STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555106	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Lodge	5053 Peck Rd. El Monte, CA 91732

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents and/or the residents' responsible parties (RP) were informed in advance, of the risk and benefits of psychotropic medication (a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior) for two of five sampled residents (Residents 7 an 8) when:1. Resident 7's Quetiapine (Seroquel) was restarted on 3/26/2026 without an informed consent (IC-a form indicating a resident or responsible party voluntarily agree to a medical treatment or procedure after understanding the risks, benefits, and alternatives) after the Quetiapine was discontinued on 10/3/2025.2. Resident 8 did not have and IC for Lexapro (a medication used to treat mental health disorders), trazodone (a medication used to treat mental health disorders and insomnia [difficulty falling asleep]) and olanzapine indicating the correct dosage (a medication used to treat mental health disorders) prior to 3/25/2026. These deficient practices violated Residents 7 and 8's rights to make an informed decision regarding the use of psychotropic medication which had the potential for unnecessary use of such medications. Findings: A. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 4/2/2025, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear. During a review of Resident 7's Quetiapine order history with the MDSN, dated 10/3/2025, the history indicated Resident 7's Quetiapine was discontinued on 10/3/2025. During a review of Resident 7's Progress Notes dated 3/1/2026 to 3/31/2026, there was no documentary evidence Resident 7 exhibited behavior for the need to restart the Quetiapine, and no documentation of notification of Resident 7's responsible party regarding restarting Quetiapine. During a review of Resident 7's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 4/7/2026, the MDS indicated Resident 7 had severe cognitive deficit and Resident 7 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene and personal hygiene. During a review of Resident 7's current Medication Administration Record (MAR) dated 5/1/2026 to 5/31/2026, the MAR indicated the Resident had an order for Quetiapine 25 milligram (mg), two times a day for agitation (started on 3/26/26). (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of informed consent forms on 5/6/2026 at 3:08 PM with the Minimum Data Set Nurse (MDSN), there was an informed consent for Quetiapine (Seroquel) 25 mg, two times a day for agitation, dated 4/26/26. During an interview on 5/6/2026 at 3:10 PM, the MDSN stated the MDSN could not find documentation indicating Resident 7's responsible party was informed when Quetiapine was restarted on 3/26/2026 after Quetiapine was discontinued on 10/3/2025. The MDSN stated the Hospice Physician was the one who restarted Quetiapine on 3/26/2025 after it was discontinued on 10/3/2025. The MDSN stated informed consent needed to be completed because it's a patient right to be notified of new medications especially psychotropic medications. B. During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including anxiety disorder (a mental illness characterized by excessive, persistent, and irrational worry or fear that can interfere with daily life), depression (a mental health disorder characterized by sadness, loss of interest, and other symptoms that impact daily life), and schizophrenia (a mental illness characterized by disturbances in thought). During a review of Resident 8's History and Physical (H&P), dated 4/23/2025, the H&P indicated Resident 8 had the capacity to understand and made decisions. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 8's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 8 required supervision/touching assistance with toileting hygiene, required setup or clean up assistance with showering, dressing, and personal hygiene, and was independent with eating and oral hygiene. During a review of Resident 8's Medication Administration Record (MAR), dated 2/1/2026-2/28/2026, 3/1/2026-3/31/2026, and 4/1/2026-4/30/2026, the MAR indicated Resident 8 had received: 1.Lexapro10 milligrams (mg-a unit of measurement) one time a day for depression manifested by changes in mood, social withdrawal, decreased concentration, feelings of sadness, and loss of interest in usual activities on 2/1/2026-2/28/2026, 3/1/2026-3/31/2026, and 4/1/2026-4/30/2026. 2. Trazodone 50 mg given at bedtime for depression manifested by an inability to sleep on 2/1/2026-2/28/2026, 3/1/2026-3/31/2026, and 4/1/2026-4/30/2026. 3. Olanzapine 5 mg two times a day for schizophrenia manifested by episodes of hearing and seeing someone wanting to kill Resident 8 causing stress leading to self-isolation on 2/1/2026-2/28/2026, 3/1/2026-3/31/2026, and 4/1/2026-4/30/2026. During a review of Resident 8's Psychotherapeutic Drug ICs, dated 3/25/2026 and 3/22/2025, the IC's indicated: 1.An IC was obtained on 3/25/2026 for Lexapro 10 mg to be given one time a day. 2. An IC was obtained on 3/25/2026 for trazodone 50mg to be given at bedtime. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. An IC was obtained on 3/25/2026 for olanzapine 5mg to be given two times a day. 4. An IC was obtained on 3/22/2025 for olanzapine 2.5 mg to be given in the morning and 5mg at bedtime. During a concurrent interview and record review on 5/7/2026 at 10:24 AM with the Director of Nursing (DON), Resident 8's medical record was reviewed. The DON stated Resident 8 had received Lexapro, trazodone, and olanzapine prior to obtaining Resident 8's ICs on 3/25/26. The DON stated there was no IC indicating the dosage change for olanzapine prior to obtaining the current IC on 3/25/2026. The DON stated before administering a psychotropic medication it was the policy of the facility to obtain an informed consent from the resident representative (RR). Additionally, the DON stated it was important to obtain an IC because it informed the family or residents (in general) of medication side effects. During a review of the facility's undated Policy and Procedure (P&P) titled, Psychotherapeutic Medications, the P&P's policy indicated, Evaluate the resident's response to psychotropic medication therapy (antianxiety, antidepressant, hypnotic and antipsychotic) to determine that the medications are appropriate and resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The P&P's procedures indicated, No psychotherapeutic medication administered prior to informed consent obtained by prescriber.