STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555257	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Terrace Healthcare & Rehabilitation Center	24962 Calle Aragon Laguna Hills, CA 92637

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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 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 plan of care was revised to reflect the resident's current care needs and interventions for three of 22 final sampled residents (Residents 4, 19 and 27). * The facility failed to ensure the care plan for pain and use of pain medication was revised to address the use of non-pharmacological interventions prior to the administration of pain medications for Residents 4, 19, and 27. This failure posed the risk of not providing the residents with individualized and person-centered care.Findings: Review of the facility's P&P titled Pain Recognition and Management revised 4/2025 showed the facility must ensure the pain management is provided to the residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the resident's goals and preferences. The care plan will include preventative or care interventions (pharmacological and non-pharmacological) to manage and/or prevent pain and consider the resident's needs, preferences, and goals. The interdisciplinary care plan will reflect the location and type of pain, pharmacological, and non-pharmacological interventions, with evaluation and revision as indicated. Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 4/2025 under the Procedure section, showed the resident's comprehensive care plan will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. 1. Medical record review for Resident 4 was initiated on 1/29/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Order Summary Report showed a physician's order dated 11/26/25, for non-pharmacological interventions for pain: 1=repositioning, 2=dim light/quiet environment, 3=relaxation, 4=distraction, 5=music, 6=massage as needed. Review of Resident 4's care plan for pain medication therapy related to the resident's left femoral fracture initiated on 11/28/25, showed interventions including administering of medication as ordered. However, the non-pharmacological interventions for pain as ordered by the physician was not included in the interventions. On 2/6/26 at 0957 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 7. LVN 7 stated Resident 4's current plan of care for pain should reflect the non-pharmacological interventions were included as one of the interventions. On 2/9/26 at 1139 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON was informed and verified the above findings. 2. Closed medical record review for Resident 19 was initiated on 2/6/26. Resident 19 was readmitted to the facility on [DATE] and discharged on 2/4/26. Review of Resident 19's Order Summary Report showed a physician's order dated 1/21/26, for non-pharmacological interventions for pain: 1=repositioning, 2=dim light/quiet environment, 3=relaxation, 4=distraction, 5=music, 6=massage as needed. Review of Resident 19's care plan for acute/chronic pain related to UTI, stroke, and seizures initiated on 1/21/26, showed interventions including administering of medication as ordered. However, the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-pharmacological interventions for pain as ordered by the physician were not included in the interventions. On 2/9/26 at 1515 hours, an interview and concurrent medical record review for Resident 19 was conducted with the DON. The DON was informed and verified the above findings. 3. On 1/29/26 at 1000 hours, during the initial tour of the facility, Resident 27 was observed awake and sitting in the wheelchair inside the resident's room. Resident 27 stated she had on and off pain in her abdomen and lower back. Resident 27 further stated she received pain medications whenever she had pain. Medical record review for Resident 27 was initiated on 1/29/26. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's Order Summary Report showed a physician's order dated 12/17/25, for non-pharmacological interventions for pain: 1=repositioning, 2=dim light/quiet environment, 3=relaxation, 4=distraction, 5=music, 6=massage as needed. Review of Resident 27's care plan for acute pain related to recent surgery, pressure injuries, medical condition, and impaired mobility initiated on 12/18/25, showed interventions including administering of medication as ordered. However, the non-pharmacological interventions for pain as ordered by the physician were not included in the interventions. On 2/6/26 at 0957 hours, an interview and concurrent medical record review for Resident 27 was conducted with LVN 7. LVN 7 stated Resident 27's current plan of care for pain should reflect the non-pharmacological interventions were included as one of the interventions. On 2/9/26 at 1139 hours, an interview and concurrent medical record review for Resident 27 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F697.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the necessary pain management care and services for three of final sampled residents (Residents 4, 19, and 27) reviewed for pain management. * The facility failed to ensure the non-pharmacological interventions were provided to Residents 4, 19, and 27 prior to administering the pain medications. These failures posed the risk for the residents to not receive the appropriate and necessary interventions to manage the residents' pain.Findings: Review of the facility's P&P titled Pain Recognition and Management revised 4/2025 showed to the extent possible, the staff will manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. The care plan will include preventative or care interventions (pharmacological and non-pharmacological) to manage and/or prevent pain and consider the resident's needs, preferences, and goals. 