STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555139	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miracle Mile Healthcare Center, LLC	1020 South Fairfax Ave Los Angeles, CA 90019

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure five of 10 sampled residents (Residents 15, 55, 3, 11, and 46) received appropriate services to prevent a decline or maintain joint range of motion (ROM, full movement potential in a joint) and mobility by failing to:1a. For Resident 55, provide Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) as ordered for both upper extremities (UE, shoulder, elbow, wrist/hand) active range of motion (AROM, movement at a given joint when the person moves voluntarily) three times a week from 3/2/26 to 3/17/26. 1b. Indicate objective range of motion measurements for impaired joints on Resident 55's Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) evaluation dated 2/3/2026.2. For Resident 3, provide Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) evaluation and treatment to assess proper fit and wear time for right elbow splint (an external device to support, align, or correct a movable part of the body) prior to starting an RNA program to wear a right elbow splint for four to six hours.3. For Resident 11, provide PT and OT evaluation and treatment to assess proper fit and wear time for left elbow splint, left resting hand splint, and both knee splints prior to starting an RNA program to wear a left elbow splint, left resting hand splint, and both knee splints for four to six hours.4. For Resident 46, provide PT and OT evaluation and treatment to assess proper fit and wear time for both elbow splints, both resting hand splints, and both knee splints prior to starting an RNA program to wear both elbow splint, both resting hand splint, and both knee splints for four to six hours.5. For residents 15, provided treatment and services to prevent a further decrease in ROM according to the facility policy and procedure (P&P) titled Resident Mobility and Range of Motion, reviewed 1/20/2026. These deficient practices had the potential to cause injury and pain due to ill-fitting and prolonged wear time of splints for Residents 3, 11, and 46, and a decline in ROM due to delayed RNA treatment in Resident15 and Resident 55 and prevent accurate monitoring of changes in ROM and provision of appropriate care for decline in ROM and mobility for Resident 55. Findings: 1. During a review of Resident 55's admission Record (AR), the AR indicated Resident 55 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to metabolic encephalopathy (any damage or disease that affects the brain), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) without dyskinesia (involuntary movements of extremities). During a review of Resident 55's Order Summary Report (OSR) dated 3/18/2025, the OSR indicated an order dated 3/2/26 for RNA program: RNA to perform BUE AROM in all available planes once a day (continued on next page)

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

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	three times a week as tolerated with rest breaks. During a review of Resident 55's care plan (CP) initiated on 3/17/26, the CP indicated Resident 55 was at risk for decline in mobility status. The CP interventions indicated to maintain ROM as tolerated and RNA program for RNA to perform BUE AROM in all available planes once a day, three times a week as tolerated with rest breaks. During a review of Resident 55's Minimum Data Set (MDS, resident assessment tool) dated 2/25/26, the MDS indicated Resident 55 was cognitively intact (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 55 had no functional limitations in ROM in both sides of the upper extremities and had functional limitations in ROM on both sides of the lower extremities. The MDS indicated Resident 55 required supervision for eating, substantial assistance with upper body dressing, personal hygiene, and sit to lying, and dependent assistance with toileting, bathing, sit to stand, and chair to bed transfers. During an observation and interview on 3/16/26 at 11:58 a.m., Resident 55 was lying in bed and was able to adjust the bed independently. 1a. During a review of Resident 55's March 2026 RNA task schedule, the RNA task schedule indicated X on all days for RNA task of RNA BUE AROM. During an interview and record review on 3/19/26 at 10:16 a.m., Minimum Data Set Coordinator Nurse (MDSC) 2 reviewed Resident 55's orders and stated Resident 55 had an order dated 3/2/26 for RNA to perform BUE AROM in all planes three times a week. MDSC 2 reviewed Resident 55's March 2026 RNA tasks and stated there was no RNA completed for BUE AROM in all planes three times a week until today 3/19/26. MDSC 2 stated nursing staff did not create an RNA task for the RNA order BUE AROM in all planes three times a week until today 3/19/26 and the RNA task should be completed right away so that there was no delay in starting RNA treatment. MDSC 2 stated RNA treatment for BUE AROM three times a week was missed during 3/2/26 and 3/18/26 and Resident 55 was at risk for a decline in ROM and functional mobility due to delay in starting RNA treatment. During an interview on 3/19/26 at 11:18 a.m., the Director of Nursing (DON) stated RNA was a restorative nursing program to help residents maintain their functional level. DON stated if an RNA program was ordered, then the RNA orders had to be carried out, or the residents were at risk for decline in their ROM or functional level. During a review of the facility's policies and procedures (P&P) reviewed 1/20/26, titled, Restorative Nursing Services, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. 1b. During a review of Resident 55's PT Evaluation and Plan of Treatment dated 2/3/2026, the PT Evaluation indicated Resident 55 had impaired ROM in both LE at both hips, both knees, and both ankles. The PT Evaluation did not indicate objective measurements and degrees of ROM movement. During an interview and record review on 3/18/26 at 2:16 p.m., the Director of Rehabilitation (DOR) stated during PT evaluations, PTs assessed ROM in normal ranges or optimal ranges of motion, because ROM help determined if residents could perform functional tasks safely and independently. DOR stated if there was an impairment at a specific joint, then PTs should get specific measurements in degrees and document the actual degrees of motion so that therapy staff could assess for changes (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tolerated with skin checks every two to three hours. During an observation and interview on 3/17/26 at 8:42 a.m., Restorative Nursing Aide (RNA) 1 stated he completed RNA treatment with Resident 11 already. Resident 11 was lying in bed and was wearing knee splints on both knees. Resident 11's knees were bent more than halfway and both hips were rotated to resident's right side. Resident 11 was able to move the right elbow straight a little from a bent position and the right hand was relaxed. Resident 11's left elbow was bent more than halfway and was able to straighten the left elbow a little. RNA 1 stated Resident 11 was not able to move the left arm very much. RNA 1 stated Resident 11 did not wear any splints on the arms. During an interview and record review on 3/18/26 at 2:16 p.m., DOR stated PT and OT assessed residents for appropriateness for a splint. DOR stated it was PT's responsibility to assess if a splint was appropriate for a resident. DOR stated PT should initially apply the splint and ensure proper fit and design and slowly increase a resident's tolerance to wear the splint. DOR stated usually a therapist would start and observe a resident wearing a splint for 30 minutes and see if they were tolerating the splint well. DOR stated if a resident could tolerate it well, then a therapist could slowly increase the splint by one hour. DOR stated it required a therapist to assess a resident's fit and safe tolerance to wear a splint. DOR stated the process was the best practice to avoid potential risk and harm to the resident, because a splint that was not properly assessed and fitted could cause skin damage, irritation, and pain. DOR reviewed Resident 11's RNA orders and confirmed Resident 11 had orders for RNA to put on a left elbow splint, left resting hand splint, and both knee splints. DOR reviewed Resident 11's therapy records and stated Resident 11 did not receive any PT or OT evaluation or treatment prior to ordering an RNA program to put on the left elbow splint, left resting hand splint, and both knee splints. DOR stated that Resident 11 should have received PT and OT evaluation and treatment to fully assess and establish a safe wear time for the splints prior to referring to RNA for splinting. During an interview on 3/19/26 at 10:03 a.m., Occupational Therapist (OT) 1 stated OT assessed whether a resident could benefit from a splint. OT 1 stated an OT would trial the splint first to see if it worked and was appropriate for a resident. Then if the splint was appropriate, the OT would train the RNAs and RNAs would continue to provide the splint with a ROM and stretching program. OT 1 stated it required an OT to trial the splint first by trying it for 30 minutes to one hour to two hours to three hours to make sure the resident tolerated the splint and did not have discomfort or skin issues when wearing the splint. OT 1 stated OTs generally recommended splints for residents who could not move the extremity and were at risk for a decline in ROM so the residents did not have a further decline in ROM. During a review of the facility's P&P reviewed 1/20/26, titled, Resident Specific Rehabilitation Medical Supplies, orthosis, and positioning devices, the P&P indicated, if a problem is identified, physician's orders shall be obtained for a complete evaluation by the appropriate therapist, usually PT or OT; therapists shall complete the assessment and make recommendations addressing prevention of contractures, orthosis, positioning needs to ensure resident's safety, comfort, and functional independence. 4. During a review of 46's admission Record dated 3/18/26, the AR indicated Resident 46 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to dysphagia, Alzheimer's disease, and aphasia. During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46 was severely (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impaired in cognitive skills for daily decision making. The MDS indicated Resident 46 had functional limitations in ROM on both sides of the upper extremities and both sides of the lower extremities. The MDS indicated Resident 46 required dependent assistance with toileting, bathing, dressing, hygiene, rolling, and bed to chair transfers. During a review of Resident 46's care plan initiated on 11/2/24 and revised 3/17/26, the CP indicated Resident 46 was at risk for decline in ROM of UE and LE related to muscular weakness. The CP goal indicated to maintain and prevent decline in resident's ROM. The CP intervention indicated RNA program to apply both elbow splints four to six hours once a day, five days a week as tolerated with routine skin checks every two hours, RNA program for application of both resting hand splint or hand roll four to six hours five times a week as tolerated with skin checks every two to three hours, and RNA for application of both knee splints three to four hours five times a week as tolerated with routine skin checks every two hours. During a review of Resident 46's Order Summary Report, the OSR indicated the following orders: -Dated 5/24/25 for RNA program to apply both elbow splints four to six hours once a day, five days a week as tolerated with routine skin checks every two hours. -Dated 3/17/26 for RNA program for application of both resting hand splint or hand roll four to six hours five times a week as tolerated with skin checks every two to three hours. -Dated 3/11/26 for RNA for application of both knee splints three to four hours five times a week as tolerated with routine skin checks every two hours. During an observation and interview on 3/17/26 at 9:04 a.m., Restorative Nursing Aide (RNA) 2 performed RNA treatment with Resident 46 in bed. Resident 46's eyes were closed and did not speak. RNA 2 moved Resident 46's shoulders up and down below shoulder level and both elbows could straighten and bend a little from a bent position. Resident 46's knees and hips were bent about halfway. RNA 2 put splints on Resident 46's left wrist/hand, right wrist/hand, right elbow, and both knees. RNA 2 stated Resident 46 usually wore the splints for about four hours. During an interview on 3/17/26 at 1:33 p.m., DOR stated Resident 46 had not received any PT or OT services since Resident 46 was admitted to the facility and there were no PT or OT records in the facility's system. During an interview and record review on 3/18/26 at 2:16 p.m., DOR stated PT and OT assessed residents for appropriateness for a splint. DOR stated it was PT's responsibility to assess if a splint was appropriate for a resident. DOR stated PT should initially apply the splint and ensure proper fit and design and slowly increase a resident's tolerance to wear the splint. DOR stated usually a therapist would start and observe a resident wearing a splint for 30 minutes and see if they were tolerating the splint well. DOR stated if a resident could tolerate it well, then a therapist could slowly increase the splint by one hour. DOR stated it required a therapist to assess a resident's fit and safe tolerance to wear a splint. DOR stated the process was the best practice to avoid potential risk and harm to the resident, because a splint that was not properly assessed and fitted could cause skin damage, irritation, and pain. DOR reviewed Resident 46's orders and confirmed Resident 46 had RNA orders for splints on both elbows and resting hand splints and both knees. DOR reviewed Resident 46's therapy records and confirmed Resident 46 never received any PT or OT services prior to starting to wear splints and ordering an RNA program to put on splints, but Resident 46 should have (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Right moderate/Severe (25-50%), the comment and recommendation section was blank. During an interview on 3/19/2026, at 1 PM, with Restorative Nursing Assistant (RNA) 1, RNA 1 stated that he is familiar with Resident 15 and has worked with resident 15 for the last six months. RNA 1 stated that Resident 15 has an order for bilateral lower extremity active ROM and upper right extremity active ROM and that the orders have been the same for the last six months and have not changed. During a concurrent interview and record review on 3/19/2026, at 1:20 P.M., with the Director of Rehabilitation (DOR), Resident 15's JMA for 10/1/2025 and 1/7/2026 and physician's orders were reviewed. The DOR stated that he was familiar with resident 15, and that Resident 15 had orders for lower extremity and upper extremity range of motion with no splinting order. The DOR stated that resident 15 had a JMA done on 10/25/2025 which indicated that right hand/wrist extension/flexion was moderate 50-75% and had a consequent JMA done on 1/7/2026 which indicated that Resident 15's right hand/wrist extension/flexion was moderate/severe 25-50%. The DOR stated that Resident 15's wrist JMA worsened from 10/25/2025 when it was moderate 50-75% to moderate/severe 25-50% when there was a reassessment done 1/7/2026. The DOR stated that the facility did not adjust resident 15's program when the assessment indicated that the ROM had changed/worsened. The DOR the facility should have made alterations to the program to prevent further decline such as fitting the resident for an orthotic (specialized brace designed to support, align, or improve function) and skilled nursing interventions would have been a reasonable response. During an interview on 3/20/2026, at 2:04 P.M., with the Director of Nursing (DON), the DON stated that if the residents JMA indicates that their ROM has worsened, the residents need to be re-evaluated by the rehabilitation department and ensure that resident receives proper treatment based on the assessment. The DON stated that if resident is not provided proper treatment, there may be further deterioration of the resident which may lead to skin breakdown, infection and possibly hospitalization. A review of the facility's P&P titled Resident Mobility and Range of Motion, with review date 1/20/2026, indicated, Policy Statement 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. 6. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miracle Mile Healthcare Center, LLC	1020 South Fairfax Ave Los Angeles, CA 90019

