STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555237	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Valley Medical Ctr D/P Snf	438 W. Las Tunas Drive San Gabriel, CA 91776

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure two (2) of 2 medication carts (Med Cart) were not left unattended and locked at all times in accordance with the facility's medication management policy. This deficient practice had the potential for unauthorized access to medications by staff and visitors which could lead to medication overdose (taking a toxic or poisonous amount of a drug or medicine), unauthorized use, adverse reactions (any unexpected or dangerous reactions to a drug), or harmful drug interactions (a reaction between two or more drugs or between a drug, and a food, beverage, or supplement).Findings: During a concurrent observation and interview of the Nurse's Station, on 4/25/2026, at 3:24 PM, Med Cart 2 was left unattended and unlocked. Medications of residents were observed inside the second and third drawers of Med Cart 2. Licensed Vocational Nurse 1 (LVN 1) stated the medication carts locked automatically once the drawers are pushed in. LVN 1 stated medication carts should always be locked when unattended. During an observation of the Nurse's Station, on 4/26/2026, at 4:49 PM, Med Cart 1 was left unattended and unlocked. During an interview, on 4/26/2026, at 4:46 PM, with the Minimum Data Set Nurse (MDS 1), MDS stated Med Carts should be locked at all times. MDS 1 stated licensed nurses need to push the drawers all the way in and listen for the locking sound before walking away from the medication carts. MDS 1 further stated licensed nurses need to make sure the medication carts are locked before walking away to prevent unauthorized staff or visitors from accessing residents' medications. MDS 1 stated unauthorized staff or visitors can steal or take the medications that are not prescribed to them. MDS 1 stated the facility's medication storage policy was not followed when Med Cart 1 and Med Cart 2 were left unlocked and unattended. During a review of the facility's Policy and Procedure (P&P) titled, Medication Management: General, revised 11/2017, the P&P indicated the following:The facility will assure that storage, administration and documentation of medications are managed to maintain patient safety.The facility will assure that access to medications is only available to appropriate licensed staff per regulatory requirements and accreditation standards.Medications are stored securely until preparation for administration.Storage of Medications in patient care areas: all non-controlled medications (medications that have a low potential for abuse, addiction, or physical dependence including prescription and over the counter medications), including refrigerated medications, will be single locked when unattended.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food-handling procedures and to maintain the food service area in a clean and sanitary manner, in accordance with the facility's policies and procedures (P&P) when: One can opener was dirty, had peeled metal lining, and was chipped and rusted.One food processor was cracked and had white, crusty buildup.One clear plastic bag of breaded chicken was not labeled with the item name and the open date (date opened or first use).A container of chopped garlic in the refrigerator was not sealed.The rubber seal on the ice machine cover door was cracked and falling apart.A container of ready-mixed mashed potato powder in the kitchen spice rack was not sealed properly. These deficient practices have the potential to expose residents to pathogens (germs), placing them at risk for developing foodborne illness (food poisoning), which may cause symptoms such as upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever.Findings: 1. During a concurrent observation and interview on 4/25/2026 at 7:57 AM in the facility's kitchen with Food Service Worker (FSW) 1, FSW 1 stated the can opener observed on the kitchen table was dirty, had peeled of metal lining, and was chipped and rusted. 2. During a concurrent observation and interview on 4/25/2026 at 7:58 AM in the facility kitchen with FSW 1, FSW 1 stated that the food processor observed was cracked and had white, crusty buildup. 3. During a concurrent observation and interview on 4/25/2026 at 8:00 AM in the facility kitchen with FSW 1, FSW 1 stated a clear plastic bag of breaded chicken was not labeled with the item name and open date. 4. During a concurrent observation and interview on 4/25/2026 at 8:02 AM in the facility kitchen with FSW 1, FSW 1 stated, a container of chopped garlic observed in the produce refrigerator was not sealed. 5. During a concurrent observation and interview on 4/25/2026 at 8:11 AM in the facility kitchen, FSW 1 stated the rubber seal on the ice machine cover door was observed to be cracked and falling apart. 6.During a concurrent observation and interview on 4/26/2026 at 11:00 AM in the facility kitchen with the Dietary Director (DD), the DD stated the container of ready mixed mashed potato powder observed in the kitchen spice rack was not sealed properly. During an interview on 4/26/2026 at 1:49 PM with FSW 1, FSW 1 stated the can opener should be in good condition and should not be dirty. FSW 1 also stated it was not acceptable that the can opener on the kitchen table was dirty, peeling off metal lining, chipped, and rusted because this could cause food contamination. FSW 1 stated the can opener needs to be cleaned after every use. During the same interview on 4/26/2026 at 1:49 PM with FSW 1, FSW 1 stated that all containers with food inside were supposed to be sealed properly and airtight to prevent food contamination and sickness, such as diarrhea or stomachache. FSW 1 added the food containers or food items should have been labeled with an open date (date of first use) and labeled the item name. FSW 1 stated if containers are not sealed properly, tiny particles can get in, which can cause mold, insects, and contamination. FSW 1 also stated this can affect the quality and flavor of the food. During the same interview as above on 4/26/2026 at 1:49 PM with FSW 1, FSW 1 stated the unlabeled plastic bag of breaded chicken should be labeled with the item name and with the open date. FSW 1 explained that it was important to know when the food item was opened so the kitchen staff know until when they can use the food item or serve the food, as serving food past its safe date or expiration date could result in serving spoiled food. During an interview on 4/26/2026 at 1:52 PM with FSW 1, FSW 1 stated the food processor should be in good condition, not cracked, and it should not have white buildup, discoloration, or multiple scratches. FSW 1 stated this is not acceptable because it can cause food contamination. During an interview on 4/26/2026 at 1:55 PM with FSW 1, FSW 1 stated the rubber seal (gasket) on the ice machine cover door was cracked and falling apart and the plastic door on the bottom right corner had an open crack. FSW 1 stated the ice machine was not supposed to be in damaged condition. FSW 1 state there should be no calcification (a buildup of minerals like calcium from water that forms hard, white residue inside the ice machine, which can affect its function) and no cracks. FSW 1 also stated that it was possible that (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tiny rubber particles could fall into the ice, which could result in contamination and sickness. During a concurrent interview and record review on 