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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, facility P&P review, and hospital Encounter Summary review, the facility failed to provide the necessary services and interventions to maintain the highest practicable well-being for one of three sampled residents (Resident 103) reviewed for closed record; and for one of 22 final sampled residents (Resident 10) reviewed for meal observation. * Resident 103 was in his room when LVN (Licensed Vocational Nurse) 8 noted the resident with oral secretions. LVN 8 performed oral suction and then obtained Resident 103's vital signs which included the blood pressure, heart rate, respiratory rate, oxygen saturation (measures the percentage of oxygen-carrying hemoglobin in the blood), and temperature. The facility failed to place Resident 103 on a non-rebreather mask (a high-concentration oxygen therapy device used in emergencies to deliver 60%-95% oxygen via a reservoir bag, typically set at 10-15 L/min (liters per minute) when the resident was identified with desaturation (low oxygen level) between 83%-85%, failed to re-assess and document the resident's condition, and failed to activate the EMS (Emergency Medical Services) in a timely manner when Resident 103 had a change in condition warranting a higher level of care. * The facility failed to ensure Resident 10 received the supplemental nourishment drink with his meal as ordered by the physician. These failures resulted in the delay of treatment and contributed to Resident 103's untimely death; and placed Resident 10 at risk for negative health outcomes such as unmet calorie and protein needs and weight loss. Findings: 1. Review of the facility's P&P titled Admission, Transfer and Discharge revised 11/2016 showed when the Facility transfers or discharges a resident, the Facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. The Facility shall permit each resident to remain in the Facility and not transfer or discharge the resident from the Facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; and the health of individuals in the Facility would otherwise be endangered. Review of the facility's Job Description for Licensed Vocational Nurse/Licensed Practical Nurse dated 12/17/21, showed the purpose of the job position is to provide primary care to specific residents under the medical direction and supervision of the residents' attending physicians or the Medical Director of the facility with emphasis on assessment, illness prevention and health care management. Further review of the Job Description showed essential duties and responsibilities which included to chart nurses' notes in professional and appropriate manner that timely, accurately, and thoroughly reflects the care provided to the resident, as well as the resident's response to the care; chart all changes in resident condition and the response to those changes; chart all communication with the resident's attending physician regarding the resident, the resident's treatment, or the response to that treatment. Review of the facility's P&P titled Oxygen Administration Per Partial Non-Rebreathing Mask revised 4/2025 showed the purpose was to deliver high-concentration oxygen quickly to a resident with acute hypoxia (a rapid, sudden drop in tissue oxygenation causing immediate symptoms like shortness of breath, rapid breathing, confusion, and cyanosis (bluish skin)) or respiratory distress until further medical evaluation or transfer occurs. In an (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	emergency situation, such as Code (an alert status to inform staff of the emergency services needed which may include, but not limited to, Code Blue- for cardiac/respiratory arrest, Code Red- for fire, Code Silver for active shooter or armed intruder, etc.) or life-threatening decrease in resident's oxygen level, partial non-rebreathing mask may be used without an immediate physician order. Documentation to include the date and time, oxygen liter flow (dictates the amount of supplemental oxygen delivered, usually ranging from 1 to 10 LPM (Liters Per Minute) for home use, with 2 LPM being a common starting point) resident's response to partial rebreathing mask, and oxygen saturation via pulse oximeter (a noninvasive, usually finger-clipped device that measures blood oxygen saturation and pulse rate). Review of the facility's P&P titled Change in Condition revised 4/2025 showed it is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. The P&P included the following: - If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following (but not limited to): change or a trending change in vital signs, to include temperature, pulse, blood pressure, heart rate, and oxygen saturation. - The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing intervention or through communication with the resident's provider using SBAR (Situation, Background, Assessment, Recommendation-a structured, four-step communication framework used primarily in healthcare to ensure concise, accurate, and rapid exchange of information) or similar process to obtain new orders or interventions). - The resident will then be placed on the 24-Hour Report and Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions. An attempt to identify the cause of decline, when it occurs, needed to assist and resident behavior/acceptance of increased need of assistance will be monitored. - The nurse will communicate the change to other departments as appropriate and updated communications will be available during morning report. - There will be certain circumstances where immediate attention will be warranted, and nursing will be responsible for notifying the appropriate department for evaluation. The nurse shall use his/her clinical judgment and shall contact the physician based on the urgency of the situation. The Medical Director shall be notified in the event that the Attending Physician or on-call Physician cannot be reached. The resident/resident representative will be notified of the change of condition and any changes in the resident's medical or nursing care. Review of the facility's P&P titled Nursing Staff Competency revised 4/2025 showed it is the 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 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at S483.70(e) (a regulatory number assigned under Code of Federal Regulations (codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government). Further review of the P&P showed the definition of competency (per CMS -Center for Medicare and Medicaid Services) as measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Closed medical record review for Resident 103 was initiated on 1/30/26. Resident 1 was readmitted to the facility on [DATE], with diagnoses including aspiration pneumonia (a serious lung infection caused by inhaling foreign materials such as food, liquid, vomit, or saliva into the airways, often due to impaired swallowing or decreased consciousness) and respiratory failure (a condition in which the lungs cannot properly transfer oxygen to the blood or remove carbon dioxide). Review of Resident 103's POLST (Physician Orders for Life-sustaining Treatment) dated 11/29/25, showed do not attempt resuscitation allowing natural (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	death with selective treatment and no artificial means of nutrition, including feeding tubes signed and dated 11/29/25, by Family Member 1 who was the resident's legal recognized decisionmaker. Review of Resident 103's H&P (History and Physical) examination dated 11/30/25, showed Resident 103 cannot 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 (a progressive neurodegenerative disorder, most common in people over 65, that destroys memory, thinking, and behavior) or vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving brain cells of oxygen and nutrients). 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, incurable lung disease- primarily caused by smoking that restricts airflow and makes breathing difficult), acute hypoxic respiratory failure (a critical condition defined by a low blood oxygen level), aspiration pneumonia (a serious lung infection caused by inhaling foreign materials such as food, liquid, vomit, or saliva into the airways, often due to impaired swallowing or decreased consciousness), Congestive Heart Failure- (CHF-a chronic condition where the heart pumps inefficiently, causing fluid buildup in the lungs and body) , and chronic atelectasis (partial or complete collapse of the lung). Interventions included to monitor signs and symptoms of respiratory distress and report to the MD (Doctor of Medicine) as needed for increased respirations, decreased pulse oximetry, increased heart rate, cough, pleuritic pain (sharp, stabbing chest pain that intensifies with breathing, coughing, or sneezing, caused by inflammation of the pleural lining of the lungs), accessory muscle usage, skin color changes to blue/grey. Review of Resident 103's MDS (Minimum Data Set-an assessment tool) assessment dated [DATE], showed Resident 103 had moderate cognitive (refers to the mental processes involved in gaining knowledge and comprehension, including thinking, knowing, remembering, judging, and problem-solving) impairment. Review of Resident 103's Change in Condition (COC) dated12/13/25 at 0530 hours, showed the facility initiated a COC for Resident 103 for thick, white phlegm in the resident's mouth. The COC documentation showed Resident 103 was observed with thick, white phlegm in the mouth and unable to spit out. Oral suction performed, obtained 200 ml (milliliters). Resident 103's blood pressure was 174/102 mmHg (normal range: top number less than 120 and lower number less 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%), and Temperature 95 degrees F (Fahrenheit) (Normal range: 97-99 degrees F). MD notified. Awaiting call back. Called and left message for Emergency Contact one, Family Member 1. Her phone went straight to voicemail. Family Member 2 (second emergency contact) notified. DON (Director of Nursing) notified. Resident is DNR (Do Not Resuscitate). Review of Resident 103's December 2025 MAR (Medication Administration Record) showed on 12/13/25 at 0630 hours, the resident's medications of levothyroxine (medication used to treat hypothyroidism) sodium oral tablet 88 MCG (micrograms) and ipratropium bromide inhalation (a medication used to treat bronchospasm, asthma, and COPD by relaxing airway muscles) were