STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555211	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure five of 19 final sampled residents (Residents 5, 10, 25, 68, and 81) were free from the unnecessary psychotropic medications. * The facility failed to ensure nonpharmacological interventions were implemented when Residents 5, 10, and 25 exhibited behaviors related to the use of the psychotropic medications. In addition, the nonpharmacological interventions were not included into the residents' plan of care. * The facility failed to ensure nonpharmacological interventions were implemented when Resident 68 exhibited behaviors related to the use of the Ativan (antianxiety), Seroquel (antipsychotic), and Geodon (antipsychotic) medications. * The facility failed to ensure nonpharmacological interventions were implemented when Resident 81 exhibited behavior episodes related to the use of the Zoloft (antidepressant) medication. These failures had the potential to cause the residents to experience adverse effects from unnecessary psychotropic medication use. Findings: Review of facility's P&P titled Psychotropic Medication Use revised 2/2025 showed the following: - Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record; - Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction; - Psychotropic medication may be considered appropriate when non-pharmacological approaches (if not clinically contraindicated) have been attempted, but did not relieve the medical symptoms which are presenting a danger or significant distress; - The clinical rationale for the use of psychotropic medication, or a change from one type of psychotropic to another, is documented in the medical record. Documentation must include that behavioral (non-pharmacological) interventions were attempted but not successful, and these interventions were deemed clinically contraindicated; - In rare situations when pharmacological intervention is required before non-pharmacological approaches can be implemented, non-pharmacological interventions are still attempted; and - Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtaining documented consent or refusal such as non-pharmacological alternatives. 1. Medical record review for Resident 5 was initiated on 5/19/26. Resident 5 was readmitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 12/12/25, showed Resident 5 had no capacity to understand and make decisions. Resident 5 had a significant history of bipolar schizophrenia. Review of Resident 5's Order Summary Report showed the following physician's orders: - dated 12/1/25, to administer clozapine (antipsychotic) 200 mg one tablet by mouth at bedtime for expressed paranoid thoughts related to schizoaffective disorder, bipolar type; - dated 12/1/25, to administer sertraline (antidepressant) hydrochloride 100 mg one tablet by mouth one time a day for depressed mood related to schizoaffective disorder, bipolar type; - dated 1/7/26, to administer Depakote (mood stabilizer) extended release 1000 mg by mouth at bedtime for labile mood-calm to aggressive related to schizoaffective disorder, bipolar type; and - dated 2/26/26, to administer gabapentin (mood stabilizer) 400 mg by mouth three times a day for mood swings/anxiety related to schizoaffective disorder, bipolar type. Review of Resident 5's Behavior Monitoring/Psychotropic Medications dated 5/2026 showed to document specific number of behaviors observed each shift: a. For the clozapine (expressed paranoid thoughts) medication showed Resident 5 was observed with the behavior on: - 5/4/26 in the morning, evening, and night shifts; and - 5/5/26 in the evening shift. b. For the sertraline (depressed mood as evidenced by self-isolation/withdrawn behavior) medication showed Resident 5 was observed with the behavior on: - 5/4/26 in the morning and evening shifts; - 5/5/26 in the evening shift; - 5/11, 5/12, 5/13, and 5/18/26 in the evening shift. c. For the Depakote (labile mood as evidenced by calm to aggressive, yelling or irritability) medication showed Resident 5 was observed with the behavior on: - 5/4/26 in the morning, evening, and night shifts; and - 5/5/26 in the evening shift. d. For the gabapentin (mood swings related to anxiety) medication showed Resident 5 was observed (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the behavior on: - 5/4/26 in the morning, evening, and night shifts; and e. For the gabapentin (anxiousness/restlessness related to anxiety) medication showed Resident 5 was observed with the behavior on: - 5/4/26 in the morning, evening, and night shifts; - 5/5/26 in the evening shift; and - 5/7/26 in the evening shift with two episodes of the behavior. Further review of Resident 5's medical record did not show documented evidence nonpharmacological interventions were implemented when the resident had the above behavior episodes. In addition, the resident's care plan lacked nonpharmacological interventions addressing these behaviors. On 5/22/26 at 1210 hours, an interview and concurrent medical record review was conducted for Resident 5 with the ADON. The ADON verified and acknowledged the above findings. The ADON stated the CNAs, licensed nurses, and all the other mental health staff could document the observed behaviors in the Behavior Monitoring/Psychotropic Medications paper log. The ADON stated the nonpharmacological interventions should have been provided when Resident 5 manifested the above behaviors prior to the administration of the psychotropic medications. The ADON further stated the staff involved in the resident's care should report to the charge nurse, supervisor, or ADON/DON when behavior episodes were observed. 2. Medical record review for Resident 10 was initiated on 5/19/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 6/20/25, showed Resident 10 had no capacity to understand and make decisions. Resident 10 had a significant history of paranoid schizophrenia. Review of Resident 10's Order Summary Report showed a physician's order dated 3/5/24, to administer Lexapro (antidepressant medication) 20 mg by mouth in the morning for depressed moods/anxiety related to paranoid schizophrenia. Review of Resident 10's Behavior Monitoring/Psychotropic Medications dated 5/2026 showed to document specific number of behaviors observed each shift: - For Lexapro (paranoid schizophrenia) showed Resident 10 was observed with the behavior on: - 5/1 and 5/2/26 in the morning shift; - 5/3/26 in the evening shift; - 5/4 to 5/11/26 in the morning and evening shifts; - 5/12 to 5/15/26 in the evening shift; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/16 /26 in the morning and evening shifts; - 5/17/26 in the evening shift; - 5/18/26 in the morning and evening shifts; - 5/19/26 in the morning shift; and - 5/20/26 in the morning and evening shifts. Further review of Resident 10's medical record did not show documented evidence nonpharmacological interventions were implemented when the resident had the above behavior episodes. In addition, the resident's care plan lacked nonpharmacological interventions addressing these behaviors. 3. Medical record review for Resident 25 was initiated on 5/19/26. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 4/17/26, showed Resident 25 had no capacity to understand and make decisions. Resident 25 had a significant history of bipolar schizophrenia. Review of Resident 25's Order Summary Report showed the following physician's orders: - dated 6/18/25, to administer lithium carbonate (mood stabilizer) 300 mg one capsule by mouth two times a day for mania related to schizoaffective disorder, bipolar type; - dated 11/20/25, to administer clozapine 200 mg by mouth at bedtime for hitting self and going to peers and asking them to hit him schizoaffective disorder, bipolar type; - dated 4/1/26, to administer haloperidol (antipsychotic) 30 mg by mouth at bedtime for restlessness related to schizoaffective disorder, bipolar type; and - dated 5/6/26, to administer Zoloft 50 mg by mouth in the morning for anxiety related to depressed mood related to anxiety disorder. Review of Resident 25's Behavior Monitoring/Psychotropic Medications dated 5/2026 showed to document specific number of behaviors observed each shift: a. For the lithium (hyperactivity) medication showed Resident 25 was observed with the behavior on: - 5/3 to 5/13/26 in the evening shift; - 5/14/26 in the morning and evening shifts; - 5/15/26 in the evening shift; - 5/16/26 in the morning and evening shifts; and - 5/19 and 5/20/26 in the evening shift. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. For the clozapine (telling peers to hit him) medication showed Resident 25 was observed with the behavior on: - 5/14/26 in the evening shift. c. For haloperidol (restlessness) showed Resident 25 was observed with the behavior on: - 5/3 to 5/8/26 in the evening shift; - 5/10 to 5/13/26 in the evening shift; - 5/14/26 in the morning and evening shifts; - 5/15/26 in the evening shift; - 5/16/26 in the morning shift; and - 5/19/26 in the evening shift. d. For the Zoloft (anxiety as evidenced by depressed mood) medication showed Resident 25 was observed with the behavior on: - 5/11 to 5/14/26 in the evening shift. Further review of Resident 25's medical record did not show documented evidence nonpharmacological interventions were implemented when the resident had the above behavior episodes. In addition, the resident's care plan lacked nonpharmacological interventions addressing these behaviors. On 5/21/26 at 1333 hours, an interview and concurrent medical record review was conducted for Residents 10 and 25 with the TRC MDS Coordinator. The TRC MDS Coordinator verified and acknowledged the above findings for Residents 10 and 25. The TRC MDS Coordinator stated the staff needed to use less restrictive interventions like the nonpharmacological interventions when the residents manifested behavior episodes related to the psychotropic medications to lessen the use of those medications. The TRC MDS Coordinator further stated the current plan of care addressing the problem behaviors above should include the nonpharmacological interventions. On 5/22/26 at 1411 hours, an interview was conducted with the DON. The DON stated nonpharmacological interventions should be attempted prior to administering the psychotropic medications because it lessened the use of the chemicals. The DON further stated if the nonpharmacological interventions were effective, the use of psychotropic medications could be decreased in dosage and/or eventually be discontinued. The DON was informed and acknowledged the above findings for Residents 5, 10, and 25. 4. Medical record review for Resident 68 was initiated on 5/19/26. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68's H&P examination dated 6/6/25, showed Resident 68 had no capacity to understand and make decisions. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 68 's Order Summary Report showed the following physician's orders: - dated 11/25/25, to administer Seroquel 100 mg by mouth at bed time for anxiety and difficulty sleeping. - dated 5/4/26, to administer Geodon oral capsule 60 mg by mouth in the evening for depressed mood related to schizoaffective disorder. - dated 5/18/26, to administer Ativan oral tablet 0.5 mg one tablet by mouth at bedtime for akathisia related to schizoaffective disorder as manifested by inability to sit still and need to pace. Review of Resident 68's Behavior Monitoring/Psychotropic Medications dated 5/2026 showed to document specific number of behavior observed each shift showed the following: - For the Geodon (schizoaffective disorder as manifested by depressed mood stating I miss my children) medication showed Resident 68 had a one episode of the behavior on 5/20/26, in the evening shift. - For the Seroquel [schizoaffective disorder as manifested by paranoid ideation (i.e. believes people are following her, and believes others are trying to harm her)] medication showed Resident 68 had one episode of the behavior on 5/20/26, in evening shift for each paranoid ideation above. - For Ativan (akathisia as manifested by inability to sit still and need to pace) showed Resident 68 had 29 behavior episodes related to the use of the medication Ativan. In addition, the Behavior Monitoring/Psychotropic Medications document did not show if nonpharmacological interventions were attempted or implemented when Resident 68 exhibited the above behavior episodes related to the use of the psychotropic medications. Further review of Resident 68's medical record did not if nonpharmacological interventions were attempted or implemented when Resident 68 exhibited the above behavior episodes related to the use of the psychotropic medication. 5. Medical record review for Resident 81 was initiated on 5/19/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's H&P examination dated 10/10/25, showed Resident 81 had no capacity to understand and make decisions. Review of Resident 81's order Summary Report showed a physician's order dated 4/11/22, to administer Zoloft 50 mg by mouth in the morning for depressed mood related to paranoid schizophrenia. Review of Resident 81's Behavior Monitoring/Psychotropic Medications dated 5/2026 showed for the Zoloft medication to document each episode of schizoaffective disorder as manifested by depressed mood (i.e. staying in bed). Resident 81 had four episodes of depressed mood in the evening shift on 5/3 ,5/10, 5/11, and 5/13/26. The Behavior Monitoring/Psychotropic Medications documentation did not show if nonpharmacological interventions were attempted or implemented when Resident 81 exhibited the above behavior. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 81's medical record did not show if nonpharmacological interventions were attempted or implemented when Resident 81 exhibited the above behavior. On 5/21/26 at 0958 hours, an interview and concurrent medical record review for Residents 68 and 81 was conducted with the ADON. The ADON verified the above findings for Residents 68 and 81. The ADON stated she was unable to find documented evidence to show if nonpharmacological interventions were implemented when Resident 68 exhibited the above behaviors related to the use of the psychotropic medications Geodon, Seroquel, and Ativan. The ADON stated she was unable to find the documented evidence to show if nonpharmacological interventions were implemented when Resident 81 exhibited the above behaviors episode related to the use of the psychotropic medication Zoloft. On 5/21/26 at 1411 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, and facility P&P review, the facility failed to ensure the recommendations from the PASARR Level II determinations were followed up and incorporated into the resident care for three of three final sampled residents (Residents 10, 25, and 81) reviewed for PASARR. * The facility failed to ensure the recommendations for PASARR Level II determination were followed up and incorporated into Residents 10, 25, and 81's plan of care. These failures had the potential to prevent residents from receiving necessary services identified by the state-designated PASARR authority, affecting their physical, mental, and psychosocial well^being. Findings: Review of the facility P&P titled admission Criteria revised 2/2026 showed all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services they need, and whether placement in the facility is appropriate. The state PASARR representative provides a copy of the report to the facility. The interdisciplinary team determines whether the facility is able to meet the needs and services of the potential resident outlined in the evaluation. Review of the facility's P&P titled Care Plans, Comprehensive Person- Centered revised 3/2022 showed the comprehensive, person-centered care plan: - Includes measurable objectives and timeframes; and - Describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, including: a. services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; b. any specialized services to be provided as a result of PASARR recommendations; and c. which professional services are responsible for each element of care. 1. Medical record review for Resident 10 was initiated on 5/19/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 6/20/25, showed Resident 10 had no capacity to understand and make decisions. Resident 10 had a significant history of paranoid schizophrenia. Review of the letter sent to Resident 10 by the Department of Health Care Services dated 2/13/24, showed the PASARR Level II evaluation was conducted on 2/12/24. The letter further showed the facility staff would receive a copy of the determination report and discuss the result with Resident 10 and would incorporate the recommendations into Resident 10's care plan. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's PASARR Individualized Determination Report dated 2/13/24, showed Resident 10 required nursing facility services due to medical and/or mental health condition and required special treatment program. The PASARR Individualized Determination Report further showed recommended specialized services which included neuropsychology consultation and additional functional medical recommendations which included sleep specialist consultation. Review of Resident 10's Care Plan dated 3/12/24, showed PASARR Level II screening was acknowledged; the care plan failed to include neuropsychology consultation and sleep specialist consultation. Further review of Resident 10's medical record failed to show documented evidence the neuropsychology consultation and sleep specialist consultation were completed. 2. Medical record review for Resident 25 was initiated on 5/19/26. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 4/17/26, showed Resident 25 had no capacity to understand and make decisions. Resident 25 had a significant history of bipolar schizophrenia. Review of Resident 25's MDS assessment dated [DATE], showed Resident 25's preferred language was Vietnamese and needed an interpreter to communicate with a doctor or health care staff. Review of the letter sent to Resident 25 by the Department of Health Care Services dated 10/21/22, showed the PASARR Level II evaluation was conducted on 10/20/22. The letter further showed the facility staff would receive a copy of the determination report and discuss the result with Resident 25 and would incorporate the recommendations into Resident 25's care plan. Review of Resident 25's PASARR Individualized Determination Report dated 10/21/22, showed Resident 25 required nursing facility services due to medical and/or mental health condition and required special treatment program. The PASARR Individualized Determination Report further showed recommended specialized services which included interpretation services. Review of Resident 25's Care Plan dated 4/23/25, showed PASARR screening acknowledgement but did not include interpretation services. Further review of Resident 25's medical record review failed to show documented evidence interpretation services were provided. On 5/21/26 at 1333 hours, an interview and concurrent medical record review for Residents 10 and 25 was conducted with the TRC MDS Coordinator. The TRC MDS Coordinator verified the above findings and stated there was no documented evidence to show if the recommendations from PASARR Level II evaluations were followed up or incorporated in Resident 10 and 25's plan of care. On 5/22/26 at 1411 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 10 and 25. 