4/26/2026 at 2:55 PM with the Clinical Nutritional Manager (CNM), the facility's Policy and Procedures (P&P) titled Infection Control, revised date 1/2025, was reviewed. CNM stated the P&P indicated all counters, shelves, equipment, and utensils are kept clean and maintained in good repair, and are free of breaks, open seams, cracks, or chipped areas. The CNM also stated that the P&P indicated can openers will be washed in hot, soapy water daily. During a concurrent interview and record review on 4/26/2026 at 2:58 PM with the CNM, the facility's P&P titled Food Storage: Left Over, Refrigerator Stock, revised date 1/2025, was reviewed. The CNM stated that the P&P indicated that food is properly covered, refrigerated, and stored appropriately to ensure safe consumption. The P&P also indicated that all foods are to be covered, labeled, and refrigerated. Items are dated, and a clear identification (product label or written label) is placed on containers. The CNM stated that the facility's P&P was not followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for two (2) of four (4) sampled residents (Resident 12 and 36) in accordance with the facility's policy and procedure (P&P) when:Contact isolation precaution (prevent the spread of infections transmitted by direct or indirect contact with a patient or their environment) signage was not posted outside Resident 12's room who was on contact isolation precaution.Licensed Vocational Nurse 3 (LVN 3) failed to don (put on) and doffed (the safe and orderly removal) personal protective equipment (PPE, such as gowns, masks, goggles, gloves) during medication pass (a structured, routine procedure in healthcare settings, such as nursing homes, where nurses or qualified personnel administer scheduled medications to patients) for Resident 36 who is in contact isolation on 4/27/2026. These deficient practices have the potential to result in a widespread infection in the facility that could compromise the health of the residents, visitors, and staff.Findings:1. During a review of Resident 12's admission Record, the admission record indicated Resident 12 was originally admitted to the facility on [DATE], with diagnosis of respiratory failure (a condition where there's not enough oxygen in your body). During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool), dated 3/11/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 12 was dependent (helper does all of the effort) with eating oral hygiene, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a review of Resident 12's Interdisciplinary Team (IDT, a collaborative group of professionals, including physicians, nurses, therapists, and social workers, who develop a personalized care plan for residents), dated 4/15/2026, indicated a documentation that Resident 12 is on contact isolation. During a review of Resident 12's Care Plan (CP) regarding actual infection, dated 4/17/2026, indicated interventions such as instruct/monitor infection control measures and contact precautions. During an observation on 4/25/2026 8:23 AM, Resident 12's isolation signage outside the room indicated enhanced barrier precaution (EBP, use of PPE beyond anticipated blood and body fluid exposures). During a concurrent observation and interview on 4/25/2026 at 2:15 PM with Registered Nurse 5 (RN 5), RN 5 verified the signage posted outside Resident 12's room is EBP signage. During a concurrent record review and interview on 4/26/2026 2:52 PM with Infection Prevention Nurse (IPN), Infection Control Log for April 2026 were reviewed. IPN stated Resident 12 is on contact isolation for Carbapenem-resistant Enterobacterales (CRE, family of germs that is difficult-to-treat) and Vancomycin-Resistant Enterococci (VRE, a bacteria that normally live in the intestines but have developed resistance to vancomycin [a powerful antibiotic]). IPN stated the isolation signage outside Resident 12's room should be contact isolation sign and not EBP. IPN stated placing a contact isolation signage was important to alert staff and visitors to wear appropriate PPE before entering Resident 12's room. IPN stated contact isolation means to covered up, wear PPE at the doorstep, to prevent and avoid possibility of infection transmission. IPN added that not posting the correct isolation signage is a noncompliance issue and placed the residents, staff and/ or visitors at risk for spread of infection. 2. During a review of Resident 36's admission Record, the admission record indicated Resident 36 was originally admitted to the facility on [DATE], with diagnosis of respiratory failure. During a review of Resident 36's MDS, dated [DATE], the MDS indicated the resident's cognitive for daily decision making was severely impaired. The MDS indicated Resident 36 was dependent with eating oral hygiene, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a review of Resident 36's Care Plan (CP) regarding actual infection, dated 5/27/2025, revised on 2/25/2026, indicated interventions such as instruct/monitor infection control measures and contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions, hand washing before and after patient care, and PPE (gown, mask, gloves) per facility protocol. During a concurrent medication administration observation and interview on 4/27/2026 at 9:15 AM, LVN 3 walked out of Resident 36's room with PPE and walked across the hallway to return the vital signs machine. LVN 3 stated I did not change PPE because I only check Resident 36's heart rate quickly and have to take the vital signs machine out of the room before I pass medications. During an interview on 4/27/2026 at 11:58 AM with Registered Nurse 3 (RN 3), RN 3 stated Resident 36 has a contact isolation signage outside the resident's room, and that means that everyone going in should use PPE which included isolation gown, gloves and mask, and remove PPE before stepping out of the resident's room. RN 3 stated LVN 3 did not and should have removed PPE before coming out of Resident 36's room and donned a new set of PPE before entering back to Resident 36's room. RN 3 stated what LVN 3 did was an infection breach, other staff and visitors who can be in the hallway might come in contact with LVN 3 who came out from a contact isolation room with soiled PPE. RN 3 stated walking out of a contact isolation room without removing the soiled PPE is not a good practice. During a concurrent record review and interview on 4/27/2026 1:35 PM with IPN, Infection Control Log for April 2026 were reviewed. IPN stated Resident 36 is on contact isolation for CRE, methicillin-resistant staphylococcus aureus (MRSA, a bacteria that does not respond to antibiotics), and Extended-Spectrum Beta-Lactamase (ESBL, a bacteria that is difficult to treat). IPN stated the licensed nurses should doffed PPE before leaving contact isolation room, and to do hand hygiene (the act of cleaning hands) and donned PPE before going back to the same room or to another resident's room. IPN stated LVN 3 coming out of a contact isolation room with the used or soiled PPE is not a good practice. During a review of facility's P&P titled Personal Protective Equipment, dated 3/2003, the P&P indicated all attire and equipment used for the care and treatment of patients in isolation are not to be worn outside of the isolation room. During a review of facility's P&P titled Infection Control, dated 4/2022, the P&P indicated each staff member assigned in the unit is responsible for ensuring that infection prevention and control procedures are followed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews, the facility failed to maintain safe, clean, comfortable, sanitary and home-like environment for two (2) of three (3) sampled residents (Resident 21 and 30) reviewed for environment by failing to: 1.Ensure that Resident 21's gastrostomy tube (G-tube pump, an electronic, battery-powered medical device that delivers liquid nutrition, fluids, or medication at a controlled rate directly into a person's stomach through a surgically placed abdominal tube) and pole were free of dried milk residue. 