

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Good Shepherd Health Care Center of Santa Monica		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 Arizona Ave. Santa Monica, CA 90401	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interview, the facility failed to update two of five sampled residents (Resident 7 and Resident 50) advance directives (AD, a legal document indicating a person's preference regarding medical treatment and end-of-life treatment decisions) documentation. This failure had the potential to result in treatment delay and/or not meeting the residents' health care preferences and end of life wishes. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was readmitted on [DATE] (original admission [DATE]) with diagnoses including but not limited to chronic obstructive pulmonary disease (a chronic lung disease causing difficulty breathing), epilepsy (a brain disorder that may cause loss of consciousness or involuntary, violent movements of the body or a limb), and bipolar disorder (a mood swings that range from the lows of depression to elevated periods of emotional highs, sometimes called manic-depressive disorder). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), the MDS indicated Resident 7's AD was available and reviewed. During a review of Resident 7's Physician Orders for Life-Sustaining Treatment (POLST) form, the POLST indicated Resident 7 had an Advance Directive (AD) dated [DATE] and was reviewed with Resident 7's Resident Representative on [DATE]. During a review of Resident 7's health record, the health record indicated a copy of Resident's AD dated [DATE]. During a review of the facility's AD acknowledgement form, dated [DATE], the AD acknowledgement form indicated Resident 7 had not executed an AD and declined to execute an AD. During an interview on [DATE] at 2:40 p.m. with Social Services Director (SSD), SSD stated the AD acknowledgment form was not filled out correctly to indicate Resident 7 had an AD as reflected on the MDS and POLST. SSD stated inconsistent information might result in confusion and failure to comply with the resident's wishes. SSD stated the incorrect information on the AD acknowledgment form was overlooked and it needs to be updated. During a review of the facility's policy and procedure (P&P) titled, Advance Directives and End-of-Life Decision-Making, unknown date, the P&P indicated interdisciplinary team responsibility to review and update AD quarterly and with significant change. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. During a review of Resident 50's admission Record, the admission Record indicated, Resident 50 was initially admitted to the facility on [DATE] with diagnoses including bronchitis (occurs when the airways of the lungs swell and produce mucus in the lungs), dementia (a progressive state of decline in mental abilities), metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood). During a review of Resident 50's History and Physical (H&P), dated [DATE] and timed at 9:39 a.m., the H&P indicated, Resident did not have the capacity (ability) to understand and make decisions. The H&P indicated, Resident 50's code status was Do Not Attempt Resuscitation (DNR- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating). During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50 required dependent assistance (helper does all of the effort) from two or more staff for activities of daily living (ADLs &ndash; toileting hygiene, shower/bathing).^^ During a review of Resident 50's physician orders titled Order Summary Report (OSR), dated [DATE], the OSR indicated, DNR was ordered on [DATE]. During an interview and record review on [DATE], at 9:27 a.m., with SSD, Resident 50's Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE] was reviewed. The POLST indicated, Resident 50 had order for Attempt Resuscitation (full treatment-prolonging life by all medically effective means). The POLST indicated, AD was missing information. The SSD stated that the POLST was not completed because there was missing signature from Resident's conservator. SSD stated, if POLST was not completed, the resident would be treated as full code and all life sustaining measures would be done during emergency per policy. The SSD stated that the nursing staff should follow the paper POLST and not the physician orders. During a concurrent interview and record review on [DATE] at 9:55 a.m., with Director of Nurses (DON), Resident 50's POLST dated [DATE], H&P dated [DATE] and physician orders active as of [DATE] were reviewed. The POLST indicated that Resident 50 was full code, while the H&P documentation that Resident 50 was DNR. The DON stated that upon admission, Resident 50 arrived at facility with DNR orders from the previous facility but without a current POLST confirming DNR status. The DON stated that staff should follow Resident 50's previous physician orders, even though the facility had not obtained a POLST confirming DNR status. The DON further stated that the current POLST in Resident 50's physical chart was not valid because it was missing signature from conservator (person legally appointed to manage financial and medical decisions for someone who is not able to do so themselves) and nursing staff should follow the physician orders from the previous facility. During a review of the facility's P&P titled, Advance Directives and End of Life Decision Making, revised^(unknown date), the P&P indicated under nursing verify advance directive status upon admission and quarterly via POLST form, Ensure POLST are signed and filed, and communicate code status to interdisciplinary team via POLST form.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop a comprehensive person-centered care plan with measurable goals, individualized interventions and target timeframes for evaluation for six of six sampled residents (Resident 2, Resident 4, Resident 5, Resident 6, Resident 8 and Resident 33) addressing: Diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities) and the use of quetiapine (a medication to treat schizophrenia) for Resident 2. The use of Triamcinolone Acetonide (topical corticosteroid used to treat various skin conditions by reducing inflammation) cream for scattered rash for Resident 4. Dialysis treatment (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) and nutrition/diet for Resident 5. The use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) for Resident 6. The use of lorazepam (medication to manage anxiety, insomnia - trouble falling asleep or staying asleep, and seizures - a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness for Resident 8. The use of urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) for Resident 33. These deficient practices had the potential to result in a delay of nursing care and interventions for the residents. Findings: 1. During a review of Resident 2's admission Records, the admission Records indicated Resident 2 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with the diagnoses including dementia, schizophrenia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's Physician Visit Progress note dated 5/13/2025, the progress note indicated Resident 2 does not have capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set ([MDS] - a resident assessment tool) dated 1/26/2026, the MDS indicated Resident 2 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with all activities of daily living (ADL) such as eating, oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing and putting on/taking off footwear. During a concurrent interview and record review on 2/24/2026 at 10:37 a.m. with Registered Nurse (RN) 1, RN 1 reviewed Resident 2's electronic and paper medical record. RN 1 stated there was an order for quetiapine 25 mg to take 1 tablet by mouth every evening for schizophrenia, aggressive and combative behavior. Review of care plan indicated no comprehensive, person-centered care plan addressing schizophrenia, dementia and quetiapine use. 2. During a review of Resident 4's admission Record, the admission record indicated that Resident 4 was initially admitted to the facility on [DATE] and last re-admission was on 12/14/2025 with diagnoses including heart failure (a condition in which the heart does not pump blood as well as it should), cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), altered mental status and metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of Resident's 4's MDS dated [DATE], MDS indicated that Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. MDS indicated that Resident 4 required maximal assistance from staff for ADLs. During a review of Resident 4's Order Summary Report, the order summary report indicated an order dated 12/17/2025 for Triamcinolone Acetonide cream 0.1% apply to upper body topically everyday shift for scattered rash until 1/16/2026. During a concurrent interview and record review with Treatment Nurse (TXN) on 2/24/26 at 1:44 p.m., Resident 4's order summary and skin check assessment dated [DATE] was reviewed. TXN stated that upon admission a skin check was completed for Resident 4. The TXN stated that Resident 4's skin check assessment was incomplete and that is the reason a (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quarterly by Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need). The DON stated that residents receiving insulin must have a diabetes care plan that includes medication