STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555114	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Driftwood Healthcare Center	4109 Emerald St Torrance, CA 90503

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the nursing staff failed to ensure the call light device was in reach for one out of three residents (Resident 1). This deficient practice had the potential to result in a delay of care and the Resident 1 needs not being met. Findings: During a concurrent observation and interview on 8/6/2025 at 4:00 p.m. with Resident 1, Resident 1 was in bed with the call light next to his lower right hip. Resident 1 stated he would like to call for help but is not able to call his nurse. Resident 1 stated when he needs help, he usually yells to his roommate to call a nurse when he needs assistance. During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses including functional quadriplegic (a complete inability to move due to severe physical disability or frailty without any physical injury), hypotension (low blood pressure) and contracture of muscles multiple sites (multiple muscles have become permanently shortened and stiff where the cannot move).During a review of Resident 1's History and Physical (H&P), dated 6/22/2025, the H&P indicated, Resident 1 has the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 6/29/2025, the MDS indicated Resident 1 is dependent (helper does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) on eating , oral hygiene, toilet hygiene, shower/bathe self, upper and lower body dressing. During a review of Resident 1's the Care Plan (CP) dated 6/24/2025, the CP, interventions indicated to monitor and anticipate needs assisting with turning and repositioning, keep call light in reach and answer promptly. During an interview on 8/6/2025 at 4:15 p.m., with Resident 1's roommate (Resident 41), Resident 41 stated he usually helps to call a nurse for Resident 1 by calling a nurse on his cell phone. During a concurrent observation and interview on 8/6/2025 at 4:30 p.m. with Certified Nurse Assistant (CNA) 1 at Resident 1's bedside, CNA 1 stated Resident 1 could not reach his call light. CNA 1 stated that because Resident 1 could not reach the call light, his needs could not be addressed. During an interview on 8/8/20205 at 10:00 a.m., with Registered Nurse 2 (RN) 2, RN 2 stated the call light should have been placed near Resident 1's chest so he could reach it. RN 2 stated it was important to have the call light in reach so Resident 1's needs can be met immediately. During an interview on 8/8/2025 at 3:38 p.m. with the Director of Nursing (DON), the DON stated the call light should be within reach of Resident 1 preferably next to his head. The DON stated that when Resident 1 cannot reach his call light, his needs cannot be met. During a review of the facility's P&P titled Communication- Call System dated 10/9/2024, the P&P indicated: Upon admission, each resident will be instructed how to use the call alert system. The P&P indicated, the call alert device will be placed within the resident's reach. The P&P indicated an adaptive call alert system will be provided to the residents who are unable to utilize the general alert call system.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interview and record review, the facility failed to investigate a claim of missing belongings for one of eight sampled residents (Resident 8).This deficient practice resulted in Resident 8 missing her blanket for three months.Findings:During a review of Resident 8's admission Record (face sheet), the admission Record indicated Resident 8 was admitted to the facility 10/26/2018 with diagnoses including muscle weakness and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 5/19/2025, the MDS indicated Resident 8 had severe cognitive impairment (inability to plan and carry out regular tasks and apply judgment).During a review of Resident 8's Inventory of Personal Effects dated 4/24/2024 and updated on 7/28/2025, the Inventory of Personal Effects section under lost, and stolen was updated to include four blankets missing per family member (FM) 1.During a review of Resident 8's Theft/ Loss Report dated 8/7/2025, the report indicated Resident 8's family member (FM) 1 stated 1 pink and red blanket with hearts was missing for three months.During an interview on 8/6/2025 at 10:37 a.m., with FM 1, FM 1 stated the facility does Resident 8's laundry and three months ago she informed the nursing staff (unknown) Resident 8's Valentine blanket with hearts was missing and still not found.During an interview on 8/7/2025 at 2:33 p.m., with the social services director (SSD), the SSD stated she had not been informed by nursing staff when FM 1 reported the missing blanket. The SSD stated if she had been informed, she would have tried to find the missing blanket and replaced the blanket if appropriate. The SSD stated she spoke with FM 1 who verified the blanket had been missing for three months (unknown actual date) and FM 1sent the SSD a photo of Resident 8 using the missing blanket while in the facility. The SSD stated FM 1 informed her that FM 1 had reported the missing blanket to multiple certified nursing assistants (CNAs) and charge nurses (unidentified) when the blanket first went missing. The SSD stated that although the blanket had not been logged into the inventory list, the photo verified Resident 8 had the blanket while in the facility so if the facility was unable to locate the item, the facility would replace the blanket. The SSD stated the nurses are supposed to report missing items to her in a timely manner (within a day or two) so the missing item could be investigated. The SSD stated it was important to investigate missing items in a timely manner, so the residents and their family know the facility cares about their grievances and