2.Ensure that the power strip, with four power cords plugged in, had electrical cables that were not coiled and tangled with Resident 21's G-tube pump base. 3.Ensure Resident 30's television's (TV's) power cord was not plugged into the distant outlet of the room. These deficient practices created an unsafe and unsanitary environment for Residents 21 and 30 and had the potential to result in accidents and the spread of disease and infection.Findings: 1. During a review of Resident 21's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of chronic respiratory failure (long term condition where the lungs cannot properly exchange oxygen and carbon dioxide over time). During a review of Resident 21'S Minimum Data Set (MDS – a resident assessment tool), dated 4/22/2026 the MDS indicated the Resident 21 was assessed to have severe impairment with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. It indicated, Resident 21 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right. During a concurrent observation and interview on 4/25/2026 at 10:10 AM with Nurse Manager (NM) in Resident 21's room, NM stated Resident 21's G-tube pump and G-tube pole base were dirty and had visible dried milk drippings on them. NM also stated the power strip, with four power cords plugged in, had electrical cables that were coiled and tangled with Resident 21's G-tube pump base. 2. During a concurrent interview and record review on 4/26/2026 at 3:57 PM with Registered Nurse (RN) 2, the facility's Policy and Procedures (P&P) titled Environmental Safety, revised on 4/20/2026, were reviewed. RN 2 stated the P&P indicated the purpose of P&P was to ensure a safe physical environment for patients, staff, and visitors. RN 2 also stated the facility did not follow the P&P for environmental safety because of the tangled and coiled power cords was unsafe for the resident and is a trip or fire hazard. RN 2 also stated milk drippings and unorganized electric cords are not acceptable. During an interview on 4/7/2026 at 12:03 PM with the License Vocational Nurse (LVN) 3, LVN 3 stated no milk drippings should be on the G-tube pump and pole, for infection control and cleanliness because this could possibly harbor bacteria that can cause sickness to Resident 21. LVN 3 also stated the coiled electrical cord on Resident 21's G-tube pole was not acceptable because it can cause electrocution to residents and staff. LVN 3 also stated everything needs to be clean and organized. 3.During a review of Resident 30's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of chronic heart failure (a long-term (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition where the heart muscle is weakened or damaged and cannot pump blood efficiently, leading to reduced oxygen delivery to body). During a record review of Resident 30's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 30 was dependent with eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During an observation on 4/25/2026 at 8:30 AM, in Resident 30's room, Resident 30's head- of- bed was close to the wall and there was a space between the foot of the resident's bed and the wall across it for staff, residents or visitors to pass by/ walk through. There was a TV on top of the resident's bedside table, and it was positioned on the left side of the bed. The TV's power cord was plugged in the power outlet located on the distant side of the TV (wall across Resident 30's bed). During a concurrent observation and interview with RN 3 on 4/26/2026 at 3:45 PM, Resident 30 was observed in the room, with a TV on top of the resident's bedside table positioned on the left side of the resident's bed while the TV cord was plugged into the power outlet located on the distant side of the TV and across the resident's bed. RN 3 stated the TV's power cord was an accident or trip hazard for the staff as it is plugged onto wall across the TV and resident's bed (distant from the TV) and facility staff can tripped when walking inside the room. During an interview on 4/27/2026 with Facility's Materials Director (FMD) and Facilities (FC) Coordinator, FMD and FC both stated Resident 30's TV power cord should not be plugged on the distant side where the TV is situated. Both FMD and FC stated maintenance staff should have been informed to provide the nurses where to plug the TV's cord where it is not blocking the way inside the room or going to the resident's right side of the bed. During a review of facility's P&P titled Environment of Care Manual, dated 2/2002, the P&P indicated in order to provide a safe working environment, it is essential that all employees have access to information regarding safe use of electrical equipment.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to secure the confidential medical records for one (1) of (1) sampled residents reviewed for privacy (Residents 33) as indicated on the facility's policy and procedure (P&P) titled Resident Privacy and Confidentiality. This deficient practice had the potential to violate the resident's right to confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the resident's representative) and privacy and misuse of Resident 33's Protected Health Information (PHI, any information that relates to an individual's health status, medical history, or treatment).Findings: During a review of Resident 33's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with admitting diagnoses of acute and chronic respiratory failure with hypoxia (long term breathing problem that became suddenly worse and blood oxygen level is too low). During a review of Resident 33'S Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2026, the MDS indicated the resident was assessed to have severe impairment with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. It indicated, Resident 33 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right. During an observation on 4/25/2026 at 7:48 AM in the hallway, observed computer was left open and unattended displaying Resident 33's flow chart selection. Observed a few facility staff and three visitors passing by the hallway. During an interview on 4/26/2026 at 4:08 PM with the Registered Nurse (RN) 2, RN 2 stated, it was Respiratory Therapist (RT) who left the computer open displaying Resident 33's flow chart selection on 4/25/2026 in the hallway. RN 2 also stated the computer monitor should be turned off when the staff is stepping away from the computer to comply with HIPAA (Health Insurance Portability and Accountability Act, law that protects the privacy and security of a person's health information. Medical information should be kept private; only authorized people can see or share it. Health care workers must protect patient/ resident information). RN2 also stated this helps prevent identity theft and emphasized that privacy must be protected at all times. During a concurrent interview and record review on 4/27/2026 at 2:57 PM with the Nurse Manager (NM), the facility's P&P titled Resident Privacy and Confidentiality, revised on 5/16/2026, was reviewed. NM stated the P&P indicated that all staff using a computer must not leave the workstation or terminal unattended without first logging off or blanking the screen or using a screen saver. NM also stated the facility did not follow its P&P if when the staff left their computer screen open on 4/25/2026 in the hallway.