1. Medical record review for Resident 4 was initiated on 1/29/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 had moderate cognitive impairment. Review of Resident 4's Order Summary Report showed the following physician's orders dated 11/26/25:- to give tramadol (pain medication) 50 mg one tablet by mouth every eight hours as needed for severe pain (7-10) (a pain scale of 0-10, 0 for no pain and 10 for severe pain);- to give tramadol 50 mg one tablet by mouth two times a day for pain management, and hold if sedated;- to give Tylenol (pain medication) 500 mg one tablet by mouth every four hours as needed for mild pain (1-3), not to exceed three grams per day of acetaminophen from all oral sources;- to give Tylenol 325 mg two tablets by mouth every four hours as needed for moderate pain (4-6), not to exceed three grams per day of acetaminophen from all oral sources; and- non-pharmacological interventions for pain: 1=repositioning, 2=dim light/quiet environment, 3=relaxation, 4=distraction, 5=music, 6=massage as needed. Review of Resident 4's MAR for November 2025 showed Resident 4 received the following:- tramadol 50 mg from 11/27 to 11/30/25 at 0900 hours and 1700 hours. Review of Resident 4's MAR for December 2025 showed Resident 4 received the following:- tramadol 50 mg from 12/1 to 12/20/25 at 0900 hours and 1700 hours; and- Tylenol 325 mg 2 tablets on 12/11/26 at 0743 hours. Review of Resident 4's MAR for January 2026 showed Resident 4 received the tramadol 50 mg on the following dates and times: - dated 1/15/26 at 2038 hours and - dated 1/18/26 at 0840 hours. Further review of Resident 4's medical record failed to show any documented evidence of the non-pharmacological interventions provided to Resident 4 prior to the administration of the pain medications. 2. On 1/29/26 at 1000 hours, during the initial tour of the facility, Resident 27 was observed awake and sitting in the wheelchair inside the resident's room. Resident 27 stated she had an on and off pain in her abdomen and lower back. Resident 27 further stated she received the pain medications whenever she had pain. Medical record review for Resident 27 was initiated on 1/29/26. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 12/17/25, showed Resident 27 could make her own medical needs known. Review of Resident 27's Order Summary Report showed the following physician's orders:- dated 12/17/25, to give acetaminophen 500 mg one tablet by mouth every four hours as needed for mild pain (1-3), not to exceed 3,000 mg of acetaminophen within 24 hours from all sources;- dated 12/17/25, to give acetaminophen 650 mg one tablet by mouth every four hours as needed for moderate pain (4-6), not to exceed 3,000 mg of acetaminophen within 24 hours from all sources;- dated 12/17/25, non-pharmacological interventions for pain: 1=repositioning, 2=dim light/quiet environment, 3=relaxation, 4=distraction, 5=music, 6=massage as needed, and- dated 12/26/25, to give hydrocodone-acetaminophen (pain medication) 5-325 mg one tablet by mouth every six hours as needed for (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severe pain (7-10), not to exceed 3,000 mg of acetaminophen within 24 hours from all sources; Review of Resident 27's MAR for December 2025 showed Resident 27 received the following pain medications:* acetaminophen 500 mg on: - 12/21/25 at 0032 hours, - 12/22/25 at 1122 hours, and - 12/27/25 at 0210 hours;* acetaminophen 650 mg on:- 12/28/25 at 1847 hours; and* hydrocodone-acetaminophen 5-325 mg on:- 12/26/25 at 2207 hours, - 12/27/25 at 1525 hours, - 12/28/25 at 0550 hours, - 12/29/25 at 1500 hours, - 12/30/25 at 1455 hours, - 12/31/25 at 1532 hours. Review of Resident 27's MAR for January 2026, showed Resident 27 received the following medications:* acetaminophen 650 mg on: - 1/3/26 at 1041 hours and - 1/9/26 at 2300 hours.* hydrocodone-acetaminophen 5-325 mg on: - 1/2/26 at 1304 hours, - 1/3/26 at 0736 hours, - 1/5/26 at 2000 hours, - 1/6/26 at 1531 hours, - 1/7/26 at 1501 hours, - 1/9/26 at 1850 hours, - 1/10/26 at 0050 hours, - 1/14/26 at 1615 hours, - 1/15/26 at 2001 hours, - 1/16/26 at 1538 hours, - 1/20/26 at 2307 hours, - 1/26/26 at 0548 hours, and - 1/28/26 at 1559 hours. Review of Resident 27's MAR for February 2026, showed Resident 27 received the following medications:- acetaminophen 500 mg on 2/5/26 at 0500 hours;- acetaminophen 650 mg on 2/3/26 at 0033 hours; and- hydrocodone-acetaminophen 5-325 mg on 2/4/26 at 2108 hours. Further review of Resident 27's medical record failed to show any documented evidence of the non-pharmacological interventions provided to Resident 27 prior to the administration of the pain medications. On 2/6/26 at 0957 hours, an interview and concurrent medical record review for Residents 4 and 27 was conducted with LVN 7. LVN 7 stated the non-pharmacological interventions such as massage, providing quiet and calm environment, music, distraction or relaxation techniques should be used when the resident was experiencing pain. LVN 7 stated the non-pharmacological interventions should be provided prior to the administration of pain medications because this could minimize the use of medications and prevent any episodes of over sedation due to the use of the medications. LVN 7 stated if the non-pharmacological interventions showed effectiveness to relieve the pain symptoms, this could assist the physician in evaluating whether to continue, discontinue or adjust the dosage and frequency of the medication. LVN 7 verified Residents 4 and 27 received the pain medications on the days listed above and were not provided with any non-pharmacological interventions prior to the administration of the pain medications. On 2/9/26 at 1139 hours, an interview and concurrent medical record review for Resident 4 and 27 was conducted with the DON. The DON verified and acknowledged the above findings. 