administration and monitoring for side effects, such as foot care and blood sugar checks. The DON added that without a care plan, staff may not know what care or interventions the resident needs.6.During the review of Resident 8's admission Records, the admission records indicated the facility admitted the resident on 4/3/2025 with diagnosis that included but not limited to cerebral infarction, depression (a condition that causes a persistent feeling of sadness and loss of interest) and anxiety (mental condition characterized by excessive worry about real or perceived situations often lead to physical symptoms like increased heart rate and muscle tension).During the review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 needs partial/moderate assistance for oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, personal hygiene and need supervision and touching assistance for eating, rolling on the side, sit to lying, lying to sitting, chair/bed transfer, tub/shower transfer and walking 10-150 feet. The MDS indicated Resident 8 has memory problems, moderately impaired for cognitive skills for daily decision making.During a review of resident 8's care plan on 02/24/2026 at 2 p.m., Resident 8's care plan was missing measurable objectives and timeframes for lorazepam.During an interview on 2/25/2026 at 8:40 a.m. with RN 1, RN 1 stated that Resident 8's care plan was missing measurable outcome and timeframes for lorazepam.During an interview on 2/25/2026 at 9:55 am with DON, DON was unable to answer regarding Resident 8's care plan missing measurable outcomes and timeframes for lorazepam.During an interview on 02/25/2026 11:30 AM with RD, the RD stated that all care plans should have measurable outcome within certain timeframe.7.During a review of Resident 33's admission Records, the admission Records indicated Resident 33 was originally admitted to the facility on [DATE], the readmitted to the facility on [DATE], with the diagnoses including chronic obstructive pulmonary disease ([COPD]-a chronic lung disease causing difficulty in breathing), benign prostatic hyperplasia (enlarged prostate), chronic pain syndrome (pain that lasts longer than three months).During a review of Resident 33's H&P dated 2/5/2026, the H&P indicated Resident 33 has the capacity to understand and make decisions.During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 had intact cognition (has normal, intact memory and orientation, allowing them to recall words and understand the date/location). The MDS indicated Resident 33 required Partial/moderate assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing and putting on/taking off footwear.During a review of Resident 33's Order Summary Report dated 2/4/2026 indicated order for suprapubic (inserted above pubic bone) urinary catheter for urinary retention (the inability to fully empty the bladder, resulting in urine building up inside).During a review of Resident 33's Care Plan for suprapubic urinary catheter, the care plan indicated no documentation of measurable goals, individualized interventions and target timeframes. During an interview on 2/24/2026 at 11:00 a.m., RN 1 stated that basic care plans were developed within 72 hours of admission for all residents and generally included areas such as bowel and bladder care, activities of daily living (ADLs), smoking, pain management, skin care, fall prevention, and psychosocial needs. RN 1 explained that care plans were documented under broad, grouped categories; for example, when a resident started a new pain medication, the medication was added under the existing pain-related care plan rather than being addressed through a specific or individualized plan. RN 1 further stated that individualized care plans were created only for residents with a specific condition or when a medication carried a black box warning. RN 1 acknowledged that many interventions were written in broad, generalized terms, such as administer medications as ordered or monitor episodes of behaviors as ordered, and clarified that detailed instructions were located in the physician's orders rather than in the care plan itself. RN 1 reported that this was the facility's standard practice per Director of Nursing (DON) policy.During an interview on 2/24/2026 at 11:20 a.m., the Director of Nursing (DON) stated that care plan interventions were intended to provide (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, the facility failed to ensure the comprehensive care plan was developed for two of two sampled residents (Resident 22 and Resident 29). This deficient practice had the potential to delay care and services that were specific to the residents' needs. 1. During a review of Resident 22's admission Record, the admission record indicated that Resident 22 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including Chronic Obstructive Pulmonary Disease (COPD- a chronic lung disease causing difficulty in breathing), pulmonary edema (a condition caused by excess fluids in the lungs usually caused by a heart condition), and shortness of breath (SOB- an intense tightening in the chest, air hunger, difficulty breathing, breathlessness or a feeling of suffocation). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool) dated 12/28/2025, MDS indicated that Resident 22 required partial/moderate assistance from staff for activities of daily living (ADLs - toileting hygiene, shower/bathing). During an observation on 2/23/2026 at 9:33 a.m. Resident 22 lay in bed with oxygen concentrator at two (2) liters per minute and nasal cannula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) in Resident 22's nose. During an observation on 2/24/2026 at 12:22 p.m., Resident 22 lay in bed with an oxygen concentrator running at 2 liters per minute, while the nasal cannula rested on their chin. CNA 3 entered the room, placed the meal tray on the bedside table, and then left the room. During a review of Resident 22's care plans, the care plans (in general) did not indicate a comprehensive care plan to address Resident 22's oxygen use and behavior of removing NC. During a review of Resident 22's Care Plan Report dated 4/15/2025 titled the resident has oxygen therapy due to COPD. The care plan interventions indicate provide oxygen as per Medical Doctor (MD) orders, provide medication as ordered, and monitor and assess for sign and symptoms of ineffective gas exchange. 2. During a review of Resident 29's admission Record, the admission record indicated that Resident 29 was initially admitted to the facility on [DATE] with diagnoses of bilateral (both) legally eye blindness (severe vision loss), dementia (a progressive state of decline in mental abilities), metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of Resident 29's MDS dated on 01/23/2026, MDS indicated that Resident 29 required substantial/maximal assistance (helper does more than half the effort) for ADLs and needs partial assistance (helper does less than half the efforts) for eating. During a review of Resident 22's Order Summary Report (OSR) dated 2/25/2026, the OSR included the following orders: a. Ordered on 11/25/2025, Oxygen concentrator to keep oxygen saturation greater than 92 percent as needed (PRN- given as needed or requested) at 2 to 5 liters per minute via nasal cannula. b. Ordered on 7/23/2025, Turn every 2 hours. Cushion all body prominences with pillows. High fall risk. Bed at lowest position. During an observation on 2/23/2026 at 8:13 a.m. in Resident 29's room, Resident 29 did not have an oxygen concentrator at the bedside, nor were there any visual indicators showing the resident was legally blind. The resident's head rested on a white pillow, and no additional cushions were observed. During an interview and record review on 2/24/2026 AT 1:34 p.m. with Licensed Nurse (LVN) 2, Resident 29's care plan report was reviewed. LVN 2 stated that nursing staff who received orders for Resident 29's should of initiate care plan for oxygen and reposition every 2 hours. LVN 2 stated that Resident 29 does not have an oxygen concentrator at bedside because Resident 29 does not need oxygen. During an interview and record review on 2/24/2026 at 2:23 p.m. with Social Services Director (SSD), Resident 29's Interdisciplinary Team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Conference Record dated 1/8/2026 was reviewed. The IDT conference record indicated that during the meeting Resident 29's care plans was reviewed. The SSD stated that Resident 29's care plan was (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed, and no changes were made since the IDT members agreed to continue the same plan of care. During an interview on 2/25/2026 at 12:48 p.m. with the Director of Nurse (DON), The DON stated that she does not attend Resident 29's IDT meeting and the care plan should have been revised to meet Resident 29's care needs. The DON stated that there should be a care plan developed for all residents on admission and revised as needed when new physician orders are given to nursing staff. DON stated that care plans are important because it indicates the care that was provided to the residents. The DON states that without a care plan, staff may not know what care or interventions the resident needs. During a review of the facility's policy and procedures (P&P) titled, Care plans, Comprehensive Person-Center dated 02/24/2026, P&P indicated that, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.		