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate assessment of the Minimum Data Set (MDS, a resident assessment tool) for one of five sampled residents (Resident 34) reviewed for unnecessary medication, to reflect the resident's diagnosis of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). This deficient practice had the potential for the facility not to develop and implement an individualized care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives, interventions and timeframes to meet a resident's medical, nursing, and mental psychosocial needs) which could negatively affect Resident 34's overall well-being.Findings: During a review of Resident 34's admission Record, the admission record indicated Resident 1 was originally admitted to the facility on [DATE], with diagnosis of respiratory failure (a condition where there is not enough oxygen in the body). During a record review of Resident 34's Minimum Data Set, dated [DATE], the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 34 was dependent (helper does all of the effort) with eating oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. Resident 34's active diagnosis did not indicate DM. The MDS indicated Resident 34 received insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injections (the act of forcing a liquid, such as medicine, into the body using a needle). During a review of Resident 34's Care Plan, dated 4/10/2026, the Care Plan indicated Resident 34 is at risk for complications from diabetes related to hypoglycemia (abnormally low blood sugar levels) and hyperglycemia (high level of sugar in the blood). The Care Plan indicated interventions included were the following:Finger stick (quick, easy test where a tiny lancet gently pricks the fingertip to get a small drop of blood for checks like blood sugar) as ordered.Monitor for signs and symptoms hypoglycemia.Implement hypoglycemia protocol as needed.Give sliding scale insulin (way to adjust insulin doses based on the resident's current blood sugar level) as ordered. During a concurrent record review and interview on 4/27/2026 at 4:07 PM with Registered Nurse 1 (RN 1), Resident 34's medical records were reviewed. RN 1 stated Resident 34 has an order of insulin for diabetes. RN 1 stated Resident 34's diagnosis of diabetes was not reflected in the resident's MDS, dated [DATE]. During an interview on 4/27/2026 at 5 PM with MDS 1 (Minimum Data Set Nurse), MDS 1 stated Resident 34's diagnosis of diabetes was not and should have been reflected in the resident's MDS, dated [DATE]. The MDS 1 stated it was important for the MDS to be accurate to ensure the development and implementation of an individualized resident care plan. During a review of the facility's Policy and Procedure (P&P) titled, MDS-Long Term Care, dated 4/2022, the P&P indicated a purpose to establish a process that will ensure all required MDS assessments will be completed in timely and accurate manner to form an individualized care plan, to address Medicare reimbursement, and to monitor the quality of care for the resident.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of quality for one (1) of one sampled resident (Resident 19) reviewed for abuse, by failing to assess and notify the physician after Resident 19 reported hitting his head on the headboard while getting repositioned up in bed (to move a Resident ensure a timely from the foot of the bed back toward the head of the bed) by Licensed Vocational Nurse 4 (LVN 4). This deficient practice has the potential to result in a lack of or delay in delivery of necessary care and services.Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE] . During a review of Resident 19's History and Physical (H&P), dated 1/19/2026, the H&P indicated Resident 19 had diagnoses that included status post cholecystectomy (previously undergone surgical removal of the bladder), recurrent aspiration pneumonia (repeated episodes of lung infection caused by the recurring inhalation of foreign materials into the airways and lungs), and coronary artery disease status post bypass (previous surgical treatment to bypass blocked arteries in the heart using a vessel taken from another part of the body). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 19 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with eating, toileting hygiene, upper/lower body dressing, personal hygiene, and rolling left and right. During a concurrent observation and interview, on 4/25/2026, at 10:20 AM in Resident 19's room, Resident 19 was observed awake in bed, wearing a Passy Muir Valve (PMV- a one-way speaking valve placed on a tracheostomy tube to allow patients to speak, swallow, and breathe more naturally), and accompanied by his Responsible Party (RP 1). Resident 19 stated LVN 4 hit him on the head sometime in 11/2025. Resident 19 stated he informed the Nurse Manager (NM) about the incident but could not remember the date he informed NM. During an interview on 4/26/2026, at 2:50 PM, with NM, NM stated sometime in 11/2025, Resident 19 and RP 1 informed her that Resident 19 hit his head while getting pulled up on the bed by LVN 4. NM stated she did not assess or notify the physician after Resident 19 informed her he hit his head on the headboard. During a concurrent interview and record review of Resident 19's medical records on 4/27/2026, at 8:58 AM with the MDS Nurse (MDS 1), MDS 1 stated there was no documentation in Resident 19's medical record indicating that staff assessed the Resident 19 or notified his physician after he reported hitting his head while being pulled up in bed by LVN 4 in 11/2025. During an interview on 4/27/2026, at 10:44 AM, with LVN 2, LVN 2 stated licensed nurses should assess the resident and notify the physician if the resident reports hitting his head while receiving care from staff. LVN 2 stated it was important to notify the physician what the resident reported so proper tests and assessments are ordered. LVN 2 stated it was important that assessments and tests are done after a resident report being hurt to ensure their safety in the facility. During an interview, on 4/27/2026, at 11:30 AM, with Registered Nurse (1) RN 1, RN 1 stated it was standard practice for facility staff to perform a head to toe assessment (a systemic physical examination used by nurses to evaluate a resident's overall health status) after receiving a report that a resident hit his head while receiving care. RN 1 stated facility staff should also interview the resident and check for injuries. RN 1 stated it was important to notify the physician about the incident so diagnostic tests and specific assessments can be ordered. RN 1 stated it was standard practice to perform a neuro check (neurological check- a quick test to evaluate head injuries) for 72 hours after hitting his head. RN 1 stated if a resident reported hitting his head while getting pulled on the bed then it was considered a change in the resident's condition. During a review of the facility's policy and procedure (P&P), titled, Change in Resident Condition, dated 4/2022, the P&P indicated the following:It is the policy of this facility that all changes of conditions will be communicated to the physician and family or legal representative.All symptoms and unusual signs will (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be communicated to the physician promptly.The nurse in charge is responsible for notification of physician and family or legal representatives prior to the end of assigned shift when a change in resident's condition is noted.Document resident change in condition and response in Nursing Progress Notes, on 24-Hour Report and update resident care plan as indicated. During a review of the facility's P&P, titled, Charting, Guidelines, dated 4/2022, the P&P indicated the following:Charting should include all assessments of resident condition, all interventions taken to resolve a problem and the progress/lack of progress with the written care plan.Document normal findings as well as abnormal findings as this shows the resident was being assessed.All residents are assessed every shift and a nurse's note is written documenting any change in condition and the care given and at least once daily a nurse note is written.