3. Review of the facility P&P titled Care Plans, Comprehensive Person- Centered dated 3/2022 showed the comprehensive, person-centered care plan: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Includes measurable objectives and timeframes. - describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, including: - services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; - any specialized services to be provided as a result of PASARR recommendations; and - which professional services are responsible for each element of care. Medical record review for Resident 81 was initiated on 5/19/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's H&P examination dated 10/10/25, showed Resident 81 had no capacity to understand and make decisions. Review of Resident 81 admission Record dated 5/20/26, showed Resident 81 had diagnoses which included insomnia and paranoid schizophrenia. Review of the letter sent to Resident 81 by the Department of Health Care Services dated 3/22/22, showed the PASARR level II evaluation was conducted on 3/20/22. The letter further showed the facility staff would receive the copy of the determination report and discuss the result with Resident 81 and would incorporate the recommendations into Resident 81's care plan. Review of Resident 81's PASARR Individualized Determination Report dated 3/22/22, showed Resident 81 required nursing facility services due to a medical and/or mental health condition and required special treatment program. The PASARR Individualized Determination Report further showed additional functional medical recommendations which included sleep specialist consultation. Review of Resident 81's plan of care revised 7/20/22, showed PASARR Level II was addressed, but the care plan did not include the required sleep specialist consultation. Further review of the medical records failed to show if sleep specialist consultation was conducted. On 5/20/26 at 1048 hours, an interview and concurrent medical record review was conducted with the TRC Program Director. The TRC Program Director verified the above findings and stated she was unable to find the documentation to show if the recommendation from PASARR level II evaluation for sleep specialist consultation was followed up or incorporated in Resident 81's plan of care. On 5/21/26 at 1411 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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, facility document review, and facility P&P review, the facility failed to ensure the menus were followed when:1. The pureed diet peas and carrots recipe was not followed;2. The minced and moist diet peas and carrots recipe was not followed; and3. The minced and moist diet glazed meat loaf recipe was not followed. These failures had the potential to not meet the residents' nutritional needs for the 18 of 87 residents (Residents 2, 7, 18, 20, 24, 26, 34, 44, 45, 52, 59, 63, 65, 66, 67, 74, 88, and 93) who received a pureed diet and nine of 87 residents (Residents 16, 21, 37, 61, 64, 76, and 84) who received a minced and moist diet. Findings: Review of the facility's matrix showed 87 of 93 residents who resided in the facility consumed food prepared in the kitchen. Review of the facility's P&P titled Menu Planning (undated), showed standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. Review of the facility's document titled Glazed Meatloaf (undated), showed 96 servings, 40 ounce ketchup, 1 1/3 lbs. brown sugar, 5 fl oz lemon juice, 3 1/4 Tbsp dry mustard, 24 lbs. ground 90/10 beef, 34 slices white bread, 2 1/3 cup chopped onions, 10 eggs, 2 1/2 oz beef base, 14 1/2 fl oz lemon juice. Method: In a small bowl; combine ketchup, brown sugar, first listed amount of lemon juice and dry mustard until smooth; set aside.Special Diet Instructions:.Mechanical Soft Ground.Ladle ketchup mix over altered meat. Ketchup should be thick, so liquid doesn't separate from solids. Review of the facility's document titled Peas and Carrots, undated showed, 96 servings, frozen peas 7 1/4 lbs., frozen carrots 6 3/4 lbs. Procedure: 1. Prepare vegetables according to package directions.Special Diet Instructions.Mechanical Soft Ground - MS Ground Omit peas.Puree - PUR Omit peas. Review of the facility's document titled Diet Extensions dated Wednesday Week 4, showed Puree diet receives pureed carrots, MS Ground receives mashed carrots. 1. On 5/20/26 at 0800 hours, an observation of the pureed diet preparation was conducted with [NAME] 1. [NAME] 1 stated he was preparing 24 servings of peas and carrots. Using a slotted spoon cook measured 24 spoons of cooked peas and carrots into a blender. [NAME] 1 added three cups of water, the peas and carrots were cooked in. [NAME] added 5 Tbsp of thickener. [NAME] 1 did not refer to the recipe during the puree process. [NAME] 1 demonstrated spoon tilt test and put item in the oven. On 5/20/26 at 1330 hours, an interview was conducted with the Dietary Services Supervisor (DSS). The DSS confirmed that [NAME] 1 incorrectly included the peas in the puree vegetable. The DSS stated the pureed diet recipes should be followed. 2. On 5/20/26 at 1330 hours, an observation of a minced and moist diet test tray and concurrent interview with the DSS was conducted in the main dining room. The plate contained a scoop of minced peas and carrots. The DSS confirmed that according to the spreadsheet the vegetable serving should contain carrots only. The DSS confirmed that according to the recipe peas should be omitted for the minced and moist diet. The DSS confirmed that the recipe was not followed. 3. On 5/20/26 at 1340 hours, an observation of a minced and moist diet test tray and concurrent interview with the DSS was conducted in the main dining room. The plate contained a scoop of minced meatloaf with gravy on top. The DSS confirmed that according to the recipe thick ketchup should be ladled over the meat. The DSS confirmed that the recipe was not followed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed for 87 of 93 residents who received meals from the facility's kitchen. * The facility failed to ensure facial hair was covered in the food preparation area. * The facility failed to ensure the ice machine was not dirty. * The facility failed to ensure open food items were dated. These failures increased the risk of foodborne illness for the highly susceptible resident population of 87 residents who received meals prepared in the facility's kitchen.Findings: Review of the facility's Resident Matrix dated 5/19/26, showed 87 of 93 residents received meals prepared in the facility's kitchen. 1. Review of the facility's P&P titled Dress Code (undated) showed beards and mustaches (any facial hair) must wear beard restraint. On 5/19/26 at 0815 hours, during the initial tour of kitchen, an observation was conducted with Diet Aide 1. Diet Aide 1 was observed working in the food preparation area with uncovered facial hair. On 5/19/26 at 0900 hours, an interview was conducted with the DSS. The DSS was asked about the facility's policy regarding hair restraints. The DSS stated facial hair should be covered. The DSS was informed of Diet Aide 1's uncovered facial hair and verified all facial hair should be covered with a hair restraint. 2. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment Food-Contact Surfaces and utensils shall be clean to sight and touch. Review of the Ice-O-Matic Maintenance Manual dated 9/1/15, showed it is the responsibility of the operator to determine the optimal frequency (of cleaning) for their particular environment. On 5/19/26 at 1500 hours, an inspection of Ice Machine 1 and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated he cleaned the ice machine monthly. The Maintenance Supervisor opened the ice machine's front panel, and the vertical evaporator grid was visibly coated with reddish-brown material in the cells where the ice cubes are formed. The Maintenance Supervisor acknowledged the reddish-brown material. Review of the email received from the Ice-O-Matic vendor dated 5/21/26, showed the unit was equipped with a nickel-plated copper evaporator. The reddish discoloration observed was characteristic of copper and did not indicate corrosion or rust. In accordance with NSF standards, the unit remains safe for continued use. It was recommended, however, that either the machine or the evaporator plate was replaced due to future mechanical failure causing possible downtime issues. 3. According to USDA Food Code 2022, Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking showed refrigerated, ready-to-eat time/ temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified. Review of the facility's P&P titled Labeling and Dating of Foods (undated) showed newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines. On 5/19/26 at 0815 hours, during the initial tour of kitchen, an observation of the dry storage area and concurrent interview was conducted with the DSS. The following was observed:- Two opened and sealed packages of dry pasta without an open date or use-by date.The DSS verified the food items were not dated.