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NAME OF PROVIDER OR SUPPLIER Good Shepherd Health Care Center of Santa Monica		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 Arizona Ave. Santa Monica, CA 90401	
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and record review, the facility failed to ensure ongoing assessment, monitoring, and accurate documentation of skin condition and wound healing for two of fourteen sampled resident (Resident 6 and Resident 29). This deficient practice resulted in untreated or unidentified skin breakdown, delayed interventions, and decline in the resident 6 and resident 29 condition. Findings: A. During a review of Resident 6's admission Record, the admission record indicated that Resident 6 was initially admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), heart disease, venous insufficiency, and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 6's Minimum Data Set (MDS – a resident assessment tool) dated 01/01/2026, MDS indicated that Resident 6's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. MDS indicated Resident 6 required maximal assistance from staffs for activities of daily living (ADLs – toileting hygiene, shower/bathing). The MDS also indicated that there were no other ulcers, wounds or skin problems documented. During a concurrent observation and interview on 02/23/2026 at 08:17 a.m. with Resident 6 was observed with generalized scab (crusty layer of dried blood that forms over a skin injury) of varying sizes on the neck and upper chest. Resident 6 stated having lesions (any area of abnormal or damaged tissue in or on the body) for several weeks and stated that they were occasionally itchy. During a review of Resident 6's medical record titled Professional Wound Specialists Progress Notes, the Nurse Practitioner (NP) documented that a follow-up evaluation and ongoing wound care were completed for wounds on both lower legs, the abdomen, and the upper chest. The NP noted that the upper chest lesions appeared as small, scattered sores with pink to red wound beds and healthy granulation tissue, with no signs of infection During a review of Resident 6's records titled, Order Summary Report dated 02/25/2026, the physician order initiated on 2/16/2026 for hydrocortisone (medication used to reduce inflammation, itching, and swelling) external cream. The physician order indicated apply to face, neck and chest topically every day and evening shift for skin picking, until 03/03/2026. During a concurrent observation and interview of Resident 6's wound care on 02/24/2026 at 1:20 p.m. with Treatment Nurse (TXN), Resident 6 was observed with generalized scabs in upper chest, as well as on both arms and legs. TXN stated that Resident 6 was receiving hydrocortisone cream for the scabbed areas. During an interview with Certified Nurse Assistant (CNA) 1 on 02/24/2026 at 1:30 p.m., CNA 1 stated that Resident 6's generalized wound was not new, and that Resident 6 requested the staff handle her skin gently. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a subsequent observation and interview with Resident 6 on 2/24/2026 at 2:55 p.m., Resident 6 was scratching her left leg. Resident 6 reported itching and requested assistance to relieve the itching. During a concurrent interview and record review of Resident 6's medical records with TXN on 2/24/2026 at 1:44 p.m., the TXN stated that wound assessments include measuring the wound, noting its color, identifying the tissue type, and assessing any drainage. The TXN stated that skin assessments are essential for evaluating wound progression and determining appropriate treatment. The TXN stated that wound assessments are documented weekly, with the most recent entry dated 02/13/2026. The TXN further reported that an assessment was performed on 02/19/2026; however, it had not yet been documented. The TXN stated that assessments were documented for Resident 6's wounds on the right leg, left leg, and abdomen. The TXN stated there was no initial documentation of the generalized scabs and stated the assessment was planned for after completion of the hydrocortisone treatment. The TXN added that Resident 6 was provided distraction techniques to help prevent skin picking. During a concurrent interview and record review on 2/25/2026 at 12:48 p.m. with Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Wound Assessment and Management, updated 01/20/2026 was reviewed. The P&P statement indicated the facility shall ensure assessment, documentation, treatment, and monitoring in accordance with applicable state regulations. DON stated according to facility's P&P that nursing responsibilities is to conduct skin assessment on admission, weekly and with significant change; measure and document wound characteristics; implement physician-ordered treatments; and notify physician of new or worsening wounds. DON stated that skin assessment is important to know how to treat the wound. DON stated she was not a certified wound nurse, so she does not know what kind of wound Resident has in the facility. DON further stated that the treatment nurse is responsible in conducting weekly wound assessments but follows the wound specialist's assessment if consulted. DON added that TXN missed his assessment for the generalized wound for Resident 6. DON stated that TXN did not adhere to the facility's P&P for wound assessment and management for Resident 6. B. During a review of Resident 29's admission Record, the admission record indicated that Resident 29 was initially admitted to the facility on [DATE] with diagnoses of bilateral (both) legally eye blindness (severe vision loss), dementia (a progressive state of decline in mental abilities), metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of Resident 29's MDS dated on 01/23/2026, MDS indicated that Resident 29 required substantial/maximal assistance (helper does more than half the effort) for ADLs and needs partial assistance (helper does less than half the efforts) for eating. During a review of Resident 29's Order Summary Repot (OSR), the OSR indicated an order dated 7/23/2025 indicated admit to Hospice care with admitting diagnosis of chronic renal failure (CKD-a longstanding disease of the kidneys leading to renal failure) under routine level of care. During a review of Resident 29's Skin Check assessment dated [DATE]b25 timed 9:10 p.m., the skin check assessment indicated that Resident 29 had right antecubital (area located directly in front of the elbow) open blister measuring 2.5 centimeter (cm- a metric unit of length) by 1.0 cm, right forearm open blister measuring 1.5 cm by 1.5 cm, left posterior (back) thigh open blister measuring 6 cm by 1.7 cm, left lateral (side) thigh open blister measuring 2.0cm by 1.0cm. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29's Hospice Re-Certification assessment dated [DATE], the assessment indicated that Resident 29 was bedbound and confined to bed with multiple wounds. The assessment indicated a right forearm skin tear measuring 1cm by 4 cm, a left thigh skin tear measuring 2cm by 4 cm, and an ulcer behind left knee measuring 2 cm by 7 cm. During a concurrent interview and record review on 2/25/2026 at 9:30 a.m. with Treatment Nurse (TXN), Resident 29's wound care notes, skin assessments and care plan were reviewed. TXN stated that Resident 29 did not have any active wounds and that the resident's wounds had resolved in 2025. TXN further stated that the electronic record did not contain documentation indicating when the wounds were resolved. TXN stated that weekly wound assessments should have been done to monitor Resident 29's wound progress. TXN stated that once wounds are resolved, staff should document the resolution in a nursing note. TXN stated that Resident 29's care plan should have been resolved since Resident 29 no longer receives wound treatment. During an interview on 2/25/2026 at 9:42 with Certified Nurse Assistant (CNA) 3, CNA 3 stated that Resident 29 is not bedbound and can ambulate with assistance. CNA 3 further stated that she assists Resident 29 during showers and that Resident 29 does not have any open areas on the skin. During an observation on 2/25/2026 at 9:46 a.m. in Resident 29's room, CNA 3 was observed assisting Resident 29 to the restroom while holding both of the resident's hands and directing him. Resident 29's both arms were intact with no open wounds. During a concurrent interview and record review on 2/25/2026 at 12:48p.m. with the Director of Nursing (DON), hospice re-certification assessment and facility care plan was reviewed. The DON stated that Resident 29's re-certification assessment dated [DATE] was not accurate because Resident 29 does not have any open wounds and is not bedbound. DON stated that hospice team coordinates with the facility staff to ensure Resident 29 receives appropriate care but could not explain why the hospice documentation did not reflect Resident 29's current condition. DON stated that the treatment nurse is responsible in conducting weekly wound assessments but follows the wound specialist's assessment if consulted. During a review of the facility's policy and procedures (P&P) titled, Hospice Services Coordination dated 1/29/26, the P&P indicated coordination of care includes collaboration between hospice IDT and skilled nursing facility team, documentation of communication, quality assurance and performance improvement committee will review hospice coordination quarterly and track communication gaps.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that staff-including the Director of Nursing (DON) and Registered Nurse (RN) 1-demonstrated the competencies and skills required to develop comprehensive, person-centered care plans with measurable goals, individualized interventions, and defined evaluation timeframes for six of six sampled residents (Resident 2, Resident 4, Resident 5, Resident 6, Resident 8, and Resident 33). This deficient practice had the potential to result in care that was not individualized to the resident's needs, inadequate monitoring of the resident's condition, failure to identify and address changes in condition, and an increased risk of adverse outcomes. Findings: 1. During a review of Resident 2's admission Records, the admission Records indicated Resident 2 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with the diagnoses including dementia, schizophrenia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's Physician Visit Progress note dated 5/13/2025, the progress note indicated Resident 2 does not have capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 1/26/2026, the MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with all activities of daily living (ADL) such as eating, oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing and putting on/taking off footwear. During a concurrent interview and record review on 2/24/2026 at 10:37 a.m. with Registered Nurse (RN) 1, RN 1 reviewed Resident 2's electronic and paper medical record. Review of care plan indicated no comprehensive, person-centered care plan addressing diagnoses schizophrenia and dementia, and the use of quetiapine (a medication to treat schizophrenia). 