3. Closed medical record review for Resident 19 was initiated on 2/6/26. Resident 19 was readmitted to the facility on [DATE] and discharged on 2/4/26. Review of Resident 19's H&P examination dated 1/5/26, showed Resident 19 had fluctuating capacity but could make her needs known. Review of Resident 19's Order Summary Report showed the following physician's orders:- dated 1/2/26, to give Percocet (pan medication) 10-325 mg one tablet by mouth every four hours as needed for severe pain (7-10) for 14 days, not to exceed three grams per day of acetaminophen from all oral sources;- dated 1/2/26, for non-pharmacological interventions for pain: 1=repositioning, 2=dim light/quiet environment, 3=relaxation, 4=distraction, 5=music, 6=massage as needed;- dated 1/17/26, to give Percocet 10-325 mg one tablet by mouth every four hours as needed for severe pain (7-10) for 14 days, not to exceed three grams per day of acetaminophen from all oral sources and hold if RR is less than 12; and- dated 1/21/26, to give Percocet 10-325 mg one tablet by mouth every four hours as needed for severe pain (7-10) for 14 days, not to exceed three grams per day of acetaminophen from all oral sources. Review of Resident 19's MAR for January 2026, showed Resident 19 received Percocet 10-325 mg on the following dates and times: - dated 1/2/26 at 2154 hours, - dated 1/3/26 at 0320 hours, - dated 1/4/26 at 0844 hours, - dated 1/5/26 at 1451 hours, - dated 1/6/26 at 1554 hours, - dated 1/8/26 at 0214 hours, - dated 1/9/26 at 0839 hours, - dated 1/10/26 at 1030 hours, - dated 1/11/26 at 0000 hours, - dated 1/12/26 at 0753hours, - dated (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/13/26 at 1040 hours, - dated 1/14/26 at 0815 hours, - dated 1/15/26 at 0230 hours, - dated 1/16/26 at 0030 hours, - dated 1/22/26 at 0347 hours, - dated 1/23/26 at 1557 hours, - dated 1/24/26 at 1728 hours, - dated 1/25/26 at 1300 hours, - dated 1/26/26 at 1100 hours, - dated 1/27/26 at 0934 hours, - dated 1/28/26 at 0132 hours, - dated 1/29/26 at 0744 hours, - dated 1/30/26 at 0923 hours, and - dated 1/31/26 at 1042 hours. Review of Resident 19's MAR for February 2026, showed Resident 19 received Percocet 10-325 mg on the following dates and times: - dated 2/1/26 at 0545 hours, - dated 2/2/26 at 0930 hours, - dated 2/3/26 at 1005 hours, and - dated 2/4/26 at 0514 hours. Further review of Resident 19's medical record failed to show any documented evidence of the non-pharmacological interventions provided to Resident 19 prior to the administration of Percocet pain medications. On 2/9/26 at 1515 hours, an interview and concurrent medical record review for Resident 19 was conducted with the DON. The DON verified and acknowledged the above findings. Cross reference to F657.

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F 0726 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure five out of five licensed nurses 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 8 had the appropriate competency and skill set to assess and provide interventions when Resident 103 was in critical condition experiencing desaturation (a drop in oxygen levels in the blood), hypothermia (a dangerous, potentially fatal medical emergency where the body loses heat faster than it produces it, causing the core temperature to drop below 95 degrees Fahrenheit), and hypertension (high blood pressure). LVN 8 was unclear of the LVN's scope of practice regarding respiratory care when caring for a resident and failed to call 911 during an emergency. * The facility failed to ensure RN 1 and LVN 2 were able to demonstrate competency in the calibration of a glucometer (accucheck machine (a device used to measure the concentration of glucose in the blood). * The facility failed to ensure LVN 4 was able to competently administer the correct oral medication to Resident 52. * The facility failed to ensure LVN 5 was able to demonstrate competency in administering 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 10. These failures resulted in the delay of treatment and contributed to Resident 103's untimely death; and had the potential to put the residents at risks for the care not provided in a safe and competent manner.Findings: Review of the facility's P&P titled Nursing Staff Competency revised 4/2025 showed it is this policy of this facility to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial (relating to interrelation of social factors and individual thought and behavior) well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity (severity of an illness or medical condition) and diagnoses of the facility's resident population in accordance with the facility assessment required at subsection 483.10(3). Review of the Board of Vocational Nursing and Psychiatric Technicians effective 10/1/25, showed LVNs could use a manual resuscitation device (provides positive pressure ventilation to the resident) and other cardio-pulmonary resuscitation (medical procedure involving repeated compression of a resident's chest, performed in an attempt to restore the blood circulation and breathing of a resident who has suffered cardiac (relating to the heart) arrest) technical skills (basic life support level) in the event of an emergency. Review of the facility's document titled RN Job Description dated 12/17/21, showed the RN must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulation and guidelines that pertain to long-term care. Review of the facility's document titled LVN Job Description dated 12/17/21, showed the following: - the LVN must possess the ability to make independent decisions when circumstances warrant such action; and - the LVN must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulation and guidelines that pertain to long-term care. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	1. Closed medical record review for Resident 103 was initiated on 1/30/26. Resident 103 was readmitted to the facility on [DATE] with diagnoses including aspiration pneumonia (lung infection caused by inhaling foreign materials, such as food or liquid) and respiratory failure (occurs when the lungs cannot properly transfer oxygen to the blood or remove carbon dioxide). Review of Resident 103's POLST (an actionalable, signed medical order form for individuals with serious, life-limiting illnesses, outlining specific, immediate treatment preferences like CPR, intubation, and feeding tubes) dated 11/29/25, showed DNR (Do Not Resuscitate) allowing natural death with selective treatment and no artificial means of nutrition, including feed tubes signed and dated 11/29/25 by Resident 103's daughter, who was the legal recognized decisionmaker. Review of Resident 103's H&P examination dated 11/30/25, showed Resident 103 could not make own medical decisions due to dementia (a progressive decline in memory, thinking, and behavior, often caused by damaged brain cells from diseases like Alzheimer's or vascular dementia). Review of Resident 103's plan of care showed a care plan problem initiated on 11/30/25, addressing the resident's altered respiratory status, difficulty breathing related to COPD (chronic obstructive pulmonary disease- a progressive, irreversible lung disease causing restricted airflow, chronic coughing, wheezing, and severe shortness of breath), acute hypoxic respiratory failure (inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function), aspiration pneumonia, congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), and chronic atelectasis (partial or complete collapse of the lung). One of the care plan approaches was to monitor signs and symptoms of respiratory distress and report to the physician as needed for increased respirations, decreased pulse oximetry (measurement of oxygen level in the blood), increased heart rate, cough, pleuritic pain (sharp, localized chest pain that worsens with deep breathing), accessory muscle usage (contraction of muscles other than the diaphragm during breathing in or the contraction of any muscle during breathing out), skin color changes to blue/grey. Review of Resident 103's MDS assessment dated [DATE], showed Resident 103 had moderate cognitive impairment. Review of Resident 103's Progress Note written by LVN 8 dated 12/13/25, showed at 0555 hours, Resident 103 was observed with thick, white phlegm (thick mucus made by the cell lining in the upper airways and lungs) in mouth and was unable to spit out. Oral suction was performed and obtained 200 ml of phlegm. Resident 103's blood pressure was 174/102 mmHg (normal range: top number less than 120 and lower number than 80), heart rate was 74 (normal range: between 60 to 100 beats per minute), respiratory rate was 22 (normal range: from 12 to 20 breaths per minute) and oxygen saturation was ranging from 83% to 85% (normal range: between 95 to 100%). Resident 103 was on oxygen 2 liters per minute (LPM) per nasal cannula (a device used to deliver supplemental oxygen). Resident 103's temperature was 95 degrees Fahrenheit. The physician was notified and staff was awaiting a call back. The document showed staff called and left a message for the resident's emergency contacts. The DON was notified. Resident 103 was DNR. Review of Resident 103's Change of Condition written by LVN 8 dated 12/13/25, showed the resident had thick, white phlegm in their mouth. Further review of the document showed Resident 103 was observed with thick, white phlegm in mouth and was unable to spit it out. Oral suction was performed and obtained 200 ml of phlegm. Resident 103's blood pressure was 174/102, heart rate was 74, respiratory rate was 22 and oxygen saturation was ranging from 83% to 85%. Resident 103 was on oxygen 2 LPM per (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	nasal cannula. Resident 103's temperature was 95 degrees Fahrenheit. The physician was notified and staff was awaiting a call back. The document showed staff called and left a message for the resident's emergency contacts. The DON was notified. Resident 103 was DNR. Review of Resident 103's Vital Signs showed the following: - dated 12/13/25, showed at 0217 hours, the resident's blood pressure was 129/75, respiratory rate was 18, oxygen saturation was 95% via nasal cannula, and an oral temperature of 98 degrees Fahrenheit; and - dated 12/13/25, showed at 0500 hours, the resident's blood pressure was 174/102, respiratory rate was 22, oxygen saturation was 85% via nasal cannula, and an oral temperature of 95 degrees Fahrenheit. Review of Resident 103's MAR for December 2025 showed on 12/13/25 at 0630 hours, Resident 103 received their levothyroxine (medication used to treat hypothyroidism- abnormally low activity of the thyroid gland, resulting in metabolic changes in adults) sodium oral tablet 88 mcg and ipratropium bromide inhalation (a medication