administered to the resident. However, following Resident 103's ipratropium bromide inhalation treatment, there was no documentation of a reassessment of Resident 103's vital signs. Review of Resident 103's Vital Signs were last documented on 12/13/25 at at 0500 hours, which showed a BP of 174/102, RR of 22 breaths/minute, O2 saturation of 85% via nasal cannula, and an oral temperature of 95 degrees Fahrenheit. Resident 103's previous vital signs taken on 12/13/25 at 0217 hours, showed BP of 129/75, RR of 18 breaths/minutes, O2 saturation of 95% on room air, and an oral temperature of 98 degrees Fahrenheit. Review of Resident 103's closed medical record showed on 12/13/25 at 1130 hours, a progress note initiated at 0915 hours showed CN (Charge Nurse) (unknown charge nurse) notified this writer to assess the resident. Vital signs obtained: BP 78/58, O2 saturation 73% on 2 L (liters) via nasal cannula, HR (heart rate) 94, RR (respiratory rate) 12. Resident observed in bed with HOB (Head of Bed) elevated, caregiver present at bedside. Resident was disoriented, unable (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	to follow commands. Code status verified as DNR. Oxygen was immediately escalated to a non-rebreather mask at 15 L/min. O2 saturation gradually improved to 77%, at the time another licensed nurse (unknown licensed nurse) was instructed to call 911. Physician 1 was notified, and a message was left for the resident's daughter, Family Member 1. Contacted second contact Family Member 2 and update was given in details agreed with transfer. Medical history/diagnoses: encephalopathy (any disease or dysfunction of the brain that alters mental state, causing symptoms like confusion, memory loss, personality changes, and in severe cases, coma or death) CHF, acute respiratory failure with hypoxia, dependence on supplemental oxygen, and recent pneumonia. Resident currently receiving IV (intravenous-through the vein) ceftriaxone (antibiotic) and Zithromax (antibiotic) IV for pneumonia. At 0935 - Resident transferred via EMS (Emergency Medical Services). Earlier in the morning (07:00-08:00), per CNA report (unknown CNA), resident received a full bed bath and shave, refused breakfast, and was at baseline at that time. At approximately 13:00, daughter arrived and reported that the resident's condition continued to decline in the ER (Emergency Room). She confirmed her wish to maintain DNR status throughout care and expressed gratitude to staff. Review of Resident 103's Order Summary Report dated 2/6/26, showed the following physician's orders: - dated 11/29/25, for continuous O2 (oxygen) at 2 l/min via N/C every shift- dated 11/29/25, for continuous: check O2 saturation every shift **call MD if O2 saturation below 92% On 2/5/26 at 0959 hours, a telephone interview for Resident 103 was conducted with LVN 8. The COC and progress note signed and dated 12/13/25, by LVN 8, were read to LVN 8 as documented in the resident's closed medical record; Resident 103's O2 saturation dated 12/13/25 at 0249 hours, showed 95% on room air and at 0500 hours showed 85% oxygen via nasal cannula. LVN 8 stated the facility contacted the physician, RN (Registered Nurse), and the DON. When asked if 911 was contacted, LVN 8 stated Resident 108 was a DNR (a legally binding medical document, signed by a doctor, instructing healthcare professionals not to perform CPR (Cardiopulmonary Resuscitation) if a resident's heart stopped or stopped breathing) and had to wait to hear back from the MD, RN, and family. When asked what interventions were implemented for Resident 103 when the COC was identified, LVN 8 stated Resident 103 was suctioned. LVN 8 was asked if the facility reassessed Resident 103's vital signs after suctioning and stated she did not remember. LVN 8 acknowledged Resident 103 was in distress. However, LVN 8 reiterated Resident 103 was a DNR and stated 911 was not contacted; the MD and family were contacted and waited to hear what they wanted to do about Resident 103. LVN 8 was asked what the meaning of a DNR was and she stated to not resuscitate if the resident stopped breathing, or the heart stopped beating. LVN 8 was asked if Resident 103 was breathing and had a heartbeat at the time they provided care and LVN 8 confirmed yes. LVN 8 stated they (facility staff) oversee Resident 103 and can make the medical decisions. LVN 8 further stated they (facility staff) did not call 911 because Resident 108 was a DNR status. On 2/5/26 at 1232 hours, an interview was conducted with CNA 4. CNA 4 stated Resident 103 responded slowly to staff on the morning of 12/13/25, which was not normal for the resident. CNA 4 stated she also recalled Resident 103 refusing to eat his breakfast that morning; CNA 4 stated Resident 103 typically had a good appetite and will eat approximately 75% of his meals. CNA 4 also stated Resident 103 was sleeping and was not typical of him. CNA 4 stated notifying RN 1 when the staff noticed Resident 103 was not breathing well, which was at the time they were assisting the resident with his breakfast. Review of Resident 103's Amount Eaten record dated 2/6/26, showed the resident refused his morning meal on 12/13/25. On 2/5/26 at 1105 hours, an interview and concurrent closed medical record review for Resident 103 was conducted with RN 1. RN 1 reviewed Resident 103's COC on 12/13/25 at 0555 hours. RN 1 also reviewed Resident 103's vital signs showing the resident's vitals taken at 0500 hours and verified were not the resident's baseline. RN 1 stated if RN 1 were to have found the resident at 0555 hours with the documented vital signs, RN 1 would have completed an assessment, changed the nasal cannula to a non-rebreather oxygen mask (non-rebreather oxygen mask is a single-use, emergency medical device designed to deliver high concentrations of oxygen up to 95% to patients who are (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and could not recall her assessment nor the vital signs following Resident 103's intervention of suctioning. Review of Resident 103's hospital Encounter Summary dated 12/13/25, showed Resident 103 had expired on 12/13/25 at 1205 hours, and the final diagnoses at the hospital included acute hypoxic respiratory failure (A critical condition where the lungs cannot adequately oxygenate the blood, resulting in a sudden, severe drop in arterial oxygen. It is the inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function. Respiratory failure is often a medical emergency and can be fatal if not treated quickly); aspiration pneumonia due to gastric secretions, unspecified laterality, unspecified part of lung; and acute on chronic respiratory failure with hypoxia (a life-threatening, sudden worsening of blood oxygen levels in residents with pre-existing chronic lung disease, triggered by acute insults like pneumonia or heart failure, it presents with severe dyspnea (difficulty breathing), confusion, tachypnea (rapid, shallow breathing, often caused by respiratory infections, asthma, COPD, or anxiety, it is a symptom of underlying distress), requiring immediate oxygen, steroids, or ventilation. It is a rapid deterioration (acute) in blood oxygenation in a patient who already has chronically impaired lung function). 2. Review of the facility's P&P titled Food and Nutrition Services, revised 7/2021 showed the recommendations based on the nutritional goals will be communicated via RD (Registered Dietician) recommendations and the Licensed Nurse will receive confirmation in order to document the physician prescription. On 1/29/26 at 1244 hours, an observation and concurrent interview was conducted with Resident 10. Resident 10 was observed in his room eating lunch. Resident 10's meal ticket showed a high protein shake, which was not observed to be on Resident 10's meal tray. Resident 10 stated he was recently cleared to start eating by mouth, and prior to eating he was on a bolus feed (a method of delivering nutrition directly into the stomach through a feeding tube using a syringe or gravity, usually mimicking mealtimes) five times a day. Resident 10 stated the bolus feed was dropped to three times a day and the RD suggested for him to have a protein shake with every meal. Medical record review for Resident 10 was initiated on 1/30/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 12/26/25, showed Resident 10 had the capacity to make medical decisions. Review of Resident 10's Plan of Care showed a care plan problem initiated on 12/23/25, for at risk for weight changes due to CHF (Congestive Heart Failure). One of the care plan approaches was to provide supplements as ordered - 4 oz (ounces) high protein nutrition shake three times a day. Review of Resident 10's Order Summary Report showed physician's order dated 1/28/26, for high protein nourishment with meals for supplement. On 1/29/26 at 1247 hours, a meal observation and concurrent interview for Resident 10 was conducted with CNA 3. CNA 3 verified the high protein shake was not on Resident 10's meal tray. CNA 3 verified the high protein shake should be served with his meal. CNA 3 was informed Resident 10 was recently cleared to eat and his bolus feed was reduced from five times a day to three times a day. CNA 3 stated it was important for Resident 10 to receive his supplemental protein shake since it's important to maintain the nutritional needs and especially since the bolus feeds were reduced. On 2/6/26 at 1503 hours, a phone interview was conducted with the RD. The RD stated a 4-ounce high protein shake was added to Resident 10's orders after passing a swallow test (a procedure that evaluates how food and liquid move from the mouth through the throat and esophagus). The RD stated the goal was to wean Resident 10 off the tube feeding (provides essential nutrients, fluids, and medications directly to the stomach or small intestine for individuals unable to eat enough by mouth). The RD stated to ensure Resident 10 was getting enough calories, reach his calorie needs and protein needs, a high protein shake was added with Resident 10's meals three times a day. The meal intake record was read to the RD for 1/29/26, and explained to the RD Resident 10 consumed 26% to 50% of his meal at lunch. The RD stated if Resident 10 was not consuming 50% to 100% of their meal, then they were concerned. The RD verified Resident 10 should have had his high protein shake on his tray to give an additional amount of calories and protein. 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.

