STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555035	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Anaheim Healthcare Center	3435 W Ball Road Anaheim, CA 92804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the ice cream freezer was free from ice build-up. * The facility failed to ensure a hair restraint was worn by staff in the kitchen. These failures had the potential to cause foodborne illnesses for the 62 out of 106 residents (census) who consumed food prepared in the kitchen.Findings: 1. According to the USDA (United States Department of Agriculture) Food Code 2022, Section 4-501.12, Cutting Surfaces, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic (causing or capable of producing disease) microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. On 3/22/26 at 0742 hours, during the initial tour of the kitchen with [NAME] 1, two cutting boards were observed heavily marred with chipped areas. [NAME] 1 verified the findings. 2. Review of the facility's P&P titled Refrigerator/Freezer Storage (undated) showed the freezers must be maintained free of excessive ice or frost buildup to ensure proper air circulation and temperature control. The Dietary staff will report any ice buildup to the Dietary Supervisor and Maintenance. On 3/22/26 at 0745 hours, during the initial tour of the kitchen with [NAME] 1, the ice cream freezer was observed with a thick ice build-up on the plastic lining of the right side interior part of the freezer, near the door. [NAME] 1 verified the above findings. 3. According to the USDA Food Code 2022, Section 2-402.11 Hair Restraints, Effectiveness, Food employees shall wear hair restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, and utensils. Review of the facility's P&P titled Sanitation and Infection Control (undated) showed the food service employees will follow the infection control policies to ensure the department operates under sanitary conditions at all times. [NAME] and/or moustache should be closely trimmed or must be covered at all times. On 3/23/26 at 1127 hours, an observation in the kitchen food preparation area and concurrent interview was conducted with Dietary Aide 1. Dietary Aide 1 had uncovered facial hair. When asked if his facial hair should be covered, Dietary Aide 1 stated he needed to use a beard net. On 3/23/26 at 1130 hours, an interview was conducted with the DSS. The DSS was informed of Dietary Aide 1's uncovered facial hair. The DSS verified the findings and stated any facial hair or beard needed to use hair restraints. On 3/24/26 at 1408 hours, an interview was conducted with the DSS. The DSS verified the above findings and stated the cutting boards which were heavily marred with chipped areas should have been replaced. When asked about the ice buildup inside the ice cream freezer, the DSS stated the ice buildup will degrade the food quality and texture. On 3/25/26 at 1211 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure safe and sanitary infection control practices were maintained. * The facility failed to ensure LVN 14 changed PPE (Personal Protective Equipment) and performed hand hygiene in between resident care for Residents 4 and 6 in an Enhanced Barrier Precautions (EBP) room. * The facility failed to ensure the Lint Trap Log was completed. * The facility failed to ensure CNA 1 performed hand hygiene in between provision of care for Residents 13 and 106. * The facility failed to ensure Resident 31's electric fan was clean and free of dusts. These failures placed the residents at risk for increased risk of infection and transmissions of diseases. Findings: 1. Review of the facility's P&P titled Enhanced Barrier Precautions dated 6/2024 showed enhanced barrier precautions (EBP's) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Enhanced barrier precautions employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. -Personal protective equipment (PPE) is changed before caring for another resident. a. Medical record review for Resident 4 was initiated on 3/22/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 3/1/26, showed Resident 4 had no capacity to understand and make decisions. Review of Resident 4's Order Summary Report for 3/2026 showed the following physician's order: - dated 2/27/26, for enhanced barrier precautions related to the presence of tracheostomy tube and GT. b. Medical record review for Resident 6 was initiated on 3/22/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 1/4/26, showed Resident 6 had no capacity to understand and make decisions. Review of Resident 6's Order Summary Report for 3/2026 showed the following physician's order: - dated 2/23/26, for enhanced barrier precautions related to the presence of tracheostomy tube and GT On 3/23/26 at 0810 hours, an observation and concurrent interview was conducted in room [ROOM (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NUMBER] with LVN 14. LVN 14 was observed wearing gown and gloves inside the room and removed Resident 6's left hand mitten while making contact with the resident's bed linen. LVN 14 was then observed assisting Resident 4 remove her hand mittens, also making contact with Resident 4's bed linen after readjusting the bed sheets without changing PPE and hand hygiene. LVN 14 acknowledge she did not change her PPE and perform hand hygiene in between provision of resident care. LVN 14 further acknowledged making contact with Resident 4 and Resident 6's bed linens. LVN 14 stated she should have changed her gown and gloves and hand washed prior to assisting another resident to ensure infection control was maintained. On 3/25/26 at 0809 hours, an interview was conducted with the IP. The IP stated she expects staff to change PPE and hand wash in between resident care. The IP stated changing PPE and performing hand hygiene prevented contamination and the spread of infection. 2. Review of the CDC's Control of Fire Hazard in Commercial Dry Cleaning Shops Using Petroleum-based Solvents dated 11/2018 showed to perform routine maintenance to prevent accumulation of fluff, lint, or waste that could ignite or cause a fire to spread rapidly. Review of the facility's document titled Lint Trap Log for 3/2026 showed multiple dates and times not documented including the following: - on 3/1/26: 2 PM, 4 PM, 6 PM, 8 PM, 10 PM, 12 AM - on 3/2/26: 2 PM, 4 PM, 6 PM, 8 PM, 10 PM, 12 AM - on 3/7 to 3/9/26: 2 PM, 4 PM, 6 PM, 8 PM, 10 PM, 12 AM - on 3/18/26: 2 AM, 4 AM, 6 AM, 10 AM, 12 PM, 2 PM, 4 PM, 6 PM, 8 PM, 10 PM, 12 am - on 3/19 to 3/21/26: 2 PM, 4 PM, 6 PM, 8 PM, 10 PM, 12 AM On 3/24/25 at 1400 hours, an interview and concurrent facility document review was conducted with the Maintenance Assistant. The Maintenance Assistant verified the lint log was missing multiple dates and times the lint trap was monitored. The Maintenance Assistant stated the staff forgot to sign. When asked why the lint trap was monitored for lint build up, the Maintenance Assistant stated lint build-up was checked to prevent fires. On 3/25/26 at 1202 hours, an interview was conducted with the Administrator, DON, and Regional Director of Operations. The Administrator, DON, and Regional Director of Operations acknowledged the above findings. 3. Review of the facility's P&P titled Hand Washing (undated) showed hand hygiene continues to be the primary means of preventing transmission of infection. The following is a list of some situations that require hand hygiene: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- before and after direct resident contact; - before and after entering isolation precaution settings; - before and after assisting a resident with personal care; - before and after changing dressings; - upon and after coming inn contact with a resident's intact skin; - before and after assisting a resident with toileting; - after contact with resident's mucous membranes and bodily fluids or excretions; - after handling soiled or use linens, dressings, bedpans, catheters and urinals; and - after removing gloves. Review of the facility's P&P titled Personal Protective Equipment – Using Gloves revised 9/2010 showed to wash hands after removing gloves. (Note: Gloves do not replace handwashing.) a. On 3/22/26 at 0955 hours, during the initial tour of the facility, CNA 1 was observed providing personal care to Resident 13. There was an EBP signage outside Resident 13's room. CNA 1 was observed wearing the appropriate PPEs. CNA 1 was observed doffing the PPEs after providing care to Resident 13. CNA 1 was not observed to have performed hand hygiene after removing the gloves, went straight to Resident 106's room, and pulled up the blanket to cover the resident. On 3/22/26 at 1015 hours, an interview was conducted with CNA 1. CNA 1 verified the above findings. CNA 1 stated he could not use the hand sanitizer outside the rooms because it caused his hands to be inflamed. CNA 1 was reminded by the surveyor that he should have then washed his hands. b. Medical record review for Resident 13 was initiated on 3/22/26. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 1/11/26, showed Resident 13 was alert and oriented to person, place and time. Review of Resident 13's Order Summary Report showed a physician's order dated 2/23/26, for Enhanced Barrier Precautions related to the presence of tracheostomy tube, GT, wound and colonization of C. auris (Candida auris- an emerging fungus which can cause severe, often multidrug-resistant infections) in axilla (armpit) /groin. c. Medical record review for Resident 106 was initiated on 3/22/26. Resident 106 was readmitted to the facility on [DATE]. Review of Resident 106's H&P examination dated 6/16/25, showed Resident 106 had no capacity to understand and make her own decisions. Review of Resident 106's Order Summary Report showed a physician's order dated 2/23/26, for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Enhanced Barrier Precautions related to the presence of GT, tracheostomy, colostomy, and history of colonization of CRAB in GT site. On 3/25/26 at 1045 hours, an interview was conducted with the IP. The IP stated hand washing or hand hygiene should always be done before and after providing care to the residents or even after just touching the surroundings in the resident's room to prevent transmission of infection. The IP was informed and acknowledged the above findings. On 3/25/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. Review of the facility's P&P titled Infection Control dated 7/2009 showed the facility has established and will maintain infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. On 3/22/26 at 0750 hours, during the initial tour to the facility, a green colored electric fan was observed on top of Resident 31's nightstand at bedside. The fan's front and rear grills and blades were full of dust particles. On 3/22/26 at 1236 hours, an observation and concurrent interview was conducted with the Maintenance Director in Resident 31's room. The Maintenance Director verified the findings and stated his team did daily rounds to check the rooms for any need of repair, but this fan was not reported to the Maintenance Department and should have been cleaned if they knew about it. On 3/22/26 at 1500 hours, an interview was conducted with LVN 9. LVN 9 verified Resident 31's green electric fan on top of the nightstand at bedside, the front, back grills and the blade were full of dust particles. LVN 9 stated, this should have been cleaned by maintenance. On 3/25/26 at 1210 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the essential equipment were maintained in a clean and safe operating conditions. * The ice machine located in the kitchen was not maintained in a sanitary condition. * The [NAME] Spunkmeyer countertop oven (used for baking cookies) was not maintained in a sanitary condition. These failures had the potential for the essential equipment not to function in the way they were intended and exposed the residents and staff to unsafe practices which may lead to negative outcomes.Findings: 1. Review of the facility's P&P titled Ice Machines and Ice Storage Chest revised 4/2023 showed the ice machines and ice storages distribution containers will be used and maintained to ensure a safe and sanitary condition. On 3/22/26 at 1411 hours, an observation of the ice machine in the kitchen and concurrent interview was conducted with the Maintenance Supervisor, Regional RD, and DSS. The top front cover of the ice machine was removed. The ice machine was wiped with a clean white towel and a black build up residue was removed from the water curtain adjacent to the ice bin. The Maintenance Supervisor was asked when the cleaning of the ice machine was last completed. The Maintenance Supervisor stated the ice machine was cleaned every month. When the Maintenance Supervisor was asked if he was aware of the black build up as identified during the ice machine inspection, the Maintenance Supervisor stated he was not aware. The Maintenance Supervisor, Regional RD, and DSS verified the above findings. 2. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, food-contact surface and utensils shall be clean to sight and touch. On 3/22/26 at 1206 hours, during the observation in the main dining, an [NAME] Spunkmeyer countertop oven was observed with brown residue on the right inside metal panel of the oven. On 3/22/26 at 1248 hours, an observation and concurrent interview was conducted with the Maintenance Assistant. The Maintenance Assistant verified the brown residue on the right inside metal panel of the oven and stated the staff should have cleaned it after every use. On 3/24/26 at 1408 hours, an interview was conducted with the DSS. The DSS verified the above findings. On 3/25/26 at 1211 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the inspection of all the bed to identify areas of possible entrapment to ensure safety was completed. In addition, the facility failed to inspect the bed for one of 23 final sampled residents (Resident 20)prior to the resident's use of bed rails. * The facility failed to ensure the entrapment assessment was completed for Resident 20 prior to the use of the bilateral upper bed rails. * The facility failed to ensure the monthly bed inspections for all beds used by the residents were completed. These failures had the potential to negatively impact the residents safety resulting in possible entrapment, serious injury, and/or death.Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapment may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Safety and Entrapment (undated) showed the facility will conduct inspections of all bed frames, mattresses and bedrails to identify areas of possible entrapment to ensure safety. The Procedure section showed: - The facility will utilize 7 (seven)-Zone as a reference for bed entrapment assessment; and - The facility will implement useful interventions to reduce the gap between the bed frames, mattresses and bedrails and the gaps between bed rails to reduce the risks for entrapment. The interventions may include, but are not limited to: pad the bedrails, replace mattresses and/or bedrails if indicated, provided extra pillow/padding, modify the bedrails as indicated, and monitoring/safety checks during daily care. Review of the facility's P&P titled Bed Safety and Bed Rails revised 3/2023 showed the resident beds (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. The Policy Interpretation and Implementation section showed: - The bed frames, mattresses and bed rails are checked for compatibility and size prior to use; - The bed dimensions are appropriate for the resident's size; - Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA; - Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks; - Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications; - The bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); and - Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g., altered mental status, restlessness, etc.) 1. On 3/22/26 at 0923 hours, during the initial tour of the facility, Resident 20 was observed awake and lying in bed with the bilateral upper bed rails elevated. The bed rails were observed with green tape around the rails. Resident 20 stated he had been in the facility for almost a month and had been using the bed rails since he got admitted to the facility. Resident 20 stated he would hold on to the bed rails when he turned on his sides or when he got out of bed and transferred to the wheelchair. Medical record review for Resident 20 was initiated on 3/22/26. Resident 20 was readmitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 3/1/26, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 needed partial/moderate assistance with mobility. On 3/23/26 at 0915 hours, Resident 20 was observed awake and lying in bed with the bilateral upper bed rails elevated. The bed rails were observed with green tape around each rails. On 3/23/26 at 1037 hours, a concurrent interview and medical record review for Resident 20 was conducted with RN 1. RN 1 verified Resident 20 was using the bilateral upper bed rails. RN 1 stated the bed rails were already installed or attached to the bed. RN 1 stated the green tapes around the bed rails meant the bed rails were elevated and being used by the resident and the red tapes meant the bed rails should be down and not being used by the resident. RN 1 stated the maintenance staff (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was the one who would complete the bed rail entrapment assessment and measurement during the bed inspection. On 3/23/26 at 1054 hours, a concurrent interview and facility document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated the maintenance department would be informed by the nurses if the resident would need to use the bed rails. The Maintenance Supervisor stated the bed rails were already attached or installed on the beds and when the resident needed to use them, the bed rails would have green tapes and would be elevated. The Maintenance Supervisor stated the maintenance staff was responsible in completing the zone assessment and measurement to ensure the resident would be free of any possible entrapment while using the bed rails. The Maintenance Supervisor further stated they would inspect the bed rails being used by the residents monthly. Review of the facility document titled Bed Safety Checklist for Residents with Side Rails for the month of February 2026 failed to show the entrapment assessment and measurement for the zone entrapment were conducted for Resident 20 related to the use of bilateral upper bed rails. The Maintenance Supervisor acknowledged the findings and stated he was not informed of Resident 20's use of bilateral upper bed rails. On 3/25/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 20. Cross reference to F700. 2. Review of the facility document titled Daily Census dated 3/22/26, showed the facility's census was 106. On 3/23/26 at 1054 hours, a concurrent interview and facility document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated one of the responsibilities of the maintenance department was to conduct a monthly bed inspection for all the beds used by the residents in the facility. The Maintenance Supervisor stated during the monthly bed inspection they would check the wheel locks, brakes, remotes, head and foot boards, mattresses, and the side rails. The Maintenance Supervisor stated the facility had a bed capacity of 115. Review of the facility's document titled Monthly Bed Maintenance Checklist showed the columns for the room number, wheel locks, side rails, mattress, bed cranks/remote, head/foot board and comments. The form further showed the following: - for the month of January 2026, only four rooms were recorded; - for the month of February 2026, only three rooms were recorded; and - for the month of March 2026, only five rooms were recorded. The Maintenance Supervisor stated they only logged the beds they would fixed and there was no monthly log for the bed inspection of all the beds being used by the residents. On 3/25/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident was notified of the result of the laboratory test for one of 23 final sample residents reviewed for a change in condition. * The facility failed to ensure Resident 13 was informed of the result of her urine culture test. This failure had the potential for the resident to not be aware of her condition and plan of care.Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised 3/2023 showed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The Policy Interpretation and Implementation section showed the following:- Unless otherwise instructed by the resident, a nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status;- Except in medical emergencies, notifications will be made within twenty-four hours of a change occurring in the resident's medical/mental condition or status; and- Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments. Medical record review for Resident 13 was initiated on 3/22/26. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 1/11/26, showed Resident 13 was alert and oriented to person, place, and time. Review of Resident 13's MDS assessment dated [DATE], showed Resident 13 was cognitively intact. Review of Resident 13's urine culture done on 3/10/26, with the result dated 3/14/26, showed it was positive for ESBL and reviewed by RN 6 on 3/14/26 at 1749 hours. The paper copy result showed a handwritten note showing seen by the physician on 3/14/26 at 1749 hours and NNO. Further review of Resident 13's medical record failed to show the documentation whether Resident 13 was informed of the result of the urine culture done on 3/10/26. On 3/25/26 at 0913 hours, an observation and concurrent interview was conducted with Resident 13. Resident 13 was observed awake, lying in bed, and on ventilator. When asked if she was informed of the result of the urine test done on 3/10/26, Resident 13 turned her head sideways and mouthing no. On 3/25/26 at 1022 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 4. RN 4 stated an abnormal laboratory result was considered a change in condition. RN 4 stated the resident or responsible party should be notified of any change in conditions. RN 4 verified Resident 13 was very alert and could understand and make decisions. RN 4 verified the medical record of Resident 13 did not show documented evidence Resident 13 was informed of the urine culture result dated 3/14/26. RN 4 stated the NNO written in the paper copy of the urine culture result dated 3/14/26 meant no new order. On 3/25/26 at 1115 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 13. Cross reference to F684, example #1.

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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, medical record review, facility document review, and facility P&P review, the facility failed to provide a reasonable accommodation to meet the needs for one of 23 final sampled residents (Resident 90). * The facility failed to ensure Resident's 90 call light was within the residents' reach. This failure had the potential for the delay of care as the resident do not have the means to call for assistance. Findings: Review of the facility's P&P titled Answering the Call Light reviewed on 3/2023 under general guidelines section, the bullet point number 4 showed to ensure that the call light is accessible to the resident when in bed or wheelchair in room, from the toilet or shower room if necessary. On 3/22/26 at 0934 hours, an observation was conducted for Resident 90. Resident 90 was observed lying in bed. Resident 90's call light was observed on the floor on the left side of the bed and far from the resident's reach. Resident 90 stated she did not know where the call light was. Resident 90 stated she would use the call light to call the staff when she needed assistance. Resident 90 attempted to reach for the call light and Resident 90 stated she was unable to see and reach for the call light. Resident 90 stated if I need help then I won't be able to reach the call light to get help. Medical record review for Resident 90 was initiated on 3/22/26. Resident 90 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 90's plan of care initiated on 9/24/23, showed a care plan problem addressing the resident's self-care deficits revised on 2/10/25. The interventions included to keep the call light within reach and attending to needs promptly. Review of Resident 90's H&P examination dated 11/14/25, showed the resident was able to make decisions for activities of daily living. Review of Resident 90's MDS assessment dated [DATE], showed Resident 90 had a BIMS score of 12, indicating the resident had moderate cognitive impairment. On 3/22/26 at 1049 hours, a follow-up observation and interview was conducted with the DON. The DON was summoned to Resident 90's room. Resident 90 was observed lying in bed, and the call light was hanging and on the floor on left side of the bed, which was not within Resident 90's reach. The DON further stated the call light should be within the reach of the resident to ensure the resident's safety and allow the resident to communicate with the facility staff when she needed assistance. The DON verified and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to maintain a copy of the advance directive was readily retrievable by any facility staff for one of five sampled residents (Resident 42) reviewed for advance directives. * The facility failed to ensure Resident 42's medical record had a copy of the advance directive. This failure had the potential for Resident 42's decisions regarding his healthcare and treatment options to not be honored.Findings: Review of the facility's P&P titled Advance Directives revised 2/2022 showed if the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident medical record and are readily retrievable by any facility staff. Medical record review for Resident 42 was initiated on 3/22/26. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's IDT Advance Directives for Care note dated 3/7/24, showed according to Resident 42's family member, Resident 42 had an Advance Directive but did not have a copy to provide to the SSD. Reviewed of Resident 42's Advance Healthcare Directive Acknowledgment form dated 2/28/25, showed Resident 42 had executed an Advance Directive. Review of Resident 42's H&P examination dated 9/23/25, showed Resident 42 had the capacity to make medical decisions. Further review of Resident 42's medical record failed to show a copy of the advance directive was maintained in Resident 42's medical record. On 3/23/26 at 0903 hours, an interview and concurrent medical record review for Resident 42 was conducted with the SSD. The SSD verified there was no copy of Resident 42's advance directive in the medical record, nor was it uploaded in Resident 42's EHR. The SSD stated according to the resident's family member, Resident 42 had an advanced directive. The SSD stated she should have documented the follow up with the family member and obtain a copy of the resident's advanced directive. The SSD further stated a copy of the advance directive should have been maintained in Resident 42's medical record and should be readily retrievable by the facility staff so the facility can follow the plan of care and honor the resident wishes. On 3/25/26 at 1038 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON further stated the SSD should have documented the follow up, obtain a copy of Resident 42's advanced directive and place it in the resident's medical record.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three final sampled residents (Residents 5) reviewed for physical restraint was free from the unnecessary restraints. * The facility failed to follow the physician's order for Resident 5 to be free from physical restraint every Sunday. This failure had the potential for increased risk of physical harm and potential negative outcome to Resident 5. Findings: Review of the facility's P&P titled Use of Restraints revised 3/2023 under the Policy Interpretation and Implementation section, showed the restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: the specific reason for the restraint (as it relates to the resident's medical symptom), how the restraint will be used to benefit the resident's medical symptom, and the type of restraint and period of time for the use of the restraint. On 3/22/26 at 0900 hours, during the initial tour of the facility Resident 5 was observed sleeping and lying in bed. Resident 5 was observed with a tracheostomy tube connected to the ventilator. Resident 5 was observed with blue hand mitten on the right hand. Medical record review for Resident 5 was initiated on 3/22/26. Resident 5 was readmitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 8/13/25, showed Resident 5 had a respiratory failure and full ventilatory support. The H&P also showed Resident 5 turns head to tactile stimuli. Review of Resident 5's Order Summary Report showed a physician's order dated 8/11/25, to apply a right hand mitten due to attempting to pull out life sustaining tubes daily and off on Sunday and hand hygiene will be provided during release of the hand mitten. On 3/22/26 at 1008, 1130, and 1230 hours (Sunday), an observation was conducted for Resident 5. Resident 5 was observed with a blue right hand mitten. On 3/22/26 at 1233 hours, an observation, interview and concurrent medical record review for Resident 5 was conducted with LVN 3. LVN 3 stated Resident 5 had an order for the right hand mitten due to the resident's attempt to pull out the tracheostomy and GT. LVN 3 stated she was responsible in doing the restraint assessment, applying the restraints, and removing it if needed. LVN 3 verified the physician's order for Resident 5's right hand mitten was to be off on Sunday. LVN 3 verified Resident 5 was still wearing the right hand mitten which should have been removed every Sunday. On 3/25/26 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 5.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 4 and 47) reviewed for psychotropic medications were free from the unnecessary psychotropic medications. * The facility failed to ensure the lorazepam (anti-anxiety) medication was administered to Resident 4 as per the physician's order. In addition, the facility failed to document the nonpharmacological interventions provided to Resident 4 prior to the administration of the lorazepam medication. * The facility failed to document what nonpharmacological interventions would be attempted when Resident 47 had episodes of depression as manifested by verbalization of hopelessness and helplessness related to Resident 47's use of escitalopram (anti-depression) medication. In addition, the facility failed to accurately monitor Resident 47's orthostatic blood pressure related to the use of escitalopram medication. These failures had the potential for the residents to have adverse complications from the psychotropic medications and having an inaccurate data with the potential to affect the prescriber's decision in determining dose adjustments of the psychotropic medications for the residents. Findings: Review of the facility's P&P titled Psychotropic Medication Use revised 3/2023 showed the residents will not receive medications that are not clinically indicated to treat a specific condition. Psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medication, permit the lowest possible dose, and allow for discontinuation of medication when possible.1. Medical record review for Resident 4 was initiated on 3/22/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 3/1/26, showed Resident 4 had no capacity to understand and make decisions. Review of Resident 4's Order Summary Report showed a physician's orders dated 3/20/26, to administer lorazepam 0.5 mg via GT every six hours as needed for anxiety as manifested by attempting pulling out life sustaining tubes and getting out of bed, and to monitor the episodes of anxiety as evidenced by attempting pulling out life sustaining tubes and getting out of bed for use of lorazepam medication. Review of Resident 4's medical record failed to show what nonpharmacological interventions would be attempted when Resident 4 had episodes of anxiety as manifested by attempting pulling out life sustaining tubes and getting out of bed related to the use of lorazepam medication. Review of Resident 4's MAR for March 2026 showed Resident 4 was administered the lorazepam medication on the following dates and times:- dated 3/20/26 at 2030 hours, - 3/21/21 at 1233 hours; and - 3/24/26 at 1715 hours. However, the MAR failed to show documentation of any nonpharmacological intervention provided to Resident 4 prior to the administration of the lorazepam medication. Further review of Resident 4's MAR for March 2026 failed to show any documented evidence of the nonpharmacological interventions and if the lorazepam medication was provided to Resident 4 when Resident 4 had episode of attempting of pulling out life sustaining tubes and getting out of the bed on the following dates and times:- dated 3/21/26 at the evening shift - one episode;- dated 3/21/26 at the night shift - one episode;- dated 3/22/26 at the day shift - two episodes;- dated 3/23/26 at the day shift - one episode; and- dated 3/24/26 at the day shift - two episodes. On 3/25/26 at 1019 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 7. LVN 7 verified the lorazepam medication was ordered every six hours as needed and there were no nonpharmacological interventions ordered prior to the administration of the lorazepam medication. LVN 7 stated the nonpharmacological interventions need to be provided to the resident if the resident have manifested a behavior. On 3/25/26 at 1034 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON was informed and verified the above findings. The DON stated the nonpharmacological intervention should be attempted prior to the psychotropic medication administration when the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had behaviors. 2. Medical record review for Resident 47 was initiated on 3/22/26. Resident 47 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 47's H&P examination dated 6/13/25, showed Resident 47 had the capacity to understand and make decisions. Review of Resident 47's Order Summary Report showed the following physician's orders;- dated 9/22/25, to monitor episode of verbalization of hopelessness, helplessness, abandoned by family members, worthlessness, such as feeling like a failure every shift for escitalopram medication use; - dated 12/17/25, to administer escitalopram 15 mg one time a day for depression as manifested by verbalization of hopeless, helplessness, abandoned by family members, worthlessness, such as feeling like a failure;- dated 1/9/26, to document every shift the nonpharmacological intervention attempted and/or used as indicated in conjunction with the routine psychotherapeutic medication use:1 = Comfort measures and Rest/Positioning provided 2 = Hunger / Thirst met and toileting needs anticipated 3 = Room temperature/adequate lighting maintained 4 = Room Placement Accommodation ensured 5 = Group Activity participation or room visit encouraged 6 = Cues/Redirection and/or reassurance provided 7 = Other, If Other please document in the progress notes; and- dated 1/12/26, to monitor orthostatic hypotension if there is a 20 mmHg drop in systolic blood pressure or a drop of 10 mmHg in diastolic blood pressure between the two readings called MD every Sunday at day shift a. Review of Resident 47's MAR for February and March 2026 for the monitoring of episode of verbalization of hopelessness, helplessness, abandoned by family members, worthlessness, such as feeling like failure show the following:- dated 2/10/26 at the night shift - one episode;- dated 2/11/26 at the evening shift - one episode;- dated 2/12/26 at the evening shift - one episode;- dated 3/6/26 at the evening shift - one episode; and- dated 3/23/26 at the evening shift - one episode. b. Review of Resident 47's MAR for March 2026 for the monitoring of Resident 47 orthostatic blood pressure showed the following:- dated 3/1/26, a blood pressure reading for lying position of 126/72 mmHg;- dated 3/8/26, a blood pressure reading for lying position of 126/74 mmHg;- dated 3/15/26, a blood pressure reading for lying position of 124/70 mmHg; and- dated 3/22/26, a blood pressure reading for lying position of 122/78 mmHg. Further review of the MAR failed to show a physician's order or documented evidence the orthostatic blood pressure was monitored for the sitting and standing positions. On 3/24/26 at 0923 hours, an interview and concurrent medical record review for Resident 47 was conducted with RN 1. RN 1 verified there was no blood pressure documentation for the sitting and standing positions. RN 1 verified there was no documentation related to what nonpharmacological interventions were attempted when Resident 47 had episodes of depressions. RN 1 stated the nonpharmacological interventions should be provided when the resident has episode of verbalization of hopelessness, helplessness, abandoned by family members, worthlessness, and such as feeling like failure. RN 1 stated if the nonpharmacological interventions showed effectiveness in relieving the behavior symptoms, this could assist the physician in evaluating whether to continue, discontinue or adjust the dosage and frequency of the psychotropic medication. On 3/25/26 at 1211 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop a comprehensive person-centered care plan for three of 23 final sampled residents (Residents 13, 20, and 102). * The facility failed to ensure a care plan was developed for Resident 13 when the resident had a change in condition. * The facility failed to ensure a care plan was developed for the use of the bilateral upper bed rails for Resident 20. * The facility failed to ensure a care plan was developed to address the use of the insulin (medication to lower the blood sugar) medication for Resident 102. These failures had the potential for the residents to receive inconsistent, inappropriate and inadequate care. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2023 under the Policy Interpretation and Implementation section showed:- The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and implements a comprehensive, person-centered care plan for each resident;- The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment;- Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to participate in the planning process, identify individuals or roles to be included, request meetings, request revisions to the plan of care, participate in establishing the expected goals and outcomes of care, participate in determining the type, amount, frequency and duration of care, receive the services and/or items included in the plan of care, and see the care plan and sign it after significant changes are made;- The comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, includes the resident's stated goals upon admission and desired outcomes, builds on the resident's strengths, and reflects currently recognized standards of practice for problem areas and conditions;- Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes. and relevant clinical decision making;- When possible, interventions address the underlying source(s) of the problem area(s) and not just symptoms or triggers;- Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change; and- The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS assessment. 1. Medical record review for Resident 13 was initiated on 3/22/26. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 1/11/26, showed Resident 13 was alert and oriented to person, place and time. Review of Resident 13's MDS assessment dated [DATE], showed Resident 13 was cognitively intact. Review of Resident 13's urine culture done on 3/10/26, with the result dated 3/14/26, showed it was positive for ESBL and reviewed by RN 6 on 3/14/26 at 1749 hours. The paper copy result showed a handwritten note showing seen by the physician on 3/14/26 at 1749 hours and NNO. Further review of Resident 13's medical record failed to show a plan of care was developed when the resident had a positive ESBL result in the urine culture. On 3/25/26 at 1022 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 4. RN 4 stated an abnormal laboratory result was considered a change in condition. RN 4 verified the result of the urine culture for Resident 13. RN 4 stated a care plan should have been developed for any change in condition in the resident. RN 4 stated the plan of care would serve as a guide for the staff to know on how to take care of the resident in terms of what to monitor, interventions to implement, and what goals were needed to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attain for each problem identified in the resident. RN 4 stated any licensed nurse, and ancillary staff could initiate and revise the plan of care. RN 4 further stated they could modify or customize the plan of care according to the resident's needs. RN 4 verified there was no plan of care developed for Resident 13 when the resident had had a positive ESBL result in the urine culture. Cross reference to F684, example #1. 2. On 3/22/26 at 0923 hours, during the initial tour of the facility, an observation was conducted for Resident 20. Resident 20 was observed awake and lying in bed with the bilateral upper bed rails elevated. The bed rails were observed with green tape around each rails. Resident 20 stated he had been in the facility for almost a month and had been using the bed rails since he got admitted to the facility. Resident 20 stated he would hold on to the bed rails when he turned on his sides or when he got out of bed and transferred to the wheelchair. Medical record review for Resident 20 was initiated on 3/22/26. Resident 20 was readmitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 3/1/26, showed Resident 20 had the capacity to understand and make decisions. Further review of Resident 20's medical record failed to show a plan of care was developed to address the use of the bilateral upper bed rails for Resident 20. On 3/23/26 at 1037 hours, a concurrent interview and medical record review for Resident 20 was conducted with RN 1. RN 1 verified Resident 20 was using the bilateral upper bed rails. RN 1 stated there should have been a plan of care developed for Resident 20's use of the bed rails to ensure the resident receive consistent and safe care. RN 1 verified there was no care plan developed to address the use of bilateral upper bed rails for Resident 20. Cross reference to F700. 3. Medical record review for Resident 102 was initiated on 3/22/26. Resident 102 was admitted to the facility on [DATE]. Review of Resident 102's H&P examination dated 9/25/25, showed Resident 102 had the capacity to understand and make decisions. The H&P also showed Resident 102 had a medical diagnosis of Diabetes Mellitus II. Review of Resident 102's Order Summary Report showed the physician's orders dated 9/23/25, to administer Insulin Glargine 40 units subcutaneously at bedtime for diabetes; and to administer Insulin Regular Human as per sliding scale subcutaneously before meals and at bedtime for DM. For blood sugar 0 - 150 mg/dl = 0 units; 151 - 200 mg/dl = 3 units; 201 - 250mg/dl = 6 units; 251 - 300 mg/dl = 9 units; 301 - 350 mg/dl= 12 units; 351 - 400 mg/dl = 15 units; 401+ mg/dl = 18 units and call MD. If the blood sugar result is less than 60 mg/dl, give Glucagon (rapid-acting treatment for critically low blood sugar) from E-kit and call MD. Further review of Resident 102's medical record failed to show a plan of care was developed to address the use of the insulin medication for Resident 102's diabetes. On 3/25/26 at 1022 hours, an interview and concurrent medical record review for Resident 102 was conducted with RN 4. RN 4 stated the plan of care would guide the staff on how to take care of the resident in terms of what to monitor, interventions to implement, if the medication being used was effective to the resident's condition like the insulin for diabetes, and what goals we needed to attain for each problem identified in the resident. RN 4 stated any licensed nurse, and ancillary staff could initiate and revise the plan of care. RN 4 further stated they could modify or customize the plan of care according to the resident's needs. RN 4 verified there was no plan of care developed for Resident 102 to address the use of insulin medication for Resident 102's diabetes. On 3/25/26, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 13, 20, and 102.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and facility's P&P review, the facility failed to ensure the care plans were revised and updated for one of 23 final sampled residents (Resident 54) reviewed for care plans. * The facility failed to ensure Resident 54's activity care plan was revised to reflect the resident ?s current condition and needs when Resident 54 was no longer on a mechanical ventilator. This failure posed the risk for the resident to not receive a current individualized and person-centered care.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person – Centered revised 3/2023 showed a comprehensive, person-centered care plan that include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the residents' condition. On 3/22/26 at 0833 hours, during the initial tour of the facility, Resident 54 was observed lying in bed, with the GT feeding off. Resident 54 observed to be nonverbal. Medical record review for Resident 54 was initiated on 3/22/26. Resident 54 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 54's H&P examination dated 1/29/26, showed Resident 54 could make simple needs known and had no capacity to report subjective complaints. Review of Resident 54's Care Plan Report showed a care plan problem dated 9/16/25, for activities: younger resident. The care plan further showed activity participation challenged by the need for social and sensory stimulation related to sub-acute unit resident, and ventilator dependent. Review of Resident 54's medical record failed to show Resident 54 was on mechanical ventilation. On 3/16/26 at 1017 hours, an interview and concurrent medical record review for Resident 54 was conducted with the Activity Director. The Activity Director verified Resident 54 was no longer on mechanical ventilation and on subacute Unit. The Activity Director verified the care plan failed to show Resident 54's current condition and needs. On 3/25/26 at 1211 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure two of 23 final sampled residents (Residents 11 and 13) attained and maintained their highest practicable well-being. * The facility failed to follow the physician's order to check and record the orthostatic blood pressure for Resident 11. * The facility failed to ensure to continuously monitor Resident 13 when the resident had a change in condition. These failures had the potential for the residents to not receive the necessary care and services when the residents had a change in condition. Findings: 1. Review of the facility's P&P titled Change in a Resident's Condition or Status revised 3/2023 under the Policy Interpretation and Implementation section showed: - Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form; and - The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Medical record review for Resident 13 was initiated on 3/22/26. Resident 13 was readmitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 1/11/26, showed Resident 13 was alert and oriented to person, place and time. Review of Resident 13's MDS assessment dated [DATE], showed Resident 13 was cognitively intact. Review of Resident 13's urine culture done on 3/10/26, with the result dated 3/14/26, showed it was positive for ESBL and reviewed by RN 6 on 3/14/26 at 1749 hours. The paper copy result showed a handwritten note showing seen by the physician on 3/14/26 at 1749 hours and NNO. Further review of Resident 13's medical record failed to show documented evidence of the continued monitoring to assess the negative impact of the urine infection to Resident 13. On 3/25/26 at 0913 hours, an observation and concurrent interview was conducted with Resident 13. Resident 13 was observed awake, lying in bed, and on ventilator. When asked if she was informed of the result of the urine test done on 3/10/26, Resident 13 turned her head sideways and mouthing no. On 3/25/26 at 0930 hours, an interview for Resident 13 was conducted with CNA 1. CNA 1 stated he knew Resident 13 well as the resident had been in the facility for a long time. CNA 1 stated Resident 13 was incontinent with both bladder and bowel. When asked about Resident 13's urine output and characteristic when he changed the resident's diaper, CNA 1 stated Resident 13's urine output was ok, but the urine color was a little darker than orange and had a strong foul odor. CNA 1 further stated Resident 13 at times would point to her lower abdomen when the resident had pain, but would not happen most of the time. On 3/25/26 at 1005 hours, an interview for Resident 13 was conducted with LVN 7. LVN 7 stated he (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knew Resident 13 well. LVN 7 stated when he assisted in cleaning Resident 13, there was no foul odor in the urine, and the color was regular yellow. LVN 7 stated Resident 13 did not manifest any signs and symptoms of infection like fever, abnormal vital signs or altered mental status. LVN 7 stated an abnormal vital sign, alteration in mental status, abnormal laboratory results, and decreased urine output were some examples of a change in conditions. LVN 7 stated when there was a change in condition, the charge nurses or CNAs would report to the RN Supervisor and the RN Supervisor would reassess the resident. LVN 7 added they would inform the physician and the resident or responsible party, implement the orders received from the physician, and would do change in condition monitoring every shift which would be recorded in the nurse's daily note assessment. LVN 7 further stated the frequency and length of the monitoring would depend on the kind of change in condition. On 3/25/26 at 1022 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 4. RN 4 stated an abnormal laboratory result was considered a change in condition. RN 4 stated once there was a change in condition reported to her, she would do her own assessment on the resident. RN 4 stated the initial assessment for the change in condition would be documented in the SBAR Communication Form or sometimes in the Nurse's Progress Note. RN 4 stated the resident should be monitored specifically related to the change in condition every shift for 72 hours or more frequently as needed if it was a significant change in condition. RN 4 further stated it was important to monitor the resident when there was a change in condition to determine if the resident was responding to the interventions or declining and it would assist them to report to the physician if there was any alteration in the status of the resident. RN 4 verified there was no documented evidence in Resident 13's medical record to show Resident 13 was monitored continuously when the resident had a positive ESBL in her urine on 3/14/26. RN 4 stated the NNO written in the paper copy of the urine culture result dated 3/14/26 meant no new order. On 3/25/26 at 1115 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 13. Cross reference to F552, example #1 and F656, example #1. 