STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555259	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mainplace Post Acute	1835 West LA Veta Avenue Orange, CA 92868

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure two of three final sampled residents (Residents 4 and 9) reviewed for accident hazards were free from accident hazards. * Resident 4 had a witnessed fall incident on 10/18/25, resulting in a left hip fracture and hospitalization. The facility failed to ensure appropriate safety measures were implemented during Resident 4's use of the sit-to-stand lift machine, including ensuring proper staff positioning and use of the sling's waist belt. Furthermore, the facility failed to conduct a thorough investigation to determine the cause of Resident 4's fall incident. * The facility failed to implement the use of a floor mattress (floor mat) as a fall risk precaution as ordered by the physician for Resident 9. These failures resulted in Resident 4 sustaining a left hip fracture, hospitalization and surgery, and placed Residents 4 and 9 at increased risk for additional falls and injury.Findings: Review of the facility's P&P titled Fall Management System revised 6/2018 showed the facility would provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurred. The policy stated that when a resident sustained a fall, a physical assessment would be completed and documented in the resident's medical record; an attending physician and resident representative should be notified of the fall and resident's status; and a post-fall risk evaluation would be completed. In addition, review of the fall incident would include an investigation to identify the probable causal factors. Review of the Direct Supply Panacea owner's manual for the Atlas Sit-to-Stand Lift dated 2021 showed under the Safety Warnings & Cautions section, staff were required to check all sling attachments prior to each use to ensure proper connections. Additional safety precautions included a recommendation to use more than one assistant for all resident lift activities. Review of the Direct Supply Panacea owner's manual for Slings Multi-Brand Compatible dated 12/2023 showed under the Instructions for Sit-to-Stand Slings section, staff were to place the sit-to-stand sling around the resident, secure the buckle on the sling's safety belt, and to adjust the belt to fit comfortably but snugly around the resident's waist. The belt must fit snugly on the resident to prevent the resident from sliding out of the sling during a transfer, which could cause injury. Review of the facility's Step-by-Step Guide for the Mechanical Stand-Assist Lift (Sit-to-Stand) (undated) showed the Sit-to-Stand Lift was indicated for residents who could bear partial weight, sit up independently, and follow simple commands. Instructions for sling placement included to place the sling around the resident's mid-back and to secure the waist belt snugly to prevent the sling from riding up. In addition, the safety checklist for skilled nursing facility staff included a two-person requirement for the use of mechanical lifts to ensure resident safety and proper positioning. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Mainplace Post Acute	1835 West LA Veta Avenue Orange, CA 92868

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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 0689 Level of Harm - Actual harm Residents Affected - Few	1. On 3/4/26 at 1315 hours, during the initial tour of the facility, an interview was conducted with Resident 4. Resident 4 stated she had a fall in the facility resulting in a left hip fracture. Resident 4 stated she fell while she was using a sit-to-stand lift to transfer from a shower chair to a wheelchair with the assistance of a CNA . Medical record review for Resident 4 was initiated on 3/4/26. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including a closed fracture of the head and neck of the left femur, history of falling, major depressive disorder, osteoporosis (chronic disease that weakens bones, making them fragile and highly susceptible to fractures, even from minor falls or daily activities), and generalized muscle weakness. Review of Resident 4's MDS (Minimum Data Set) assessment dated [DATE], showed Resident 4 was dependent on staff for chair-to-chair transfers. Further review of the MDS showed to code the resident as dependent, when the resident did not provide any effort to complete the activity or the assistance of two or more helpers were required for the resident to complete the activity. Review of Resident 4's N Adv – Fall Risk Evaluation dated 8/21/25, showed a score of 12, indicating a high fall risk. Review of Resident 4's eINTERACT Change in Condition Evaluation – V 5.1 dated 10/18/25, showed Resident 4 had a fall incident. The clinician was notified and instructed the staff to contact 911 and perform a neurological assessment per facility protocol. Review of Resident 4's Nursing Progress Notes dated 10/18/25, showed the following: - at 1500 hours, a CNA (Certified Nursing Assistant) notified LVN 9 (Licensed Vocational Nurse) Resident 4 fell on the floor. Resident 4 reported she was being transferred to a shower chair and slipped down to the floor. The clinician was notified and ordered a transfer to an acute care hospital for further evaluation; and - at 1553 hours, RN 2 (Registered Nurse) entered Resident 4's room and observed Resident 4 seated on the floor and leaning against the bathroom door. Resident 4 was crying and with pain rated 8/10 (on the pain scale of 0 to 10 with 0 = no pain and 10 = worst) from her hip and bilateral legs. CNAs were transferring Resident 4 from a wheelchair to a shower chair using a sit-to-stand lift machine and it was reported Resident 4 accidentally slipped from the shower chair and landed on the floor. a. Review of Resident 4's Incident Report dated 10/18/25, showed the following: - an interview was conducted with CNA 6. CNA 6 stated Resident 4 was using the sit-to-stand lift machine prior to the fall incident and Resident 4 let go of the handlebars of the sit-to-stand lift machine which led to her fall; - a written statement from CNA 6 stating CNAs 6 and 7 were transferring Resident 4 from a shower chair to a wheelchair by using the sit-to-stand lift machine. When the patient was being transferred, Resident 4 accidentally slipped from the sling when Resident 4 let go of the lift's handlebars; - a written statement from CNA 7 stating CNA 7 was helping CNA 6 transfer Resident 4 from a shower chair to a wheelchair, when Resident 4 accidentally slipped her hands outside of the sling, slipped, and fell. CNA 7 stated she went to get LVN 9 to assist Resident 4; and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- a written statement from LVN 9 stating a CNA reported to her Resident 4 was on the floor. LVN 9 found Resident 4 sitting on the floor and was unable to move her bilateral lower extremities due to severe pain. Review of Resident 4's Acute Care Hospital Record dated 10/23/25, showed Resident 4 fell onto her hips, which caused increased pain. Resident 4 remained on the floor until the paramedics transported her to the acute care hospital. The Left Hip X-Ray showed an impacted left subcapital femoral neck fracture (a fracture just below the femoral head (subcapital) where broken ends are wedged together, keeping the fracture relatively stable). Resident 4 had a left hip hemiarthroplasty (a surgical procedure that replaces half of a damaged hip joint) on 10/19/25. Review of Resident 4's H&P (History and Physicial) examination dated 10/27/25, showed