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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. Based on observation, interview, and facility P&P review, the facility failed to ensure the infection control practices were followed. * The facility failed to ensure Room A's door frame had no yellow discoloration. * The facility failed to ensure Room A's toilet seat was in good repair. * The facility failed to ensure the floor tiles in hallways throughout the facility and in the laundry room were intact and cleanable. * The facility failed to ensure the laundry room vents and surfaces were free of dust and cobwebs. * The facility failed to ensure clean towels used for residents were stored covered and protected from contamination. * The facility failed to ensure the clean PPE gowns were stored properly and not adjacent to a lintˆproducing machine. * The facility failed to ensure eye protection was available for staff to use while sorting soiled laundry. * The facility failed to ensure laundry equipment was clean and free of rustˆlike discoloration or structural damage. * The facility failed to ensure the facility staff were provided with education about the signs and symptoms of Legionnaire's disease. In addition, the facility's P&P for Legionnaires did not include the temperature range required for Legionella prevention. * The facility failed to ensure LVN 2 performed hand hygiene and changed gloves before administering care to Resident 90 after contact with potentially contaminated surfaces. These failures increased the risk of infection transmission to the residents. Findings: According to the CDC environmental cleaning guidelines, floors were to be inspected for breaks to ensure proper cleaning and disinfecting could be conducted. 1. On 5/19/26 at 0900 hours, during the initial tour of the facility, the bottom of Room A's restroom door frame was observed with yellow discoloration and peeling. In addition, the toilet seat in Room A was observed with multiple scratches. On 5/22/26 at 1159 hours, an observation and concurrent interview was conducted with the IP. The IP verified the above findings. 2. a. On 5/19/26 at 0920 hours, cracked floor tiles were observed in a hallway outside of the laundry room, creating an uncleanable surface. b. On 5/19/26 at 0930 hours, cracked floor tiles were observed outside Room B, creating an uncleanable surface. c. On 5/19/26 at 0940 hours, a horizontal crack was observed across the floor tiles outside Room C, creating an uncleanable surface. On 5/19/26 at 1203 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the above findings. 3. Review of the facility's P&P titled Laundry Guidelines (undated) showed laundry equipment and area were to be kept in good repair and in clean, sanitary condition. Review of the facility's P&P titled Laundry and Bedding, Soiled dated 2001 showed the use of designated spaces with a closing door would be used to store clean linen and to reduce the risk of accidental contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/26 at 1445 hours, the laundry room door was observed open. The following was observed: - Clean towels stored uncovered in open cabinets, exposed to dust blown in from the open doorway- Dust buildup on the laundry room vent- Cobwebs on the laundry room door- Unsealed clean PPE gowns stored next to a lintˆproducing pump outside the laundry room- Cracked, uncleanable floor tiles behind one washing machine- Yellow discoloration and a hole on the side of another heavyˆduty washing machine On 5/19/26 at 1500 hours, an observation and concurrent interview was conducted with the IP. The IP verified the above findings. The IP acknowledged the clean PPE gowns should not be stored next to the dryer pump. On 5/19/26 at 1514 hours, an observation and concurrent interview was conducted with Laundry Staff 1. When asked about eye protection to use when sorting soiled laundry, Laundry Staff 1 stated there was no eye protection available for the laundry staff to use. When asked about the floor tiles behind one of the washing machines, Laundry Staff 1 stated the cracked floor tiles had not been reported. Laundry Staff 1 verified there was a hole and yellow discoloration to one side of a second washing machine inside the laundry room. 4. a. Review of the facility's P&P titled Legionella Surveillance and Detection dated 2022 showed the staff were to be trained about legionnaire's disease. On 5/21/26 at 1056 hours, an interview and concurrent facility document review was conducted with the IP. When asked about education provided to the facility staff regarding the signs and symptoms of Legionnaire's disease, the IP verbalized the staff had not been provided education. b. According to CDC, hot water temperatures are to be stored above 140 degrees F. Review of the facility's P&P titled Legionnaire's (undated) showed temperature testing would be conducted to monitor; however, the P&P did not show the temperature range required for Legionella prevention. On 5/22/26 at 1002 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. When asked how the facility monitored the risk of Legionnaire's disease, the Maintenance Supervisor stated he tested the water temperatures to keep the water temperatures below 120 degrees F. The water boiler temperatures for the units in the facility were observed and verified to be 115 degrees F and 110 degrees F. On 5/22/26 at 1030 hours, an interview and concurrent review of the facility's P&P was conducted with the Administrator. When asked about the facility's prevention plan to reduce risk of Legionella in the facility, the Administrator stated the facility planned to use a water management testing company. The Administrator verified although water temperature checks were being conducted, the P&P did not include a documented temperature range required for Legionella prevention. 5. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 12/2025 showed hand hygiene is the primary means for preventing healthcare-associated infections (HAIs) and the transmission of multidrug-resistant organisms (MDROs). This facility requires strict adherence to evidence-based hand hygiene practices (as described in this policy) for all personnel, including licensed, unlicensed, contracted, therapy, dining, housekeeping, volunteers, and students. Hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene is indicated: a. before touching a resident; b. before preparing or handling food, medications, or parenteral solutions; c. before clean or aseptic procedures (for example, before wound care or inserting an intravenous catheter); d. before moving from work on a soiled body site to a clean body site on the same resident; e. after exposure to blood, body fluids, excretions, or contaminated surfaces; f. after touching a resident; g. after touching the resident's environment or belongings (e.g., bedrails, wheelchair, etc.); h. after glove removal; and i. whenever hands are visibly soiled. The use of gloves does not substitute for hand hygiene. Always perform hand hygiene after gloves are removed. On 5/20/26 at 0906 hours, a medication administration observation for Resident 90 was conducted with LVN 2. LVN 2 was observed performing hand hygiene and donning new gloves. LVN 2 stopped the tube feeding pump and touched Resident 90's gown and blanket then proceeded with checking the GT for residual and administered the without performing hand hygiene and changing gloves. On 5/20/26 at 0925 hours, an interview was conducted with LVN 2. LVN 2 acknowledged she did not perform hand hygiene and changed gloves after she touched Resident 90's tube feeding pump, gown and blanket. LVN 2 stated she should have performed hand hygiene and donned new gloves for infection prevention. On 5/22/26 at 1016 hours, an interview was conducted with the IP. The IP stated the licensed nurses were expected to perform hand hygiene and change with new gloves after touching the equipment, linens or the surroundings in the resident's room before handling medical devices attached to the resident and administering medications to prevent cross contamination. The IP was informed and acknowledged the above findings. On 5/22/26 at 1411 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the residents or their representatives were informed in advance of the proposed treatments regarding the use of the psychotropic medications (medications affecting brain activity) for two of five final sampled residents (Residents 68 and 81) reviewed for psychotropic medication use. * The facility failed to ensure the informed consent for Geodon (antipsychotic medication) and Seroquel (antipsychotic medication) included the diagnosis for which medications were prescribed for Resident 68. * The facility failed to ensure informed consent for Zoloft (antidepressant medication) and Zyprexa (antipsychotic medication) included the benefits and the manifested behaviors for Resident 81. These failures posed the risk of the residents and their representatives not understanding the clinical rationale, expected benefits, or the behavioral indications for the psychotropic medications being administered.Findings: Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the facilities may use the CDPH (California Department of Public Health) Psychotherapeutic Drug Informed Consent Form or use their own in-house form as long as the in-house form contains all the data elements on the CDPH form. The form must be in use by January 1, 2026, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the CDPH 9168 document titled Psychotherapeutic Drug Informed Consent Form dated 12/2025 showed to include the following psychotherapeutic drug information: drug category, drug name, dosage prescribed, frequency, duration, administration method, caution and earning summary, reason for use of the psychotherapeutic drug and benefits, the probable side effects and significant risks associated with the use of the psychotherapeutic drug, and the reasonable alternative mode(s) of treatment or possible non-pharmacological approaches that could address the resident's needs. Review of the facility's P&P titled Informed Consents dated 4/2024 showed under the Guidelines section, the disclosure of material information and obtaining informed consent is the responsibility of the licensed health care practitioner who, in acting within the scope of his/her professional licensure, performs or orders the procedure or treatment for which informed consent is required. The information shall be determined by the licensed health care practitioner and shall include at least the following:- The reason for the treatment and the nature and seriousness of the resident's illness.- The nature of the procedures to be used in the proposed treatment includes their probable frequency and duration.- The probable degree and duration (temporary or permanent) of improvement or remission expected with or without such treatment.