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow the facility's policy and procedure (P&P) for psychotropic medications titled, Psychotherapeutic Medications, undated for two of two residents (Residents 1 and 7) by: A. failing to monitor for side effects of Resident 1's mirtazapine (medication used to treat depression.)B. failing to have adequate indication for the use Seroquel for Resident 7 (Quetiapine -Quetiapine is FDA approved for schizophrenia [mental disorder characterized by abnormal social behavior and failure to understand what is real], acute manic episodes [A manic episode is a stretch of time when you have one or more symptoms of mania. An episode typically lasts for a week or longer, unless treatment cuts it short] and monitor a specific behavior for it's use.These deficient practices had the potential for Resident 1 and Resident 7 to experience unwanted side effects that could affect their physical wellbeing.Findings: A. During a review of Resident 1's admission Record, (AR) the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including depression (mood disorder causing persistent sadness, emptiness, or irritability, along with loss of interest in activities once enjoyed), anxiety (persistent, excessive, and uncontrollable fear or worry that interferes with daily life) and dementia (a gradual decline in mental ability usually caused by a brain disease.) During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had impaired cognition (ability to understand and process information) and required substantial/ maximal assistance for toileting and bathing. During a review of Resident 1's Care Plan (CP, a form where one can summarize a person's health conditions, specific care need, and current treatments) for antidepressant Remeron (brand name for mirtazapine), revised 4/20/2026, the CP indicated an intervention to observe for side effects and document occurrence of side effects per psychotropic policy. During a review of Resident 1's Order Summary Report (OSR) dated with active orders as of 5/7/2026, the OSR indicated Resident 1 had a physician order for Mirtazapine (antidepressant) tablet 7.5 milligrams (mg- unit of weight) by mouth at bedtime for depression manifested by poor oral intake of less than 50% of meals with start date 3/12/2026. During a concurrent interview and record review with the Director of Nursing (DON), on 5/8/2026, at 11:09 AM, Resident 1's Medication Administration Record (MAR) dated 5/7/2026 was reviewed. The DON stated the DON did not any side effect monitoring for Resident 1's use of Mirtazapine. The DON stated it was important to monitor side effects to know if Resident 1 experienced any undesirable effects while on the medication. During a review of the facility's policy and procedure (P&P) titled, Psychotherapeutic Medications, undated, the P&P indicated the licensed nurse will assess resident to ensure: G. Monitoring of side effects on psychotherapeutic medication on medication sheets. B. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 4/2/2025, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), anxiety (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear. During a review of Resident 7's Quetiapine order history, the history indicated Resident 7's Quetiapine was discontinued on 10/3/2025 and restarted on 3/29/2026. During a review of Resident 7's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 4/7/2026, the MDS indicated Resident 7 had severe cognitive deficit and Resident 7 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene and personal hygiene. During a review of Resident 7's current Medication Administration Record (MAR) dated 5/1/2026 to 5/31/2026, the MAR indicated an order for Seroquel 25 mg. two times a day for agitation. During an interview on 5/7/2026 at 2:44 PM, Registered Nurse Supervisor 1 (RN 1) stated Resident 7's behavior would be the resident's noncompliance with activities of daily living, Resident 7 had sporadic episodes of getting up. RN 1 stated Resident 7's baseline would be awake, confused and might still attempt to get up. During a concurrent review of Resident 7's Progress Notes and Change of Condition for March 2026 and interview on 5/7/2026 at 3:15 PM, the MDS Nurse stated there was no documentary evidence Resident 7 exhibited behaviors that would need Seroquel to be restarted. The MDS Nurse stated Seroquel was restarted when Resident 7 was placed on hospice care. During an interview and a concurrent review of Resident 7's medical records on 5/07/2026 at 2:46 PM, the MDS Nurse MDSN stated there was no record of monitoring for behaviors for the use of Seroquel. Resident 7's Medication Administration Record (MAR) for March 2026, April 2026 and May 2026 indicated there was no records for behaviors for the use of Seroquel. During an interview on 5/7/2026 at 2:52 PM, the MDS Nurse stated monitoring the specific behavior ordered for the use of Seroquel would determine if the medication was effective at controlling the behavior and a gradual dose reduction could be attempted once the behavior had been controlled. The MDS Nurse stated we need to add the monitoring order when licensed nurses enter the psychotropic orders. During a concurrent review of Resident 7's physician orders and interview on 5/8/2026 at 3:26 PM, Resident 7 had an order for Seroquel 25 mg. two times a day for agitation. The Director of Nurse (DON) stated Seroquel was ordered for agitation. The DON stated the behavior needed to be specific so the behavior could be monitored by staff. During an observation on 5/08/2026 at 8:28 AM, Resident 7 was sitting on a wheelchair, awake with helmet on. During an observation on 5/8/2026 at 10:19 AM, Resident 7 was sitting inside the activity room. Resident 7 was calm. During an interview on 5/8/2026 at 2:36 PM, Certified Nursing Assistant (CNA) 6 stated Resident 7 was very confused and combative. CNA 6 stated today the resident was still combative when CNA 6 changed the resident. CNA 6 stated Resident 7 would pushed CNA 6 away, and pinch CNA 6. Resident (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7 would get irritated during ADL's (activities of daily living such as grooming, baths, oral care) which was the same baseline as before, CNA 6 stated the only difference would be Resident 7 would not walk now. During a review of the facility's Policy and Procedure (P&P) titled, Psychotherapeutic Medications, the P&P indicated the licensed nurse will assess the resident to ensure proper diagnosis supporting drug order behavior that cause danger to self, danger to others, significance interference with daily activity, psychotic symptoms (hallucinations, paranoia, delusions that create frightful distress in the resident), specific behavior being monitored every shift.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to reduce the potential for accidents and/or hazards for two of two residents (Residents 23 and 34) by failing to ensure:1. Resident 23's bed-exit alarm (designed to inform staff by letting them know when a person is attempting to leave the bed, has gotten out of bed. Whether directly attached to the resident as a garment clip or position change alarm, or part of the bed itself [e.g., pressure-sensitive mats, bedside infrared beam detectors, or in-bed pressure sensors] was kept in a place where the alarm could easily be heard by staff and was not muffled. 