Resident 4 had the capacity to make decisions. On 3/5/26 at 1700 hours, a telephone interview was conducted with CNA 6. CNA 6 stated on 10/18/25, she was transferring Resident 4 from a shower chair to a wheelchair using a sit-to-stand lift machine. CNA 6 further stated Resident 4 fell next to the bathroom door inside Resident 4's room. CNA 6 stated Resident 4 fell because Resident 4 let go of the sit-to-stand lift machine's handlebars before CNA 6 instructed her to let go. CNA 6 stated she was operating the sit-to-stand lift machine, while CNA 7 was positioned behind the shower chair, behind Resident 4. CNA 6 stated neither CNAs 6 nor 7 were holding or supporting Resident 4 when Resident 4 was elevated in the sling. On 3/5/26 at 1717 hours, an interview was conducted with CNA 7. CNA 7 stated she was positioned behind Resident 4's shower chair while CNA 6 placed the sling on Resident 4 prior to using the sit-to-stand lift machine. CNA 7 stated CNA 6 was holding Resident 4 at the side of the sit-to-stand lift machine during the transfer. CNA 7 stated Resident 4 was not wearing the sling's waist belt while being lifted in the sling. CNA 7 further stated if Resident 4 had been properly strapped, the fall could have been prevented. CNA 7 explained the sling was required to be positioned under the resident's armpits and secured around the waist with the belt. On 3/9/26 at 1306 hours, an interview was conducted with CNA 8. CNA 8 stated the residents were not required to wear the sling's waist belt and stated the belt was applied for the residents who could not stand upright. On 3/9/26 at 1330 hours, an interview was conducted with CNA 9. CNA 9 stated the sling's waist belt should be applied every time the sit-to-stand lift was used for safety purposes. CNA 9 demonstrated the use of the sit-to-stand lift machine and stated one staff member operated the machine while a second staff member stood behind the resident to guide them. When asked whether a resident could fall from the sling if they let go of the lift's handlebars, CNA 9 stated a fall would not occur if the waist belt was properly applied. On 3/9/26 at 1402 hours, an interview was conducted with the COTA (Certified Occupational Therapy Assistant). The COTA stated he in-serviced the facility's staff regarding the use of the sit-to-stand lift machine. The COTA further stated two staff members were required when using the lift: one staff member operated the lift, while the second staff member should be positioned behind the resident to guide and support them. The COTA stated the facility's expectation for the use of the sit-to-stand lift machine was to ensure the residents were secured with the sling's waist belt for safety. When asked whether a resident could fall from the sling if they let go of the lift's handlebars, the COTA stated a fall would not occur if the resident was properly secured in the sling. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/11/26 at 1446 hours, an interview was conducted with the DON (Director of Nursing). The DON stated Resident 4 should have been held or supported during the lift transfer by the staff members. On 3/11/26 at 1450 hours, a follow-up interview was conducted with CNA 7. CNA 7 stated neither CNAs 6 nor 7 were holding or supporting Resident 4 while she was elevated in the lift machine. On 3/11/26 at 1511 hours, an observation and concurrent interview was conducted with CNA 7, the COTA and the DON. CNA 7, the COTA and DON demonstrated how to operate the sit-to-stand lift. CNA 7 performed the transfer and one of the surveyors served as the example resident. CNA 7 applied the sling's waist belt to the surveyor, attached the sling to the lift machine, and instructed the surveyor to hold onto the lift's handlebars. During the demonstration, the surveyor was properly strapped into the sling. When the surveyor released her grip from the handlebars, she remained supported in the sling. The COTA stated a resident who was properly secured in the sling would not fall if they let go of the lift's handlebars. The COTA further stated one staff member should operate the lift while a second staff member should always remain behind the resident to provide support and guidance. During the demonstration, CNA 7 clarified that in her earlier statement, she meant Resident 4 was not wearing a gait belt at the time of the lift transfer. The COTA stated a gait belt was not required when using the sit-to-stand lift machine. b. On 3/10/26 at 1155 hours, an interview was conducted with Resident 4. Resident 4 stated she was not wearing the sling's waist belt when she was lifted using the sit-to-stand lift machine. Resident 4 further stated she continued to feel fear when using the sit-to-stand lift machine because she did not want to fall again. Review of Resident 4's eINTERACT Change in Condition Evaluation – V 5.1 dated 11/3/25, showed Resident 4 verbalized feeling depressed due to her left hip fracture, hospitalization, and the fall incident. The clinician was notified and a psychiatric consultation was ordered. Review of Resident 4's Psychiatric Follow-Up Note dated 11/24/25, showed Resident 4 was provided cognitive behavioral therapy to help reduce Resident 4's symptoms of depression and anxiety. c. On 3/9/26 at 1415 hours, a follow-up interview was conducted with CNA 7. CNA 7 stated LVN 9, RNs 1 and 2 conducted Resident 4's fall investigation. CNA 7 stated she informed someone Resident 4 was not wearing the sit-to-stand sling's waist belt but could not recall if it was LVN 9, RNs 1 or 2. CNA 7 confirmed the sling's waist belt was not used during Resident 4's transfer. On 3/10/26 at 1213 hours, an interview was conducted with LVN 9. LVN 9 stated she conducted Resident 4's fall investigation and interviewed CNAs 6, 7 and Resident 4 regarding the events surrounding the fall incident. LVN 9 stated she concluded Resident 4 accidentally fell after letting go of the lift's handlebars. LVN 9 stated she checked the locks of the wheelchair, shower chair, and sit-to-stand lift machine, and verified the sling was attached to the lift properly. LVN 9 stated she was not aware the sling's waist belt was not applied to Resident 4 during the transfer. LVN 9 further stated she was unfamiliar with how to operate the sit-to-stand lift machine and stated two-person assistance was not always required when using the lift machine. On 3/10/26 at 1300 hours, an interview was conducted with RN 1. RN 1 stated she assisted with Resident 4's fall investigation by collecting the written statements from the staff members involved. RN 1 stated that the most important tasks to complete when a resident experiences a fall was to conduct a thorough investigation and complete an assessment of the resident. RN 1 stated she was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	not aware Resident 4 was not wearing the sling's waist belt during the lift transfer. RN 1 stated she asked CNA 6, but did not recall asking CNA 7. RN 1 stated the fall investigation was not thorough and should have included whether Resident 4 had been properly secure in the sling. On 3/11/26 at 1446 hours, an interview was conducted with the DON. The DON stated she was not aware Resident 4 was not wearing the sling's waist belt at the time of the incident. When asked whether she verified if the belt was applied with CNAs 6 or 7, the DON stated she only asked CNA 6. The DON stated both CNAs should have been asked whether either CNA was holding or supporting Resident 4 during the lift transfer. On 3/11/26 at 1450 hours, an interview was conducted with CNA 7. When asked whether Resident 4 was wearing the sling's waist belt, CNA 7 stated in her earlier statement, she meant Resident 4 was not wearing her personal belt. This conflicted with CNA 7's earlier interviews on 3/5/26 at 1717 hours and 3/9/26 at 1415 hours, during which she stated the sling's waist belt had not been applied. CNA 7 verified no one was holding or supporting Resident 4 while she was elevated in the sit-to-stand lift machine. On 3/11/26 at 1511 hours, a demonstration of how to operate the sit-to-stand lift was conducted with CNA 7, the COTA and DON . The COTA was asked what steps he would expect in a fall investigation involving the sit-to-stand lift machine. The COTA stated he would have interviewed all the staff members involved, confirmed the lift machine functioned properly, and verified the sling and belt were applied correctly. The COTA stated he would then investigate additional possible causes, and he would only attribute the cause of the fall to the resident letting go of the handlebars if all the equipment was properly used and safety procedures had been followed. 