physician. * The facility failed to obtain and document Resident 7's blood pressure and heart rate per the physician's ordered parameters for two medications: amlodipine-olmesartan (blood pressure medication) and metoprolol succinate (blood pressure medication). These failures had the potential to negatively affect the residents' well-being.Findings: 1. Review of the facility's P&P titled Medication Administration (undated) showed medications will be administered as prescribed by the physician, and only by persons lawfully authorized to do so. Medications are administered in accordance with the written orders of the attending physicians. On 2/24/26 at 0836 hours, a medication administration observation for Resident 74 was conducted with LVN 7. LVN 7 prepared and administered the following medications to Resident 74: - one tablet of amiodarone (medication to treat abnormal heartbeat) 200 mg; - one tablet of Eliquis (blood thinner medication) 5 mg; - one tablet of gabapentin (medication to treat pain or seizures) 600 mg; - one capsule of duloxetine (medication to treat depression) 40 mg; - two tablets of methocarbamol (medication to treat muscle spasm) 500 mg; and - two tablets of oxycodone (narcotic analgesic medication) 5mg. Medical record review for Resident 74 was initiated on 2/22/26. Resident 74 was readmitted to the facility on [DATE]. Review of Resident 74's H&P examination dated 1/30/26, showed Resident 74 had the capacity to understand and make decisions. Review of Resident 74's Order Summary Report dated 2/24/26, showed a physician's order dated 1/27/26, to administer probiotic (supplement) oral tablet one tablet by mouth one time a day for supplement. On 2/24/26 at 1120 hours, an interview and concurrent medical record review for Resident 74 was conducted with LVN 7. LVN 7 verified she failed to administer the probiotic to Resident 74 during the medication administration observation. On 2/25/26 at 0857 hours, an interview was conducted with the DON. The DON was informed of the above findings. The DON stated the licensed nurses needed to follow the five rights of medication administration to prevent medication error and the medications ordered by physicians should be administered as ordered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/26 at 1008 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Charting and Documentation revised 4/2008 showed all observations, medications administered, services performed must be documented in the resident's clinical records. Documentation of procedures shall include care-specific details such as the assessment data and/or any unusual findings obtained during the procedure/treatment. Medical record review for Resident 7 was initiated on 2/22/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 7/24/25, showed Resident 7 had a medical diagnosis of hypertension (high blood pressure). Review of Resident 7's Order Summary Report showed the following physician's orders: - dated 7/22/25, to administer amlodipine-olmesartan 5-40 mg one tablet by mouth one time a day for hypertension. Hold the medication if the systolic blood pressure was less than 110 mmHg or the heart rate was less than 60 beats per minute (bpm); and- dated 7/22/25, to administer metoprolol succinate extended release 25 mg tablet by mouth one time a day for hypertension. Hold the medication if the systolic blood pressure was less than 110 mmHg or the heart rate was less than 60 bpm. Review of Resident 7's MAR for February 2026 showed when Resident 7's amlodipine-olmesartan and metoprolol succinate medications were not administered to Resident 7 and coded the number 12, which indicated the blood pressure was below the set parameter. However, the blood pressure and heart rate were not obtained or documented on the following dates: 2/2, 2/5, 2/9, 2/12, 2/13, and 2/20/26 at 0900 hours. Further review of Resident 7's medical record failed to show the blood pressure or heart rate was obtained on 2/2, 2/5, 2/9, 2/12, 2/13, and 2/20/26 at 0900 hours. On 2/24/26 at 1423 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 5. LVN 5 stated Resident 7 was prescribed the metoprolol and amlodipine medications; and his blood pressure and heart rate should be obtained and documented prior to administering the medications. LVN 5 verified the above findings. On 2/24/26 at 1622 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Resident 7's blood pressure and heart rate should have been obtained and documented because there should be a reason to show why the medications were held. On 2/25/26 at 1029 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON was informed and verified the above findings. The DON stated the expectation for the licensed nurses was to obtain the vital signs of the residents prior to holding or administering the medications per the physician's orders.