2. Review of the facility's P&P titled Blood Pressure, measuring revised 3/2023 showed orthostatic (postural) hypotension is defined as a 20 mm/Hg (or greater) decline in systolic blood pressure (SBP) or a 10 mm/Hg (or greater) decline in diastolic blood pressure (DBP) upon standing. Hypotension should be reported to the physician. The staff should record several readings throughout the day, including before and after meals. Medical record review for Resident 11 was initiated on 3/24/26. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's H&P examination dated 12/18/25, showed Resident 11 had no have the capacity to understand and make decisions. Review of Resident 11's Order Summary Report dated 3/24/26, showed a physician's order dated 1/12/26, to monitor the orthostatic hypotension on day shift, call MD if there was a 20 mmHg in systolic blood pressure or a drop of 10 mmHg in diastolic blood pressure between the two readings, every Sunday (Standing, Sitting and Lying positions). Review of Resident 11's MAR for March 2026 showed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 3/1/26, the BP readings were 126/74 mmHg for the standing, sitting and lying positions, - dated 3/8/26, the BP readings were 124/80 mmHg for the standing, sitting and lying positions, - dated 3/15/26, the BP readings were 120/70 mmHg for standing, sitting and lying positions; and - dated 3/22/26, the BP reading were 122/80 mmHg for standing, sitting and lying positions. On 3/24/26 at 1537 hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 1. RN 1 stated orthostatic hypotension BPs were checked weekly in lying, sitting, and standing positions or as ordered by the physician. RN 1 verified the above findings and stated the BP reading results should have changes in values. When asked how much of a drop in SBP and DBP would be considered orthostatic hypotension, RN 1 stated a drop of 20 mmHg for both SBP and DBP. On 3/25/26 at 1044 hours, an interview was conducted with the DON. The DON was informed and acknowledged Resident 11's MAR showed the orthostatic hypotension BP readings for both lying and sitting were the same values. The DON stated the BP readings were not accurate. The DON further stated the BP readings for standing, lying, and sitting positions would have some differences in the readings. The DON verified and acknowledged the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries or worsening of the existing pressure injuries for one of two final sampled residents (Resident 40) reviewed for pressure injuries. * The facility failed to ensure Resident 40's LAL mattress setting was appropriate to the resident's weight. This failure had the potential for Resident 40 to develop pressure injuries or worsening of the existing pressure injuries.Findings: Review of the facility's document titled Proactive Medical Products Operation Manual for Protekt Aire 4000DX/5000DX (undated) showed users can adjust air mattress to a desired firmness according to patient's weight. Medical record review for Resident 40 was initiated on 3/22/26. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's H&P examination dated 3/10/26 , showed the resident had the capacity to understand and make decisions. Review of Resident 40's Order Summary Report dated 3/24/26 , showed the following physician's orders:- dated 3/11/26, for Low Air Loss mattress for wound care management every day shift;- dated 3/11/26 for sacrococcyx extending to left and to right buttock pressure injury, cleanse with normal saline, pat dry, apply zinc oxide (a topically applied skin protectant used to treat and prevent diaper rash, minor burns, cuts, and scrapes by forming a physical, moisture-proof barrier) and cover with border gauze x 30 days, every day, for pressure injury. Review of Resident 40's Weights and Vital Summary showed Resident 40 weighed 82 pounds on 3/17/26. On 3/22/26 at 0944 hours, Resident 40 was observed in bed lying on a LAL mattress with the weight setting at 400 pounds mark. On 3/22/26 at 1050 hours, an observation and concurrent interview was conducted with LVN 2 inside Resident 40's room. LVN 2 verified the weight setting was at 400 pounds mark. LVN 2 further verified Resident 40 did not weigh 400 pounds and verified the resident's current weight was 82 pounds. LVN 2 stated the mattress weight setting should be based on the resident's weight to prevent skin breakdown or worsening of the wound. On 3/25/26 at 1036 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON further stated the LAL mattress should be set based on resident's current weight.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P (Policy and Procedures) review, the facility failed to ensure the necessary care and services were safely provided using two person assistance for one of 23 final sampled residents (Resident 12) and three of three nonsampled residents (residents who are not included in the finalized survey sample, Residents 22, 49, and 70) reviewed for falls. * The facility failed to ensure the two person assistance was provided when providing ADL (Activities of Daily Living) care to Resident 12. Resident 12 sustained a fall when a one person assistance was provided during care which resulted to a right foot first metatarsal (big toe) fracture. In addition, the facility failed to ensure Residents 22, 49, and 70 were provided with two person assistance during care. These failures had the potential to affect Residents 12, 22, 49, and 70 care and safety, and may have contributed to Resident 12's fall which resulted to right foot first metatarsal fracture.Findings: Review of the facility's P&P (Policy and Procedure) titled Activities of Daily Living (ADLs), Supporting revised 3/2023 showed the residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to activities of ADLs. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming, and oral care);b. mobility (transfer and ambulation, including walking);c. elimination (toileting); andd. dining (meals and snacks) Review of the facility's document titled Job Description for Certified Nursing Assistant (CNA) - Sub-Acute (specialized, short-term healthcare setting for patients needing intensive, daily nursing care and rehabilitation, but who no longer require high-level hospital acute care) dated 6/2013 showed the CNA assists in providing a clean, safe, dignified, happy and healthy environment for residents by performing the duties as described below:- Must be aware of and understand the needs of the residents; and- The employee must frequently lift and/or move 50 to 60 pounds, as well as lift and/or move over 60 pounds using a buddy system (a safety or support procedure where two individuals are paired to assist and support each other, ensuring safety) or appropriate lift equipment or tools. Review of the facility's P&P titled Falls - Clinical Protocol revised 3/2018 showed the staff will review each resident's risk factors for falling and document in the medical record. The physician will identify medical conditions affecting fall risk (for example, a recent stroke or medications that cause dizziness or hypotension) and the risk for significant complications of falls (for example, increased fracture risk in someone with osteoporosis or increased risk of bleeding in someone taking an anticoagulant). Falls should be categorized as:c. Other circumstances such as sliding out of a chair or rolling from a low bed to the floor. The P&P further showed the staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved.a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to serval weeks after a fall. Moreover, the facility's P&P showed the staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.a. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. 1. Medical record review for Resident 12 was initiated on 3/22/26. Review of Resident 12's Facesheet (a document providing summary of a patient's essential information, used primarily in healthcare for admissions, billing, and quick clinical reference) dated 3/23/26, showed Resident 12 was admitted to the facility on [DATE], and readmitted back to the facility on 6/7/25. Resident 12 had diagnoses including but not limited to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	traumatic brain injury (a disruption in the normal function of the brain), tracheostomy (a surgical procedure that creates an opening in the neck and into the windpipe to provide direct airway), bed confinement, and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to become stiff) to the left elbow, left wrist, left hand, left knee, and right knee. Review of Resident 12's H&P (History and Physical) examination dated 6/9/25, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Annual Minimum Data Set (MDS) - Version 3.0 Resident Assessment and Care Screening, Section GG - Functional Abilities dated 10/2/25, showed under the Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed was coded as 01 (Dependent - helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 (two) or more helpers is required for the resident to complete the activity). Review of Resident 12's NC (Nursing Home Comprehensive)-COC (Change of Condition)/Interact Assessment Form (SBAR -situation/ background/ assessment/ recommendation) v1.4 dated 12/19/25 at 0036 hours, showed Resident 12 had a fall while being repositioned on 12/18/25 at 2130 hours. The document showed CNA 6 was repositioning Resident 12 to the right side and the resident turned. Resident 12 started moving and CNA 6 lost her grip on Resident 12's body. The document further showed while CNA 6 tried to hold Resident 12's body, Resident 12's legs fell down and the upper body followed. Review of Resident 12's NC - COC/Interact Assessment Form (SBAR) v1.4 dated 12/19/25 at 1207 hours, showed Resident 12 was identified with swelling and bruises on his right metatarsal (the five long bones found in each foot). Review of Resident 12's Addendum Radiology Report for the right foot x-ray done on 12/19/25, showed concern for impacted fracture (a bone break where the broken ends are driven or wedged into each other due to high-force trauma) of the head/neck of the first metatarsal. On 3/23/26 at 0858 hours, an interview was conducted with CNA 7. CNA 7 stated he worked with Resident 12 before and verified Resident 12 needs two persons assistance during care to maintain the resident's and staff's safety. On 3/23/26 at 1026 hours, an interview and concurrent medical record review for Resident 12 was conducted with LVN (Licensed Vocational Nurse) 11. LVN 11 verified Resident 12 had a fall while being repositioned on 12/18/25, and sustained a right foot first metatarsal fracture. LVN 11 stated Resident 12 was a long term resident in the subacute unit who was non-ambulatory and nonverbal. LVN 11 further stated Resident 12 was dependent on the staff's care and would always require two persons assistance. On 3/23/26 at 1600 hours, an interview and concurrent medical record review for Resident 12 was conducted with RN (Registered Nurse) 3. RN 3 verified Resident 12's Annual MDS dated [DATE], was coded as dependent on his functional ability. RN 3 stated the dependent residents would require two persons assistance when providing the resident care. RN 3 stated CNA 6 was the only staff who assisted Resident 12 during the time of the fall. RN 3 further stated Resident 12 should have been provided with two persons assistance. On 3/23/26 at 1625 hours, an interview was conducted with CNA 6. CNA 6 verified she was the CNA for Resident 12 when Resident 12 had a fall on 12/18/25. CNA 6 stated Resident 12 was totally dependent and required assistance with ADLs including turning and repositioning. CNA 6 stated while repositioning Resident 12 to his right side, the resident slipped out of her grasp and fell from the bed. CNA 6 verified