2. During a review of Resident 4's admission Record, the admission record indicated that Resident 4 was initially admitted to the facility on [DATE] and last re-admission was on 12/14/2025 with diagnoses including heart failure (a condition in which the heart does not pump blood as well as it should), cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), altered mental status and metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of Resident's 4's MDS dated [DATE], MDS indicated that Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. MDS indicated that Resident 4 required maximal assistance from staff for ADLs. During a concurrent interview and record review with Treatment Nurse (TXN) on 2/24/26 at 1:44 p.m., the TXN stated that Resident 4's treatments should be care planned. The TXN stated that Resident 4's skin check assessment was incomplete and that is the reason a care plan was not initiated for Resident 4's Triamcinolone Acetonide Cream (used to reduce inflammation, itching, and redness in various skin and inflammatory conditions.). 3. During a review of Resident 5's admission Records, the admission Records indicated Resident 5 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with the diagnoses including chronic kidney disease stage 4 (a disease when kidneys are severely damaged and working at only 15-29% of their normal capacity), Diabetes Mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a chronic condition where the heart muscle becomes too weak to pump blood efficiently). During a review of Resident 5's History and Physical (H&P) dated 9/1/2025, the H&P indicated Resident 5 did not have capacity to understand and make decisions. During a review of Resident 5's MDS dated [DATE], the MDS indicated that Resident 5 had moderate cognitive impairment (has some cognitive issues-such as occasional, minor mistakes in daily routines or difficulty recalling certain information-but still retains significant cognitive function). The MDS indicated Resident 5 required (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supervision or touching assistance with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 5's Care Plans for dialysis treatment and nutrition/diet, the care plans indicated no documentation of measurable goals, individualized interventions and target timeframes. During a concurrent interview and record review on 2/25/2026 at 11:00 a.m. with Registered Dietician (RD), reviewed Resident 5's care plan for nutrition/diet care plan. The RD stated that the care plan did not indicate all measurable goals and interventions for Resident 5. 4. During a review of Resident 6's admission Record, the admission record indicated that Resident 6 was initially admitted to the facility on [DATE], with diagnoses including type II DM, heart disease, venous insufficiency, and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 6's MDS dated [DATE], MDS indicated that Resident 6's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 6 required maximal assistance from staff for ADLs. During an interview and record review on 02/24/2026 at 12:39 p.m. with RN 1, Resident 6's records were reviewed. RN 1 stated that there was no care plan for Resident 6's insulin use. RN 1 said this depends on the DON and that they follow the DON's policy, which is to include three interventions per system. RN 1 stated the interventions listed for Resident 6 were not sufficient. 5. During the review of Resident 8's admission Records, the admission records indicated Resident 8 was admitted to the facility on [DATE], with diagnosis that included but not limited to cerebral infarction, depression unspecified (a condition that causes a persistent feeling of sadness and loss of interest) and anxiety (mental condition characterized by excessive worry about real or perceived situations often lead to physical symptoms like increased heart rate and muscle tension). During the review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 needed partial/moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, personal hygiene and need supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating, rolling on the side, sit to lying, lying to sitting, chair/bed transfer, tub/shower transfer and walking 10-150 feet. The MDS indicated Resident 8 has moderately impaired for cognitive skills for daily decision making and has a BIMS ([Brief Interview for Mental Status] - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 99 (BIMS score 99 - unable to complete due to resident condition). During a review of resident 8's care plan, the care plan indicated no measurable objectives and timeframes for Lorazepam (a medication to manage anxiety, insomnia - trouble falling asleep or staying asleep, and seizures - a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During an interview on 2/25/2026 at 8:40 a.m. with RN 1, RN 1 stated Resident 8's care plan was missing measurable outcomes and timeframes for Lorazepam. 6. During a review of Resident 33's admission Records, the admission Records indicated Resident 33 was originally admitted to the facility on [DATE], the readmitted to the facility on [DATE], with the diagnoses including chronic obstructive pulmonary disease ([COPD]-a chronic lung disease causing difficulty in breathing), benign prostatic hyperplasia (enlarged prostate), chronic pain syndrome (pain that lasts longer than three months). During a review of Resident 33's H&P dated 2/5/2026, the H&P indicated Resident 33 has the capacity to understand and make decisions. During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 had intact cognition (has normal, intact memory and orientation, allowing them to recall words and understand the date/location). The MDS indicated Resident 33 required Partial/moderate assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 33's Care Plan for suprapubic urinary catheter, the care plan indicated no documentation of measurable goals, individualized interventions and target timeframes. During an interview on 2/24/2026 at 11:00 a.m., RN 1 stated that basic care plans were developed within 72 hours of admission for all residents and (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	generally included areas such as bowel and bladder care, activities of daily living (ADLs), smoking, pain management, skin care, fall prevention, and psychosocial needs. RN 1 explained that care plans were documented under broad, grouped categories; for example, when a resident started a new pain medication, the medication was added under the existing pain-related care plan rather than being addressed through a specific or individualized plan. RN 1 further stated that individualized care plans were created only for residents with a specific condition or when a medication carried a black box warning. RN 1 acknowledged that many interventions were written in broad, generalized terms, such as administer medications as ordered or monitor episodes of behaviors as ordered, and clarified that detailed instructions were located in the physician's orders rather than in the care plan itself. RN 1 reported that this was the facility's standard practice per Director of Nursing (DON) policy. During an interview on 2/24/2026 at 11:20 a.m., the Director of Nursing (DON) stated that care plan interventions were intended to provide general direction and guidance for staff. The DON explained that detailed interventions, specific monitoring requirements, and measurable goals were outlined within the physician's orders rather than in the care plan itself. The DON further stated that a medication-specific care plan was required only when the medication carried a black box warning, and that for all other medications-including routine medications-interventions and potential side effects were addressed through the corresponding physician's orders. During a review of the facility's policy and procedure (P&P) titled Care Plan, Comprehensive Person-Centered reviewed on 2/24/2026, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d. Describe any specialized services to be provided as a result of Preadmission Screening and Resident Review ([PASARR] - a federal rule requiring all nursing home applicants to be screened for mental illness or intellectual disabilities before admission) recommendations; e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; [NAME]. Reflect currently recognized standards of practice for problem areas and conditions.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure:a. licensed staff completed proper documentation of disposal of non-controlled medications indicating reconciliation (a system of recordkeeping that ensures an accurate inventory of medications that have been received, dispensed, administered, and wasted) for one of one Medication Storage area. b. medications were administered as prescribed by the physician for two of four sampled residents (Resident 2 and Resident 42) when Licensed Vocational Nurse (LVN) 1 administered the incorrect dosage of sodium bicarbonate (used to relieve heartburn, sour stomach, or acid indigestion by neutralizing excess stomach acid) for Resident 42, and insulin (a hormone that removes excess sugar from the blood, produced by the body or given artificially via medication) administration was held without indication for Resident 2. These deficient practices placed the facility at risk for inaccurate medication reconciliation and increased the potential for drug diversion involving non-controlled medications. Additionally, the failures in medication administration created the potential for clinically significant adverse outcomes, including elevated gastric or blood acid levels for Resident 42 and elevated blood glucose levels for Resident 2, which could result in further complications. Findings: During a concurrent observation and interview on 02/24/2026 at 10:17 a.m. with Licensed Vocational Nurse (LVN) 1 in Medication Storage area, the pharmaceutical waste container was placed inside a locked cabinet. LVN 1 stated the medication disposal process was when non-controlled medication is discontinued, licensed nurse must document the prescription number, name of the medication, count, and have it witnessed by two licensed staff on the medication destruction record. During a concurrent interview and record review on 02/24/2026 at 11:47 a.m. with Director of Staff Development (DSD), Medication Destruction Record and facility's Policy and Procedures (P&P) titled Medication Discarding and Destroying Medications dated 02/24/2026 was reviewed. The P&P indicated that the medication disposition record will contain the following information; the resident's name; date medication disposed; the name and strength of the medication; the name of the dispensing pharmacy; the quantity disposed; method of disposition; reason for disposition; and signature of witnesses.DSD stated that the Medication Destruction Record indicated the following: 1.On 06/23/2025 and 06/24/2025, the destruction method and the second witness was incomplete. 