used to treat bronchospasm, asthma, and COPD (Chronic Obstructive Pulmonary Disease (a progressive, irreversible lung disease causing restricted airflow, chronic coughing, wheezing, and severe shortness of breath) by relaxing airway muscles) mediations. Further review failed to show the resident's vital signs were reassessed following the ipratropium bromide inhalation treatment. Review of Resident 103's Progress Note dated 12/13/25, showed at 0915 hours, the charge nurse notified the writer (RN 1) to assess the resident. Resident 103's blood pressure was 78/58, heart rate was 94, respiratory rate was 12 and oxygen saturation was ranging from 73%. Resident 103 was observed in bed with the head of the bed elevated. Caregiver was present at bedside. Resident 103 was disoriented and unable to follow commands. Resident 103's code status was DNR. Oxygen was immediately escalated to a non-rebreather mask (a single-use mask, emergency medical device designed to deliver high concentrations of oxygen up to 95% to patients who are breathing on their own but require high-flow oxygen) at 15 LPM. Resident 103's oxygen saturation gradually improved to 77% at the time, and another licensed nurse was instructed to call 911. The physician was notified and a message was left for the resident's daughter. The resident's second emergency contact was notified and updated of the situation, and agreed with the transfer to the acute care hospital. Resident 103 was transferred to the acute care hospital at 0935 hours. At approximately 1300 hours, Resident 103's daughter arrived and reported the resident's condition continued to decline in the acute care hospital. Resident 103's daughter confirmed her wish to maintain DNR status throughout care and expressed gratitude to staff. On 2/5/26 at 0959 hours, a phone interview and concurrent medical record review was conducted with LVN 8. LVN 8 reviewed the Progress Notes and the Change of Condition notes dated 12/13/25. LVN 8 stated they contacted the physician, RN, and the DON. LVN 8 was asked if 911 was contacted. LVN 8 stated Resident 103 was DNR and they had to wait to hear back from the MD, RN, and family. LVN 8 stated Resident 103 was suctioned. LVN 8 stated they did not remember if they reassessed Resident 103's vital signs after suctioning. LVN 8 acknowledged Resident 103 was in distress. LVN 8 reiterated Resident 103 was a DNR, and 911 was not to be contacted. LVN 8 stated the physician and family were contacted and they were waiting to hear what they wanted to do. LVN 8 stated DNR meant to not resuscitate if the resident stops breathing or heart stops beating. LVN 8 confirmed Resident 103 was still breathing and had a heartbeat at the time they provided care. LVN 8 stated they oversaw Resident 103 and could make the medical decision. LVN 8 stated they didn't call 911 because the resident was a DNR. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's in-service education record titled Nursing Advantage UDA/LVN Scope for Respiratory Devices dated 9/23/25, failed to show LVN 8's name on the attendance sheet. On 2/6/26 at 1145 hours, an interview and medical record review and facility document review and review of the Board of Vocational Nursing document was conducted with the DON. The DON stated in an emergency, the LVN's role for respiratory care was to provide basic life support in a life saving event, such as oral suctioning, initiate/apply oxygen, switch from a nasal cannula to a non-rebreather mask, and could titrate (adjust) up to 15 liters per minute. The DON further stated LVN 8 focused primarily on Resident 103's breathing and failed to address the additional abnormal vital signs. The DON stated they spoke to LVN 8 at approximately 0600 hours and was informed Resident 103 was suctioned and stable. The DON stated LVN 8 did not inform them of Resident 103's oxygen saturation, blood pressure, respiratory rate, or temperature. The DON verified they failed to ask LVN 8 for Resident 103's vital signs and to describe their meaning of stable. The DON reviewed the in-service attendance sheet and verified LVN 8 was not in attendance of the in-service. On 2/6/26 at 1546 hours, a follow up interview and concurrent medical record review was conducted with LVN 8. LVN 8 reviewed the Progress Notes and the Change of Condition notes dated 12/13/25. LVN 8 stated they noted thick white phlegm and Resident 103 was unable to spit it out, which was at the time of medication pass. LVN 8 stated they suctioned first and then obtained vital signs. LVN 8 verified a reassessment was not documented and could not recall their assessment nor their vital signs following Resident 8's intervention of suctioning. LVN 8 stated they focused on airway and breathing. LVN 8 stated they felt if someone with COPD was not showing signs of distress, hyperventilation (rapid or deep breathing), nothing to suction, breathing was stable at 86%, they did not see the need to send them out. LVN 8 further stated they did not do a follow-up note showing a reassessment of the patient, nor could they remember what their assessment was. On 2/6/26 at 1645 hours, an interview was conducted with the Administrator, DON, and Clinical Resource. The Administrator, DON, and Clinical Resource acknowledged the above findings. Cross-reference F684. 