she did not have another staff with her while she was repositioning Resident 12. CNA 6 stated, at that time, I thought one person was ok. I made a mistake and should have asked for extra help. The LVNs do help, but I just thought I was ok to turn him by myself. CNA 6 acknowledged Resident 12 required two persons assistance. On 3/24/26 at 0915 hours, an interview was conducted with the DOR (Director of Rehabilitation). The DOR stated the residents in the subacute unit were recommended to have two persons assistance for safety. When asked if Resident 12 required two persons assistance with turning, repositioning, and other ADL care, the DOR stated two persons assistance was needed for Resident 12 due to his high tone (an abnormal increase in muscle tension, resulting in stiff, rigid muscles that resist stretching), contractures, height and being dependent with care. The DOR further stated during turning and repositioning, when the residents in subacute were (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rolled to the side, the resident's tone and momentum could carry over causing the resident to roll off the bed and fall. b. On 3/24/26 at 1100 hours, an interview was conducted with Resident 49 in his room. Resident 49 was a resident in the subacute unit and able to verbalize his needs. When asked if he was able to turn by himself, Resident 49 stated no and would need the help of the nurses to turn him. Resident 49 was also asked how many staff were present when he was being cleaned or repositioned, Resident 49 stated one. Medical record review for Resident 49 was initiated on 3/24/26. Review of Resident 49's Facesheet dated 3/25/26, showed Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's H&P examination dated 7/10/25, showed Resident 49 had the capacity to make medical decisions. c. On 3/24/26 at 1104 hours, an interview was conducted with Resident 22 in her room. Resident 22 is a resident in the subacute unit and able to verbalize her needs. When asked how many staff would assist her during changing, turning, and repositioning, Resident 22 stated two persons; however, sometimes it was just one person. Medical record for Resident 22 was initiated on 3/24/26. Review of Resident 22's Facesheet dated 3/25/26, showed Resident 22 was admitted to the facility on [DATE], and readmitted on [DATE]. d. On 3/25/26 at 0940 hours, an observation was conducted for Resident 70. CNA 7 was observed placing Resident 70's dirty linens in the soiled linen cart outside of Resident 70's room. There were no other staff inside Resident 70's room. CNA 7 was then observed asking CNA 1 to assist him with pulling Resident 70 up. On 3/25/26 at 0947 hours, an interview was conducted with CNA 7 outside Resident 70's room. CNA 7 verified he cleaned and changed Resident 70 by himself before asking CNA 1 to assist him. When asked if CNA 7 cleaned, turned, and repositioned Resident 70 on his own, CNA 7 stated yes. On 3/25/26 at 0953 hours, an interview and concurrent medical record review for Resident 70 was conducted with LVN 12. LVN 12 verified Resident 70's Quarterly MDS dated [DATE], showed Resident 70's functional abilities to roll left and right: the ability to roll from lying on back to left and right side and return to lying on back on the bed was coded as Dependent. LVN 12 stated Resident 70 cannot turn on her own and would require two persons assistance with repositioning and care. On 3/24/25 at 1122 hours, an interview was conducted with the DSD (Director of Staff Development). The DSD stated the CNAs job description would include doing ADL care and direct care to the residents. The DSD stated during the CNAs orientation, the topics covered would include fall precaution, bed making, transferring, ADL care, and how to reposition residents with multiple medical devices. When asked if the dependent residents were reviewed upon orientation, the DSD stated yes. The DSD stated the CNAs were informed two persons assistance were encouraged for ADL care including pull ups, log roll, turning during brief changes, and transferring for the residents' and staff safety. The DSD verified Resident 12 was a total care resident who was dependent and would need two persons assistance. The DSD also verified CNA 6 was educated about the dependent residents required two persons assistance during her orientation. On 3/25/26 at 1140 hours, an interview and concurrent medical record review for Resident 12 was conducted with the DON (Director of Nursing). The DON stated the residents in the subacute unit would require more attention as some residents were non-ambulatory, nonverbal, or may not be as alert as the residents in the skilled nursing side. The DON verified Resident 12 was a resident in the subacute unit who required total dependent care. The DON verified Resident 12's MDS dated [DATE], showed the resident was dependent in his functional abilities including turning or rolling from left to right. When asked what the expectation was for the residents who were dependent, the DON stated they would require two persons assistance with ADLs including showers, changing, and repositioning of the residents. The DON stated two persons assistance could help prevent fall incidents and would also protect the staff's safety. Moreover, when the DON was asked if Resident 12's fall with right foot first metatarsal fracture could have been prevented, the DON stated the fall could have been prevented if there was another staff on the other side of Resident 12's bed to prevent the resident from rolling over and falling off the bed. On 3/25/26 at 1202 hours, an interview was conducted with the Administrator, DON, and Regional Director of Operations. The Administrator, DON, and Regional Director of Operations were made aware and acknowledged the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for five of 23 final sampled residents (Resident 8, 12, 42, 54 and 104) with enteral feeding orders. * The facility failed to ensure Residents 8, 12, 42, and 104 were administered the total amount of enteral feedings as ordered by the physician. * The facility failed to ensure Resident 54 was positioned safely at 30 to 45 degrees during the enteral feeding via GT. In addition, the facility failed to follow Resident 54's physicians order to hold the enteral feeding one hour before the administration of phenytoin (a prescription anticonvulsant used to treat and prevent seizure). These failures had the potential for the residents to have undesirable outcomes, including aspiration and risk for weight loss.Findings: 1. According to Taylor's Fundamentals of Nursing seventh edition, Nursing Considerations with Tube Feeding, make sure the resident is as upright as possible during feeding. If the resident is in bed during feedings, elevate the head of the bed at least 30 degrees during feeding and for one hour afterward to prevent reflux and aspiration. Review of the facility's P&P titled Enteral Tube Feedings via Continuous Pump revised 3/2023 showed to position the head of the bed at 30 – 45 degree (semi-Fowler's position) for feeding, unless medically contraindicated. Medical record review for Resident 54 was initiated on 3/22/26. Resident 54 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 54's H&P examination dated 1/29/26, showed the resident could make simple needs known and had no capacity to report subjective complaints. Review of Resident 54's Order Summary Report showed the following physician's orders: - dated 1/2/26, to administer Nutren 2.0 (enteral feeding formula) via GT for a total of 1200 ml/2400 kcal at a rate of 60 ml per hour for 20 hours; - dated 1/29/26, to elevate the head of the bed between 30 to 45 degrees at all times during feeding; and - dated 3/14/26, to administer phenytoin (anticonvulsant medication) chewable tablet 50 mg, to give six tablet via GT every 12 hours, hold feeding one hour before and after administering the medication. a. On 3/23/26 at 1454 hours, an observation and concurrent interview for Resident 54 was conducted with LVN 6. Resident 54 was observed in bed with the bed slightly elevated. Resident 54's GT feeding of Nutren (a calorically dense, nutritionally complete tube-feeding formula designed for residents with elevated energy needs or fluid restrictions) 2.0 was observed infusing via feeding pump at 60 ml per (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hour. LVN 6 verified Resident 54's head of the bed was not elevated at 30 - 45 degree while the GT feeding was infusing. LVN 6 further stated that they did not have any measuring device to ensure head of the bed was between 30-45 degree. b. On 3/24/26 at 0904 hours, Resident 54 was observed lying in bed, with the GT feeding infusing at 60 ml per hour with the head of the bed elevated. On 3/24/26 at 0918 hours, an interview and concurrent medical record review for Resident 54 was conducted with LVN 6. LVN 6 stated he just finished giving Resident 54 all her medications. When asked regarding the phenytoin medication, LVN 6 verified Resident 54 had an order for the phenytoin medication to hold the GT feeding one hour before and after the administering of the phenytoin medication. LVN 6 verified he did not hold the GT feeding one hour before administering the phenytoin medication. On 3/25/26 at 0845 hours, an interview was conducted with the DON. The DON verified the above findings and stated the licensed nurses should follow the physician's order when administering the phenytoin medication to ensure adequate absorption of the medication and maintaining a therapeutic for the phenytoin level. 2. Medical record review for Resident 8 was initiated on 3/22/26. Resident 8 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 1/14/26, showed the resident had no capacity to understand and make decisions. Review of Resident 8's Order Summary Report showed the following physician's orders: - dated 1/12/26, to administer Glucerna 1.2 (an enteral feeding formula) at 72 ml per hour for 20 hours to provide 1440 ml/1728 kcal, via GT; and - dated 1/12/26, to start infusion at 1200 hours, and continue until 0800 hours, or until total volume is complete. On 3/23/26 at 0855 hours, Resident 8 was observed in bed with the GT feeding hanging and connecting via a feeding pump. The feeding formula was full, with a label showing Glucerna 1.2 (a full bag had a total of 1500 ml) and dated as administered from 3/23/26 at 0215 hours for 72 ml per hour for 20 hours. The feeding pump was observed off. On 3/23/26 at 0901 hours, an observation for Resident 8 and concurrent interview was conducted with LVN 7. LVN 7 verified the above findings. The bag of Glucerna 1.2 connected to the GT pump machine was full and the GT pump machine was observed off. When asked to show the total amount (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of feeding given to Resident 8, LVN 6 stated that he cleared the volume when he turned off the GT feeding. On 3/23/26 at 0913 hours, an observation and concurrent interview was conducted with the DON. The DON verified the findings the GT feeding bag was full at 1500ml. On 3/25/26 at 1211 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 3. Medical record review for Resident 42 was initiated on 6/22/25. Resident 42 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 42's H&P examination dated 9/23/25, showed Resident 42 had the capacity to understand and make decisions. Review of Resident 42's Order Summary Report showed the following physician's orders: - dated 10/13/25, to administer Nepro 1.8 (enteral feeding formula) at 50 ml/hr for 20 hours to provide 1000 ml/1800 kcal per day. On 3/22/26 at 1019 hours, an observation and concurrent interview for Resident 42 was conducted with LVN 1. Resident 42 was observed lying in bed with enteral feeding pump with Nepro 1.8 (enteral formula) bottle hanging from the feeding pump pole, and the pump was currently turned off. The enteral formula bottle was labeled 3/21/26 at 1200 hours, and the volume in the bottle was 1000 ml. LVN 1 verified she hung the formula bottle on 3/21/26 at 1200 hours, and it was her hand writing on the label of the bottle, but did not know why it was still full. LVN 1 stated, the physician's order was to hang the formula at 1200 hours with a rate of 50 ml/hr and turn off the feeding the next day at 0800 hours. LVN 1 verified the bottle was hung yesterday, 3/21/26, but there was 1000 ml left in the tube feeding bottle (0 (zero) ml of the prescribed volume had infused). On 3/22/26 at 1041 hours, the DON was summoned to come to Resident 42's room where a concurrent observation and interview for Resident 42 was conducted with the DON. The DON verified there was a 1000 ml of formula left in the bottle, which was labeled hung on 3/21/26 at 1200 hours. The DON stated, looks like nothing was infused. The DON stated if the tube feeding was not infused as ordered, it might affect the resident's health status and may potentially lead to the resident having weight loss. The DON further stated, do not know what had happened but will investigate. The DON verified the above findings. 