2. A spray bottle of bleach was not left unattended at Resident 34's bedside table. These deficient practices resulted in Resident 23's fall on 5/5/2026 and had the potential to cause harm to Resident 34. Findings: A. During a review of Resident 23's admission Record (AR), the AR indicated the facility admitted Resident 23 on 3/8/2026, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), metabolic encephalopathy (is a change in how your brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness). During a review of Resident 23's Fall Risk Evaluation dated 4/15/2026, the evaluation indicated was Resident 23 was a high risk for fall. During a review of Resident 23's Minimum Data Set (MDS – a standardized resident assessment tool) dated 4/19/2026, the MDS indicated Resident 23 rarely/never able to express ideas or wants and sometimes understands verbal content. During a review of Resident 23's Order Summary Report (OSR), dated 4/20/2026, the OSR indicated an order to apply tab alarm when resident in bed as nursing intervention to alert staff for unassisted transfer. Charge Nurse to check proper placement and function. During a review of Resident 23's Care Plan Report titled, Support & Safety Device, revised on 4/28/2026, the Care Plan indicated for staff to apply sensor pad alarm when resident is in bed as nursing intervention to alert staff for unassisted transfer. Charge nurse to check proper placement and function. The care plan interventions included to monitor the alarm for good working condition and proper placement as needed and for staff to respond promptly to resident once alarm is activated. During an observation on 5/5/2026 at 8:50 AM, there were residents inside the Activity Room with loud music playing from a speaker placed close to the wall in between the Activities Room and Resident 23's room. During an observation on 5/5/2026 at 11:24 AM, there was loud music being played from the black speaker box (approximately 2 feet in length by 1 foot in width) placed along the wall adjacent to the door leading to Resident 23's room. The Minimum Data Set Nurse (MDSN) was walking at the hallway and all of a sudden the MDSN turned and walked inside Resident 23's room. Resident 23 was lying on resident's left side away from the floor mat with the foley catheter tubing stretched taut. The foley catheter bag was hanging on the side of Resident 23's lower bed frame. Resident 23's bed alarm was ringing. The bed alarm's sound was heard ringing when the surveyor was moving closer to Resident 23's doorframe, the MDSN reached inside the drawer of a bedside table placed along the wall adjacent (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the door, found the bed alarm and turned it off. During a review of Resident 23's Change in Condition (COC) Form dated 5/5/2026 at 12:01 PM, the form indicated at 7 AM, Resident 23 was in bed resting, the tab alarm was on the bed in proper placement to alert staff. During an interview on 5/5/2026 at 12:59 PM, the MDSN stated the MDSN ran to the room when the MDSN saw Resident 23 stood up and fell to the floor. The MDSN stated the MDSN heard the alarm as MDSN got into the room, the MDSN called another staff member for help and then noticed the alarm was going off and found the alarm inside a closed drawer and turned the alarm off. The MDSN stated the alarm should not be placed inside the drawer because that would affect the accessibility of hearing the alarm sound. The MDSN stated facility staff could have heard the alarm more prominently if the alarm was placed out of the drawer. The MDSN stated Resident 23 was two to three feet away from the bed when the MDSN saw Resident 23 stood up from the bed. The MDSN stated We would have heard the alarm as soon as Resident 23 got up from the bed if the bed alarm was not place inside the drawer and we could have provide intervention to prevent the fall. The MDSN stated the music was playing outside Resident 23's room and the MDSN did not hear Resident 23's bed alarm sound. During an interview on 5/5/2026 at 1:07 PM, Certified Nursing Assistant 2 (CNA 2) stated Resident 23 was sleeping when CNA 2 left for lunch break. CNA 2 stated CNA 2 would watch Resident 23 because Resident 23 would try to get up all the time, CNA 2 stated CNA 2 made sure the bed-exit alarm was on the side of the bed, if the alarm was inside the drawer, the sound of the alarm would not be the same. During a concurrent observation and interview on 5/5/2026 at 1:10 PM with the MDSN, the MDSN opened the drawer inside Resident 23's room, the alarm was placed inside the closed drawer. The MDSN stated the bed-exit alarm needed to be out of the drawer and placed outside so staff could hear the alarm sounds when the bed-exit alarm activated. During a review of the facility's Policy and Procedure (P&P) titled, Falls and Fall Risk, Managing, dated March 2023. The P&P indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. B. During a review of Resident 34's admission Record (AR), the AR indicated Resident 34 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including paranoid schizophrenia (mental health condition where a person loses touch with reality through intense, irrational distrust) bipolar disorder (mental health condition characterized by extreme, alternating shifts in mood, energy, and activity level) and obsessive-compulsive personality disorder (mental health condition defined by strict, chronic preoccupation with perfectionism, orderliness, and control). During a review of Resident 34's Care Plan (CP, a form where one can summarize a person's health conditions, specific care need, and current treatments), revised 9/2/2025, the CP indicated Resident 34 had impaired visual functioning related to cataracts (a cloudy or opaque area in the lens of the eye that blocks light from passing through, resulting in blurry or dim vision). The CP indicated an intervention to provide for a safe environment, free of hazards. During a review of Resident 34's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 2/17/2026, the MDS indicated Resident 34 had severely impaired cognition (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(ability to understand and process information) and required partial/ moderate (helper does less than half the effort) assistance from staff for toilet and personal hygiene. During an observation on 5/7/2026 at 8:22 AM, in Resident 34's room, Resident 34's bedside table was observed with an unattended spray bottle full of clear liquid labeled, bleach, and Resident 34 in bed. During a concurrent observation and interview on 5/7/2026 at 8:24 AM in Resident 34's room with Certified Nurse Assistant (CNA) 1, Resident 34's bedside table was observed with the spray bottle labeled, bleach. CNA 1 stated it was not good for the spray bottle to be left on Resident 34's bedside table. CNA 1 stated Housekeeper (HK) 1 had recently been in the room to