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** a. Based on interview and record review, the facility failed to ensure that a physician was notified and documentation pertaining to the resident's refusal of medication was done for one of three sampled residents (Resident 89) according to the facility's policy and procedures (P&P) titled Requesting, Refusing, and/or Discontinuing Care or Treatment, reviewed 1/20/2026, when Resident 89 frequently refused the following medications;1. Antiseizure (calm overactive electrical signals in the brain to prevent or stop seizures) medications, 18 times in January 2026, 27 times in February 2026, and 22 times from 3/1/2026 to 3/19/2026.2. Antipsychotic (used to treat serious mental health conditions by managing symptoms such as hallucinations, delusions, or severe loss of touch with reality) medications 20 times in January 2026, 27 times in February 2026, and 17 times from 3/1/2026 to 3/19/2026. b. Based on interview and record review, for two of three residents (Residents 75 and 81), the facility failed to implement the facility's policies and procedures (P&P) titled, Seizures and Epilepsy - Clinical Protocol, review date 1/202/2026, Requesting, Refusing and/or Discontinuing Care or Treatment, review date 1/20/2026, and Administering Medications, review date 1/20/2026, by failing to: 3. Administer to Resident 81 Metformin with food as ordered on 3/18/2026.4. Reassess and evaluate Resident 81 for appropriateness of antiseizure medication, Keppra, after resident refused Keppra 126 times between 12/2025 - 3/19/20265. Inform Resident 75 of medications being administered during medication pass observation. This deficient practice had the potential to prevent Resident 75 from exercising his right to accept or refuse care and treatment. These failures had the potential to:Result in adverse reactions for Resident 81 and failing to inform Resident 75 of medications being administered in accordance with the facility's policies and procedures titled, Administering Medications, and Requesting, Refusing and/or Discontinuing Care or Treatment, both review date 1/20/2026.Result in Resident 89's change in behavior, seizures and hospitalization. Findings: 1.A review of Resident 89's admission Record indicated the facility admitted Resident 89 on 7/3/2025 with diagnoses including schizoaffective disorder (a chronic mental health condition including hallucinations, delusions, disorganized thinking), epilepsy (a neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical surges in the brain), and major depressive disorder (a serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy lasting at least two weeks). A review of Resident 89's Minimum Data Set (MDS – resident assessment tool) dated 1/9/2026, indicated Resident 89 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 89 required supervision to partial/moderate assistance from staff with Activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) care. During a concurrent interview and record review on 3/19/2026, at 11:17 A.M., with Licensed Vocational Nurse (LVN) 1, Resident 89's physicians orders, medication administration record (MAR - a legal, daily checklist used by nurses and caregivers to document every medicine given to a patient) from 1/2026 to 3/2026 and nursing progress notes from 1/2026 to 3/2026 were reviewed. LVN 1 stated that Resident 89 was on Aripiprazole (antipsychotic medication), Mirtazapine (antipsychotic medication), and was also on Divalproex (antiseizure medication). LVN 1 stated that the number 2 documented on Resident 89's MAR indicates that Resident 89 refused the medication. LVN 1 stated (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident 89 refused his antipsychotic medications 64 times and antiseizure medications 67 times from 1/2026 to 3/19/2026. LVN 1 stated that the facility's process when resident refuses their medication, is that the facility staff must try 3 (three) times and if resident continues to refuse, then the doctor is notified and documentation of the refusal and doctor notification is done in the residents nursing progress notes. LVN 1 stated that facility did not have any documented evidence that Resident 89's physician was notified that Resident 89 had been refusing medications. LVN 1 stated that the physician needs to be notified of the resident's refusal of medication to see if the physician would like to order something else. LVN 1 stated if the residents do not take their antipsychotic medications and antiseizure medications may lead to a decline in their health and possible transfer to the hospital. During an interview on 3/20/2025, at 12:10 P.M., with Resident 89's physician (MD 4), MD 4 stated that the facility staff expectation when resident refuses medication is to notify the physician and document it. MD 4 stated that when a resident misses antipsychotic and antiseizure medication over a prolonged period, the residents may lose the effects for which the medication was being used to prevent, and what was being prevented from happening would happen such as changes in behaviors and seizures. During an interview on 3/20/2025, at 2:07 P.M., with the Director of Nursing (DON), the DON stated that the facility expectations when a resident refuses medication is to notify the physician and document the refusal. The DON stated that refusal of antiseizure and antipsychotic medication may lead to seizures, increased behaviors or lack of behavior control which may lead to hospitalization. A review of the facility's P&P titled Requesting, Refusing, and/or Discontinuing Care or Treatment, reviewed 1/20/2026, indicated, Documentation pertaining to a resident's request, discontinuation or refusal of treatment shall include at least the following: . g. The date and time the practitioner was notified as well as the practitioner's response; . The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious conseqt1ences of the reqt1est. A review of the facility's P&P titled Administering Medication, reviewed 1/20/2026, indicated, Policy Statement Medications are administered in a safe and timely manner, and as prescribed. A review of the facility's P&P titled Charting and Documentation, reviewed 1/20/2026, indicated, Goals, or any changes in the resident's medical, physical, functional or psychosocial co11dition, shall be docume11ted h1 the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 7. Documentation of procedures and treatments will include care-specific details, including: . e. Whether the resident refused the procedure/treatment; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. Notification of family, physician or other . 3. and 4. During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses that included Epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity) and acute kidney failure (the sudden, temporary loss of the kidneys' ability to filter waste products from the blood, balance fluids, and manage electrolytes), Type 2 Diabetes Mellitus (a disease that occurs when your blood glucose [BG], also called blood sugar [BS], is too high) with Hyperglycemia (high blood sugar [glucose]), and Hypocalcemia (abnormally low levels of calcium in the blood). During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated that Resident 81 was independent for eating, oral hygiene, toileting, upper and lower body dressing, transfer from bed to chair, and required setup or clean up assistance for shower/bathing self and personal hygiene. During a review of Resident 18's Physician Order Summary Report, dated 3/17/2026, the order summary report indicated but not limited to the following physician order: a. Keppra (levetiracetam) oral tablet 1000 milligram ([mg] a unit of measurement for mass), give 1000 mg by mouth two times a day for Seizure Disorder (a chronic neurological condition characterized by recurrent, unprovoked seizures), order date 10/21/2024. b. Monitor seizure episodes every shift. Document (Y) or (+) if noted, (N) or (-) if none. Ensure safety, notify MD immediately if noted, order date 12/4/2020. c. Metformin oral tablet 500 mg, give 500 mg by mouth two times a day for DM (diabetes mellitus). Take with meals, order date 10/15/2024 During a medication pass observation on 3/17/2026 between 9:41 AM to 10:01 AM, with a Licensed Vocational Nurse (LVN) 4 at Medication Cart (MedCart) 2, LVN 4 was observed preparing the following morning medications for Resident 81: Metformin 500 mg, one tablet Amlodipine (treat high blood pressure) 5 mg, one tablet Oyster Shell Calcium (treat low calcium levels) 500 mg, five tablets (2500 mg) Docusate Sodium (treat or prevent constipation) 250 mg, one gel capsule Folic Acid (is a B vitamin supplement) 1 mg, one tablet Keppra (generic name – levetiracetam) 1000 mg, one tablet Acetaminophen (a pain reliever and fever reducer) 325 mg, two tablets (650 mg) Vitamin B1 (Thiamine, supplement) 100 mg, one tablet (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Vitamin B Complex with Vitamin B12 (supplement), one tablet During a concurrent medication pass and observation on 3/17/2026 at 9:57 AM, LVN 4 entered Resident 81's room administered the morning medications, except for Keppra, which the resident refused. Resident 81 was observed accepting the remaining medications. LVN 4 stated that he will let Resident 81's physician know that the resident refused the Keppra. 3. During an interview on 3/17/2026 at 10:01 AM with Resident 81, in the presence of LVN 4, Resident 81 stated that he has not had a seizure in over four years and was started on the seizure medication, Keppra after admission to the facility. Resident 81 stated, I don't need it, referring to the Keppra medication. During an interview on 3/17/2026 with LVN 4, LVN 4 stated that Resident 81 has been refusing Keppra and that the doctor was already aware the resident was refusing the seizure medication. LVN 4 stated the code 2 entered on the MAR indicated, drug refused During a concurrent interview and record review on 3/18/2026 at 12:28 PM with the DON, Resident 81's Nursing Progress Notes and Administration Detail Report for the month of 3/2026 for the administration of Keppra were reviewed. DON stated the code 0, means the medication was administered and code 2, means the drug was refused. The DON reviewed the Administration Detail Report dated 3/15/2026, documented at 18:45 (6:45 PM) with a code 0, meaning administered, and the Nursing Progress Note dated 3/15/2026, documented at 20:31 (8:31 PM) indicated, Resident refused scheduled Keppra tablet this evening. The DON stated that the dose documented the administration of Keppra to Resident 81 on 3/15/2026 in the evening was incorrect, because the resident was documented to have refused the Keppra medication. During a telephone interview on 3/18/2026 at 4:03 PM with Pharm 1, in the presence of the DON, Pharm 1 stated that she reviews all residents in the facility's medications. Pharm 1 stated that she do not look at the residents' MARs regularly. Pharm 1 stated that she reviews the physician order recaps and the nursing notes. Pharm 1 stated the records she reviewed for Resident 81 did not document observation of seizure activity for the resident since admission in 2020. Pharm 1 stated that she did not send any recommendations to Resident 81's physician when the resident was noted to frequently refuse seizure medications. Pharm 1 stated that she did not see Resident 81's MARs and was not aware of how many times the resident refused Keppra. Pharm 1 stated that disruptions of seizure medications can lead to seizures. Pharm 1 stated if a resident is not having seizures, Pharm 1, would not expect the resident to be on the medication. During a concurrent interview and record review on 3/19/2026 at 9:31 AM with the DON, Resident 81's MARs were reviewed between 12/1/2025 through 3/19/2026. The DON acknowledged and counted the amount of times Resident 81 refused Keppra, the seizure medication as follow: - During the month of 12/2025 the resident refused seizure medication Keppra 37 times - During the month of 1/2026 the resident refused seizure medication Keppra 39 times - During the month of 2/2026 the resident refused seizure medication Keppra 33 times - During the month of 3/1/2026 through 3/19/2026 the resident refused seizure medication 17 times (for a total of 126 refusals of seizure medication between 12/2025 through 3/19/2026) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 81's MAR indicated zero seizure activity across all three shifts (Day, Evening, and Night) for the months of 12/2025, 1/2026, 2/2026, and through 3/17/2026. During a telephone interview on 3/19/2026 at 10:33 AM with Resident 81's Responsible Party (RP) 2, RP 2, stated that Resident 81's seizure started happening at the facility, shortly before COVID. RP 2 stated they were not aware of Resident 81 having seizures prior to getting sick, was malnourished and had low potassium when the resident was first placed in the facility in 2020. RP 2 stated Resident 81 sounds better than he was before, and they want the resident to remain at the facility. RP 2 stated they do not remember the facility calling to notify them of Resident having a seizure in more than three years. RP 2 stated that facility has not mentioned that Resident 81 was refusing seizure medications. RP 2 stated the facility will call when Resident is sick or have an outburst. During a telephone interview on 3/19/2026 at 12:27 PM with Resident 81's physician (MD 1) in the presence of the DON, MD 1 stated that Resident 81 constantly refusing the seizure medication, Keppra. MD 1 stated that Resident 81 had a possible seizure while seen in the hospital. MD 1 stated that Resident 81 just do not want to take the medication (Keppra). MD 1 stated Resident 81 was started on Keppra 1000 mg twice a day prior to admission to the facility at an acute hospital. MD 1 stated that he had continued the Keppra order upon Resident 81's admission to the facility. MD 1 stated he would not make any change to Keppra order, must be done by a neurologist. MD 1 stated that he has not seen any neurologist notes for Resident 81 but requested that the resident be seen by a neurologist. MD 1 stated his expectation is for the facility to follow up on his request for the resident to be seen by a neurologist and an endocrinologist. MD 1 stated a seizure may be triggered in Resident 1 with the wide swings from receiving the seizure medications sometimes and not receiving the medication. DON stated there were no neurologist notes, and no documentation of a physician ordered request for Resident 81 to be seen by a neurologist in the resident's clinical records. DON stated she will write the order now for Resident 81 to be seen by a neurologist under MD 1's stated request. MD 1 acknowledged and agreed for the DON to order a neurologist referral for Resident 81. A review of the facility's P&P titled, Seizures and Epilepsy – Clinical Protocol, review date 1/202/2026, indicated, Assessment and Recognition. 