2.a. Review of the blood glucose meter manufacturer's information sheet titled Quality Assurance/ Quality Control Reference Manual revised 12/17 showed the following: - under Performing a Control Solution Test section showed the first two of six steps were: Step 1: Insert test strip into the blood glucose meter, and Step 2: Press the Back or Forward button one time to enter the control solution mode. A control solution bottle will appear at the top right of the screen; - under the Troubleshooting Control Procedure section showed to make sure the test strips and control solutions are not past expiration date. The date is shown in the bottle. Discard control solution 90 days after the bottle is opened; and - results that fall outside the range may be caused by the test strip bottle was opened for more than three months. On 2/2/26 at 1020 hours, a review of the glucometer quality control record and glucometer quality control observation and concurrent interview was conducted with LVN 2. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Review of the Quality Control Record for the glucometer with serial number 1040-4439383 for February 2026 showed the following: - the meter strip lot number was documented as 638025u with an expiration date of 3/18/27; and - the normal control and high control solution was documented with an expiration date of 7/14/27. The container of the glucose strip was observed to not have an open date and did not match the lot number documented in the Quality Control Record. The normal control and high control solution bottles were labeled with an open date of 1/30/26. LVN 2 verified the above findings. When LVN 2 was asked to calibrate the glucometer, LVN 2 stated she was only shown once, and the NOC (night) shift nurses do it. LVN 2 stated she was not sure when to calibrate a glucometer. LVN 2 stated if a glucometer needed to be calibrated, she would ask her RN supervisor to do it for her. b. On 2/2/26 at 1103 hours, an observation of the glucometer quality control, review of the glucometer quality control record and concurrent interview was conducted with RN 1. When RN 1 was asked to calibrate the glucometer, RN 1 inserted a glucose test strip into the glucometer and performed the control solution test. When asked if she had to push the back or forward button, RN 1 stated no, she just had to turn it on and do the control solution test right away. After calibrating the glucometer, RN 1 was observed documenting 94 as the normal control result and 366 as the high control result. RN 1 stated they had to replace the glucometer because the high control result was not within the range. When asked about the expiration dates of the glucose strips and the control solutions, RN 1 stated they go by the expiration dates printed on the box, and not by the number of days after opening the bottles of glucose strips and control solution bottles. When RN 1 was informed the test strips and control solution expire 90 days after opening, RN 1 stated they followed the expiration dates as printed on the box of the control solution, not when they were opened. On 2/5/26 at 1234 hours, an interview and concurrent employee file review for LVN 2 and RN 1 was conducted with the DSD. Review of LVN 2's Skills Checklist – Licensed Nurse (undated) showed under Pharmacy, glucometer calibration competency and was signed by the DSD on 10/25/25. Review of LVN 2's LN (Licensed Nurse) Comprehensive Clinical Competency Review dated 11/11/25, under Oxygen/ Crash Cart Supplies, showed LVN 2 met the competency on performing the calibration of accucheck (blood glucose monitoring) machine. Review of RN 1's LN Comprehensive Clinical Competency Review dated 11/11/25, under Oxygen/ Crash Cart Supplies, showed RN 1 met the competency on performing the calibration of accucheck machine. RN 1 signed the review herself. The DSD verified the above findings. The DSD stated the competency skills check including calibration of the glucometer was done upon hire, annually, and as needed. The DSD stated she performed the glucometer calibration skills check for LVN 2 on 10/25/25, and LVN 2 was able to perform a return demonstration. The DSD stated RN 2 accidentally signed for herself for the annual competency skills check but it was RN 3 and LVN 5 who conducted the competency review on performing the calibration of accucheck machine for LVN 2 and RN 1. Cross-reference to F908. 3. On 1/29/26 at 0941 hours, during an interview with Resident 52, Resident 52 stated she had a concern with LVN 4 who had repeatedly given her the wrong medications throughout her stay at the facility. Resident 52 stated she recognized the medications, and informed LVN 4 she was given the wrong medication. Resident 52 was observed teary-eyed, and she stated this had made her terribly upset and got her angry because she was concerned for the residents who do not know their medications and cannot advocate for themselves. Resident 52 stated she informed RN 2 and the DON regarding her concern (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	about LVN 4. Medical record review for Resident 52 was initiated on 1/28/26. Resident 52 was admitted to the facility on [DATE]. Review of Resident 52's Progress Note H&P dated 11/29/26, showed Resident 52 was capable and independent with decision-making. Review of Resident 52's Order Summary Report showed a physician's order dated 11/27/25, to administer calcium 600 mg by mouth one time a day for supplement. On 2/5/26 at 1010 hours, an interview for Resident 52 was conducted with RN 2. When asked about Resident 52's concern about LVN 4, RN 2 stated she remembered Resident 52 coming to the nursing station and showing her a medication on her hand. RN 2 stated Resident 52 told her she wanted RN 2 to verify what the medication was which was given to her by LVN 4. RN 2 stated she checked the medication and it was calcium with vitamin D. RN 2 stated she verified the order for Resident 52, and it was only for calcium and not calcium with vitamin D. RN 2 stated she informed LVN 4 about it and told her to follow the physician's order, and she cannot give whatever is available. On 2/5/26 at 1234 hours, an interview and concurrent employee review for LVN 4 was conducted with the DSD. Review of LVN 4's Skills Checklist – Licensed Nurse (undated) showed under Pharmacy Med Pass Procedure, it was signed by the DON on 12/10/25. Review of an untitled document dated 1/19/26, showed LVN 4 was followed by the pharmacist during a medication pass observation. The DSD verified the above findings. Cross-reference to F755 #1. 