2.On 8/27/2025 and 08/28/2025, the method of destruction and the licensed staff name was incomplete. 3.On 01/05/2026, the method of destruction, and the licensed staff name was incomplete. 4.On 02/01/2026, the licensed staff name and signature was incomplete. 5.On 02/21/2026, the number or quantity destroyed, method of destruction, and licensed staff name and signature was incomplete. DSD further stated that the medication destruction record log was incomplete, lacking reasons for disposition, the destruction method, and witness signatures with names or titles. DSD further stated (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that the facility's P&P was not followed. During an interview on 02/25/2026 at 12:48 p.m. with Director of Nursing (DON), DON indicated that the DON, DSD, and/or the licensed nurses handled the disposal of non-controlled medication. DON stated that the staff remove the medication from the cart and deliver it to the DON, who documents the medication count. DON added there should be two witnesses of licensed staff present at the disposal of the medication for accountability. B. During a review of Resident 2's admission Records, the admission Records indicated Resident 2 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with the diagnoses including dementia, schizophrenia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2's Physician Visit Progress note dated 5/13/2025, the progress note indicated Resident 2 does not have capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set ([MDS] - a resident assessment tool) dated 1/26/2026, the MDS indicated Resident 2 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with all activities of daily living (ADL) such as eating, oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing and putting on/taking off footwear. During a concurrent interview and record review on 2/24/2026 at 11:20 a.m. with Director of Nursing (DON), the DON reviewed Resident 2's electronic medical records. The DON stated there was an order for Insulin Glargine solution 100 Unit/milliliter ([m]l &ndash; unit of measurement) to inject 20 unit subcutaneously (underneath the skin) at bedtime for DM, hold if blood sugar is less than 100. The DON stated medication administration record (MAR) indicated that on 2/21/2026 at 9:00 p.m. Resident 2's blood sugar level was 102 and Insulin administration had been marked with a code 5. The DON stated that code 5 was interpreted as Hold/see progress notes. Review of the progress notes dated 2/21/2025 indicated no documentation explaining why insulin was held, despite the physician's order parameters. The DON stated if insulin was not administered as ordered, the resident did not receive the therapeutic dose necessary to maintain safe and effective blood glucose control, which could increase the risk for hyperglycemia (high blood sugar levels) and other complications. During a review of the facility's P&P titled, Medication Administration, reviewed on 1/29/2026, the P&P indicated, Medications shall be administered safely and accurately by licensed nursing personnel in accordance with physician orders, accepted standards of practice, and regulatory requirements. The facility shall ensure proper storage, documentation, monitoring, and follow-up. Document omissions and reasons. During a concurrent observation and interview on 02/24/2026 at 10:17 a.m. with Licensed Vocational Nurse (LVN) 1 in Medication Storage area, the pharmaceutical waste container was placed inside a locked cabinet. LVN 1 stated the medication disposal process was when non-controlled medication is discontinued, licensed nurse must document the prescription number, name of the medication, count, and have it witnessed by two licensed staff on the medication destruction record. During a concurrent interview and record review on 02/24/2026 at 11:47 a.m. with Director of Staff (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Development (DSD), Medication Destruction Record and facility's Policy and Procedures (P&P) titled Medication Discarding and Destroying Medications dated 02/24/2026 was reviewed. The P&P indicated that the medication disposition record will contain the following information; the resident's name; date medication disposed; the name and strength of the medication; the name of the dispensing pharmacy; the quantity disposed; method of disposition; reason for disposition; and signature of witnesses. DSD stated that the Medication Destruction Record indicated the following: On 06/23/2025 and 06/24/2025, the destruction method and the second witness was incomplete. On 8/27/2025 and 08/28/2025, the method of destruction and the licensed staff name was incomplete. On 01/05/2026, the method of destruction, and the licensed staff name was incomplete. On 02/01/2026, the licensed staff name and signature was incomplete. On 02/21/2026, the number or quantity destroyed, method of destruction, and licensed staff name and signature was incomplete. DSD added that the medication destruction record log was incomplete, lacking reasons for disposition, the destruction method, and witness signatures with names or titles. DSD further stated that the facility's P&P was not followed. During an interview on 02/25/2026 at 12:48 p.m. with Director of Nursing (DON), DON indicated that the DON, DSD, and/or the licensed nurses handled the disposal of non-controlled medication. DON stated that the staff remove the medication from the cart and deliver it to the DON, who documents the medication count. DON added there should be two witnesses of licensed staff present at the disposal of the medication for accountability.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 18) received care in a manner that maintained the resident's dignity and respect when Registered Nurse (RN) 1 did not fully close the privacy curtains while providing personal care. This failure had potential to negatively affect the resident's sense of dignity and respect during the care. Findings: During the review of Resident 18's admission Record, the admission record indicated the facility admitted the resident on 8/6/2025 with diagnosis that included but not limited to hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (neurological condition characterized by reduced muscle strength, or partial paralysis to one side of the body), cerebral infarction unspecified (loss of blood flow to a part of the brain) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During the review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 2/12/2026, the MDS indicated Resident 18's need supervision and touching assistance for eating, oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, personal hygiene, putting and taking off footwear, rolling left or right, sitting to laying, laying to sitting, walking 10-150 feet. The MDS dated [DATE] indicated Resident 18 is alert, oriented and has a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (normal cognitive/brain function). During an observation on 2/23/2026 at 8:44 am, in Resident 18's room, RN 1 was about to provide personal hygiene care to Resident 18. RN 1 pulled the privacy curtain to provide the resident privacy during the care. The curtain was not completely closed didn't provide complete privacy for Resident 18. During an interview on 2/23/2026 at 8:44 am with RN 1, RN 1 stated that the curtain was not closed all the way and did not provide complete privacy to Resident 18. RN 1 stated that it is important to have privacy curtains closed completely to protect Resident 18's dignity. RN 1 stated that if the privacy curtain was short the maintenance must be notified. During an interview on 2/25/2026 at 9:55 am with DON, DON stated If any facility resident is exposed during the care is provided, due to curtain not pulled all the way or curtain being short, resident will feel embarrassed and feel bad and it will affect resident's dignity negatively. DON stated that the residents should get privacy when care is provided. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights dated 01/29/2026, the P&P indicated the facility residents have Right to dignity, respect, privacy, and confidentiality. During a review of the facility's Policy and Procedure (P&P) titled, Patient Privacy Curtains dated 01/29/2026, the P&P indicated Curtains must be fully drawn during personal care, treatments, dressing, and assessments.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation and interview, the facility failed to provide a private space for the Resident Council (RC) meetings for 5 of 5 residents. This failure resulted in the residents expressing discomfort to discuss issues and concerns openly and without fear of retaliation. Findings: During an observation on 2/24/2026 at 9:50 a.m. in the dining/activity room, the room was open to a hallway with access to the staff restroom, facility kitchen, and resident rooms. There was no barrier in the hallway entrance of the dining/activity room to give the residents privacy. During an interview on 2/24/2026 at 9:55 a.m. with Activity Director (AD). AD stated the dining/activity room is where Resident Council meetings are held, and a sign is posted to let staff know a Resident Council meeting is in progress. During an interview on 2/24/2026 at 10:10 a.m. with RC, RC members stated the facility offers the dining/activity room for their meetings. RC members stated the area is open to the hallway, and staff or other people passing by may overhear meeting discussions. RC members stated they do not feel free to openly discuss issues and concerns because meetings are not held in a private closed room. During a review of the facility's policy and procedure (P&P) titled, Resident Council Meetings, updated 1/29/2026, the P&P indicated RC meetings shall be held free from interference in an accessible and private location.