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	555027	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beachside Nursing Center	7781 Garfield Avenue Huntington Beach, CA 92648

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure for proper storage, labeling, and disposal of the medications for two final sampled residents (Residents 2 and 33), one nonsampled resident (Resident 19) and one of three medication carts (Medication Cart A) observed. * The facility failed to ensure Resident 2's hydrocodone-acetaminophen (a controlled drug used to manage severe pain) and Resident 19's oxycodone (a controlled drug used to manage severe pain) medication bubble packs were properly stored in Medication Cart A. * The facility failed to ensure the accurate labeling of one insulin pen stored in Medication Cart A. * The facility failed to ensure the calmospetine (a moisture barrier designed to protect and heal skin irritations, diaper rash, incontinence, and minor wounds) cream was not left unattended by the licensed nurse on Resident 33's bedside table. These failures had the potential to negatively impact on the residents' well-being, posed the risk for the occurrence of errors in the medication administration and the potential for the medications to lose stability and effectiveness.Findings: 1. Review of the facility's P&P titled Labelling Requirement (undated) showed drugs will be labeled in accordance with state and federal laws. Containers with soiled, damaged, incomplete, ineligible or makeshift labels are not to be used. They are to be returned to the pharmacy for relabeling or they are disposed of per facility policy. On 2/22/26 at 1509 hours, an inspection of Medication Cart A was conducted with LVN 1. The following was observed: - Resident 2's hydrocodone-acetaminophen bubble pack (a sealed package of drugs where one pill is enclosed in each plastic blister. Each bubble pack usually contains about 30 pills) was observed with the back of blister pack for number 17 open. - Resident 19's oxycodone bubble pack was observed with the back of the blister pack for number 25 open. On 2/22/26 at 1511 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the above findings and stated he did not notice the open bubble pack blister when he counted the controlled drugs with the outgoing licensed nurse. On 2/22/26 at 1512 hours, an observation and concurrent interview was conducted with the DON. The DON verified the findings and stated the facility would discard the medications inside the opened blister packs with two licensed nurses. 2. Review of the facility's P&P titled Labelling Requirement (undated) showed drugs will be labeled in accordance with state and federal laws. All prescription drugs labels shall include the following information: b). Strength of Drug. (Injectable drugs will include the concentration). 1. Quantity (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Expiration date. 3. Resident's name 4. Direction of Use 5. Physician's Name 6. Date of Dispensing 7. Name, Address and Phone number of Pharmacy Dispensing 8. Prescription number 9. Any applicable Auxiliary Labels On 2/22/26 at 1506 hours, an inspection on Medication Cart A and concurrent interview was conducted with LVN 1. One Lantus Solostar (medication to manage high blood sugar) pen with instructions for single resident use only was observed without a label with the resident's name, direction for use, physician's name and the pharmacy dispensing the medication. LVN 1 verified the findings and stated the medication should have been labeled to show who the medication belongs to, to prevent the spread of infection. On 2/25/26 at 0857 hours, an interview was conducted with the DON. The DON was asked regarding the process of open bubble packs for the controlled medication. The DON stated there should be no open bubble packs for the controlled medications to prevent medication for contamination and infection control. The DON further stated that all insulin pen medications should have labels with the resident's name and direction for use to prevent medication error and spread of infection. The DON verified the above findings. On 2/25/26 at 1008 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Review of facility's P&P titled Drug Storage and Labeling (undated) showed drugs and biologicals will be stored in a safe, secure, and orderly fashion, and will be accessible only to licensed nursing or pharmacy personnel. On 2/22/26 at 0910 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 33. Resident 33 was observed lying on the bed in her room. A pink cream and a tongue depressor inside a medication cup was observed on top of the resident's bedside table. Resident 33 stated the pink cream was for her buttocks. Medical record review for Resident 33 was initiated on 2/22/26. Resident 33 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 33's H&P examination dated 1/26/26, showed the resident had no capacity to understand and make decisions. Review of Resident 33's Order Summary Report dated 2/25/26, showed a physician's order on (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/23/26, to apply antifungal cream 2 % to the perineal (thin layer of skin between the vagina or scrotum and anus) for skin management every shift. On 2/22/2026 at 0912 hours, an observation of Resident 33's bedside table and concurrent interview was conducted with LVN 9. LVN 9 verified the pink cream inside the medication cup was Calmoseptine (a moisture barrier designed to protect and heal skin irritations, diaper rash, incontinence, and minor wounds) cream. LVN 9 stated she did not know who put the Calmoseptine cream on the resident's bedside table. LVN 9 was observed removing the cream from the resident's bedside table. LVN 9 stated the Calmoseptine cream should not have been left on the resident's bedside table for safety. Further review of Resident 33's medical record failed to show a physician's order to apply Calmoseptine cream to the resident. On 2/23/26 at 1029 hours, an interview was conducted with CNA 4. CNA 4 stated she helped the treatment nurse apply the Calmoseptine cream to the resident earlier in the morning. On 2/23/26 at 1412 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 9. LVN 9 verified Resident 33 did not have a physician's order for the Calmoseptine cream. On 2/23/26 at 1449 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 8. LVN 8 stated the resident had wound treatment for skin management but denied applying the Calmoseptine cream to Resident 33 earlier in the morning. LVN 8 verified the resident used the antifungal 2% cream for skin management. LVN 8 verified the resident did not have a physician's order for the Calmoseptine cream. On 2/25/26 at 0952 hours, an interview was conducted with the DON. The DON stated there should be no medication left unattended at the resident's bedside table. The DON was informed and acknowledged the findings as above.