4. Medical record review for Resident 12 was initiated on 3/22/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's H&P examination dated 6/9/25, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Order Summary Report for 3/2026 showed the following physician's orders: - dated 7/17/25, for Jevity (an enteral feeding formula) 1.5 at 70 ml per hour for 20 hours via pump to (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide 1400 ml/2100 kcal per day. - dated 6/7/25, to turn pump on at 12 PM and turn off at 8 AM (or until dose is completed). On 3/23/26 at 1026 hours, an observation and concurrent interview and medical record review for Resident 12 was conducted with LVN 11. LVN 11 verified Resident 12's Jevity 1.5 tube feeding was hung at 0430 hours at 70 ml/hr as shown on the tube feeding label. LVN 11 verified the tube feeding was turned off at 0800 hours; therefore, from 0430 hours to 0800 hours, Resident 12 should have received 245 ml of feeding. However, the tube feeding showed it was still full at 1500 ml. Review of the GT pump showed a one-day history of 1225 ml feeding received. LVN 11 verified the findings and stated the GT feeding ensured the residents who cannot eat by mouth received the supplements and nutrition through the tube feeding. 5. Medical record review for Resident 104 was initiated on 3/22/26. Resident 104 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 104's H&P examination dated 12/1/25, showed Resident 104 had no capacity to understand and make decisions. Review of Resident 104's Order Summary Report for 3/2026 showed the following physician's orders: - dated 12/13/24, for Glucerna 1.2 at 72 ml per hour for 20 hours via pump to provide 1440 ml/1728 kcal per day. - dated 12/13/24, to turn pump on at 12 PM and turn off at 8 AM (or until dose is completed). On 3/23/26 at 1005 hours, an observation and concurrent interview and medical record review for Resident 104 was conducted with LVN 7. LVN 7 verified Resident 104's Glucerna with Carbsteady 1.2 Cal tube feeding was hung at 0200 hours at 72 ml/hr as shown on the tube feeding label. LVN 7 stated the tube feeding was turned off at 0800 hours; therefore, Resident 104 should have received 432 ml feeding from 0200 hours to 0800 hours. However, LVN 7 verified the 1500 ml tube feeding showed approximately 1450 ml of feeding was still in the bag. Review of the GT pump showed a one day history of 1343ml feeding received. LVN 7 verified the findings and stated Resident 104 did not receive the full dose. LVN 7 stated the resident needed to receive the full dose as ordered to ensure the resident receive the proper nutrition and maintain the targeted weight. On 3/25/26 at 1202 hours, an interview was conducted with the Administrator, DON, and Regional Director of Operations. The Administrator, DON, and Regional Director of Operations were informed acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P record review, the facility failed to provide the respiratory care and services for one of two nonsampled residents (Resident 84) reviewed for respiratory care. * The facility failed to ensure Resident 84 was administered with the oxygen as prescribed by the physician. This failure had the potential to negatively impact the resident's health outcomes.Findings: Review of the facility's P&P titled Oxygen Administration dated 10/2010 showed:- under preparation: to verify there is a physician's order and to review the physician's order.- under procedure steps: to turn on the oxygen and unless otherwise ordered, start the flow of oxygen at the rate of two to three liters per minute. Medical record review for Resident 84 was initiated on 3/23/26. Resident 84 was admitted to the facility on [DATE]. Review of Resident 84's H&P examination dated 8/28/25, showed Resident 84 was too ill to make simple needs known due to her poorly responsive state and underlying hypoxic ischemic encephalopathy (a serious brain injury caused by reduced oxygen and blood flow, often resulting in long-term neurological deficits or death) and had no full medical capacity to make decisions at this time. On 3/22/26 at 0954 hours, during the initial tour of the facility, Resident 84 was observed lying in bed with oxygen being administered via nasal cannula between two to two and a half LPM using an oxygen concentrator. Review of Resident 84's Order Summary Report showed a physician's order dated 8/28/25, to administer oxygen at three LPM via nasal cannula, may titrate up to five liters per minute for oxygen saturation less than 92% every shift. On 3/22/26 at 1515 hours, an interview and concurrent observation and medical record review for Resident 84 was conducted with LVN 9. LVN 9 verified the oxygen rate administered to Resident 84 was between two to two and a half LPM. LVN 9 stated he checked the oxygen rate this morning and did not realize Resident 84's oxygen rate administered was two and a half LPM. LVN 9 further stated I will call the supervisor; I am not allowed to touch or change the oxygen. On 3/22/26 at 1519 hours, an interview and concurrent observation and medical record review for Resident 84 was conducted with RN 2. RN 2 verified the oxygen rate was between two to two and a half LPM, which was below the oxygen rate the physician ordered to administer to Resident 84. RN 2 stated, I basically know the resident's rate working here for a long time, and further stated, if there are any changes I will know during the report and upon review of the new orders during the start of shift, this should have been three liters. On 3/25/26 at 1210 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care and services were provided for one of 23 final sampled residents (Resident 10) reviewed who was receiving dialysis (life sustaining medical treatment which filters waste, toxins, and excess fluids from the blood when the kidneys fail) care. * The facility failed to ensure the instructions from the dialysis center was addressed for Resident 10 on 11/27/25. This failure had the potential to result in health complications for Resident 10.Findings: Review of the facility's P&P titled Care of a Resident with End Stage Renal Disease (ESRD) dated 9/2010 showed agreements between this facility and the contracted ESRD facility included all aspects of how the resident's care will be managed , including but not limited to how the care plan will be developed and implemented, how transportation will be arranged and how the information will be exchanged between the facilities and the resident's care plan will reflect the residents' needs to ESRD/ dialysis care. Medical record review for Resident 10 was initiated on 3/23/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 11/24/25, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's Dialysis Communication Record dated 11/27/25, showed under additional comments: Please remove old/ previous left arm graft dressing at 5 PM (post dialysis) to avoid clotting (is the process by which blood changes from a liquid to a gel, forming a blood clot) of access site. Review of Resident 10's progress note dated 11/27/25 at 1314 hours, showed Resident 10 was back from the dialysis center, dialysis site positive for bruit (a whooshing sound heard over a stethoscope) and thrill (buzzing vibration felt), vital signs stable and within normal range. However, there was no documented evidence the instructions communicated by the dialysis center was addressed and documented in the progress notes, Resident 1's physician was informed, and the instructions were carried out by the licensed nurses. On 3/23/26 at 1436 hours, an interview and concurrent medical record and facility record review for Resident 10 was conducted with LVN 8. LVN 8 was asked about the process of addressing the instructions received from the Dialysis Communication Record. LVN 8 stated, usually I tell the nurses then I follow up in the morning if it was done. When asked if the dialysis instruction on 11/27/25 was addressed, LVN 8 stated the recommendation was addressed; however, LVN 8 was not able to show documentation if it was done. LVN 8 verified the findings. On 3/25/26 at 1145 hours, an interview and concurrent medical record and facility document review for Resident 10 was conducted with the ADON. The ADON verified there was no documentation to show the instructions dated 11/27/25, received from the dialysis center was addressed. The ADON further stated the Dialysis Communication Record should have been checked, the physician should have been informed, the physician order should have been obtained, the family should have been called, documented in the progress notes, care plan should have been updated, and the team should have been notified using the PCC communication board. On 3/25/26 at 1210 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided for the used of side rails for one of three final sampled residents (Resident 20) reviewed for the use of the bed rails. * The facility failed to ensure the physician's order and informed consent were obtained, the physical assessment was completed, and less restrictive alternatives were attempted prior to Resident 20's use of the bed rails. These failures had the potential for the resident to receive unnecessary measures and for the resident to not be aware of the risk and benefits of the side rails' use. Findings: Review of the facility's P&P titled Bed Safety and Bed Rails revised 3/2023 showed before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:- The assessed medical needs that will be addressed with the use of bed rails;- The resident's risks from the use of bed rails and how these will be mitigated;- The alternatives that were attempted but failed to meet the resident's needs; and- The alternatives that were considered but not attempted and the reasons. Review of the facility's P&P titled Bed Safety and Bed Rails revised 3/2023 under the Use of Bed Rails section showed:- Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body;- The definition of restraints is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint;- The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent;- Alternatives to the use of side or bed rails are attempted. Alternatives may include: roll guards, foam bumpers, lowering the bed, and/or use of concave mattresses to reduce rolling off the bed; and- If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs, the resident's risk associated with the use of bed rails, input from the resident and/or representative, and consultation with the attending physician. Review of the facility's P&P titled Bed Safety and Entrapment (undated) under the Procedure section showed:- The facility will complete physical restraint assessment and document the proper medical symptoms that warrant the use of bedrails; and- The facility will include the resident's positioning, movements, or weight in bed safety assessment. On 3/22/26 at 0923 hours, during the initial tour of the facility, Resident 20 was observed awake and lying in bed with the bilateral upper bed rails elevated. The bed rails were observed with green tape around each rails. Resident 20 stated he had been in the facility for almost a month and had been using the bed rails since he got admitted to the facility. Resident 20 stated he would hold on to the bed rails when he turned on his sides or when he got out of bed and transferred to the wheelchair. Medical record review for Resident 20 was initiated on 3/22/26. Resident 20 was readmitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 3/1/26, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20 needed partial/moderate assistance with mobility. Further review of Resident 20's medical record failed to show documented evidence of a physician's order and informed consent were obtained, physical restraint assessment, and documentation of the proper medical symptoms that warrant the use of the bed rails were completed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In addition, there was no documented evidence less restrictive alternatives were attempted prior to Resident 20's use of the bed rails. On 3/23/26 at 0915 hours, a follow-up observation was conducted for Resident 20. Resident 20 was observed awake and lying in bed with the bilateral upper bed rails elevated and green tape around each rails. On 3/23/26 at 1037 hours, a concurrent interview and medical record review for Resident 20 was conducted with RN 1. RN 1 stated the resident was being evaluated by the RN Supervisor for the use of the bed rails and reevaluated by the MDS RN. RN 1 stated the bed rail assessment was being done quarterly or as needed. RN 1 stated the less restrictive alternatives like lowering the bed, applying pillows to the side of the resident, or frequent checking to the resident to attend to the resident's needs would be implemented prior to the use of the bed rails. RN 1 stated once the nurse determined the resident would need the bed rails because the less restrictive alternatives did not work, the attending physician would be informed to obtain an order for the use of the bed rails. RN 1 stated the informed consent should be obtained from the resident or responsible party prior to the use of the bed rails, so they would be informed of the risks and benefits of the bed rails use. RN 1 stated the plan of care for the use of the bed rails should also be initiated to ensure the residents receive consistent and safe care. RN 1 stated the bed rails were already installed or attached to the bed. RN 1 stated the green tapes around the bed rails meant the bed rails were elevated and being used by the resident and the red tapes meant the bed rails should be down and not being used by the resident. RN 1 verified Resident 20 was using the bilateral upper bed rails. RN 1 verified an order and informed consent were not obtained, the bed rails assessment to determine the use of the bed rails was not completed, the less restrictive alternatives were not implemented prior to the use of the bed rails for Resident 20. On 3/25/26 at 1115 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 20. Cross reference to F909, example #1.