

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 Pine Ave Maywood, CA 90270	

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)
<p>F 0575</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Office of the State Long-Term Care Ombudsman program (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) contact information was posted in a visible area to residents. This deficient practice had the potential to violate residents rights to file a complaint. Findings: During a review of Resident 52's admission Record, the admission Record indicated Resident 52 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), hypertension (HTN-high blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 52's History and Physical (H&P) dated 9/9/2025, the H&P indicated Resident 52 had the capacity to understand and make decisions. During a review of Resident 52's Minimum Data Set (MDS- a resident assessment tool), dated 12/10/2025, the MDS indicated Resident 52 was cognitively intact (ability to think and understand). The MDS indicated Resident 52 required staff supervision for eating and toileting and partial staff assistance with bathing and personal hygiene. During an interview on 3/25/2026 at 2:14 p.m. with Resident 52, Resident 52 stated he did not know where to find the Ombudsman's contact information in the facility. During a concurrent observation and interview on 3/24/2026 at 4:00 p.m. with the Infection Prevention Nurse (IPN), observed the walls of the front lobby and the walls throughout the entire facility. There was no Ombudsman contact information posted. The IPN stated Ombudsman contact information was usually posted in the front lobby of the facility. The IPN stated the Ombudsman contact information was not posted. The IPN stated the Ombudsman contact information should be posted in a visible place for residents because it was their right to be able to report concerns or make complaints to the Ombudsman. During an interview on 3/26/2026 at 9:21 a.m. with the Director of Nursing (DON), the DON stated Ombudsman information was usually posted in the front lobby of the facility but was taken down when the walls were recently repainted. The DON stated it was important for Ombudsman contact information to be visible to residents because it honors the residents rights to report concerns or make complaints to the Ombudsman. During a review of the facility's policy and procedure (P&P) titled, Grievances and Complaints dated 10/2/2025, the P&P indicated, If the resident is not satisfied with the result of the investigation, or the recommended actions, he or she may file a written complaint with the local Long Term Care Ombudsman's office or with the California Department of Public Health. Addresses and telephone numbers of these agencies are posted on the facility consumer board.</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of 11 sampled residents (Resident 106, Resident 25, and Resident 4) received treatment and care in accordance with professional standards of care when: 1. Licensed Vocational Nurse (LVN) 2 did not clarify Resident 106's order for cholecalciferol (also known as Vitamin D3, a vitamin essential for building and maintaining strong bones and immune function) and accurately document the omission on the Medication Administration Report (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). 2. Resident 25's physician order for a urinalysis (UA- lab test to check the urine for signs of disease) and culture and sensitivity (C&S- a lab test to determine the specific bacteria and what medication works best to treat it) were not carried out due to the incorrect input of the physician order and ineffective follow up, documentation, and communication between the licensed nurses. 3. Resident 4 was not monitored for sedation, drowsiness, and possible side effects while receiving Haldol (an antipsychotic used to treat mental health conditions) 4 milligrams (mg, a unit of measurement) twice a day. These deficient practices resulted in Resident 106 missing her daily dose of cholecalciferol and potential for additional missed doses. These deficient practices also had the potential to result in a delay in treatment and diagnosis of a possible urinary tract infection (UTI- an infection in the bladder/urinary tract) for Resident 25. These deficient practices also had the potential to result in undetected drowsiness, sedation, and side effects which could result in delay in Resident 4's treatment. Cross Reference F759 and F656. Findings: 1. During a review of Resident 106's admission Record, the admission Record indicated Resident 106 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 106's diagnoses included protein-calorie malnutrition (when an individual does not eat enough protein and calories to meet nutritional needs), generalized muscle weakness, and generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 106's Minimum Data Set (MDS- a resident assessment tool), dated 12/12/2025, the MDS indicated Resident 106's cognition (process of thinking) was intact. The MDS indicated Resident 106 required supervision or touching assistance with eating, oral hygiene, bathing, dressing, and personal hygiene. During a review of Resident 106's History and Physical (H&P), dated 9/9/2025, the H&P indicated Resident 106 had the capacity to understand and make decisions. During a review of Resident 106's physician order, dated 9/28/2023, the physician order indicated to administer cholecalciferol (also known as Vitamin D3, a vitamin essential for building and maintaining strong bones and immune function) 1000 units, by mouth, once a day for supplement. During an observation on 3/24/2026 at 8:04 a.m., in Resident 106's room, observed Licensed Vocational Nurse (LVN) 2 prepare Resident 106's medications. Resident 106 received five medications by mouth and one medication by injection. LVN 2 did not prepare and administer cholecalciferol to Resident 106. LVN 2 returned to the medication cart and documented the medications administered to Resident 106. During a concurrent interview and record review on 3/24/2026 at 1:41 p.m., with LVN 2, Resident 106's Medication Administration Report (MAR), dated 3/1/2026 through 3/31/2026, was reviewed. The MAR indicated, on 3/24/2026, LVN 2 administered cholecalciferol to Resident 106. LVN 2 stated she did not administer cholecalciferol to Resident 106 and she documented incorrectly. During an interview on 3/24/2026 at 1:45 p.m., with LVN 2, LVN 2 stated during the observed medication administration she was confused by the cholecalciferol order and the house supply medications (over-the-counter medications). LVN 2 stated none of the medication bottles in her medication cart indicated cholecalciferol and did not want to risk giving the wrong medication. LVN 2 stated by the time she clarified the medication with another licensed nurse, it was past the acceptable medication administration time frame. LVN 2 stated she should have clarified with another licensed nurse during the medication administration timeframe to ensure Resident 106 received her daily cholecalciferol (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review with the DON on 3/24/2026 at 2:16 p.m., Resident 4's MAR, dated 3/2025, was reviewed. The MAR did not indicate monitoring was in place for sedation. The DON stated it was important to monitor for sedation or drowsiness due to the risk for falls or excessive sedation. The DON stated it was important to monitor for sedation so that the licensed staff could notify the physician so adjustments could be made to the medication. The DON stated Resident 4 was placed at risk for sedation.</p> <p>During a review of the facility's P&P titled, Behavior/Psychoactive Medication Management, revised 1/30/2026, the P&P indicated the facility was to ensure the resident would be observed and/or monitored for side effects, and adverse consequences, including sedation. All complications and side effects should be reported to the Healthcare practitioner.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>Based on interview and record review, the facility failed to ensure direct care staffing information [actual, hands-on hours worked by qualified staff such as registered nurses (RN), licensed vocational nurses (LVN) and certified nursing assistants (CNA) providing direct nursing services to residents] was submitted to the Centers for Medicaid Services (CMS- federal agency responsible for regulating healthcare quality). This deficient practice had the potential to place the facility at risk of unidentified staffing issues. Findings: During a review of the Payroll Based Journal (PBJ- dataset that provides information submitted by nursing homes quarterly) Staffing Data Report dated 3/19/2026, the PBJ Staffing Data Report indicated the facility failed to submit data for quarter one (10/1/2025-12/31/2025). During a concurrent interview and record review on 3/25/2026 at 1:50 p.m. with the Administrator (ADM), the CMS Submission Report dated 2/13/2026 was reviewed. The CMS Submission Report indicated direct care staffing information was submitted for quarter two (1/1/2026-3/31/2026) on 2/13/2026. The ADM stated direct care staffing information was submitted quarterly by a third-party company. The ADM stated the facility submitted required data to their contracted third-party company and direct care staffing information should have been submitted for quarter one. The ADM stated failing to submit direct care staffing information placed the facility at risk of not identifying large scale staffing issues. During an interview on 3/26/2026 at 10:00 a.m. with the Clinical Project Director (CPD), the CPD stated the database used to submit direct care staffing information to CMS changed the selection for submission for quarter one to quarter two. The CPD stated quarter one's data was submitted, but the error in quarter selection went unnoticed. The CPD stated this error caused the facility to be triggered for failing to submit data for quarter one. During an interview on 3/26/2026 at 9:21 a.m. with the Director of Nursing (DON), the DON stated submitting direct care staffing hours was important because it ensured the facility met the required hours and helped identify staffing issues. The DON stated direct care staffing hours helped indicate the level of care being provided to residents, with higher staffing hours being optimal for resident care. During a review of the facility's policy and procedure (P&P) titled, Electronic Staffing Data Submission Payroll-Based Journal dated June 2025, the P&P indicated Direct care staffing and census data will be collected quarterly, and it is required to be timely and accurate.