acts upon them. The SSD stated if she was aware, she could have tried to locate the item or replace it sooner. The SSD stated not knowing caused a delay in action.During an interview on 8/8/2025 at 3:33 p.m., with the director of nursing (DON), the DON stated missing items needed to be reported to the SSD right away (within a day or two). The DON stated it was important to investigate the missing item quickly because if the missing item was wanted or needed by the resident it could affect the way the resident feels, and the item might be important to them.During a review of the facility's policy and procedure (P&P) Theft and loss dated 7/11/2017, the P&P indicated all inquiries regarding lost or stolen items are reported to the administrator and/or designee (SSD). The P&P indicated when personal property was reported missing, the staff will immediately begin a search for the missing property.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure psychotropic medications (medications that affect brain activities associated with mental processes and behavior) were not used unnecessarily for one of five sampled residents (Resident 66) by failing to define and monitor resident specific, measurable target behaviors related to the use of Seroquel [an atypical antipsychotic used to improve mood, thoughts, and behaviors] for people with schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs)] for Resident 66.These deficient practices increased the risk of Resident 66 experiencing adverse effects (unwanted or dangerous medication-related side effects) such as drowsiness, dizziness, constipation, or increased risk of fall, and possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status.Findings:During a review of Resident 66's admission Record, the admission Record indicated, Resident 66 was admitted to the facility on [DATE] with diagnoses including Lewy Bodies dementia (a disease associated with abnormal deposits of a protein called alpha-synuclein in the brain), delusional disorder (a mental health condition characterized by persistent, false beliefs that are not based on reality), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 66's History and Physical (H&P), dated 7/1/2025, the H&P indicated, Resident 66 had no capacity (ability) to understand and make decisions.During a review of Resident 66's Minimum Data Set (MDS - a resident assessment tool), dated 7/7/2025, the MDS indicated Resident 66 required maximal assistance (Helper does more than half the effort) from one staff for transfer, dressing, moderate assistance (Helper does less than half the effort) from one staff for hygiene, supervision or touching assistance (Helper provides verbal cues and /or touching/steadying and /or contact guard assistance as resident completes activity) from one staff for bed mobility, and set up or touching assistance (Helper sets up or cleans up) for eating. The MDS section E (behavior) indicated, Resident 66 did not have physical and verbal behavioral symptoms directed toward others. The MDS section E indicated Resident 66 did not have hallucination (an experience involving the apparent perception of something not present) and delusions (something that is believed to be true or real but that is false or unreal). The MDS section E indicated Resident 66 did not have behavior related to rejection of care.During a review of Resident 66's Care Plan (CP), revised on 7/10/2025, the CP Focus indicated, Resident 66 uses psychotropic medication for psychosis. The CP Goal indicated, Resident 66 will be free from psychotropic drug related complications. The CP Interventions indicated, give one tablet of Seroquel by mouth 50 mg once a day and at bedtime for psychosis manifested by delusional thoughts and sexually inappropriate thoughts.During a review of Resident 66's Psychiatric Assessment/Evaluation/ Consultation, dated on 7/16/2025, the Psychiatric Assessment/Evaluation/ Consultation indicated, Resident 66 did not hallucinate, delusions, or behavioral issues.During a concurrent interview and record review on 8/7/2025, at 4:16 p.m., with Registered Nurse (RN) 4, Resident 66's Order Summary Report (OSR), dated 8/7/2025 was reviewed. The OSR indicated, to monitor target behaviors for use of Seroquel due to psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by psychomotor agitation (a state of restlessness and anxiety that results in repetitive and unintentional movements) and indicate the number of behavior occurrences ordered on 7/7/2025. The OSR indicated to give Seroquel 50 milligram (mg [unit of measurement]) one tablet by mouth once a day and 50 mg at bedtime (total of 100 mg per day) for psychosis. RN 4 stated, she was not sure what psychomotor agitations to monitor for Seroquel. RN 4 stated, target behavior should be specific and measurable, so a psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) could refer to and consider Gradual Dose Reduction (GDR- a systematic approach to stepwise tapering of medication dosage to assess if a lower dose can effectively manage symptoms, conditions, or risks, or if the medication can be discontinued entirely). RN 4 stated, the staff should monitor specific target behaviors. During a concurrent interview and record review on 8/8/2025, at 9:45 a.m., with RN 1, Resident 66's Medication Administration Record (MAR), dated from 7/7/2025 to 8/6/2025 was reviewed. The MAR indicated there was no psychomotor agitation. RN 1 stated, she did not witness any agitation since Resident 66 was admitted from the General Acute Care Hospital (GACH). RN 1 stated that monitoring psychomotor agitations should be clarified with psychiatrist because they are too general as a target behavior. RN 1 stated, if the target behavior was not specific and measurable for the