- The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions.- The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment. 1. Medical record review for Resident 68 was initiated on 5/19/26. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68's H&P examination dated 6/6/25, showed Resident 68 had no capacity to understand and make decisions. Review of Resident 68 ?s Order Summary Report showed the following physician's orders:- dated 11/25/25, to administer Seroquel 100 mg by mouth at bed time for anxiety and difficulty sleeping.- dated 5/4/26, to administer Geodon oral capsule 60 mg one capsule by mouth in the evening for depressed mood related to schizoaffective disorder. Review of Resident 68's Psychotherapeutic Drug Informed Consent for the Geodon medication dated 3/9/26, showed the section Reason for Use of Psychotherapeutic Drug and Benefits listed depressed mood and eliminate symptoms related to mood. The form did not include the diagnosis supporting the use of the Geodon medication. Review of Resident 68's Psychotherapeutic Drug Informed Consent for Seroquel dated 3/9/26, showed the section Reason for Use of Psychotherapeutic Drug and Benefits listed anxiety and difficulty falling asleep with the expected benefits of promoting sleep and relieving anxiety. The form did not include a diagnosis supporting the use of the Seroquel medication. 2. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 81 was initiated on 5/19/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's H&P examination dated 10/10/25, showed Resident 81 had no capacity to understand and make decisions. Review of Resident 81's order Summary Report showed the following physician's orders:- dated 4/11/22, to administer Zoloft 50 mg by mouth in the morning for depressed mood related to paranoid schizophrenia.- dated 11/10/22, to administer Zyprexa 20 mg by mouth every morning and at bedtime for paranoid schizophrenia as manifested by paranoia. Review of Resident 81's Psychotherapeutic Drug Informed Consent for Zyprexa dated 3/19/26, showed the section Reason for Use of Psychotherapeutic Drug and Benefits listed paranoid schizophrenia. The form did not include the resident's manifested behaviors or expected benefits associated with the use of the Zyprexa medication. Review of Resident 81's Psychotherapeutic Drug Informed Consent for Zoloft dated 3/19/26, showed the section Reason for Use of Psychotherapeutic Drug and Benefits listed paranoid schizophrenia. The form did not include the resident's manifested behaviors or expected benefits associated with the use of the Zoloft medication. On 5/21/26 at 0958 hours, an interview and concurrent medical record review for Residents 68 and 81 was conducted with the ADON. The ADON verified the above findings and stated the informed consents for Resident 68 (Geodon and Seroquel medications) did not include the diagnoses related to the medications. The ADON also verified the informed consents for Resident 81 (Zoloft and Zyprexa medications) did not include manifested behaviors and or benefits related to the medications. On 5/21/26 at 1411 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to maintain a homelike environment for the residents. * Yellow stains observed ceiling tiles in multiple areas throughout the facility. * Cracks and peeling paint observed on the lobby ceiling. These failures posed the risk of the residents not being able to enjoy a clean, well-maintained interior environment.Findings: On 5/19/26 at 0830 hours, the residents were observed seated in the facility's lobby. On 5/19/26, at 920 hours, yellow stains were observed on the ceiling tiles located outside the residents' dining room and activities room. Additionally, the ceiling of the facility's lobby, an area used for the residents requiring supervision was observed to have cracks and peeling paint. On 5/19/26, at 1203 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance/Housekeeping Supervisor verified the above findings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive person-centered care plan was revised to reflect the residents' current care needs and interventions for three of 19 final sampled residents (Residents 7, 10, and 77). * The facility failed to ensure the care plan for pain and pain medication was revised to include nonpharmacological interventions prior to administration as ordered, for Residents 10 and 77. * The facility failed to ensure the care plan was updated to reflect the current use of wheelchair alarm for Resident 7. These failures increased the risk that residents would not receive individualized and personˆcentered care in accordance with their assessed needs. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed: - The comprehensive, person-centered care plan reflects currently recognized standards of practice for problem areas and conditions; - Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change; and - The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. Review of the facility's P&P titled Pain Assessment and Management revised 6/2025 showed during the pain assessment, gather the following information, as indicated, from the resident (or legal representative): history of pain (onset and duration) and its treatment, including pharmacological and non-pharmacological interventions. 1. Medical record review for Resident 10 was initiated on 5/19/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's Order Summary Report showed a physician's order dated 5/11/26, to administer Tylenol (acetaminophen; pain reliever) 325 mg, give 650 mg by mouth every four hours as needed for pain. Provide NPI prior to administration: 1=conversation/listening, #2=music/tv, #3=repositioning for comfort, #4=exercises/stretches, #5=rest period/sleep, # 6=Reassuring, #7= remove from stimuli, #8 deep breathing/relaxation, and #9=return to med room. Review of Resident 10's care plan addressing the resident's alteration in comfort related to pain (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised on 1/25/26, included medication administration as ordered; however, it did not include the physician ordered NPIs as interventions. On 5/21/26 at 1333 hours, an interview and concurrent medical record review for Resident 10 was conducted with the TRC MDS Coordinator. The TRC MDS Coordinator verified the above findings and stated Resident 10's current plan of care for pain should include NPIs as interventions. 2. Medical record review for Resident 77 was initiated on 5/19/26. Resident 77 was readmitted to the facility on [DATE]. Review of Resident 77's Order Summary Report showed a physician's order dated 3/18/26, for pain management to provide Non-pharmacological Interventions as follows: 1. One on one; 2. Activity; 3. Change position; 4. Backrub; 5. Offer fluids/offer Food; 6. Redirect/return to room; 7. Remove resident from environment; 8. Toilet/brief change; 9. Pen & paper/magazines; 10. Family phone call; 11. Watch tv/listen music; #12. Verbal reassurance; 13. Meal replacement; 14. Explain all care; 15. Return at a later time; 16. Doll/busy apron; 17. Warm blanket; 18. Ambulation/walk; 19 Naptime; and 20. Nurse note every shift. Review of Resident 77's care plan for pain related to chronic pain – musculoskeletal pain arthritis revised on 5/7/26, included administering medication as ordered; however, it did not include the ordered NPIs. On 5/22/26 at 1000 hours, an interview and concurrent medical record review for Resident 77 was conducted with LVN 1. LVN 1 verified the care plan should include NPIs and acknowledged the care plan had not been updated to reflect these interventions. On 5/22/26 at 1411 hours, an interview was conducted with the DON. The DON was informed of and acknowledged the above findings for Residents 10 and 77. 3. On 5/19/26 at 1009 hours, and on 5/20/26 at 1150 hours, Resident 7 was observed in the wheelchair with a wheelchair alarm attached. Medical record review for Resident 7 was initiated on 5/19/26. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's H&P examination dated 5/14/26, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's Order Summary Report showed a physician's order dated 5/11/26, for wheelchair alarm to alert staff when the resident attempted to get up unassisted to prevent fall injury due to poor safety awareness. Review of Resident 7's Care Plan dated 5/11/26, showed a care plan problem addressing Resident 7's use of a lap buddy (soft, supportive pad that fits snugly over the arms of a wheelchair) as a restraint due to confusion, impaired mobility and balance, unaware of safety needs, impulsive behavior and short attention span. However, the care plan did not include the current intervention of wheelchair alarm use. On 05/20/26 at 1152 hours, an observation and concurrent interview was conducted with CNA 1. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 7 was observed seated in his wheelchair in the hallway outside his room. A wheelchair alarm was attached to the wheelchair. CNA 1 verified the observation and stated Resident 7 previously used a lap buddy but was currently using a wheelchair alarm. On 5/20/26 at 1215 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 1. LVN 1 stated the lap buddy had been used to prevent Resident 7 from falling out of the wheelchair, but it was discontinued, and a wheelchair alarm was initiated to alert staff when the resident attempted to get up unassisted. LVN 1 reviewed the care plan and verified there was no care plan problem addressing the wheelchair alarm and that the care plan still listed the discontinued lap buddy. On 5/21/26 at 1411 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to meet the resident's care needs for one of 19 final sampled residents (Resident 81). * The facility failed to ensure side effects of the psychotropic medication (any drug that affects brain activity associated with mental processes and behavior) were monitored, documented and reported to the physician for Resident 81. This failure had the potential to cause avoidable complications, delayed interventions, worsening health conditions, and overall compromised residents' wellˆbeing.Findings: Review of the facility's P&P titled Psychotropic Medication use dated 2/2025 showed under the section Monitoring and Adverse Consequences, residents are monitored for adverse consequences associated with psychotropic medication including neurologic effects - agitation, distress, and extrapyramidal symptoms {drug-induced movement disorders that primarily occur as side effects of medications like antipsychotics. The four main extrapyramidal symptoms are acute dystonia (muscle spasm), akathisia (restlessness), drug-induced parkinsonism (rigidity and tremors), and tardive dyskinesia (involuntary facial movements). If a psychotropic medication is possibly causing or contributing to adverse consequences, the prescriber will determine whether the medication(s) should be discontinued. If the medication is not discontinued, the rational for this decision must be documented. On 5/19/26 at 1101 hours, Resident 81 was observed ambulating inside her room. The resident was noted with a tremor in her left hand. On 5/21/26 at 0904 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 stated Resident 81's left hand had been shaking for a long time and believed it might be related to the resident's medication for mental illness. When asked whether she had reported the tremor to the nursing staff, CNA 2 stated she had reported it once a long time ago, and assumed the nurses were aware, and had not reported it again. Medical record review for Resident 81 was initiated on 5/19/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's H&P examination dated 10/10/25, showed Resident 81 had no capacity to understand and make decisions. Review of Resident 81's Order Summary Report showed the following physician's orders:- dated 4/11/22, to administer Zoloft (antidepressant) 50 mg tablet by mouth every morning for depressed mood related to paranoid schizophrenia.