1b. Acute seizure may occur in relation to a metabolic disturbance (for example, hypoglycemia, hyponatremia [low sodium in the blood] or hypocalcemia) or an acute central nervous system (CNS) illness such as a stroke or head injury. Epilepsy refers to repeated, unprovoked seizures. Treatment/ Management The physician will treat underlying causes and risk factors, where possible; for example, correct sodium or calcium imbalance, or taper, stop, or change medications associated with an increased seizure risk. The physician will identify and order appropriate treatment for an acute seizure and a seizure disorder. Antiepileptic medications should be instituted if there is a reasonable chance that seizures will recur but may not be necessary if a single seizure with an identified cause (for example, hyponatremia or an adverse drug reaction) does not indicate an underlying tendency toward recurrent seizures. The physician will explain and/or document when an antiepileptic medication is not indicated. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Antiepileptic medications should be used in the lowest possible dose, consistent with seizure control. Most antiepileptic medications have prominent side effects, including lethargy, dizziness, and ataxia Monitoring.1. The staff and physician will monitor the progress of individuals with a new seizure or a seizure disorder, and will modify interventions accordingly. For individuals who have been seizure-free for an extended time, the physician will periodically consider tapering antiepileptic medications especially when their initial use was for idiopathic seizures, an underlying acute medical cause was corrected, or seizure prophylaxis had been initiated in the absence of an identifiable structural cortical lesion. The physician will document clinically valid reasons for maintaining a current dose without attempting any reduction. A review of the facility's P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment, review date 1/20/2026, indicated, Residents have the right to request, refuse and/or discontinue treatment prescribed by his or her healthcare practitioner, as well as care routines outlined on the resident's assessment and plan of care.If a resident requests, discontinues or refuse care or treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will meet with the resident to: a. Determine why the resident is requesting, refusing or discontinuing care or treatment b. Try to address the resident's concerns and discuss alternative options; and c. Discuss the potential outcomes or consequences (positive and negative) of the resident's decision. The resident will not, under any circumstances be coerced, intimidated, manipulated or threaten for refusing, discontinuing or requesting care or treatment. 3. A review of Resident 81's physician orders and Medication Administration Record (MAR, a legal document that provides a comprehensive account of all medications administered to a resident) for Metformin indicated the resident was ordered to be administered Metformin with meals and was scheduled to be administered at 7:30 AM. Resident 81 was observed receiving Metformin on 3/17/2026 at 9:57 AM without a meal. During an interview on 3/17/2026 at 3:00 PM with LVN 4, LVN 4 stated that Resident 81's breakfast is served daily between 7:30 AM to 8:00 AM. During an interview on 3/17/2026 at 3:02 PM with Resident 81 in the presence of LVN 4, LVN 4 asked Resident 81, when did he eat breakfast this morning (3/17/2026). Resident 81 stated, I did not eat breakfast. I ate lunch at 12 PM. Resident 81 stated that he usually do not eat breakfast. During a concurrent interview and record review on 3/17/2026 at 3:04 PM with LVN 4, Resident 81's physician order and scheduled administration time for Metformin was reviewed. LVN 4 stated that Resident 81's Metformin was scheduled to be given at 7:30 AM with a meal. LVN 4 stated that Resident 81's Metformin is given with a meal to control the resident's blood glucose level and if given on an empty stomach can cause hypoglycemia (low blood sugar). LVN 4 stated if Resident 81's blood sugar drops too low the resident could become unresponsive and could lead to hospitalization. LVN 4 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated if the resident does not eat breakfast the physician should have been called. During a concurrent interview and record review on 3/18/2026 at 12:09 PM with the Director of Nursing (DON), Resident 81's physician order, scheduled administration time, and administration detail report for the resident's Metformin administration on 3/17/2026 were reviewed. The DON stated that Resident 81 was ordered Metformin 500 mg two times a day with meals and was scheduled to be administered daily at 7:30 AM and 5:30 PM with meals. The DON reviewed Resident 81's administration detail report and stated the resident was documented to have received Metformin 500 mg on 3/17/2026 at 10:03 AM. The DON stated giving Metformin on an empty stomach could result in adverse reactions, that may include hypoglycemia, sweats, shock, coma, or hospitalization. The DON stated the licensed nurse could have offered the resident a snack or something to eat when Resident 81 was not having a full meal. A review of the facility's P&P titled, Administering Medications, review date 1/20/2026, indicated, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: Enhancing optimal therapeutic effect of the medication; Preventing potential medication or food interactions; and Honoring resident choices and preferences, consistent with his or her care plan. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 5. During a review of Resident 75's admission record, the admission record indicated that Resident 75 was admitted to the facility on [DATE] with diagnoses that included Post-laminectomy syndrome (also called failed back surgery syndrome, is when a patient still has pain after spine surgery), Muscle Spasm, Post-traumatic stress disorder, chronic (PTSD, is a long-term [chronic] mental health condition that is caused by an extremely stressful or terrifying event), Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), Bipolar disorder (a mental health condition characterized by severe, unpredicted shifts in mood, energy, and activity levels), and Anxiety (excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 75's MDS dated [DATE], the MDS indicated that Resident 75's cognitive skills (ability to think and reason) were intact. During a record review of Resident 75's Order Summary Report, dated 3/18/2026, the order Summary Report included the following orders for the resident: Morphine Sulfate Extended Release (ER) Oral Tablet (an opioid [narcotic] that is used to manage pain severe enough to require daily around-the-clock, long-term treatment), instructions indicated to give one tablet by mouth two times a day for pain management, order date 2/21/2026 Gabapentin (used to seizures and nerve pain) Oral Capsule 300 mg, instructions indicated to give 300 mg by mouth one time a day for neuropathy. Hold for respiration rate less than 12 or if drowsy, order (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date 2/20/2026 Aripiprazole (used to treat mental disorders) Oral Tablet 5 mg, instructions indicated to give one tablet by mouth one time a day for bipolar disorder easily angered AEB (as evidenced by) screaming and yelling with no provocations, order date 2/21/2026 Baclofen (used to treat muscle spasms) Oral Tablet 10 mg, instructions indicated to give one tablet by mouth one time a day for muscle spasms, order date 2/21/2026 Bupropion Hydrochloride (used to treat major depression) Oral Tablet 75 mg, instructions indicated to give one tablet by mouth one time a day for major depressive disorder M/B (manifested by) verbalization of sadness and loss of interest in pleasurable activities, order date 2/21/2026 Acetaminophen Oral Tablet 500 mg, instructions indicated to give two tablets by mouth three times a day for pain management, not to exceed three (3) grams of Acetaminophen in 24 hours from all sources, order date 2/20/2026 Sennosides (used to treat constipation) Oral Tablet 17.2 mg, instructions indicated to give one tablet by mouth two times a day for bowel management, hold if loose stools, order date 2/20/2026 During a medication pass observation on 3/18/2026 at 9:16 AM, with a Licensed Vocational Nurse (LVN) 2 at MedCart 3, LVN 2 was observed preparing the following morning medications for Resident 75: Acetaminophen 500 mg, two tablets (1000 mg) Sennosides 8.6 mg, two tablets (17.2 mg) Aripiprazole 5 mg, one tablet Baclofen 10 mg, one tablet Bupropion HCL 75 mg, one tablet Gabapentin 300 mg, one capsule Morphine Sulfate ER 15 mg, one tablet During a concurrent interview and observation on 3/18/2026 at 9:27 AM, with LVN 2, LVN 2 stated that she prepared a total of seven medications for Resident 75. LVN 2 entered Resident 75's room and administered the seven medications to resident without explaining to the resident what medications the resident was being administered or what the medications were for. During an interview on 3/18/2026 at 9:32 AM, with LVN 2 at MedCart 3, LVN 2 stated that she did not let Resident 75 know what medications she was administering to the resident this morning, 3/18/2026. LVN 2 stated Resident 75 does have the right to know what medications he is being administered. During an interview on 3/18/2026 at 12:45 PM with the DON, the DON stated the licensed nurses must (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	explain the medications to the residents during medication pass. The DON stated the licensed nurses must let the residents know what they are getting and the details of the medications. A review of the facility's P&P titled, Requesting, Refusing, and/or Discontinuing Care or Treatment, review date 1/20/2026, indicated, Residents/representatives will be informed (in advance) of the care that will be furnished or made available to the resident based on his or her assessment and plan of care.The resident is not forced to accept any medical care or treatment and may refuse or discontinue care or treatment at any time. This includes care or treatment prescribed by a physician, care or treatment that has been administered previously.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 3/17/2026 by failing to:1.Ensure minced and moist texture bread and cabbage was prepared according to the IDDSI- Level Five minced and moist foods- (All foods prepared for this diet must be soft, moist with all excess fluid drained, and minced to size no larger than 4mm fits through the gaps of fork prongs) when 5 residents received bread and cabbage with carrots that was not small (minced) did not fit through the fork prongs.2. Ensure cooks followed the food production recipe for 28 residents on the soft and bite size diet (food particle are soft and chopped into 1/2 inch pieces) who received minced (ground beef consistency) corned beef instead of chopped into 1/2 inch pieces. These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake and increased choking risk for the five residents on minced and moist diet. Findings: 1.During an observation of the tray line (tray line - a system of food preparation, in which trays move along an assembly line and cook serves food on the plates) service for lunch on 3/17/2026 at 12:15PM, the minced and moist bread was prepared with large pieces of bread soaked in milk. The cabbage was chopped and the carrots were shredded into 1-inch-long strips instead of minced. During a concurrent observation and interview with cook (cook) 1 on 3/17/2026 at 12:15PM, cook1 stated the bread for minced and moist is not blended it is cut up bread and soaked in milk to make it moist. Cook1 stated cabbage with carrots is the same as the regular diet except the carrots are shredded for the minced and moist diet. During a concurrent interview and taste test (sampling the flavor and texture of the prepared meal) of the minced and moist bread, cabbage and carrots with cook 1, cook 2 and Dietary Supervisor (DS) on 3/17/2026 at 12:30PM, cook1 stated the bread has large pieces which require chewing, not appropriate for the minced and moist diet. Cook1 stated the carrots are shredded instead of minced. Cook1 stated bread and cabbage are soft and moist but not minced and it can be a problem for residents who have some chewing issues. During the same observation and interview DS stated there are some large pieces of bread in the minced and moist bread, and the cabbage and carrots are large and do not fit the gaps of the fork prongs per minced and moist policy. DS stated not following the menu can cause not preparing the correct texture and potential for some residents to have difficulty swallowing and not liking the food. During a review of the facility's recipe titled Recipe: Bread IDDSI LEVEL 5-Minced and Moist (dated 2025) indicated, Tear bread into pieces and place them in a food processor to pulse into crumbs.Transfer the breadcrumbs to a bowl and add liquid start with melted margarine.if more moisture is needed add milk.let the mixture sit for 5 minutes to fully absorb the liquid then serve. During a review of the facility's recipe titled Recipe: Fresh Cabbage and Carrots (dated 2026) the recipe indicated, soft. Mince cabbage and carrots separately until food is in pieces =4mm by 15mm. Moisten with gravy/sauce at appropriate thickness as needed. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 5 Minced and Moist is usually eaten with spoon or fork, for people who cannot bite off pieces of food safely but have some basic chewing ability. It is important that food is not sticky. You should be able to scoop food onto a fork, with no liquid dripping and no crumbles falling off the fork. Size of the food is 4mm, which is about the gap between the prongs of a standard dinner fork. Food testing method: Spoon tilt test and Fork drip test. 2.During an observation in the kitchen on 3/17/2026 at 12:15PM, Cook1 served minced and moist corned beef to residents who were on soft and bite size diet (food particles are soft and chopped into 1/2 inch pieces). During a concurrent observation and interview with cook1 and DS on 3/17/2026 at 12:30PM cook1 stated I didn't follow the recipe to prepare the soft and bite corned beef. Cook1 stated he was trained to put everything in the food processor and blend until small pieces. Cook1 stated instead of serving corned beef cut into 1/2 inch size, I made a minced corned beef (similar to a ground meat). Cook1 stated residents may not like minced and not eat the food. During an interview with DS (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 3/17/2026 at 12:30PM, DS stated cooks should always follow the menu and recipe to make sure correct texture and recipe are prepared. DS stated not following the menu can make some residents not happy with food and decrease intake. During a review of the facility's recipe titled Recipe: Corned Beef (dated 2026) the recipe indicated, Tender meat, chop into pieces=1.5cm (1/2 inch) by 1.5 (1/2 inch) cm in size. During a review of facility policy and procedures (p & p) titled, Menu Planning (dated 2025), the p & p indicated, The menus are planned to meet nutritional needs of residents in accordance with established national guidelines.Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when:1.Two open packages of hot dog with dates 3/10/26-3/13/26 expired and stored in the walk-in refrigerator. Fully cooked Corned beef was stored on the bottom shelf below raw ground beef. One box containing 70 single serve containers of juice with a thaw date of 3/5/26 expired exceeding storage period for frozen juice and stored in the walk-in refrigerator. 2. There was water accumulation around the grease trap (A kitchen grease trap (or interceptor) is a plumbing device designed to capture fats, oils, and grease (FOGs) from wastewater/dish machine before they enter drainage systems, preventing clogs, backups, and odors.), oil-like substance was floating over the water build up. Potential for contamination of food, utensils, equipment, food contact surfaces and attract pests to the kitchen area.3. One can opener blade was dirty with dried brown residue, and the blade was worn and dented with the potential to harbor harmful bacteria.4. Food Brought to residents from outside of the facility was stored in the resident's food refrigerator located in a locked room next to the DONs office with no label and not monitored for the expiration date. The refrigerator temperature log was missing for the current month. There was one medium container of leftover food with no date and one container of milk with date 3/16/26 expired and stored in the refrigerator.5. Facility failed to ensure food was labeled and dated in a manner to prevent growth of microorganisms 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 one out of one residents (Resident 106) These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 98 out of 102 residents who received food from the facility and including residents who had food stored in the resident refrigerator. Findings; 1. During an observation in the kitchen on 3/17/2026 at 9:50AM two plastic bags containing hotdogs dated 3/10/26-3/13/26 were stored in the walk-in refrigerator. During a concurrent observation and interview with Dietary Supervisor (DS), DS stated the date is when the hotdogs were removed from freezer and stored in the refrigerator to thaw. DS stated we keep hotdogs for five days per policy. DS said hot dogs should be removed and discarded because they have been stored for longer than five days and they can turn bad. During the same observation and interview with DS on 3/17/2026 at 9:50AM, there was one large fully cooked corned beef stored on the bottom shelf in the walk-in refrigerator below the raw ground beef. DS stated fully cooked food should be stored on the top shelf to prevent contamination with raw meats thawing and potentially dripping over the fully cooked food and can make residents sick. During an observation in the kitchen on 3/17/2026 at 9:55AM, there was one large cardboard box containing 70 single serve containers of juice stored in the walk-in refrigerator with a date of 3/5/26. During a concurrent observation and interview with DS and on 3/17/2026 at 9:55AM, DS stated the juice was delivered frozen and they are stored in the freezer. DS did not know the expiration date of the juices. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and review of the juices manufactures instruction for storage, the label indicated to store frozen and once thawed use within 10 days. DS stated the juice was stored longer than 10 days. DS stated when juice goes bad it can make residents sick. Observed DS remove the box from the walk-in refrigerator to discard. During a review of facility's policy and procedures (P&P) titled, Procedure for refrigerated storage (dated 2019) the P&P indicated, Frozen food should be left in a refrigerator to thaw. Once thawed, uncooked meat is to be used within 2 days. The exception is cured meat, which is to be used within 5 days. Supplemental shakes which are taken from the frozen stated and thawed in the refrigerator must be dated as soon they are placed in the refrigerator. Follow the manufactures recommendations for shelf life. During a review of facility's refrigerated storage guide (dated 2019), the storage guide indicated luncheon meats, ham, bacon, frankfurters maximum refrigeration time once meat has thawed is 5 days. During a review of facility's P&P titled, Food Preparation (dated2018) the P&P indicated, Store raw meat, poultry, and fish separately from cooked and ready to eat food to prevent cross contamination. Store cooked or ready to eat food above raw meat, poultry, and fish, if these items are stored in the same unit. This will prevent raw-product juices from dripping onto the prepared food and causing food borne illness. 2. During an observation in the kitchen's dishwashing area on 3/17/2026 at 10:14AM, there was water accumulated around the grease trap. Oil-like substances were floating on the water. There were storage shelves for pots next to the grease trap in the dishwashing area. During a concurrent observation and interview with DS on 3/17/2026 at 10:14AM, DS stated an outside company comes every three months to clean the grease trap. DS stated there is significant amount of water or backflow from the grease trap and will contact the grease trap cleaning company. DS stated there shouldn't be any water on the floor because it can cause bacteria growth and contamination of utensils, equipment, and food. DS said it can be a risk for slips and attract pests to the kitchen area. During a concurrent observation and interview with Maintenance Supervisor (MS) on 3/17/2026 at 10:20AM, MS stated outside company has been called to assess the grease trap. MS stated the water should be mopped and there should not be any standing water on the floors to prevent pests and contamination in the kitchen. MS stated kitchen staff should clean and make sure the area is dry. During a review of facility's policy and procedures (P&P) titled General appearance of Food and Nutrition Department (dated 2018) the P&P indicated, Floors must be mopped at least once per day; Use caution signs on wet floors. Mop under and around equipment, along the walls and in corners. The wet floor should not be walked on until it is thoroughly dry; wipe up all spills as they occur. During a review of the 2022 U.S. Food and Drug Administration Food Code, code 5-402.12 titled Grease Trap code indicated, Failure to locate a grease trap so that it can be properly maintained and cleaned could result in the harborage or vermin and or the failure of the sewage system. During a review of the 2022 U.S. Food and Drug Administration Food Code, code 5-402.11 titled Backflow Prevention code indicated, Improper plumbing installation or maintenance may result in (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potential health hazards such as cross connections, back siphonage or backflow. These conditions may result in the contamination of food, utensils, equipment, or other food-contact surfaces. It may also adversely affect the operation of equipment such as ware washing machines. 3. During an observation in the kitchen food preparation area on 3/17/2026 at 12:02PM, one can opener blade was noted to be worn out and dirty. The blade was not smooth, stained and covered with sticky and dry brown colored residue. During a concurrent observation and interview with DS on 3/17/2026 at 12:02PM, DS verified that there is sticky brown residue and the blade is worn out. DS stated can opener needs to be wiped and sanitized. DS stated the blade has not changed for a year and can't clean the blade because of the dents. During a review of facility's policy and procedures (P&P) titled Can opener and base (dated 2018) the P&P indicated, proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredding can result from a dull cutting blade. The can opener must be thoroughly cleaned each work shift. Replace blade on can opener as needed. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Good Repair and proper Adjustment Code # 4-501.11(C), indicated, Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened. A review of 2022 Food Code titled, Can Openers Code# 4-202.15 indicated, Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized. 4. During an observation in the resident refrigerator located in the facility's ice room on the 2nd floor on 3/18/2026 at 12:19PM, the refrigerator temperature log for the month of March 2026 was missing. March2026 was crossed out and February was written on the log. The temperatures logged for February 2026 ranged from 68-70. During a concurrent observation and interview with DON, DON did not know what happened to the temperature monitoring log for the month of March and did not understand the temperatures documented for the month of February 2026. DON stated, refrigerated temperatures should be 41 degrees Fahrenheit and below. During the same observation and interview with DON on 3/18/2026 at 12:19PM, There was one small container with resident leftover food with no label or date. There was one container of milk dated 3/16/26 expired stored in the resident refrigerator. DON stated when food is brought from outside, any leftovers will be stored in the resident refrigerator, labeled and dated for the time it was brought in. DON stated will discard the food and milk because there are no temperature logs for March 2026, no dates and we don't know when the food was brought in. DON said it's important to make sure the refrigerator temperature is monitored and food dated so no spoiled food is given to residents. During a review of facility's policy and procedures (P&P) titled Food Brought by Family/Visitors (dated March 2022) the P&P indicated, Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. The nursing staff will discard perishable foods on or before the use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P&P titled Procedure for Refrigerated Storage indicated the Refrigerator temperatures is at 41 degrees F (Fahrenheit) or lower. 5. A review of the admission record indicated Resident 106 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included paranoid schizophrenia (intense, irrational persistent distrust or suspicion of others, often involving the unfounded belief that one is being threatened, harmed, or persecuted, featuring prominent delusions and auditory hallucinations), major depressive disorder (persistent low mood, loss of interest in pleasurable activities,), atrial fibrillation (an irregular and often very rapid heart rhythm.), anemia (low levels of healthy red blood cells), anxiety disorder (persistent, excessive, and uncontrollable fear, worry, or dread that is out of proportion to actual danger) and malignant neoplasm, of the endometrium (cancer that develops in the lining of the uterus). A review of Resident 106's Minimum Data Set (MDS - resident assessment tool) dated 1/23/2026, indicated Resident 106's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. Resident 106 required supervision or touching assistance with eating, partial moderate assistance with oral hygiene and upper body dressing, Resident 106 required substantial maximum assistance for shower/bathing, lower body dressing and personal hygiene and was totally dependent for toileting hygiene and putting on and taking off footwear. A review of Resident 106's order summary dated 3/20/2026 indicated Resident 106 was on a no added salt, diet, regular texture, regular/thin liquid consistency. During a tour observation and interview on 03/16/2026 at 9:58 AM, Resident 106's bedside table was observed to have five (5) undated disposable condiments cups with a light yellow liquid inside the cups, during an interview Resident 106 stated the yellow liquid in the undated condiment cups was lime juice she used for her salads and was provided by facility kitchen. During an interview on 3/18/2026 at 10:08 am, LVN 3 stated she did not know the nature of the light-yellow liquid inside the 5 condiment cups at Resident 106's bedside because it was not labeled and had no use by date. LVN 3 left Resident 106's bedside with a 1 condiment cup stating she is going to find out the nature of the liquid in the condiment cups. LVN 3 returned to Resident 106's bedside and told surveyor the yellow liquid in the condiment cups was lime juice. LVN 3 stated consuming undated and/or unlabeled condiments can cause Residents to acquire to food borne illness and/or cause an allergic reaction which can result in unnecessary hospitalization and poor patient outcomes. During an interview on 3/18/2026 at 1:55 pm, Dietary Supervisor (DS) stated Resident 106 was using the lime juice in the condiment cups for salads. DS stated the lime juice in the condiment cups should not be left at bedside, they should be discarded within two (2) hours after every meal for infection control. During an interview with Director of Nursing (DON) on 3/20/2026 at 1:36 pm, DON stated leaving the unlabeled, undated condiments at bedside places Residents at risk of consuming expired food which can lead to severe food borne illness, allergic reactions, resulting in unnecessary hospitalization, poor patient outcomes and even death. A review of facility policy and procedures titled Storage of Food and Supplies dated 01/20/2026, indicated, Foods shall be stored properly in a safe manner.Liquid foods. will be tightly closed, labeled and dated. Foods in unlabeled. containers shall not be retained or used.