clean and the bottle must have been left by HK 1. CNA 1 stated the bottle's label indicated there was bleach inside and the bottle should not have been left on Resident 34's bedside table because Resident 34 could get bleach on themselves or drink it. During an interview on 5/7/2026 at 8:31 AM with the Maintenance Supervisor (MS), the MS stated the cleaning bottles used at the facility should be labeled so if the bottle is labeled bleach, that means there is bleach inside the bottle. The MS stated after the housekeepers use the cleaning bottles, they are supposed to place the bottle into the cleaning cart and lock it. The MS stated the housekeepers should not leave cleaning bottles with the residents because the residents could grab the bottles and hurt themselves if they drink it. During an interview on 5/7/2026 at 4:13 PM with the Administrator, the ADM stated the facility took resident safety very seriously and no other cleaning bottles had been found left with residents. During a review of the facility's policy and procedure (P&P) titled Safety, undated the P&P indicated to never leave cleaning equipment or chemicals unattended in a resident's room or in a corridor. During a review of the facility's policy and procedure (P&P) titled, Housekeeping Supplies and Equipment, undated the P&P indicated to store al housekeeping equipment in a designated place. Always return the equipment to its proper storage place after using it and cleaning it. The P&P further indicated chemicals were to remain secure and locked up in janitorial closets and carts.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 13) received the right amount of water flush and enteral feeding via gastrostomy feeding tube (G-tube - a device used for providing nutrition directly to the stomach) as ordered by the physician.These deficient practices had the potential for Resident 13 to experience further weight loss and dehydration. Findings: During a review of Resident 13's admission Record (AR), the AR indicated the facility admitted Resident 13 on 1/15/2014 and readmitted the resident on 4/16/2026, with diagnoses that included adult failure to thrive (FTT-is characterized by unexplained weight loss, malnutrition and disability. FTT has been associated with multiple primary conditions (e.g., infections and malignancies), but always includes 2 defining clinical elements, namely nutritional impairment and disability), acute kidney failure (the kidneys are operating at less than 10 percent of normal function which means body wastes such as build up in the bloodstream and become ill). During a review of Resident 13's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/19/2026, the MDS indicated Resident 13 rarely/never able to express ideas and wants and sometimes understands verbal content. The MDS indicated Resident 13 had weight loss of 5% or more and Resident 13 was on feeding tube. During an observation on 5/6/2026 at 3:19 PM, the Tube Feeding (TF) pump was off and there was a full container of Glucerna 1.2 and a full bag of water hanging with a labeled date of 5/6/2026 at 2 PM. During an observation and interview on 5/6/2026 at 3:46 PM, the TF pump's setting indicated flush setting was at 30 milliliter (ml) every 20 hours (hrs) [30m//20hrs]. Licensed Vocational Nurse 2 (LVN 2), stated the TF pump was set at 30 ml every 20 hrs. During a concurrent record review and interview on 5/6/2026 at 3:51 PM, the Director of Nursing (DON) stated Resident 13's physician's order indicated Resident 13 needed 30 ml of flush every hour (30 ml/1hr) to receive 600 ml of water in 20 hours. The DON stated the G-tube feeding pump setting indicated, flush 30 ml every 20 hours. The setting on the pump would mean Resident 13 would get 30 ml. in 20 hours. The DON stated Resident 13 would be getting less hydration than the ordered amount. During an interview and observation on 5/6/2026 at 4:05 PM, the DON stated Resident 13 needed to receive the water as ordered to prevent dehydration, signs and symptoms of dehydration may include tiredness, fatigue, and changes in level of consciousness. The DON checked the resident, Resident 13 was asleep, easily arousable. During a review of the facility's undated Policy and Procedure (P&P) titled, Hydration, the P&P indicated additional fluids may be recommended by the registered dietitian to meet calculated fluid needs. For residents on enteral feedings, fluid need shall be calculated following admission by the registered dietitian. to observe for signs of dehydration, dry mouth, dry skin, and poor skin turgor. 2. During an observation on 5/08/2026 at 8:28 AM, Resident 13 was sitting on a Geri chair (geriatric recliner, a specialized medical chair designed for patients who spend long periods of time sitting) inside the Activity Room with activities ongoing, Resident 13 was awake. There was no TF running at this time. Resident 13's enteral feeding pump was off with no enteral feeding bag hanging. During a concurrent review of Resident 13's physician orders, observation and interview on 5/08/2026 at 9 AM, Resident 13's physician orders indicated Glucerna 1.2 at 45 ml/hr start at 2 PM for 20 hours, stop feeding at 10 AM or until dose is met. Registered Nurse 1 (RN 1) stated LVN 3 turned off the enteral feeding at 8 AM because the dose was completed. RN 1 checked the history of enteral feeding given in 1 day was 802 milliliters. Resident 13 did not received 900 ml of Glucerna per day as the physician ordered. During an interview on 5/8/2026 at 9:15 AM, Licensed Vocational Nurse (LVN 3) stated LVN 3 stopped the enteral feeding because the Electronic Medication Administration Record (EMAR) had turned yellow, LVN 3 stated LVN 3 thought the enteral feeding was complete because it had turned yellow on the electronic Medication Administration Record (eMAR) During an interview on 5/08/2026 at 3 PM, the Regional Registered Dietitian stated the nurses needed to follow the physician order of how much enteral feeding to administer to prevent (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	further weight loss. During an interview on 5/8/2026 at 3:23 PM, the Director of Nursing (DON) stated Resident 13 needed to get the enteral feeding as ordered for the resident to get the required caloric intake. During a review of Resident 13's weight log, the weight log indicated the following weight. Resident 13's weight upon readmission on [DATE] was 104 pounds (lb).On 4/28/2026, weight was 102 lb.On 5/4/2026, weight was 102 lb. During a review of the facility's Policy and Procedure (P&P) titled, Weight Assessment and Intervention, dated August 2025, the P&P indicated resident-centered care plans shall be documented in the IDT - Weight Management Care Plan or thegeneral care plan, and will address:a. Identified cause of weight changesb. Assessment/evaluation for weight changesc. goals and benchmarks for improvement; andd. Interventions/Approaches, which includes but is not limited to .diet modification such as change of food texture, including use of artificial nutrition if indicated, offer food substitutes as needed, adjust the diet frequency, calorie, protein, supplement, food portion/size as needed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure two of 10 sampled residents (Resident 4 and Resident 7) were free from unnecessary medications:1.For Resident 4, the resident did not meet the Mc Geer's criteria (a criteria used to define true infections by providing surveillance criteria the Infection Preventionist (IP) is required to report for definitive case events (i.e., diagnosed infections) and to estimate the actual incidence/prevalence of disease conditions) for the use of Levaquin on 3/19/2026 and ciprofloxacin on 4/22/2026 for true infections. 