4. On 1/29/26 at 1632 hours, a medication administration observation for Resident 10 and concurrent interview was conducted with LVN 5. The following was observed: - LVN 5 did not flush the GT with 50 ml water before and after medication administration; - LVN 5 did not flush in between the medications; and - LVN 5 did not wear the appropriate PPE (Personal Protective Equipment- such as gloves, safety glasses, masks and gown) when administering medications via GT for Resident 10 who was on EBP. LVN 5 verified the above findings. On 2/5/26 at 1234 hours, an interview and concurrent employee review for LVN 5 was conducted with the DSD. Review of LVN 5's Skills Checklist – Licensed Nurse (undated) showed under Tube Feedings, GT and Maintenance and Treatment, Infection Control sections, showed LVN 5 was signed off by the DON on 6/10/25. The DSD verified the above findings. Cross-reference to F759 #1, and F880 #1.

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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, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services to ensure accurate administration and reconciliation of medications. * The facility failed to ensure LVN 5 flushed Resident 10's GT with 50 ml of water before and after medication administration as per the physician's order. In addition, the facility failed to ensure LVN 5 flushed Resident 10's GT in between medications. * The facility failed to ensure the oxycodone (opioid pain medication to treat moderate to severe pain) removed from the bubble pack was recorded and accounted for in the Narcotic and Hypnotic Record for Resident 109. * The facility failed to ensure the correct medication was administered to Resident 52. * The facility failed to ensure the voltaren topical gel (topical medication use to relieve pain) was available for Resident 12. * The facility failed to ensure the lidoderm patch (topical hydrogel patch use to relieve pain) was available for Resident 45. These failures had the potential to affect the residents' well-being by not being given the prescribed medications and not administering the correct GT flushes. In addition, there was a risk for the diversion of controlled medication when they were not recorded and accounted for. Findings: 1. According to Taylor's Fundamentals of Nursing seventh edition, under Administering Medications Through an Enteral Feeding Tube, medications should be crushed to a fine powder and mixed with 15 to 30 ml of water before being delivered through the tube and give medications separately with water between each drug. Some medications may interact with each other or become less effective if mixed with other drugs. On 1/29/26 at 1610 hours, a medication administration observation for Resident 10 was conducted with LVN 5. LVN 5 prepared the following medications for Resident 10: - apixaban (anticoagulant)5 mg one tablet; - Florastor (probiotic) 250 mg one capsule; - sennoside (laxative) 8.6 mg two tablets; and - docusate sodium (stool softener) 100 mg two tablets. During the medication administration, the following was observed: - LVN 5 crushed each medication and poured into separate medication cups; - LVN 5 poured 5 ml of water to each medication cup to dissolve the crushed medications; - LVN 5 connected the syringe to the tubing, and flushed the GT with 10 ml water; - LVN 5 poured the apixaban medication in syringe connected to the GT, then added 10 ml to the medication cup, and poured it in the syringe. - While the water was still in the tubing, LVN 5 poured the Florastor medication in the syringe connected to the GT, then added 10 ml to the medication cup and poured it into the syringe. LVN 5 did (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not flush in between the two medications; - While the water was still in the tubing, LVN 5 poured the docusate sodium medication in the syringe connected to the GT, then added 10 ml to the medication cup and poured it into the syringe. LVN 5 did not flush in between the two medications; and -While the water was still in the tubing, LVN 5 poured the senna medication in the syringe connected to the GT, then added 10 ml to the medication cup and poured it into the syringe. LVN 5 did not flush in between the two medications. Medical record review for Resident 10 was initiated on 1/28/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's Order Summary Report showed the following physician's orders: - dated 12/23/25, to flush tubing with 50 ml of water pre and post medication administration via tube; - dated 12/23/25, to administer sennosides 8.6 mg two tablets via GT two times a day; - dated 12/24/25, to administer Eliquis (apixaban) 5 mg via GT two times a day; - dated 12/24/25, to administer docusate sodium 100 mg two tablets via GT two times a day; and - dated 1/14/25, to administer saccharomyces boulardii (Florastor) 250 mg one capsule enterally two times a day. On 1/29/26 at 1640 hours, an interview was conducted with LVN 5. LVN 5 verified she did not flush Resident 10's GT with 50 ml of water before and after medication administration per the physician's orders. LVN 5 further verified she did not flush Resident 10's GT in between the medications. On 2/9/26 at 1107 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. 