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infection. The facility failed to ensure Resident 24's wound vacuum machine and the connector tubing were not stored and touching the floor. This failure posed the risk for the resident to develop a wound infection that could negatively affect the resident's health and well-being. Findings: Review of the facility's P&P titled Infection Prevention and Control Program revised 10/2022 showed the infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection prevention and control program consist of coordination/ oversight, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. On 2/22/26 at 0859 hours, during the initial tour of the facility, an observation was conducted for Resident 24. Resident 24's wound vacuum machine and the connector tubing was observed on the floor by the left side of Resident 24's head of the bed. On 2/22/26 at 0904 hours, a follow-up observation of Resident 24 and concurrent interview was conducted with LVN 4. LVN 4 verified Resident 24's wound vacuum machine and the connector tubing was observed on the floor by the left side of Resident 24's head of the bed. LVN 4 stated the wound vacuum connection tubing and wound vacuum machine should not be stored on the floor for infection control. Medical record review for Resident 24 was initiated on 2/22/26. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's Order Summary Report dated 2/23/26, showed a physician's orders dated 2/7/26, to connect the left lower leg to wound vacuum; irrigate the wound with normal saline, pat dry, fill with black foam, apply skin protectant to peri wound, secure with transparent dressing, apply [NAME] pad, and secure with transparent dressing; wound vacuum on continuous suction at 125mmhg every shift; and apply stocking then place the fiberglass splint and wrap with ace wrap every day shift, every Mondays, Wednesdays, and Fridays. On 2/23/26 at 1421 hours, an interview was conducted with LVN 8. LVN 8 stated Resident 24's wound vacuum machine and the connector tubing should be stored lower than the resident's wound; however, the wound vacuum machine and the connector tubing should not be on the floor to prevent infection. On 2/25/26 at 0950 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, immunization document review, and facility P&P review, the facility failed to ensure the necessary services related to COVID-19 vaccination was provided for two of five residents (Residents 5 and 7) reviewed for immunizations. * The facility failed to ensure Residents 5 and 7 were provided the education specific to eligibility to receive COVID-19 vaccine. This failure posed the risk for the residents to acquire COVID-19 infection and could negatively affect the residents' health and well-being.Findings: Review of the facility's P&P titled Resident Immunizations revised 4/2025 showed it is the policy of the facility to offer and administer COVID-19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine and obtaining consent. To minimize the risk of residents acquiring, transmitting, or experiencing complications from COVID-19, each resident is informed about the benefits and risks of immunizations; and has the opportunity to receive the COVID-19 vaccine, unless medically contraindicated, declined, or already immunized. Based on current CDC guidelines, the facility will determine the COVID-19 immunization status of the resident and offer COVID-19 vaccines the resident may be eligible to receive. Eligibility may be based on timing of previous illness or immunization, medical status or other considerations. 1. Medical record review for Resident 5 was initiated on 2/23/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's MDS assessment dated [DATE], showed Resident 7 was cognitively intact. Review of Resident 5's current California Immunization Registry Immunization Record showed Resident 5 last received a COVID-19 vaccine on 10/11/21. The recommended date for Resident 5 to receive a seasonal COVID-19 vaccine was on 8/22/25, and Resident 5's COVID-19 vaccine was past due. Review of Resident 5's Consent for COVID-19 Vaccination dated 12/29/25, showed Resident 5 declined COVID-19 vaccination, as Resident 5 was previously vaccinated and up to date. On 2/23/26 at 1103 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified Resident 5's California Immunization Registry Immunization Record showed Resident 5 was eligible and past due to receive a seasonal COVID-19 vaccination. The IP also verified Resident 5's Consent for COVID-19 Vaccination dated 12/29/25, showed Resident 5 declined COVID-19 vaccination as Resident 5 was previously vaccinated and up to date. The IP stated Resident 5's consent form was inaccurate as Resident 5 was not up to date with the seasonal COVID-19 vaccine. The IP stated she would follow up with Resident 5 and provide him with education specific to his eligibility to receive the seasonal COVID-19 vaccine and explain the risks and benefits of receiving the COVID-19 seasonal vaccine. 2. Medical record review for Resident 7 was initiated on 2/23/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Consent for COVID-19 Vaccination dated 7/22/25, showed Resident 7's Responsible Party (RP) declined COVID-19 vaccination as Resident 7 was previously vaccinated and up to date. On 2/23/26 at 1103 hours, an interview and concurrent medical record review was conducted with the IP. The IP reviewed Resident 7's California Immunization Registry Immunization Record and Resident 7's medical record specific to Resident 7's COVID-19 immunization history. The IP stated there was no record of Resident 7 ever having received the COVID-19 vaccine. The IP then verified Resident 7's Consent for COVID-19 Vaccination dated 7/22/25, showed Resident 7's RP declined COVID-19 vaccination as Resident 7 was previously vaccinated and up to date. The IP stated Resident 7 was not up to date with COVID-19 vaccination and would need to contact Resident 7's RP to provide education specific to Resident 7's eligibility to receive the COVID-19 vaccine and the risk and benefits of the COVID-19 vaccine.