2. For Resident 7, there was no behavior monitoring for Resident 7 when Resident 7 was prescribed Seroquel (Quetiapine -Quetiapine is FDA approved for schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real), acute manic episodes (A manic episode is a stretch of time when you have one or more symptoms of mania. An episode typically lasts for a week or longer, unless treatment cuts it short). There was no specific behavior indicated on the order for Resident 7's use of Seroquel. These deficient practices had the potential to increase Resident 4's resistance to antibiotics and Resident 7's use of psychotropic medications that could potentially affect the residents physical and psychosocial wellbeing. Findings: 1a. During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 9/26/2025, with diagnoses that included sepsis (life-threatening condition that arises when the body's response to infection injures its own tissues and organs), urinary tract infection (UTI- infection that affects part of the urinary tract). During a review of Resident 4's urine culture results, the report indicated urine was collected on 3/13/2026 with the result released on 3/19/2026. The IP Nurse (IPN) stated Levaquin 500 milligram (mg) was ordered when the urine culture result was released on 3/19/2026. The IPN stated there was no notes to indicate there was communication with the ordering physician that Mc Geer's criteria for a UTI was not met for the use of Levaquin. During a review of Resident 4's Progress Notes dated 3/19/2026 to 3/20/2026, there was no notes to indicate Resident 4 met criteria 1 for UTI with Indwelling Catheter. During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/3/2026, the MDS indicated Resident 4 had intact cognition and Resident 4 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene and personal hygiene. During a concurrent interview and and a review of the facility's Order Listing Report (OLR), on 5/8/2026 at 11:33 AM, with the Infection Prevention Nurse (IPN). Resident 4's OLR dated from 3/1/2026 to 5/31/2026 indicated Resident 4 had an order for Levaquin (antibiotic) 500 mg, one time a day for UTI for 10 days (started on 3/20/2026) and Ciprofloxacin (antibiotic) 500 mg, two times a day (started pm 4/25/2026 until 4/28/2026 at 11:59 PM). The IPN stated Resident 4 had physician orders for antibiotic medications but the IPN did not complete the Mc Geer's Surveillance Collection Form for UTI with Indwelling [urinary] Catheter (Resident 4 had a urinary catheter on 3/20/2026) for the use of Levaquin on 3/20/2026. The IPN stated the facility process the licensed nurses followed when new antibiotic physician orders were received was for licensed nurses to communicate the new orders to the IPN followed by the IPN initiating the facility's antibiotic surveillance and the IPN would check if the use of antibiotics met the McGeer's criteria. The IPN stated, the IPN did not complete the Mc Geer's Surveillance Data for UTI with Indwelling Catheter for the use of Levaquin 500 mg for Resident 4. A review of the Mc Geer's Surveillance Data for UTI with Indwelling Catheter Form indicated criteria 1 and criteria 2 must be present. Criteria 1 consists of at least one of the following; fever, rigors, or new onset hypotension, either an acute change in mental status or acute functional decline, new onset suprapubic pain of costovertebral pain or tenderness, purulent discharge from around the catheter or acute pain, swelling, or tenderness of the the urinary area. Criteria 2 consists of a positive urine culture result. 1b. During a review of Resident 4's Urine Culture collected on 4/22/2026 and resulted on 4/24/2026 with the IPN, the result indicated 2 different bacteria were identified and both bacteria were resistant to Ciprofloxacin. During a review of Resident 4's (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration Record (MAR) for the month of April 2026, the MAR indicated Ciprofloxacin 500 mg was administered to Resident 4 from 4/22/2026 to 4/28/2026. During an interview on 3/8/2026 at 12:15 PM, the IPN stated there was no communication to the ordering physician regarding the results of the urine culture indicating Resident 4 was resistant to Ciprofloxacin. The IPN stated Resident 4 continued to receive Ciprofloxacin. The IPN should taking Ciprofloxacin when the bacteria were resistance to Ciprofloxacin is ineffective in treating UTI and could make Resident 4 more resistant to other antibiotics. During an interview on 5/8/2026 at 3:35 PM, the Director of Nursing stated administering antibiotics to Resident 4 who was resistant to the antibiotics would not be effective in treating UTI. 2. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 4/2/2025, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear. During a review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/7/2026, the MDS indicated Resident 7 had severe cognitive deficit and Resident 7 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene and personal hygiene. During a review of Resident 7's Quetiapine order history for the month of March 2026, the history indicated Resident 7's Quetiapine was discontinued on 10/3/2025 and restarted on 3/29/2026. During a review of Resident 7's current Medication Administration Record (MAR) dated 3/1/2026 to 3/31/2026, the MAR indicated an order for Quetiapine 25 mg. two times a day for agitation (started on 3/26/2026). During a concurrent review of Resident 7's Progress Notes and Change of Condition for March 2026 and interview on 5/7/2026 at 3:15 PM, the MDS Nurse (MDSN) stated there was no documentary evidence Resident 7 exhibited behaviors that would need Seroquel to be restarted. The MDSN stated Seroquel was restarted when Resident 7 was placed on hospice care. During a review of Resident 7's Medication Administration Record (MAR) for March 2026, April 2026 and May 2026 on 5/07/2026 at 2:40 PM, the MDSN stated there was no record of monitoring for behaviors for the use of Seroquel. During an interview on 5/7/2026 at 2:52 PM, the MDSN stated monitoring the specific behavior ordered for the use of Seroquel would determine if the medication was effective at controlling