2. On 2/2/26 at 1020 hours, an inspection of Medication Cart A, interview and concurrent medical record review for Resident 109 was conducted with LVN 2. Resident 109's bubble pack of oxycodone 10 mg was counted with LVN 2. There were 25 tablets left in the bubble pack. Review of Resident 109's Narcotic and Hypnotic Record for oxycodone 10 mg tablet showed there were 26 tablets left. The documentation showed one tablet of oxycodone medication was removed on 2/1/26 at 0457 hours. Review of Resident 109's MAR for February 2026 showed Resident 109 was administered the oxycodone medication on 2/1/26 at 0457 and 1913 hours. LVN 2 verified the above findings. LVN 2 stated the nurse who removed the oxycodone medication and administered to Resident 109 did not document the removal in the Narcotic and Hypnotic Record for the oxycodone medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/9/26 at 1116 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. 3. On 1/29/26 at 0941 hours, during an interview with Resident 52. Resident 52 stated she had a concern with LVN 4 who repeatedly had given her the wrong medications throughout her stay at the facility. Resident 52 stated she recognized the medications, and she informed LVN 4 she was given the wrong medication. Resident 52 stated she also informed RN 2 and the DON regarding her concern about LVN 4. Medical record review for Resident 52 was initiated on 1/28/26. Resident 52 was admitted to the facility on [DATE]. Review of Resident 52's Progress Note H&P dated 11/29/26, showed Resident 52 capable and independent with decision-making. Review of Resident 52's Order Summary Report showed a physician's order dated 11/27/25, to administer calcium 600 mg by mouth one time a day for supplement. On 2/5/26 at 1010 hours, an interview and concurrent medical record review for Resident 52 was conducted with RN 2. When asked about Resident 52's concern about LVN 4, RN 2 stated she remembered Resident 52 coming to the nursing station and showing her a medication on her hand. RN 2 stated Resident 52 told her she wanted RN 2 to verify what the medication was which was given to her by LVN 4. RN 2 stated she checked the medication and it was calcium with vitamin D. RN 2 stated she verified the order for Resident 52, and it was only for calcium and not calcium with vitamin D. RN 2 stated she informed LVN 4 about it and told her to follow the physician's order, and she cannot give whatever is available. Cross-reference to F726 #3. 4. Review of the facility's P&P titled Transmitting Medication Orders undated under the Refill Orders section, showed to reorder the medications when a three to five-day supply remains in the medication storage and place the peel-off sticker on the pharmacy order sheet and initial the entry: liquid medications, prn medications, topical medications, other non-punch card medications, skilled residents who get 14 day supply of medications, and schedule III, IV and V controlled narcotics. On 1/29/26 at 1632 hours, a medication administration observation for Resident 12 was conducted with LVN 10. LVN 10 started preparing the medications he would administer to Resident 12. LVN 10 stated he could not administer the voltaren topical gel medication to Resident 12 because it was not available. LVN 10 verified the voltaren topical gel medication was a routine medication of Resident 12 and was to be given three times a day at 0900 hours, 1300 hours, and 1700 hours. Medical record review for Resident 12 was initiated on 1/29/26. Resident 12 was readmitted to the facility on [DATE]. Review of Resident 12's Order Summary Report showed a physician's order dated 8/27/25, to apply two grams of voltaren external gel 1% to right shoulder topically three times a day for pain management. On 1/29/26 at 1640, an interview for Resident 12 was conducted with LVN 1. LVN 1 stated the last (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time she applied the voltaren topical gel to Resident 12 was at noontime. LVN 1 stated the medication refill was just ordered today. LVN 1 stated the refill for the resident's medication was usually ordered three days before the medication ran out. On 1/29/26 at 1645 hours, an interview was conducted with the DON. The DON stated the nurses should order the refill of the routine medication of the resident four to five days prior to the last dose of the medication. The DON was informed and acknowledged the above findings for Resident 12. Cross reference to F759, example #2. 5. On 1/30/26 at 0829 hours, a medication administration observation for Resident 45 was conducted with LVN 9. LVN 9 stated the lidoderm patch for Resident 45 was not available. LVN 9 stated the Lidoderm patch should be applied to Resident 45 daily at 0900 hours. LVN 9 stated she would order the refill of the medication. LVN 9 stated the nurses ordered the refill of the resident's medication four to five days prior to the last day of supply. Medical record review for Resident 45 was initiated on 1/30/26. Resident 45 was readmitted to the facility on [DATE]. Review of Resident 45's Order Summary Report showed a physician's orders dated 1/25/26, to apply Lidoderm external patch 5% to right shoulder topically one time a day for pain management, 12 hours on and 12 hours off and remove per schedule. On 2/9/26 at 1139 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 45.