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure an accurate nurse staffing information was posted daily for residents and visitors to view, for one of three nursing stations (Station A). * The facility's posted staffing information observed on 3/22/26, had a date of 3/18/26. This failure had the potential of not having the staffing information be available to the residents and the public to determine if sufficient staff were available to care for the residents.Findings: Review of facility's P&P titled Posting Direct Care Daily Staffing Numbers revised 8/2022 showed our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents; the information record on the form shall include the current date (the date for which the information is posted). On 3/22/26 at 0911 hours, the Daily Nurse Staffing information posting on the bulletin board in front of Station A, SNF side, next to the storage room was observed with the date of 3/18/26. On 3/22/26 at 1540 hours, an observation and concurrent interview was conducted with the DSD. Observed Daily Nurse Staffing Information posting on the bulletin board in front of Station A, SNF side, next to the storage room with the date of 3/18/26. The DSD stated he posted the new Census and DHPPD (Direct Care Hours Per Patient Day) daily, and on the weekend the Manager of the Day would be the one who would post it. The DSD further stated the nurse staffing information should be posted daily to have daily projection correct and accurate for staffing needs. The DSD verified the staffing information on the SNF side of the facility was not posted for the current date of 3/22/26. On 3/25/26 at 1053 hours an interview was conducted with the DON and Administrator. The DON and the Administrator were informed and acknowledged the above findings. The DON further stated the staff posting should be posted daily at the beginning of the shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the drugs, biologicals, or medical supplies were stored in a safe manner. * The facility failed to ensure Resident 104's GT feeding was not left at the bedside unattended. This failure had the potential for the GT feeding to be accidentally administered or used inappropriately.Findings: Review of the facility's P&P titled Administering Medications revised 3/2023 showed the medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medical record review for Resident 104 was initiated on 3/22/26. Resident 104 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 104's H&P examination dated 12/1/25, showed Resident 104 had no capacity to understand and make decisions. Review of Resident 104's Order Summary Report for 3/2026 showed the following physician's orders: - dated 12/13/24, for Glucerna (a calorically dense nutritional formula designed to manage blood sugar levels in residents with diabetes or those with high blood sugar, may be used for oral or tube feeding as a sole or supplemental source of nutrition) 1.2 at 72 ml per hour for 20 hours via pump to provide 1440 ml/1728 kcal per day. - dated 12/13/24, to turn pump on at 12 PM and turn off at 8 AM (or until dose is completed). On 3/22/26 at 0847 hours, during the initial tour of the facility, an observation of Resident 104's room was conducted. One Glucerna with Carbsteady (a specialized carbohydrate blend designed to minimize blood sugar spikes) 1.2 tube feeding was observed left unattended at bedside. Further observation showed the label was dated 3/23 with the resident's name, room number, and the GT feeding rate. On 3/22/26 at 0948 hours, an observation of Resident 104's room was conducted. The Glucerna with Carbsteady 1.2 Cal tube feeding was still observed at bedside left unattended. Observations made outside Resident 104's room showed multiple staff, residents, and visitors passed by the resident's room. On 3/22/26 at 0957 hours, an observation and concurrent interview was conducted with LVN 13 in Resident 104's room. LVN 13 verified a Glucerna with Carbsteady 1.2 Cal tube feeding was left unattended at the resident's bedside. LVN 13 stated the night shift left it at bedside for the next shift to use; however, LVN 13 stated the tube feedings should not be left unattended at bedside and should be kept in the utility room. LVN 13 stated leaving the tube feeding unattended at bedside causes the risk for the tube feedings to be contaminated or used inappropriately. On 3/25/26 at 1202 hours, an interview was conducted with the Administrator, DON, and Regional Director of Operations. The DON stated the tube feedings should not be kept unattended at the bedside and should be stored until ready to use. The Administrator, DON, and Regional Director of Operations acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555035	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Anaheim Healthcare Center	3435 W Ball Road Anaheim, CA 92804

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the nursing staff reported laboratory results to the physician in a timely manner for one of 23 final sampled residents (Resident 20). * The facility failed to ensure the UA C&S (Urinalysis with Culture and Sensitivity) laboratory results were reported to the physician in a timely manner. Resident 20's UA C&S laboratory results were available on 3/15/26; however, the results were not reported to the physician until 3/19/26. This failure had the potential to result in a delay of care and risk for adverse complications for Resident 20.Findings: Review of the facility's P&P titled Lab and Diagnostic Test Results - Clinical Protocol revised 3/2023 showed when the test results are reported to the facility, a nurse will first review the results. a. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results in their implications, another nurse in the facility (supervisor, charge nurse) should follow or coordinate the procedure. 5. A nurse will identify the urgency of communicating with the attending physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Further review of the facility's P&P showed a physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff). Medical record review for Resident 20 was initiated on 3/24/26. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 20's H&P examination dated 3/1/26, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's UA C&S laboratory results dated [DATE], showed Resident 20 had a colony count of greater than 100,000 of enterococcus faecalis (type of infectious bacteria). Review of Resident 20's progress note dated 3/19/26 at 1645 hours, showed RN 2 documented Resident 20's urinalysis with culture and sensitivity was reported to MD 1 with new orders for Amoxicillin (an antibiotic) 500 mg TID (three times a day) for 10 days, noted and carried out. Review of Resident 20's medical record failed to show MD 1 was notified of the abnormal UA C&S laboratory result on 3/15/26. Review of Resident 20's Order Summary Report for 3/2026 showed the following physician's order:- dated 3/19/26, for Amoxicillin 500 mg one tablet by mouth three times a day for UTI for 10 days. On 3/24/26 at 1430 hours, an interview and concurrent medical record review of Resident 20 was conducted with the IP. The IP verified Resident 20's UA C&S final report was dated 3/15/26 at 1643 hours. The IP further verified Resident 20's UA C&S laboratory result was not reported to the resident's physician until 3/19/26, four days after the final laboratory results were available to the facility. The IP stated the laboratory results should be reported right away to avoid delay in care and treatment for the residents. On 3/24/26 at 1600 hours, a telephone interview was conducted with RN 2 and with the IP present. RN 2 verified the facility missed reporting Resident 20's UA C&S laboratory results in a timely manner and stated he reported the result to the resident's physician four days later on 3/19/26. RN 2 stated the facility can improve on reporting laboratory results sooner. On 3/25/26 at 1202 hours, an interview was conducted with the Administrator, DON, and Regional Director of Operations. The DON stated the laboratory results should be reported timely to ensure there was no delay in the resident's care. The Administrator, DON, and Regional Director of Operations were informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555035	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Anaheim Healthcare Center	3435 W Ball Road Anaheim, CA 92804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure complete and accurate medical records for one of 23 final sampled residents (Resident 7). * The facility failed to ensure the amount of GT feeding formula administered to Resident 7 was documented on the resident's Intake record. This failure had the potential for Resident 7's care needs not being met as the resident's medical information was inaccurate.Findings: Review of the facility's P&P titled Procedure: Measuring & Recording Fluid Intake & Output (undated) showed the facility will monitor intake or output as ordered; measure and record the amount of intake and output for every 24-hour period. Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. Medical record review for Resident 7 was initiated on 3/24/26. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's H&P examination dated 3/2/26, showed Resident 7 had the capacity to understand and make decisions. Review of Resident 7's Order Summary Report dated 3/24/26, showed the physician's orders as follows:- dated 2/27/26, for Enteral (delivers liquid nutrients directly to the stomach or small intestine for individuals unable to meet their nutritional needs orally) feeding VITAL AF (a peptide-based, therapeutic nutrition formula designed for residents with impaired gastrointestinal function, maldigestion, or inflammation) at 50 ml/hr for 24 hours via pump to provide 1200 kcal per day. - dated 3/2/26, to monitor intake and output every shift x 30 days, every day and night shift for 30 days in ml. - dated 3/19/26, for enteral feeding VITAL AF at 65 ml/hr for 20 hours via pump to provide 1560 kcal per day for weight management. Review of Resident 7's Intake Record for the month of February - March 2026 showed the intake for tube feeding was missing documentation for the following dates: - On 2/27/26, for 3 -11 PM shift - On 2/28/26, for 7 AM - 3 PM shift - On 3/2/26, for 11 PM - 7 AM shift - On 3/3/26, for 11 PM - 7 AM shift - On 3/5/26, for 11 PM - 7 AM shift - On 3/6/26, for 7 AM - 3 PM shift On 3/24/26 at 1055 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 1. RN 1 verified the above dates were missing documentation of the intake amount of the tube feeding administered to Resident 7. RN 1 stated the licensed nurses should record the intake of the tube feeding administered every shift per physician's order and as required. On 3/25/26 at 1041 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.