the behavior and a gradual dose reduction could be attempted once the behavior had been controlled. The MDSN stated we need to add the monitoring order when licensed nurses enter the psychotropic orders. During a concurrent review of Resident 7's physician orders and interview on 5/8/2026 at 3:26 PM, the DON stated Seroquel was ordered for agitation, the behavior needed to be specific so the behavior can be monitored by staff. During a review of the facility's Policy and Procedure (P&P) titled, Unnecessary Medication, the P&P indicated the facility will follow state and federal regulations that all residents will be free from unnecessary psychotropic medications and unnecessary drugs. The P&P indicated licensed nurse will review resident's drug regimen based on the following criteria:Excessive doseExcessive durationAdequate indicationAdequate MonitoringPRN Medication, discontinue prn medication if it has not been used for more than 30 days.Presence of adverse consequencesAny combinations of the reasons aboveThe P&P indicated Licensed nurse will communicate with the primary physician in adjusting the medication dosage, duration, frequency and/or discontinue the medication if indicated

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage practices at one of one nurse's station when the residents' (in general) food from home refrigerator was observed with debris and dried liquid on the shelves for two consecutive days.This failure had the potential to result in pests and cross-contamination (transfer of harmful bacteria from one place to another) placing residents (in general) at risk and significantly impacting the residents' health.Findings:During a concurrent observation and interview on 5/7/2026 at 1 PM with the Certified Dietary Manger (CDM), in the Nurse's Station, the residents' (in general) food from home refrigerator was observed with debris on two shelves and dried brown liquid on the main bottom shelf along with dried brown liquid on the side shelf. The CDM stated this was the refrigerator where residents' food from home was stored. The CDM stated the refrigerator was not clean. Additionally, the CDM stated the importance of keeping the refrigerator clean was to prevent cross contamination.During a concurrent observation and interview on 5/8/2026 at 9:35 AM with Registered Nurse (RN) 1, in the Nurse's Station, the residents' (in general) food from home refrigerator was observed with debris on two shelves and dried brown liquid on the main bottom shelf along with dried brown liquid on the side shelf. RN 1 stated the refrigerator needed to be wiped. During a review of the facility's Policy and Procedure (P&P) titled, Refrigerators and Freezers, revised November 2022, the P&P's policy statement indicated, This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. The P&P's policy interpretation and implementation indicated, Refrigerators and freezers are kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often as necessary.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on observation, interview, and record review, the facility failed to implement the facility's antibiotic stewardship program (a coordinated healthcare initiative designed to promote the most appropriate, safe, and effective use of antibiotics [medication that kills or stops bacteria from reproducing]) for one of three sampled residents (Resident 4) by failing to,A. Ensure Mc Geer's criteria (a standardized, evidence-based definitions used to identify and track infections in long-term care facilities, allows healthcare workers to accurately count and monitor infections) for infection surveillance was met for Resident 4 for the use of the Levaquin (antibiotic used to treat serious bacterial infections).B. Ensure Resident 4 was not administered Ciprofloxacin when Resident 4's urine culture and sensitivity (C&S, a two-part laboratory procedure used to diagnose infections) result indicated Resident 4 was resistant (bacteria has changed so antibiotic drugs can no longer kill them or stop the growth, the bacteria causing the infection has adapted, making the disease harder to treat) to Ciprofloxacin.This deficient practice had the potential to result in a physical decline due to an unresolved infection and inappropriate use of antibiotics. Additionally, the deficient practice had the potential to result in antibiotic resistance to Resident 4.Findings:During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 9/26/2025 with diagnoses that included sepsis (a life-threatening blood infection [the invasion and growth of germs in the body]), urinary tract infection (UTI- infection that affects part of the urinary tract).During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 4/3/2026, the MDS indicated Resident 4 had intact cognitive (the ability to think and process information) and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene and personal hygiene.During a review of Resident 4's Order Summary Report (OSR), dated from 3/1/2026 to 5/31/2026, on 5/8/2026 at 11:33 AM with the IPN. Resident 4's OSR indicated physician orders for the following antibiotics:1. Macrobid 100 mg. two times a day for UTI for 10 days, dated 3/13/2026.2. Levofloxacin (Levaquin, potent broad-spectrum antibiotic used to treat serious bacterial infections) 500 mg one time a day for UTI for 10 days, dated 3/20/2026.3. Ciprofloxacin (Cipro, antibiotic used to treat serious or hard-to-treat bacterial infections) 500 mg two times a day for UTI for 7 days, dated 4/22/2026.4. Ciprofloxacin 500 mg, two times a day for UTI until 4/28/2026 at 11:59 PM, dated 4/25/2026.A. During a review of Resident 4's [Mc Geer's] Surveillance Data Collection Form, dated 3/13/2026, the form indicated the following,1. Resident 4 met the criteria for the use of Macrobid 100 mg, two times a day for UTI.2. The form did not indicate if Resident 4 met the criteria for the use of Levaquin.The Surveillance Data Collection Form was not completed for the used of the Levaquin. During a review of Resident 4's urine culture result, urine collection date 3/15/2026, result reported [to the facility] on 3/19/2026. The IPN stated the culture was positive for pseudomonas aeruginosa (type of bacteria). The IPN stated Levaquin 500 mg was ordered when the urine culture result was reported to the facility on 3/19/2026. The IPN stated there was no documented evidence in Resident 4's notes indicating a Surveillance Data Collection Form was completed on 3/19/2026 or 3/20/2026. The IPN stated there was no documented evidence in Resident 4's notes indicating Resident 4 was symptomatic (presented with symptoms) for UTI on 3/20/2026 or communication with the ordering physician regarding results of Resident 4's Mc Geer's criteria for a UTI and the use of Levaquin.During a review of Resident 4's Lab Results Report, collection date 3/15/2026, the report indicated for long-term care patients [residents], most positive urine cultures represent