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one out of two sampled residents (Resident 6) had their Level 1 Preadmission Screening and Resident Review ([PASRR], a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) completed accurately. This deficient practice had the potential to delay care for Resident 6 and had the potential of not receiving the proper level of care or services required.Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance or illness elsewhere in the body that disrupts the brain's normal functioning, leading to various brain symptoms), rhabdomyolysis (a serious condition where damaged muscle tissue breaks down, releasing its contents into the bloodstream that can lead to kidney damage), post-traumatic stress disorder ([PTSD], a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it), and anxiety (a mental health condition that cause fear, dread and other symptoms that are out of proportion to the situation). During a review of Resident 6's Minimum Data Set ([MDS], a resident assessment tool) dated 6/5/2025, the MDS indicated Resident 6 had intact cognitive (thought process) function and was set up assistance (helper sets up while resident completes the activity) with self-care abilities such as eating, oral hygiene, personal hygiene and upper body dressing. The MDS indicated a mood total severity score (indicates the overall severity of a person's depression or mood disturbance) of 13 (5-9 indicating mild, 10-14 indicating moderate, involves a greater number of symptoms and a more significant impact on daily functioning).During a review of Resident 6's Order Summary Report DATED 7/31/2025, the Order Summary Report indicated Sertraline (a prescription medication used to treat depression and other mental health conditions) Tablet (pill) 100 milligram ([mg], a unit of measurement) give one tablet by mouth one time a day for depression manifested by excessive worries of life situation ordered on 8/6/2025, alprazolam (a prescription medication used to treat anxiety disorder, and panic disorder) oral tablet 0.5 mg give one tablet by mouth every morning and at bedtime for anxiety manifested by irritability (a state of increased sensitivity and a tendency to react with anger, frustration, or annoyance to stimuli, often triggered by small things)/restlessness ordered on 7/31/2025. During a review of Resident 6's PASRR Level 1 screening dated 5/29/2025, the PASRR Level 1 screening was negative, and a Level 2 screening was not required. The reason noted for Resident 6's negative PASRR Level 1 screening was no serious mental illness. The PASRR Level 1 indicated NO was checked on question number nine, does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance. There was no other screening done for Resident 6 after this screening was completed.During a concurrent interview and record review on 8/8/2025 at 11:16 a.m. with the Director of Nursing (DON), the PASRR Level 1 screening dated 5/29/2025 was reviewed. The DON stated the PASRR Level 1 screening, on question number nine, should have been answered YES to trigger a Level 2 screening to be done. The DON stated Resident 6 started on new psychotropic medications after the first screening was done and that a resident review status change screening should have been done. The DON stated the importance of an accurate PASRR screening assessment was if a resident was positive for mental illness, the facility can provide appropriate care and treatment services for the resident. The DON stated residents who are positive for mental illness, a psychology/psychiatry consultation would be ordered, and care plan would be updated accordingly. During a review of the facility's policy and procedure (P&P), titled admission Screening Resident Review (PASRR), revised 4/24/2024, The P&P indicated the Facility MDS Coordinator will be responsible for accessing and ensure updates to the PASRR are completed by MDS guidelines such as significant change of statues MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a care plan for two of the three sampled residents (Resident 52 and Resident 6) by failing to:A. Ensure Resident 52 had a care plan for impaired hearing. B. Ensure Resident 6 who had a diagnosis of post-traumatic stress disorder ([PTSD], a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it), had a care plan and included the use of psychotropic medications for mood disorders. These deficient practices had the potential to negatively affect the quality of life and wellbeing for Resident 6 and Resident 52 and could result in preventing them from achieving their highest practical well-being or needs not being met. Findings: A. During a review of Resident 52’s admission Record, the admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses including muscle weakness, type 2 diabetes mellitus (high blood sugar) and major depressive disorder (a mental illness that negatively affects how you feel, think and act). During a review of Resident 52’s Minimum Data Set ([MDS], a resident assessment tool) dated 6/12/2025, the MDS indicated Resident 52’s cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 52 was dependent on toilet hygiene, substantial /maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) on shower/bathe self, upper and lower body dressing and partial/moderate assistance (helper does more than half the effort) with oral hygiene personal hygiene and upper body dressing. During a concurrent interview and record review on 8/8/2025 at a.m., with the Social Service Director (SSD), the SSD stated Resident 52 has signs of hearing loss. The SSD stated it is important that the resident has a care plan to address her hearing loss so that everyone is aware and knows how to care for the resident. During an interview on 8/8/2025 at 3:38 p.m., with the Director of Nursing (DON), the DON stated that because Resident 52 is hard of hearing there should have been a care plan