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure the trash stored in the dumpster area was maintained in a sanitary manner. Three of four trash bins were overfilled, lids kept open and flies were present inside the dumpster room. There was trash (plastic cups, food containers, plastic utensils, gloves and paper) scattered on the ground, and under the trash bins. This deficient practice had the potential for harborage and feeding of pests. Findings: During an observation in the main dumpster area located in an alley behind the facility on 3/17/2026 at 10:30AM; The facility dumpster area was behind a locked gate. Three of four trash bins were overfilled, and trash lids were open. The trash room was filled with flies. During a concurrent observation and interview with Maintenance Supervisor (MS) and Dietary Supervisor (DS) on 3/17/2026 at 10:30AM, MS stated trash lids should stay closed, so it doesn't bring in pests like flies and rats. MS stated the ground is full of trash and should be swept more often by housekeeping. DS stated there are plastic utensils, cups and food containers on the ground under the trash bins, DS said trash should be inside the dumpster bins. A review of facility's policy and procedures (P&P) titled Miscellaneous Areas-Garbage and Trash (dated 2020), the P&P indicated, All food waste must be placed in sealed containers (plastic bags); Trash Procedure: Garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. Trash Collection Area: the trash collection Area-The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean 1. The area must be swept and washed down by maintenance with a detergent on a regular basis. A review of Food and Drug Administration (FDA) Food Code 2022 dated 1/18/2023, code number 5-501.113 titled Covering receptacles, indicated: receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable indicated refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection control practices for one of one residents (Resident 115) and for three of three sampled staff by failing to: Change Resident 115's Peripherally Inserted Central Catheter (PICC-a long, thin, flexible tube inserted into a peripheral vein in the arm and advanced to the heart used to deliver medication intravenously (IV-into a vein) access for weeks or months) dressing within 7 days according to the facility's P&P titled, Central Venous Catheter Dressing Changes.Fit test three of three sampled staff (Certified Nursing Assistant [CNA] 2, Licensed Vocational Nurse [LVN] 2 and LVN 3) for their N95 mask (also known as a respirator, it is a respiratory protective device designed to achieve a very close facial fit and provide efficient filtration of airborne particles)These deficient practices placed the Resident 115 at risk for infection had the potential to result in blood stream infections through contamination of Resident 115's, Triple Lumen (three channel) Peripherally Inserted Central Catheter (PICC-a long, thin, flexible tube inserted into a peripheral vein in the arm and advanced to the heart used to deliver multiple medications simultaneously via intravenous (IV) access for weeks or months. These deficient practices also had the potential to spread respiratory infections throughout the facility to all residents and staff. Findings: a. A review of Resident 115's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included peritoneal abscess (a pocket of pus and infected fluid in your belly), Abdominal actinomycosis (bacterial infection caused by Actinomyces species), Pneumonia due to Klebsiella Pneumoniae (bacterial infection caused by Gram-negative, encapsulated Klebsiella pneumoniae bacteria), Surgical aftercare following Surgery on the digestive system, protein-calorie malnutrition (a severe, often life-threatening deficiency intake or absorption of protein and total energy (calories), colostomy status (surgical procedure to create a stoma (opening) in the abdomen, through which a portion of the colon (large intestine) is redirected to allow waste to leave the body), type 2 diabetes (disease in which there is a high level of sugar (glucose) in the blood) and hypertension (HTN-high blood pressure). A review of Resident 115's Minimum Data Set (MDS - resident assessment tool) dated 2/26/2026 indicated the resident 115's cognition (The mental ability to make decision of daily living) was intact, Resident 115's required supervision/touching assistance for eating and oral hygiene, partial/moderate assistance with upper body dressing, and personal hygiene and, substantial/maximal assistance with toileting/hygiene, shower/bathe, lower body dressing and putting on/taking off footwear. A review of Resident 115's order summary report dated 3/20/2026 indicated an order for Total Parental Nutrition (TPN-a method of delivering all essential nutrients—carbohydrates, proteins, fats, vitamins, minerals, and electrolytes—directly into the bloodstream via PICC line on right upper arm (RUA) During a facility tour on 3/17/2026 at 1:10 pm, Resident 115 was observed to have a triple lumen PICC line on her RUA with a labeled sticker indicating a PICC line dressing change date of 3/15/2026, during the inspection of the PICC line dressing, another sticker label attached to the PICC lines transparent dressing that covered the triple lumen PICC line completely and securely dated 3/8/2026 was observed beneath the 1st sticker dated (3/15/2026). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/17/2026 at 1: 15 p.m. LVN 9 stated he (LVN 9) does not know who placed the sticker with a labeled dressing change dated 3/15/2026 on top of the PICC line dressing. During an interview on 3/17/2026 at 1:20 p.m. the Registered Nurse (RN) 1 stated PICC line changes are done every 7 days and as needed if soiled to prevent infection at the catheter site. RN stated failing to change a PICC dressing weekly, significantly increases the risk of serious blood stream infections, catheter dislodgement and skin damage causing unnecessary hospitalization and extended antibiotic therapy and poor patient outcomes. During an interview on 3/20/2026 at 1:29pm, Director of Nursing (DON) stated, PICC line dressing changes are done every 7 days and as needed if soiled. Dressing changes are made to assess PICC line site for signs and symptoms of infection and dislodgment. DON stated failing to change the dressing places Residents at risk of infections which could lead to unnecessary hospitalization, extended antibiotic treatment and poor outcomes. A review of facility's policy and procedures (P&P) titled, Central Venous Catheter Dressing Changes dated, 1/20/2026, indicated, the purpose of this procedure is to prevent catheter -related infections that are associated with contaminated, soiled, or wet dressing changes. Guidelines: . Change the dressing the semi-permeable membrane (TSM) dressing at least every 5-7 days and as needed (PRN). A review of facility's P&P titled Policies and Practices-Infection Control dated 1/20/2026 indicated,the facility's infection control policies and practices are intended to . help prevent and manage transmission of diseases and infections. b. During an interview on 03/20/2026 at 10:29 AM, Infection Preventionist (IP) stated she could not find an N95 fit test for CNA 2, LVN 2 and LVN 3. The IP stated fit test are completed upon hire, yearly and as needed. The IP stated, the fit test is completed to make sure the mask fits properly, to prevent one from getting a respiratory infection. CIP further stated a possible outcome of not being fit tested is the spread of respiratory infections. During an interview on 03/20/2026 at 1:46 PM, the Director of Nursing (DON) stated the facility fit tests all staff annually. ADM stated the fit test is conducted to make sure the N95 mask fits one's face properly and to prevent the spread of infection. The DON further stated staff not being fit tested could lead to passing infection among staff and residents. A review of the facility's policy and procedures titled, Policies and Practices – Infection Control, dated 1/20/2026, indicated, the objectives of the facility's infection control policies and practices are to: a. prevent, detect, investigate, and control infections in the facility; b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	public; c. establish guidelines for implementing isolation precautions, including standard and transmission-based precautions; d. establish guidelines for the availability and accessibility of supplies and equipment necessary for standard and transmission-based precautions; e. maintain records of incidents and corrective actions related to infections; The P&P also indicated All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. A review of the Center for Disease Control and Prevention (CDC) guideline title, The Respiratory Protection Information Trusted Source, indicated that users are required to be fit tested to confirm the fit of any respirator that forms a tight seal on your face before using it in the workplace. Fit testing is important to ensure the expected level of protection is provided by minimizing the total amount of contaminant leakage into the facepiece through the seal. It also indicated that one should be fit tested yearly to ensure that N95 mask fits properly (https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/respsource3fittest.html#:~:text=You%20should%

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's staff and practitioner failed to assess one (1) out of 1 sampled resident (Resident 115's) mental and physical abilities to determine whether self-administering medications are clinically appropriate for the Resident prior to leaving medications at Resident 115's bedside.This deficient practice paused the risk of improper use/ingestion, and accidents with the potential for adverse reactions, unnecessary hospitalization and possible poor outcomes for Resident 115 and for residents with wandering behavior. Findings: A review of Resident 115's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included peritoneal abscess (a pocket of pus and infected fluid in your belly), Abdominal actinomycosis (bacterial infection caused by Actinomyces species), Pneumonia due to Klebsiella Pneumoniae (bacterial infection caused by Gram-negative, encapsulated Klebsiella pneumoniae bacteria), Surgical aftercare following Surgery on the digestive system, protein-calorie malnutrition (a severe, often life-threatening deficiency intake or absorption of protein and total energy (calories), colostomy status (surgical procedure to create a stoma (opening) in the abdomen, through which a portion of the colon (large intestine) is redirected to allow waste to leave the body), type 2 diabetes (disease in which there is a high level of sugar (glucose) in the blood) and hypertension (HTN-high blood pressure). A review of Resident 115's Minimum Data Set (MDS - resident assessment tool) dated 2/26/2026 indicated Resident 115's cognition (The mental ability to make decision of daily living) was intact, Resident 115's required supervision/touching assistance for eating and oral hygiene, partial/moderate assistance with upper body dressing, and personal hygiene and, substantial/maximal assistance with toileting/hygiene, shower/bathe, lower body dressing and putting on/taking off footwear. During a facility tour on 3/17/2026 at 1:10 pm, Resident 115's bedside drawer was observed to have two (2) prefilled syringes (device used to inject medication and fluids into or withdraw fluids/gases from the body) with 10cc's (unit dose) cubic centimeter (cc-unit of measure) of normal saline (an aqueous solution of electrolytes) unattended at bedside. During an interview on 3/17/2026 at 1: 15 p.m. Licensed Vocational Nurse (LVN) 9 stated he (LVN 9) did not know who placed the 2 prefilled saline syringes on Resident 115 bedside drawer. During an interview on 3/17/2026 at 1:20 p.m. the Registered Nurse (RN) 1 stated the pre-filled saline flushes should not be left at bedside unattended due to improper use and contamination if a confused Resident might access and/or consume the liquid in the syringe. During an interview on 3/20/2026, at 1:29 pm, the Director of Nursing (DON) stated Residents are only allowed for have Meds at bedside if they have been assessed to be cognitive and physically demonstrated they can safely able to do so and have a physician approval. DON stated medication at bedside should be in a locked container. DON further stated medications should not be left at bedside, because of the risk of improper use/ingestion, and accidents. which could lead to an adverse reactions, unnecessary hospitalization and possible poor outcomes, A review of the facility's policy and procedures (P&P) titled Self-Administration of Medication dated 01/20/2026 indicated, .Residents have the right to self-administer medications if the interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the Resident), has determined that it is clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner will assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the Resident. Self-administered medications are stored in a safe and secure place, which is not accessible by other Residents.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on observation, interview, and record review, the facility failed to prevent employing a staff member who had been found guilty of abuse or mistreatment by a court of law when one of 10 contracted therapy staff (Physical Therapy Assistant [PTA] 1) continued to work at the facility after PTA 1 was cited by the Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) Board of California (PTBC) on 2/5/2025 for a conviction of a misdemeanor (criminal offense) violation of inflict corporal injury (willful, direct application of physical force) and failure to notify the PTBC. This deficient practice had the potential for PTA 1 to abuse or mistreat any resident residing at the facility. Findings: During a review of the facility's Therapy Department Rehabilitation Staff Schedule, the Rehab Staff Schedule indicated PTA 1 was a current full time therapy staff at the facility. During a review of PTA 1's PTBC PTA license, PTA 1's PTBC license indicated a citation was issued on 2/5/2025. During a review of the PTBC citation issued 2/5/2025, the citation indicated PTA 1 was convicted of a misdemeanor violation of penal code 273.5(A) - Inflict Corporal Injury: Spouse/Cohabitant/Date in the Superior Court of California, County of Riverside, on or about 8/29/2024. The citation also indicated a citation for failure to notify the PTBC within 30 days of the conviction of the misdemeanor violation. During a review of the Physical Therapy Daily Activity Schedule dated 3/18/2026, the PT Daily Activity Schedule indicated PTA 1 had a PT schedule to work and residents for PT treatment. During a review of PTA 1's signed Job Description, the Job Description indicated PTA 1 started employment with Rehab 1 on 3/4/2020. During an observation, interview, and record review on 3/18/2026 at 10:44 a.m. in the rehabilitation gym, the Director of Rehabilitation (DOR) stated the facility rehab staff were employed by a contract rehab company (Rehab 1). DOR stated PTA 1 was a full-time PTA at the facility and was in the rehabilitation gym and working today. DOR reviewed PTA 1's facility employee file stated there was a citation on the PTA 1's PTBC license issued on 2/5/2025. DOR stated he was aware of the citation but was not aware of any details of the citation and that PTA 1 discussed it with Rehab 1's human resources. DOR stated to his knowledge, PTA 1 was able to work at the facility. During an interview and record review on 3/18/2026 at 11:13 a.m. with the Director of Staff Development (DSD) and Assistant Director of Staff Development (ADSD), DSD stated the facility reviewed the rehab staff licenses when they expire every two years. DSD stated she reviewed PTA 1's license during the renewal period around May 2025 and noticed there was a citation on the license. DSD stated she tried to open the citation on the PTBC website, but