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was readily accessible and within reach for one of six sampled residents (Resident 112). The call light was observed positioned behind the resident's bed, preventing immediate access. This deficient practice had the potential to significantly compromise Resident 112's safety by delaying Resident 112's ability to request assistance, thereby increasing the risk for unmet needs, injury, and adverse outcomes. Findings: During a review of Resident 112's admission Record, the admission Record indicated Resident 112 was admitted to the facility on [DATE]. Resident 112's diagnoses included falls, muscle weakness, dysphagia (difficulty swallowing), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), chronic obstructive pulmonary disease (COPD- a progressive lung disease that restricts airflow causing significant breathing difficulties) and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the right and left knee. During a review of Resident 112's History and Physical (H&P), dated 3/14/2026, the H&P indicated Resident 112 could make needs known but could not make medical decisions. During a review of Resident 112's Minimum Data Set (MDS, a resident assessment tool), dated 12/9/2025, the MDS indicated Resident 112 cognitive skills for daily decision making (the ability to think and process information) was mildly impaired. The MDS indicated Resident 112 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 3/23/2026 at 10:04 a.m., at Resident 112's bedside, Resident 112 was observed lying in bed. The call light was hanging behind and under Resident 112's bed. During a concurrent interview and record review on 3/24/2026 at 1:40 p.m. with Licensed Vocational Nurse (LVN) 1, a photo of Resident 112's call light, dated 3/23/2026 and timed at 10:04 a.m., was reviewed. The photo revealed the call light was hanging behind the bed and not within reach. LVN 1 stated Resident 112 was able to make her needs known. LVN 1 stated that regardless of residents being able to make their needs known, the call light should always be within reach of the residents. LVN 1 stated call lights were a way for residents to call out for assistance and prevent injuries. LVN 1 stated staff were expected to ensure call lights were placed within reach during and after all care, including after repositioning, toileting, and transfers. LVN 1 stated that failing to ensure the call light was accessible could delay a resident's ability to request assistance, increasing the risk for falls, incontinence (inability to control bladder and bowel functions) episodes, or other unmet needs. LVN 1 stated that it was the responsibility of all nursing staff to verify call light accessibility as part of routine safety checks and that this expectation applied to all residents at all times. LVN 1 stated that the call light for Resident 112 should have been within reach and that not having it accessible did not meet the facility's standard of care and safety practices. During a review of the facility's policy and procedures (P&P) titled Communication- Call System, dated 8/24/2024, the P&P indicated The call alert device will be placed within the residents reach.</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify one of one sampled resident's (Resident 91) physician of the resident's preference of taking Depakote Sprinkle (an anticonvulsant medication, used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] with small beads within a capsule that could be sprinkled onto soft food) capsules whole. This deficient practice had the potential to result in Resident 91 choking. Cross Reference F657 and F759. Findings: During a review of Resident 91's admission Record, the admission Record indicated Resident 91 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 91's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 91's Minimum Data Set (MDS, a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 91's cognition (process of thinking) was intact. The MDS indicated Resident 91 required supervision or touching assistance with oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 91 received anticonvulsant medication (medication to treat seizures). During a review of Resident 91's History and Physical (H&P), dated 11/11/2025, the H&P indicated Resident 91 had the capacity to understand and make decisions. During a review of Resident 91's care plan titled, At Risk/Potential for Aspiration/Choking, initiated 11/10/2025, the care plan indicated to crush medications and mix with apple sauce if indicated. During an observation on 3/24/2026 at 9 a.m., outside of Resident 91's room, observed Licensed Vocational Nurse (LVN) 5 preparing Resident 91's routine medications. LVN 5 removed four capsules from Resident 91's Depakote Sprinkle bubble pack (also known as a blister pack, a plastic tray with individual compartments of medication doses sealed with foil). LVN 5 divided the four capsules into two medication cups, with two capsules in each medication cup. LVN 5 prepared five medications and kept all capsules and tablets whole. LVN 5 entered Resident 91's room with six labeled medication cups and a cup of water. During an observation on 3/24/2026 at 9:09 a.m., in Resident 91's room, observed LVN 5 explain each medication to Resident 91. LVN 5 administered all of Resident 91's medications. During a concurrent interview and record review on 3/24/2026 at 1:49 p.m., with LVN 5, Resident 91's Physician Order for Depakote Sprinkle, dated 11/9/2025, was reviewed. The order indicated to administer Depakote Sprinkle 500 milligrams (mg, unit of measurement) by mouth twice a day for epilepsy, mix with apple sauce. LVN 5 stated Resident 91's Depakote Sprinkle was supposed to be administered with apple sauce. LVN 5 stated the capsule had to be opened and the beads poured over apple sauce prior to administration. LVN 5 stated she did not follow the physician's order. LVN 5 stated, I know the resident and already know he does not like to take it like that. LVN 5 stated the purpose of mixing with apple sauce was to reduce the risk of choking. LVN 5 stated although taking the capsules whole were Resident 91's usual preference, she should still ask Resident 91 prior to administering the Depakote Sprinkle. LVN 5 stated she did not notify Resident 91's physician of Resident 91's preference to take the Depakote Sprinkle whole. LVN 5 stated notifying Resident 91's physician was necessary to ensure allowing Resident 91 to take the Depakote Sprinkle whole was safe. During an interview on 3/25/2026 at 1:45 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses were responsible for following all medication administration instructions. The DON stated Depakote Sprinkle had the instruction to mix with apple sauce to reduce the risk of choking. The DON stated Resident 91's physician should have been notified of Resident 91's (continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>preference. The DON stated the physician ordered for the Depakote Sprinkle to be mixed with apple sauce and the physician would be able to determine whether taking the Depakote Sprinkle capsule whole was safe to do. During a review of the facility's policy and procedure (P&P) titled, Change in Condition, dated 8/25/2022, the P&P indicated the physician must be notified of any change in condition.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' clothing and personal belongings were protected from view and potential loss when closet doors were left uncovered without doors or adequate protective measures for three out of six sampled residents (Resident 11, Resident 25, and Resident 116). This deficient practice had the potential to create a risk for theft and compromise the residents' sense of security and homelike environment. Findings: 1. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 11's diagnoses included pneumonia (an infection/inflammation in the lungs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), Alzheimer's (a disease characterized by a progressive decline in mental abilities), and muscle weakness. During a review of Resident 11's Minimum Data Set ([MDS], a resident assessment tool), dated 3/4/2026, the MDS indicated Resident 11's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 11 was dependent on staff for oral hygiene, bathing, toileting, and dressing. 