initiated. The DON stated that when you are talking to Resident 52 her needs may not be met because she is hard of hearing. A review of the facility's policy and procedure (P&P) titled Person- Centered Care Planning, with a revised date of 4/24/2025, indicated the baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. The P&P indicated it should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision and behavioral interventions, and assistance with activities of daily living. B. During a review of Resident 6’s admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including PTSD, anxiety (a mental health condition that cause fear, dread and other symptoms that are out of proportion to the situation), opioid (a class of drugs that are used to reduce moderate to severe pain) use disorder (a mental health condition where a pattern of opioid use affects your health and daily life), and muscle weakness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6’s MDS dated [DATE], the MDS indicated Resident 6 had intact cognitive (thought process) functioning and was set up assistance (helper sets up while resident completes the activity) with self-care abilities such as eating, oral hygiene, personal hygiene and upper body dressing. During a review of Resident 6’s Order Summary Report, the Order Summary Report indicated Sertraline HCl (a prescription medication used to treat depression and other mental health conditions) tablet (pill) 100 milligram ([mg], a unit of measurement) give one tablet by mouth one time a day for depression manifested by excessive worries of life situation ordered on 8/6/2025, and alprazolam (a prescription medication used to treat anxiety disorder, and panic disorder) oral tablet 0.5 mg give one tablet by mouth every morning and at bedtime for anxiety manifested by irritability (a state of increased sensitivity and a tendency to react with anger, frustration, or annoyance to stimuli, often triggered by small things) or restlessness ordered on 7/31/2025. During a review of Resident 6’s untitled care plan dated 5/30/2025, the care plan did not indicate a goals or interventions for PTSD, or the use of psychotropic medications. There was no care plan in place for the focus, goals, and interventions for Resident 6’s diagnosis of PTSD or psychotropic medications used for mood disorders. During a concurrent observation and interview on 8/5/2025 at 10: 06 a.m. with Resident 6 in their room, Resident 6 stated she went through trauma in the past and has PTSD but did not want to discuss it any further. Resident 6 stated the facility staff are aware of the past trauma. During a concurrent interview and record review on 8/8/2025 at 10:52 a.m., with the Social Service Director (SSD), the untitled care plan dated 5/30/2025 was reviewed. The SSD stated there should be a care plan for Resident 6’s PTSD diagnosis. The SSD stated the importance of having a care plan for PTSD was so the facility staff that care for the residents can care for them with caution. During a concurrent interview and record review on 8/8/2025 at 2:58 p.m. with the Director of Nursing (DON), the untitled care plan dated 5/30/2025 was reviewed. The DON stated there should be a care plan in place for Resident 6’s PTSD diagnosis and the psychotropic medications Resident 6 was taking for mood disorders. The DON stated having a care plan for PTSD was important so facility staff can be aware of resident’s triggers and how to care for the residents appropriately. The DON stated if there was no care plan for PTSD, facility staff may retrigger the trauma and it may affect the resident’s mood, and affect the resident’s activities of daily living, and everyday life. The DON stated the importance of a care plan for the psychotropic medication Resident 6 was taking was the medication may alter the resident’s moods and behaviors and that the care plan lets facility staff know how to monitor for side effects of the medication, if the medication was targeting behaviors it was ordered for and if the medication was effective at targeting the behaviors. The DON stated the importance of having a comprehensive person-centered care plan was, so the facility staff are providing appropriate care for the residents, addressing any issues medically, and emotionally. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s policy and procedures (P&P) titled Person Centered Care Planning revised 4/24/2025, indicated, trauma informed care is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. The P&P indicated the facility must develop and implement comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: the services that are to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial wellbeing, the services provided or arranged by the facility, as outlined by the comprehensive care plan, must be culturally competent and trauma informed. The P&P indicated comprehensive care plans must be reviewed and revised by the interdisciplinary team after each assessment, including both comprehensive and quarterly review assessments.