could not and did not review the citation on PTA 1's license. DSD stated she asked DOR regarding the citation and DOR assured her that PTA 1 could work at the facility. DSD and ADSD proceeded to review PTA 1's PTBC license on the PTBC website and ADSD stated the citation was issued for a misdemeanor for corporal injury. DSD and ADSD stated the facility cannot employ anyone that has been convicted of any personal abuse. DSD stated if the facility employed staff that had a conviction of physical harm, then there was a potential for the staff member to harm residents in the facility and could be serious. DSD stated it was the facility's responsibility to ensure that all contracted staff complied with all regulations and the facility should not rely on Rehab 1's staff to clear staff to work at the facility. During an interview on 3/18/2026 at 11:34 a.m., PTA 1 stated he started working at the facility in 3/2020 as a full-time PTA. PTA 1 stated the Superior Court of California notified Rehab 1's human resources and manager on 3/7/2025 when the Court emailed the company (PTA 1 checked his emails) and PTA 1 explained the incident to Rehab 1. PTA 1 stated the company was ok with PTA 1 continuing to work as long as he completed court ordered requirements and renewed PTA 1's license. PTA 1 stated he had been working full-time at the facility since 3/2020. During an interview on 3/18/2026 at 3:35 p.m., the Administrator (ADM) stated PTA 1's conviction was for physical hitting and if PTA 1 continued to work at the facility, there was a potential for PTA 1 to physically harm residents in the facility. ADM stated therapy staff worked with elderly and vulnerable residents and there would be a higher likelihood of PTA 1 to harm a resident, (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	even if the incident occurred outside of the workplace. During an interview on 3/19/2026 at 11:18 a.m., the Director of Nursing stated any staff member that had any known occurrence or conviction of abuse or mistreatment could not work at the facility, because vulnerable residents resided at the facility. During a review of the facility's policies and procedures (P&P) reviewed on 1/20/2026, titled, Abuse Prevention/Prohibition, the P&P indicated the facility does not employ anyone who has been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law. During a review of the facility's Therapy Services Agreement effective 10/1/2019 with Rehab 1, the Therapy Services Agreement indicated Rehab 1 shall ensure that all therapists shall meet all applicable federal and state laws, rules, and regulations for providers of therapy services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that resident or their representative were notified timely in writing of resident transfer and bed hold provision according to the facility's policy & procedures (P&P) titled Bed-Holds and Returns with review date 1/20/2026 for one of five sampled residents (Resident 110). This deficient practice resulted in Resident 110 and/or their representative not being aware of the facility's bed hold policy upon transfer to the hospital from the facility. Findings: A review of Resident 110's admission Record indicated the facility admitted Resident 110 on 12/23/2025 with diagnoses including peripheral vascular disease (PVD - a slow, progressive circulation disorder where blood vessels outside the heart and brain-usually in the legs-become narrow, blocked, or spasm), hypertension (HTN-high blood pressure), and hyperlipidemia (HLD -too much fats in the bloodstream). A review of Resident 110's Bed hold informed consent indicated Resident 110 was admitted [DATE], .Confirmation of Transfer and Bed hold provision; and 24 hours notification sections were both blank. A review of Resident 110's Minimum Data Set (MDS resident assessment tool) dated 12/29/2025, indicated Resident 110 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 110 required supervision or touching to partial/moderate assistance from staff with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) care. A review of Resident 110's Physician Order dated 1/5/2026, at 9:55 A.M., indicated, . may transfer resident out to the general acute care hospital (GACH) . During a concurrent interview and record review, on 3/19/2026, at 10:09 A.M., with Licensed Vocational Nurse (LVN) 1, Resident 110's Bed hold informed consent, dated 12/23/2025 was reviewed. The Bed hold informed consent confirmation of Transfer and Bed hold provision; and the 24-hour notification sections were both blank. LVN 1 stated that the facility's process is that bed hold consents are completed upon admission and upon transfer to GACH. LVN 1 stated that the section of Resident 110 Bed hold informed consent confirmation of Transfer and Bed hold provision were blank indicating that Resident 110 was not notified of the bed hold. LVN 1 stated that residents need to be notified of the 7 day bed hold because it is the residents right to know about the 7 days bed hold and if the residents is not given the 7 day bed hold then the resident will not know about it and there is no confirmation that it was given. During an interview, on 3/20/2026, at 1:48 P.M., with the Director of Nursing (DON), the DON stated a 7-day bed hold is given to the residents upon admission, and discharge to the hospital indicating that the resident have 7 days in which a resident can return to the facility to come back to the same bed. The written notification needs to be emailed, faxed or mailed to the residents of their representative. A review of the facility's P&P titled Bed-Holds and Returns with review date 1/20/2026, indicated,Policy StatementPrior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policyPolicy Interpretation and Implementation2. The current bed-hold and return policy established by the state (if applicable) will apply to Medicaid residents in the facility.3. Prior to a transfer, written information will be given to the residents and the residents' representatives that explains in detail .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide s speech and language pathology (SLP, profession that identifies, assesses, and treats speech, language, cognitive communication and swallowing disorders) services to improve communication for one of 25 sampled residents (Resident 92) who had difficulty with speech and communication. This deficient practice had the potential to prevent Resident 92 from communicating effectively with other residents, staff, healthcare providers, and the community. Findings: During a review of Resident 92's admission Record (AR), the AR indicated Resident 92 was initially admitted [DATE] and readmitted [DATE] with diagnoses including, but not limited to hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting right dominant side and dysarthria (difficulty speaking) and anarthria (loss of ability to articulate speech). During a review of Resident 92's Minimum Data Set (MDS, resident assessment tool) dated 3/1/2026, the MDS indicated Resident 92 had unclear speech and usually makes self understood. During a review of Resident 92's care plan (CP) initiated on 4/2/2025 and revised on 3/13/2026, the CP indicated Resident 92 had a communication problem, unclear speech or at risk for communication due to cerebrovascular accident (CVA, stroke, loss of blood flow to a part of the brain), dysarthria and anarthria. The CP goal indicated Resident 92 will be able to effectively comprehend commands. The CP interventions indicated evaluate Resident 92's ability to comprehend, observe effectiveness of communication strategies. During an observation and interview on 3/16/2026 at 10:47 a.m., Resident 92 was sitting at the edge of the bed and had a laptop on the bedside table and a communication book and white paper on the bed to the left of Resident 92. Resident 92 was able to answer simple yes/no questions about less than half of the time. Resident 92 stated no when asked if Resident 92 had therapy services in the facility. Resident 92 was able to lift the right shoulder a little and was not able to move the right elbow or hand. Resident 92 was able to move the left arm without restrictions. Resident 92 was not able to use the communication book to answer any questions. During an interview and record review on 3/18/2026 at 2:16 p.m., the Director of Rehabilitation (DOR) reviewed therapy records and stated Resident 92 has never had any SLP services at the facility (records go as far back as 2/2020). During an interview on 3/18/2026 at 3:22 p.m., the Speech and Language Pathologist (SLP) 1 stated Resident 92 had communication deficits and could not communicate effectively, including expressive communication or understanding communication. SLP 1 stated Resident 92 should have had speech therapy before today and Resident 92 absolutely could have benefited from speech therapy so that Resident 92 could have more effective communication with others or be trained to use a communication device. During an interview on 3/18/2026 at 3:45 p.m., Activities Aide (AA) 1 stated Resident 92 did not really come to activities room for activities. AA 1 stated Resident 92 could say a couple of words and when Resident 92 tried to communicate with AA 1, Resident 92 would point or staff would start guessing. AA 1 stated it was hard to communicate with Resident 92. During an interview on 3/18/2026 at 3:48 p.m., Certified Nursing Assistant (CNA) 1 stated Resident 92 would point to the medication cart if he wanted medications. CNA 1 stated Resident 92 would try to say words, but it was sometimes difficult to know what Resident 92 wanted or needed. CNA 1 stated staff try a lot of things to try to understand what he wanted and sometimes Resident 92 would get frustrated and angry. During an interview on 3/18/2026 at 3:54 p.m., the Social Services Director (SSD) stated Resident 92 sometimes would write or try to use the communication book, and sometimes staff were successful in understanding Resident 92. SSD stated Resident 92 sometimes get frustrated when Resident 92 tried to communicate with staff. SSD stated Resident 92 would have benefited from speech therapy services and tried to recommend speech therapy, and acknowledged (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 92 never received speech therapy services at the facility. During an interview on 3/19/2026 at 10:16 a.m., Minimum Data Set Coordinator Nurse (MDSC) 2 stated Resident 92 could talk a little, but it was unclear and staff had difficulty understanding Resident 92. MDSC 2 stated Resident 92 could have benefited from speech therapy to improve Resident 92's communication with others and decrease Resident 92's frustration with communication. MDSC 2 stated the facility missed providing Resident 92 speech therapy services and the facility should have requested a SLP evaluation. During an interview on 3/19/2026 at 11:18 a.m., Director of Nursing (DON) stated it was important to address communication difficulties with Resident 92, because communicating effectively helped the facility establish care for Resident 92. DON stated there could be care gaps if the facility could not effectively communicate with Resident 92 and the facility may not know how effective the care was. DON stated Resident 92 was a candidate for speech therapy services and this was missed. During a review of the facility's policy and procedures (P&P) reviewed 1/20/2026, titled, Activities of Daily Living (ADL), Supporting, indicated, residents with be provided with care, treatment, and services to ensure their ADLs do not diminish including appropriate support and assistance with communication (speech, language, and any functional communication systems). During a review of the facility's P&P reviewed 1/20/2026, titled Speech Pathology, the P&P indicated, the Speech-Language Pathologist is trained in the evaluation and treatment of communication disorders. Services provided include but are not limited to: language disorders including aphasia, speech production disorders, voice disorders, and non-vocal communication device training.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to ensure the environment remained free of accident hazards for one of seven sampled residents (Resident 38) by failing to provide Resident 38 with a wheelchair with two hand brakes. This deficient practice has the potential to result in Resident 38 falling or sustaining an injury. Findings: A review of Resident 38's admission Record indicated the facility admitted the resident on 3/2/2026 with diagnoses that included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (decrease in size and thinning of muscle tissue), osteoarthritis (aka arthritis, when the cushion between the bones wear down causing bones to rub together) and asthma (condition that causes your airways to swell, narrow and fill with mucus). A review of Resident 38's admission Fall Evaluation, dated 3/2/2026, indicated the resident was not able to perform the gait/balance and was not able to walk straightforward nor was able walk through a doorway and turn. A review of Resident 38's Fall Risk Care Plan, initiated 3/4/2026, indicated the resident was a fall risk. The care plan goal was for Resident 38 to be free from falls. The care plan interventions included physical therapy to evaluate and treat, During a concurrent interview and observation on 3/16/2024 at 10:18 AM at Resident 38's bedside, Resident 38 stated she is unable to walk and that the facility provided her wheelchair that doesn't have a second hand brake. Resident 38 stated she is unable to walk, needed the wheelchair and was scared of falling due to not having a second hand brake. During an interview on 3/19/2026 at 12:08 PM, outside the physical therapy room, Resident 38 sitting in the wheelchair was observed with the Director of Rehabilitation (DOR). The DOR stated Resident 38's wheelchair needed a left side hand brake. During an interview on 3/19/2026 at 1:51 PM, the DOR stated facility staff gave Resident 38 the wheelchair. The DOR further stated Resident 38's wheelchair required two hand brakes for the resident's safety and to reduce the risk for falls when the resident gets in and out of the chair. During an interview on 3/20/2026 at 1:40 PM, the Director of Nursing (DON) stated the facility provides wheelchairs to residents who need them. The DON further stated the resident's wheelchair requires two hand brakes for their safety in order to prevent an accident or injury to the resident. A review of the facility's policy and procedures titled, Falls - Clinical Protocol, dated 1/20/2026, indicated, While many falls are isolated individual incidents, a significant proportion occur among a few residents/patients. Those individuals may have a treatable medical disorder or functional disturbance as the underlying cause. The P&P also indicated The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk.a. Risk factors for subsequent falling include lightheadedness or dizziness, multiple medications, musculoskeletal abnormalities, peripheral neuropathy, gait and balance disorders, cognitive impairment, weakness, environmental hazards, confusion, visual impairment, and illnesses affecting the central nervous system and illnesses affecting the central nervous system and blood pressure.