- dated 11/10/22, to administer Zyprexa (antipsychotic) 20 mg tablet by mouth every morning and at bedtime for paranoid schizophrenia as manifested by paranoia.- dated 7/18/25, for antipsychotic medication monitoring: directing staff to monitor for the following side effects: dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea, vomiting, lethargy, drooling, and extrapyramidal symptoms (tremor, disturbed gait, increased agitation, restlessness, involuntary movement of the mouth or tongue). Staff were instructed to tally side effects each shift, using 0 for none, Y for yes, and N for no.- dated 7/18/25, for antidepressant medication monitoring: directing staff to monitor for headache, dizziness, tremor, fatigue, anxiety, nausea, diarrhea, dyspnea, anorexia, constipation, dry mouth, excessive sweating, fever, and other symptoms. Staff were instructed to tally side effects each shift, using 0 for none, Y for yes, and N for no. Review of Resident 81's MAR dated 5/1- 5/31/26, showed to monitor the above side effects of the antidepressant and antipsychotic medications. However, the MAR did not show Resident 81's left hand tremor. Further review of Resident 81's medical record showed no documentation that Resident 81's leftˆhand tremor was monitored, assessed, or reported to the physician. On 5/21/26 at 0958 hours, an interview and concurrent medical record review for Resident 81 was conducted with the ADON. The ADON was informed of the previous observation of Resident 81's involuntary tremor in her left hand. The ADON reviewed the resident's documentation and stated she was unable to locate any documentation indicating the resident had a tremor. The ADON verified the MAR did not reflect any reported side effects related to psychotropic medications. The ADON stated side effects from psychotropic medication must be documented and the physician should be notified. On 5/21/26 at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1355 hours, an observation and concurrent interview was conducted with the ADON for Resident 81. Resident 81 was observed in the activity room with the ADON present. The ADON instructed Resident 81 to lift both arms to chest level. Resident 81 complied, and a visible tremor was observed in the left hand. The ADON verified the tremor and stated she would notify the physician. The ADON further stated CNA 2 should have notified the nursing staff when she observed tremors of Resident 81's hand, and the physician should have been informed of the observed tremor. On 5/21/26 at 1411 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries for one of three final sampled residents (Resident 1) reviewed for pressure injuries. * The facility failed to ensure Resident 1's LAL mattress was not set in a static mode while the resident was in bed. This failure had the potential to result in the development of pressure injuries or the worsening of existing pressure injuries. Findings: Review of the facility document titled Med-Aire 8" Alternating Pressure Mattress Replacement System with Low Air Loss user manual showed in static mode, the mattress provides a firm surface that makes it easier for the patient to transfer or reposition. The static mode prevents the patient from bottoming out when in a sitting position. Medical record review for Resident 1 was initiated on 5/19/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 3/20/26, showed the had no capacity to understand and make decisions. Review of Resident 1's Order Summary Report dated 5/21/26, showed the following physician's order:- dated 5/19/26, for Low Air Loss (LAL) mattress for skin management due to immobility, set mode to alternating pressure and set to weight of resident; special instruction: check functionality and mode setting assure it is alternating pressure and not static every shift. On 5/19/26 at 0958 hours, Resident 1 was observed lying in bed on a LAL mattress. The mattress was set at normal pressure and static mode. Resident 1 was not interviewable. On 5/19/26 at 1000 hours, an observation and concurrent interview was conducted with LVN 1 in Resident 1's room. LVN 1 verified that the LAL mattress was in static mode. LVN 1 stated the LAL mattress should not be in the static mode while Resident 1 was in bed. LVN 1 further stated Resident 1 has high risk for developing pressure injuries due to immobility, and the LAL mattress helped prevent and promote healing of existing pressure injuries by providing alternate normal pressure. On 5/20/26 at 1127 hours, an interview was conducted with the DON. The DON stated static mode should not be used when the resident was lying in bed, except during meals or during care such as bathing or repositioning. The DON was informed Resident 1's LAL mattress had been observed in the static mode and acknowledged this was not accurate per the resident's needs or physician's order.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of two final sampled residents (Resident 7) reviewed for weight loss received the necessary services to maintain acceptable nutritional status. * The facility failed to notify Resident 7's physician and resident's responsible party, when Resident 7 experienced significant weight loss upon readmission to the facility. This failure had the potential to delay needed medical intervention, contribute to further nutritional decline, and increase the resident's risk for adverse health outcomes related to unaddressed significant weight loss.Findings: Review of the facility P&P titled Nutrition (Impaired) unplanned weight Loss- Clinical Protocol dated September 2012 showed the staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. The physician will review for medical causes of weight gain, anorexia and weight loss before ordering interventions. Medical record review for Resident 7 was initiated on 5/19/26. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's H&P examination dated 5/14/26, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's Weight Summary showed the following dates and weights:- on 3/3/2026, 124 lbs.- on 4/7/2026, 120 lbs.;- on 5/1/2026, 119 lbs.; and- on 5/11/2026, 110 lbs.; a weight loss of 14 lbs. from 3/3/26. Review of Resident 7's Progress Notes showed following:- dated 5/8/26 at 2226 hours, Resident 7 was transferred to the acute care hospital; and,- dated 5/11/26 at 1600 hours, Resident 7 was readmitted to the facility from the acute care hospital. Review of Resident 7's Nutritional Status Update dated 5/18/26, showed the resident's ideal weight range was 117-140 lbs. The document indicated Resident 7 had experienced a 7.5% weight loss within 10 days. The Nutritional Status Update further showed the resident was receiving four ounces of nutritional shake (supplement) three times daily with meals, providing approximately 720 calories and 24 grams of protein per day, as well as juice three times daily, providing an additional 180 calories. The update documented Resident 7 was readmitted from the acute care hospital with a 9 (nine)ˆpound weight loss in 10 days and noted that the further weight loss was not clinically indicated. However, further review of the Nutritional Status Update did not show evidence that the physician or resident's representative was notified of the significant 9ˆpound (7.5%) weight loss in 10 days. Further review of Resident 7's medical record failed to show the physician and resident's representative were notified when significant weight changes of Resident 7 was identified on readmission. On 5/20/26 at 1215 hours, an interview and concurrent medical record review for Resident 7 were conducted with LVN 1. LVN 1 stated a weight loss greater than 5% in one month or greater than 10% in six months constituted a significant weight change for a resident. LVN 1 verified Resident 7's weight changes met the criteria for significant weight loss upon readmission. LVN 1 stated when a resident experienced significant weight change, the physician and resident's responsible party must be notified. LVN 1 further stated he was unable to locate documented evidence the physician or resident's responsible party had been notified when Resident 7 experienced significant weight loss upon readmission. On 5/21/26 at 1411 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON was informed and verified the above findings. The DON stated the physician and resident's responsible party should have been notified when Resident 7 had significant weight loss on readmission.