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the activity of resident's preference for one of two sampled residents (Resident 19) reviewed for activities in accordance with Resident 19's Activity Assessment. Resident 19 was not able to watch television for more than a year. This deficient practice resulted in Resident 19 not being able to watch television, which had the potential to affect Resident 19's quality of life, sense of self-worth, and psychosocial (how a person's mental/emotional state interacts with their social environment, relationships, and surroundings) well-being and meaningfulness.Findings:During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE]. During a review of Resident 19's History and Physical (H&P), dated 1/19/2026, the H&P indicated Resident 19 had diagnoses that included status post cholecystectomy (previously undergone surgical removal of the bladder), recurrent aspiration pneumonia (repeated episodes of lung infection caused by the recurring inhalation of foreign materials into the airways and lungs), and coronary artery disease status post bypass (previous surgical treatment to bypass blocked arteries in the heart using a vessel taken from another part of the body). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 19 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with eating, toileting hygiene, upper/lower body dressing, personal hygiene, and rolling left and right. During a review of Resident 19's Activity Assessment, dated 6/3/2024, the Activity Assessment indicated Resident 19 currently preferred to watch television/movies and news/basketball games for leisure and recreation. During a review of Resident 19's Care Plan, dated 2/13/2026, the Care Plan indicated Resident 19 had an actual activity participation deficit related to bedfast/bedrest. The Care Plan interventions indicated to turn on television to provide stimulation. During a concurrent observation and interview, on 4/25/2026, at 10:30 AM in Resident 19's room, Resident 19 was observed awake in bed, wearing a Brand 1 Valve (PMV- a one-way speaking valve placed on a tracheostomy tube to allow patients to speak, swallow, and breathe more naturally). Resident 19 was accompanied by his Responsible Party (RP 1). RP 1 stated Resident 19 liked watching the news and sports. Resident 19 pointed at the television and stated his television has not worked for almost two years. RP 1 stated they (RO 1 and Resident 19) informed facility staff numerous times in the past two years that Resident 19's television did not show any channels, and the television was never fixed. Resident 19 stated he was bored and felt like the facility did not care because his television had not worked for a long time. During an interview, on 4/26/2026, at 1:53 PM, with Activities Assistant 1 (AA 1), AA 1 stated Resident 19 was alert, and his (Resident 19) preferred activity was watching sports on television. AA 1 stated Resident 19's television signal was weak which caused the channels to go on and off. AA 1 stated the Engineering Department (department responsible for maintaining equipment, infrastructure, and utilities to ensure resident safety and operations) was informed over a year ago that Resident 19's television was not working. AA 1 stated the facility was Resident 19's home and it was important to keep Resident 19 engaged and stimulated with activities that the resident prefers. AA 1 stated Resident 19 would feel frustrated because his television was not being repaired and is not working. During an interview, on 4/26/2026, at 2:19 PM, with the Nurse Manager (NM), NM stated she was aware (unable to recall since when) that Resident 19's television was not working. NM stated she sent numerous requests to engineering department to have Resident 19's television repaired but the television continued to not get fixed. NM stated it was important for Resident 19 to have a working television in the resident's room because the facility was the resident's home. NM stated the facility was responsible for providing Resident 19 with a homelike environment where the resident can have his preferred activities in his room. NM stated not fixing (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 19's television after making numerous requests would make Resident 19 feel bored, mad, and ignored. During a record review of the facility's policy and procedure (P&P), titled, Activities Program Requirements, revised 5/2011, the P&P indicated, Activities shall be available on a daily basis.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a bladder training program (use of a timed schedule for bladder based on the resident's identified need and routine to maximize control of the resident's bladder function as much as possible) was implemented for one (1) of 1 sampled resident (Resident 34) reviewed for bowel and bladder care as indicated on the facility's policy and procedure (P&P) and physician's order.This deficient practice had the potential to prevent the restoration of the resident's bowel and bladder function and contribute to the development of a urinary tract infection (UTI-an infection in any part of the urinary system, including the kidneys, bladder, or urethra). Findings:During a review of Resident 34's admission Record, the admission record indicated Resident 34 was originally admitted to the facility on [DATE], with diagnosis of respiratory failure (a condition where there's not enough oxygen in your body). During a record review of Resident 34's Minimum Data Set, dated [DATE], the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 34 was dependent (helper does all of the effort) with eating oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 34 has indwelling catheter (Foley catheter [brand name] a flexible tube (a catheter) inserted into the bladder that remains (dwells) there to provide continuous urinary drainage). During a review of Resident 34's Nursing Order, dated 4/24/2026, timed 1:45 PM, the Nursing Order indicated an order on 4/22/2026, to start bladder training on 4/23/2026 for three (3) days then discontinue foley. It also indicated to do bladder scan every shift for three days and if bladder scan (test that uses a handheld ultrasound device placed on the lower belly which measures how much urine is in the bladder without needing to insert a catheter) is more than 300 milliliters (ml, unit of measurement), do in and out catheter (also known as an intermittent catheter which is a thin, flexible tube that is briefly inserted through the urethra into the bladder to drain urine and then immediately removed). The order further indicated that if second bladder scan is