2. Review of the facility's P&P titled Fall Management System revised 6/2018 showed the facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents. It is the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and minimize complications if a fall occurs. On 3/9/26 at 1007 hours, during an observation, Resident 9 was lying in bed. One floor mattress was observed leaned against the wall. There was no floor mattress on one side of the bed. Medical record review for Resident 9 was initiated on 3/5/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 10/9/25, showed Resident 9 had no capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed a physician's order dated 12/22/25, for floor mattress at bedside for safety. Review of Resident 9's Quarterly MDS assessment dated [DATE], showed Resident 9 had moderate cognitive impairment. Section GG of the MDS showed Resident 9 had an impairment on one side of the upper and lower extremities. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/9/26 at 1016 hours, an observation in Resident 9's room and concurrent interview was conducted with LVN 2. LVN 2 verified one floor mattress was leaned against the wall and not next to the bed. LVN 2 stated floor mattresses were used for safety and fall precautions, and should be in place. On 3/11/26 at 1630 hours, the DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 interview and facility document review, the facility failed to ensure one out of one CNA (CNA 7) demonstrated the competencies and skill sets needed to provide safe nursing care. * The facility failed to ensure CNA 7 had the appropriate competence and skill set required to safely operate the sit-to-stand lift machine. In addition, CNA 7 was unable to differentiate between the types of belts used with the lift and was unable to identify the appropriate sling size for the sit-to-stand lift machine. This failure resulted in Resident 4 experiencing a fall on 10/18/25, from the sit-to-stand lift machine, sustaining a left hip fracture requiring hospitalization for surgery and symptoms of depression following the incident; 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 Direct Supply Panacea specification sheet for Sit-to-Stand Lift Slings dated 2021 showed padded standing slings were available in different sizes, ranging from extra small to large. Extra small and small padded standing slings with red loops were recommended for residents weighing between 50 to 150 lbs (pounds).; medium padded standing slings with yellow loops were recommended for residents weighing between 125 to 200 lbs.; and large padded standing slings with green loops were recommended for residents weighing between 175 to 500 lbs. Review of the facility's document titled CNA Job Description/Physical Demands assessment dated [DATE], showed the following:- assist with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc.;- use only equipment you have been trained on; and- operate all the equipment in a safe manner. Review of the Direct Supply Panacea owner's manual for Slings Multi-Brand Compatible dated 12/2023 showed under the Instructions for Sit-to-Stand Slings section, staff were to place the sit-to-stand sling around the resident, secure the buckle on the sling's safety belt, and to adjust the belt to fit comfortably but snugly around the resident's waist. The belt must fit snugly on the resident's lower back to prevent the resident from sliding out of the sling during a transfer, which could cause injury. Review of the facility's Step-by-Step Guide for the Mechanical Stand-Assist Lift (Sit-to-Stand) (undated) showed the Sit-to-Stand Lift was indicated for residents who could bear partial weight, sit up independently, and follow simple commands. Instructions for sling placement included to place the sling around the resident's mid-back and to secure the waist belt snugly to prevent the sling from riding up. In addition, the safety checklist for skilled nursing facility staff included a two-person requirement for the use of mechanical lifts to ensure resident safety and proper positioning. On 3/4/26 at 1315 hours, during the initial tour of the facility, an interview was conducted with Resident 4. Resident 4 stated she had a fall in the facility resulting in a left hip fracture. Resident 4 stated she fell while she was using a sit-to-stand lift to transfer from a shower chair to a wheelchair with the assistance of a CNA. Medical record review for Resident 4 was initiated on 3/4/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 4 was hospitalized due to a left hip fracture on 10/18/25, and returned to the facility on [DATE]. Review of Resident 4's eINTERACT Change in Condition Evaluation - V 5.1 dated 10/18/25, showed Resident 4 had a fall incident. The clinician was notified and instructed the staff to contact 911 and to perform a neurological (relating to the nervous system, which includes the brain, spinal cord, and nerves) assessment per facility's protocol. Review of Resident 4's Nursing Progress Notes dated 10/18/25 showed the following:- at 1500 hours, a CNA notified LVN 9 Resident 4 fell on the floor. Resident 4 reported she was being transferred to a shower chair and slipped down to the floor. The clinician was notified and ordered a transfer to an acute care hospital for further evaluation; and- at 1553 hours, RN 2 entered Resident 4's room and observed Resident 4 seated on the floor and leaning against the bathroom door. Resident 4 was crying and with pain rated 8/10 (on the pain scale of 0 to 10 with 0 = no pain and 10 = worst) from her hip and bilateral legs. CNAs were transferring Resident 4 from a wheelchair to a shower chair using a sit-to-stand lift (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	machine and it was reported Resident 4 accidentally slipped from the shower chair and landed on the floor. Review of Resident 4's H&P examination dated 10/27/25, showed Resident 4 had the capacity to make decisions. On 3/5/26 at 1700 hours, a telephone interview was conducted with CNA 6. CNA 6 stated on 10/18/25, she was transferring Resident 4 from a shower chair to a wheelchair using a sit-to-stand lift machine. CNA 6 further stated Resident 4 fell next to the bathroom door inside Resident 4's room. CNA 6 stated Resident 4 fell because Resident 4 let go of the sit-to-stand lift machine's handlebars before CNA 6 instructed her to let go. CNA 6 stated she was operating the sit-to-stand lift machine, while CNA 7 was positioned behind the shower chair, behind Resident 4. CNA 6 stated neither CNAs 6 nor 7 were