asymptomatic bacteriuria (presence of bacteria in the urine) or contamination with urogenital flora (the natural community of harmless bacteria that normally inhabit the urinary and reproductive tracts). The report indicated antibiotic therapy is not recommended without signs and symptoms localizing to the urinary tract.During a review of Resident 4's Progress Notes dated 3/19/2026 to 3/20/2026, there was no documented evidence in the notes indicating Resident 4 met criteria 1 for the used of Levaquin.During an interview on 5/5/2026 at 8:54 AM with Resident 4, (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4 stated Resident 4 was being administered antibiotics at the facility but had been off antibiotics for 20 days. Resident 4 stated Resident 4 completed antibiotic treatment and had another UTI days later. Resident 4 stated the indwelling catheter (tube left in the bladder [hollow muscular balloon-like organ that stores urine] to drain urine) was removed 4 days ago.During an interview on 5/8/2026 at 11:23 AM with the Infection Prevention Nurse (IPN), the IPN stated the IPN did not complete the Mc Geer's Surveillance Collection Form for UTI with Indwelling [urinary] Catheter (Resident 4 had a urinary catheter on 3/20/2026) for the use of Levaquin on 3/20/2026. The IPN stated the facility process the licensed nurses followed when new antibiotic physician orders were received was for licensed nurses to communicate the new orders to the IPN followed by the IPN initiating the facility's antibiotic surveillance and the IPN checking if the use of antibiotics met the McGeer's criteria.B. During a review of Resident 4's urine culture, collection dated 4/22/2026, resulted on 4/24/2026, the result indicated 2 different bacteria were identified and both were resistant to Ciprofloxacin.During a review of Resident 4?s Medication Administration Record (MAR), dated for the month of April 2026, the MAR indicated Ciprofloxacin 500 mg was administered from 4/22/2026 to 4/28/2026.During an interview on 5/8/2026 at 12:15 PM with the IPN, the IPN stated there was no documented evidence (notes) indicating the ordering physician was notified of the urine culture results indicating Resident 4 was resistant to Ciprofloxacin. The IPN stated Resident 4 continued to receive Ciprofloxacin and Ciprofloxacin could be ineffective in treating Resident 4's UTI and [the continuing the medication] could make Resident 4 more resistant to antibiotics.During an interview on 5/8/2026 at 3:35 PM with the Director of Nursing (DON), the DON stated administering an antibiotic that Resident 4 was resistant to [Ciprofloxacin] could result in the antibiotic not being effective, the UTI go unresolved, or recurrent UTIs to Resident 4.During a review of the facility's Policy and Procedure (P&P) titled Antibiotic Stewardship, dated 1/2020, the P&P's purpose indicated the antibiotic stewardship program is to monitor the use of antibiotics in the residents. The P&P indicated training, and education will include emphasis on the relationship between antibiotic use and gastrointestinal disorders, opportunistic infections medication interactions and the evolution of drug-resistant pathogens. The P&P indicated when a culture and sensitivity (C&S) is ordered, lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide discharge notification documentation for one of one sampled resident (Resident 49) as indicated in the facility's Policy and Procedure (P&P) titled, Transfer or Discharge Notice, when Resident 49's Notice of proposed transfer and discharge (a document a nursing facility must give a resident and/or their representative before the resident is moved out of the facility, explaining why the resident is being discharged , where they are going, the effective date, their right to appeal, and how to contact the State Longˆ Term Care Ombudsman [an advocate who helps protect the rights, safety, and well-being of residents in nursing homes and other long-term care facilities]) was not given to the Ombudsman following Resident 49's discharge on [DATE].This failure resulted in the State Long-Term Care Ombudsman being uninformed of Resident 49's discharge and had the potential to result in Resident 49's discharge needs not being met.Findings:During a review of Resident 49's admission Record (AR), the AR indicated Resident 49 was originally admitted to the facility on [DATE] and readmitted on [DATE] and 1/22/2026 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) and schizoaffective disorder (a mental illness causing a person to experience dramatic changes in thoughts, moods, and behaviors).During a review of Resident 49's History and Physical (H&P), dated 1/23/2026, the H&P indicated Resident 49 did not have the capacity to understand and make decisions.During a review of Resident 49's Minimum Data Set (MDS- a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 49's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 49 required supervision or touching assistance with oral, toileting, and personal hygiene and showering, required setup or clean-up assistance with dressing and was independent with eating.During a review of Resident 49's Notice of Proposed Transfer and Discharge, dated 2/18/2026, the notice indicated Resident 49 was discharged on 2/18/2026.During an interview on 5/7/2026 at 3:04 PM with the Social Services Director (SSD), the SSD stated it was the practice of the facility to send discharge notifications to the Ombudsman via fax within 30 days of the residents' (in general) discharge date . The SSD stated the facility did not send Resident 49's discharge notification to the Ombudsman. Additionally, the SSD stated it was important to notify the Ombudsman regarding Resident 49's discharge to ensure the Ombudsman could check on the resident if needed.During a review of the facility's P&P titled, Transfer or Discharge Notice, revised March 2021, the P&P's policy statement indicated, Residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge. The P&P's policy interpretation and implementation indicated, A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one resident's (Resident 1) diagnosis of depression was accurately reflected in the Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/14/2026.This deficient practice resulted in inaccurate Medical Record for Resident 1 and had the potential for Resident 1 to have unmet needs.Findings:During a review of Resident 1's admission Record, (AR) the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including depression (mood disorder causing persistent sadness, emptiness, or irritability, along with loss of interest in activities once enjoyed), anxiety (persistent, excessive, and uncontrollable fear or worry that interferes with daily life) and dementia (a gradual decline in mental ability usually caused by a brain disease.)During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had impaired cognition (ability to understand and process