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that one of two sampled resident (Resident 29) was provided with assistive device to maintain independence in activities of daily living (ADL's). This deficient practice has the potential for Resident 29 unable to communicate with staff due to inability to know his surroundings. Findings: During a review of Resident 29's admission Record, the admission record indicated that Resident 29 was initially admitted to the facility on [DATE] with diagnoses of bilateral (both) legally eye blindness (severe vision loss), dementia (a progressive state of decline in mental abilities), metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of Resident 29's MDS dated on 01/23/2026, MDS indicated that Resident 29 required substantial/maximal assistance (helper does more than half the effort) for ADLs and needs partial assistance (helper does less than half the efforts) for eating. During observation on 2/23/2026 at 8:13 a.m. in Resident 29's room, Resident 29 was lying on his back in bed at lowest position, call light on the floor. Resident 29 did not have an oxygen concentrator at bedside or any visual sign indicating that Resident is legally blind. Resident head was resting on a white pillow, and no other cushions were observed. During an interview on 2/24/2026 at 12:45 p.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated that staff must do everything for Resident 29 because he is blind and is not able to select his own clothes or feed himself. CNA 2 stated that Resident 29 walks with assistance because he must be guided and should not be left alone. CNA 3 stated that staff cannot always stay with Resident 29. CNA 3 states that there should be a communication binder and a visual board at bedside for Resident 29. CNA 3 stated that when Resident 29 is in his room he cannot use the call light because he does not know how to use it. CNA stated that Resident 29 is continent of bladder and staff must borrow a walker from the therapy department to use when taking resident to the restroom. During an interview on 2/24/2026 at 2:23 p.m. with Social Services Director (SSD) in Resident 29's room, the SSD stated that Resident 29 has been seen once a year by the optometrist. SSD stated that the optometrist does not make any recommendations, the facility staff cannot implement any interventions to assist Resident 29's with activities of daily living. SSD stated that vision is important because it can affect activities of daily living if it is not addressed. SSD stated Resident 29 does not have a visual sign in the room indicating that resident is legally blind. SSD stated that there should be a visual sign to notify others of Resident 29's impairment. During a review of the facility's policy and procedures (P&P) titled, Resident Rights dated 1/29/2026, indicated that resident has the right to safe environment.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that Licensed Vocational Nurse (LVN) 1 administered the correct dosage of sodium bicarbonate (used to relieve heartburn, sour stomach, or acid indigestion by neutralizing excess stomach acid) as ordered by the physician for one of three sampled residents (Resident 42). This deficient practice had the potential to result in elevated stomach or blood acid levels for Resident 42 which could lead to complications. Findings: During a review of Resident 42's admission Record, the admission record indicated that Resident 42 was initially admitted to the facility on [DATE], with diagnoses including epilepsy, chronic kidney disease (CKD-a longstanding disease of the kidneys leading to renal failure), hypertension (HTN-high blood pressure), gastroesophageal reflux disease (the stomach acid flowing back into the tube connecting the mouth and the stomach) and type II diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]). During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool) dated 12/17/2025, MDS indicated that Resident 42's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 42 required maximal assistance from staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 42's medical records titled, Order Summary Report dated 02/25/2026, indicated a physician order that was initiated on 12/11/2025 for sodium bicarbonate oral tablet 650 milligrams (mg-unit of measurement) give two tablets by mouth three times a day for supplement. During a medication administration observation on 02/23/2026 at 09:12 a.m. with LVN 1, LVN 1 administered two tablets of sodium bicarbonate 325 mg to Resident 42. LVN 1 indicated that the order is sodium bicarbonate 650mg give two tablets by mouth three times a day. LVN 1 stated my bad. LVN 1 explained that not giving the ordered dosage reduces the medication's effectiveness as an antacid. During a concurrent interview and record review on 02/25/2026 at 12:48 p.m. with Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled Medication Administration updated on 01/29/2026 was reviewed. The P&P indicated, Medications shall be administered safely and accurately by licensed nursing personnel in accordance with physician orders, accepted standards of practice, and regulatory requirements. The DON stated that licensed nurses must verify the five rights, assess the resident, and document during medication administration. The DON further stated that according to the facility's P&P, the five rights of medication administration include the right resident, right medication, right dose, right route and right time. The DON stated that adhering to the five rights of medication administration was important to ensure that residents receive the appropriate and effective care and treatment. A review of the facility's Policy and Procedures (P&P) titled Medication Administration updated on 01/29/2026, indicated that, Medications shall be administered safely and accurately by licensed nursing personnel in accordance with physician orders, accepted standards of practice, and regulatory requirements.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to receive input from the resident for their preferred foods for one of one sampled resident (Resident 1). This failure had the potential for the resident to lose weight because they were not receiving the foods they liked to eat. Findings: During the review of Resident 1's admission record, the admission record AR indicated the facility admitted the resident on 7/27/2024 and then readmitted on [DATE] with diagnosis that included but not limited to chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), severe protein-calorie malnutrition (a severe condition resulting from insufficient intake of protein and calorie, can lead to muscle waste, fat loss, and functional decline) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During the review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 1 need supervision and touching assistance for eating, Resident 1 need partial/moderate assist for oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, personal hygiene, putting and taking off footwear, rolling left or right, sitting to laying and laying to sitting. The MDS dated [DATE] indicated the resident is alert, oriented and has a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (normal cognitive/brain function). During an observation on 2/23/2026 at 12:17 pm, Resident 1 ate 4 ounces (oz) of Jello (gelatin dessert) from the lunch tray and didn't eat rest of the lunch meal. During an observation on 2/24/2026 at 12:49 pm, Resident 1 was served ground beef, vegetables and dessert. Resident 1 took 3 bites of the dessert and two bites of the meat and drank 4 oz of milk. During an observation on 2/25/2026 7:50 am, Resident 1 was served fried/scrambled eggs, potatoes, yoghurt, coffee and milk for breakfast. Resident1 ate half of the eggs, 3 oz of milk, 4 oz of juice and 4 oz of coffee. During an observation on 2/25/2026 at 12:42 pm, Resident 1 was served scrambled eggs, grounded carrots and mashed potatoes for lunch. Resident 1 ate two bites of scrambled eggs, two bites of mashed potato, 4 oz of juice and 4 oranges slices. During an observation on 2/25/2026 at 12:42 pm, Resident 1's meal card did not indicate the resident's preferred foods and non-preferred foods. During an interview on 2/25/2026 at 12:42 pm with Resident 1, Resident 1 stated she informed the staff in the past regarding her preferred food choices. Resident 1 stated she preferred fried egg, scrambled eggs, fruits and oatmeal for breakfast. Resident 1 stated that for lunch or dinner, she preferred egg salad, fresh fruits, fresh salad, hamburger patty and french fries crispy at the edges. Resident 1 stated she disliked chili, spicy foods and pureed/ground meat. Resident 1 stated she was served oatmeal for breakfast every day for breakfast when she came to the facility, she does not like oatmeal anymore. During an interview on 2/24/2026 at 10:58 am with Dietary Supervisor (DS), DS stated that the facility has the list of all resident's preferred and non-preferred food items. The assessment of the food preference is completed by DS upon admission and quarterly. During an interview on 2/24/2026 at 11:42 am with DS, DS stated that Resident 1's quarterly assessment on preferred foods was done on 1/17/25, 7/9/25, 9/17/25 and 1/13/2026. DS stated there was no assessment done besides those dates and quarterly assessments was missed between 1/17/25 - 7/9/25 and between 9/17/25 and 1/13/2026. During an interview on 02/24/2026 at 12:49 pm with DS, DS stated that not assessing residents for their food preference quarterly can affect the residents and residents can be at risk of not eating their meals which can eventually make residents at risk of losing weight. DS stated that the preferred foods assessment for the resident had documented American food as preferred food which is not specific enough. During a review of the facility's Policy and Procedures (P&P) titled Resident Rights dated 01/29/2026, the P&P indicated the facility residents have Right to dignity and respect. During a review of the facility's P&P titled Food Preferences and Resident Choice dated 01/29/2026, the P&P (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that the facility will provide nutritionally adequate meals while incorporating resident preferences, cultural considerations, religious practices, and individualized dietary needs.