

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026

Form Approved OMB

No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER College Vista Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4681 Eagle Rock Blvd. Los Angeles, CA 90041	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed maintains acceptable parameters of nutritional status, to prevent unintended significant weight loss for Two of three sampled residents (Resident 28 and Resident 8) in accordance to the facility's policy and procedures titled Weight Management Policy and Nutritional Assessment. 1. For Resident 28 who lost 17.3 pounds (lbs.) with 16.29 (%) percent of body weight six months from 106.2 lbs. on 10/3/2025 to 88.9 lbs. on 4/3/2026 the facility failed to: a. Reassess Resident 28's food preferences, according in which the resident reported her preferred food. b. Conduct an IDT Interdisciplinary Team- with the party responsible involved to determine the possible root cause of Resident 28's weight loss. c. Update the care plan interventions to address her continued weight loss. d. Monitor, evaluate and document how much Resident 28 consumed with each supplement provided to determine if the supplement was consumed or not. These deficient practices had resulted in Resident 28's unintended significant weight loss and continued severe weight loss. 2. For Resident 8 who had kidney failure (failure of the kidney to filter toxins and remove extra fluid in the body) and receives hemodialysis (dialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) fluid intake restriction was added to the plan of care as recommended by the Registered Dietitian's (RD) fluid recommendation of 1800 milliliters (ml, unit of measure). This failure had the potential to place Resident 8 at risk for altered hydration status which may lead to severe dehydration or fluid overload which may result in hypotension (low blood pressure) or hypertension (high blood pressure), edema (swelling), shortness of breath, heart failure (heart cannot effectively pump blood to the rest of the body) and may lead to hospitalization. Findings: 1. During a review of Resident 28's admission Record (AR), the AR indicated the facility admitted Resident 28 on 11/27/2024 with diagnoses that include type II diabetes mellitus (a condition when the blood sugar was too high) and depression (a common, serious mood disorder that causes persistent sadness, loss of interest, and physical or emotional symptoms). During a review of Resident 28's Minimum Data Set (MDS, a resident screening tool), dated 4/28/2026, indicated Resident 28's had intact cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 28 required setup or clean-up assistance with eating and personal hygiene, supervision or touching assistance with oral hygiene, and partial/moderate (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 28's IDT Care Conference, dated 12/4/2025, the IDT indicated the Director of Nursing (DON) and Registered Dietitian (RD) participated in the meeting. The IDT report indicated Resident 28 was receiving supplements such as fortified foods (the addition of one or more essential nutrients to a food), Health Shake (high-calorie, high-protein shakes are essential for managing weight loss) three times a day, snacks three times a day, and Boost (a nutritional drink) three times a day. The IDT report indicated Resident 28's average meals eaten was 61 percent with one to three meals per day, and no snack intake. The IDT indicated Resident 28 had significant weight loss of 22 pounds in six months, without new labs to review and the RD recommended for Resident 28 to receive medical evaluation for appetite stimulant (a medication to increase appetite). During a review of Resident 28's Weight summary, dated 5/14/2026, the summary indicated Resident 28's weights decreased as follows: 10/3/2026: 106.2 lbs. 10/31/2026: 93.4 lbs. 11/3/2026: 93.6 lbs. 12/2/2025: 88 lbs. 1/2/2026: 88.4 lbs. 2/2/2026: 88.6 lbs. 3/3/2026: 89.8 lbs. 4/3/2026: 88.9 lbs. During a review of Resident 28's Order Summary Report (OSR), dated 5/14/2026, the OSR indicated the physician ordered for the resident to receive fortified foods with meals, starting on 3/31/2025; Magic cup twice a day five with lunch and dinner for malnutrition, starting on 5/1/2026; snack three times a day for at risk for malnutrition/additional supplement, starting on 5/28/2025; and Boost oral liquid give one unit by mouth three times a day for additional supplement, starting on 5/28/2026. During a concurrent interview and record review on 5/14/2026 at 9:09 AM with Licensed Vocational Nurse (LVN) 1, Resident 28's Medication Administration Record (MAR)s, dated from 10/2025 to 5/2026, were reviewed. LVN 1 stated Resident 28 were on nutritional supplements, including Boost, (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Health Shake, Magic Cup, and snacks. LVN 1 stated he documented the supplements as given on the MAR when he provided the supplements to the resident, but he did not check and did not document how much the resident consumed from each supplement provided. LVN 1 stated the MAR for supplement only reflected that the supplement was offered to the resident and did not reflect if the resident took it or how much she took it. LVN 1 stated he was not aware that Resident 28 had any weight change issues since 10/2025. During a concurrent interview and record review on 5/14/2026 at 9:11 AM with LVN 1, Resident 28's weight summary, dated from 10/3/2025 to 5/11/2026, and Resident 28's Change in Condition Evaluation (COC), dated from 10/2025 to 5/14/2026, were reviewed. LVN 1 stated Resident 28 had weight loss within a month from 10/3/2025 to 10/31/2025 and continue to have from severe weight loss within six months from 10/3/2025 to 3/3/2026, but the nurse did not complete a COC regarding the resident's weight loss issue. LVN 1 stated the licensed nurse should complete a COC to indicate the resident's weight loss was addressed and notified to the physician and the responsible party. During a concurrent interview and record review on 5/14/2026 at 9:41 AM with Certified Nursing Assistant (CNA) 2, Resident 28's Documentation Survey Reports, dated from 10/2025 to 5/2026, were reviewed. CNA 2 stated the CNAs did not monitor and did not document how much Resident 28 consumed from the supplements, including Boost, Health Shake, Magic Cup, and snack. CNA 2 stated licensed nurses were supposed to record how much the resident completed the supplements. During an interview on 5/14/2026 at 10:40 AM with the Registered Dietitian (RD), the RD stated Resident 28 lost weight and was currently underweight, so the physician ordered different supplements to Resident 28, but the facility staff did not monitor and document the amount of the supplements Resident 28 consumed because the supplements were the extra nutritional support to the resident. During an interview on 5/15/2026 at 8:30 AM with Resident 28, Resident 28 stated she did not like the food prepared in the facility. Resident 28 stated she preferred Asian food, such as Pilipino and Chinese food, but the facility did not offer this type of food. Resident 28 stated the staff did not ask her what she liked and disliked eating. During a telephone interview on 5/15/2026 at 8:46 AM with Family Member (FM) 1, FM 1 stated he regularly visited Resident 28 and sometimes brought her food that she liked. FM 1 stated the facility did not inform him that Resident 28 had lost weight. FM 1 stated if he knew Resident 28 had lost so much weight, he would bring more food from home and work with the facility to help the resident to gain her weight back. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/15/2026 at 9:15 AM with the Dietary Supervisor (DS), Resident's Progress Notes, dated from 10/4/2026 to 4/9/2026, and Resident 28's Meal Ticket, dated 5/16/2026, were reviewed. The DS stated she did not reassess and document what Resident 28's likes and dislikes after Resident 28 had severe weight loss since 10/2025. During a concurrent interview and record review on 5/15/2026 at 9:20 AM with the DS, the updated facility's Alternate Menu Slip, and the facility's Menu, dated from 12/21/2025 to 5/23/2026, were reviewed. The DS stated the facility did not offer any Asian food choice to Resident 28. During an interview on 5/15/2026 at 9:41 AM with the Director of Nursing (DON), the DON stated she was responsible for documenting COCs and IDT meeting for Resident 28's weight loss issue. The DON stated she failed to document key clinical actions related to Resident 28's significant weight loss, such as document the Change of Condition (COC) when the resident lost over 10% of body weight in one month (10/31/2025) or the continued loss of over 15% in six months (as of 4/3/2026). The DON also did not document required Interdisciplinary Team (IDT) meetings addressing the resident's severe and ongoing weight loss. The DON stated she spoke with the physician about an appetite stimulant, she did not document the rationale for the physician declining it. Additionally, the DON stated she did not inform the family or ask them to provide preferred foods, stating that family involvement should have occurred. She further stated the facility staff did not reassess, document, or provide foods the resident preferred, nor did they monitor or record supplement intake, preventing evaluation of whether supplements were effective. During a review of the facility's policy and procedure (P&P) titled, Dietary Services-Staffing, dated 12/19/2022, the P&P indicated the facility to take into consideration resident assessment and individual plans of care. The P&P also indicated the dietary staff to provide meals and/or supplements in accordance with residents' needs, preferences, and care plan. During a review of the facility's P&P titled, Weight Management Policy, revised on 11/1/2024, the P&P indicated Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range . The P&P indicated will a. Identifying and assessing each resident's nutritional status and risk factors b. Evaluating/analyzing the assessment information c. Developing and consistently implementing pertinent approaches d. Monitoring the effectiveness of interventions and revising them as necessary. The P&P also indicated Interventions will be identified, implemented, monitored, and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status. The P&P indicated a significant change in weight is defined as 5% change in weight in 1 month (30 days) or 10% change in weight in 6 months (180 days). The P&P indicated Documentation of significant weight changes shall be completed in accordance with the facility's documentation policies and procedures and accepted standards of practice. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Documentation in Medical Record, dated 12/18/2025, the P&P indicated Each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress and Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical records. 2.During a review of Resident 8's admission Record (AR), the facility admitted Resident 8 on 6/22/2023 and readmitted on [DATE] with included diagnoses of: End Stage Renal Disease (ESRD &ndash; irreversible kidney failure), chronic pulmonary edema (excess fluid in your lungs). Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS &ndash; a resident assessment tool) dated 3/9/2026 the MDS indicated that Resident 8 's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 8 needed assistance (helper sets up or cleans up) for meals. During a review of Resident 8's Care Plan titled, The Resident Has Nutritional Problem or Potential Nutritional Problem . dated 3/11/2026, the care plan indicated that Resident 8 will comply with recommended diet daily. The care plan's interventions included honor residents' food preferences within diet parameters, monitor resident's weight and notify the physician and Registered Dietitian in addition to monitor intake and food eaten every meal. During a review of Resident 8's Nutritional Assessment dated 3/12/2026, done by the RD the assessment indicated that Resident 8 had significant large weight changes related to fluid shifts, it also indicated that Resident 8 had non-pitting edema (swelling cause by excess fluid trapped in the body's tissues) to the extremities. The RD recommended to continue to monitor weight trend and to monitor all intake. During an observation on 5/12/2026 at 9:31 AM in Resident 8's room, Resident 8 was observed lying in bed with a full water pitcher on top of Resident 8's bedside table (a small adjustable table designed to roll over a bed and provide a flat surface). During a review of Resident 8's Order Summary Report dated 5/13/2026, Resident 8 had a physician (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for fluid restriction of 1200 ml in a 24-hour period including 8 ounces with breakfast, lunch and dinner and 8 ounces when necessary. During an observation on 5/13/2026 at 4:08 PM in Resident 8's room, Resident 8 was observed lying in bed with a full water pitcher on top of Resident 8's bedside table. During an observation on 5/14/2026 at 9:45 AM in Resident 8's room, Resident 8 was observed lying in bed with a full water pitcher on top of Resident 8's bedside table. Resident 8 stated that he was not aware that he had fluid restriction order by his physician. During an observation on 5/14/2026 at 11:49 AM in Resident 8's room, Resident 8 was observed lying in bed with a full water pitcher on top of Resident 8's bedside table. Resident 8 stated that he is on a medication named Lasix (prescribed medication that helps get rid of extra fluid in the body's tissues) stated that he has not been told by the facility that he has a fluid recommendation/restriction. Resident 8 stated that he does not have too much urine output and that is not measured by the facility. During a concurrent record review and interview with RD on 5/14/2026 at 2:29 PM stated that Resident 8 is in and out of the hospital, stated that he sees Resident 8 monthly or as needed. RD stated that on 3/12/2026 when he did the nutritional assessment, he calculated for Resident 8 the recommended fluid intake of 1800 ml based it was based on his caloric needs. RD stated that he did not include the recommended fluid intake in Resident 8's care plan. During a concurrent observation and interview on 5/14/2026 at 4:08 PM with Director of Nurses (DON) Resident 8 was observed lying in bed with a full water pitcher on top of Resident 8's bedside table. DON stated that if Resident 8 had an increase of fluid intake above the recommended it could cause fluid overload, pneumonia (an infection/inflammation in the lungs), respiratory distress and hospitalizations. DON stated that Resident 8 should have been on a fluid restriction. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8' s care plan titled, The Resident Has Nutritional Problem or Potential Nutritional Problem Related to Pulmonary Edema dated 5/14/2026 indicated a fluid restriction of a total of 1200 ml every 24 hours. During a concurrent observation and interview on 5/15/2026 at 9:54 AM with Certified Nurse Assistant (CNA)1. Resident 8 was observed lying in bed with a full water pitcher on top of Resident 8's bedside table. CNA 1 stated that Resident 8 was not on a fluid water restriction. During an interview on 5/15/2026 at 9:56 AM with Licensed Vocational Nurse (LVN)1 stated that he had already administered Resident 8 his morning medications and that Resident 8 should not have had a full water pitcher at bedside due to the physician order of fluid restriction of 1200 ml. During an interview on 5/15/2026 at 3:33 PM with Resident 8's Medical Doctor (MD)1 stated that Resident 8 who is a dialysis resident should be managed with proper renal diet and appropriate hydration to avoid hospitalizations due to fluid overload. During a review of facility's policy and procedure (P&P) titled Comprehensive Care Plan dated 12/19/2022, indicated that the comprehensive care plan will be prepared by an interdisciplinary team that includes but is not limited to a member of the food and nutrition services staff. During a review of facility's P&P titled, Hemodialysis dated 12/18/2025, indicated that nutritional/fluid management including documentation of the resident's weights, and compliance with intake and output measurements as ordered. In addition, it indicated that the staff would communicate with the dialysis facility, attending physician and or nephrologist of any significant weight changes, and nutritional concerns. During a review of facility 's P&P titled, Fluid Restriction dated 12/18/2025, indicated that fluid restriction will be followed to physician orders. The policy stated that fluid restrictions are basically the restriction of fluid intake for an underlying medical condition such as ESRD. The fluid restriction will be distributed into consideration of fluid to be given with mealtimes, snacks and medication passes.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food and consumption items were handled appropriately to prevent contamination and spread of foodborne and waterborne illnesses by failing to: 1. Ensure the internal component of the ice machine, reservoir pan, was cleaned every 30 days as indicated on the manufacturer's specifications. 2. Ensure Certified Nurse Assistant (CNA) 1 performed hand hygiene after assisting in setting up Resident 23's meal tray and then immediately assisting Resident 7. These deficient practices had the potential to result in foodborne/waterborne illnesses and for the residents residing in the facility. Findings: 1. During a concurrent observation and interview on 5/12/2026 at 8:47 AM with the Dietary Supervisor (DS), the bottom of the reservoir pan located inside the ice machine was wiped with a white paper towel. After the reservoir pan was wiped, small black particles were observed on the white paper towel. The DS stated small black particles should not be inside the ice machine's reservoir pan. During a concurrent observation and interview on 5/12/2026 at 8:50 AM with [NAME] 1, [NAME] 1 stated he recently cleaned the inside of the ice machine however did not clean the reservoir pan. [NAME] 1 stated the small black particles on the white paper towel, after the reservoir pan was wiped, was mineral buildup and must be removed when routine cleaning of the ice machine was done. During a concurrent interview and record review on 5/12/2026 at 4:20 PM with the Maintenance Supervisor (MS), the facility's log for Ice Machine Cleaning Monthly, dated from 1/2026 to 5/2026, was reviewed. The MS stated the ice machine was cleaned on 1/23/2026, 2/5/2026, 3/3/2026, 4/29/2026 and 5/1/2026. The MS stated the staff did not clean the ice machine for 57 days from 3/3/2026 to 4/29/2026. During an interview on 5/15/2026 at 10:20 AM with the Infection Preventionist (IP), the IP stated the staff should thoroughly clean the inside and outside of the ice machine monthly, with the interval of every 30 days to ensure the production of ice was free of contamination and prevent infection among residents. During a review of the facility's policy and procedure (P&P) titled, Installation, Start-Up and Maintenance Manual ICE SERIES CUBERS., dated 9/1/2015, the P&P indicated to thoroughly wash and sanitize all surfaces within the bin. During a review of the facility's P&P titled, Ice Machine Cleaning Policy, revised 6/23/2025, the P&P indicated The ice machine needs to be cleaned and sanitized monthly. The internal components are cleaned monthly or per manufacturer recommendations. 2. During a review of Resident 23's admission Record (AR), the AR indicated the facility admitted Resident 23 on 12/10/2025 with diagnoses that include chronic congestive heart failure (CHF, a serious, progressive condition where the heart cannot pump blood efficiently) and dementia (a decline in mental ability severe enough to interfere with daily life). During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2026, the MDS indicated Resident 23 had severely impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 23 required setup or clean-up assistance with eating, oral hygiene and toileting hygiene, and supervision or touching assistance with shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 7' s AR, the AR indicated the facility initially admitted Resident 7 on 1/3/2024 and readmitted on [DATE] with diagnoses that include dementia and Parkinson's disease (a progressive condition that affects movement). During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 had severely impaired cognition and memory. The MDS indicated Resident 7 required partial/moderate assistance with oral hygiene and personal hygiene, substantial/maximal assistance with toileting hygiene and shower/bathe self and was (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependent on chair/bed-to-chair transfer. During a dining observation on 5/13/2026 at 12:29 PM, Certified Nursing Assistant (CNA) 1 picked up Resident 23's meal tray from the meal cart and entered Resident 23's room and placed the meal tray onto Resident 23's bedside table. CNA 1 prepared Resident 23's meal tray by assisting in opening food items and setting up the meal tray. CNA 1 then touched Resident 23's shoulder and assisted Resident 23 to sit up in bed. Immediately after Resident 23's meal tray was set up, CNA 1 left the room and did not perform hand hygiene. CNA 1 was then observed obtaining a meal tray for Resident 7 from the meal cart and placed the meal tray on Resident 7's bedside table. During an interview on 5/13/2026 at 12:30 PM with CNA 1, CNA 1 stated she was in a hurry and forgot to perform hand hygiene before and after passing meal trays between residents. CNA 1 stated it was important to perform hand hygiene to prevent infection. During an interview on 5/15/2026 at 3:16 PM with the Director of Nursing (DON), the DON stated it was important to perform hand hygiene when passing meal trays between residents to prevent the spread of infection. During a review of the facility's P&P titled, Personal Hygiene-Safety-Food Handling-Infection Control, revised 12/19/2022, the P&P indicated hands must always be washed after handling any unsanitary items. During a review of the facility's P&P titled, Hand Hygiene, revised on 12/18/2025, the P&P indicated all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitor. The P&P also indicated hand hygiene is indicated and will be performed between resident contacts.		