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure a medication listed on the oral medications' Emergency kit (Ekit) index (list) matched the medication found inside the Ekit.This failure had the potential to result in a delay in the administration of emergency medication and medication error. Findings: During an observation and concurrent interview with Registered Nurse (RN) 1 at Nurses' Station 1 of the Ekit on 8/7/2025 at 11:27 a.m., the medication listed on slot number 25 in the Ekit medication list indicated potassium chloride 20 milliequivalents (mEq, unit of weight). The medication observed in slot 25 was four tablets of nitrofurantoin 50 milligrams (mg, unit of weight). Registered Nurse (RN) 1 stated the pharmacist verifies the Ekit contents when delivered to the facility. RN 1 stated if a medication was not in the Ekit, there was a risk for medication error, or delay in administration of the needed medication.During a telephone interview on 8/7/2025 at 11:47 a.m., the dispensing pharmacist (Pharmacist) stated Ekits were re-filled when a licensed nurse makes a request. The Pharmacist stated the on-duty pharmacist was responsible for verifying Ekit contents with the medication list on the front of Ekit. The Pharmacist stated if there was a discrepancy between Ekit contents and list then the Ekit should be returned to the pharmacy to be fixed. During a review of the facility's policy titled Emergency Pharmacy Service and Emergency Kits updated February 2020, the policy indicated Emergency kits are monitored/inventoried by the consultant pharmacist at least every 30 days for completeness and expiration dating of the contents.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the nursing staff failed to document monitoring on the medication administration record (MAR) for signs and symptoms of bleeding for one out of three residents (Resident 63) who is on Apixaban (a medication that thins the blood, prevents clots). This deficient practice had the potential to result in Resident 63 having blood in the stool or urine, bruising or severe headaches. Findings:During a review of Resident 63's admission Record (face sheet) dated 8/8/2025, the admission record indicated Resident 63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypotension (low blood pressure), hyperlipidemia (high cholesterol) and atrial flutter (a heart rhythm disorder where the upper chambers of the heart beat very rapidly, typically between 250 and 350 times per minute).During a review of Resident 63's MDS dated [DATE], the MDS indicated Resident 63 was dependent (resident does none of the effort to complete the activity or the assistance of two or more helpers is required to for the resident to complete the activity) on toilet transfer, chair/bed to chair transfer, toilet hygiene, shower/bathing self, oral hygiene and lower and upper body dressing. During a review of Resident 63's Order Summary Report dated 1/19/2025, the report indicated Resident 63 had an active order for Apixaban oral tablet 2.5 mg (unit of measure) 1 tablet two times a day. During a review of Resident 63's Care Plan (CP) initiated 1/28/2025, the CP indicated to monitor and document every shift for signs and symptoms of bleeding related to Apixaban. During a concurrent interview and record review on 8/8/2025 at 09:31 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 reviewed Resident 63's MAR. LVN 1 stated Resident 63 has not been monitored for the use of the Apixaban. LVN 1 stated the monitoring should have been documented and recorded on Resident 63' s MAR. LVN 1 stated the licensed nurses are not documenting monitoring for episodes of bleeding and bruising, which is important so we can notify the doctor. During an interview on 8/8/2025 at 10:00 a.m., with Registered Nurse 2 (RN 2), RN 2 stated Resident 63 is on an Apixaban, and it should be monitored and documented for bleeding every shift. During an interview on 8/8/2025 at 3:38 p.m., with the Director of Nursing (DON), the DON stated Apixaban is an anticoagulant, and we must monitor bleeding and bruising. The DON stated monitoring should be on the MAR and because it is not documented on the MAR this means we are not monitoring episodes of bleeding. During a review of the facility's Policy and Procedure (P&P) titled, Medication- Black Box Warning, revised July 2018, the P&P indicated:1. The Licensed Nurse will review the Black Box Warning (the most serious type of warning required by the U.S. Food and Drug Administration (FDA) on the labeling of prescription drugs) for signs and symptoms of those high risks medication(s) for health risks and monitor.2. The Licensed Nurse will document signs and symptoms related to parameters and document any adverse consequences in nursing progress notes or on the MAR.3. The Licensed Nurse will inform the Attending Physician of any signs and symptoms related to monitoring parameters and /or any adverse consequences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper medication storage according to requirements indicated on the pharmacy label and labelling medications when: 1.One vial of unopened Humulin R [type of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication)] was not stored inside the refrigerator. 2.One bottle of unopened latanoprost eye drops (medication used to manage elevated pressure in the eye) was not stored inside the refrigerator. 3.One bottle of artificial tears (lubricating eye drops used to help relieve dry and irritated eyes) was not labeled with resident's full name, bottle showed room number, had a broken seal, and no open date. 4. One bottle of omeprazole sodium liquid (medication used to reduce stomach acid) was not removed from use after the label discard date of 8/6/2025. 5. One bottle of AZO Cranberry (used to aid in maintaining urinary tract health) was not labeled with an open date.6. Voltaren External Gel 1% (Brand name for Diclofenac Sodium topical gel, used to relieve arthritic pain) was not labeled with an open date.These deficient practices had the potential to result in medication errors, reduced therapeutic effects, and adverse outcomes from administering the wrong or expired medications, including loss of medication efficacy. Findings: 1.During a review of Resident 38's admission Record, the admission Record indicated the facility admitted the resident on 6/2/2020, with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paraplegia (loss of movement and or sensation, to some degree, of the legs) and dementia (progressive state of decline in mental abilities). During a review of Resident 38's History and Physical (H&P) dated 