2. During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 25's diagnoses included diabetes (poor blood sugar control), Alzheimer's, muscle weakness, and neuromuscular dysfunction of the bladder (a condition where nerve damage from diseases or injuries disrupts the brain-bladder communication). During a review of Resident 25's MDS, dated [DATE], the MDS indicated Resident 25's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 25 required moderate assistance (helper does less than half the effort) for oral hygiene, toileting, and dressing. 3. During a review of Resident 116's admission Record, the admission Record indicated Resident 116 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 116's diagnoses included COPD, muscle weakness, and dysphagia (trouble swallowing). During a review of Resident 116's MDS, dated [DATE], the MDS indicated Resident 116's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 116 was dependent on staff for oral hygiene, toileting, bathing and dressing. During observations made on 3/23/2026 at 12:17 p.m., and on 3/24/2026 at 12:19 p.m., in Room A, all three closet doors were missing. Residents 11, 25, and 116's clothing and personal belongings were exposed. During an interview on 3/24/2026 at 12:19 p.m. with Resident 116, Resident 116 stated, The closets are not supposed to be like that and I do not want people seeing my stuff. During an interview on 3/24/2026 at 2:25 p.m. with the Director of Nursing (DON), the DON stated the absence of closet doors made the residents' personal belongings exposed and at risk for potential theft. The DON stated the facility was aware of the issue. During a review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, revised 1/1/2012, the P&P indicated the facility was to ensure the facility provides residents with a safe, clean, comfortable, and homelike environment. The P&P indicated the facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. The P&P indicated the facility encouraged residents to use their personal belongings to the extent possible. The P&P indicated facility staff would aim to create a personalized, homelike atmosphere, paying close attention to personalized furniture and room arrangements.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the correct Preadmission Screening and Resident Review (PASRR- a federally mandated screening process designed to ensure individuals with serious mental illnesses or intellectual/development disabilities receive the necessary support) Level 1 Screening was received from the general acute care hospital (GACH) for one of three sampled residents' (Resident 12). This deficient practice resulted in the failure of a more in-depth Level 2 Mental Health Evaluation not being conducted and had the potential for Resident 12 to not receive the necessary and appropriate psychiatric level treatment and evaluation in the facility. Findings: During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE]. Resident 12's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool), dated 9/12/2025, the MDS indicated Resident 12's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 12 required moderate assistance (helper does less than half the effort) with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 12 had a diagnosis of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). The MDS indicated Resident 12 received antipsychotics (medication used to treat mental health conditions) and antidepressants (medication to treat depression). During a review of Resident 12's History and Physical (H&P), dated 3/1/2026, the H&P indicated Resident 12 could make needs known but could not make medical decisions. During a review of the General Acute Care Hospital (GACH) H&P, dated 9/3/2025, the GACH H&P indicated Resident 12 had diagnoses of bipolar disorder and schizophrenia. During a review of the GACH Discharge Reconciliation, dated 9/4/2025, the GACH Discharge Reconciliation indicated to continue aripiprazole (an antipsychotic medication) 5 milligrams (mg, a unit of measurement), fluoxetine 10mg (an antidepressant medication), and mirtazapine (an antidepressant) 15mg upon discharge from the GACH. During a review of Resident 12's Physician Orders, dated 9/5/2025, the Physician Orders indicated to administer: 1. Aripiprazole 10 mg, give one tablet by mouth, in the morning for schizophrenia manifested by aggressive behavior as evidenced by striking out during care. 2. Fluoxetine 10mg, give four tablets by mouth, at bedtime for depression as manifested by refusing to participate with previously enjoyed activity. During a review of Resident 12's Physician Orders, dated 9/8/2025, the Physician Orders indicated to administer mirtazapine 15mg, give one tablet by mouth, at bedtime for depression as manifested by poor oral intake. During a review of Resident 12's Psychiatric Evaluation, dated 9/16/2025, the Psychiatric Evaluation indicated Resident 12 had diagnoses of schizophrenia, bipolar disorder, and depression and received psychotropic medication (medications that affect the mind, emotions, and behavior). During an interview on 3/24/2026 at 2:33 p.m., with MDS Nurse (MDSN) 2, MDSN 2 stated the PASRR level 1 was completed at the GACH before the resident was discharged to the facility. MDSN 2 stated the PASRR level 1 was reviewed upon the resident's admission to the facility to check if a more in-depth level 2 assessment was required. MDSN 2 stated the PASRR level 1 should be reviewed to ensure accuracy and if there were any errors, the facility could submit a new PASRR level 1. During a concurrent interview and record review on 3/24/2026 at 2:40 p.m., with MDSN 2, Resident 12's PASRR Level 1 Screening, dated 9/5/2025, was reviewed. The PASRR Level 1 Screening indicated Resident 12 was not diagnosed with a serious mental illness nor taking psychotropic medication. The PASRR Level 1 Screening indicated Resident 12 was negative for severe mental illness and a Level 2 Assessment was not required. MDSN 2 stated Resident 12's PASRR Level 1 was not accurate because Resident 12 had schizophrenia and bipolar disorder and received psychotropic medications to manage the manifested behaviors. MDSN 2 stated the error (continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>should have been identified and a new PASRR Level 1 submitted to ensure a Level 2 assessment was completed. During an interview on 3/25/2026 at 1:19 p.m., with the Director of Nursing (DON), the DON stated the PASRR Level 1 was conducted to identify those residents with mental conditions and to refer for a PASRR Level 2 assessment. The DON stated the purpose of the PASRR Level 2 assessment was to determine whether Resident 12 required additional psychiatric help, behavioral management, or whether Resident 12's behaviors could be managed in the facility. The DON stated Resident 12's PASRR Level 1 came from the GACH and should have been reviewed by the nursing and admissions departments to ensure the PASRR Level 1 was completed accurately. The DON stated Resident 12's inaccurate PASRR Level 1 should have been identified upon his admission and a new PASRR Level 1 should have been submitted to ensure a PASRR Level 2 assessment was done. The DON stated without a PASRR Level 2 assessment conducted, Resident 12 was at risk for mismanagement of his psychiatric diagnoses and behaviors and may not receive all the additional behavioral resources. During a review of the facility's Policy and Procedure (P&P) titled, admission Screening Resident Review (PASRR), dated 6/12/2024, the P&P indicated, The facility staff will ensure that a PASRR Level 1 is completed for each resident prior to admission. The facility staff will complete a new PASRR upon readmission from the acute hospital if there has been a significant change in the resident's condition.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a care plan was developed and implemented in a timely manner for three of six sampled residents (Resident 22, Resident 28, and Resident 4), who required the use of dentures and who was administered Haloperidol (an antipsychotic [a drug used for the treatment of symptoms of psychosis and other severe mental and emotional disorders]). This deficient practice had the potential to place Residents 22 and 28 at risk for impaired nutrition, oral discomfort, and difficulty with eating. This deficient practice also had the potential to place Resident 4 at risk for compromised mobility, social isolation, and pressure ulcer development (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence).</p> <p>Findings:</p> <p>1. During a review of Resident 22's admission Record, the admission Record indicated Resident 22 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 22's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 22's cognitive skills for daily decision making (process of thinking) was moderately impaired. The MDS indicated Resident 22 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 22 was edentulous (not having any natural teeth or tooth fragments). During a review of Resident 22's History and Physical (H&P), dated 5/24/2025, the H&P indicated Resident 22 could make her needs known but could not make medical decisions. During a review of Resident 22's Dental Notes, dated 1/3/2025, the Dental Notes indicated on 1/3/2025, Resident 22's dentures (removable, artificial teeth and gums designed to replace lost natural teeth) were delivered to the facility. During a review of Resident 22's Dental Notes, dated 1/5/2026, the Dental Notes indicated on 1/5/2025, Resident 22 had full upper and lower dentures. During a concurrent observation and interview on 3/23/2026 at 9:51 a.m., with Resident 22, in Resident 22's room, Resident 22 was observed lying in bed. Resident 22 did not have any natural teeth. Resident 22 stated she lost her natural teeth and had dentures but did not know where they were. Resident 22 stated, They took them. During an interview on 3/24/2026 at 12:26 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 22 did not have any natural teeth and received dentures from the dentist. LVN 5 stated Resident 22 refused to wear her dentures. During an interview on 3/24/2026 at 12:35 p.m., with Resident 22, Resident 22 stated she did not want to wear her dentures and was okay with not wearing them. During a concurrent interview and record review, on 3/25/2026 at 9:56 a.m., with MDS Nurse (MDSN) 1, Resident 22's care plan titled, Resident is Edentulous (without natural teeth), dated 3/23/2026, was reviewed. MDSN 1 stated he developed the care plan on 3/23/2026 after Resident 22's annual MDS was completed. MDSN 1 stated Resident 22 was edentulous for an unknown amount of time and the care plan addressing Resident 22's dental status should have been developed sooner. MDSN 1 stated a care plan addressing Resident 22's refusal to wear her dentures should also be developed. MDSN 1 stated care plans addressing Resident 22's lack of natural teeth and refusal to wear her dentures were important so the licensed nurses and dietary department could assess the appropriateness of Resident 22's diet and Resident 22's ability to chew and swallow. During an interview on 3/25/2026 at 1:26 p.m., with the Director of Nursing (DON), the DON stated care plans were developed to identify the necessary (continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>individualized care for each resident. The DON stated actual and potential problems, and refusals of care should be care planned. The DON stated care plans were necessary to outline the interventions to properly care for Resident 22. The DON stated the interventions would focus on monitoring Resident 22 for weight loss, tolerance to her diet, and the location of Resident 22's dentures. The DON stated due to the untimely development of Resident 22's care plans, Resident 22 was at risk of not receiving the necessary dental care and treatment.2. During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE]. Resident 28 diagnosis included, COPD, amenia (a condition marked by deficiency of healthy red blood cells to transport oxygen in the blood), muscle weakness, gastro esophageal [a muscular tube that connects the throat to the stomach] reflux disease (GERD- a condition in which stomach acid flows back into esophagus causing heartburn), and diabetes.</p> <p>During a review of Resident 28's H&P, dated 10/19/2025, the H&P indicated Resident 28 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28 cognitive skills for daily decision making was mildly impaired. The MDS indicated Resident 28 required supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 28's Dental Evaluation Report from the facility's contracted mobile dental services dated 12/30/2025 was reviewed. The dental evaluation report indicted on 12/30/2025, the facility received Resident 28's full upper and lower dentures.</p> <p>During an observation and interview on 3/23/26 at 11:21 a.m., with Resident 28. Resident 28 stated that she used upper and lower dentures. Resident 28 stated, I have no real teeth. I need my dentures to eat.</p> <p>During a concurrent interview and record review on 3/24/26 at 10:54 a.m., with the Social Services Director (SSD), the dental evaluation report from the contracted mobile dental services dated 12/30/2025, was reviewed. The dental evaluation report indicated Resident 28 received full upper and lower dentures on 12/30/2025. The SSD stated that it was the responsibility of the Social Services Department to inform the nursing staff when Resident 28 receives the new dentures. The SSD stated that once nursing staff are notified, it is the nursing staff responsibility to initiate care plans for dentures. The SSD stated that developing care plans was not the responsibility of the social service department. The SSD stated that this process was not followed for Resident 28, resulting in the omission of dentures from both the special needs list and the resident's belongings record</p> <p>During a concurrent interview and record review on 3/24/26 at 4:19 a.m., with the Director of Nursing (DON), the Dental Evaluation Report from the contracted mobile dental services dated 12/30/2025, was reviewed. The dental evaluation report indicated the social services department received Resident 28's dentures. The DON stated that upon receipt, the social services department should have informed nursing so nursing could develop a care plan. The DON stated that there was a breakdown in communication and nursing staff was never informed of Resident 28's dentures. The DON stated that residents with upper and lower dentures required an individualized care plan to address their specific oral health needs. The DON stated a care plan was necessary to ensure proper denture care, including cleaning, storage, monitoring for proper fit, and assessment for any signs of discomfort, irritation, or oral breakdown. The DON stated that without a comprehensive care plan, there was an increased risk for poor oral hygiene, infection, impaired nutrition, and decreased quality of life. The DON stated that (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>it was the facility's responsibility to develop and implement a care plan to ensure the resident's dentures were maintained appropriately and that staff were aware of and followed the resident's specific care needs.</p> <p>3. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included COPD, muscle weakness, dysphagia (trouble swallowing) and dementia.</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 4's hearing was adequate. The MDS indicated Resident 4 was dependent on staff for toileting, bathing, and dressing.</p> <p>During a review of Resident 4's H&P, dated 5/23/2025, the H&P indicated Resident 4 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 4's Physician Order, dated 11/5/2025, the order indicated to administer Haloperidol (an antipsychotic [a drug used for the treatment of symptoms of psychosis and other severe mental and emotional disorders]) oral tablet four (4) milligrams (mg, a unit of measurement) by mouth two times a day.</p> <p>During an observation on 3/23/2023 at 10:00 a.m., with Certified Nursing Assistant (CNA) 3, in Resident 4's room, Resident 4 was observed in bed asleep. CNA 3 called Resident 4's name three times with increasing volume. Resident 4 slowly opened his eyes after the fourth attempt.</p> <p>During a concurrent observation and interview on 3/24/2026 at 11:05 a.m. with LVN 6, in Resident 4's room, Resident 4 was observed lying in bed with both of his eyes closed. Resident 4 did not respond to verbal stimuli. LVN 6 called Resident 4's name four times with increasing volume and applied tactile (touch) stimulation by tapping the resident's shoulders, with no response. Resident 4 opened his eyes after LVN 6 performed a sternal rub (is a painful stimulus technique used by medical professionals to check for responsiveness in unconscious or unresponsive patients). LVN 6 stated Resident 4 liked to be in bed and asleep.</p> <p>During a concurrent interview and record review on 3/26/2026 at 9:20 a.m. with LVN 6, Resident 4's care plan titled Resident 4 Prefers to Stay in Bed During Daytime, initiated 3/24/2026 was reviewed. LVN 6 stated Resident 4 exhibited behaviors of napping for extensive periods throughout the day and keeping his eyes closed for approximately one to two months prior to the initiation of the care plan. LVN 6 stated the care plan should have been initiated sooner to ensure appropriate interventions were implemented. LVN 6 stated the lack of timely implemented care plan interventions placed Resident 4 at risk for the development of pressure ulcers and self-isolation.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Refusal of Treatment, revised 1/1/2012, the P&P indicated, When the resident's refusal brings about a significant change in the resident's condition, a reassessment is made, and new information is incorporated into the resident's Care Plan.