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that specialized rehabilitative services were provided by qualified personal when the Director or Rehabilitation (DOR), who was a Certified Occupational Therapist Assistant (COTA), transcribed the Physical Therapist (PT) evaluation findings into the Joint Mobility Assessment (JMA, brief assessment of a resident's range of motion in each joint of both arms and legs) for two of two sample residents (Resident 5 and Resident 34). This practice resulted in Resident 5 and Resident 34's JMAs that were not independently assessed or completed by a qualified PT, as required for accurate identification of joint-mobility limitations, which lead to an inaccurate assessment of Resident 5 and Resident 34's JMA that could lead to inappropriate care planning, missed changes in functional decline, and failure to implement timely interventions to maintain or improve range of motion (ROM, full movement potential of a joint). Cross Reference with F688 and F641 Findings: 1. During a review of Resident 5's admission Record (AR), the AR indicated that the facility admitted Resident 5 on 3/31/2021 and readmitted Resident 5 on 3/17/2025 with diagnoses that include Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement) without dyskinesia (uncontrollable muscle movements), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, and left knee contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 5's care plan, revised 9/29/2024, the care plan indicated that Resident 5 had limited physical mobility related to weakness, osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), Parkinson's Disease, and history of stroke. The care plan's intervention included to monitor, document, report any signs and symptoms of immobility such as contractures forming or worsening, thrombus formation (blood clot), and skin breakdown as needed, and to provide gentle range of motion as tolerated with daily care. During a review of Resident 5's history and physical (H&P), dated 3/19/2025, the HP indicated that Resident 5 does not have the capacity to understand and make decisions. During a review of Resident 5's care plan, revised 4/7/2025, the care plan indicated that Resident 5 received left upper extremity PROM exercises and bilateral lower extremity ROM exercises with splint application. The care plan's interventions included applying the left knee splint and left-hand splint for 6 hours or as tolerated and the specific exercises for the left upper extremity which included elbow, wrist, and finger flexion and extension. The care plan did not provide documented evidence of the specific exercises for the bilateral lower extremity ROM. During a review of Resident 5's MDS, dated [DATE], the MDS indicated that Resident 5's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 5's active diagnoses included hemiplegia or hemiparesis and Parkinson's Disease. The MDS indicated that Resident 5 was dependent on ADLs such as lower body dressing, toileting, and showering and for functional mobility such as repositioning in bed, transitioning from sitting to lying, and transferring from chair/bed to chair. The MDS indicated that the bilateral upper extremities did not have any impairment and there was one-sided impairment on the lower extremity. During a review of Resident 5's PT Evaluation and Plan of Treatment record, written by PT 1, dated 5/8/2026 timed at 12:06 PM, the record indicated that Resident 5's right knee PROM had no movement in flexion or extension and fixed in neutral position. The record indicated that Resident 5's (continued on next page)		

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AROM for the bilateral lower extremities were not applicable. The record indicated that Resident 5's PROM of the right knee was fixed in a straight position with no flexion or extension in neutral position. The record indicated Resident 5's PROM of the right and left ankle was fixed in a 50-degree plantar flexion with no available dorsiflexion. The record indicated that Resident 5's PROM of the left knee was bent at 40 degrees and cannot fully straighten to neutral position. During a review of Resident 5's JMA record, written by the Director of Rehabilitation (DOR), dated 5/8/2026 timed at 3:08PM, the record indicated that Resident 5's left knee flexion was within functional limits and the right knee extension was minimally impaired. The record indicated that Resident 5's bilateral knees and bilateral ankles flexion and extension were moderately impaired. During an observation on 5/12/2026 at 10:19 AM in Resident 5's room, Resident 5 was observed sleeping in bed with her left leg bent at the knee towards the body and left foot bent forward at the ankle with toes bent away from the body. Resident 5's right leg was observed straight in bed with right foot bent forward at the ankle with toes bent away from the body. During a concurrent observation and interview on 5/14/2026 at 2:16 PM in Resident 5's room with Restorative Nurse Aide (RNA) 1, RNA 1 was observed performing PROM exercises on Resident 5's left upper extremity and bilateral lower extremities. RNA 1 stated that Resident 5's left leg was able to bend towards the body but cannot straighten all the way. RNA 1 stated Resident 5's right leg was straight and stiff, and Resident 1 opened her eyes and straight at RNA 1 as RNA 1 attempted to bend her leg towards the body. RNA 1 stated Resident 5's bilateral ankles were bent forward, and her toes were facing away from the body. RNA 1 stated Resident 5's bilateral ankles cannot bend backwards, and her toes had a little bit of flexion and extension during ROM exercises. During the concurrent interview and record review on 5/15/2026 at 12:28 PM with PT 1, Resident 5's JMA, dated 5/8/2026, was reviewed. PT 1 stated that the DOR completed the JMA in the facility. PT 1 stated that Resident 5's JMA only indicated within functional limits, mildly impaired, moderately impaired, or severely impaired. PT 1 stated, in her other place of employment, the PT completed the JMA and referenced the joint mobility assessment tool with angular measurements and visual diagrams to assess the resident's range of motion. During the same concurrent interview and record review on 5/15/2026 at 12:45 PM with PT 1, Resident 5 PT Evaluation and Plan of Treatment record, dated 5/8/2026, and JMA record, dated 5/8/2026, was reviewed. PT 1 stated, Resident 5's JMA record for the right knee extension was moderately impaired, but the PT Evaluation and Plan of Treatment, record indicated her right knee extension was fixed and contracted in a straight position with no flexion or extension available. PT 1 stated, she would consider Resident 5's JMA of the right knee flexion and extension to be severely impaired because the PT Evaluation and Plan of Treatment indicated Resident 5's right knee to be fixed and contracted in a straight position. During the same concurrent interview and record review on 5/15/2026 at 12:48 PM with PT 1, Resident 5 PT Evaluation and Plan of Treatment record, dated 5/8/2026, and JMA record, dated 5/8/2026, was reviewed. PT 1 stated, Resident 5's JMA record indicated her flexion and extension ROM of the bilateral ankles were moderately impaired. PT 1 stated, she would consider Resident 5's JMA of the bilateral ankles to be severely impaired because the PT Evaluation and Plan of Treatment record indicated that her bilateral ankles were fixed and contracted in a 50-degree plantar flexion position with no flexion or extension available at the ankles. PT 1 stated, she did not know why the JMA was inaccurate as the DOR was the one who completed the resident's JMA within the facility. During a concurrent interview and record review on 5/15/2026 at 3:43 PM with the DOR, Resident 5's JMA and PT Evaluation and Plan of Treatment, record, both dated 5/8/2026, was reviewed. The DOR stated, completes and documents the resident's JMA based on the PT's assessment on the PT Evaluation and Plan of Treatment, record, date 5/8/2026. The DOR (continued on next page)		

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, the JMA record indicated that Resident 5's bilateral ankles were moderately impaired, which meant that Resident 5's ankle only had 20 to 40-degrees of ROM. The DOR stated, the PT's Evaluation and Plan of Treatment record indicated that Resident's 5's bilateral ankle flexion and extension was fixed and contracted at 50-degrees. During the same concurrent interview and record review on 5/15/2026 3:50 PM with the DOR, the Complete Orthopedics Ankle Flexion diagram, date unknown, and Resident 5's JMA, dated 5/8/2026, were reviewed. The DOR stated, this chart was a diagram used to determine the degree of the ankle's loss of function. The DOR indicated that she did not know what minimally impaired, moderately impaired, and severely impaired indicated on the JMA, and the DOR stated, I cannot tell you the degrees of each. The DOR stated, she evaluates the PT's assessment on the PT Evaluation and Plan of Treatment record, and she transposes the PT's assessment into the JMA. 2. During a review of Resident 34's AR, the AR indicated that the facility admitted Resident 34 on 10/29/2019 and readmitted Resident 34 on 1/31/2021 with diagnoses that include spinal stenosis (narrowing of the spine) of the lumbar (lower back) region, spondylolysis (small fractures or cracks in the vertebra of the spine) of the lumbar region, and dementia (a progressive state of decline in mental abilities). During a review of Resident 34's care plan, initiated 6/10/2022, the care plan indicated that Resident 34 received assisted active range of motion (AAROM, use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) on his bilateral lower extremities 5 times a week as tolerated. The care plan's interventions included flexion and extension exercises for his hip, knee, and ankle. During a review of Resident 34's MDS, dated [DATE], the MDS indicated that Resident 34's cognitive skills were severely impaired. The MDS indicated that Resident 34 required moderate assistance (helper does less than half the effort) for ADLs such as showering and dressing the lower body and required moderate assistance with function mobility such as transitioning from sitting to lying and transferring from chair/bed to chair. The MDS indicated that Resident 34 did not have any functional ROM limitations in his upper and lower extremities. During a review of Nurse Practitioner (NP) 1's Medical Progress Note record, dated 4/6/2026, the record indicated that Resident 34's musculoskeletal assessment included decreased range of motion or pain with ROM. During a review of Resident 34's MDS, dated [DATE], the MDS indicated that Resident 34's cognitive skills were severely impaired. The MDS indicated that Resident 34 required moderate assistance for ADLs such as showering and dressing the lower body and required moderate assistance with function mobility such as transitioning from sitting to lying and transferring from chair/bed to chair. The MDS indicated that Resident 34 had functional ROM limitations impairments on one side of his lower extremity. During a review of Resident 34's PT Evaluation and Plan of Treatment record written by PT 1, dated 4/28/2026, the record indicated that the bilateral lower extremity ROM was within functional limits. The record indicated Resident 34's right lower extremity (hip, knee, and ankle) strength was within functional limits, but his left lower extremity (hip, knee, and ankle) strength was impaired. During a review of Resident 34's JMA record, written by DOR, dated 5/11/2026, the record indicated Resident 34's bilateral lower extremities (knees and ankles) extension and flexion were within functional limits. During a concurrent observation and interview on 5/14/2026 at 11:46 AM with the DOR in Resident 34's Room, Resident 34 was observed sitting up in his wheelchair with his bilateral toes and ankles bent downwards pointed away from the body. The DOR stated that the PT were the ones who assessed the residents for the JMA and completed lower body extremities ROM with the resident. The DOR stated, since Resident 34 was not walking, his lower extremities were within functional limits. During the same concurrent interview and record review on 5/15/2026 at 12:25 PM with PT 1, Resident 34's JMA record, dated 4/28/2026, was reviewed. PT 1 stated that a resident's functional (continued on next page)		