more than 300 ml, insert back Foley catheter. During a review of Resident 34's Bladder Training record, the record indicated that on 4/23/2026 at 12 midnight, the Foley was clamped and released at 2 AM. The record indicated a last documentation on 4/24/2026 that Resident's 34 Foley was clamped at 9:30 PM and released at 11:30 PM. During a review of Resident 34's Patient Care Flowchart, dated 4/25/2026 at 12:39 AM, the Patient Care Flowchart indicated Resident 34's Foley catheter was discontinued after bladder training protocol. It further indicated that Resident 34 tolerated well, no bleeding noted and will be monitored for voiding. During an interview on 4/26/2025 at 5:13 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that Resident 34's bladder training order was not followed because Registered Nurse 4 (RN 4) discontinued the Foley catheter early. LVN 1 stated that Resident 34's Foley catheter was removed after only two (2) days, and the 3ˆday bladder training order was not completed. LVN 1 stated that the Foley catheter should have been removed after 3 full days of bladder training. During a concurrent record review and interview on 4/27/2026 at 2:43 PM with RN 3, Resident 34's bladder training record, dated 4/23/2026, was reviewed. RN 3 stated that the bladder training order was not followed because RN 4 removed the Foley catheter on the second day of training. RN 3 stated that not completing the 3ˆday bladder training did not allow enough time for Resident 34's bladder to return to normal function. RN 3 further stated as a result, six (6) hours after the Foley catheter was removed, Resident 34 retained 400 ml of urine, and an inˆandˆout catheterization was performed on 4/25/2026 at 6:16 AM to drain the urine. RN 3 stated not following the physician's order was not the facility's practice. RN 3 added that bladder training was important because it helps staff to be aware and understand the residents' voiding patterns and timing. During a concurrent record review and interview with RN 1 on 4/27/2026 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:38 PM, Resident 34's medical records were reviewed. RN 1 stated that Resident 34 was admitted on [DATE] with a Foley catheter for wound management. RN 1 stated that on 4/22/2026, bladder training was ordered to start on 4/23/2026. RN 1 stated that bladder training began on 4/23/2026 at 12 AM and should have ended on 4/25/2026 at 11:59 PM. RN 1 stated that bladder training was included in Resident 34's care plan, but it was not implemented. RN 1 stated that Resident 34's bladder training order and care plan were not implemented accordingly. During a review of facility's P&P titled, Bowel and Bladder Management, dated 3/2024, the P&P indicated the following purpose:To enable the resident to regain bowel and/or bladder controlTo restore the resident to the highest level of independence possibleTo improve/restore the resident's dignity, self-image and morale.To avoid the possibility of urinary tract infections from the use of indwelling catheter.To avoid the possibility of skin breakdown due to incontinence.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for two (2) of five (5) sampled residents (Resident 19 and Resident 36) reviewed and observed for medication administration, in accordance with the physician's order and facility's Policy and Procedure (P&P) by failing to ensure: Licensed Vocational Nurse 2 (LVN 2) administered Resident 19's ferrous sulfate (a supplement used to increase iron levels to support red blood cell production) not exceeding 2 hours of the scheduled dosing time of 8 AM on 4/27/2026.LVN 3 administered Resident 36's order for doxazosin (Cardura, medication used to treat high blood pressure and symptoms of an enlarged prostate [a small, walnut-sized gland in males that sits just below the bladder and surrounds the urethra, which produces fluid that helps make semen, which carries sperm]). This deficient practice had the potential for Resident 19 to experience fatigue, shortness of breath or dizziness and for Resident 36 to experience high blood pressure which could result in harm and hospitalization to both residents. Findings: 1.During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE]. During a review of Resident 19's History and Physical (H&P), dated 1/19/2026, the H&P indicated Resident 19 had diagnoses that included status post cholecystectomy (previously undergone surgical removal of the bladder), recurrent aspiration pneumonia (repeated episodes of lung infection caused by the recurring inhalation of foreign materials into the airways and lungs), and coronary artery disease status post bypass (previous surgical treatment to bypass blocked arteries in the heart using a vessel taken from another part of the body). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 19 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with eating, toileting hygiene, upper/lower body dressing, personal hygiene, and rolling left and right. During a review of Resident 19's Physician's Medications Report, dated 4/27/2026, the Physician's Medications Report indicated a physician's order for ferrous sulfate 300 milligrams (mg- unit of measurement for weight) / (per) milliliters (ml- unit of measurement for volume), give 300 mg via gastric tube (G-tube- a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration) twice daily with meals. During a review of Resident 19's Medication Administration Record (MAR), from 4/27/2026 to 4/30/2026, the MAR indicated Resident 19 was scheduled to receive ferrous sulfate 300mg/5ml solution at 8 AM. During an observation of the medication pass, on 4/27/2026, at 10:24 AM, LVN 2 administered ferrous sulfate 300mg/5ml solution via G-tube to Resident 19. During an interview, on 4/27/2026, at 10:39 AM, with LVN 2, LVN 2 stated Resident 19's ferrous sulfate was scheduled for 8 AM and 6 PM. LVN 2 stated ferrous sulfate was administered late. LVN 2 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 19's ferrous sulfate should have been administered no later than 9 AM. During an interview on 4/27/2026, at 12:42 PM, with MDS Nurse (MDS 1), MDS 1 stated Resident 19's ferrous sulfate was administered late. MDS 1 stated not giving Resident 19's ferrous sulfate as ordered can affect the therapeutic levels of medication and his treatment. MDS 1 stated it was important to give the residents' medications as scheduled and ordered by the physician and to follow the facility's P&P for medication administration. During a review of the facility's P&P titled, Medication Management: General, revised 11/2017, the P&P indicated, Medications prescribed more frequently than daily, but no more frequently than every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window that does not exceed 2 hours. 