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	555139	A. Building B. Wing	03/20/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to effectively manage a resident's pain by not making a pain consultation appointment as ordered by the physician for one of one residents (Resident 16) sampled residents for pain management. This deficient practiced had the potential to negatively affect the residents' physical comfort and psychosocial well-being and had the potential to increase the resident's pain level. Findings: A review of Resident 16's admission information indicated Resident 16 was admitted to the facility on [DATE] with diagnoses that included low back pain, paraplegia (loss of movement and/or sensation, to some degree, of the legs) and stage 4 pressure ulcers (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the left and right buttock. A review of Resident 16's Risk for Pain Care Plan (CP), initiated on 7/23/2025, indicated the goal was for the resident's pain to be minimized. The CP interventions included to medicate the resident for pain as ordered, to monitor/record/report to nurse resident complaints of pain or requests for pain treatment and to notify the physician if interventions are unsuccessful. A review of Resident 16's Pain Assessment, dated 1/1/2026, indicated the resident verbalized to staff he had chronic pain that was present due to his current condition. The Pain Assessment also indicated Resident 16's pain affected his ability to participate in rehabilitation therapy sessions occasionally and his pain impacted his mood, behavior and ability to accept/receive care. A review of Resident 16's History and Physical (H&P), dated 1/5/2026, indicated the resident had a bullet left in his spine. The H&P also indicated Resident 16 had the capacity to make medical decisions. A review of Resident 16's Minimum Data Set (MDS- a resident assessment tool]) dated 1/29/2026, indicated the resident was cognitively intact (mental ability to make decisions of daily living). Resident 16 required partial to substantial assistance from staff with dressing lower body, showering and toileting hygiene. The MDS also indicated the resident frequently had pain and the pain frequently affected his sleep. A review of Resident 16's Physician Orders dated 3/2/2026 indicated the facility to provide Resident 16 with a stat (immediate) pain management referral. A review of the Resident 16's Order Summary Report, dated 3/20/2026, indicated the physician ordered the resident to receive the followingBaclofen (muscle relaxant) 20 milligrams (mg) by mouth three times a day for muscle spasm on 7/22/2025Imitrex 50 mg every two hours as needed for migrain headache on 7/22/2025Lidocaine External Patch (pain patch) apply to back topically once a day as needed for back pain on 8/17/2025Norco (narcotic pain medication) 5/325 mg tablet by mouth every 4 hours as needed for breakthrough pain on 12/17/2025Oxycodone (narcotic pain medication) 5mg by mouth every four hours as needed for severe pain (8-10/10) on 12/17/2025 During an interview on 3/19/2026 at 11:48 AM, Resident 16 stated he has chronic pain in his back. Resident 16 stated his pain level was a 6 out of 10 (a numerical pain assessment tool where zero no pain, and 10 the worst pain). Resident 16 stated his pain he receives pain medication about three times a day for his stabbing pain and his pain is unrelieved by his current pain regimen. Resident 16 further stated he has been asking for a pain consult since his admission and has not received a consult. During an interview on 3/19/2026 at 2:50 PM Licensed Vocational Nurse (LVN) 2 stated Resident 16 received oxycodone and baclofen for pain management. During a concurrent record review of physician's order LVN 2 stated the physician ordered Resident 16 to receive a stat (immediate) pain consultation on 3/2/2026. LVN 2 stated Resident 16 never received the pain consultation. LVN 2 stated the nurse who received the order should have set up the pain consultation. During a phone interview on 3/20/2026 at 11:34 AM, Medical Doctor (MD) 3, the facility's pain consultant physician, stated he has not visited the facility since 2/10/2026 and has not done a consultation with Resident 16 regarding his pain. MD 3 stated he visits the facility once a month unless there is an urgent consult ordered. MD 3 further stated he was never contacted regarding a pain consult for Resident 16. During an interview on 3/20/2026 at 1:44 PM, the Director of Nursing (DON) stated stat consults should be done urgently. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON further stated a Resident 16's pain may not be effectively managed from not receiving the ordered pain consult. A review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, reviewed 1/20/2026, indicated the purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The P&P also indicated If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 13), who had diagnosis of paranoid schizophrenia (type of schizophrenia associated with feelings of being persecuted or plotted against) was provided with the necessary behavioral health care as indicated in the plan of care and per physician order when the facility failed to monitor and document the targeted behaviors of Resident 13's psychotropic medications (drug that affects behavior, mood, thoughts, or perception). This deficient practice had the potential for Resident 13 to not receive the correct medication dosage or psychiatric care.Findings: A review of Resident 13's admission Record (Face Sheet) indicated the facility admitted the resident on 6/16/2025, with diagnoses including paranoid schizophrenia, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and depression. disorder. A review of Resident 13's Psychotropic Medications Care Plan developed on 6/17/2025, indicated the resident was taking psychotropic medication to manage the resident's behavior. The interventions included to administer psychotropic medications, discuss with physician and family regarding the ongoing need for the medication, and monitor/record occurrence of the target behaviors symptoms and document. A review of Resident 13's History and Physical Examination (H&P), dated 1/5/2026, indicated Resident 13 was admitted to the facility after receiving inpatient psychiatric treatment for severe agitation, restlessness, impulsivity, irritability, anger episodes, intrusive and threatening behavior. The H&P further indicated the resident did not have the capacity to make medical decisions. A review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 1/8/2026, indicated Resident 13 was cognitively intact (mental ability to make decisions of daily living). Resident 13 had hallucinations (perceptual experiences in the absence of real external sensory stimuli), manifested verbal behavior symptoms directed towards others, was receiving antipsychotic medications (used to control behavioral symptoms), anti-anxiety medications and was not on antidepressant medications (used to reduce symptoms of depression). Resident 13 required supervision with activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). A review of Resident 13's Physician's Orders, dated 2/24/2026, indicated the facility was to administer to Resident 13 the following:Haldol (an antipsychotic medication) 5 milligrams (mg) twice a day for schizoaffective disorder manifested by mood swings, from manic episodes, elevated mood, irritability, agitation/restlessness to depressive episodes verbalizing sadness, helplessness/worthlessness, thoughts or emotions disconnect from realityMonitor/Document number of episodes of schizoaffective disorder manifested by mood swings, from manic episodes elevated mood, irritability, agitation/restlessness to depressive episodes verbalizing sadness, helplessness/worthlessness, thoughts or emotions disconnect from reality every shift for Haldol useRisperdal (an antipsychotic medication) 3 mg twice a day for Schizoaffective Disorder, Bipolar Type manifested by auditory hallucinations/ Hearing voices responding to internal stimuli leading to talking to self, yelling and pacingDocument number of episodes of auditory hallucinations/hearing voices responding to internal stimuli leading to self yelling and pacing for Risperdal use A review of Resident 13's SBAR dated 3/6/2026, indicated Resident 13 charged towards nursing staff. Staff attempted to calm the resident however Resident 13 remained agitated. Law enforcement was called. Law enforcement arrived and calmed the resident down. The SBAR further indicated a physician ordered Resident 13 to received Ativan (an anti-anxiety medication) 1mg and Haldol 2.5 mg x 1 and to be transferred to a hospital for further treatment. A review of Resident 13's March 2026 medication administration record (MAR - a log of medications given to the restroom) indicated there were no episodes of agitation for Haldol documented from 3/1/2026 to 3/18/2026 and specifically not on 3/6/2026 (date of the SBAR for agitation). A further review of the March 2026 MAR indicated there was no episodes of mood swings, manic episodes of elevated mood, irritability, agitation/restlessness to depressive episodes (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbalizing sadness, helplessness/worthlessness, thought or emotions disconnect from reality documented from 3/12026 to 3/18/2026 including the date of the SBAR on 3/6/2026. During an observation on 3/16/2026 at 10:03, Resident 13 was observed walking in the hallway near his room, talking to himself and a staff was following the resident. During an observation on 3/18/2026 at 11:53 AM, Resident 13 was observed standing in the hallway near the nursing station and laughing, smiling and speaking to himself. During an interview on 3/18/2026 at 12:50 PM, Registered Nurse (RN) 1 stated nursing staff are to document target behaviors and side effects of ordered psychotropic medications. RN 1 stated behavior episodes are tallied for the resident monthly and evaluated by the IDT and physician every 3 months. During a concurrent review of Resident 13's 3/6/2026 SBAR from, Resident 13's ordered psychotropic medications and the residents March 2026 MAR, RN 1 stated there was no documented behaviors for agitation, yelling or anxiety as would be expected with the behaviors noted in the 3/6/2026 SBAR. RN 1 stated not documenting the targeted behaviors for psychotropic medications could lead to the resident not prescribing the correct treatment and the resident's care would be ineffective. During an interview on 3/19/2026 at 11:12 AM, Licensed Vocational Nurse (LVN) 2 stated Resident 13 was taking Haldol and Risperdal for schizoaffective disorder twice a day. LVN 2 stated Resident 13 usually had disorganized thinking and responds to internal stimuli. LVN 2 stated Resident 13 is usually observed pacing and talking to himself. LVN 2 further stated the resident could have increased agitation in the morning. During an interview on 03/20/2026 at 1:42 PM, the Director of Nursing (DON) stated on we document the number of resident behaviors on the resident's MAR. The DON sated if a resident was yelling or agitated should be documented on the MAR. The DON further stated we document a resident's behaviors, tally the number of episodes monthly in order to evaluate the resident's progress. The DON also stated not documenting the resident's behaviors might result in the resident not receiving the correct dosage. A review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention and Monitoring, reviewed 1/20/2026, indicated the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The P&P also indicated 2. Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility and consultant pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) failed to identify irregularities during medication regimen review/ drug regimen review (MRR or DRR a comprehensive evaluation of a patient's current medication list to identify potential drug interactions, adverse effects, and other medication-related issues) related to administration of Keppra (generic name - levetiracetam, a medication used to treat or prevent seizures (a sudden, temporary surge of uncontrolled electrical activity in the brain that causes temporary changes in behavior, movement, feelings, or consciousness) when one of three residents (Resident 81) reviewed during medication pass observation, refused antiseizure medication, Keppra, 126 times between 12/2025 through 3/19/2026. This failure to identify and report irregularities resulted in Resident 81 failing to receive Keppra as ordered, inconsistent dosing which had the potential to increase the resident's risk for adverse reactions, and failing to consider gradual dose reduction when initial indication for use was no longer present. Findings: During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses that included Epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity) and acute kidney failure (the sudden, temporary loss of the kidneys' ability to filter waste products from the blood, balance fluids, and manage electrolytes). During a review of Resident 81's Minimum Data Set (MDS-resident assessment tool), dated 1/2/2026, the MDS indicated Resident 81's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated that Resident 81 was independent for eating, oral hygiene, toileting, upper and lower body dressing, transfer from bed to chair, and required setup or clean up assistance for shower/bathing self and personal hygiene. During a review of Resident 18's Physician Order Summary Report, dated 3/17/2026, the order summary report indicated but not limited to the following physician order: 1. Keppra (levetiracetam) oral tablet 1000 milligram ([mg] a unit of measurement for mass), give 1000 mg by mouth two times a day for Seizure Disorder (a chronic neurological condition characterized by recurrent, unprovoked seizures), order date 10/21/2024. 2. Monitor seizure episodes every shift. Document (Y) or (+) if noted, (N) or (-) if none. Ensure safety, notify MD immediately if noted, order date 12/4/2020. During a concurrent medication pass observation and interview on 3/17/2026 between 9:04 AM through 10:01 AM with a Licensed Vocational Nurse (LVN) 4, LVN 4 prepared Resident 81's morning medications that included, but was not limited to Keppra 1000 mg. After medication preparation LVN 4 entered Resident 81's room and offered a dose of Keppra 1000 mg. Resident 81 was observed refusing the seizure medication Keppra 1000 mg on 3/17/2026 at 10:01 AM. During an interview on 3/17/2026 at 10:01 AM, in the presence of LVN 4, Resident 81 stated, I don't need it. Referring to the seizure medication, Keppra. During a concurrent telephone interview and review of pharmacist MRR on 3/18/2026 at 3:38 PM in the presence of the Director of Nursing (DON), the facility's Consultant Pharmacist Director (Pharm) 2 was called. Pharm 2 reviewed the facility's assigned Consultant Pharmacist (Pharm) 1's MRR for Resident 81's use and refusal of Keppra. Pharm 2 stated that he did not see any notes from Pharm 1, during Pharm 1's review for 1/2026 or 2/2026 regarding irregularities in Resident 81's Keppra therapy for seizures. DON stated there was no recommendation from the facility's Consultant Pharmacist (Pharm 1) on Resident 81 refusing Keppra multiple times. During a telephone interview on 3/18/2026 at 4:03 PM with Pharm 1, in the presence of the DON, Pharm 1 stated that she reviews all residents in the facility's medications. Pharm 1 stated that she do not look at the residents' MARs regularly. Pharm 1 stated that she reviews the physician order recaps and the nursing notes. Pharm 1 stated the records she reviewed for Resident 81 did not document observation of seizure activity for the resident since (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission in 2020. Pharm 1 stated that she did not send any recommendations to Resident 81's physician when the resident was noted to frequently refuse seizure medications. Pharm 1 stated that she did not see Resident 81's MARs and was not aware of how many times the resident refused Keppra. Pharm 1 stated that disruptions of seizure medications can lead to seizures. Pharm 1 stated if a resident is not having seizures, Pharm 1, would not expect the resident to be on the medication. Pharm 1 stated that she did not send any recommendations to Resident 81's physician based on the multiple times the resident refused the seizure medications. DON confirmed that there was no pharmacist recommendations for Resident 81 during the MRR for 1/2026 and 2/2026. During a concurrent interview and record review on 3/19/2026 at 9:31 AM, with the DON, Resident 81's physician orders and Medication Administration Record (MAR, a legal document that provides a comprehensive account of all medications administered to a resident) were reviewed between 12/1/2025 through 3/19/2026. DON acknowledged that Resident 81 MAR documented refusal of seizure medication as follow:- During the month of 12/2025 the resident refused seizure medication Keppra 37 times- During the month of 1/2026 the resident refused seizure medication Keppra 39 times- During the month of 2/2026 the resident refused seizure medication Keppra 33 times- During the month of 3/1/2026 through 3/19/2026 the resident refused seizure medication 17 times (for a total of 126 refusals of seizure medication between 12/2025 through 3/19/2026) During a review of Resident 81's MAR indicated zero seizure activity across all three