</p> <p>During a review of the facility's P&P titled Oral Healthcare & Dental Services, dated 7/14/2017, the P&P indicated Develop a plan of care to ensure that the resident can eat and drink adequately. Implementation of a daily dental and oral hygiene plan of care including daily denture hygiene. (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Person-Centered Care Planning, dated 5/22/2025, the P&P indicated, The facility must develop and implement a 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. Within 7 days from the completion of the comprehensive Minimum Data Set (MDS) assessment, the comprehensive care plan will be developed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 Pine Ave Maywood, CA 90270	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise one of one sampled resident's (Resident 91) care plan to reflect Resident 91's preference of taking Depakote Sprinkle (an anticonvulsant medication, used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] with small beads within a capsule that could be sprinkled onto soft food) capsules whole. This deficient practice had the potential to result in Resident 91 choking. Cross Reference F580 and F759. Findings: During a review of Resident 91's admission Record, the admission Record indicated Resident 91 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 91's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 91's Minimum Data Set (MDS, a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 91's cognition (process of thinking) was intact. The MDS indicated Resident 91 required supervision or touching assistance with oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 91 received anticonvulsant medication (medication to treat seizures). During a review of Resident 91's History and Physical (H&P), dated 11/11/2025, the H&P indicated Resident 91 had the capacity to understand and make decisions. During a review of Resident 91's Physician Order, dated 11/9/2025, the Physician Order indicated to administer Depakote Sprinkle (an anticonvulsant medication, used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] with small beads within a capsule that could be sprinkled onto soft food) 500 milligrams (mg, unit of measurement) by mouth twice a day for epilepsy. Mix with apple sauce. During a review of Resident 91's Care Plan titled, At Risk/Potential for Aspiration/Choking, initiated 11/10/2025, the Care Plan indicated to crush medications and mix with apple sauce if indicated. During a review of Resident 91's Care Plan titled, High Risk for Trauma/Injuries Related to Seizure Disorder, initiated 11/10/2025, the Care Plan indicated to administer Depakote Sprinkle 500 mg by mouth twice a day. During an observation on 3/24/2026 at 9 a.m., outside of Resident 91's room, observed Licensed Vocational Nurse (LVN) 5 began preparing Resident 91's medications. LVN 5 removed four capsules from Resident 91's Depakote Sprinkle bubble pack (also known as a blister pack, a plastic tray with individual compartments of medication doses sealed with foil). LVN 5 divided the four capsules into two medication cups, with two capsules in each medication cup. LVN 5 prepared five medications and kept all capsules and tablets whole. LVN 5 entered Resident 91's room with six labeled medication cups and a cup of water. During an observation on 3/24/2026 at 9:09 a.m., in Resident 91's room, observed LVN 5 explain each medication to Resident 91. LVN 5 administered all of Resident 91's medications. During a concurrent interview and record review on 3/24/2026 at 1:49 p.m., with LVN 5, Resident 91's Physician Order for Depakote Sprinkle, dated 11/9/2025, was reviewed. The order indicated to administer Depakote Sprinkle with apple sauce. LVN 5 stated the capsule had to be opened and the beads poured over the apple sauce prior to administration. LVN 5 stated she did not follow the physician's order. LVN 5 stated, I know the resident and already know he does not like to take it like that. LVN 5 stated the purpose of mixing the medication with apple sauce was to reduce the risk of choking. During an interview on 3/25/2026 at 1:45 p.m., with the Director of Nursing (DON), the DON stated Resident 91 had the right to take his medications however he preferred as long as it was safe. The DON stated Resident 91's care plans should have been updated. The DON (continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 Pine Ave Maywood, CA 90270	

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated Resident 91's care plans should have been revised to indicate the resident's preference to take the Depakote Sprinkle capsules whole as long as there were no safety concerns. During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, dated 5/22/2025, the P&P indicated, The facility must develop and implement a 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.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure one of three sampled residents (Resident 94) who was visually impaired was orientated to his meal tray during lunch time. This failure had the potential to put the resident at risk for serious physical harm (choking, aspiration, malnutrition, and/or burns) and negatively impacts their psychological well-being, dignity, and independence Findings: During a review of Resident 94's admission Record (AR) dated 3/25/2026, the AR indicated Resident 94 was a [AGE] year-old male, admitted on [DATE], with the diagnosis that included but not limit to: legal blindness (when a person's eyesight is very poor), chronic obstructive pulmonary disease (a long lasting lung disease that makes it hard to breathe), muscle weakness and hypertension (high blood pressure.) During a review of Resident 94's Minimum Data Set (MDS, a resident assessment tool) dated 2/4/2026, MDS indicated Resident 94 had severely impaired vision and needs supervision or touching assistance while eating. During a review of Resident 94's care plan dated 2/24/2026, the care plan indicated Resident 94 is legally blind, needs assistance with activities of daily living, including eating to maintain a hazard free and safe environment. During a concurrent observation and interview on 3/23/2026 at 12:24 p.m. in Resident 94's room. Resident 94 was sitting on the bed with his lunch tray in front of him, eating by himself, Resident 94 stated he could not find his spoon on the meal tray. Resident 94 also stated the staff did not orient him to his meal tray. During an observation on 3/24/2026 at 12:20 p.m. in Resident 94's room. Resident 94 was eating by himself with no utensil in his hand, Resident could not find his spoon on his meal tray. During an interview on 3/24/2026 at 12:30 p.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated she placed the meal tray on Resident 94's table. CNA 2 also stated Resident 94 is legally blind, she did not provide Resident 94 with a detailed orientation of the meal tray, and she should do it for the resident's convenience and safety. During an interview on 3/24/2026 at 2:15 p.m. with Director of Nursing (DON), DON stated that Resident 94 is legally blind and should receive coaching when a meal tray is provided so the resident knows where each item is located. The DON explained that without proper coaching or orientation, Resident 94 is at risk of hazards, such as accidentally spilling hot coffee or soup, which could cause burns. During a review of the facility's policy and procedure (P&P) titled, Resident safety, dated 4/15/2021, the P&P indicated staffs should identified the safety risk and provide more frequent safety check according to residents' person-centered care plan.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure their error rate was less than five percent (%) during the medication administration observation for two of five randomly selected residents (Residents 106 and 91).The outcome was four medication errors out of 27 opportunities for errors, which resulted in a medication administration error rate of 14.81%, based on the following:1. Resident 106 was given a multivitamin (dietary supplement containing a combination of essential vitamins) instead of multivitamin-minerals (multivitamin with minerals).2. Resident 106's cholecalciferol (also known as Vitamin D3, a vitamin essential for building and maintaining strong bones and immune function) was unnecessarily omitted and incorrectly documented.3. Resident 106's Colace (stool softener) refusal was inaccurately documented on the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident).4. Resident 91's Depakote Sprinkle (an anticonvulsant medication, used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] with small beads within a capsule that could be sprinkled onto soft food) was not administered in accordance with the physician's order. These deficient practices had the potential for Resident 106 to develop nutritional deficiencies that affect her bone health and immune function and potential for Resident 106 to develop constipation or loose stools with inaccurate explanation. These deficient practices also had the potential for Resident 91 to have difficulty swallowing the Depakote Sprinkle capsules. Cross Reference F580, F657, and F684.Findings:1. During a review of Resident 106's admission Record, the admission Record indicated Resident 106 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 106's diagnoses included protein-calorie malnutrition (when an individual does not eat enough protein and calories to meet nutritional needs), generalized muscle weakness, and generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).During a review of Resident 106's Minimum Data Set (MDS- a resident assessment tool), dated 12/12/2025, the MDS indicated Resident 106's cognition (process of thinking) was intact. The MDS indicated Resident 106 required supervision or touching assistance with eating, oral hygiene, bathing, dressing, and personal hygiene. During a review of Resident 106's History and Physical (H&P), dated 9/9/2025, the H&P indicated Resident 106 had the capacity to understand and make decisions.During a review of Resident 106's physician order, dated 9/28/2023, the physician order indicated to administer: 1. Cholecalciferol (also known as Vitamin D3, a vitamin essential for building and maintaining strong bones and immune function) 1000 units, by mouth, once a day for supplement.2. Colace (stool softener) 100 milligrams (mg, a unit of measurement), by mouth, one time a day for bowel management. Hold for loose stools.3. Multivitamin-Minerals (dietary supplement containing a combination of essential vitamins and minerals), one tablet by mouth, once a day for supplement.During an observation on 3/24/2026 at 8:04 a.m., outside of Resident 106's room, observed Licensed Vocational Nurse (LVN) 2 began preparing Resident 106's medications. LVN 2 removed one tablet from a pill bottle labeled Multivitamin. LVN 2 prepared seven medications that totaled 10 tablets and one injection. LVN 2 did not prepare the cholecalciferol capsule. LVN 2 crushed the tablets separately and poured the contents from the sleeve (thick plastic pouch designed to hold medication safely while it is crushed into a fine powder) into individual medication cups. LVN 2 entered Resident 106's room with six labeled medication cups, one injection, a cup of juice, and a cup of apple sauce. During an observation on 3/24/2026 at 8:15 a.m., in Resident 106's room, observed LVN 2 explain each medication to Resident 106 prior to mixing with apple sauce. Resident 106 refused to take the Colace. LVN 2 explained the risks and benefits. LVN 2 administered the rest of Resident 106's medications. During a concurrent interview and record review on 3/24/2026 at 1:37 p.m., with LVN 2, Resident 106's Physician Order for Multivitamin-Minerals, dated 9/28/2023, was reviewed. (continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The order indicated to administer one tablet by mouth, once a day for supplement. LVN 2 stated the Multivitamin-Minerals contained additional minerals to supplement Resident 106's body. LVN 2 stated the Multivitamin-Minerals was not the same as the regular Multivitamin supplement. During a concurrent observation and interview on 3/24/2026 at 1:39 p.m., with LVN 2, at LVN 2's medication cart, observed LVN 2 compare the Multivitamin-Minerals bottle and Multivitamin. LVN 2 stated she administered the Multivitamin to Resident 106 instead of the ordered Multivitamin-Minerals. LVN 2 stated she gave the incorrect medication to Resident 106. LVN 2 stated it was important to give the correct multivitamin because Resident 106 could have a mineral deficiency and the Multivitamin-Minerals would help supplement those missing minerals. During an interview on 3/25/2026 at 1:30 p.m., with the Director of Nursing (DON), the DON stated LVN 2 was responsible for administering the correct multivitamin to Resident 106. The DON stated when preparing medication, LVN 2 was responsible for checking the Five Medication Rights such as right medication, right dose, right route, right resident, and right time. The DON stated Multivitamin and Multivitamin-Minerals were not the same medication. The DON stated Resident 106 did not receive the additional minerals when she received the Multivitamin. The DON stated the additional minerals were essential to increase the immune system and other health benefits. 2. During a concurrent interview and record review on 3/24/2026 at 1:41 p.m., with LVN 2, Resident 106's Medication Administration Record (MAR), dated 3/1/2026 through 3/31/2026, was reviewed. The MAR indicated The MAR indicated, on 3/24/2026, LVN 2 administered cholecalciferol to Resident 106. LVN 2 stated she did not administer cholecalciferol to Resident 106 and she documented it incorrectly. LVN 2 stated during the observed medication administration she was confused by the cholecalciferol order and the house supply medications (over-the-counter medications). LVN 2 stated none of the medication bottles in her medication cart indicated cholecalciferol and did not want to risk giving the wrong medication. LVN 2 stated by the time she clarified the medication with another licensed nurse, it was past the acceptable medication administration time frame. LVN 2 stated she should have clarified with another licensed nurse during the medication administration timeframe to ensure Resident 106 received her daily cholecalciferol dose. During an interview on 3/25/2026 at 1:35 p.m., with the Director of Nursing (DON), the DON stated medications should be administered to the resident unless the resident refused or the medication parameters (instructions that dictate when a medication should be given, withheld, or adjusted) were not met. The DON stated LVN 2 was responsible for consulting another licensed nurse, or himself, as soon as possible to clarify which bottle in the medication cart contained cholecalciferol. The DON stated LVN 2 should not have documented anything in the MAR for cholecalciferol during the medication administration so she could remember to clarify the medication. The DON stated because LVN 2 did not timely clarify Resident 106's cholecalciferol, LVN 2 should have consulted with Resident 106's physician for an order to administer the medication late or hold the medication until the following day. The DON stated due to LVN 2's actions, Resident 106 did not receive her daily dose of cholecalciferol, on 3/24/2026, which was important for her bone health and immune function.3. During a concurrent interview and record review on 3/25/2026 at 2:50 p.m., with LVN 2, Resident 106's MAR, dated 3/1/2026 through 3/31/2026, was reviewed. The MAR indicated The MAR indicated, on 3/24/2026, LVN 2 administered Colace to Resident 106. LVN 2 stated she incorrectly documented Resident 106's refusal. LVN 2 stated she did not intend to document the Colace as given. During an interview on 3/25/2026 at 2:55 p.m., with the DON, the DON stated Resident 106's refusal to take Colace should have been accurately documented on the MAR. The DON stated accurate documentation was necessary to track Resident 106's bowel movements. The DON stated if Resident 106 ceased to have bowel movements or began to have loose stools, knowing that Resident 106 did not take Colace would help determine Resident 106's plan of care. 4. During a review of Resident 91's admission Record, the admission Record indicated Resident 91 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 91's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [a sudden, uncontrolled (continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness)), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 91's MDS, dated [DATE], the MDS indicated Resident 91's cognition was intact. The MDS indicated Resident 91 required supervision or touching assistance with oral hygiene, toileting, bathing, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 91 received anticonvulsant medication (medication to treat seizures).During a review of Resident 91's H&P, dated 11/11/2025, the H&P indicated Resident 91 had the capacity to understand and make decisions. During a review of Resident 91's Care Plan titled, At Risk/Potential for Aspiration/Choking, initiated 11/10/2025, the Care Plan indicated to crush medications and mix with apple sauce if indicated.During an observation on 3/24/2026 at 9 a.m., outside of Resident 91's room, observed LVN 5 began preparing Resident 91's medications. LVN 5 removed four capsules from Resident 91's Depakote Sprinkle bubble pack (also known as a blister pack, a plastic tray with individual compartments of medication doses sealed with foil). LVN 5 divided the four capsules into two medication cups, with two capsules in each medication cup. LVN 5 prepared five medications and kept all capsules and tablets whole. LVN entered Resident 91's room with six labeled medication cups and a cup of water. During an observation on 3/24/2026 at 9:09 a.m., in Resident 91's room, observed LVN 5 explain each medication to Resident 91. LVN 5 administered all of Resident 91's medications.During a concurrent interview and record review on 3/24/2026 at 1:49 p.m., with LVN 5, Resident 91's Physician Order for Depakote Sprinkle, dated 11/9/2025, was reviewed. The order indicated to administer Depakote Sprinkle (an anticonvulsant medication with small beads within a capsule that could be sprinkled onto soft food) 500mg, by mouth twice a day for epilepsy, mix with apple sauce. LVN 5 stated Resident 91's Depakote Sprinkle was supposed to be administered with apple sauce. LVN 5 stated the capsule had to be opened and the beads poured over apple sauce prior to administration. LVN 5 stated she did not follow the physician's order. LVN 5 stated, I know the resident and already know he does not like to take it like that. LVN 5 stated the purpose of mixing with apple sauce was to reduce the risk of choking. LVN 5 stated although taking the capsules whole were Resident 91's usual preference, she should still ask Resident 91 prior to administering the Depakote Sprinkle. During an interview on 3/25/2026 at 1:45 p.m., with the DON, the DON stated the licensed nurses were responsible for following all medication administration instructions. The DON stated Depakote Sprinkle had the instruction to mix with apple sauce to reduce the risk of choking. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 8/19/2025, the P&P indicated, All medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper cleaning and sanitization of resident-use dining equipment, and properly label and store one of one resident's (Resident 54) food item brought in from the outside. These deficient practices had the potential to result in the use of improperly cleaned dishware and placed residents at risk for exposure to bacteria and contaminants, increasing the risk of foodborne illness, infection, and compromised health and safety. Findings:</p> <p>1. During a concurrent observation and interview on 3/23/2026 at 8:40 a.m. with [NAME] 1, in the kitchen, observed the storage rack designated for clean water pitchers. Six water pitchers labeled as clean were observed with a sticky residue with previously dated labels (dated 3/21/2026 and 3/22/2026) on the lids. [NAME] 1 stated the residue of the old labels indicated the pitchers had not been thoroughly cleaned prior to being placed in the clean storage area. [NAME] 1 stated that all labels should be removed prior to washing and that the pitchers should have been properly washed, rinsed, and sanitized before being stored. [NAME] 1 stated that the pitchers were not properly cleaned and should not have been placed in the clean storage area.</p> <p>During an interview on 3/23/2026 at 8:50 a.m. with Dishwasher 1, Dishwasher 1 stated that all dining equipment must be inspected after removal from the dishwasher to ensure cleanliness. Dishwasher 1 stated that any items observed to have residual food or debris must be rewashed and sanitized prior to placement in the clean storage area. Dishwasher 1 stated that the labels should have been removed prior to placing the water pitchers in the dishwashing machine.</p> <p>During a concurrent observation and interview on 3/23/2026 at 9:30 a.m. with the Dietary Supervisor (DS), multiple breakfast bowls were observed with dried food residue remaining on the surfaces. The DS stated that all resident-use dishware, including bowls and water pitchers, must be thoroughly washed, rinsed, and sanitized in accordance with facility policy and infection control standards prior to reuse. The DS stated that all kitchen staff should report the dirty dishware to the supervisor or dishwasher so that proper washing can occur. The DS stated that failure to follow proper dishwashing and sanitization procedures was unacceptable and placed residents at risk for potential health complications, including foodborne illness. The DS stated that the observed condition did not meet facility expectations for safe food handling and sanitation practices.</p> <p>During a review of the facility's policy and procedures (P&P) titled Dietary Assistant/Dishwasher the P&P indicated maintain a safe and sanitary work environment.</p> <p>2. During a review of Resident 54's admission Record, the admission Record indicated Resident 54 was admitted to the facility on [DATE]. Resident 54's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 54's Minimum Data Set (MDS- a resident assessment tool), dated 12/10/2025, the MDS indicated Resident 54's cognition (process of thinking) was intact. The MDS indicated Resident 54 required supervision or touching assistance with eating and oral hygiene. During a review of Resident 54's History and Physical (H&P), dated 12/2/2025, the H&P indicated Resident 54 had the capacity to understand and make decisions. During a review of Resident 54's physician order, dated 11/30/2025, the physician order indicated a No Added Salt (NAS) and (continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Consistent Carbohydrate (CCHO) diet (diet to manage blood sugar and blood pressure by limiting sugar intake and sodium), regular texture. During an observation on 3/23/2026 at 10:19 a.m., 3/23/2026 at 3:54 a.m., and 3/23/2026 at 3:54 p.m., in Resident 54's room, observed an opened bag of green grapes stored on top of Resident 54's nightstand. The bag of green grapes was not labeled with the brought in date. During a concurrent observation and interview on 3/24/2026 at 12:23 p.m., in Resident 54's room, observed a cup full of green grapes on top of Resident 54's bedside table. The cup was not labeled/dated. Resident 54 stated the grapes were brought to her by a family member. Resident 54 stated the bag of grapes were at her bedside for about two days and was put into the cup to save space. During an interview on 3/24/2026 at 2:03 p.m., with the DS, the DS stated when food was brought into the facility by a visitor, the visitor or resident had to inform the nurse. The DS stated the nurse would look at the food and determine whether the food item was safe to eat and/or store. The DS stated all food brought in from visitors had to be labeled with the resident's name and the date it was brought into the facility. The DS stated labeling with the date was necessary to keep track of the food's freshness and to know when the food had to be thrown away. The DS stated grapes could be stored at the bedside or the refrigerator, however, the refrigerator was the best practice to keep the grapes fresh and prolong their shelf life. The DS stated the grapes should have been stored in the refrigerator. The DS stated unsafe food storage placed the grapes at risk of bacterial contamination and flies which could make Resident 54 sick. During a review of the facility's P&P titled, Food Brought in by Visitors, dated 5/22/2025, the P&P indicated the proper way to store food brought in by visitors was to: 1. Place the food in a food container that is labeled with the resident's name and date received and store in the designated refrigerator. 2. Perishable food, when refrigerated, would be discarded after two hours at the bedside. 3. When refrigerated, the food would be labeled, dated, and discarded after 48 hours if not consumed.</p>		

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NAME OF PROVIDER OR SUPPLIER Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 6025 Pine Ave Maywood, CA 90270	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Fall Risk Assessment was updated and accurately reflected the health status for two of 16 sampled residents (Resident 105 and Resident 82), and ensure the List of Residents with Special Needs and Resident Belongings List was updated to reflect upper and lower dentures were received for one of six sampled residents (Resident 28). These deficient practices had the potential to place Residents 105 and 82 at an increased risk for a fall, and resulted in the loss of Resident 28's dentures placing Resident 28 at risk for compromised nutritional intake due to impaired chewing ability, impaired communication, and increasing the potential for unmet needs and a decline in overall health and well-being.</p> <p>Findings:</p> <p>a. During a review of Resident 105's admission Record, the admission Record indicated Resident 105 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 105's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 105's History and Physical (H&P), the H&P indicated Resident 105 had the capacity to understand and make decisions.</p> <p>During a review of Resident 105's Minimum Data Set (MDS- a resident assessment tool), dated 12/16/2025, the MDS indicated Resident 105 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 105 had moderately impaired vision. The MDS indicated Resident 105 required supervision from staff for toileting, dressing, and personal hygiene. The MDS indicated Resident 105 required moderate assistance for bathing.</p> <p>During a concurrent interview and record review on 3/24/2026 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 105's Fall Risk Evaluation dated 3/18/2026 was reviewed. The Fall Risk Evaluation indicated Resident 105's vision status was adequate. LVN 2 stated Resident 105 was visually impaired and required orientation to objects in his environment. LVN 2 stated the vision status section of Resident 105's Fall Risk Evaluation should have indicated poor instead of adequate. LVN 2 stated accurate fall risk evaluations were important to ensure staff knew the appropriate interventions and level of assistance residents required.</p> <p>During a concurrent interview and record review on 3/24/2026 at 9:52 a.m. with Registered Nurse (RN) 1, Resident 105's Ophthalmology note (branch of medical science dealing with the structure, functions, and diseases of the eye) dated 3/3/2026 and Fall Risk Evaluation dated 3/18/26 were reviewed. Resident 105's Ophthalmology note indicated Resident 105 was blind in his right eye. Resident 105's Fall Risk Evaluation indicated Resident 105's vision status was adequate. RN 1 stated Resident 105's Fall Risk Evaluation was inaccurate and should have indicated poor vision instead of adequate. RN 1 stated inaccurate fall risk evaluations placed residents at an increased risk for falls.</p> <p>During an interview on 3/26/2026 at 9:21 a.m. with the Director of Nursing (DON), the DON stated resident assessments should be accurate. The DON stated accurate assessments were important to (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ensure nursing staff knew the appropriate interventions to implement for residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Fall Management Program dated 11/11/2025, the P&P indicated, As part of the admission and re-admission Assessment, the licensed nurse will complete a fall risk evaluation and document interventions on the Resident's care plan.