holding or supporting Resident 4 when Resident 4 was elevated in the sling. On 3/5/26 at 1717 hours, an interview was conducted with CNA 7. CNA 7 stated she was positioned behind Resident 4's shower chair while CNA 6 placed the sling on Resident 4 prior to using the sit-to-stand lift machine. CNA 7 stated CNA 6 was holding Resident 4 at the side of the sit-to-stand lift machine during the transfer. CNA 7 stated Resident 4 was not wearing the sling's waist belt while being lifted in the sling. CNA 7 further stated if Resident 4 had been properly strapped, the fall could have been prevented. CNA 7 explained the sling was required to be positioned under the resident's armpits and secured around the waist with the belt. On 3/9/26 at 1402 hours, an interview was conducted with the COTA. The COTA stated he in-serviced the facility's staff regarding the use of the sit-to-stand lift machine. The COTA further stated two staff members were required when using the lift: one staff member operated the lift, while the second staff member was positioned behind the resident to guide and support them. The COTA stated the facility's expectation for the use of the sit-to-stand lift machine was to ensure the residents were secured with the sling's waist belt for safety. When asked whether a resident could fall from the sling if they let go of the lift's handlebars, the COTA stated a fall would not occur if the resident was properly secured in the sling. On 3/11/26 at 1446 hours, an interview was conducted with the DON. The DON stated Resident 4 should have been held or supported during the lift transfer by the staff members. On 3/11/26 at 1450 hours, a follow-up interview was conducted with CNA 7. CNA 7 stated neither CNAs 6 nor 7 were holding or supporting Resident 4 while she was elevated in the lift machine. When asked whether Resident 4 was wearing the sling's waist belt, CNA 7 stated in her earlier statement, she meant Resident 4 was not wearing her personal belt. This conflicted with CNA 7's earlier interview on 3/5/26 at 1717 hours, during which she stated the sling's waist belt had not been applied. On 3/11/26 at 1511 hours, an observation and concurrent interview was conducted with CNA 7, the COTA and DON. CNA 7, the COTA and DON demonstrated how to operate the sit-to-stand lift. CNA 7 performed the transfer and one of the surveyors served as the example resident. CNA 7 applied the sling's waist belt to the surveyor, attached the sling to the lift machine, and instructed the surveyor to hold onto the lift's handlebars. During the demonstration, the surveyor was properly strapped into the sling. When the surveyor released her grip from the handlebars, she remained supported in the sling. The COTA stated a resident who was properly secured in the sling would not fall if they let go of the lift's handlebars. The COTA further stated one staff member should operate the lift while a second staff member should always remain behind the resident to provide support and guidance. During the demonstration, CNA 7 clarified in her earlier statement, she meant Resident 4 was not wearing a gait belt (a crucial safety device, usually 2 to 4 inches wide and made of durable canvas or nylon, worn around a resident's waist to provide caregivers a secure, ergonomic handle for assisting with walking, standing, or transferring) at the time of the lift transfer. These inconsistencies demonstrated CNA 7 could not differentiate between the three belts (personal belt, gait belt, and the sling's waist belt). When asked whether a gait belt was required during sit-to-stand lift machine use, the COTA stated it was not required. CNA 7 stated the slings with yellow loops were size small and medium, while the slings with blue loops were size large and extra-large. CNA 7 stated she was unsure which sling was applied to Resident 4. CNA 7's uncertainty regarding sling sizes further demonstrated a lack of competency in selecting appropriate lift equipment. On 3/11/26 at 1726 hours, an interview and (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	concurrent employee personnel file review for CNA 7 was conducted with the DSD. The following was identified:- Review of CNA 7's Comprehensive Clinical Competency Review - Skills Checklist and Return Demonstration dated 9/8/25, failed to show CNA 7 was competent to use a hydraulic lift and provide accident prevention and safety measures. The DSD stated CNA 7 was assessed in those areas; however, the competency items were not checked off on the document. - Review of the facility's document titled Transfers, Gait, Splints in-service dated 9/18/25, showed a lesson plan's course content included manual transfers with a gait belt and how to utilize a Hoyer lift machines (a mechanical device used to safely transfer individuals with limited mobility). The lesson plan did not include how to operate a sit-to-stand lift machine. The DSD verified the above findings and stated there were no other in-services provided prior to 10/18/25, for the use of the sit-to-stand lift machine. Cross Reference to F689.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services 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 dialysis care and services for three of five final sampled residents (Residents 1, 63, and 135) reviewed for dialysis. * The facility failed to monitor Residents 1 and 63's fluid intake accurately as per the physician's order. In addition, the facility failed to monitor Resident 1 and 63's dialysis access site accurately. * The facility failed to ensure Resident 135's dialysis access site was consistently and accurately assessed as ordered by the physician. These failures had the potential for the residents not being provided with the appropriate care and services, and the possibility of medical complications related to the dialysis access site and fluid overload.Findings: 1. On 3/5/26 at 0913 hours, an observation and concurrent interview was conducted with Resident 63. Resident 63 was observed sitting in bed. An opened bottled water and an opened bottle of soda were observed at the bedside table. Resident 63 stated he drank half of the soda yesterday. Resident 63 also stated he drank the bottled water today, and he had more bottled water inside his closet. On 3/5/26 hours, during an observation, CNA 10 was observed placing a graduated pitcher with 250 ml water on Resident 62's bedside table. Medical record review for Resident 63 was initiated on 3/4/26. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report showed the following physician's orders: - dated 2/26/26, for dialysis treatment on Mondays, Wednesdays and Fridays; - dated 2/26/26, dialysis type: hemodialysis Permacath. Location: right chest wall; and - dated 3/4/26, for a fluid restriction of 1200 ml per day. The nursing department was to provide 240 ml in the day shift, 240 ml in the evening shift, and 120 ml in the NOC shift (a nursing fluid intake total of 600 ml per day), while the dietary department was to provide 240 ml in the day shift, 120 ml in the evening shift, and 240 ml in the NOC shift (a dietary fluid intake total of 600 ml per day). a. Review of Resident 63's Fluid Intake record dated 3/4 to 3/8/26, showed Resident 63 had a fluid intake more than the prescribed dietary fluid intake of 600 ml per day. The record showed the following: - On 3/4/26, Resident 63's total dietary fluid intake was 750 ml; - On 3/5/26, Resident 63's total dietary fluid intake was 1400 ml; - On 3/6/26, Resident 63's total dietary fluid intake was 810 ml; - On 3/7/26, Resident 63's total dietary fluid intake was 1410 ml; and - On 3/8/26, Resident 63's