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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 (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	oxygen 2 LPM per 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 (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	they oversaw Resident 103 and could make the medical decision. LVN 8 stated they didn't call 911 because the resident was a DNR. 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 (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	control observation and concurrent interview was conducted with LVN 2. 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 (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	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 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure six of 22 final sampled residents (Residents 2, 3, 5, 14, 27, and 106) were free from the unnecessary psychotropic medications. * The facility failed to ensure the alprazolam (antianxiety medication) was administered to Resident 2 as per the physician's order. The facility failed to ensure the behavior manifestation was monitored and documented, and the non-pharmacological interventions were provided prior to the administration of the alprazolam medication. * The facility failed to ensure the monitoring of Resident 3's meal intake was accurate to identify when the resident had a meal intake of less than 50% related to the use of mirtazapine (antidepressant medication). * The facility failed to accurately monitor Resident 14's orthostatic blood pressure related to the use of Seroquel (antipsychotic medication). * The facility failed to accurately monitor Resident 106's orthostatic blood pressure related to the use of risperidone (antipsychotic) medication. * The facility failed to document what non-pharmacological interventions would be attempted when Resident 5 had episodes of depression as manifested by verbalization of sadness related to Resident 5's use of fluoxetine medication. * The facility failed to ensure the non-pharmacological interventions were provided to Resident 27 prior the administration of alprazolam medication. In addition, the facility failed to ensure the behavior manifestation was monitored and documented related to the use of the alprazolam medication for Resident 27. These failures had the potential for the residents to have adverse complications from the medications and not providing accurate data to the prescriber in determining the dose adjustments of the psychotropic medications for the residents. Findings: 1. Review of the facility's P&P titled Chemical Restraints and Psychotropic Medication Management revised 4/2025 showed the psychotropic medications shall not be administered for the purpose of discipline or convenience. They are to be administered only when required to treat the resident's medical symptoms and will be considered only after nonpharmacological interventions have been attempted and failed. The attending physician will review the resident's treatment plan to re-evaluate the use of psychotropic medication. Medical record review for Resident 2 was initiated on 1/28/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed the following physician's orders dated 12/21/25: - to administer alprazolam 0.5 mg by mouth daily as needed for anxiety manifested by verbalization of nervousness for 14 days; - to monitor episodes of anxiety as evidenced by verbalization of nervousness for alprazolam use; and - for non-pharmacological interventions such as back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks/fluid/milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities, and provide reassurance for alprazolam use. Review of Resident 2's MAR for January 2026 showed the following: - dated 1/4/26 at 1457 and 2055 hours, Resident 2 was administered the alprazolam medication; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 1/4/26, there was no documentation of any non-pharmacological intervention provided to Resident 2 prior to the administration of the alprazolam medication; and - dated 1/4/26, there was no documentation if Resident 2 had any episode of verbalization of nervousness when the alprazolam medication was administered to Resident 2. Further review of Resident 2's medical record failed to show any documented evidence of the non-pharmacological interventions provided to Resident 2 prior to the administration of the alprazolam medication on 1/4/26, and any episode of verbalization of nervousness on 1/4/26, when the alprazolam medication was administered to Resident 2. On 2/6/26 at 0957 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 1. RN 1 verified the alprazolam medication was ordered daily as needed; however, Resident 2 was administered the alprazolam medication twice on 1/4/26 at 1457 and 2055 hours. RN 2 verified there were no non-pharmacological interventions provided to Resident 2 prior to the administration of the alprazolam medication on 1/4/26, and no documentation of behavior manifestation of verbalizing nervousness on 1/4/26, when the alprazolam medication was administered to Resident 2. On 2/9/26 at 1052 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was informed and verified the above findings. 2. Medical record review for Resident 3 was initiated on 1/28/26. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's Order Summary Report showed the following physician's orders: - dated 12/23/25, to administer mirtazapine 15 mg one tablet by mouth at bedtime for depression manifested by poor oral intake; and - dated 1/22/26, to monitor for poor oral intake as evidenced by meal intake less than 50% with meals or meal refusal. Review of Resident 3's MAR for January and February 2026 showed Resident 3 was administered the mirtazapine medication on 1/1 to 2/1/26 at 2100 hours and Resident 3's monitoring for episodes of depression as evidenced by poor meal intake of less than 50% or meal refusal showed the following: - 0 on 1/21, 1/30, 1/31 and 2/1/26 in the evening shift; 1/23 and 1/24/26 in all shifts, 1/25 and 2/1/26 in the day shifts, 1/26/25 in the evening and night shifts, and 1/27/26 in the day and evening shifts; - 1 on 1/22/26, in the evening shift, - 25 on 2/1/26, in the day shift, - 50 on 1/31/26, in the day and evening shifts, and on 2/1/26 in the evening shift, - 75 on 1/27/26, in the evening shift, on 1/28 and 1/29/26 in all shifts, and on 1/30/26 in the day and evening shifts, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's Documentation Survey Report, under Amount Eaten section from 1/21 to 2/2/26, showed the following meal intakes for Resident 3: * refused meals on the following dates and times: - 1/22/26 at 1855 hours, - 1/24/26 at 1341 hours, - 1/27/26 at 1305 and 1745 hours, - 1/28/26 at 0952 and 1405 hours, and - 1/31/26 at 2123 hours. * 0 to 25% on the following dates and times: - 1/21/26 at 2218 hours, - 1/23/26 at 0949 hours, - 1/26/26 at 2056 hours, - 1/27/26 at 1015 hours, - 1/31/26 at 0730 hours, and - 2/2/26 at 1108 hours. * 26 to 50% on the following dates and times: - 1/22/26 at 1236 hours, - 1/25/26 at 1200 hours, and - 1/30/26 at 1426 hours. * 51 to 75% on the following dates and times: - 1/15/26 at 2012 hours, - 1/25/26 at 1429 hours, - 1/30/26 at 1056 hours, - 1/31/26 at 1200 hours, and - 2/2/26 at 1811 hours. (continued on next page)

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Palm Terrace Healthcare & Rehabilitation Center	24962 Calle Aragon Laguna Hills, CA 92637

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* 76 to 100% on the following dates and times: - 1/21/26 at 1352 hours, - 1/22/26 at 1357 hours, - 1/23/26 at 342 and 1749 hours, - 1/24/26 at 1056 and 2215 hours, - 1/25/26 at 1816 hours, - 1/26/26 at 1050 and 1357 hours, - 1/28/26 at 1716 hours, - 1/29/26 at 1049, 1416, 2106 hours, - 1/30/26 at 2217 hours, - 2/1/26 at 0904, 1418 and 1718 hours, and - 2/2/26 at 1428 hours. Further review of Resident 3's medical record showed the monitoring of Resident 3's meal intake by the licensed nurses as documented in the MAR did not match the monitoring of Resident 3's meal intake by the CNAs as documented in the Documentation Survey Report. On 2/5/26 at 1033 hours, an interview and medical record review for Resident 3 was conducted with RN 2. When asked what the licensed nurses considered as poor intake, RN 3 stated poor intake was when Resident 3 consumed less than 50% of the meal tray. RN 3 stated the licensed nurses and CNAs monitored Resident 3's meal intake. RN 3 verified the licensed nurses were documenting the number of episodes of poor meal intake and Resident 3's meal intake percentage. RN 3 verified the meal intake documentation showed Resident 3 consumed 26-50% on several occasions. When asked how they identify when Resident 3 consumed less than 50%, RN 3 stated they could not really identify because the electronic health record only provided the ranges from 0 to 25%, 26 to 50%, 51 to 75%, and 76 to 100%. RN 2 further verified the monitoring of Resident 3's meal intake by the licensed nurses as documented in the MAR did not match the monitoring of Resident 3's meal intake by the CNAs as documented in the Documentation Survey Report On 2/9/26 at 1056 hours, an interview and medical record review for Resident 3 was conducted with the DON. The DON was informed and verified the above findings. 3. Medical record review for Resident 14 was initiated on 1/28/26. Resident 14 was readmitted to the facility on [DATE]. Review of Resident 14's Order Summary Report showed the following physician's orders dated 12/27/25: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- to administer Seroquel 50 mg at bedtime for psychosis as manifested by agitation and verbal outbursts; and - to monitor the orthostatic blood pressure every Monday for antipsychotic medication use. Review of Resident 14's MAR for January 2026 for the monitoring of Resident 14's orthostatic blood pressure showed the following: - dated 1/5/26, lay-123, sit-118 and stand-N/A; - dated 1/12/26, lay-123, sit-118 and stand-N/A; - dated 1/19/26, lay-121, sit-120 and stand-N/A; and - dated 1/26/26, lay-121, sit-120 and stand-N/A. Review of the MAR only showed the three digit numbers and did not show the systolic and diastolic blood pressure of Resident 14 on 1/5, 1/12, 1/19, and 1/28/26 for the lying and sitting positions. In addition, there was no monitoring of Resident 14's orthostatic blood pressure in the standing position. On 2/5/26 at 1019 hours, an interview and medical record review for Resident 3 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated the three digits documented in the MAR was probably Resident 14's systolic blood pressure, and there was no place for the licensed nurses to document the diastolic blood pressure. RN 2 further verified, there was no monitoring of Resident 14's orthostatic blood pressure in the standing position. RN 2 stated the licensed nurses could check Resident 14's blood pressure in a standing position with the therapist's assistance. On 2/9/26 at 1040 hours, an interview and medical record review for Resident 3 was conducted with the DON. The DON was informed and verified the above findings. Findings: 4. Medical record review for Resident 106 was initiated on 1/28/26. Resident 106 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 106's H&P examination dated 1/24/26, showed Resident 106 had the capacity to make medical decisions. Review of Resident 106's Order Summary Report showed the following physician's orders: - dated 1/23/26, to monitor the orthostatic blood pressure every Monday for risperidone medication use; and - dated 1/28/26, to administer risperidone (anti-psychotic medication) 0.5 mg by mouth, two times a day for psychotic behavior as manifested by delusional and disoriented thinking. Review of Resident 106's MAR for January 2026 showed Resident 106's orthostatic blood pressure monitoring dated 1/26/26, the documentation showed lay-134, sit-130 and stand-N/A. The MAR only showed the three digits numbers and did not show the systolic and diastolic blood pressure of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 106 for the lying and sitting positions. In addition, there was no monitoring of Resident 106's orthostatic blood pressure in the standing position. Review of Resident 106's MAR for February 2026 showed Resident 106's orthostatic blood pressure monitoring dated 2/2/26, the documentation showed lay-132, sit-128 and stand-N/A. The MAR only showed the three digit numbers and did not show the systolic and diastolic blood pressure of Resident 106 for the lying and sitting positions. In addition, there was no monitoring of Resident 106's orthostatic blood pressure in the standing position. On 2/5/26 at 1614 hours, an interview and medical record review for Resident 106 was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the reading for orthostatic hypotension should have a systolic blood pressure and diastolic blood pressure reading to monitor the side effect of the medication where the blood pressure causes dizziness, fainting and potential fall. 5. Review of the facility's P&P titled Chemical Restraints and Psychotropic Medication Management revised 4/2025 showed the psychotropic medications shall not be administered for the purpose of discipline or convenience. They are to be administered only when required to treat the resident's medical symptoms and will be considered only after nonpharmacological interventions have been attempted and failed. The attending physician will review the resident's treatment plan to re-evaluate the use of psychotropic medication. Medical record review for Resident 5 was initiated on 1/28/26. Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 5's MDS - Significant Change of Status assessment dated [DATE], showed Resident 5 had a BIMS score of 13 (meaning cognitively intact). Review of Resident 5's Order Summary Report showed a physician's orders dated 1/30/26, to administer fluoxetine 20 mg one time a day for depression as manifested by verbalization of sadness. Further review of Resident 5's medical record failed to show what non-pharmacological intervention would be attempted when Resident 5 had episodes of depression as manifested by verbalization of sadness related to the use of fluoxetine medication. On 2/5/26 at 1100 hours, an interview and concurrent medical record review for Resident 5 was conducted with LVN 1. LVN 1 verified there was no documentation related to what nonpharmacological interventions would be attempted when Resident 5 had episodes of depression as manifested by verbalization of sadness related to the use of fluoxetine medication. On 2/9/26 at 1341 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 6. 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 own medical needs known. Review of Resident 27's Order Summary Report showed the following physician's orders: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 12/17/25, for alprazolam oral tablet 0.5 mg by mouth as needed for anxiety for 14 days at bedtime, to monitor episodes of anxiety as evidenced by restlessness, reparative/frequent movements, and verbalization of anxiety for alprazolam use and for non-pharmacological interventions such as back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks/fluid/milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities, and provide reassurance for alprazolam use; and - dated 12/25/25, for alprazolam oral tablet 0.5 mg by mouth every 12 hours as needed for anxiety as manifested by inability to relax for 14 days. a. Review of Resident 27's MAR for December 2025, showed Resident 27 received alprazolam 0.5 mg on the following dates and times: - dated 12/19 at 0353 hours; - dated 12/21 at 0030 hours; - dated 12/22 at 2013 hours; - dated 12/23 at 2054 hours; - dated 12/24 at 2041 hours; - dated 12/25 at 1523 hours; and - dated 12/26/25 at 0300 hours. Review of Resident 27's medical record failed to show documentation of any non-pharmacological intervention provided to Resident 27 prior to the administration of the alprazolam medication on 12/19, 12/21, 12/22, 12/23, 12/24, 12/25, and 12/26/25. In addition, there was no documentation if Resident 27 had any episodes of anxiety as evidenced by restlessness, reparative/frequent movements, and verbalization of when the alprazolam medication was administered to Resident 27 except on 12/25/25. b. Review of Resident 27's MAR for January 2026, showed Resident 27 received alprazolam 0.5 mg on the following dates and times: - dated 1/2/26 at 2001 hours; - dated 1/5/26 at 2000 hours; - dated 1/8/26 at 2049 hours; - dated 1/9/26 at 1850 hours; and - dated 1/10/26 at 0653. Review of Resident 27's medical records failed to show documentation of any non-pharmacological intervention provided to Resident 27 prior to the administration of the alprazolam medication on 1/2, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/5, 1/8, 1/9, and 1/10/26. In addition, there was no documentation if Resident 27 had any episodes of anxiety as evidenced by restlessness, reparative/frequent movements, and verbalization of anxiety when the alprazolam medication was administered to Resident 27 except on 1/2/26. 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 the non-pharmacological interventions such as massage, providing quiet and calm environment, music, and speaking to the resident in a calm and caring manner to assist in verbalizing concerns should also be used when the resident was experiencing unusual behavior like anxiety. LVN 7 stated the non-pharmacological interventions should be provided prior to the administration of any psychotropic 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 behavior symptoms, this could assist the physician in evaluating whether to continue, discontinue or adjust the dosage and frequency of the medication. LVN 7 further stated the episodes of the manifested behavior should be documented to justify the administration of the medication to the resident. 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were in good condition. * The facility failed to ensure the kitchenware, kitchen utensils, and one heavy-duty blender used for puree preparation were clean and free of food particles or residue. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the hot food and cold beverage were maintained within the acceptable temperature range during tray line. These failures had the potential for cross contamination and foodborne illnesses for the residents consuming the food prepared in the facility's kitchen.Findings: Review of the facility's Diet Type Report dated 1/29/26, showed 95 of 99 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Plastic ware, China, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 1/28/26 at 0832 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the DSS. The following was observed and verified by the DSS: - One stainless steel slotted scoop with black handle discolored and partially melted. - Three stainless steel scoop with green handles peeling and discolored. - One stainless steel scoop with blue handle discolored and partially cracked. - One stainless steel whisk with purplish-gray rubber handle was observed deformed and broken. - Three rubber spatulas with red handles were chipped, cracked at the edges, and discolored. The DSS acknowledged the above findings and stated old and worn-out kitchen utensils should have been discarded and replaced for infection control purposes. 2. Review of the facility's P&P titled Sanitation dated 2023, showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 1/28/26 at 0832 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the DSS. The following was observed and verified by the DSS: - One cutting knife with black handle had dry, crusted residue on the blade. - Two stainless steel scoops with white handles had dry, crusted residue and watermarks. - One stainless steel scoop with green handle had dry, crusted residue. - One stainless steel scoop with black handle had dry, crusted residue. - One stainless steel scoop with blue handle had dry, crusted residue. - One stainless steel scoop with purple handle had dry, crusted residue. - One stainless steel scoop with yellow handle had dry, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	crusted residue. - One stainless steel scoop with dark gray handle had dry, crusted residue and watermarks. - One stainless steel scoop with red handle had dry, white paper residue. - Three stainless steel spatula with white handles were observed dirty with dry, crusted residue and had watermarks. - Two stainless steel spatula with wooden handles were observed dirty with dry, crusted residue and had watermarks. - Three stainless steel tongs had dry, crusted residue and watermarks. - Three stainless steel measuring cups had dry, crusted residue and watermarks. - One stainless steel black peeler was observed dirty and had dry residue. - Two stainless steel spoons were observed fuzzy, had cloudy film and watermarks. - One stainless steel ladle was observed fuzzy, had cloudy film and watermarks. - Four stainless steel measuring spoons had dry, crusted residue and watermarks. - One heavy-duty blender used for puree preparation stored under the countertop shelf was observed dirty and had dry, crusted food residue inside. The DSS acknowledged the above findings and stated all the dirty and crusted kitchenware should have been washed thoroughly for infection control purposes. 3. Review of the facility's P&P titled Sanitation dated 2023 showed, separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 1/28/26 at 0832 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the DSS. Two white cutting boards were observed fuzzy, heavily marred and had deep groves. The DSS verified the findings and stated the cutting boards were changed every month to other month when food gets stuck on them and couldn't be properly cleaned. The DSS acknowledged the cutting boards should have been replaced. 4. Review of the facility's P&P titled Meal Service dated 2023 showed the food will be served on tray line at the recommended temperatures indicated below and recorded on the daily therapeutic menu. Hot food serving temperature must be at or above minimum holding temperature of 140 degrees. The temperature of the foods should be periodically monitored throughout the meal service to ensure proper hot or cold holding temperatures. Further review of the facility's P&P showed the service temperature for milk or juice was 41 degrees or less, the service temperature for meat, casseroles, potatoes, rice, pastas, beans, vegetables, gravies, and sauces was 160 degrees to 180 degrees. Cold food items will be placed on the trays as close to serving time as possible to assure the temperature is below 41 degrees Fahrenheit. The recommended temperature at the delivery to the resident for milk/cold beverages showed less than or equal to 45 degrees. On 2/5/26 at 1148 hours, during the tray line observation, a concurrent observation and interview was conducted with the DSS. The DSS checked and verified the following temperatures: - regular chicken enchiladas - 147.9 degrees Fahrenheit; - regular refried beans - 136 degrees Fahrenheit; - regular rice - 155 degrees Fahrenheit; - regular fish - 132.9 degrees Fahrenheit; - regular chicken breast - 105.7 degrees Fahrenheit; - regular string beans - 147.7 degrees Fahrenheit; - regular broccoli - 123.8 degrees Fahrenheit; - puree chicken enchiladas - 134.7 degrees Fahrenheit; - pureed refried beans - 131 degrees Fahrenheit; - pureed green peas - 130.2 degrees Fahrenheit; - minced and moist chicken enchiladas - 122.7 degrees Fahrenheit; - minced and moist broccoli - 129 degrees Fahrenheit; - minced and moist green peas - 121.6 degrees Fahrenheit; - milk - 38.6 degrees Fahrenheit; - orange juice - 44.3 degrees Fahrenheit; The DSS and RD acknowledged the above findings. The DSS stated the food should have been reheated.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the informed consent was obtained for the use of psychotropic medications for three of five final sampled residents (Residents 4, 5, and 27) reviewed for unnecessary medications. * The facility failed to ensure the informed consent for Seroquel (antipsychotic medication) contained the frequency and route for Resident 4. * The facility failed to ensure the informed consent for alprazolam (antianxiety medication) contained the correct dosage, frequency, and duration for Resident 27. * The facility failed to ensure the informed consent for Xanax (antianxiety medication) was renewed after six months for Resident 5. These failures had the potential for the resident to be unaware of the risks associated with the use of psychotropic medications which could negatively affect the resident's well-being.Findings: Review of the facility's P&P titled Chemical Restraints and Psychotropic Medication Management revised 4/2025 showed an informed consent was obtained prior to medication use. Upon change of condition or initiation of a new order for psychoactive medications, the facility will obtain consent prior to the initiation of the new medication or if the dosage of an existing psychoactive medication increases. 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 a physician's order dated 12/12/25, for Seroquel oral tablet 25 mg by mouth in the evening for psychomotor restlessness. Review of Resident 4's MAR for December 2025 showed Resident 4 received the Seroquel medication from 12/12 to 12/29/25 at 1700 hours. Review of Resident 4's Consent for Treatment: Use of Anti-Psychotic Medication dated 12/12/25, showed an informed consent for the Seroquel for 25 mg and the reason for treatment was for psychomotor restlessness. However, the informed consent did not contain or specify the frequency and route of the administration for the Seroquel medication. 2. 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 own medical needs known. Review of Resident 27's Order Summary Report showed the following physician's orders: - dated 12/17/25, for alprazolam oral tablet 0.5 mg by mouth as needed for anxiety for 14 days at bedtime; and - dated 12/25/25, for alprazolam oral tablet 0.5 mg by mouth every 12 hours as needed for anxiety as (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manifested by inability to relax for 14 days. Review of Resident 27's MAR for December 2025, showed Resident 27 received alprazolam 0.5 mg medication on the following dates and times: - dated 12/19 at 0353 hours; - dated 12/21 at 0030 hours; - dated 12/22 at 2013 hours; - dated 12/23 at 2054 hours; - dated 12/24 at 2041 hours; - dated 12/25 at 1523 hours; and - dated 12/26/25 at 0300 hours. Review of Resident 27's Consent for Treatment: Use of Anti-Psychotic Medication dated 12/17/25, showed an informed consent for the medication alprazolam 0.25 mg by mouth at bedtime as needed for anxiety, restlessness, vocalization. However, the informed consent did not contain the duration for the medication. Review of Resident 27's Consent for Treatment: Use of Anti-Psychotic Medication dated 12/25/25, showed an informed consent for the medication Xanax (alprazolam) 0.5 BID as needed for anxiety as manifested by inability to relax. However, the informed consent did not contain the duration of the medication. On 2/6/26 at 1440 hours, an interview and concurrent medical record review for Residents 4 and 27 was conducted with LVN 2. LVN 2 stated prior to the administration of psychotropic medications, an informed consent should be obtained from the resident or responsible party. LVN 2 stated the informed consent should show or contain the correct medication, dosage, frequency, route, duration and reason for treatment. LVN 2 verified the following: - the informed consent for the Seroquel medication dated 12/12/25 for Resident 4 did not show the frequency and route of administration for the medication; - the informed consent for the alprazolam medication dated 12/17/25 for Resident 27 showed the wrong dosage of 0.25 mg instead of the 0.5 mg. In addition, it did not show the duration of the medication; and - the informed consent for the alprazolam medication dated 12/25/25 for Resident 27 did not show the correct unit for the dosage and frequency, and duration of the medication. On 2/9/26 at 1139 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified and acknowledged the findings for Residents 4 and 27. 3. Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Form dated 2/3/26, showed facilities must renew the Informed Consent form every six months during which the resident receives a psychotherapeutic drug. Within six months after the Consent Form is signed, and every six months thereafter during which the resident receives a psychotherapeutic drug, the facility shall, using the Informed Consent form, inform the resident and, if applicable, the resident's representative, of any recommended dosage adjustments and the resident's right to revoke consent and to receive gradual dose reductions and behavioral interventions in an effort to discontinue the psychotherapeutic drug. Medical record review for Resident 5 was initiated on 1/28/26. Resident 5 was readmitted to the facility on [DATE]. Review of the MDS, Significant Change of Status assessment dated [DATE], showed Resident 5 had a BIMS score of 13 (meaning cognitively intact) Review of Resident 5's Order Summary Report dated 2/5/26, showed the following physician's orders: - dated 9/9/24, to administer Xanax (medication to treat anxiety disorders) 1 mg by mouth two times a day, and - dated 9/27/23, informed consent obtained by MD from the responsible party for anti-anxiety use (Xanax). On 2/5/26 at 1100 hours, an interview and concurrent medical record review for Resident 5 was conducted with LVN 1. LVN 1 verified the most recent informed consent for Resident 5's Xanax medication was obtained on 2/2/25. On 2/9/26 at 0949 hours, an interview and concurrent medical record review for Resident 5 was conducted with the DON. The DON verified the informed consents for Xanax medications was not renewed. The DON stated the prescribing physician would call the family or resident representative to obtain the consent for psychotropic medication. The DON stated the nursing staff would fill out the Informed Consent form. The DON acknowledged the informed consents should be renewed every six months. On 2/9/26 at 1341 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and facility P&P review, the facility failed to provide a homelike environment for one of 22 final sampled residents (Resident 35). * The facility failed to ensure the sound coming from the room air conditioning unit was at an acceptable level for Resident 35. This failure posed the risk for Resident 35 to not have a comfortable place to rest and sleep.Findings: Review of the facility's P&P titled Resident Rights: Accommodation of Needs and Preferences and Homelike Environment Policy (undated) showed the resident's environment will be maintained in a homelike manner to ensure appropriate housekeeping, clean linens in good repair, private closet space for each resident, adequate and comfortable lighting, comfortable and safe temperatures, and comfortable sound levels. On 1/29/26 at 0910 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 35 in the resident's room. Resident 35 was observed awake and sitting on the bed. A loud vibrating noise was observed in the room. Resident 35 stated the loud noise was coming from the air conditioner. Resident 35 stated the Maintenance Director came twice last month to check the air conditioner. Resident 35 stated the noise from the air conditioner was worse when she turned on the heater and in addition, it took a long time for the heat to come out. Resident 35 stated when the temperature reached 80 degrees Fahrenheit, the noise level would go down but then the noise level would become loud again when the temperature would go down below the temperature she set. Resident 35 stated she used the heater especially at night because it was cold. Resident 35 stated the loud noise was distracting her sleep pattern. Resident 35 stated she would be awakened when the loud noise would start again in the middle of the night and caused her to have a hard time going back to sleep. Resident 35 stated the nurses knew about it and even asked her how she could sleep with the loud noise. Resident 35 stated the Maintenance Director told her nothing could be done about the noise but to replace the air conditioner with a new one since it was old. Resident 35 stated the Maintenance Director told her he had to get approval from the management to get a new air conditioner. Resident 35 further stated her last conversation with the Maintenance Director was a month ago and he did not come back to give her an update. Resident 35 stated she was still waiting for the facility to replace her air conditioner with the new one. Medical record review for Resident 35 was initiated on 1/29/26. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 11/27/25, showed Resident 35 had the capacity to understand and make decisions. Review of Resident 35's MDS assessment dated [DATE], showed Resident 35 was cognitively intact. On 1/30/26 at 1510 hours, a follow-up observation and concurrent interview was conducted with Resident 35. The air conditioner was observed to have a loud vibrating noise again. Resident 35 stated she turned on the heater, that was why. On 1/30/26 at 1520 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 was asked to enter Resident 35's room. LVN 2 verified the air conditioner in Resident 35's room was making a loud vibrating noise. LVN 2 stated having the loud noise was not a homelike environment. LVN 2 stated she would inform the maintenance department when she observed any appliance in the resident's room not functioning well. The SA asked LVN 2 to call the Maintenance Director. On 1/30/26 at 1548 hours, an interview was conducted with Resident 35 and the Administrator. The Administrator stated the Maintenance Director was not available. Resident 35 informed the Administrator regarding her communication with the Maintenance Director a month ago about the air conditioner noise which needed to be replaced. Resident 35 stated the Maintenance Director told her the air conditioner needed to be replaced and he would inform the manager to get an approval. Resident 35 stated she had not heard anything about the update. Resident 35 stated the noise was distracting her sleep. The Administrator stated for any equipment or appliance which needed to be replaced, the Maintenance Director would inform him, after he gave the approval, the Maintenance Director would order it. The (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated a new air conditioner was ordered and the Maintenance Director had the order slip. On 2/6/26 at 1544 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director stated he was familiar with Resident 35. The Maintenance Director stated Resident 35 was very alert and oriented. Review of the facility document titled Maintenance Repair Log showed on 12/16/25, Resident 35's room had an issue for the heater not working. The column Maintenance Aware showed the heater was fully functional and the column for the Date Resolved showed 12/17/25. The Maintenance Director stated it was the heater function of the air conditioner because Resident 35 complained the temperature was not going up. The Maintenance Director stated he was aware of the noise when the heater was being used. The Maintenance Director verified he told Resident 35 there was nothing he could do about the noise because the air conditioner was old and it needed to be replaced with a new one. The Maintenance Director stated he reported directly to the Administrator so any equipment or appliance which needed replacement would be approved by the Administrator and once approved, he would place the order. The Maintenance Director stated he could not recall if he reported a new air conditioner would be needed in Resident 35's room to the Administrator in December 2025. Review of the HD Supply order confirmation #W235161936 showed the air conditioner was ordered electronically on 1/30/26. The Maintenance Director verified the air conditioner was just ordered on 1/30/26. The Maintenance Director stated Resident 35 did not complain about the air conditioner noise until the surveyors came to the facility. The Maintenance Director acknowledged the facility should provide the residents a homelike environment which included free of any noise. On 2/6/26 at 1600 hours, an interview was conducted with Resident 35 and LVN 7. Resident 35 reminded LVN 7 about the incident when LVN 7 observed the loud noise from the air conditioner last December 2025 and when LVN 7 told Resident 35 she would inform the maintenance department about the noise. LVN 7 stated she could not recall when it was. On 2/9/26 at 1005 hours, an interview was conducted with the Administrator. The Administrator stated the Maintenance Director did not report to him about Resident 35's air conditioner making a loud noise and needed to be replaced. The Administrator stated if he had known about it, the air conditioner would have been replaced immediately. The Administrator stated if the appliance was not functioning well, the facility did not need to wait for the resident to complain before replacing any appliance. The Administrator further stated the facility aimed to always accommodate the needs of all the residents and to provide a safe and homelike environment. 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 35.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the level 1 PASRR Screening was conducted after a hospital exemption lapsed for one of one resident (Resident 12) reviewed for PASRR. * The facility failed to resubmit a new Level 1 PASRR Screening when Resident 12 had remained in the facility longer than 30 days as recommended in Level 1 PASRR Screening dated 4/30/25. This failure posed the risk for Resident 12 to not receive the necessary mental health evaluation and had the potential for the facility to not incorporate the recommendations from the determination and evaluation report into Resident 12's assessment, care planning, and transition of care.Findings: Medical record review for Resident 12 was initiated on 1/28/26. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 12's MDS assessment dated [DATE], showed Resident 12 had a diagnosis of psychotic disorder. On 2/2/26 at 1144 hours, an interview and concurrent medical record review was conducted with RN 4. Review of Resident 12's Level 1 PASRR Screening dated 4/30/25, showed Resident 12 had been prescribed the psychotropic medications for a serious mental illness. However, Resident 12's Level 1 Screening was negative, and a Level II mental health evaluation referral was not required due to an exempted hospital discharge. Resident 12's Level 1 PASRR Screening dated 4/30/25, further showed if Resident 12 remained in the facility longer than 30 days, the facility should resubmit a new Level 1 PASRR Screening on the 31st day. RN 4 reviewed Resident 12's PASRR submissions and verified the facility failed to resubmit a new Level 1 PASRR Screening on the 31st day (post admission to the facility). RN 4 stated the facility should have resubmitted a new Level 1 PASRR Screening on the 31st day to determine if a Level II mental health evaluation was necessary to ensure an accurate plan of care for Resident 12 was developed specific to mental health services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 develop and implement the comprehensive person-centered care plan for two of 22 final sampled residents (Resident 24 and 53). * The facility failed to develop a comprehensive person-centered care plan for the use of a wander guard for Residents 24. * The facility failed to implement the bilateral floor mats in accordance with Resident 53's risk for falls care plan. These failures posed the risk of not providing the appropriate, consistent, and individualized care to the residents.Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 4/2025 showed it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The facility IDT will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and resident's goals and desired outcomes, preferences for future discharge and discharge plan. 1. Medical record review for Resident 24 was initiated on 1/28/26. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's H&P examination dated 2/1/26, showed Resident 24 cannot make her own medical decision. Review of Resident 24's Phone order showed a physician's order dated 1/23/26, for wander guard on right wrist to prevent the resident from wandering outside unattended due to poor safety awareness secondary to dementia. Review of Resident 24's plan of care failed to show a person-centered care plan was developed to address Resident 24's use of the wander guard. On 1/28/26 at 0920 hours, during the initial tour of the facility, Resident 24 was observed lying in bed with wander guard on the right wrist. When asked about the wander guard on the right wrist, Resident 24 just looked at the wander guard. On 2/5/26 at 1039 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified there was no person-centered care plan for Resident 24's wander guard use. LVN 1 stated Resident 24's care plan should have been initiated by the licensed nurse. On 2/9/26 at 1018 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated that the licenses nurse should have initiated a plan of care for Resident 24's use of wander guard to make sure the license nurses would follow the intervention outlined on the specific care needs, preferences and goals for the use of the wander guard for Resident 24. The DON verified there was no person-centered care plan to address Resident 24 use of wander guard. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/9/26 at 1341 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 53 was initiated on 1/28/26. Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 53's Care Plan Report showed a care plan initiated on 8/21/25, indicated Resident 53 would be free of falls through the care plan review date on 2/14/26. The interventions included the floor mats at the bedside initiated on 10/25/25. On 1/28/26 at 1006 hours, an observation was conducted of Resident 53. Resident 53 was observed lying in her bed. Resident 53's bed was observed with only one floor mat in place adjacent to Resident 53's bed. The opposite side of Resident 53's bed did not have a floor mat in place. On 1/28/26 at 1057 hours, an observation and interview was conducted with CNA 2. CNA 2 stated Resident 53 was a fall risk. Resident 53 was observed lying in her bed. Resident 53's bed was observed with only one floor mat in place adjacent to Resident 53's bed. The opposite side of Resident 53's bed did not have a floor mat in place. CNA 2 verified the findings. CNA 2 stated he thought there was an order for only one floor mat to be in place adjacent to Resident 53's bed. CNA 2 reviewed Resident 53's active physician's orders and verified there was no active order for only one floor mat to be implemented. CNA 2 stated there had been an order in the past to implement only one floor mat. On 1/28/26 at 1249 hours, an observation and concurrent interview was conducted with LVN 6. LVN 6 stated Resident 53 was at risk for falls related to weakness. LVN 6 stated in accordance with Resident 53's active fall care plan with target date of 2/14/26, the floor mats should be placed on both sides of Resident 53's bed. LVN 6 stated the floor mats functioned to mitigate injury in the event Resident 53 would fall from either side of her bed onto the floor.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to ensure the comprehensive 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 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, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure one of one resident (Resident 53) reviewed for accident hazards remained free from accident hazards. * The facility failed to ensure the bilateral floor mats were provided in accordance with Resident 53's risk for fall plan of care.Findings: Medical record review for Resident 53 was initiated on 1/28/26. Resident 53 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 53's Fall Risk Evaluation dated 1/27/26, showed Resident 53 ?s fall risks included intermittent confusion, bedbound status, and incontinence. Review of Resident 53's Care Plan Report showed a care plan initiated on 8/21/25, indicated Resident 53 would be free of falls through the care plan review date on 2/14/26. The interventions initiated on 8/21/25, included a bed and chair alarm to always be in place, to alert staff of Resident 53 attempting unassisted transfers. Further review of the care plan showed an intervention initiated on 10/25/25, for the floor mats at the bedside. The care plan showed these interventions were scheduled to be reviewed on 2/14/26. On 1/28/26 at 1006 hours, an observation was conducted of Resident 53. Resident 53 was observed lying in her bed. Resident 53's bed was observed with only one floor mat in place adjacent to Resident 53's bed. The opposite side of Resident 53's bed did not have a floor mat in place. On 1/28/26 at 1057 hours, an observation and interview was conducted with CNA 2. CNA 2 stated Resident 53 was a fall risk. Resident 53 was observed lying in her bed. Resident 53's bed was observed with only one floor mat in place adjacent to Resident 53's bed. The opposite side of Resident 53's bed did not have a floor mat in place. CNA 2 verified the findings. CNA 2 stated he thought there was an order for only one floor mat to be in place adjacent to Resident 53's bed. CNA 2 reviewed Resident 53's active physician's orders and verified there was no active order for only one floor mat to be implemented. CNA 2 stated there had been an order in the past to implement only one floor mat. On 1/28/26 at 1249 hours, an observation and concurrent interview was conducted with LVN 6. LVN 6 stated Resident 53 was at risk for falls related to weakness. LVN 6 stated in accordance with Resident 53's active fall care plan with target date of 2/14/26, the floor mats should be placed on both sides of Resident 53's bed. LVN 6 stated the floor mats functioned to mitigate injury in the event Resident 53 would fall from either side of her bed onto the floor. Cross reference to F656, example #2.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous access for one of two final sampled residents (Resident 105) reviewed for intravenous care. * The facility failed to ensure the PICC line external catheter and arm circumference measurements were completed and documented in Resident 105's medical record upon admission to the facility. This failure had the potential to delay the identification of catheter related complications for the resident.Findings: Review of the facility's P&P titled Central Venous Access Guidelines and Procedures (undated) showed the purpose of this procedure is to provide guidelines for observation and assessment of residents following insertion of a central vascular access device (thin, flexible tube inserted into a large vein with the tip extending to a major vein near the heart) in order to provide prompt interventions for complications that may develop. Internal catheter length shall be transcribed from the insertion report into the nurse's notes Peripheral and Central Line Treatment Record and IV MAR. Arm circumference shall be monitored and documented on the treatment record. Medical record review for Resident 105 was initiated on 1/28/26. Resident 105 was admitted to the facility on [DATE]. Review of Resident 105's admission H&P examination dated 1/28/26, showed Resident 105 had the capacity to understand and make decisions. Review of Resident 105's Clinical admission assessment dated [DATE], failed to show the information of the measurement and assessment of Resident 105's PICC line upon admission to the facility. Review of Resident 105's plan of care showed a care plan problem dated 1/28/26, addressing the resident's PICC line on the right upper arm with two lumens. The interventions included measuring the arm circumference in inches on admission and measuring the external catheter length in cm from end to hub to insertion site into the skin. Review of Resident 105's Order Summary Report for 2/2026 showed the following physician's orders:- dated 1/26/26, to measure the arm circumference in inches on admission. - dated 1/31/26, to measure the arm circumference in inches every seven days during dressing changes on Saturday and to measure external catheter length in cm every Saturday. However, further review of Resident 105's medical record failed to show documented evidence for the measurements of the length of the PICC line catheter above the insertion site and arm circumference were obtained upon admission. On 2/9/26 at 1100 hours, an interview and concurrent medical record review for Resident 105 was conducted with RN 1. RN 1 verified Resident 105's medical record did not show the PICC line external catheter and arm circumference measurements upon admission to the facility. RN 1 stated there should have been a measurement of the length of the catheter and arm circumference upon admission the resident's to the facility. In addition, RN 1 stated the arm circumference measurement would indicate signs and symptoms of infection, such as swelling and blood clots (semi-solid clumps of blood cells and fibrin that form to stop bleeding). On 2/9/26 at 1207 hours, an interview was conducted with RN 5. RN 5 was informed and verified the above findings. RN 5 stated the PICC line was measured upon admission to provide the baseline for any future complications.

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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 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, - (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. On 2/9/26 at 1116 hours, an interview was conducted with the DON. The DON was informed and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 time she applied the voltaren topical gel to Resident 12 was at noontime. LVN 1 stated the medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure two of 22 final sampled residents (Residents 4 and 27) were free from the unnecessary medications. * The facility failed to ensure Residents 4 and 27 were monitored for the signs and symptoms of bleeding related to the use of apixaban medication (anticoagulant medication, use to treat or prevent blood clots). These failures had the potential for the residents to receive unnecessary medications and delay in detecting significant side effects.Findings: According to DailyMed Drug Label Information for apixaban updated 6/15/21, the section for Warnings and Precautions included Bleeding. The apixaban tablets increases the risk of bleeding and can cause serious, potentially fatal, bleeding. 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 a physician's order dated 11/26/25, to administer apixaban 2.5 mg one tablet by mouth two times a day for DVT (deep vein thrombosis, formation of blood clot) prophylaxis. Review of Resident 4's care plan initiated on 11/28/25, showed a care plan focus problem addressing Resident 4's anticoagulant therapy related to DVT prophylaxis. The interventions included to monitor/document/report to the physician as needed the signs and symptoms of anticoagulant complications: blood tinged or frank blood in the urine, black tarry stools, dark or bright red blood in stools, severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, bleeding, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in the vital signs. Review of Resident 4's MAR for November and December 2025 and January 2026 showed Resident 4 received the apixaban medication on the following dates:- on 11/26 at 1700 hours and 11/27 to 11/30/25 at 0900 hours and 1700 hours; - on 12/1 to 12/31/25 at 0900 hours and 1700 hours; and- on 1/1 to 1/21/26 at 0900 hours and 1700 hours. Further review of Resident 4's medical record did not show documented evidence if Resident 4 was monitored for the signs and symptoms of bleeding related to the use of apixaban medication. 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. A sign showing no bp (blood pressure) on left arm was observed posted on the wall. Resident 27 stated she had a blood clot in her left arm and was taking blood thinner medication. 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 a physician's order dated 12/17/25, to administer apixaban 2.5 mg one tablet by mouth two times a day for atrial flutter (irregular heartbeat). Review of Resident 27's care plan initiated on 1/18/26, showed a care plan focus problem addressing Resident 27's anticoagulant therapy related to atrial flutter. The interventions included to monitor/document/report to the physician as needed the signs and symptoms of anticoagulant complications: blood tinged or frank blood in the urine, black tarry stools, dark or bright red blood in stools, severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, bleeding, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in the vital signs. Review of Resident 27's MAR for December 2025, January and February 2026 showed Resident 27 received the apixaban medication on the following dates:- on 12/18 to 12/31/25 at 0900 hours and 1700 hours; - on 1/1 to 1/31/26 at 0900 hours and 1700 hours; and- on 2/1 to 2/4/26 at 0900 hours and 1700 hours and 2/5/26 at 0900 hours. Further review of Resident 27's medical record did not show documented evidence if Resident 27 was monitored for the signs and symptoms of bleeding related to the use of apixaban medication. On 2/5/26 at 1129 hours, an interview and concurrent medical record review for Residents 4 and 27 was conducted with LVN 6. LVN 6 stated the resident needed to be monitored for the signs and symptoms of bleeding when the resident was taking any (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anticoagulant medication to make sure there were no adverse reactions and if they observed any signs and symptoms of bleeding, the physician could be notified immediately. LVN 6 stated the monitoring for the signs and symptoms of bleeding related to the anticoagulant medication use was documented in the MAR. LVN 6 verified Residents 4 and 27 had been receiving the apixaban medication on the days listed above and both residents were not being monitored for the signs and symptoms of bleeding related to the use of apixaban medication. On 2/9/26 at 1139 hours, an interview and concurrent medical record review for Residents 4 and 27 was conducted with the DON. The DON stated it was important to monitor the residents who were receiving anticoagulant medication for the sign and symptoms of bleeding because the residents had the potential to experience internal bleeding. The DON further stated by monitoring and knowing the signs and symptoms of bleeding, it could alert the nurses, the physician could be notified immediately, and the necessary interventions could be provided immediately. The DON was verified and acknowledged the above findings.