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mobility assessment identified the extent the resident's functional mobility affected the resident's bed mobility, transfer mobility, and ambulation status. PT 1 stated that a resident's JMA provided an estimate of the resident's joint limitations and loss of range of motion. PT 1 stated, Resident 34's JMA indicated his bilateral lower extremities were within functional limits. PT 1 stated that Resident 34, who does not ambulate, was not considered to be within functional limits on the JMA. During a concurrent observation and interview on 5/15/2026 at 1:04 PM with PT 1 in Resident 34's room, Resident 34 was observed lying in bed with his bilateral ankles pointed away from the body and bilateral toes facing away from the body. PT 1 stated that Resident 34's right ankle strength was worse than the left ankle strength. During the same concurrent interview and record review on 5/15/2026 at 1:15 PM with PT 1, Resident 34's PT Evaluation and Plan of Treatment record, dated 4/28/2026, was reviewed. PT 1 stated that the record indicated Resident 34's ROM for the bilateral lower extremities were within functional limits. PT 1 stated that the record indicated that the left ankle strength had trace muscle contraction. PT 1 stated, she did not document Resident 34's right ankle strength on 4/28/2026 because Resident 34 complained of right ankle discomfort during the evaluation, but she did not go back to reassess Resident 34 on 4/28/2026. During the same interview on 5/15/2026 at 3:54 PM with the DOR, the DOR stated that the JMA was the functional mobility assessment. The DOR stated that the JMA was based on the resident's ability to complete a task based on the functionality of the joint not the limitation or degrees of joint loss. During an interview on 5/15/2026 at 4:11 PM with Consultant 2, Consultant 2 stated the JMA was an assessment completed by the physical therapists to determine the resident's passive range of motion and to monitor the resident's range of motion to ensure no loss of range of motion. Consultant 2 stated, JMA indicated the limitation of the joint, and nursing needs to be aware of a resident's joint limitation as it impacts their care. During a review of the facility's policies and procedures (P&P) titled Joint Mobility Assessment, dated 12/19/2022, the P&P indicated that the Rehabilitative staff will complete the Joint Mobility Assessment form to document this and the Joint Mobility Assessment form will be completed by the rehabilitative staff upon initial admission, annual assessment, and change in condition. During a review of the facility's job description titled Job Description - Occupational Therapist Assistant, dated 12/19/2022, the job description indicated that the job summary of the Occupational Therapist Assistant was to assist in providing appropriate aspects of quality patient care, under the supervision of licensed therapists. The job description indicated the Occupational Therapist Assistant's essential functions including implementing and executing on established patient treatment plan under the supervision of an occupational therapist. During a review of the facility's job description titled Job Description - Occupational Therapist, dated 12/19/2022, the job description indicated that the job summary of the Occupational Therapist was to provides, directs, and supervises all aspects of quality patient care, including, but not limited to screening, evaluation and treatment, treatment planning, goal setting, family education and documentation, in order to assure the best outcome possible for the patient. The job description indicated that the Occupational Therapist's essential functions included to appropriately and effectively completes documentation including evaluations, daily notes, progress, discharge summaries, or monthly reports as required. During a review of the facility's job description titled Job Description - Physical Therapist, dated 12/19/2022, the job description indicated the Physical Therapist job summary was to provides, directs, and supervises all aspects of quality patient care, including, but not limited to: screening, evaluation, and treatment, treatment planning, goal setting, family education, and documentation, in order to assure the best outcome possible for the patient. The job description indicated that the Physical Therapist's essential functions included to appropriately and effectively completes documentation including (continued on next page)		

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evaluations, daily notes, progress notes, discharge summaries, or monthly reports as required. During a review of the California Board of Occupational Therapy, as codified in the California Code of Regulations, Occupational Therapist Assistants (OTAs) may contribute to the evaluation process but OTAs may not evaluate independently. The regulation indicated that the supervising Occupational Therapist (OT) was responsible for interpretation of referrals or prescriptions for occupational therapy services and the interpretation and analysis for evaluation purposes. During a review of the California Board of Occupational Therapy, as codified in the Business and Professions Code and [NAME] Regulations, occupational therapists are not authorized to practice physical therapy.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of one sampled resident (Resident 7). This deficient practice has a potential for Resident 7 not able to call for help when needed for comfort and safety. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was re-admitted on [DATE] with diagnoses including parkinsonism (brain condition causing movement issues, dementia (progressive state of decline in mental abilities), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 7's Minimum Data Sheet (MDS-a resident assessment tool) dated 3/27/26, the MDS indicated Resident 7 has clear speech, minimum hearing difficulty, impaired vision, sometimes understood, sometimes understands, on mechanically altered diet (modified to be soft, easy to chew and swallow safely). Resident 7 bladder and bowel is always incontinent, and dependent with activities of daily living (ADLs-routine personal care). During a review of Resident 7's Care Plan dated 3/23/24, Resident 7's Care Plan indicated Resident 7 has an ADL's self-care performance deficit related to activity intolerance, impaired balance, and functional quadriplegia (the complete inability to move all four limbs and the body due to severe frailty) interventions include encourage use of call bell for assistance. During observation on 5/12/26 at 12:25 PM in Resident 7's room, Resident 7 was in bed, talking to self, and stated, her back is itchy, was trying to wiggle her back against the mattress, ^at call light at head of bed (HOB) above pillow. During an observation and interview on 5/12/26 at 12:25 PM of CNA 1, CNA 1 entered Resident 7's room bringing pureed (smooth thick liquid) lunch for oral gratification. CNA 1 stated call light is beyond reach of Resident 7 and she cannot use the call light because she cannot move her hands, hands are tucked under the blanket. During an observation and interview on 5/12/26 at 12:28 PM with the Director of Nursing (DON), The DON found call light hanging over HOB and stated call light is not within reach of Resident 7. During an interview on 5/12/26 at 12:54 PM with CNA 1, CNA 1 stated he usually puts call light on her chest, a bit to the right but he just forgot to put call light back on her chest after he served her lunch. CNA 1 stated call light should be placed on the chest, not hands, because hands are stiff. During an interview on 5/14/26 3:30 PM with the DON, The DON stated Resident 7 has parkinsonism, rigidity. If we provide call light with button, she would not be able to click it, so we provided the ^at call light for her. The DON stated resident can access it so she can just tap it. The DON stated there are two ways to put it: side of chest, she taps with her face, and within reach of her hand on abdomen. Resident 7 taps it on accident, does not have to necessarily push it hard. The DON stated Resident 7 does not call often, if she calls, she needs her back scratched. During a subsequent interview on 5/14/26 3:30 PM with DON, the DON stated if ^at call light is not within reach, her needs will be unmet, Resident 7's call light should be always within reach. During a review of facility's policy and procedure (P&P) dated 12/19/22, P&P indicated, Special accommodations will be identified on the resident's person-centered plan of care and provided accordingly. (Examples include touch pads .) Staff will ensure the call light is within reach of resident and secured, as needed.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure the Notice of Proposed Transfer/Discharge notification was sent to the Office of the State Long-Term Care Ombudsman (a state employee that advocate for the residents) for one of three sample residents (Resident 45) in accordance with the facility's policy and procedure titled Transfer and Discharge. This deficient practice had the potential to result in the Ombudsman not being aware of Resident 45's discharge to the General Acute Care Hospital (GACH) on 1/2/2026 Findings: During a review of Resident 45's admission Record (AR), the AR indicated that the facility admitted Resident 45 on 12/18/2025 with diagnoses that included acute respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and malignant neoplasm of the lung (lung cancer). During a review of Resident 45's History and Physical (H&P), dated 12/25/2025, the H&P indicated that he had the capacity to understand and make decisions. During a review of Resident 45's Minimal Data Set (MDS, a resident assessment), dated 4/29/2026, the MDS indicated that Resident 45's cognitive (a resident's thought process) skills for daily decisions making were moderately impaired (decisions poor; cues/supervisions required). During a concurrent interview and record review on 5/15/2026 at 9:50 AM with the Medical Records Director (MRD), Resident 45's Transmission Verification Report (fax record) record, dated 1/2/2026, was reviewed. The MRD stated the fax record showed the transmission result to the Ombudsman was busy. The MRD explained this indicated the Ombudsman did not receive the required notice of Resident 45's transfer/discharge to the hospital on 1/2/2026. The MRD stated the Ombudsman must be notified to ensure they are aware of the resident's status and location and to provide advocacy related to the resident's rights and follow-up needs. During a concurrent interview and record review on 5/15/2026 at 10 AM with Licensed Vocational Nurse (LVN) 1, Resident 45's Transmission Verification Report (fax record) record, dated 1/2/2026, was reviewed. LVN 1 stated, he signed Resident 45's Notice of Transfer/Discharge and faxed the notice to the Ombudsman on 1/2/2026. LVN 1 stated that he did not notice the fax record's result was busy. LVN 1 stated, it was important to verify that the Ombudsman received the Notice of Transfer/Discharge so the Ombudsman representative could follow up with the resident and their representative party. During a review of the facility's policies and procedures (P&P) titled Transfer and Discharge (including AMA [Against Medical Advice]), dated 12/19/2022, the P&P indicated that the facility will maintain evidence that the notice was sent to the Ombudsman.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that two of three sample residents (Resident 5 and Resident 32)'s Minimal Data Set (MDS, a resident's assessment) accurately reflected the resident's status to indicate the residents' functional range of motion (ROM, full movement potential of a joint) limitations in accordance to the facility's policy and procedure (P&P) titled Resident Assessment - RAI. This deficient practice resulted in the inaccurate documentation of Resident 5 and Resident 32's functional ROM limitations on the MDS and had the potential to negatively affect Resident 5 and Resident 32's plan of care and delivery of necessary care and services related to the range of motion. Cross Reference with F688 and F826 Findings: 1. During a review of Resident 5's admission Record (AR), the AR indicated that the facility admitted Resident 5 on 3/31/2021 and readmitted Resident 5 on 3/17/2025 with diagnoses that include Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement) without dyskinesia (uncontrollable muscle movements), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, and left knee contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 5's care plan, revised 9/29/2024, the care plan indicated that Resident 5 had limited physical mobility related to weakness, osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), Parkinson's Disease, and history of stroke. The care plan's intervention included to monitor, document, report any signs and symptoms of immobility such as contractures forming or worsening, thrombus formation (blood clot), and skin breakdown as needed, and to provide gentle range of motion as tolerated with daily care. During a review of Resident 5's history and physical (H&P), dated 3/19/2025, the HP indicated that Resident 5 does not have the capacity to understand and make decisions. During a review of Resident 5's care plan, revised 4/7/2025, the care plan indicated that Resident 5 received left upper extremity PROM exercises and bilateral lower extremity ROM exercises with splint application. The care plan's interventions included to apply the left knee splint and left-hand splint for 6 hours or as tolerated and the specific exercises for the left upper extremity which included elbow, wrist, and finger flexion and extension. The care plan did not provide documented evidence of the specific exercises for the bilateral lower extremity ROM. During a review of Resident 5's MDS, dated [DATE], the MDS indicated that Resident 5's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 5's active diagnoses included hemiplegia or hemiparesis and Parkinson's Disease. The MDS indicated that Resident 5 was dependent on ADLs such as lower body dressing, toileting, and showering and for functional mobility such as repositioning in bed, transitioning from sitting to lying, and transferring from chair/bed to chair. The MDS indicated that the bilateral upper extremities did not have any impairment and there was one-sided impairment on the lower extremity. During a review of Resident 5's PT Evaluation and Plan of Treatment record, written by PT 1, dated 5/8/2026 timed at 12:06 PM, the record indicated that Resident 5's right knee passive range of motion (PROM, movement of a joint through the range of motion with no effort from the person only with the assistance of another person) had no movement in flexion (bending the joint towards the body, shortening the angle between 2 body parts) or extension (straightening the joint away from the body, lengthening the angle between 2 body parts) and fixed in neutral position (the joint's natural resting position. The record indicated that Resident 5's active (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	range of motion (AROM, performance of exercise to move a joint without any assistance or effort of another person) for the bilateral lower extremities were not applicable. The record indicated that Resident 5's PROM of the right knee was fixed in a straight position with no flexion or extension in neutral position. The record indicated Resident 5's PROM of the right and left ankle was fixed in a 50-degree plantar flexion with no available dorsiflexion. The record indicated that Resident 5's PROM of the left knee was bent at 40 degrees and cannot fully straighten to neutral position. During a review of Resident 5's Joint Mobility Assessment (JMA, brief assessment of a resident's range of motion in each joint of both arms and legs) record, written by the Director of Rehabilitation (DOR), dated 5/8/2026 timed at 3:08PM, the record indicated that Resident 5's left knee flexion was within functional limits and the right knee extension was minimally impaired. The record indicated that Resident 5's bilateral knees and bilateral ankles flexion and extension were moderately impaired. 