2. During a review of Resident 36's admission Record, the admission record indicated Resident 36 was originally admitted to the facility on [DATE], with diagnosis of respiratory failure (a condition where there's not enough oxygen in your body). During a review of Resident 36's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2026, the MDS indicated the resident's cognitive for daily decision making was severely impaired. The MDS indicated Resident 36 was dependent with eating oral hygiene, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a review of Resident 36's Medication Reconciliation Report, dated 3/25/2026, Medication Reconciliation Report indicated the following orders: Doxazosin one (1) mg tablet, give 2 mg daily via percutaneous endoscopic gastrostomy (PEG tube, a soft feeding tube placed through the skin directly into the stomach to deliver nutrition, fluids, and medications), hold if systolic (the top number in a blood pressure reading) blood pressure is less than 95. For diagnosis of urinary retention, start date of 12/25/2025. Sodium chloride (a compressed salt pill) tablet 1 gram (unit of measurement), three (3) times a day via gastric tube. For hyponatremia (a condition where the sodium [salt] level in your blood is abnormally low), with start date of 3/18/2026. Polyethylene glycol (MiraLAX, laxative used to treat constipation), 17 grams packet, 1 each, 2 times a day via gastric tube, mix with four (4) to eight (8) ounces (unit of measurement) of water. For constipation, with start date of 10/20/2025. During a concurrent medication administration observation in Resident 36's room and interview on 4/27/2026 at 9:28 AM with LVN 3, LVN 3 stated she was not administering Resident 36's doxazosin order because the resident's heart rate was 72. During a concurrent record review and interview on 4/27/2026 at 11:35 AM with Registered Nurse 3 (RN 3), Resident 36's medication administration record (MAR) was reviewed. RN 3 verified Resident 36's doxazosin was documented not given on 4/27/2026 at 9:19, LVN 3's documentation indicated hold order for heart rate of 72. During an interview on 4/27/2026 at 4:26 PM with RN 1, RN 1 stated the doxazosin order for Resident 36 was important and was ordered to be administered once a day. RN 1 stated that if Resident 36 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missed the medication, the resident might not be able to urinate and could lead to high blood pressure. RN 1 stated it was important to read medication orders properly and completely to ensure medication was administered to residents as indicated. During a review of facility's P&P titled, Medication Management: Administration of Medication by Nursing, dated 10/2003, the P&P indicated to use the MAR when administering medications. Do not give from memory. Verify medication label with MAR. The P&P indicated if vital signs are required for the administration of the medication, they must be taken within one hour by nursing personnel prior to pouring the medication. Record the reading and administer the medication and chart that it was given. The P&P also indicated special considerations for Antihypertensives medications: 1. Check the MAR, medication label or physician's order to determine blood pressure rates that the physician requests to be notified for and/or for which to hold the medication. 2. Take blood pressure before administering. Hold the medication if the blood pressure under prescribed parameters and notify the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Valley Medical Ctr D/P Snf	438 W. Las Tunas Drive San Gabriel, CA 91776

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Two (2) medication errors (the observed or identified preparation of administration of medication or biologicals which is not in accordance with the prescriber's order/manufacturer's specifications/accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error which yielded a facility medication error rate of 8% for 2 of 5 sampled residents (Resident 19 and Resident 36) observed for medication administration. Licensed Vocational Nurse 2 (LVN 2) administered Resident 19's ferrous sulfate (a supplement used to increase iron levels to support red blood cell production) more than 2 hours of the scheduled dosing time of 8 AM as indicated on the physician's order and facility's policy. LVN 3 omitted (left out) Resident 36's order for doxazosin (Cardura, medication used to treat high blood pressure and symptoms of an enlarged prostate [a small, walnut-sized gland in males that sits just below the bladder and surrounds the urethra, which produces fluid that helps make semen, which carries sperm]). These deficient practices have the potential to result in harm to Resident 19 and Resident 36 by not administering medications as prescribed by the physician in order to meet their individual medication needs.Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE]. During a review of Resident 19's History and Physical (H&P), dated 1/19/2026, the H&P indicated Resident 19 had diagnoses that included status post cholecystectomy (previously undergone surgical removal of the bladder), recurrent aspiration pneumonia (repeated episodes of lung infection caused by the recurring inhalation of foreign materials into the airways and lungs), and coronary artery disease status post bypass (previous surgical treatment to bypass blocked arteries in the heart using a vessel taken from another part of the body). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 19 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with eating, toileting hygiene, upper/lower body dressing, personal hygiene, and rolling left and right. During a review of Resident 19's Physician's Medications Report, dated 4/27/2026, the Physician's Medications Report indicated a physician's order for ferrous sulfate 300 milligrams (mg- unit of measurement for weight) / (per) 5 milliliters (ml- unit of measurement for volume), give 300 mg via gastric tube (G-tube- a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration) twice daily with meals. During a review of Resident 19's Medication Administration Record (MAR), from 4/27/2026 to 4/30/2026, the MAR indicated Resident 19 was scheduled to receive ferrous sulfate 300mg/5ml solution at 8 AM. During an observation of the medication pass, on 4/27/2026, at 10:24 AM, LVN 2 administered ferrous sulfate 300mg/5ml solution via G-tube to Resident 19. During an interview, on 4/27/2026, at 10:39 AM, with LVN 2, LVN 2 stated Resident 19's ferrous (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sulfate was scheduled for 8 AM and 6 PM. LVN 2 stated ferrous sulfate was administered late. LVN 2 stated Resident 19's ferrous sulfate should have been administered no later than 9 AM. During an interview on 4/27/2026, at 12:42 PM, with MDS Nurse (MDS 1), MDS 1 stated Resident 19's ferrous sulfate was administered late. MDS 1 stated not giving Resident 19's ferrous sulfate as ordered can affect the therapeutic levels (the specific concentration of a medication in the bloodstream that is high enough to treat a condition effectively but low enough to avoid causing harmful side effects) of medication and his treatment. MDS 1 stated it was important to give the residents' medications as scheduled and ordered by the physician and to follow the facility's P&P for medication administration. During a review of the facility's Policy and Procedure (P&P) titled, Medication Management: General, revised 11/2017, the P&P indicated, Medications prescribed more frequently than daily, but no more frequently than every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window that does not exceed 2 hours. 