6/2/2020, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 38's Minimum Data Set (MDS-a resident assessment tool) dated 5/212025, indicated the resident had severely impaired cognition (ability to think and understand). The MDS indicated the resident was dependent on staff for bed mobility, locomotion, dressing and personal hygiene. During a review of Resident 38's Order Summary Report, a physician's order dated 2/8/2022, indicated to administer Humulin R insulin subcutaneously two times a day for DM. During a review of Resident 38's Medication Administration Record (MAR), the MAR indicated Humulin R insulin was administered to the resident on 8/7/2025, during the 6:30 a.m. medication administration. During a concurrent observation and interview on 8/7/2025 at 10:36 a.m., with Licensed Vocational Nurse 1 (LVN) 1, Resident 38's Humulin R insulin vial was unopened with yellow top seal (cap) and label indicated Refrigerate was found inside medication cart 3. LVN 1 stated medications need to be at certain temperature to work and if improperly stored, residents may get adverse reactions. During an interview on 8/7/2025, at 3:38 p.m., with the Director of Nursing (DON), the DON stated medications are refrigerated to maintain stability and potency and may have reactions if not kept at a certain temperature. During a review of facility's policies and procedures (P&P) titled Medication Storage in the Facility updated on 8/2019, indicated medications requiring refrigeration or temperatures between 2 C (36F) and 8C (46F) are kept in a refrigerator with a thermometer to allow temperature monitoring. The P&P also indicated outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication, and reordered from the pharmacy, if a current order exists. During a review of facility's P&P titled Medication Ordering and Receiving from Pharmacy updated on 2/2020, indicated each prescription medication label includes resident name, medication name, strength of medication, date dispensed, specific directions for use, prescriber name, quantity of medication, prescription number, dispensing pharmacy name, address, telephone number and beyond use or expiration date of medication. 2. During a review of Resident 100's admission Record, the admission Record indicated the facility admitted the resident on 11/10/2023, and was readmitted on [DATE], with diagnoses including glaucoma (a group of eye diseases that damage the optic nerve, which is crucial for sending visual information to the brain), paraplegia (loss of movement and or sensation, to some degree, of the legs) and generalized muscle weakness. During a review of Resident 100's Minimum Data Set (MDS- a resident assessment tool) dated 7/13/2025, the MDS indicated the resident had moderately impaired cognition (ability to think and understand). The MDS indicated the resident was dependent on staff for toileting hygiene, bathing and lower body dressing. The MDS indicated total dependence on staff for bed to chair transfers. During a review of Resident 100's Order Summary Report, a physician 's order dated 8/6/2025, indicated to instill latanoprost 0.005% solution 1 drop in both eyes at

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to store food in a sanitary manner to prevent growth of microorganisms (an organism that can be seen only through a microscope) that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as toxins) for 85 out of 91 total residents in the facility by failing to:A. Ensure food items were labelled, dated, and sealed properly.B. Discard expired thickened water and kiwi strawberry flavored syrup for juice dispenser.C. Follow a meal ticket/tray card during tray line (Resident's trays are assembled and check for accuracy before food is delivered to them).D. Ensure [NAME] (CK) 2 did not wear jewelry while serving food during tray line.E. Ensure Dietary Aid (DA)1 performed hand hygiene and wear gloves while placing residents' utensils on tray during tray line. These failures had the potential to affect residents and to result in pathogen (germ) exposure and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever, and can lead to other serious medical complications including hospitalization.Findings:A. During a concurrent observation and interview on 8/5/2025, at 8:28 a.m., with CK 1, in the dry storage area, there were food items that were not dated and sealed properly as follows:a. Opened, used and unsealed breadcrumbs in a plastic bin (lid was not close tightly) with Receiving Date (RD- the day of delivery) of 3/3/2025, Open Date (OD) of 4/5/2025, and Use By (UB) of 9/5/2025. b. Opened, used and unsealed cracker crumbs in a plastic bin (lid was not sealed) with no RD, OD of 3/3/2025, and UB of 3/3/2026.c. Opened and used shredded coconut in a plastic bin (lid was not sealed) with RD of 5/24/2025, OD of 5/24/2025, and UB of 11/24/2025. CK 1 stated, all food items should have been labeled with receiving date when the facility got delivery from vendors. CK 1stated, all food items should have an open date and used by date (expiration date). CK 1 stated, it was all the dietary staff responsibility to check all food items for labels, dates, properly stored and sealed. CK 1 stated these practices were important to make sure all food items were in good condition because the residents consumed these food items. CK 1 stated that all opened food items should be closed tightly to prevent contamination. CK 1stated, once the food items were opened, there should be different shelf life. CK 1 stated, all staff should refer to Dry Goods Storage Guidelines for shelf life (the length of time for which an item remains usable, fit for consumption) after opening and labeled UB date on food items.During a review of the facility's Policy and Procedure (P&P) titled, Dry Goods Storage Guidelines, dated 2023, the P&P indicated, breadcrumbs and shredded coconuts