2. During a review of Resident 34's AR, the AR indicated that the facility admitted Resident 34 on 10/29/2019 and readmitted Resident 34 on 1/31/2021 with diagnoses that include spinal stenosis (narrowing of the spine) of the lumbar (lower back) region, spondylolysis (small fractures or cracks in the vertebra of the spine) of the lumbar region, and dementia (a progressive state of decline in mental abilities). During a review of Resident 34's care plan, initiated 6/10/2022, the care plan indicated that Resident 34 received assisted active range of motion (AAROM, use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) on his bilateral lower extremities 5 times a week as tolerated. The care plan's interventions included flexion and extension exercises for his hip, knee, and ankle. During a review of Resident 34's care plan, revised 5/9/2024, the care plan indicated Resident 34 had limited physical mobility due to spinal stenosis, and lumbar spondylosis. The care plan's interventions included monitoring signs and symptoms of pain associated with mobility and monitoring, documenting, and reporting any signs and symptoms of immobility such as contractures forming or worsening, thrombus formation, and skin breakdown as needed. During a review of Resident 34's MDS, dated [DATE], the MDS indicated that Resident 34's cognitive skills were severely impaired. The MDS indicated that Resident 34 required moderate assistance (helper does less than half the effort) for ADLs such as showering and dressing the lower body and required moderate assistance with function mobility such as transitioning from sitting to lying and transferring from chair/bed to chair. The MDS indicated that Resident 34 did not have any functional ROM limitations in his upper and lower extremities. During a review of Resident 34's MDS, dated [DATE], the MDS indicated that Resident 34's cognitive skills were severely impaired. The MDS indicated that Resident 34 required moderate assistance for ADLs such as showering and dressing the lower body and required moderate assistance with function mobility such as transitioning from sitting to lying and transferring from chair/bed to chair. The MDS indicated that Resident 34 had impaired functional ROM limitations on one side of his lower extremity. During a review of Resident 34's PT Evaluation and Plan of Treatment record written by PT 1, dated 4/28/2026, the record indicated that the bilateral lower extremity ROM was within functional limits. The record indicated Resident 34's right lower extremity (hip, knee, and ankle) strength was within functional limits, but his left lower extremity (hip, knee, and ankle) strength was impaired. During a review of Resident 34's JMA record, written by DOR, dated 4/28/2026, the record indicated Resident 34's bilateral lower extremities (knees and ankles) extension and flexion were within functional limits. During an observation on 5/12/2026 at 10:19 AM in Resident 5's room, Resident 5 was observed sleeping in bed with her left leg bent at the knee towards the body and left foot bent forward at the ankle with toes bent away from the body. Resident 5's right leg was observed straight in bed with right foot bent forward at the ankle with toes bent away from the body. During a concurrent (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview and record review on 5/13/2026 at 3:28 PM with the MDS nurse (MDSN), Resident 34's MDS, dated [DATE] and 4/21/2026, and Resident 34's JMA record, dated 4/22/2026, were reviewed. The MDSN stated that the MDS, dated [DATE], indicated Resident 34 did not have any functional limitations on his bilateral lower extremities. The MDSN stated that the MDS, dated [DATE], indicated Resident 34 had an impaired on one side of his lower extremity. The MDSN stated that the PT were the ones who assessed the residents for the JMA and completed lower body extremities ROM with the resident. The DOR stated, since Resident 34 was not walking, his lower extremities were within functional limits. During a concurrent observation and interview on 5/14/2026 at 11:46 AM with the DOR in Resident 34's Room, Resident 34 was observed sitting up in his wheelchair with his bilateral toes and ankles bent downwards pointed away from the body. The DOR stated that the PT were the ones who assessed the residents for the JMA and completed lower body extremities ROM with the resident. The DOR stated, since Resident 34 was not walking, his lower extremities were within functional limits. During a concurrent observation and interview on 5/14/2026 at 2:16 PM in Resident 5's room with Restorative Nurse Aide (RNA) 1, RNA 1 was observed performing PROM exercises on Resident 5's left upper extremity and bilateral lower extremities. RNA 1 stated that Resident 5's left leg was able to bend towards the body but cannot straighten all the way. RNA 1 stated Resident 5's right leg was straight and stiff, and Resident 1 opened her eyes and straight at RNA 1 as RNA 1 attempted to bend her leg towards the body. RNA 1 stated Resident 5's bilateral ankles were bent forward, and her toes were facing away from the body. RNA 1 stated Resident 5's bilateral ankles cannot bend backwards, and her toes had a little bit of flexion and extension during ROM exercises. RNA 1 stated, there was no change in Resident 1's care and exercises that I have noticed. During the concurrent interview and record review on 5/15/2026 at 12:25 PM with PT 1, Resident 34's JMA record, dated 4/28/2026, was reviewed. PT 1 stated that a resident's functional mobility assessment indicated the extent a resident's functional mobility affected the resident's bed mobility, transfer mobility, and ambulation status. PT 1 stated that a resident's JMA provided an estimate of the resident's joint limitations and loss of range of motion. PT 1 stated that Resident 34, who does not ambulate, was not considered to be within functional limits on the JMA. During the concurrent interview and record review on 5/15/2026 at 12:40 PM with PT 1, Resident 5's PT Evaluation and Plan of Treatment record, dated 3/18/2025, and JMA record, dated 3/18/2025, were reviewed. PT 1 stated that according to the JMA record, Resident 5's left knee extension was minimally impaired, but the PT Evaluation and Plan of Treatment, record indicated her left knee extension was bent at 35 degrees and cannot fully straighten to neutral position. PT 1 stated, she would consider Resident 5's JMA of the left knee to be moderate/severe impairment because the knee remained bent at 35-degrees and cannot be straightened. During the same concurrent interview and record review on 5/15/2026 at 12:45 PM with PT 1, Resident 5 PT Evaluation and Plan of Treatment record, dated 5/8/2026, and JMA record, dated 5/8/2026, was reviewed. PT 1 stated, Resident 5's JMA record for the right knee extension was moderately impaired, but the PT Evaluation and Plan of Treatment, record indicated her right knee extension was fixed and contracted in a straight position with no flexion or extension available. PT 1 stated, she would consider Resident 5's JMA of the right knee flexion and extension to be severely impaired because the PT Evaluation and Plan of Treatment indicated Resident 5's right knee to be fixed and contracted in a straight position. During the same concurrent interview and record review on 5/15/2026 at 12:48 PM with PT 1, Resident 5 PT Evaluation and Plan of Treatment record, dated 5/8/2026, and JMA record, dated 5/8/2026, was reviewed. PT 1 stated, Resident 5's JMA record indicated her flexion and extension ROM of the bilateral ankles were moderately impaired. PT 1 stated, she would consider Resident 5's (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	JMA of the bilateral ankles to be severely impaired because the PT Evaluation and Plan of Treatment record indicated that her bilateral ankles were fixed and contracted in a 50-degree plantar flexion position with no flexion or extension available at the ankles. PT 1 stated, she did not know why the JMA was inaccurate as the DOR was the one who completed the resident's JMA within the facility. During a concurrent observation and interview on 5/15/2026 at 1:04 PM with PT 1 in Resident 34's room, Resident 34 was observed lying in bed with his bilateral ankles pointed away from the body and bilateral toes facing away from the body. PT 1 stated that Resident 34's right ankle strength was worse than the left ankle strength. During the same concurrent interview and record review on 5/15/2026 at 1:15 PM with PT 1, Resident 34's PT Evaluation and Plan of Treatment record, dated 4/28/2026, was reviewed. PT 1 stated that the record indicated Resident 34's ROM for the bilateral lower extremities were within functional limits. PT 1 stated that the record indicated that the left ankle strength had trace muscle contraction. PT 1 stated, she did not document Resident 34's right ankle strength on 4/28/2026 because Resident 34 complained of right ankle discomfort during the evaluation, but she did not go back to reassess Resident 34 on 4/28/2026. During an interview and record review on 5/15/2026 at 4:36 PM with the MDSN, Resident 34's MDS, dated [DATE], was reviewed. The MDSN stated that the MDS indicated Resident 34 was impaired one side. The MDSN stated that she inputted the inaccurate information from the JMA gathered by the Rehabilitation department on 4/21/2026. The MDSN stated that it was important ensure accuracy of residents' MDS to develop the correct care plan for Resident 34 to ensure the necessary services were provided to Resident 34. During an interview on 5/15/2026 at 5:04 PM with the Director of Nursing (DON), the DON stated that if Resident 5 and Resident 34's JMA was inaccurate then their MDS was inaccurate. The DON stated it was important to ensure the MDS indicated the resident's accurate status to ensure the plan of care developed by the interdisciplinary team may prevent complications or a decline in status. During an interview on 5/15/2026 at 5:13 PM with the MDSN, Resident 5's MDS, dated [DATE], was reviewed. The MDSN stated that the MDS indicated Resident 5 was impaired on one side. The MDS stated that the information of the MDS reflected the information on the JMA on 5/8/2026. During a review of the facility's policies and procedures (P&P) titled Joint Mobility Assessment, dated 12/19/2022, the P&P indicated that Licensed Nurses will complete the appropriate sections on the MDS to reflect the residents functional and movement abilities. During a review of the facility's P&P titled Resident Assessment - RAI, dated 12/19/2022, the P&P indicated that the facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences using the resident assessment instrument (RAI) specified by CMS. The P&P indicated that the assessment process will include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a comprehensive person-centered care plan was developed and implemented for two of three residents (Resident 8, and Resident 34) by failing to: Resident 8's care plan was not developed to address fluid limitation which can cause fluid overload and can cause edema (retention of fluid in the body tissues). For Resident 34, a person-centered care plan was not developed for the left ankle contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion). These failures had the potential to place Resident 8 at risk for fluid overload --and Resident 34 at risk for further joint mobility decline and contractures. Findings: During a review of Resident 8's admission Record (AR), the facility admitted Resident 8 on 6/22/2023 and readmitted on [DATE] with included diagnoses of: End Stage Renal Disease (ESRD) - irreversible kidney failure, chronic pulmonary edema (excess fluid in your lungs). Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool) dated 3/9/2026 the MDS indicated that Resident 8's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 8 needed assistance (helper sets up or cleans up) for meals. During a review of Resident 8's Care Plan titled, The Resident Has Nutritional Problem or Potential Nutritional Problem dated 3/11/2026, the care plan goal showed that Resident 8 will comply with recommended diet daily. The interventions included honor residents' food preferences within diet parameters, monitor resident's weight and notify the physician and Registered Dietitian in addition to monitor intake and food eaten every meal. During a review of Resident 8's Nutritional Assessment dated 3/12/2026, indicated that Resident 8 had non-pitting edema to bilateral lower extremities with history of large weight changes due to fluid shifts with a recommended fluid intake of 1800 milliliters (ml - (ml- metric unit of measurement). During an interview on 5/15/2026 at 10:12 AM with the Director of Nurses (DON) stated that Resident 8 was not in a fluid restriction diet as recommended by the Registered Dietitian on 3/12/2026 of 1800 ml. DON stated that dialysis residents unless they refused, they have a fluid restriction care plan, and that Resident 8 should have had a fluid restriction care plan. During a review of facility's policy and procedure (P&P) titled, Fluid Restriction dated 12/18/2025, indicated that fluid restriction will be followed as ordered by the physician. The policy stated that fluid restrictions are the restriction of fluid intake for an underlying medical condition such as ESRD. During a review of Resident 34's admission Record, (AR) the AR indicated that the facility admitted Resident 34 on 10/29/2019 and readmitted Resident 34 on 1/31/2021 with diagnoses that include spinal stenosis (narrowing of the spine) of the lumbar (lower back) region, spondylolysis (small fractures or cracks in the vertebra of the spine) of the lumbar region, and dementia (a progressive state of decline in mental abilities). During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2026, the MDS indicated that Resident 34's cognitive skills were severely impaired. The MDS indicated that Resident 34 required moderate assistance (helper does less than half the effort) for Activities of Daily Living (ADL) such as showering and dressing the lower body and required moderate assistance with function mobility such as transitioning from sitting to lying and transferring from chair to bed and bed to chair. The MDS indicated that Resident 34 did not have any functional Range of Motion limitations in his upper and lower extremities. During a review of Resident 34's care plan, revised 5/9/2024, the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan indicated Resident 34 had limited physical mobility due to spinal stenosis, and lumbar spondylosis. The care plan's interventions included monitoring signs and symptoms of pain associated with mobility and monitoring, documenting, and reporting any signs and symptoms of immobility such as contractures forming or worsening, thrombus formation, and skin breakdown as needed. During a concurrent record review and interview on 5/13/2026 at 3:28 PM with the MDS Coordinator (MDSN), MDSN stated that the MDS dated [DATE] indicated that the functional limitation in range of motion was coded for impairment to lower extremity only on one side. MDSN stated there was no care plan developed for the right ankle contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) and due to the limitation of both bilateral right and left ankle there should have been a care plan to address the limitation of the joint and prevent further decline. During an interview on 5/15/2026 at 12:02 PM with the Physical Therapist (PT) 1, PT 1 stated that it is important for nurses to know when the resident has a joint mobility limitation and how it impacts their daily care. PT 1 stated that she is not responsible to initiate or update a joint mobility limitation care plan unless physical therapy is directly working with the resident. During an observation and interview on 5/15/2026 at 2:52 PM in the Resident 34's room with PT 1 assessing Resident 34's right and left ankle joint mobility PT 1 stated that Resident 34 had a joint mobility limitation on the right and left ankle. During an interview on 5/15/2026 at 5:04 PM with the Director of Nurses (DON), DON stated that Resident 32 should have a care plan to address the contracture with the purpose to prevent worsening contracture of the joints. DON stated that the MDS accuracy is important because it assist in the development of the comprehensive person-centered care plan. During a review of facility's P&P titled Comprehensive Care Plan dated 12/19/2022, indicated that a comprehensive care plan should include the services that are needed to maintain the residents highest physical, mental and psychosocial well-being. Any services that would benefit the resident but are not provided due to the resident's exercise of his or her right to refuse treatment. ^		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that two of three sample Residents (Resident 5 and Resident 34), with limited range of motion (ROM, full movement potential of a joint) received the appropriate treatment and services by failing to: 1.Ensure Resident 5 and Resident 34's Joint Mobility Assessment (JMA, brief assessment of a resident's range of motion in each joint of both arms and legs) accurately reflected the Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Treatment from on 5/8/2026 and 5/11/2026. 2.Ensure Resident 5 and Resident 34's Minimal Data Set (MDS, a resident assessment) accurately indicated the residents' functional ROM limitations. 3.Ensure that Resident 34 received the annual PT assessment in 2025. 4. Ensure that Resident 5 and Resident 34 had accurately indicated in the quarterly and yearly MDS and JMA monitoring of their joint mobility function. These deficient practices resulted in Resident 5 and Resident 34's inaccurate joint mobility and functionality in their JMA and MDS. These deficient practices resulted in a 5-degree ROM loss in Resident 5's left knee extension ROM from 2025 to 2026. These deficient practices resulted in Resident 34 right ankle strength not being assessed properly. These deficient practices had the potential to result in further decline in Resident 5 and Resident 34's range of motion. Cross Reference with F641 and F826 Findings: 1. During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted Resident 5 on 3/17/2025 with diagnoses that include Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement) without dyskinesia (uncontrollable muscle movements), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (stroke, loss of blood flow to a part of the brain) affecting left non-dominant side, and left knee contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 5's care plan, revised on 9/29/2024, the care plan indicated that Resident 5 had limited physical mobility related to weakness, osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), Parkinson's Disease, and history of stroke. The care plan's intervention included to monitor, document, report any signs and symptoms of immobility such as contractures forming or worsening, thrombus formation (blood clot), and skin breakdown as needed, and to provide gentle range of motion as tolerated with daily care. During a review of Resident 5's history and physical (H&P), dated 3/19/2025, the HP indicated that Resident 5 does not have the capacity to understand and make decisions. During a review of Resident 5's PT Evaluation and Plan of Treatment record, written by Physical Therapist (PT) 2, dated 3/18/2025 timed at 6:55 PM, the record indicated Resident 5's active range of motion (AROM, performance of exercise to move a joint without any assistance or effort of another person) right knee was in fixed, in a straight position with no flexion (bending the joint towards the body, shortening the angle between 2 body parts) or extension (straightening the joint away from the body, lengthening the angle between 2 body parts) in neutral position (the joint's natural resting position). The record indicated Resident 5's AROM right and left ankle were fixed in a 50-degree plantar flexion (ankles bent away from the body) with no available dorsiflexion (ankles bent upwards towards the body for the toes to point towards the body). The record indicated that AROM Resident 5's left knee remains bent at 35 degrees and cannot fully straighten to neutral position. The record did not show any documented evidence of the (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	passive range of motion (PROM, movement of a joint through the range of motion with no effort from the person only with the assistance of another person). During a review of Resident 5's JMA record, written by PT 2, dated 3/18/2025 timed at 6:55 PM, the record indicated that Resident 5's left knee extension was minimally impaired. The record indicated that Resident 5's right knee and bilateral ankles' flexion and extension were severely impaired. During a review of Resident 5's MDS, dated [DATE], the MDS indicated that Resident 5's cognitive (a resident's thought process) skills for daily decision making were severely impaired. The MDS indicated that Resident 5's active diagnoses included hemiplegia or hemiparesis and Parkinson's Disease. The MDS indicated that Resident 5 was dependent (helper does all the effort) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) such as lower body dressing, toileting, and showering and for functional mobility such as repositioning in bed, transitioning from sitting to lying, and transferring from chair/bed to chair. The MDS indicated that Resident 5 had impairment on one side for the upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). During a review of Resident 5's care plan, revised 4/7/2025, the care plan indicated that Resident 5 received left upper extremity PROM exercises and bilateral lower extremity ROM exercises with splint application. The care plan's interventions included applying the left knee splint and left-hand splint for 6 hours or as tolerated and the specific exercises for the left upper extremity which included elbow, wrist, and finger flexion and extension. The care plan did not provide documented evidence of the specific exercises for the bilateral lower extremity ROM. During a review of Resident 5's PT Discharge Summary record, dated 5/9/2025 timed at 7:29 AM, the record indicated Resident 5 would receive PROM of the bilateral lower extremities and the left knee extension splint as tolerated. During a review of Resident 5's MDS, dated [DATE], the MDS indicated that Resident 5's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 5's active diagnoses included hemiplegia or hemiparesis and Parkinson's Disease. The MDS indicated that Resident 5 was dependent on ADLs such as lower body dressing, toileting, and showering and for functional mobility such as repositioning in bed, transitioning from sitting to lying, and transferring from chair/bed to chair. The MDS indicated that the bilateral upper extremities did not have any impairment and there was one-sided impairment on the lower extremity. During a review of Resident 5's PT Evaluation and Plan of Treatment record, written by PT 1, dated 5/8/2026 timed at 12:06 PM, the record indicated that Resident 5's right knee PROM had no movement in flexion or extension and fixed in neutral position. The record indicated that Resident 5's AROM for the bilateral lower extremities were not applicable. The record indicated that Resident 5's PROM of the right knee was fixed in a straight position with no flexion or extension in neutral position. The record indicated Resident 5's PROM of the right and left ankle was fixed in a 50-degree plantar flexion with no available dorsiflexion. The record indicated that Resident 5's PROM of the left knee was bent at 40 degrees and cannot fully straighten to neutral position. During a review of Resident 5's JMA record, written by the Director of Rehabilitation (DOR), dated 5/8/2026 timed at 3:08PM, the record indicated that Resident 5's left knee flexion was within functional limits and the right knee extension was minimally impaired. The record indicated that Resident 5's bilateral knees and bilateral ankles flexion and extension were moderately impaired. 2. During a review of Resident 34's AR, the AR indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted Resident 34 on 1/31/2021 with diagnoses that include spinal stenosis (narrowing of the spine) of the lumbar (lower back) region, spondylolysis (small fractures or cracks in the vertebra of the spine) of the lumbar region, and dementia (a progressive state of decline in mental abilities). During a review of Resident 34's care plan, initiated 6/10/2022, the care plan indicated that Resident 34 received assisted active range of motion (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(AAROM, use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) on his bilateral lower extremities 5 times a week as tolerated. The care plan's interventions included flexion and extension exercises for his hip, knee, and ankle. During a review of Resident 34's care plan, revised 5/9/2024, the care plan indicated Resident 34 had limited physical mobility due to spinal stenosis, and lumbar spondylosis. The care plan's interventions included monitoring signs and symptoms of pain associated with mobility and monitoring, documenting, and reporting any signs and symptoms of immobility such as contractures forming or worsening, thrombus formation, and skin breakdown as needed. During a review of Resident 34's Occupational Therapy (OT, treatment to help residents regain skills to participate in everyday life) Evaluation and Plan of Treatment record, written by Occupational Therapist (OT) 1, dated 4/22/2026, the record indicated OT 1 assessed Resident 34's bilateral upper extremities strength. The record did not show any documented evidence OT 1 assessed Resident 34's bilateral lower extremities. During a review of Resident 34's JMA record, written by OT 1, dated 4/22/2025, the record indicated Resident 34's left knee flexion and left and right ankle were minimally impaired. During a review of Resident 34's MDS, dated [DATE], the MDS indicated that Resident 34's cognitive skills were severely impaired. The MDS indicated that Resident 34 required moderate assistance (helper does less than half the effort) for ADLs such as showering and dressing the lower body and required moderate assistance with function mobility such as transitioning from sitting to lying and transferring from chair/bed to chair. The MDS indicated that Resident 34 did not have any functional ROM limitations in his upper and lower extremities. During a review of