shifts (Day, Evening, and Night) for the months of 12/2025, 1/2026, 2/2026, and through 3/17/2026. During a review of the facility's policy and procedures (P&P) titled, Monthly Drug Regimen Review, dated 11/2020, the P&P indicated, .drug regimen review (DRR). DRR is defined as the systematic evaluation of drug therapy viewed within the context of resident-specific data. The consultant pharmacist shall review the medication regimen of each resident at least monthly. Findings and recommendations shall be reported to the administrator, director of nursing, the attending physician, and the medical director, where appropriate. DRR activities shall include, but are not limited to, the following.Evaluating medication orders to determine that the resident's orders represent optimal therapy for that individual. The duration of therapy is indicated and is appropriate for the resident. Evaluating response to drug therapy to assure that each resident receives optimal drug therapy:The resident's response to drug treatment is evaluated through the use of laboratory data, physical assessment, medication administration record, and other data to determine if therapeutic goals are achieved.Side effects, adverse reactions, and interactions (drug-drug, drug-diet, drug-lab test and drug-disease) are evaluated, and modifications or alternatives are considered.Medical condition and response to drug therapy are used to evaluate the drug regimen for unnecessary medications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow doctor's orders to administer pain medication for severe pain at or above a pain score of eight out of ten (8/10- a numerical pain assessment tool where zero [0] is no pain and 10 is severe pain)for severe pain, per doctor's orders. This deficient practice did not provide treatment and care in accordance with professional standards of practice and physician's order for Resident 48. Findings: A review of Resident 48's admission Record indicated Resident 48 was admitted to the facility on [DATE], with medical diagnoses that included: Anemia (A condition where the blood lacks enough healthy red blood cells), hyperlipidemia (A common condition where there are too many fat particles in the bloodstream), and hypotension (a medical condition when the blood pressure is low). A review of Resident 48's Minimum Data Set (MDS - a resident assessment tool), dated 1/23/2026 indicates Resident 48's cognition (the mental ability to make decisions of daily living) was intact. Resident 48 requires moderate assistance from staff for toileting, hygiene, bathing, upper and lower body dressing, and personal hygiene. During a concurrent interview and record review on 3/19/2026 at 3:15pm the Director of Nursing (DON) stated the Norco (Hydrocodone-Acetaminophen- controlled strong pain medication) order parameters for Resident 48 was as follows: Norco Oral Tablet 5-325 MG (milligrams-unit of measurement) give 1 tablet orally every 8 hours as needed for Severe Pain of 8-10/10 not to exceed 3 grams APAP in 24 hours. The DON stated the Norco 5-325 MG was given for light pain of 3 out of ten. The medication administration is not within the MD orders to be given. Therefore, the staff member did not follow MD orders. During a phone interview on 3/19/26 at 3:28 PM LVN 11 stated she does not remember what pain level Resident 48 stated before she administered the pain medication on February 8th at 6:47 PM. LVN 11 stated if Resident 48 was at a pain level of 3 then she would not have given the Norco 5-325 for that level of pain. A review of the facility's policy and procedures (P&P) titled Administering Medications, with date reviewed 1/20/2026, indicated the following: Policy StatementMedications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation4. Medications are administered in accordance with prescriber orders, including any required time frame.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper storage, labeling, and/or disposal of medications by failing to ensure: 1. An open box of Assure Prism Blood Glucose (BG; amount of sugar in the blood) Control Solution (used to check blood glucose monitors) included an open date (the date the medication was first opened) to prevent the potential use of blood glucose control solution after expiration for residents with diabetes (a condition where the body has trouble controlling blood sugar) receiving diabetic treatment from Medication Cart 4 (MedCart) 4, in accordance with the manufacturer's specification for Assure Prism Blood Glucose Monitoring System, dated 12/2025. 2. Resident 12, who was no longer in the facility's medications were removed from MedCart 2 and not stored with active residents' medications. These deficient practices increased the risk of using expired or ineffective BG Control Solution, which could result in inaccurate BG readings, harm to diabetic residents that may lead to incorrect medication dosing, uncontrolled blood sugar levels, harm, and potential hospitalization. Storing medications for discharged Resident 12 in MedCart 2 increased the risk of medication errors for current residents. Findings: 1. During a concurrent observation, interview, and review of Assure Prism BG Control Solution manufacturer specification on [DATE] at 10:23 AM with a Licensed Vocational Nurse (LVN) 7, observed inside of MedCart 4 was one opened package of Assure Prism BG Control Solution. LVN 7 reviewed the BG controlled solution package and the two bottles inside and stated the package was opened and that there was no open date. LVN 7 reviewed the manufacturer's package labeling that indicated, the BG controlled solution expiration is shortened to three months once opened. LVN 7 stated the BG control solution was used to calibrate the BG monitors and the readings may not be correct after expiration. LVN 7 stated expired BG control solution may lead to wrong blood sugar ([BS or BG] readings for resident and if the BS readings are inaccurately high then the resident may be administered insulin which would not be good for the resident and could lead to low BS and negatively affect the resident's health. During an interview on [DATE] at 4:50 PM with the Director of Nursing (DON), the DON stated the Assure Prism BS Control Solution must have an open date and the licensed nurse must know when the BG control solution expires to prevent use after expiration. The DON stated the false BS readings could lead to administering the wrong dose of diabetic medications to residents and could result in adverse reactions (negative or harmful responses to a medication or treatment). A review of the manufacturer's instructions for, Assure Prism Blood Glucose Monitoring System, dated 12/2025, indicated, Assure Prism Control Solutions are for use with Assure Prism multi test strips to check that the meter and the test strips are working together properly and the test is performing correctly.When you first open a control solution bottle, record the discard date (date opened plus three [3] months) in the space provided on the label.Out of range results may occur due to the following factors. When the control solution is past its discard date (the date the bottle was opened plus three [3] months). When the control solution is contaminated. Discard the used control solution and repeat the test using a new bottle of control solution. A review of the facility's policy and procedures (P&P) titled Storage of Medications dated 1/2026, indicated, Drug containers that have missing, incomplete, improper or incorrect labels, are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 2. A review of Resident 12's admission Record indicated the resident was admitted to the facility on [DATE], diagnoses included hypertension (high blood pressure), Type 2 Diabetes Mellitus (high blood sugar), and Gastro-esophageal reflux disease (a condition where stomach acid flows back into the throat, causing heartburn). A review of Resident 12's form titled, SNF/NF to Hospital Transfer Form, indicated the resident was transferred to hospital on [DATE]. During a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555139	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miracle Mile Healthcare Center, LLC	1020 South Fairfax Ave Los Angeles, CA 90019

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent observation and interview on [DATE] at 10:39 AM with LVN 8, observed inside of MedCart 2 were the following medications labeled for Resident 12, Vitamin B-6 (supplement) 50 mg, quantity of 30, Repaglinide (used together with diet and exercise to treat high blood sugar [glucose] levels in patients with type 2 diabetes) 1 mg, quantity of 30, and Sucralfate (used to help heal and protect the stomach lining) 1 gm, quantity of 14. LVN 8 stated Resident 12 was transferred out of the facility on [DATE] to the hospital for hypertensive episode (a sudden increase in blood pressure) and oxygen desaturation (low oxygen level in the blood, symptoms include shortness of breath and confusion). During an interview on [DATE] at 10:53 AM with LVN 8, LVN 8 stated when the resident is transferred out of the facility the medication orders are discontinued. LVN 8 stated discontinued medications should not be stored in the medication cart. LVN 8 stated discontinued medication should be stored inside of the medication room to prevent accidental administration of the discontinued medication to the wrong resident which could lead to medication errors, drug interactions, and side effects. LVN 8 stated the resident has been gone from the facility for 7 days now. During an interview on [DATE] at 4:51 PM, with the DON, the DON stated once residents are transferred or discharged from the facility the resident's medications are discontinued and must be removed from the medication cart and placed in the medication room. The DON stated the removal of the discharged resident's medications from the medication cart is to prevent medication errors or mistakes. A review of the facility's P&P titled, Medication Holds, dated [DATE], indicated, When medications are held, they must be stored in a separate location in the medication room or returned to the issuing pharmacy.If the medication was discontinued, a new order must be given. A review of the facility's P&P titled, Storage of Medications, dated [DATE], indicated, Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a bed grab bar (a medical device designed to assist with mobility, allowing users to reposition, turn, and safely transfer in and out of bed) was maintained and in good working order for one out of one sampled Resident (Resident 76). This deficient practice had the potential to create severe safety risks, such as entrapment, asphyxiation and falls with injury. Findings: A review of Resident 76's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included dementia (progressive decline in cognitive function including memory, thinking, behavior, and language that is severe enough to interferes with activities of daily life), type 2 diabetes mellitus (high blood sugar (hyperglycemia)), Benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), cognitive impairment (problems with thinking, memory, concentration, and decision-making that interfere with daily life) A review of Resident 76's Minimum Data Set (MDS - resident assessment tool) dated 1/27/2026 indicated the resident 76's cognition (The mental ability to make decisions of daily living) was severely impaired, Resident 76's required setup or clean up with eating, oral care and toileting hygiene. Resident 76 required partial moderate assistance with shower/bathing self, upper and lower body dressing, personal hygiene and putting on/taking off footwear. Resident 76 was ambulatory and independent with bed mobility. During a facility tour on 3/16/2026 at 10:26 am, Resident 76's left bed grab bar was observed to be insecurely fastened and unstable. During an interview on 3/16/2026 at 10:30 am Licensed Vocational Nurse (LVN) 9 stated Resident 76 has a limp and uses the bed grab bars to balance and walk, LVN 9 stated the grab bar was loose and missing a bolt and that he would notify maintenance supervisor (MS) immediately to fix the loose grab bar. LVN 9 stated the unsecured grab bar could cause a Resident to lose their balance and fall resulting in severe injury, unnecessary hospitalization. On 3/16/2026 at 10:34 am maintenance supervisor observed securing and tightening the left bed grab bar. During an interview on 3/20/2026 at 1:37 pm, the Director of Nursing (DON) stated it is the responsibility of all staff during rounds to identify and place a sign on any facility equipment that is broken and/or in poor working condition and immediately notify the maintenance supervisor to fix the equipment. DON stated an insecurely fastened unstable grab bar places Residents at risk of falls with injury, unnecessary hospitalization and poor patient outcomes. A review of facility policy and procedures (P&P) titled Hazardous Areas, Devices and Equipment dated 1/20/2026 indicated, all hazardous., Devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards . A review of facility P&P titled Bed Safety dated 1/20/2026 indicated, facility shall strive to provide a safe sleeping environment for the resident. To prevent deaths/injuries from the bed and related equipment (including frame siderails.accessories) facility shall promote the following approaches:Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks.Ensure bed rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide at least 80 square feet (sq. ft. -unit of measure) of useable living space for 30 out of the 38 resident rooms per regulation requirement. This deficient practice had the potential to result in crowded living conditions, increased physical injury and lack of privacy from inadequate useable living space for the residents and working space for the health caregivers.Findings: A review of the Request for Room Size Waiver letter, dated 4/2/2026, submitted by the Administrator, indicated there are 30 rooms that did not meet the 80 square feet requirement per resident according to federal regulation. The letter indicated that the rooms square footage did not compromise the Residents' privacy, allow for adequate storage, ambulation/wheelchairs and provide toilet accessibility and allows sufficient space for nursing care. A review of the Client Accommodations Analysis dated 3/17/2026 submitted by the facility indicated the following rooms with their corresponding measurements:Rooms # total Sq. Ft/Resident # Beds Floor Area Sq. Ft/Resident.room [ROOM NUMBER] is 154.1 square feet with 2 beds (77.1 square feet per resident)room [ROOM NUMBER] is 317.5 square feet with 4 beds (79.4 square feet per resident)room [ROOM NUMBER] is 221.4 square feet with 3 beds (73.8 square feet per resident)room [ROOM NUMBER] is 221.2 square feet with 3 beds (73.7 square feet per resident)room [ROOM NUMBER] is 221.2 square feet with 3 beds (73.7 square feet per resident)room [ROOM NUMBER] is 221.2 square feet with 3 beds (73.7 square feet per resident)room [ROOM NUMBER] is 221.2 square feet with 3 beds (73.7 square feet per resident)room [ROOM NUMBER] is 239.8 square feet with 3 beds (79.9 square feet per resident)room [ROOM NUMBER] is 239.8 square feet with 3 beds (79.9 square feet per resident)room [ROOM NUMBER] is 239.8 square feet with 3 beds (79.9 square feet per resident)room [ROOM NUMBER] is 239.8 square feet with 3 beds (79.9 square feet per resident)room [ROOM NUMBER] is 220.4 square feet with 3 beds (73.5 square feet per resident)room [ROOM NUMBER] is 239.8 square feet with 3 beds (79.9 square feet per resident)room [ROOM NUMBER] is 317.5 square feet with 4 beds (79.4 square feet per resident)room [ROOM NUMBER] is 313.6 square feet with 4 beds (78.4 square feet per resident)room [ROOM NUMBER] is 318.9 square feet with 4 beds (79.7 square feet per resident)room [ROOM NUMBER] is 218.4 square feet with 3 beds (72.8 square feet per resident)room [ROOM NUMBER] is 238.7 square feet with 3 beds (79.6 square feet per resident)room [ROOM NUMBER] is 238.7 square feet with 3 beds (79.6 square feet per resident)room [ROOM NUMBER] is 238.7 square feet with 3 beds (79.6 square feet per resident)room [ROOM NUMBER] is 238.7 square feet with 3 beds (79.6 square feet per resident)room [ROOM NUMBER] is 239.8 square feet with 3 beds (79.9 square feet per resident)room [ROOM NUMBER] is 237.6 square feet with 3 beds (79.2 square feet per resident)room [ROOM NUMBER] is 238.7 square feet with 3 beds (79.6 square feet per resident)room [ROOM NUMBER] is 239.8 square feet with 3 beds (79.9 square feet per resident)room [ROOM NUMBER] is 238.7 square feet with 3 beds (79.6 square feet per resident)room [ROOM NUMBER] is 234.3 square feet with 3 beds (78.1 square feet per resident)room [ROOM NUMBER] is 238 square feet with 3 beds (79.3 square feet per resident)room [ROOM NUMBER] is 316.7 square feet with 4 beds (79.2 square feet per resident)room [ROOM NUMBER] is 318.1 square feet with 4 beds (79.5 square feet per resident)The minimum square footage for multiple Resident rooms should be 80 sq. ft. per federal regulation. During the general observations of the residents' rooms on 3/16/2026 to 3/20/2026, the residents had ample space to move freely inside the rooms. The listed rooms had sufficient spaces to provide freedom of movement for the residents and for provision of nursing care by staff for the residents. There was also sufficient space for beds, side tables and resident care equipment.