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure appropriate care and services were provided for the residents with GT for two of three final sampled residents (Residents 3 and 87) reviewed for the tube feeding management. * The facility failed to ensure LVN 3 administered diluted medications via GT by gravity flow as required, for Resident 3. * The facility failed to ensure Resident 87's enteral feeding formula and water feeding bag were changed within 24 hours per facility P&P and accepted standards. These failures placed the residents at risk for complications related to GT use, including tube dislodgement, gastrointestinal injury, contamination, or infection. Findings: 1. Review of the facility's P&P titled Administering Medications Through an Enteral Tube revised 11/2018 showed under the Steps in the Procedure section, to administer medication by gravity flow: pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion, open the clamp and deliver medication slowly, and begin flush before the tubing drains completely. Medical record review for Resident 3 was initiated on 5/20/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 2/28/26, to administer fludrocortisone acetate (steroid) 0.1 mg one tablet via GT one time a day for adrenal insufficiency; - dated 2/28/26, to administer Dilantin (antiseizure) suspension 125 mg/5ml, four ml via GT one time a day for seizure disorder; - dated 2/28/26, to administer Pepcid 20 mg one tablet via GT two times a day for GI prophylaxis; - dated 3/5/26, to administer Pro-Stat (supplement) oral liquid 30 ml via GT two times a day for supplement; - dated 3/11/26, to administer Tylenol (pain reliever) 325 mg two tablets (650 mg) via GT one time a day for pain management prior to daily wound treatment; - dated 4/2/26, to administer multivitamins and mineral oral liquid 15 ml via GT one time a day for supplement; and - dated 4/8/26, to administer aspirin (used to treat mild pain, reduce fever and decrease inflammation) 81 mg one tablet via GT one times day for CVA prophylaxis. On 5/20/26 at 0806 hours, a medication administration observation for Resident 3 was conducted with LVN 3. LVN 3 was observed administering the diluted fludcortisone acetate medication via GT to Resident 3. The medication flowed slowly and LVN 3 used the syringe plunger to push 10 ml of water (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the GT rather than allowing gravity flow. The same technique was used for Dilantin, Pepcid, multivitamins, aspirin, Tylenol, and Proˆ Stat. On 5/20/26 at 1140 hours, an interview was conducted with LVN 3. LVN 3 verified she used the plunger to push the medications into the GT rather than having using gravity flow Resident 3. LVN 3 stated she should have stopped and checked the GT's patency when the flow was slow. LVN 3 further stated she believed, based on prior facility training, that slowly pushing medications with the plunger was acceptable. On 5/22/26 at 1411 hours, an interview was conducted with the DON. The DON stated the medications given via GT should be administered by gravity flow because if it was flushed forcefully, it could cause pressure to the stomach, gastrointestinal issues, and the GT might get dislodged. The DON was informed and acknowledged the above findings. Cross reference to F726. 2. Review of the facility's P&P titled Enteral Feedings - Safety Precautions revised 4/2026 showed to change the administration sets open-system enteral feeding at least every 24 hours, or as specified by the manufacturer. Medical record review for Resident 87 was initiated on 5/19/26. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's H&P examination dated 5/31/24, showed Resident 87 had no capacity to understand and make decisions. Review of Resident 87's Order Summary Report showed the following orders: - dated 2/23/24, to administer Jevity (type of enteral feeding) 1.5 or equivalent running at 40 ml/hr x 12 hours for a total of 480 ml or 720 calories; on at 1600 hours and off at 0400 hours or when total dose finished, may pause or hold feeding during ADL care. - dated 7/10/25, to administer water flush at 80 ml/hr for 12 hours to provide 960 ml to run concurrently with GT feeding. On 5/19/26 at 0937 hours, an observation and concurrent interview for Resident 87 was conducted with RN 1. Resident 87 was observed lying in bed. The enteral feeding pump had Jevity 1.5 bottle hanging from the feeding pump pole and labeled 5/17/26 at 1530 hours. The enteral feeding water bag was also labeled with 5/17/26 at 1530 hours. RN 1 verified the findings and stated the enteral feeding formula, and the water bag should be changed every 24 hours when starting the enteral feeding at 1600 hours. On 5/20/26 at 1112 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary care for one of one resident reviewed for respiratory care (Resident 7). * The facility failed to ensure Resident 7's suction canister, tubing, and opened Yankauer suction was labeled. This failure had the potential for Resident 7 to not receive appropriate respiratory care and increase risk of infection.Findings: On 5/19/26 at 1007 hours, during an observation in Resident 7's room, the suction canister connected to the suction tubing was observed on top of the drawer located on the right side of the resident's bed. The suction tubing contained yellowish fluid. The suction tubing was connected to a Yankauer, which was stored inside the top shelf of the drawer. The Yankauer was stored in an opened original package. The suction canister, suction tubing, and Yankauer were not labeled to indicate the date they were last changed. Resident 7 was not present in the room at the time of the observation. On 5/19/26 at 1009 hours, an observation and interview was conducted with the IP. The IP stated Resident 7's was currently in the activity room. The IP verified the above observation and stated Resident 7's suction canister, suction tubing, and Yankauer were not labeled. The IP stated Resident 7's suction canister, suction tubing, and Yankauer should be labeled indicating when it was last changed, and it should be changed weekly to minimize the risk of infection.Medical record review for Resident 7 was initiated on 5/19/26. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's Order Summary Report showed an order dated 5/11/26, for suctioning as needed for excessive saliva/drooling as needed. Review of Resident 7's H&P examination dated 5/14/26, showed Resident 7 had no capacity to understand and make decisions. On 5/21/26 at 1411 hours, an interview was conducted with the DON . The DON was informed and acknowledged the above findings.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure one licensed nurse reviewed for competency had specific competencies and standard of practice skill sets needed to provide safe and efficient nursing care. * The facility failed to ensure LVN 3 was able to competently administer the medications via GT (gastrostomy tube, a small tube placed through the abdominal wall into the stomach, used to provide enteral feedings and/or administer medications) to Resident 3. This failure had the potential to put the resident at risks for the care not provided in a safe and competent manner. Findings: Review of the facility's document titled Charge Nurse Job Description - Nursing Services dated 2003, showed the Charge Nurse must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to nursing care facilities, must implement and maintain established nursing objectives and standards, and must be able to administer professional services such as: catheterization, tube feedings, suction, applying and changing dressings/bandages, packs, colostomy, and drainage bags, taking blood, giving massages and range of motion exercises, care for the dead/dying, etc., as required. Review of the facility's P&P titled Administering Medications Through an Enteral Tube revised 11/2018 under the Steps in the Procedure section showed to administer medication by gravity flow: pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion, open the clamp and deliver medication slowly, and begin flush before the tubing drains completely. On 5/20/26 at 0806 hours, a medication administration observation for Resident 3 was conducted with LVN 3. LVN 3 was observed administering the diluted fludcortisone acetate medication via GT to Resident 3. The medication was slowly going down in the GT. LVN 3 was observed pouring 10 ml of water into the enteral syringe and flushed the medication using the syringe plunger. The same process was observed when LVN 3 administered the Dilantin (anticonvulsant), Pepcid (heartburn relief), multivitamins (supplement), aspirin (pain and fever relief and preventing cardiovascular events), Tylenol (analgesic), and pro-stat (protein supplement) medications to Resident 3. On 5/20/26 at 1140 hours, an interview was conducted with LVN 3. LVN 3 verified she pushed the medications into the GT using the enteral syringe plunger rather than having those flow by gravity for Resident 3. LVN 3 further stated she should have stopped administering the medications and checked the GT patency as to why the medications were flowing into the GT very slowly. LVN 3 stated she was told during one of the facility's trainings for medication administration via GT she could push the medications into the GT using the syringe plunger slowly. On 5/22/26 at 1038 hours, an interview and concurrent employee file review for LVN 3 were conducted with the DSD. Review of LVN 3's Skills Checklist - Licensed Nurse Medication Administration revised 3/1/16, showed under Medications Given Via Proper Technique - Gastric/NG Tubing showed the following:- dated 8/7/25, check placement, check residual, flush before and after medications, multiple medications are to be crushed and given separately, flush as ordered. Met and Not Met columns were blank. The Comments section showed only 1 med to be given, no residual, not done 30 ml flush?. The evaluation form was signed by a previous facility's trainer per DSD; and- dated 10/29/25, check placement, check residual, flush before and after medications, multiple medications are to be crushed and given separately, flush as ordered. The Met column was marked with check. The Comments section showed Difficulty with administration of medication buts medications were given - position was changed as needed. The evaluation form was signed by a previous facility's trainer per DSD. The DSD stated she assisted the DON for some of the skills competency training for the licensed nurses. The DSD stated the licensed nurses should complete the initial skills competency which included the medication administration via different routes upon hired within the first 40 hours of work and on their 90th days. The DSD stated all newly hired licensed nurses got a minimum of two days floor orientation with experienced licensed nurses and could be extended depending on their skills (continued on next page)

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	555211	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Westminster	206 Hospital Circle Westminster, CA 92683

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performance and knowledge needs. The DSD stated the newly graduated licensed nurses' trainings were always extended more. The DSD further stated the nurse consultant from the corporate would come also to the facility to assist with the training for licensed nurses. On 5/22/26 at 1411 hours, an interview was conducted with the DON. The DON stated she was responsible for providing and reviewing the skills competency of the licensed nurses. The DON stated the DSD would assist her and the Pharmacy Consultant would also do the medication administration training for the licensed nurses. The DON stated licensed nurse's skills competency was being reviewed upon hire, on the 90th day from the date hired, and annually together with the annual employee review. The DON further stated the skills competency training was being provided as needed and if there was a new device introduced for residents' use. The DON was informed and acknowledged the above findings for LVN 3. Cross reference to F693, example #1.