total dietary fluid intake was 800 ml. Review of Resident 63's Intake and Output Record dated 3/4 to 3/8/26, showed Resident 63's (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring of his daily fluid intake was inaccurate and inconsistent. The record showed the following: - On 3/4/26, Resident 63's total fluid intake was 880 ml; - On 3/5/26, Resident 63's total fluid intake was 900 ml; - On 3/6/26, Resident 63's total fluid intake was 850 ml; - On 3/7/26, Resident 63's total fluid intake was 750 ml; and - On 3/8/26, Resident 63's total fluid intake was 650 ml. b. Review of Resident 63's Facility/Dialysis Center Nursing Communication Record showed the licensed nurses inaccurately assessed Resident 63's Permacath. The record dated 3/2/26, under Facility Nurse/ Post-Dialysis section, showed bruit/thrill were present. On 3/6/26 at 1049 hours, an interview was conducted with CNA 10. When asked about Resident 63's fluid restriction, CNA 10 stated Resident 63 wanted to drink his own drinks but they encouraged him not to drink too much fluid. CNA 10 stated Resident 63 was only supposed to drink 240 ml during the 0700 to 1500 hours shift. CNA 10 stated the CNAs documented the resident's fluid intake from the meal trays and water pitcher at bedside, and not including what the nurse gives during the medication pass to the resident. CNA 10 verified there were half consumed bottled water and ¾-consumed bottle of soda at bedside yesterday. CNA 10 stated Resident 63 did not want her to remove the bottles water and the bottle of soda and further stated she did not include those in the resident's fluid intake, because she did not see him take a sip from the bottled water, and the bottle of soda. When asked if she asked Resident 63 if he drank the bottled water and the soda, CNA 10 answered no. On 3/9/26 at 1102 hours, an observation and concurrent interview was conducted with CNA 10. Resident 63 was observed sitting in the wheelchair in the room, and holding an empty pouch of a fruit-flavored drink. An unopened bottle of soda, and non-graduated water pitcher were observed at the bedside table. CNA 10 came to the room and verified the above findings. Resident 63 threw the empty pouch away. On 3/9/26 at 1121 hours, an observation, interview and concurrent medical record review for Resident 63 was conducted with LVN 11. LVN 11 verified an unopened bottle of soda at Resident 63's bedside table. LVN 11 stated Resident 63's fluid restriction at 1200 ml per day, and the nurses documented the fluid intake from the medication pass, and the CNAs documented the resident's fluid intake from the meal trays and the water pitcher at the bedside table. On 3/9/26 at 1129 hours, an interview and concurrent medical record review for Resident 63 was conducted with Unit Manager 1. Unit Manager 1 stated the residents on fluid restrictions should be given a graduated water pitcher, but the resident could refuse to have a graduated pitcher. Unit Manager 1 was informed Resident 63 was given water in a non-graduated pitcher. Unit Manager 1 stated someone told me he refused a graduated pitcher. When asked what she did or documented when Resident 63 refused a graduated water pitcher, Unit Manager 1 stated she overheard it but did not get back to it. Unit Manager 1 stated the CNAs monitor Resident 63's dietary fluid intake from the meal trays and water pitcher, and the nurses monitor Resident 63's nursing fluid intake from the medication pass. Unit Manager 1 reported Resident 63's dietary fluid intake to the charge nurse, and then the charge nurse would document Resident 63's total fluid intake from the dietary and nursing (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	departments in the Intake and Output Record. Unit Manager 1 verified Resident 63 had a fluid intake more than the prescribed dietary fluid intake of 600 ml per day as per the CNAs' documentation. Unit Manager 1 also verified Resident 63's monitoring of his daily fluid intake was inaccurate and inconsistent as per the nurses' documentation in the Intake and Output Record. Unit Manager 1 stated Resident 63 had a Permacath access. Unit Manager 1 verified the licensed nurse inaccurately assessed Resident 63's Permacath when it was documented to have bruit and thrill present. On 3/11/26 at 1210 hours, the DON was informed and acknowledged the findings. 2. On 3/9/26 at 1042 hours, Resident 1 was observed in bed. A non-graduated pitcher of water was observed at bedside. On 3/9/26 at 1044 hours, an observation for Resident 1 and concurrent interview was conducted with CNA 1. Resident 1 was observed in bed with a non-graduated pitcher of water at bedside. Resident 1 was also observed drinking a bottle of cold coffee drink. CNA 1 verified the above findings. CNA 1 stated she was not aware Resident 1 was on fluid restriction, and the nurses did not tell her anything about him or any precautions or fluid restrictions. Medical record review for Resident 1 was initiated on 3/4/26. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed the following physician's orders: - dated 1/28/26, to monitor permacath to right upper chest to ensure site is intact daily; - dated 2/13/26, for a fluid restriction of 1000 ml per day. The nursing department was to provide 240 ml in the day shift, 240 ml in the evening shift, and 160 ml in the NOC shift, while the dietary department was to provide 120 ml in the day shift, 120 ml in the evening shift, and 120 ml in the NOC shift; and - dated 2/25/26, for dialysis every Tuesdays, and Saturdays. a. Review of Resident 1's Fluid Intake record dated 2/13/26 to 3/8/26, showed Resident 1 had a fluid intake more than the prescribed dietary fluid intake of 360 ml per day. The record showed the following: - On 2/13/26, Resident 1's total dietary fluid intake was 1425 ml; - On 2/14/26, Resident 1's total dietary fluid intake was 800 ml; - On 2/15/26, Resident 1's total dietary fluid intake was 1340 ml; - On 2/16/26, Resident 1's total dietary fluid intake was 1060 ml; - On 2/17/26, Resident 1's total dietary fluid intake was 650 ml; - On 2/18/26, Resident 1's total dietary fluid intake was 1000 ml; - On 2/19/26, Resident 1's total dietary fluid intake was 875 ml; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 2/20/26, Resident 1's total dietary fluid intake was 930 ml; - On 2/21/26, Resident 1's total dietary fluid intake was 1000 ml; - On 2/22/26, Resident 1's total dietary fluid intake was 900 ml; - On 2/23/26, Resident 1's total dietary fluid intake was 1500 ml; - On 2/24/26, Resident 1's total dietary fluid intake was 1700 ml; - On 2/25/26, Resident 1's total dietary fluid intake was 1420 ml; - On 2/26/26, Resident 1's total dietary fluid intake was 800 ml; - On 2/27/26, Resident 1's total dietary fluid intake was 1240 ml; - On 2/28/26, Resident 1's total dietary fluid intake was 1140 ml; - On 3/1/26, Resident 1's total dietary fluid intake was 500 ml; - On 3/2/26, Resident 1's total dietary fluid intake was 890 ml; - On 3/3/26, Resident 1's total dietary fluid intake was 500 ml; - On 3/4/26, Resident 1's total dietary fluid intake was 1000 ml; - On 3/5/26, Resident 1's total dietary fluid intake was 700 ml; - On 3/6/26, Resident 1's total dietary fluid intake was 940 ml; - On 3/7/26, Resident 1's total dietary fluid intake was 700 ml; and - On 3/8/26, Resident 1's total dietary fluid intake was 890 ml. b. Review of Resident 1's Intake and Output Record dated 2/13 to 3/10/26, showed Resident 1's monitoring of his total daily fluid intake was inaccurate and inconsistent. The record showed the following: - On 2/13/26, Resident 1's total fluid intake was 