Nurse Practitioner (NP) 1's Medical Progress Note record, dated 4/9/2026, the record indicated that Resident 34's musculoskeletal assessment included decreased range of motion or pain with ROM. During a review of Resident 34's MDS, dated [DATE], the MDS indicated that Resident 34's cognitive skills were severely impaired. The MDS indicated that Resident 34 required moderate assistance for ADLs such as showering and dressing the lower body and required moderate assistance with function mobility such as transitioning from sitting to lying and transferring from chair/bed to chair. The MDS indicated that Resident 34 had impaired functional ROM limitations on one side of his lower extremity. During a review of Resident 34's PT Evaluation and Plan of Treatment record written by PT 1, dated 4/28/2026, the record indicated that the bilateral lower extremity ROM was within functional limits. The record indicated Resident 34's right lower extremity (hip, knee, and ankle) strength was within functional limits, but his left lower extremity (hip, knee, and ankle) strength was impaired. During a review of Resident 34's JMA record, written by the Director of Rehabilitation (DOR), dated 4/28/2026, the record indicated Resident 34's bilateral lower extremities (knees and ankles) extension and flexion were within functional limits. During an observation on 5/12/2026 at 10:19 AM in Resident 5's room, Resident 5 was observed sleeping in bed with her left leg bent at the knee towards the body and left foot bent forward at the ankle with toes bent away from the body. Resident 5's right leg was observed straight in bed with right foot bent forward at the ankle with toes bent away from the body. During a concurrent interview and record review on 5/13/2026 at 3:28 PM with the MDS nurse (MDSN), Resident 34's MDS, dated [DATE] and 4/21/2026, and Resident 34's JMA record, dated 4/22/2026, were reviewed. The MDSN stated that the MDS, dated [DATE], indicated Resident 34 did not have any functional limitations on his bilateral lower extremities. The MDSN stated that the MDS, dated [DATE], indicated Resident 34 was impaired on one side of his lower extremity. The MDSN stated that the JMA, dated 4/22/2026, indicated Resident 34's bilateral lower extremities were within functional limits. The MDSN stated that the information on the MDS was based on the JMA completed by the rehabilitation department. During a concurrent observation and interview on 5/14/2026 at 11:46 AM with the DOR in Resident (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	34's Room, Resident 34 was observed sitting up in his wheelchair with his bilateral toes and ankles bent downwards pointed away from the body. The DOR stated that the PT assessed the residents for the JMA and completed lower body extremities ROM with the resident. The DOR stated, since Resident 34 was not walking, his lower extremities were within functional limits. During a concurrent observation and interview on 5/14/2026 at 2:16 PM in Resident 5's room with Restorative Nurse Aide (RNA) 1, RNA 1 was observed performing PROM exercises on Resident 5's left upper extremity and bilateral lower extremities. RNA 1 stated that Resident 5's left leg was able to bend towards the body but cannot straighten all the way. RNA 1 stated Resident 5's right leg was straight and stiff. RNA 1 attempted to bend Resident 5's leg towards the body. RNA 1 stated Resident 5's bilateral ankles were bent forward, and her toes were facing away from the body. RNA 1 stated Resident 5's bilateral ankles cannot bend backwards, and her toes had a little bit of flexion and extension during ROM exercises. RNA 1 stated, there was no change in Resident 1's care and exercises that I have noticed. During a concurrent interview and record review on 5/15/2026 at 12:15 PM with PT 1, Resident 5's PT Evaluation and Plan of Treatment record, dated 5/8/2026, was reviewed. PT 1 stated, the record indicated that Resident 5's ankles were fixed and contracted at 50-degrees away from neutral with ankles pointed downwards and toes pointed away from the body. PT 1 stated, the record indicated that Resident 5's right knee was fixed and contracted in a straight position with no flexion or extension possible. PT 1 stated, the record indicated that Resident 5's left knee was able to bend towards the body and could only be bent to 40-degrees, and cannot fully straighten to neutral position. During the same concurrent interview and record review on 5/15/2026 at 12:20 PM with PT 1, Resident 5's PT Evaluation and Plan of Therapy record, dated 3/18/2025, was reviewed. PT 1 stated that the record indicated that there was no documented evidence of the bilateral lower extremity PROM but stated that I think AROM was supposed to be documented as PROM. PT 1 stated, the record indicated Resident 1 already had fixed contractures of the right knee, left ankle, and right ankle on 3/18/2025 (1 year ago from 5/15/2026). PT 1 stated, the record indicated Resident 1 was able to bend her left knee towards the body but Resident 5's left knee could only be bent to 35-degrees and cannot be fully straightened to neutral position. PT 1 stated, Resident 5's right knee lost 5 degrees of ROM from 2025 (1 year ago from 5/15/2026) and was unaware of the loss of ROM. During the concurrent interview and record review on 5/15/2026 at 12:25 PM with PT 1, Resident 34's JMA record, dated 4/28/2026, was reviewed. PT 1 stated that a resident's functional mobility assessment indicated the extent a resident's functional mobility affected their bed mobility, transfer mobility, and ambulation status. PT 1 stated that a resident's JMA provided an estimate of the resident's joint limitations and loss of range of motion. PT 1 stated, Resident 34's JMA indicated his bilateral lower extremities were within functional limits. PT 1 stated that Resident 34, who does not ambulate, was not considered to be within functional limits on the JMA. During a concurrent interview and record review on 5/15/2026 at 12:28 PM with PT 1, Resident 5's JMA, dated 5/8/2026, was reviewed. PT 1 stated that the DOR completed the JMA in the facility. During a concurrent interview and record review on 5/15/2026 at 12:40 PM with PT 1, Resident 5's PT Evaluation and Plan of Treatment record, dated 3/18/2025, and JMA record, dated 3/18/2025, were reviewed. PT 1 stated that according to the JMA record, Resident 5's left knee extension was minimally impaired, but the PT Evaluation and Plan of Treatment, record indicated her left knee extension was bent at 35 degrees and cannot fully straighten to neutral position. PT 1 stated, she would consider Resident 5's JMA of the left knee to be moderate/severe impairment because the knee remained bent at 35-degrees and cannot be straightened. During the same concurrent interview and record review on 5/15/2026 at 12:45 PM with PT 1, Resident 5 PT Evaluation and Plan of Treatment record, dated 5/8/2026, and (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	JMA record, dated 5/8/2026, was reviewed. PT 1 stated, Resident 5's JMA record for the right knee extension was moderately impaired, but the PT Evaluation and Plan of Treatment, record indicated her right knee extension was fixed and contracted in a straight position with no flexion or extension available. PT 1 stated, she would consider Resident 5's JMA of the right knee flexion and extension to be severely impaired because the PT Evaluation and Plan of Treatment indicated Resident 5's right knee to be fixed and contracted in a straight position. During the same concurrent interview and record review on 5/15/2026 at 12:48 PM with PT 1, Resident 5 PT Evaluation and Plan of Treatment record, dated 5/8/2026, and JMA record, dated 5/8/2026, was reviewed. PT 1 stated, Resident 5's JMA record indicated her flexion and extension ROM of the bilateral ankles were moderately impaired. PT 1 stated, she would consider Resident 5's JMA of the bilateral ankles to be severely impaired because the PT Evaluation and Plan of Treatment record indicated that her bilateral ankles were fixed and contracted in a 50-degree plantar flexion position with no flexion or extension available at the ankles. PT 1 stated, she did not know why the JMA was inaccurate as the DOR was the one who completed the resident's JMA within the facility. During the same interview on 5/15/2026 at 12:53 PM with PT 1, PT 1 stated that the JMA was used to determine the degree of the resident's range of motion. PT 1 stated that if the nurses were not aware of the resident's JMA, they would not be aware of the resident's joint-mobility limitations when assisting the residents with ADLs. PT 1 stated the JMA provided a baseline for nursing staff to monitor for any gradual decline in Resident 5's ROM and completing the annual JMA was too infrequent to detect gradual loss of range of motion. During a concurrent observation and interview on 5/15/2026 at 1:04 PM with the PT 1 in Resident 34's room, Resident 34 was observed sitting in his wheelchair wearing bilateral shoes. PT 1 removed Resident 34's bilateral shoes and proceeded to assess Resident 34's ankle ROM. PT 1 stated that Resident 34's right ankle PROM was more restricted and could only complete a partial ROM without gravity, which was worse than Resident 34's left ankle. During the same concurrent interview and record review on 5/15/2026 at 1:15 PM with PT 1, Resident 34's PT Evaluation and Plan of Treatment record, dated 4/28/2026, was reviewed. PT 1 stated that the record indicated Resident 34's ROM for the bilateral lower extremities were within functional limits. PT 1 stated that the record indicated that the left ankle strength had trace muscle contraction. PT 1 stated, she did not document Resident 34's right ankle strength on 4/28/2026 because Resident 34 complained of right ankle discomfort during the evaluation, but she did not go back to reassess Resident 34 on 4/28/2026. During an interview on 5/15/2026 at 2:52 PM with the DOR, the DOR stated that Resident 34 did not receive the annual evaluation of the lower extremities for the year 2025. The DOR stated, Resident 34's upper extremities were evaluated by the OT, but his lower extremities were not evaluated by the PT. During a concurrent interview and record review on 5/15/2026 at 3:43 PM with the DOR, Resident 5's JMA and PT Evaluation and Plan of Treatment, record, both dated 5/8/2026, was reviewed. The DOR stated, she documented the resident's JMA and based the information of the PT's Evaluation and Plan of Treatment record, dated 5/8/2028. The DOR stated, the JMA record indicated that Resident 5's bilateral ankles were moderately impaired, which meant that Resident 5's ankle only had 20 to 40-degrees of ROM. The DOR stated, the PT's Evaluation and Plan of Treatment record indicated that Resident's 5's bilateral ankle flexion and extension was fixed and contracted at 50-degrees. During the same concurrent interview and record review on 5/15/2026 3:50 PM with the DOR, the Complete Orthopedics Ankle Flexion diagram, date unknown, and Resident 5's JMA, dated 5/8/2026, were reviewed. The DOR stated, the diagram was used to determine the degree of the ankle's loss of function. The DOR indicated that she did not know what minimally impaired, moderately impaired, and severely impaired indicated on the JMA, and the DOR stated, I cannot tell you the degrees of each. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview on 5/15/2026 at 3:54 PM with the DOR, Resident 34's JMA record, dated 4/28/2026, was reviewed. The DOR stated that the JMA was the functional mobility assessment. The DOR stated that the JMA was based on the resident's ability to complete a task based on their functionality of the joint not the limitation or degrees of joint loss. During an interview on 5/15/2026 at 4:11 PM with Consultant 2, Consultant 2 stated the JMA was an assessment completed by the physical therapists to determine the resident's PROM and to monitor the resident's ROM to ensure no loss of range of motion. Consultant 2 stated, JMA indicated the limitation of the joint, and nursing needs to be aware of a resident's joint limitation since a resident with functional limitations impact nursing care. During a review of the facility's policies and procedures (P&P) titled Joint Mobility Assessment, dated 12/19/2022, the P&P indicated that the Rehabilitative staff will complete the Joint Mobility Assessment form to document this and the Joint Mobility Assessment form will be completed by the rehabilitative staff upon initial admission, annual assessment, and change in condition. During a review of the facility's policies and procedures (P&P) titled Joint Mobility Assessment, dated 12/19/2022, the P&P indicated that the initial Joint Mobility Assessment will provide the baseline information of the resident's functional abilities including joint mobility. Subsequently information from the previous quarterly MDS assessment will be compared to the data entered in the current MDS assessment to identify changes in the resident's joint mobility. During a review of the facility's job description titled Job Description - Physical Therapist, dated 12/19/2022, the job description indicated the Physical Therapist job summary was to provides, directs, and supervises all aspects of quality patient care, including, but not limited to: screening, evaluation, and treatment, treatment planning, goal setting, family education, and documentation, in order to assure the best outcome possible for the patient. The job description indicated that the Physical Therapist's essential functions included to appropriately and effectively completes documentation including evaluations, daily notes, progress notes, discharge summaries, or monthly reports as required.