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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 medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 20% * The facility failed to ensure LVN 5 administered the correct dosage of the apixaban (anticoagulant), docusate sodium (stool softener) and sennoside (laxative) medications via GT to Resident 10. The medication cups were observed with significant residue after the medications were administered. * The facility failed to ensure Resident 12 received the voltaren topical gel (topical medication use to relieve pain). * The facility failed to ensure LVN 9 administered the correct dosage of the diclofenac sodium topical medication (medication used to relieve joint pain) for Resident 45. These failures posed the risk for the residents to have potential side effects or complications related to the medications.1. 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 5 mg one tablet; - sennoside 8.6 mg two tablets; and - docusate sodium 100 mg two tablets. 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 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 On 1/29/26 at 1640 hours, during an observation, LVN 5 took medication cups out of Resident 10's overbed table and stated she was done. There was a significant amount of medication residue observed in all the medication cups. LVN 5 verified the above findings. On 2/9/26 at 1107 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. The DON stated the LVN should have ensured there was no residual medications left in the medication cups when administering medications via GT. 2. 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 it was being 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]. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 12's Order Summary Report showed a physician's orders 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 1645, 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. The DON stated the voltaren medication would be delivered before 1800 hours and it could still be administered within the facility's timeframe for medication administration. On 1/30/26 at 1520 hours, an interview and concurrent medical record review for Resident 12 was conducted with LVN 10. LVN 10 verified he was not able to administer the voltaren topical gel to Resident 12 during his shift on 1/29/26 because it was not delivered until late last night. LVN 10 further stated he did not remember what time the medication was delivered. Cross reference to F755, example #4. 3. Review of the Manufacturer's User Guide for the diclofenac sodium topical gel undated under the Measuring the Correct Amount Using the Dosing Card section, showed the following: - remove the dosing card from the inside of the carton. The dosing card should always be used to measure out the correct dose; - for each upper body area (a hand, a wrist, or an elbow): squeeze gel from the tube equal to the length shown on the upper body section of the dosing card (2.25 inches); and - for each lower body area (a hip, a foot, an ankle, or a knee): squeeze gel from the tube equal to the length shown on the lower body section of the dosing card (4.5 inches). On 1/30/26 at 0829 hours, a medication administration observation for Resident 45 was conducted with LVN 9. LVN 9 was observed squeezing the diclofenac sodium topical gel to the medicine cup. 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 9/9/24, to apply diclofenac sodium 1% topical to left hip topically two times a day for left hip pain every 12 hours. Use four grams. On 1/30/26 at 1114 hours, an interview for Resident 45 was conducted with LVN 9. LVN 9 stated the very first time she administered the diclofenac sodium topical gel, she used the measurement tool enclosed in the medication's carton and transferred the amount of the medication to a medicine cup when asked how she determined the correct dosage of the diclofenac sodium topical gel she administered to Resident 45. LVN 9 further stated the four grams filled up to the second line of the medicine cup and since then she would just squeeze the medication directly to the medicine cup. LVN 9 verified the dosing card should always be used to measure the correct amount of the diclofenac sodium medication. 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, medical record review and facility P&P review, the facility failed to ensure proper storage of medications in one of four medications cart inspected (Medication Cart A). * The facility failed to ensure the ondansetron (antiemetic medication) for Resident 63 who was discharged from the facility was removed from Medication Cart A. This failure had the potential for the medication to be accidentally administered and/or diverted. * The facility failed to ensure the amiodarone (antiarrhythmic medication) and ondansetron medications in the bubble packs for Resident 96 were secured/sealed and free from tears or damage. This failure posed the risk of affecting the potency of the medications, and potential for medications to be diverted. * The facility failed to ensure an opened glargine (long-acting insulin) pen for Resident 108 was dated. This failure posed the risk of affecting the potency of the insulin medication.Findings: Review of the facility's P&P titled Medication Storage and Labeling (undated) showed discontinued drug containers shall be marked or otherwise identified, to indicate that the drug has been discontinued, or shall be stored in a separate location which shall be identified solely for this purpose. According to FDA, it requires certain products to have tamper-evident packaging. A bubble pack is one such type of packaging, and the law requires it to be intact and sealed in a way that shows visible evidence if it has been opened or compromised. The seal that holds the plastic bubble to the backing material must be complete and intact all the way around. On 2/2/26 at 1020 hours, an inspection of Medication Cart A, concurrent interview, and medical record review was conducted with LVN 2. The following was observed: a. A box containing ondansetron medications for Resident 63. Review of Resident 63's medical record showed a physician's order dated 2/2/26 (a late entry for 1/31/26), to release body to the mortuary. b. A bubble pack of amiodarone medication for Resident 96 was observed with a tear on one of the individual bubbles where an amiodarone medication was individually stored. c. A bubble pack of ondansetron medication for Resident 96 96 wasserved with a tear on one of the individual bubbles where an ondansetron medication was individually stored. d. An insulin glargine pen for Resident 108 was opened with no open date. Review of the drug label information for insulin glargine-YFGN dated 3/3/25, showed an in-use opened should be used within 28 days. LVN 2 verified the above findings. On 2/2/26 at 1116, an interview was conducted with the DON. The DON was informed and verified the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **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 the menus were followed for two of 22 final sampled residents (Residents 14 and 85) * The lunch meal ticket for Resident 14 was not followed when he was served with only one carton of milk. * The facility failed to follow the weekly food menu on 1/29/26 at noon and ensure food preferences and flavor of a boost glucose control were provided to Resident 85. These failures had the potential for the residents not to receive adequate nutrition. Findings: 1. On 1/29/26 at 1013 hours, an interview was conducted with Resident 14. Resident 14 stated he had a concern about not getting the correct amount of milk every meal. Resident 14 stated he was supposed to get two eight ounces of milk every meal, but he was seldom getting the milk that he should. Resident 14 stated he was frustrated, and he had been in the facility for a long time, and they still cannot work it out. On 1/29/26 at 1234 hours, Resident 14 was observed sitting in bed, with his lunch tray containing one carton of eight ounces of milk. Review of Resident 14's meal ticket showed a standing order of two eight ounces of milk. On 1/29/26 at 1236 hours, an observation for Resident 14 and concurrent interview was conducted with CNA 3 CNA 3 verified Resident 14 received only one carton of eight ounces of milk. CNA 3 stated they verified the meal ticket first before delivering the meal tray to the resident, and if there was anything missing, they could go to the kitchen to get the missing item. On 1/29/26 at 1040 hours, an interview was conducted with the DON. When asked how they ensured the residents received what was on the meal ticket, the DON stated it would start at the tray line where the dietary staff checked the meal tickets, and then upon the delivery of the meal cart, the licensed nurses checked the diet and the food items in the meal trays. The DON further stated after the licensed nurses checked the meal trays, the CNAs could also check what was missing on the list. Findings: 2. Review of the facility's P&P titled Food Preferences, undated, showed resident's food preferences will be adhered to within reason. On 1/29/26 at 1059 hours, during the initial tour of the facility, an interview was conducted with Resident 85. Resident 85 stated the facility provided a slip with their meal tray but never matched what was served to them. Resident 85 stated it was a reoccurring issue. Medical record review for Resident 85 was initiated on 1/29/26. Resident 85 was admitted to the facility on [DATE]. Review of Resident 85's H&P examination dated 12/11/25, showed Resident 85 had the capacity to understand and make decisions. Review of Resident 85's Order Summary Report dated 2/5/26, showed a physician's order dated (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/29/26, for Boost Glucose Control (a nutritional drink designed to help manage blood sugar levels) one time a day every Monday and Friday for supplement. On 1/29/25 at 1246 hours, an observation and concurrent interview was conducted with Resident 85. Resident 85 was eating lunch. Resident 85 stated the meal ticket and the food tray did not match and there were items missing on her tray. Review of Resident 85's meal ticket dated 1/29/26 showed a preference of chopped foods and soup. Additionally, the meal ticket showed 4four fluid ounce juice (orange or apple), eight fluid ounce of water, 1/2 cup orange slices, and six fluid ounces of soup. Review of the Food Menu for 1/29/26, for lunch, showed Salisbury steak/gravy, parslied rice, seasoned peas, bread roll with margarin, peach cobbler, and beverage. On 1/29/26 at 1246, an observation and concurrent interview with Resident 85 did not have the parslied rice, bread roll with margarin, missing gravy per resident, meat was not chopped and chewy for Resident 85. Resident 85 had to dip it in her soup since there was not enough gravy, which made it tough for the meat to go down. On 1/29/26 at 1307 hours, an observation and concurrent interview for Resident 85 was conducted with CNA 3. CNA 3 verified Resident 85's food tray did not have parslied rice, gravy, 1/s cup of orange slices, bread roll with margarin, and the meat was not chopped. CNA 3 stated the meal ticket should match what was on the resident's food tray. CNA 3 stated it is important for the resident to ensure the resident satisfied with her meal along with meeting her nutritional needs. On 1/30/26 at 1457 hours, an interview and concurrent medical record review for Resident 85 was conducted with LVN 11. LVN 11 verified Resident 85 had a physician's order for a CCHO (Consistent, Constant, or Controlled Carbohydrate Diet) fortified diet with a preference of chopped and small portions; LVN 11 also verified Resident 85 had a physician's order for Boost Glucose Control one time a day every Monday and Friday for supplement. When LVN 11 was asked if the meal ticket and food tray should match before being served to the resident, LVN 11 stated it was important for the meal ticket and food tray to match, especially if the resident had preferences. On 2/6/25 at 1021 hours, an observation and concurrent interview was conducted with Resident 85. Resident 85 stated she received her Boost Glucose Control supplement drink; however, she did not drink it because it wasn't her preferred flavor. Resident 85 was asked if she informed anyone of her preferred flavor and she stated mentioning to the RD about her preferred chocolate flavor. On 2/6/26 at 1406 hours, a telephone interview was conducted with the RD. The RD stated updating Resident 85's preferences, such as oranges at lunch time and a Boost drink a couple of times a week. The RD also stated Resident 85 preferred to have her meat chopped and in small portion. The RD verified Resident 85 has made complaints regarding her meals but could only recalled being told Resident 85 was not getting her orange slices. The RD was asked if Resident 85 had a preference in flavor for her Boost Glucose Control drink and the RD stated it would show on the resident's meal ticket if there was a preference in flavor. On 2/6/26 at 1529, an interview and concurrent medical record review was conducted with the DSS. The DSS stated during tray line, the residents' meal tray and meal tickets were checked prior to being sent out to the residents to ensure everything matched. The DSS verified Resident 85 had a (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preference in having her meals chopped and in small portions. A photo was shown to the DSS dated 1/29/26 at 1246 hours, and verified Resident 85's meat was not chopped and not in small portions, also verified the meal tray was missing the parslied rice, roll of bread with margarine, and 1/2 cup of sliced oranges. Review of Resident 85's meal ticket showed 8 fluid ounces of boost glucose control – chocolate. The DSS confirmed the facility had chocolate flavor and stated Resident 85 was served the wrong flavor since they had to change out the flavors for Resident 85. The DSS stated the kitchen needed to pay closer attention to the meal tickets and trays before sending them out to the residents. 