150 ml; - On 2/14/26, Resident 1's total fluid intake was 350 ml; - On 2/15/26, Resident 1's total fluid intake was 550 ml; - On 2/16/26, Resident 1's total fluid intake was 500 ml; - On 2/17/26, Resident 1's total fluid intake was 450 ml; - On 2/18/26, Resident 1's total fluid intake was 450 ml; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 2/19/26, Resident 1's total fluid intake was 425 ml; - On 2/20/26, Resident 1's total fluid intake was 350 ml; - On 2/21/26, Resident 1's total fluid intake was 450 ml; - On 2/22/26, Resident 1's total fluid intake was 450 ml; - On 2/23/26, Resident 1's total fluid intake was 525 ml; - On 2/24/26, Resident 1's total fluid intake was 550 ml; - On 2/25/26, Resident 1's total fluid intake was 500 ml; - On 2/26/26, Resident 1's total fluid intake was 425 ml; - On 2/27/26, Resident 1's total fluid intake was 450 ml; - On 2/28/26, Resident 1's total fluid intake was 600 ml; - On 3/1/26, Resident 1's total fluid intake was 450 ml; - On 3/2/26, Resident 1's total fluid intake was 400 ml; - On 3/3/26, Resident 1's total fluid intake was 350 ml; - On 3/4/26, Resident 1's total fluid intake was 300 ml; - On 3/5/26, Resident 1's total fluid intake was 440 ml; - On 3/6/26, Resident 1's total fluid intake was 540 ml; - On 3/7/26, Resident 1's total fluid intake was 520 ml; - On 3/8/26, Resident 1's total fluid intake was 510 ml; and - On 3/9/26, Resident 1's total fluid intake was 480 ml. c. Review of Resident 63's Facility/Dialysis Center Nursing Communication Record showed the licensed nurses inaccurately assessed Resident 63's Permacath. The record showed the following: - On 1/29/26, under Facility Nurse/Post Dialysis section, bruit and thrill were present; - On 2/7/26, under Facility Nurse/Pre-Dialysis and Facility Nurse/Post Dialysis sections, bruit and thrill were present; - On 2/14/26, under Facility Nurse/Pre Dialysis section, bruit and thrill were present; - On 2/28/26, under Facility Nurse/Pre-Dialysis and Facility Nurse/Post Dialysis sections, bruit and (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thrill were present; - On 3/7/26, under Facility Nurse/Post Dialysis section, bruit and thrill were present; and - On 3/10/26, under Facility Nurse/Pre-Dialysis section, bruit and thrill were present. On 3/9/26 at 1147 hours, an interview and concurrent medical record for Resident 63 was conducted with Unit Manager 1. Unit Manager 1 verified the above findings. On 3/11/26 at 1225 hours, the DON was informed and acknowledged the findings. Cross-reference to F656, example #2. 3. Review of the facility's P&P titled Dialysis (Renal), Pre- and Post-Care revised date 4/2025 showed to assess and maintain patency of renal dialysis access; participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. In addition, documentation related to pre- and post-dialysis care will be placed in the clinical record and include assessment of renal dialysis access site, to include presence or absence and quality of a bruit and thrill for residents with an arteriovenous fistula. Medical record review for Resident 135 was initiated on 3/5/26. Resident 135 was admitted to the facility on [DATE]. Resident 135 had a diagnosis of ESRD which required hemodialysis. Review of Resident 135's Order Summary Report showed a physician's order dated 10/7/25, for monitoring the dialysis access site on right upper chest Permacath for signs and symptoms of infection, swelling and bleeding every shift. Review of Resident 135's care plan for hemodialysis treatment dated 10/8/25, showed interventions including to monitor Resident 135's right upper chest Permacath for signs and symptoms of infection, swelling and bleeding every shift. Review of Resident 135's H&P examination dated 10/9/25, showed Resident 135 had the capacity to understand and make decisions. Review of the Dialysis Center Nursing Communication Records for January and February 2026 showed the following: - On 1/21/26, the dialysis access location was documented as the right upper chest and was assessed for bruit and thrill pre and post dialysis; - One Dialysis Center Nursing Communication Record (undated) showed the access site for pre dialysis was left blank but was assessed for bruit and thrill post dialysis; - On 1/26/26, Resident 135's right upper chest permacath site was assessed for bruit and thrill post dialysis; - On 1/30/26, Resident 135's right upper chest permacath site was assessed for bruit and thrill pre dialysis; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 2/4/26, Resident 135's right upper chest permacath site was assessed for bruit and thrill pre and post dialysis; - On 2/11/26, Resident 135's right upper chest permacath site was assessed for bruit and thrill pre and post dialysis; - On 2/20/26, the dialysis access location was documented as the left upper arm when Resident 135's dialysis access was a permacath located on the right upper chest; and - On 2/25/26, Resident 135's right upper chest permacath site was assessed for bruit and thrill post dialysis. Review of the form titled Orange County Vascular Access Center dated 3/3/26, showed a physician's order to start using left arm fistula for dialysis access on 3/4/26. On 3/10/26 at 1616 hours, an interview and concurrent medical record review for Resident 135 was conducted with RN 3. RN 3 stated the licensed nurses were responsible for the documentation on the Dialysis Center Nursing Communication Record. RN 3 acknowledged Resident 135's Permacath was on the right upper chest and not properly documented and assessed on the medical records. RN 3 stated Resident 135's dialysis access should be assessed correctly and documented accurately. On 3/11/26 at 1630 hours, the DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility had a medication error rate of 12% when three medication errors occurred out of 25 opportunities during the medication administration for one of one final sampled resident (Resident 51) and two nonsampled residents (Residents 72 and 156) reviewed for medication administration. * Resident 51 was almost given an outdated zinc sulfate capsule (used for wound healing). * Resident 72's apixaban (blood thinner, used to reduce the risk of blood clot) was not administered during the medication administration because the medication was not available. * Resident 156 dorzolamide ophthalmic solution (used to reduce high pressure inside the eye) was not administered because it was not available. These failures resulted in ordered medications not given and outdated medication almost administered with potential for poor resident outcome.Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed medications are administered in accordance with prescriber's orders . The expiration/beyond use date on the medication label is checked prior to administering. 1. On [DATE] at 0808 hours, a medication administration observation for Resident 51 and concurrent interview was conducted with LVN 1 in front of Resident 51's room. LVN 1 was preparing Resident 51's medications scheduled for 0900 hours. LVN 1 added the medications into a medication cup, sanitized his hands and put on gloves. LVN 1 then picked up the medication cup with medications, knocked on the door of Resident 51's room and entered. LVN 1 was then asked to step out of the room. LVN 1 stated he checked the medications to be given on the MAR, checked the medication's name, expiration date, route to be given and time to be given prior to pulling the medications. LVN 1 was asked about the expiration date of the zinc sulfate capsules medication. LVN 1 rechecked the container and confirmed the zinc sulfate capsule medication had an expiration date of 1/2026. LVN 1 stated expired medication will not be effective and may have adverse effects. 