2. During a review of Resident 36's admission Record, the admission record indicated Resident 36 was originally admitted to the facility on [DATE], with diagnosis of respiratory failure (a condition where there's not enough oxygen in your body). During a review of Resident 36's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2026, the MDS indicated the resident's cognitive for daily decision making was severely impaired. The MDS indicated Resident 36 was dependent with eating oral hygiene, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a review of Resident 36's Medication Reconciliation Report, dated 3/25/2026, Medication Reconciliation Report indicated the following orders: Doxazosin one (1) mg tablet, give 2 mg daily via percutaneous endoscopic gastrostomy (PEG tube, a soft feeding tube placed through the skin directly into the stomach to deliver nutrition, fluids, and medications), hold if systolic (the top number in a blood pressure reading) blood pressure is less than 95. For diagnosis of urinary retention, start date of 12/25/2025. Sodium chloride (a compressed salt pill) tablet 1 gram (unit of measurement), three (3) times a day via gastric tube. For hyponatremia (a condition where the sodium [salt] level in your blood is abnormally low), with start date of 3/18/2026. Polyethylene glycol (MiraLAX, laxative used to treat constipation), 17 grams packet, 1 each, 2 times a day via gastric tube, mix with four (4) to eight (8) ounces (unit of measurement) of water. For constipation, with start date of 10/20/2025. During a concurrent medication administration observation in Resident 36's room and interview on 4/27/2026 at 9:28 AM with LVN 3, LVN 3 stated she was not administering Resident 36's doxazosin order because the resident's heart rate was 72. During a concurrent record review and interview on 4/27/2026 at 11:35 AM with Registered Nurse 3 (RN 3), Resident 36's medication administration record (MAR) was reviewed. RN 3 verified Resident 36's doxazosin was documented not given on 4/27/2026 at 9:19, LVN 3's documentation indicated hold order for heart rate of 72. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/27/2026 at 4:26 PM with RN 1, RN 1 stated the doxazosin order for Resident 36 was important and was ordered to be administered once a day. RN 1 stated that if Resident 36 missed the medication, the resident might not be able to urinate and could lead to high blood pressure. RN 1 stated it was important to read medication orders properly and completely to ensure medication was administered to residents as indicated. During a review of facility's P&P titled, Medication Management: Administration of Medication by Nursing, dated 10/2003, the P&P indicated to use the MAR when administering medications. Do not give from memory. Verify medication label with MAR. The P&P indicated if vital signs are required for the administration of the medication, they must be taken within one hour by nursing personnel prior to pouring the medication. Record the reading and administer the medication and chart that it was given. The P&P also indicated special considerations for Antihypertensives medications: 1. Check the MAR, medication label or physician's order to determine blood pressure rates that the physician requests to be notified for and/or for which to hold the medication. 2. Take blood pressure before administering. Hold the medication if the blood pressure under prescribed parameters and notify the physician.

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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 and record review, the facility failed to ensure the medical records were complete and accurately documented for one (1) of 1 sampled resident (Resident 19) reviewed for abuse, (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) by failing to document Resident 19's report of hitting his head on the headboard while getting repositioned up in bed (to move a resident from the foot of the bed back toward the head of the bed) by Licensed Vocational Nurse 4 (LVN 4). This deficient practice had the potential to result in incomplete assessment of Resident 19's needs and could lead to a lack of or delay in delivery of necessary care and services.Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE]. During a review of Resident 19's History and Physical (H&P), dated 1/19/2026, the H&P indicated Resident 19 had diagnoses that included status post cholecystectomy (previously undergone surgical removal of the bladder), recurrent aspiration pneumonia (repeated episodes of lung infection caused by the recurring inhalation of foreign materials into the airways and lungs), and coronary artery disease status post bypass (previous surgical treatment to bypass blocked arteries in the heart using a vessel taken from another part of the body). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 19 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with eating, toileting hygiene, upper/lower body dressing, personal hygiene, and rolling left and right. During a concurrent observation and interview, on 4/25/2026, at 10:20 AM in Resident 19's room, Resident 19 was observed awake in bed, wearing a Passy Muir Valve (PMV- a one-way speaking valve placed on a tracheostomy tube to allow patients to speak, swallow, and breathe more naturally), and accompanied by his Responsible Party (RP 1). Resident 19 stated LVN 4 hit him on the head sometime in 11/2025. Resident 19 stated he informed the Nurse Manager (NM) about the incident but could not remember when he informed NM. During an interview on 4/26/2026, at 2:50 PM, with NM, NM stated sometime in 11/2025, Resident 19 and RP 1 informed her that Resident 19 hit his head while getting pulled up on the bed by LVN 4. NM stated she spoke to LVN 4 about the incident and LVN 4 confirmed Resident 19 head hit his head while LVN 4 provided care and pulled Resident 19 up on the bed. NM stated she did not document the incident between Resident 19 and LVN 4 in Resident 19's medical record. During a concurrent interview and record review of Resident 19's medical records on 4/27/2026, at 8:58 AM with the Minimum Data Set Nurse (MDS 1), MDS 1 stated there was no documentation in Resident 19's medical record by LVN 4 or any licensed nurse that Resident 19 hit his head while pulling him up on the bed. During an interview on 4/27/2026, at 10:44 AM, with LVN 2, LVN 2 stated if a resident reported getting hurt while receiving care, the report should be documented in the residents' medical record. LVN 2 stated the facility staff who was involved in the residents' care and who received the report were responsible for documenting the incident in the residents' medical record. During an interview, on 4/27/2026, at 11:30 AM, with Registered Nurse (1) RN 1, RN 1 stated it was standard practice for facility staff to document incidents that involved residents' care in the medical record. RN 1 stated the documentation should include a description of the incident, head to toe assessment (a systemic physical examination used by nurses to evaluate a resident's overall health status), interventions performed, injuries, and if the physician was notified. RN 1 stated the facility's policy for documentation was not followed. During a review of the facility's policy and procedure (P&P), titled, Charting, Guidelines, dated 4/2022, the P&P indicated the following:All charting should be done as soon as possible after a given event.Keep entries factual and specific. They must be accurate and informative. Document any changes in (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident condition as well as steps taken in response to the change. Continue to chart on a resident as often as condition warrants until the condition is resolved. During a review of the facility's P&P, titled, Documentation in the Medical Record, Legal, dated 4/2022, the P&P indicated the following:A clear, concise, accurate, legible, and chronological written history of the Resident's stay will be documented, in accordance with state and federal guidelines, and The Joint Commission (JCAHO- an accreditation organization for hospitals, clinics and nursing homes) standards.Entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the residents' continuing care.