had shelf life of six months after opening.During a concurrent observation and interview on 8/5/2025, at 8:44 a.m., with CK1, in Refrigerator #1 near the sink area, there were food items that were not labeled, dated, and sealed properly as follows:a. opened, used, and unsealed tortillas in a plastic bag with no RD, OD of 8/3/2025, and UB 8/6/2025.CK 1 stated, all food items should be dated, and dietary staff should follow the Refrigerator Storage Guide to ensure safety of perishable items that required refrigeration. Ck 1 stated, all opened items should be sealed properly to prevent contamination.During a review of the facility's Policy and Procedure (P&P) titled, Dry Goods Storage Guidelines, dated 2023, the P&P indicated, opened tortillas should be refrigerated and had shelf life of two months after opening.During a concurrent observation and interview on 8/5/2025, at 8:55 a.m., with CK1, in Freezer #1 near the sink area, there were food items that were not sealed properly as follows: a. opened, used, and unsealed kernel corns in a box with RD of 7/28/2025, OD of 7/31/2025, and UB of 9/31/2025.CK1 stated, all food items should be sealed tightly, and dietary staff should follow Freezer Storage guideline to ensure safety of perishable items.During a review of the facility's Policy and Procedure (P&P) titled, Produce Storage Guidelines, dated 2023, the P&P indicated, frozen vegetable in freezer had shelf life of ten months after opening.During a review of the facility's Policy and Procedure(P&P) titled, Food Storage and Handling, revised 2/29/2024, the P&P indicated, 9. Frozen Vegetable Storage: Label and date all food items, use within 6 months.13. Dry Storage Area: place opened products in storage containers with tight fitting lids, label and date all storage products.B. During a concurrent observation and interview on 8/5/2025, at 9:02 a.m., with DA 1, there were two boxes of juice mixer that were expired, but connected to juice dispenser as follows: a. Box of thicken Water for juice dispenser with RD of 7/14/2025, OD of 7/22/2025, and UB of 7/28/2025 (expired). b. Kiwi Strawberry flavored syrup in a box with RD of 7/7/2025, OD of 7/27/2025, and UB of 8/3/2025 (expired).DA 1 stated, she should have called and let the vendor know about expired boxes to be changed, because expired drink could cause sickness to residents. C. During a concurrent observation and interview on 8/5/2025, at 12:05 p.m., with DA 2 during the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure accurate documentation for two of 16 sampled residents (Resident 6 and Resident 15) by failing to:a. Ensure Resident 6, who had a diagnosis of depression (a serious mood disorder that affects how you think, feel, and handle daily activities) and taking an antidepressant medication (medications used to treat depression and other conditions) was documented on the medical diagnosis list.b. Ensure Resident 15's Medication Administration Record for the month of August 2025 was accurate when it indicated Resident 15 received Naloxone (a medicine that rapidly reverses an opioid [strong pain medication] overdose) on 8/1/2025, when Resident 15 did not receive Naloxone.These deficient practices resulted in Resident 15 having a documented medication error in the MAR, had the potential to negatively impact the provision of necessary care and services and portray an inaccurate reflection of Resident 6 diagnosis list in the facility. Findings: a. During a review of Resident 6’s admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder ([PTSD], a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it), anxiety (a mental health condition that cause fear, dread and other symptoms that are out of proportion to the situation), opioid (a class of drugs that are used to reduce moderate to severe pain) use disorder (a mental health condition where a pattern of opioid use affects your health and daily life), and rhabdomyolysis (a serious condition where damaged muscle tissue breaks down, releasing its contents into the bloodstream that can lead to kidney damage). During a review of Resident 6’s Minimum Data Set ([MDS], a resident assessment tool) dated 6/5/2025, the MDS indicated Resident 6 had intact cognitive (thought process) function and was set up assistance (helper sets up while resident completes the activity) with self-care abilities such as eating, oral hygiene, personal hygiene and upper body dressing. The MDS indicated a mood total severity score (indicates the overall severity of a person's depression or mood disturbance) of 13 (5-9 indicating mild, 10-14 indicating moderate, involves a greater number of symptoms and a more significant impact on daily functioning). During a review of Resident 6’s Order Summary Report dated, the Order Summary Report indicated to give sertraline (a prescription medication used to treat depression and other mental health conditions) tablet (pill) 100 milligram ([mg], a unit of measurement) give one tablet by mouth one time a day for depression manifested by excessive worries of life situation ordered on 8/6/2025, and alprazolam (a prescription medication used to treat anxiety disorder, and panic disorder) oral Tablet 0.5 mg give one tablet by mouth every morning and at bedtime for anxiety manifested by irritability (a state of increased sensitivity and a tendency to react with anger, frustration, or annoyance to stimuli, often triggered by small things) or restlessness ordered on 7/31/2025. During a review of Resident 6’s primary doctor progress note dated 7/17/2025, the primary doctor progress note indicated Resident 6 had a past medical history of chronic opioid use, anorexia (an eating disorder that causes people to weigh less than is considered healthy for their age and height, usually by excessive weight loss), and depression. Resident 6 note indicated depression, anxiety and to continue a psychology (the study of the human mind and its functions)/psychiatry (the branch of medicine of study, diagnosis, and treatment of mental illness) consultation and continue medication of alprazolam 0.5 mg every 12 hours and sertraline 50 mg daily. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6’s psychiatry doctor progress note dated 8/6/2025, the psychiatry doctor progress note indicated Resident 6 was currently on sertraline 50 mg by mouth daily and alprazolam 0.5 mg by mouth twice a day for anxiety disorder and depressive disorder. During a concurrent observation and interview on 8/5/2025 at 10: 06 a.m. with Resident 6 in their room, Resident 6 was lying in bed watching from their electronic device. Resident 6 stated he takes medication for mood but does not remember the names of the medications at this time. During a concurrent interview with record review on 8/8/2025 at 11:41 a.m. with the Director of Nursing (DON), the admission record, the primary doctor progress note, and psychiatry doctor progress note were reviewed. The DON stated Resident 6’s medical diagnosis list should have listed that Resident 6 had some type of depressive mood disorder. The DON stated the importance of having accurate documentation of medical diagnosis was so the facility staff would know current condition of resident and accurate assessment of the resident to know what's going on and to provide appropriate care. The DON stated the two doctor’s progress notes indicated Resident 6 had depression, the medical diagnosis list should have indicated some type of depressive mood disorder since Resident 6 was taking anti-depression medication. During a review of the facility’s policy and procedures (P&P) titled, “Completion and Correction” revised 1/1/2012, indicated, the purpose was to ensure that medical records are complete and accurate, the facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation, entries will be complete, legible, descriptive and accurate. b. During a review of Resident 15’s admission Record (Face Sheet), the admission Record indicated Resident 15 was admitted to the facility 2/12/2025 with diagnoses including fibromyalgia (a chronic condition that causes pain in muscles and soft tissues all over the body) and falls. During a review of Resident 15’s minimum data set (MDS, a resident assessment tool) dated 7/17/2025, the MDS indicated Resident 15 had moderate cognitive (the broad set of mental processes that relate to acquiring knowledge and understanding through thought, experience, and senses) impairment. During a review of Resident 15’s Order Summary Report, the Order Summary Report indicated an order was placed on 5/25/2025 for Naloxone HCl Nasal Liquid 4 milligrams (mg, a unit of measurement)/ 0. 25 milliliters (ml, a unit of measurement): 1 spray in nostril as needed for opioid overdose. During a review of Resident 15’s MAR for 8/2025, the MAR indicated Resident 15 received a dose of Naloxone on 8/1/2025 at 6:18 a.m. During an interview on 8/7/2025 at 11:55 a.m., with Registered Nurse (RN) 3, RN 3 stated he was working on 8/1/2025 and Resident 15 was okay and never received Naloxone. RN 3 stated it was a “mistake” that Naloxone was marked as given on the MAR for 8/1/2025. During an interview on 8/8/2025 at 3:25 p.m., with the director of nursing (DON), the DON stated the Naloxone was not given to Resident 15 and it was a medication error due to documentation. The DON stated it was important to ensure documentation was correct for medication administration because it could lead to errors in giving care or responding to changes of condition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s policy and procedure (P&P) titled Completion and Correction, Medical Records Manual- General dated 1/1/2012, the P&P indicated the purpose of the policy was to ensure medical records were complete and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to prevent the spread of infection for 91 of 91 residents in the facility by failing to: 1. Ensure the hot water temperature logs of the washing machines were accurate and monitored daily.2. Implement policies and procedures (P&P) of proper washing machine temperatures and accurate documentation logs. This deficient practice had the potential to spread infection to all 91 residents in the facility.Findings: During a concurrent interview and record review on 8/7/2025 at 4:15 p.m. with the Housekeeping Supervisor (HS), the HS stated the staff should record the temperatures of the washing machine daily on the Washer Water Temperature Log. The HS stated he did not actually take the temperatures of the hot water and stated the previous managers told him to write 160 degrees (unit of measurement) on the temperature log daily. During a concurrent interview and record review on 8/8/2025 at 9:00 a.m. with the Laundry Assistant (LA), the LA stated the correct temperature of the washing machines should be 160 degrees Fahrenheit ([F] temperature scale) for the laundry to be sanitized. The LA stated no one has taught the staff how to monitor the water temperature. The LA stated we were told by the previous supervisor to just fill in the temperature log sheet daily and write 160 degrees. During a concurrent interview and record review on 8/8/2025 at 10:00 a.m. with the Maintenance Supervisor, the MS produced records of the water temperature monitoring log. The MS stated the laundry hot water temperature was recorded Monday to Friday only and no one monitors the hot water temperature on the weekends when he is off. The Maintenance Director stated he does not have any policies on monitoring the temperature of the washing machines. The MS stated it is important to check the laundry hot water temperature to make sure the facility follow regulations to kill germs and prevent the spread of infection.