2. On [DATE] at 0844 hours, a medication administration observation for Resident 72 was conducted with LVN 2. LVN 2 prepared and administered several medications to Resident 72. Medical record review for Resident 72 was initiated on [DATE]. Resident 72 was readmitted to the facility on [DATE]. Review of Resident 72's Order Summary Report showed an order dated [DATE], for apixaban oral tablet 5 mg, to give 5 mg by mouth every 12 hours for paroxysmal atrial fibrillation (an irregular, rapid heart rhythm that start and stop suddenly) to be given at 0900 and 2100 hours. The apixaban medication was not observed administered during the above medication administration. On [DATE] at 1227 hours, an interview was conducted with LVN 2. LVN 2 confirmed the above findings. LVN 2 stated resident's apixaban was not given on [DATE] at 0900 hours, because it was not available. LVN 2 also stated she called the pharmacy for refill, but she did not document it. 3. On [DATE] at 0924 hours, a medication administration observation for Resident 156 was conducted with LVN 3. LVN 3 prepared and administered several medications to Resident 156 including four pills and cyclosporine 0.05% ophthalmic emulsion (used to increase tear production in patients with chronic dry eye disease or severe eye inflammation). Medical record review for Resident 156 was initiated on [DATE]. Resident 156 was admitted to the facility on [DATE]. Review of Resident 156's Order Summary Report showed an order dated [DATE], for Dorzolamide hydrochloride Ophthalmic Solution 2%, to instill one drop in both eyes two times a day related to glaucoma (increased pressure within the eyeball causing gradual loss of sight) to be given at 0900 and 1700 hours. The Dorzolamide hydrochloride Ophthalmic Solution medication was not observed administered during the above medication administration On [DATE] at 1235 hours, during an interview, LVN 3 verified the Dorzolamide solution was not given because it was not available. LVN 3 stated she called the pharmacy for refill. LVN 3 was unable to provide documentation the pharmacy was called for refill. LVN 3 stated she did not document the call to the pharmacy. On [DATE] at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F760.

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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 and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the two microwaves utilized to warm up the food was in a sanitary condition. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the ice machine utilized for residents and staff was maintained in a sanitary condition. * The facility failed to ensure the kitchen equipment was air dried prior to storage. * The facility failed to ensure the expired juice was discarded. 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 3/4/26, showed 148 of 153 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 3/4/26 at 0807 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Manager. The following was observed:- three rubber spatulas with red handles were chipped and had cracked at the edges;- one stainless steel spatula with white handle discolored and partially melted; and- one white basting brush had frayed and worn out bristles. The Dietary Manager acknowledged the above findings and stated old and worn-out kitchen utensils should have been discarded. 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. Review of the facility's P&P titled Dishwashing dated 2023 showed gross food particles shall be removed by careful scraping and pre-rinsing in running water. 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 3/4/26 at 0807 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Manager. The following was observed:- seven cutting knives with white handles had dry, crusted residue on the blade, had cloudy film and watermarks; - one stainless steel spatula with white handle was observed dirty and had watermarks;- one stainless steel potato masher with black handle was observed dirty and had dry, crusted food residue; and - three stainless steel tongs had dry, crusted residue and watermarks. The Dietary Manager acknowledged the above findings and stated all the dirty and (continued on next page)

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	555259	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mainplace Post Acute	1835 West LA Veta Avenue Orange, CA 92868

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	crusted kitchenware should have been washed for infection control purposes. 3. Review of the facility's P&P titled Sanitation dated 2023 showed all equipment shall be maintained as necessary and kept in working order. 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 3/4/26 at 0807 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the Dietary Manager. The kitchen microwave on a countertop shelf was observed dirty with dry food residue in the microwave door and inside the microwave. The microwave located inside the utility room was observed dirty with dry food residue in the microwave door and inside the microwave. The Dietary Manager verified the findings and stated the microwaves should have been cleaned for infection control purposes. 4. Review of the facility's P&P titled Hoods, Filters, and Vents dated 2023 showed the hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 3/4/26 at 0807 hours, an observation and concurrent interview was conducted with the Dietary Manager. The kitchen hood over the stove had black dirt residue. The Dietary Manager acknowledged the findings. The Dietary Manager stated the dietary staff cleaned the hood weekly and was last cleaned by an outside company in January 2026. The Dietary Manager further stated the dirt residue should not be present because it was a fire hazard. 5. Review of the facility's P&P titled Ice Machine Cleaning Procedures dated 2023 showed the ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufacturer's recommendations, and the date recorded when cleaned. The Maintenance Supervisor can keep this record or it can be posted on the ice machine. Review of the facility's P&P titled Sanitation dated 2023 showed ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanitary manner. According to the USDA Food Code 2017, Section 4-601.11, the equipment food-contact surfaces and utensils shall be clean to sight and touch. On 3/4/26 at 0902 hours, an inspection of the ice machine in the utility room and concurrent interview was conducted with the Maintenance Director and the Dietary Manager. The Maintenance Director stated ice machine was cleaned and sanitized by an outside company every six months, the filter was changed every six months and was last serviced on 10/14/25. The internal panel of the ice machine adjacent to the water curtain located directly above and lateral to the ice bin had yellow and black dirt residue. The Maintenance Director and Dietary Manager verified the above findings and stated the ice machine needs to be cleaned. 6. Review of the facility's P&P titled Dishwashing dated 2023 showed dishes are to be air dried in racks before stacking and storing. According to the USDA Food Code 2017, Section 4-901.11, Equipment and Utensils, Air-Drying Required, items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms. On 3/4/26 at 0807 hours, an observation and concurrent interview was conducted with the Dietary Manager. One stainless steel scoop with a gray handle used for food portioning was stored wet in the metal drawer. There were traces of water observed inside the drawer and on the scoop. The Dietary Manager verified the findings and stated it should have been (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	air dried to prevent the growth of bacteria. 