information) and required substantial/ maximal assistance for toileting and bathing. The MDS did not indicate Resident 1 had a diagnosis for depression.During a review of Resident 1's Order Summary Report (OSR) dated with active orders as of 5/7/2026, the OSR indicated Resident 1 had a physician order for Mirtazapine (antidepressant) tablet 7.5 milligrams (mg- unit of weight) by mouth at bedtime for depression manifested by poor oral intake of less than 50% of meals with start date 3/12/2026.During an interview on 5/8/2026 at 11:50 AM with the MDS nurse (MDSN), the MDSN stated there was a discrepancy on Resident 1's MDS and Resident 1 should have been marked as having depression because Resident 1 was actively taking medication for depression at the time. The MDSN stated it is important to have accurate information on the MDS so that it could be reported to Resident 1's insurance and ensure Resident 1's insurance is informed of Resident 1's current treatments.During a review of the facility's policy and procedure (P&P) titled, Record Content, dated 1/04, the P&P indicated, a resident's health record should be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555106	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Lodge	5053 Peck Rd. El Monte, CA 91732

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure a liquified diet was served as ordered by the physician for one of one sampled resident (Resident 3) who had a history of dysphagia (difficulty swallowing).The deficient practice had the potential to result in complications like aspiration pneumonia (lung infection [the invasion and growth of germs in the body] caused by inhaling foreign substances like food into the airways rather than swallowing them), choking, and a physical decline to Resident 3.Findings:During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 6/9/2016, with diagnoses that included dementia (a progressive state of decline in mental abilities) and dysphagia. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 3/7/2026, the MDS indicated Resident 3 had severe cognitive (the ability to think and process information) deficit and was dependent with activities of daily living such as eating, oral hygiene, toileting hygiene.During a review of Resident 3's Order Summary Report (OSR), the OSR indicated a physician's order, dated 4/9/2026, for a regular diet, liquidized texture. Okay with Speech Therapist (ST) for liquidized pureed (food that is smooth and easy to swallow and digest) items for all meals for ease of swallow. During an observation on 5/5/2026 at 12:28 PM, Certified Nursing Assistant (CNA) 1 assisted Resident 3 with lunch, there were three cups with liquids inside on Resident 3's bedside: 1 brown colored thickened liquid, 1 light brown colored liquified food, and a cup of dark yellow liquified food. There was one bowl of yellow colored mashed food.During the following observations on 5/5/2026,At 12:36 PM CNA 1 started to feed the mashed food to Resident 3, Resident 3 did not cough.At 12:37 PM CNA 1 continued to feed the mashed food and assisted Resident 3 to drink from a glass of milk.At 12:37 PM CNA 1 fed Resident 3 a third halfway full spoon of mashed food.At 12:41 PM, the Director of Nursing (DON) tested the mashed food with CNA 1 using the spoon tilt test (placed mashed food on the spoon and tilted the spoon down after 20 seconds) the mashed food did not fall from the spoon. During an interview on 5/5/2026 at 12:50 PM, the DON stated ordered food needed to be in the form it was ordered to prevent choking.During an observation on 5/5/2026 12:51 PM, the DON tilt tested the brown colored food, the light brown colored food, and the dark yellow food using the spoon. The liquid food fell off the spoon quickly; the other foods did not fall off the spoon.During an interview on 5/5/2026 at 1:19 PM with the Regional Registered Dietitian (RRD), the RRD stated a syringe was used to test a liquidized diet (flow test to ensure the liquid is the correct, safe thickness for individuals with swallowing difficulties, how fast the liquid flows through the syringe in 10 seconds).During an interview on 5/5/2026 at 1:30 PM, the [NAME] stated Resident 3 was on a liquified diet, and the bowl of mashed food on Resident 3's tray must have been a mistake. The [NAME] stated a liquified diet was tested by using a syringe. The [NAME] showed the facility's supply of special syringes used to conduct these tests. The [NAME] stated providing liquified diet as ordered [by the physician] prevented Resident 3 from choking. The [NAME] stated the dark brown liquified food was pork roast, the light brown liquified food was mixed vegetables, the dark yellow liquified food was rice pilaf, and the yellow-colored food was lemon bar.During a review of the facility's lunch recipe/menu, dated 5/5/2026, the menu included pork roast, rice pilaf, mixed vegetables, and lemon bar.During a review of the Complete International Dysphagia Diet Standardization Initiative (IDDSI) Framework, dated 4/2026, the IDDSI developed a standard that can be used to describe the characteristics of foods and drinks - from the point of view of a person with swallowing difficulties. To accompany this standard, the IDDSI has also developed testing methods to determine if any food or drink conforms to the requirements of the IDDSI Standard) Framework consisted of 8 levels (0-7) where Level 7 is regular food, Level 6 is soft and bite-sized (1.5 centimeter in size of adults), Level 5 is minced and moist (can be scooped and shaped, testing method includes the spoon tilt test where a full spoonful must fall off easily if the spoon if the spoon is tilted with very little food left on the spoon), Level 4 Pureed, Extremely Thick with a testing (continued on next page)

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	555106	A. Building B. Wing	05/08/2026

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	method using a spoon, a spoonful must plop off the spoon if the spoon is titled or turned sideways; a very gentle flick (using only fingers and wrist) may be necessary to dislodge the sample from the spoon, but the sample should slide off easily with very little food left on the spoon. Level 3 Liquidized (can be tested using a spoon tilt test, a full spoonful must plop off the spoon if the spoon is titled or turned sideways; a very gentle flick (using only fingers and wrist) may be necessary to dislodge the sample from the spoon, but the sample should slide off easily with very little food left on the spoon. Level 2 Mildly Thick Liquid (food flows off the spoon), Level 1 Slightly Thick Liquid (slightly thicker than water with a testing method using the syringe test and Level 0 (Thin Liquids, flows like water).During a review of the facility's undated Policy and Procedure (P&P) titled Food Preparation Policy the P&P indicated all modified diets, and thickened liquids will be prepared and served in accordance with the IDDSI Framework.