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to: Ensure the dishwasher sanitizer machine had the correct chlorine concentration to clean the dishware. Date food items and discard expired food stored in the refrigerator and dry storage area. These failures had the potential to result in food borne illness in the residents. Findings:1. During and observation on 2/23/2026 at 8:06 AM in the kitchen, [NAME] 1 tested the chlorine concentration of the dishwasher sanitizer machine three times. The test strip indicated the chlorine concentration was 25 parts per million (ppm) all three times. During an interview on 2/23/2026 at 8:06 AM with [NAME] 1, [NAME] 1 stated the correct chlorine concentration level should be at least 50 ppm, and they need to adjust the sanitizer concentration if it is below 50 ppm. [NAME] 1 stated if dishes are not sanitized well the residents could get sick. During an interview on 2/23/2026 at 10:10 AM with Dietary Supervisor (DS), DS stated the chlorine sanitizer test reading should be at 50 ppm to ensure dishes have been sanitized well. DS stated they need to manually re-wash and re-sanitize dishes used for breakfast to ensure they are safe to use for the next meal; and not use dishwasher until they get the chlorine sanitizer level to 50 to 100 ppm. During a review of the facility's policy and procedure (P&P) titled, Kitchen Dishwashing and Sanitation, dated 1/29/2026, the P&P indicated the dishwashing machine chemical sanitizer should be 50 to 100 ppm. 2. During a concurrent observation and interview on 2/23/2026 at 7:51 AM with [NAME] 1 in the kitchen, there was a baking powder container with an unreadable expiration/used by date in the dry food storage cabinet next to the stove. [NAME] 1 stated unlabeled or expired food items should not be used and put in the trash. [NAME] 1 stated unlabeled food items could be expired and can make residents sick. During a concurrent observation and interview on 2/23/2026 at 7:53 AM with [NAME] 1 in the kitchen, the refrigerator to the left of the kitchen entrance had a lemon juice concentrate bottle labeled used by 2/18/2026. [NAME] 1 stated expired food items should be discarded, if used could make residents sick. During a concurrent observation and interview on 2/23/2026 at 7:54 AM with [NAME] 1 in the kitchen, the freezer to left of the kitchen entrance had broccoli florets bags with no expiration date (1 opened, 2 unopened) and Japanese vegetables bags with no expiration date. [NAME] 1 stated foods with no expiration date could be spoiled and if given to residents can make residents sick. ^ During a concurrent observation and interview on 2/23/2026 at 7:58 AM with [NAME] 1 in the dry storage room outside the kitchen, there was a banana extract bottle with no expiration date. [NAME] stated unlabeled or undated food items should be removed and discarded. During a review of the facility's policy and procedure (P&P) titled, Food Use and Storage, updated 1/29/2026, the P&P indicated opened food items, and refrigerated and frozen food shall be labeled with product name, use by date, and date opened or prepared. P&P indicated facility shall discard all expired and spoiled food immediately.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that infection prevention and control program was followed by failing to: Ensure that the antibiotic surveillance log (a record-keeping tool used by nursing homes to track, analyze, and manage infections among residents) was completed for Resident 4 and Resident 6. Ensure that the facility's Water Management Program (WMP) - a written, step-by-step plan for buildings to ensure their water system was safe, clean, and efficient) was implemented and maintained as written. These deficient practices placed the residents, staff and visitors at risk for exposure to and transmission of infectious organisms, incomplete monitoring and follow up of infections, missed trends or outbreaks due to lack of surveillance data analysis, and unsafe water conditions. Findings: 1a. During a review of Resident 4's admission Record, the admission record indicated that Resident 4 was initially admitted to the facility on [DATE] and last re-admission was on 12/14/2025 with diagnosis including heart failure (a condition in which the heart does not pump blood as well as it should), cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), altered mental status and metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of Resident's 4's Minimum Data Set (MDS-a resident assessment tool) dated 12/20/2025, MDS indicated that Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision were moderately impaired. MDS indicated that Resident 4 required maximal assistance from staff for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 4's physician orders titled Order Summary Report (OSR) dated 1/01/2026, the OSR indicated Mupirocin (topical antibiotic cream or ointment used to treat skin infections) External Ointment 2% was ordered on 12/24/2025 for left index finger. 1b. During a review of Resident 6's admission Record, the admission record indicated that Resident 6 was initially admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), heart disease, venous insufficiency, and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 6's MDS dated [DATE], MDS indicated that Resident 6's cognitive skills for daily decisions were moderately impaired. MDS indicated Resident 6 required maximal assistance from staffs for ADLs. During a review of Resident 6's medical records titled Order Summary Report indicated a physician order. Mupirocin initiated on 02/04/2026 for Right Lower Leg venous stasis ulcer (a wound that takes longer than usual to heal): cleanse with wound cleanser, pat dry, apply mupirocin to open area, cover with xeroform (petrolatum-impregnated gauze dressing), secure with kerlix (non-adherent wound dressing made of fine mesh gauze) and coban wrap (cohesive material that sticks only to itself) every day shift until 03/07/2026. B. Mupirocin initiated on 4/26/2025 for Abdominal wall non-pressure chronic ulcer: cleanse with normal saline, pat dry, apply Mupirocin ointment, cover with dry dressing daily for 30 days until 05/26/2025. During a concurrent interview and record review on 02/25/2026 at 09:56 a.m. with Infection Preventionist Nurse (IPN), Resident 4 and Resident 6 medical records were reviewed. IPN stated she was responsible for implementing and managing the facility's infection control program to protect residents, staff, and visitors. IPN added that she conducts surveillance, ensures compliance with protocols and oversees the antibiotic stewardship. IPN indicated that antibiotic stewardship was to ensure the appropriate use of antibiotics to prevent resistance. IPN stated that she does the surveillance the day after the antibiotic was ordered. IPN indicated in the medical records the following: 1. On the month of December 2025 and January 2026, the antibiotic surveillance was not completed when Resident 4 was receiving mupirocin. 2. On the month of April 2025 and February 2026, the antibiotic surveillance was not completed when Resident 6 was receiving mupirocin. IPN stated that mupirocin is considered an antibiotic and should have done surveillance for Resident 4 on December 2025 and January 2026; and for Resident 6 on April 2025 and (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Good Shepherd Health Care Center of Santa Monica		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 Arizona Ave. Santa Monica, CA 90401	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	February 2026. 2. During a concurrent interview and record review on 2/25/2025 at 12:15 p.m. with Maintenance Supervisor (MS), the water management plan was reviewed. The MS stated that he does not test the facility water for chlorine and pH levels. The MS states that pH testing is only conducted in the kitchen's dishwasher and not throughout the facility. During a subsequent concurrent interview and record review on 2/25/2026 at 12:25 p.m. with IPN, IPN stated that the maintenance supervisor was responsible for monitoring the water. The IPN further stated the facility did not have logs for water testing for temperature readings, water chlorine and pH and the results as indicated in the facility's WMP. The IPN added that failure to routinely test and document water quality, may allow the growth and spread of waterborne pathogens (bacteria, viruses, or parasites found in contaminated water), which could place residents, staff and visitors at risk for waterborne infections (illnesses caused by bacteria, viruses, or parasites from human or animal waste that contaminate drinking or recreational water) when used or ingested. During an interview on 02/25/2026 at 12:48 p.m. with Director of Nursing (DON), DON stated that the IPN is responsible for overseeing antibiotic surveillance to ensure compliance with the facility's infection control program. The DON stated that antibiotic use must be monitored carefully and should be prescribed only for confirmed infections supported by documented clinical evidence to prevent unnecessary antibiotic usage. The DON further stated that topical antibiotics are included in antibiotic surveillance. The DON added that without documentation of infection outcomes in the surveillance logs, the facility is unable to evaluate treatment effectiveness or determine whether resident care needs are being met. During a subsequent interview on 2/25/2026 at 1:05 p.m. with the DON, The DON also stated that a professional conducts the facility's annual water testing. The DON reported awareness of the facility's Water Management Plan (WMP) but did not have detailed knowledge of its components. The DON stated that the maintenance supervisor is responsible for monitoring the water system, including checking the water source, inspecting for pipe leaks, and verifying water temperatures. The DON added that failure to monitor compliance with the WMP could compromise water quality and allow bacterial growth, including Legionella, which may expose residents to contaminated water and increase the risk of infection. During a review of the facility's P&P titled Antibiotic Stewardship revised on 12/2016, the P&P indicated that Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: Drug name; Dose; Frequency of administration; Duration of treatment; Start and stop date; or Number of days of therapy; Route of administration; and Indications for use. During a review of facility's WMP document, titled Water Safety Plan-2023, undated, the WMP indicated that, the plan aimed to control the growth and survival of Legionella and other waterborne pathogens in water systems and manage epidemics in the facility. Under the Task Scheduling and Verification Forms, it indicated that Following the planning chart, customized log sheets are provided for maintenance procedures. These log sheets, or an equivalent method of documentation should be utilized to demonstrate successful completion of program tasks.		