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.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, facility document review and facility P&P review, the facility failed to ensure food prepared for the residents was cooked to preserve nutritive value. * The vegetables were cooked more than one hour prior to meal service and held in the steam table with a temperature set on high. This failure had the potential to affect the nutritive content of the food and the amount of food residents consume, potentially resulting in a decrease in residents' food intake leading to poor nutrition and health outcomes.Findings: Review of the professional reference titled https://www.healthline.com/nutrition/cooking-nutrient-content dated 11/7/19, showed in part, the following nutrients are often reduced during cooking: water-soluble vitamins: vitamin C and the B vitamins - thiamine (B1), riboflavin (B2), niacin (B3), pantothenic acid (B5), pyridoxine (B6), folic acid (B9), and cobalamin (B12), fat-soluble vitamins: vitamins A, D, E, and K, and minerals: primarily potassium, magnesium, sodium, and calcium. [NAME] peas contained vitamin C, which is water-soluble and sensitive to heat therefore storing it in the oven at high temperatures for hours likely led to reduced vitamin C content. Review of the facility's P&P titled Preparation of Vegetables (undated) showed cook vegetables in small amount of water for a short amount of time. Review of the facility's P&P titled Food and Nutrition Services date revised 2/2023 showed under intent, to assure that the nutritive value of food is not compromised and destroyed because of prolonged holding on steam table. Food should be palatable, attractive, and at an appetizing temperature as determined by the type of food to ensure resident's satisfaction, while minimizing the risk for scalding and burns. Providing palatable, attractive, and appetizing food and drink to residents can help to encourage residents to increase the amount they eat and drink. Improved nutrition and hydration status can help prevent, or aid in the recovery from illness or injury. In addition, method of storage and preparation should cause minimum loss of nutrients. For example, foods are prepared as directed or not held at hot temperature for hours prior to meal service because prolonged hot temperatures can result in a loss of vitamins. On 1/29/26 at 0958 hours, an interview was conducted with the DSS. The DSS stated puree preparation was already completed by the cook and tray line starts at 1130 hours. The DSS verified the vegetables were prepared more than one hour prior to meal service. On 1/29/26 at 1051 hours, an observation of the steam table and concurrent interview was conducted with the DSS. The steam table had serving pans of Salisbury steak, parslied rice and green peas vegetables covered with foil. The numbers on the steam table dial indicated the temperature was set at high. The DSS acknowledged the findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services for one of one final sampled resident (Resident 13) reviewed for hospice services. * The facility failed to ensure the hospice skilled nurse visit notes were available and included in Resident 13's medical records. This failure posed the risk of delay in communication between the hospice provider and facility which may affect resident care.Findings: Review of the facility's P&P titled End of Life Care; Hospice revised date 11/2007 showed it is the policy of the facility to provide end of life care for dying residents that emphasizes prevention and relief of symptoms as well as compassionate attention to the resident's dignity and preferences. Through continuing interdisciplinary assessment, individualized plans will be developed and implemented to address the residents' physical, intellectual, emotional, social, spiritual, and practical needs. Hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into an overall individualized, interdisciplinary care plan. Medical record review for Resident 13 was initiated on 1/28/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Internal Medicine H&P dated 10/20/25, showed Resident 13 had no capacity to understand and make decisions. Review of Resident 13's Order Summary Report showed a physician's order dated 1/6/25, admitted to hospice with primary diagnosis of senile degeneration of brain on routine level of care. Review of Resident 13's hospice medical records failed to show any skilled nurse hospice progress notes for December 2025 to February 2026. On 2/9/26 at 1154 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 1. RN 1 acknowledged the above findings. On 2/9/26 at 1435 hours, a follow up interview and concurrent medical record review for Resident 13 was conducted with RN 1. RN 1 stated there should be a copy of the hospice progress notes in the chart for staff to be aware of any updates in Resident 13's status to incorporate in the resident's care and a way of communication with the facility. In addition, RN 1 stated medical records should have followed through with hospice.

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	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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure LVN 5 wore a gown when administering medications via GT for Resident 10 who was on EBP. * The facility failed to ensure Resident 24's call light was disinfected prior to use, when it was on the floor. These failures had the potential for cross-contamination and spread of infectious organisms in the facility.Findings: 1. Review of the CMS QSO-24-08-NH dated 3/20/24, for Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of MDROs, showed MDRO transmission is common in long-term care facilities such as nursing homes, contributing to substantial resident morbidity and mortality and increased healthcare costs. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of MDROs that employ targeted gown and glove use during high-contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions dated 10/2022 showed the following: - EBP expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident such as resident with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs; and - examples of high-contact resident care activities requiring gown and glove use for EBP included device care or use: feeding tube. On 1/29/26 at 1610 hours, a medication administration observation for Resident 10 was conducted with LVN 5. An EBP sign was observed posted outside Resident 10's room alerting the providers and staff to wear gloves and a gown for high-contact resident care activities. LVN 5 performed hand hygiene and donned a pair of clean gloves, but did not wear a gown. LVN 5 proceeded to administer medications to Resident 10 via GT. 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 order dated 12/23/25, for EBP: PPE required for high contact care activities. Indication: GT. On 1/29/26 at 1640 hours, an interview was conducted with LVN 5. LVN 5 verified the EBP sign was placed outside Resident 10's room. LVN 5 verified he was only wearing gloves and did not wear a gown while administering medications via GT to Resident 10, which was one of the high-contact activities indicated for EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1/28/26 at 0920 hours, during the initial tour of the facility, Resident 24 was lying in bed and the call light was on the floor. CNA 1 walked inside the room, picked up Resident 24's call light from the floor and gave it to the resident. CNA 1 did not disinfect the call light prior to giving it to the resident. CNA 1 stated the call light should have been disinfected prior to giving it to the resident. CNA 1 verified she did not disinfect the call light prior to giving it to Resident 24. On 2/2/26 at 1101 hours, an interview was conducted with the IP. The IP stated call lights on the floor were considered contaminated and should be disinfected prior to use. The IP stated the call light should have been disinfected before giving it back to Resident 24 to prevent infection. On 2/9/26 at 1341 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to ensure one of one glucometer was maintained in a safe operating condition. * The facility failed to ensure the glucometer calibration was performed correctly. In addition, the facility failed to ensure the glucose strip bottle had an open date and the lot number of the glucose strips was documented in the quality control record. Furthermore, the facility failed to ensure the glucose strips and control solutions had an expiration date of 90 days after opening, as per the manufacturer's information. This failure had the potential for residents requiring glucose checks to have inaccurate readings.Findings: Review of the blood glucose meter manufacturer's information sheet titled Quality Assurance/ Quality Control Reference Manual revised 12/2017 showed the following:- under the Performing a Control Solution Test section, 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, 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, an observation of the glucometer quality control, review of the glucometer quality control record and concurrent interview was conducted with LVN 2. 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 did 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 was not able to perform glucometer calibration. 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 was not able to perform the glucometer calibration correctly. 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 or three months 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 2/9/26 at 1116 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F726 examples #1 and #2.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in two of seven garbage dumpsters. * Two of seven garbage dumpsters were observed with the lids partially propped open by cardboard boxes, preventing the lids from fully closing. This failure had the potential to attract pest/rodents that carried diseases.Findings: Review of the facility's P&P titled Garbage and Trash revised date 5/2023 showed all food waste must be placed in sealed leak-proof, non-absorbent, tightly closed containers (i.e., plastic bags) and shall be disposed of as necessary to prevent a nuisance or unsightliness. Adequate, clean, vermin-proof areas must be provided for storage of garbage and rubbish. Garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean. According to the 2022 FDA Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 1/28/26 at 1015 hours, an observation and concurrent interview was conducted with the Maintenance Director. Two of seven outside garbage dumpsters were observed with the lids partially propped open by cardboard boxes preventing the lids from fully closing. The Maintenance Director verified the findings and stated the dumpster lids should always be closed for rodents prevention and infection control purposes.