</p> <p>During a review of the facility's LVN Job Description, the job description indicated, Records care information accurately, timely and concisely.</p> <p>b. During a review of Resident 82's admission Record dated 3/26/2026, the admission Record indicated Resident 82 was admitted to the facility on [DATE]. Resident 82's diagnoses that included but not limit to: history of falling, diabetes, muscle weakness, and hypertension (high blood pressure).</p> <p>During a review of Resident 82's MDS dated [DATE], the MDS indicated Resident 82 had history of fall, and history of a fracture (broken bone) prior to admission.</p> <p>During a review of Resident 82's Fall Risk Evaluations, dated 1/20/2026 and 2/28/2026, both evaluations indicated Resident 82 was a high risk for fall.</p> <p>During a review of Resident 82's post-fall evaluation dated 2/28/2026, the evaluation indicated on 2/28/2026, Resident 82 had a fall. The evaluation did not indicate the contributing factors for the resident's fall.</p> <p>During a review of Resident 82's post-fall-evaluation dated 3/5/2026, the evaluation indicated on 3/5/2026, Resident 82 had a fall. The evaluation did not indicate all contributing factors for the resident's fall.</p> <p>During an interview on 3/26/2026 at 8:38 a.m. with LVN 1, LVN 1 stated Resident 82 sustained a fall on 3/5/2026. LVN 1 stated she completed the post fall evaluation. LVN 1 stated that the post fall evaluation was not fully completed, noting that several contributing factors were left blank and should have been documented.</p> <p>During an interview on 3/26/2026 at 9:15 a.m. with the DON, the DON stated Resident 82 had two falls, one on 2/28/2026 and one on 3/5/2026. The DON stated it was important to fully complete the post-fall-evaluation, so all factors contributing to Resident 82's fall could be identified, and it would help prevent Resident 82 from falling again.</p> <p>c. During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE]. Resident 28 diagnosis included COPD, anemia (a condition marked by deficiency of healthy red blood cells to transport oxygen in the blood), muscle weakness, gastro esophageal [a muscular tube that connects the throat to the stomach] reflux disease (GERD- a condition in which stomach acid flows back into esophagus causing heartburn), and diabetes.</p> <p>During a review of Resident 28's H&P, dated 10/19/2025, the H&P indicated Resident 28 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28 cognitive skills for daily decision making was mildly impaired. The MDS indicated Resident 28 required supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>toileting a person performs daily to care for themselves).</p> <p>During a concurrent observation and interview on 3/23/26 at 11:21 a.m., with Resident 28, Resident 28 stated wore upper and lower dentures. Resident 28 stated, I have no real teeth. I need my dentures to eat. Resident 28 stated that she had dentures for a few weeks until they went missing. Resident 28 stated she could not remember when her dentures went missing. Resident 28 stated that she informed the nurses she needed her dentures to be able to properly eat. Resident 28 stated, The nurses can't find my dentures and maybe they went missing with the dirty sheets.</p> <p>During a concurrent interview and record review on 3/24/26 at 10:54 a.m., with the Social Services Director (SSD), the Dental Evaluation Report from the facility's contracted mobile dental services dated 12/30/2025, was reviewed. The dental evaluation report indicated Resident 28 received full upper and lower dentures on 12/30/2025.</p> <p>During a concurrent observation and interview on 3/24/26 at 10:54 a.m., with the Social Services Assistant (SSA) and Resident 28, in Resident 28's room, the SSA searched Resident 28's personal belongings for her dentures. The SSA was unable to locate Resident 28's dentures. The SSA stated that Resident 28's dentures were missing.</p> <p>During a concurrent interview and record review on 3/24/2026 at 4:10 p.m., with the Social Services Designee (SSD), the document titled List of Residents with Special Needs, was reviewed. The SSD confirmed that Resident 28 was not identified on the list as having dentures. The SSD stated that Resident 28 received dentures on 12/30/2025 but the list was not updated at that time to reflect this change in status. The SSD stated that residents with special items, including dentures, hearing aids, and glasses, were to be added to the list either upon admission or upon receipt of the items. The SSD stated that the list was maintained in a binder located at each nursing station for staff reference. The SSD stated that it was the responsibility of the Social Services Department to update the List of Residents with Special Needs and to communicate any updates to nursing staff. The SSD stated that once nursing staff was notified, it was their responsibility to initiate or update the resident's belongings list and develop care plans to include the item(s) upon receipt. The SSD stated that this process was not followed for Resident 28, resulting in the omission of dentures from both the special needs list and the resident's belongings record.</p> <p>During a concurrent interview and record review on 3/24/2026 at 4:19 p.m., with the DON, the Dental Evaluation Report dated 12/30/2025 and Resident 28's belongings list dated 10/17/2025, was reviewed. The DON stated that the dental evaluation report indicated that Resident 28 received upper and lower dentures on 12/30/2025 and the belongings list was not updated to reflect Resident 28's dentures. The DON stated that all resident personal items, including dentures, were to be documented and updated on the belongings list upon admission and when new items were received. The DON stated that failure to accurately maintain this list impeded the facility's ability to track and safeguard resident property. The DON stated Resident 28's dentures should have been added to the belongings list when they were obtained and that the absence of documentation reflected a breakdown in facility policy and procedure. The DON stated that staff were responsible for ensuring ongoing updates to residents' belongings and that this oversight contributed to the inability to locate Resident 28's dentures. The DON stated that dentures were essential to a resident's overall health and well-being, as they directly impacted the Resident 28's ability to chew and properly consume food, which could affect the resident's nutritional intake. The DON stated that missing dentures may also impair Resident 28's ability to speak clearly, potentially affecting communication with staff and contribute to overall decline in health status.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P, titled Personal Property dated 10/2/2025, the P&P indicated The facility will ensure that resident's personal property is respected, safeguarded, and properly documented. An inventory of personal belongings will be completed upon admission and updated as necessary to reflect additions, removals or changes. To ensure the facility takes reasonable steps to protect Residents personal property.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure one of three sampled residents' (Resident 55) nasal cannula oxygen tubing and humidifier bottle were labeled with a date. This failure had the potential to increase the risk of infection of Resident 55. Findings: During a review of Resident 55's admission Record (AR) dated 3/25/2026, the AR indicated Resident 55 was a [AGE] year-old female, admitted on [DATE], with the diagnosis that included but not limited to: chronic obstructive pulmonary disease (a long lasting lung disease that makes it hard to breathe), respiratory failure (a condition when the lungs cannot get enough oxygen into the body), diabetes (a condition where the body has trouble controlling the amount of sugar in the blood), and heart failure (a condition the heart is not pumping blood as well as it should.) During a review of Resident 55's Minimum Data Set (MDS, a resident assessment tool) dated 2/27/2026, MDS indicated Resident 55 is on oxygen therapy. During a review of Resident 55's physician's order dated 2/20/2026, the order indicated Resident 55 is on oxygen at 2 liters per minute via nasal cannula as needed and for the oxygen tubing should be changed every 7 days. During an observation on 3/23/2026 at 11:18 a.m. in Resident 55's room, Resident 55 was lying on the bed wearing her nasal cannula for oxygen. The oxygen tubing and the humidifier bottle did not have any dates on them. During a concurrent observation and interview on 3/24/2026 at 10:30 a.m. with Registered Nurse (RN) 1 in Resident 55's room, Resident 55 was sitting on the bed reading a book while wearing a nasal cannula for oxygen. The oxygen tubing and humidifier bottle were not dated. RN 1 stated that both items did not have a date on them and should be labeled with a date. RN 1 stated the oxygen tubing must be changed every 7 days. Without a date label, the staff cannot determine if the tubing has been changed, increasing Resident 55's risk of infection. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, dated 10/31/2025, the P&P indicated oxygen tubing should be changed at least every 7 days and labeled with the date of change.</p>		