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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. Based on observation and interview, the facility failed to provide the necessary pharmacy services to ensure proper storage of the medications in one of one medication storage room inspected. * The facility failed to ensure over the counter medications were stored in a locked compartment. This failure resulted in unauthorized staff having access to the medications.Findings: On 5/20/26 at 0900 hours, an observation and concurrent interview was conducted with the Central Supply Staff. When asked about the medication storage areas, the Central Supply Staff showed an unlocked, and easily accessible storage room located within the facility's administrative office building. Inside the unlocked storage area, multiple bottles of over-the-counter medications including bottles of aspirin, loratadine (antihistamine), artificial tears (eye drops), and arthritis pain medications were observed stored openly on a counter and inside an open box. When asked who had keys to the office building, the Central Supply Staff stated the Business Office Manager, Chief Financial Officer, Administrator, and housekeeping staff all had keys providing access to the office building. On 5/20/26 at 1000 hours, an observation and concurrent interview was conducted with the DON. The DON verified and acknowledged the over-the-counter medications were not secured and were accessible to unauthorized personnel.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed for 87 of 93 residents who received meals from the facility's kitchen. * The facility failed to ensure facial hair was covered in the food preparation area. * The facility failed to ensure the ice machine was not dirty. * The facility failed to ensure open food items were dated. These failures increased the risk of foodborne illness for the highly susceptible resident population of 87 residents who received meals prepared in the facility's kitchen.Findings: Review of the facility's Resident Matrix dated 5/19/26, showed 87 of 93 residents received meals prepared in the facility's kitchen. 1. Review of the facility's P&P titled Dress Code (undated) showed beards and mustaches (any facial hair) must wear beard restraint. On 5/19/26 at 0815 hours, during the initial tour of kitchen, an observation was conducted with Diet Aide 1. Diet Aide 1 was observed working in the food preparation area with uncovered facial hair. On 5/19/26 at 0900 hours, an interview was conducted with the DSS. The DSS was asked about the facility's policy regarding hair restraints. The DSS stated facial hair should be covered. The DSS was informed of Diet Aide 1's uncovered facial hair and verified all facial hair should be covered with a hair restraint. 2. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment Food-Contact Surfaces and utensils shall be clean to sight and touch. Review of the Ice-O-Matic Maintenance Manual dated 9/1/15, showed it is the responsibility of the operator to determine the optimal frequency (of cleaning) for their particular environment. On 5/19/26 at 1500 hours, an inspection of Ice Machine 1 and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated he cleaned the ice machine monthly. The Maintenance Supervisor opened the ice machine's front panel, and the vertical evaporator grid was visibly coated with reddish-brown material in the cells where the ice cubes were formed. The Maintenance Supervisor acknowledged the reddish-brown material. Review of email received from the Ice-O-Matic vendor dated 5/21/26, showed the unit was equipped with a nickel-plated copper evaporator. The reddish discoloration observed was characteristic of copper and did not indicate corrosion or rust. In accordance with NSF standards, the unit remains safe for continued use. It was recommended, however, that either the machine or the evaporator plate was replaced due to future mechanical failure causing possible downtime issues. 3. According to USDA Food Code 2022, Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking showed refrigerated, ready-to-eat time/ temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified. Review of the facility's P&P titled Labeling and Dating of Foods (undated) showed newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines. On 5/19/26 at 0815 hours, during the initial tour of kitchen, an observation of the dry storage area and concurrent interview was conducted with the DSS. The following was observed:- Two opened and sealed packages of dry pasta without an open date or use-by date.The DSS verified the food items were not dated.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on interview, facility document review, and facility P&P review, the facility failed to ensure residents in the TRC were offered suitable alternate meal choices in accordance with their food when refusing a planned meal. * The residents in the TRC were offered only nutritional supplement drinks when planned meals were refused. This failure had the potential to prevent the 45 TRC residents receiving meals from the facility's kitchen from meeting the residents' nutritional needs.Findings: Review of the facility's Census (undated) showed 45 residents resided in the TRC. Review of the facility's P&P titled Food Substitutions for Residents Who Refuse the Meal (undated) showed the residents will be provided a suitable nourishing alternate meal after the planned, served meal has been refused. Nursing personnel will ask any resident who does not eat his meal of food item as to why he is not eating and offers a food substitution in accordance with the resident's diet order. On 5/19/26 at 1115 hours, an interview was conducted with LPT 1 in the main dining room. LPT 1 stated if a resident refused a meal or remained hungry after a meal, the resident was offered a nutritional supplement drink only. On 5/19/26 at 1527 hours, an interview was conducted with the DSS. The DSS stated in the TRC dining room, the residents who did not eat their meals were offered only a nutritional supplement drink and were not provided an alternate meal of choice in accordance with the facility's P&P.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the medical record was complete and accurate for one of 19 final sampled residents (Resident 8). * The facility failed to ensure Section D of the POLST, and the Advance Directive Acknowledgement form were completed accurately for Resident 8. This failure had the potential to result in unmet care needs for the resident due to inaccurate medical information.Findings: Review of the facility's P&P titled Charting and Documentation dated 7/2017 showed documentation in the medical record will be objective (not opiniated or speculative), complete and accurate. Medical record review for Resident 8 was initiated on 5/20/26. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's H&P examination dated 12/18/25, showed the resident had no capacity to understand and make decisions. Review of Resident 8's POLST dated 3/15/22, shown under Section D - Information and Signatures, the box indicating No Advance Directive was checked. Review of Resident 8's Advanced Directive Acknowledgement dated 3/15/22, showed Durable Power of Attorney for Healthcare was not checked off. Howver, review of Resident 8's medical record showed a copy of Resident 8's DPOA for Healthcare dated 2/18/19. On 5/20/26 at 1033 hours, an interview and concurrent medical record review for Resident 8 was conducted with the SSD. The SSD stated the Social Services were responsible for reviewing the POLST and the Advanced Directive Acknowledgment form was not updated to reflect Resident 8 had an active DPOA for healthcare. The SSD stated Section D of Resident 8's POLST should have indicated the resident's legal decision maker and that Resident 8 had DPOA for healthcare and the Advance Directive Acknowledgment form should have been updated to show Resident 8's had an active DPOA for healthcare. On 5/22/26 at 1500 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged above findings.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following:1. A plan to maximize recruitment and retention of direct care staff; and2. A contingency plan for staffing needs. These failures had the potential not to meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show a plan to maximize recruitment and retention of the direct care staff and a contingency plan for staffing needs. On 5/20/26 0902 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator reviewed the Facility Assessment and verified the above findings. The Administrator stated he was not aware of the current guidance. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.