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a current informed consent from the resident or resident's representative at the time influenza (an infection of the nose, throat and lungs, which are a part of the respiratory system) vaccine (a preparation that is used to stimulate the body's immune response against diseases) was administered for one of four sampled residents (Resident 6). This deficient practice violated Resident 6 or Resident 6's responsible party's rights to make an informed decision. Findings: During a review of Resident 6's admission Record, the admission record indicated that Resident 6 was initially admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar), heart disease, venous insufficiency, and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool) dated 01/01/2026, MDS indicated that Resident 6's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. MDS indicated Resident 6 required maximal assistance from staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 6's record titled Order Summary Report dated 02/25/2026, indicated a physician's order initiated on 12/26/2025 of may have influenza vaccine 0.5 milliliters (ml- a unit of volume) intramuscular injection (IM- into a muscle) injection every year. During a concurrent interview and record review on 02/25/2026 at 09:56 a.m. with Infection Preventionist Nurse (IPN), Resident 6 medical records were reviewed. The IPN indicated that immunization is crucial for preventing severe illness when contracting disease. The IPN stated that obtaining an informed consent is important because it informs residents about the risks, benefits, potential side effects, and the consequences of not getting vaccinated. The IPN stated that informed consent should be obtained as soon as the vaccine becomes available. The IPN stated that informed consent for the influenza vaccine for Resident 6 was obtained on 09/25/2025 and it was administered on 01/24/2026. The IPN stated that a new informed consent was needed before giving the influenza vaccine on 01/24/2026, as the resident or their representative could have changed their mind since it was obtained four months ago. During a review of facility's Policy and Procedures (P&P) titled Influenza Vaccine, revised 10/2019, the P&P indicated that, prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record. During a review of facility's P&P titled Informed Consent, updated on 01/29/2026, the P&P indicated that informed consent must be obtained from residents or their legal representatives before starting treatments, procedures, medications, or care changes requiring consent under federal or state law. It also indicated that residents have the right to make informed care decisions. The P&P indicated that facility aims to inform residents of risks, benefits, and alternatives; comply with federal and state regulations; and promote ethical and person-centered care practices.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to ensure to provide documented evidence for two of four sample employees (Medical Director and Registered Dietitian (RD) Corona virus ([COVID-19] - contagious infectious disease) vaccination status and the provision of education on benefits and potential side effects. This failure had the potential to result in staff (refers to those individuals who work in the facility on a regular basis, this also includes individuals under contract) and residents contracting COVID-19 which can cause serious illness, hospitalization, and death. Findings: During a concurrent interview and record review on 2/25/2026 at 11:13 a.m., with Infection Prevention Nurse (IPN), the Employee's Vaccination Record 2025 was reviewed for the Medical Director and RD. The employee vaccination record indicated no documentation of COVID-19 vaccination status and provision of education on benefits and potential side effects of COVID-19 vaccine, and documentation that the COVID-19 vaccine was offered. The IPN stated that all staff members should be offered COVID-19 vaccine and if staff members refuse vaccine, it should be documented. The IPN states that it is important to know their vaccination status because they have contact with the residents and staff. During a review of the facility's policy and procedures (P&P) titled, Staff Vaccination Program, reviewed on 1/29/2026, the P&P indicated the following: policy applies to all employees, contractors, agency personnel, volunteers, and individuals providing services within the facility. Facility shall maintain a staff vaccination program consistent with CDC recommendations and regulatory requirements. Vaccination status shall be tracked, documented, and monitored to promote resident and staff safety.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the requirement of 80 square feet per resident in a double occupancy patient room and 100 square feet (sq.ft) per resident in a single occupancy room. There were 23 out of 24 resident rooms in the facility that did not meet the requirement of 80 square 1 feet per resident.This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents.Findings: During a review of the facility's room waiver letter and the client accommodations analysis form completed by the facility on 2/23/2026, indicated the following 23 rooms provided less than 80 feet per resident:Rooms# Beds Room Size(ft.) Sq. Ft/Bed3 2 138.7 69.354 2 138.7 69.355 2 138.7 69.356 2 138.7 69.357 3 150.7 50.258 2 138.7 69.359 2 138.7 69.3510 2 138.7 69.3511 2 138.7 69.3512 2 138.7 69.3514 2 138.7 69.3515 2 138.7 69.3516 2 138.7 69.3517 2 138.7 69.3518 2 138.7 69.3519 2 138.7 69.3520 2 138.7 69.3521 2 138.7 69.3522 2 138.7 69.3523 2 138.7 69.3524 2 138.7 69.3525 2 138.7 69.35 The minimum square footage for a 2-bed room should be 160 Sq. Ft. The client accommodations analysis form indicated room [ROOM NUMBER] accommodated 1 resident, and rooms #3, #4, #5, #6, #8, #9, #10, #11,#12,#14, #15,#16,#17,#18,#19,#20,#21,#22, #23, #24, and #25 accommodated 2 residents each and room [ROOM NUMBER] accommodated 3 residents. During an observation on 2/25/2026 at 8:52 a.m., observations were made in rooms 2, 3, 4, 5, 6,7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25 that nursing staff had enough space to provide care to the residents, and the rooms had direct access to the corridors. There were no noted concerns with privacy, nursing care and/or safety to the residents.The facility presented a request for the continuation of the waiver for twenty-three (23) rooms, which did not meet the room size requirement of 80 square feet per resident in a double occupancy room and one hundred (100) square feet per resident in a single occupancy room [ROOM NUMBER]/23/2026.		