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on observation, interview and record review the facility failed to prevent unnecessary use of psychotropic medications (medication that affects mood and behavior) in accordance with the physician's order, and the facility policy and procedure titled, Use of Psychotropic Medication(s) for one of three sampled residents (Resident 2) by not monitoring side effects of Respirone (prescribed medication for mood and behavior) 0.5 milligrams (mg - unit of measurement). This failure had the potential to result in the resident receiving unnecessary medication or not sufficient dosage of medication to treat the behavioral disorder, and the potential to experience side effects with delayed or no treatment and prolonged use of the medication. Findings: During a review of Resident 2's admission Record, (AR), AR indicated that the facility admitted Resident 2 on 4/22/2026 with included diagnoses of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), Dementia (a progressive state of decline in mental abilities) Psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 2's Order Summary Report dated 5/11/2026, indicated a physician order for Risperidone oral tablet 0.5 milligram (mg - a metric unit of measurement, used for medication dosage and/or amount) twice a day for psychosis manifested by sudden angry outburst. During a review of Resident 2's care plan titled, Resident 2 had a Diagnosis of Psychosis dated 4/22/2026, the care plan indicated to notify Medical Doctor (MD) if there are any present behaviors/side effects/adverse effects present for Resident 2. During an interview on 5/13/2026 at 10:22 AM with Licensed Vocational Nurse (LVN)2 stated that there was a physician order to monitor side effects, but the physician's order did not have specific side effects to monitor the resident. LVN 2 stated that for monitoring side effects, LVN 2 would monitor altered mental status. During an interview on 5/13/2026 at 10:38 AM with Licensed Vocational Nurse (LVN)1, LVN 1 stated that Resident 2 had an order to monitor side effects, LVN1 stated that when considering side effects for Risperidone he would consider nausea and vomiting which was not included in the physician's order. During an interview on 5/13/2026 at 11:28 AM with the Director of Nurses (DON) stated that the staff should know where to locate for the side effects of medication also, stated that the side effects are not included with the physician order and that the nurses need to look it up. DON stated that the side effects need to be included in the physician order. During a review of the facility's policy and procedure (P&P) titled, Use of Psychotropic Medication dated 12/19/2022 indicated that the facility will monitor the effects of the psychotropic medication on a resident's physical, mental, and psychosocial well-being this will be on an ongoing basis in accordance with nurse assessment and medication monitoring consistent with standards of practice.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately document two of three residents (Resident 8 and Resident 4) in their electronic medical record by failing to ensure that: 1.Resident 4's indicated use of Lorazepam (a psychotropic medication [medications that affect brain chemistry, altering mood, thoughts, perceptions, and behaviors] used to treat anxiety disorder) was accurately documented in Medication Administration Record (MAR) on 5/4/2026. 2.Resident 8's accurate weight was documented on the Interdisciplinary team (IDT a team of facility staff responsible in care planning residents care) assessment. 3.the corrected amount of Dilaudid (medication used to relieve pain) medication for Resident 8 was documented on Resident 8's progress notes and pre/post dialysis assessment communication form. These deficient practices had resulted in the inaccurate documentation for the intended use of Lorazepam for Resident 4 and the potential to result in confusion regarding the validity of Resident 8's weight and medication treatment to determine the effectiveness or ineffectiveness of the therapy. Findings: 1.During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 6/11/2025 and readmitted on [DATE] with diagnoses that include dementia (a decline in mental ability severe enough to interfere with daily life) and anxiety disorder (a disorder involves persistent, excessive fear or worry that interferes with daily life). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 4's had severely impaired cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 4 required supervision or touching assistance with toileting hygiene, shower/bathe self and chair/bed-to-chair transfer. During a review of Resident 4's Order Summary Report, dated 5/15/2026, the report indicated the physician ordered to administer Lorazepam oral tablet 1 milligram (MG, a measurement unit) one tablet every eight hours as needed for anxiety manifested by verbalization of anxiety, excessive crying for 14 days. During a review of Resident 4's Medication Administration Record (MAR), dated 5/2026, the MAR indicated Lorazepam was administered to Resident 4 on 5/4/2026 at 10:11 AM with the behavior observation indicated of NO. The documented behavior of NO indicated Resident 4 did not exhibit any behaviors of anxiety prior to the administration of Lorazepam. During a telephone interview on 5/15/2026 at 12:33 PM with Licensed Vocational Nurse (LVN) 3, LVN (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3 stated he administered Lorazepam to Resident 4 and mistakenly documented 'No under behaviors observed on 5/4/2026, which indicated Resident 4 was not exhibiting behavioral symptoms prior to the administration of Lorazepam. LVN 3 stated the MAR was inaccurate since LVN 3 indicated Resident 4 did not have behavior symptoms when actually, Resident 4 did. During a concurrent interview and record review on 5/15/2026 at 2:32 PM with the Director of Nursing (DON), Resident 4's MAR, dated 5/2026, was reviewed. The DON stated the nurse mistakenly documented that Lorazepam was administered without a specific behavior indicated for the intended use of Lorazepam. The DON stated as the standard of practice, the nurses should document correctly on the MAR. During a review of the facility's P&P titled, Documentation in Medical Record, dated 12/18/2025, the P&P indicated documentation shall be factual, objective; false information shall not be documented; documentation shall be accurate and complete. 2. During a review of Resident 8's admission Record (AR), the facility admitted Resident 8 on 6/22/2023 and readmitted on [DATE] with diagnoses that included End Stage Renal Disease (ESRD &ndash; irreversible kidney failure), chronic pulmonary edema (excess fluid in the lungs). Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS &ndash; a resident assessment tool) dated 3/9/2026 the MDS indicated that Resident 8 's cognitive (a resident's thought process) skills were intact. The MDS indicated that Resident 8 needed assistance (helper sets up or cleans up) with eating meals. During a review of Resident 8's Order Summary Report dated 5/8/2026 indicated a physician order to give Dilaudid (prescribed medication for severe pain) 1 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) by mouth every 6 hours as needed for severe pain. During a review of Resident 8's Progress Notes dated 5/12/2026 at 3:39 AM documentation done by staff the progress notes indicated that Resident 8 was administered Dilaudid 2 mg by mouth. The Progress Note documentation did not indicate Dilaudid 1 mg as ordered by the physician). During a concurrent observation, interview and record review on 5/14/2026 at 3:27 PM with the Director of Nurses (DON), the DON stated, it was verified that staff had given the appropriate amount dose of Dilaudid, but the licensed staff had documented inaccurately. DON stated the staff had (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the wrong amount dose given to Resident 8. During a review of Resident 8's weight record, Resident 8 on 4/3/2026 weighed 185.2 pounds (Lbs. - a standard unit used to measure how heavy something is) and on 5/12/2026 re-weighed 179.7 lbs. During a concurrent interview and record review on 5/14/2026 with the DON the Interdisciplinary Care Conference dated 5/11/2026 was reviewed with the DON, DON stated that 171.6 lbs. was documented as Resident 8's current weight and not the correct weight of 179.3 pounds when the resident was re-weighed. DON stated that the physician was not notified because that was not the correct weight of the resident and that it was documented incorrectly in Resident 8's clinical record. DON stated that it is important to document residents' information accurately in their clinical record to ensure proper and prompt treatment. During a review of the facility's policy and procedure (P&P) titled Documentation in Medical Record dated 12/19/2022, indicated that each resident's medical record should be documented with factual details and false information shall not be documented in the resident's clinical record.		

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform and ensure that three of three sample residents (Resident 6, 20, and 12) understood the terms of the facility's arbitration agreement (an agreement that allows parties to resolve disputes and lawsuits privately rather than going to court) as indicated in the facility's policy and procedures titled Arbitration Agreement. This deficient practice had the result in Resident 6, 20, and 12 not being informed of their rights and choices about important aspects of the residents' health, safety, and welfare under the binding arbitration agreement. Findings: 1. During a review of Resident 6's admission Record (AR), the AR indicated that the facility admitted Resident 6 on 2/27/2026 with diagnoses that included multiple sclerosis (MS, a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), Gastro-esophageal reflux disease (GERD, chronic acid reflux causing heartburn), and hydronephrosis (swelling of the kidney due to urine blockage). During a review of Resident 6's history and physical (H&P), dated 2/28/2026, the H&P indicated that Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimal Data Set (MDS, a resident assessment), dated 5/2/2026, the MDS indicated that Resident 6's cognitive (a resident's thought process) skills were intact. During a concurrent interview and record review on 5/15/2026 at 8:32 AM with Resident 6, Resident 6's Arbitration Agreement record, signed 3/3/2026 was reviewed. Resident 6 stated, the signature on the record looked like [her] signature, but she did not recall anyone explaining or informing her what an arbitration agreement was. Resident 6 stated she either confused upon admission and she could not remember it, or the facility staff came into my room and just told me to sign it. 2. During a review of Resident 20's AR, the AR indicated that the facility admitted Resident 20 on 2/3/2026 with diagnoses that included acute kidney failure (kidneys cannot filter waste products from the blood), hypothyroidism (condition where the thyroid does not make enough hormones for bodily functions), and acute respiratory failure (condition where the lungs cannot get enough oxygen to the body) with hypoxia (the body's tissue cannot get enough oxygenated blood). During a review of Resident 20's H&P, dated 2/8/2026, the H&P indicated that Resident 20 had the capacity to understand and make decisions. During a review of Resident 20's MDS, dated [DATE], the MDS indicated that Resident 20's cognitive skills were intact. During a concurrent interview and record review, on 5/15/2026 at 9:10 AM with Resident 20, Resident 20's Arbitration Agreement record, signed 2/4/2026, was reviewed. Resident 20 stated, the Arbitration Agreement record does look vaguely familiar, but she does not recall what the arbitration agreement was about. Resident 20 stated, the Arbitration Agreement form does not look familiar to her. 3. During a review of Resident 12's AR, the AR indicated that the facility admitted Resident 12 on 1/12/2026 with diagnoses that included rhabdomyolysis (rapid muscle tissue breakdown), cardiomegaly (enlarge heart), and Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 12's H&P, dated 1/13/2026, the H&P indicated that Resident 12 had the capacity to understand and make decisions. During a review of Resident 12's MDS, dated [DATE], the MDS indicated that Resident 12's cognitive skills were intact. During a concurrent interview and record review on 5/15/2026 at 9:27 AM with Resident 12, Resident 12's Arbitration Agreement record, signed 1/13/2026, was reviewed. Resident 12 stated, the record does not look familiar to [him] and he does not remember the arbitration agreement being explained to him. During an interview on 5/15/2026 at 11:26 AM with the Admission's Coordinator (AC), the AC stated she was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555030	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2026
NAME OF PROVIDER OR SUPPLIER College Vista Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4681 Eagle Rock Blvd. Los Angeles, CA 90041	
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 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	responsible for explaining the arbitration agreement within 48-72 hours of a new admission. The AC stated, she determines whether an alert resident understands the information by asking the resident if the resident understood the agreement, and the AC stated, some [residents] say yes while other residents will respond I know what [the arbitration agreement] is. During a review of the facility's Arbitration Agreement record, date unknown, the record indicated that the resident and/or the person executing this Agreement certifies that he/she has read this agreement, understands this Agreement, and has been given a copy of this agreement.		