7. According to the FDA Food Code 2017, Section 3-501.17 Ready-To-Eat, Time/Temperature Control for Safety Food, Date Marking: Marking the date or day the original container is opened with a procedure to discard the food on or before the last date by which the food must be consumed. On 3/4/26 at 0807 hours, an observation and concurrent interview was conducted with the Dietary Manager. One pitcher of cranberry juice was stored in the refrigerator label with a prep date of 3/1/26 and a use by date 3/3/26. The Dietary Manager verified the above findings and stated expired items should have been discarded. On 3/11/26 at 1630 hours, the DON was informed of and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program from January 2025 through February 2026. The facility conducted surveillance of the resident infections only when the residents were prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and symptoms of infection and were not prescribed antimicrobial medications met the facility's criteria for infection (utilizing McGeer's Criteria). The facility failed to include these residents in the facility's infection control surveillance program. * LVN 4 failed to disinfect the insulin pen injector prior to attaching a new needle for administration of the medication for Resident 42. * LVN 3 failed to wash her hands with soap and water prior to the administration of Resident 156's eye solution. * LVN 8 failed to ensure the infection control practices were implemented during Resident 102's wound treatment. * LVN 6 failed to intervene when Resident 146 continued to use straws touching the wheel of the wheelchair to drink water. These failures posed the risk for not preventing and identifying the residents' infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program revised 10/2022 showed for surveillance of infections there is ongoing monitoring among residents and personnel and subsequent documentation of infections that occur. Surveillance tools are used to recognize the occurrence of infections, record their number and frequency, detect outbreaks and epidemics, monitor personnel infections, and detect unusual pathogens with infection control implications. This also includes reporting of communicable diseases per the Centers for Disease Control guidelines. Under the infection control program, the facility will: Investigate, control and prevent infections in the facility. Decide what measures and interventions should be applied in individual circumstances. Maintain a record of the incidence of infections and corrective action taken. The facility uses McGeer's Criteria as the nationally recognized surveillance criteria to define infections. The infection preventionist completes the infection surveillance monthly and reports to the Administrator and Director of Nursing. On 3/9/26 at 1410 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's infection surveillance program specific to residents. The IP stated when a resident was prescribed an antimicrobial medication he would then determine if the resident met the McGeer's Criteria. The IP stated McGeer's Criteria was utilized to determine if a resident had an infection and if a prescribed antibiotic was appropriate. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from January 2025 through February 2026, showed the following infection surveillance data for HAIs, CAIs, and residents who did not meet McGeer's Criteria (DNMC): - 1/2025, HAI – 14, CAI – 22, and DNMC - 9 - 2/2025, HAI – 23, CAI – 19, and DNMC - 39 - 3/2025, HAI – 14, CAI – 22, and DNMC - 29 - 4/2025, HAI – 10, CAI – 16, and DNMC - 32 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 5/2025, HAI - 16, CAI – 21, and DNMC - 19 - 6/2025, HAI - 7, CAI – 22, and DNMC - 23 - 7/2025, HAI – 3, CAI –21, and DNMC - 18 - 8/2025, HAI - 17, CAI – 37, and DNMC - 16 - 9/2025, HAI - 13, CAI – 26, and DNMC - 27 - 10/2025, HAI - 19, CAI – 14, and DNMC - 24 - 11/2025, HAI -15, CAI –17, and DNMC – 14 - 12/2025, HAI - 18, CAI – 14, and DNMC - 12 - 1/2026, HAI - 23, CAI –27, and DNMC - 25 - 2/2026, HAI - 21, CAI – 19, and DNMC – 30 Further review of the facility's monthly Infection Prevention and Control Surveillance Logs from January 2025 through February 2026, showed documentation all the residents categorized as having an HAI, CAI, or not having met McGeer's Criteria were prescribed antimicrobial medications. There was no documentation showing whether the residents who exhibited signs and/or symptoms of infection and were not prescribed an antimicrobial medication, had met McGeer's Criteria. The IP was asked when the residents exhibited signs and/or symptoms of an infection and were not prescribed antimicrobial medications, if he determined whether these residents had met McGeer's Criteria. The IP stated when a resident exhibited signs and/or symptoms of an infection, however, was not prescribed antimicrobial medications, the facility did not determine if these residents met the McGeer's Criteria. The IP was asked how many residents in the facility from January 2025 through February 2026, who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications, met the McGeer's Criteria. The IP stated he was uncertain, as the facility did not determine if a resident with signs and/or symptoms of infection met McGeer's Criteria, unless they were prescribed an antimicrobial medication. 2. Review of the facility's P&P titled Administering Medication revised 4/2019 showed staff follows established facility infection control procedures (examples, handwashing, antiseptic technique, gloves, isolation precautions) for the administration of medications, as applicable. Review of the facility's P&P titled Eye Drop Administration revised 1/2018 revealed hand washing with soap and water prior to administration of eye drops. On 3/4/26 at 0924 hours, a medication administration observation for Resident 156 was conducted with LVN 3. LVN 3 prepared and administered several medications to Resident 156 including four pills and cyclosporine 0.05% ophthalmic emulsion (used to increase tear production in patients with chronic dry eye disease or severe eye inflammation). LVN 3 first administered the pills, then she administered (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the eye solution using the same gloves. LVN 3 did not wash her hands with soap and water. On 3/4/26 at 1302 hours, during an interview, LVN 3 stated she sanitized her hands and put on gloves, then administered the pills and the eye drops. LVN 3 stated after administering the oral medications, she should have sanitized her hands again before administering the eye drops. In addition, LVN 3 stated if hands were not cleaned before administering the eye solution, it could lead to eye infection. 3. Review of the facility's P&P titled Insulin Injection revised 2/2015 showed to prepare injection by swabbing rubber cap with alcohol wipe. On 3/5/26 at 1137 hours, a medication administration observation for Resident 42 was conducted with LVN 4. LVN 4 removed Novolog insulin pen 100 units/ml 3 ml from the medication cart and checked IT against the MAR. LVN 4 attached a new needle to the insulin pen without sanitizing the pen tip. LVN 4 then primed the insulin pen to remove air and dialed the required insulin dose. LVN 4 washed her hands with soap and water. LVN 4 then knocked and entered Resident 42's room. LVN 4 stated Resident 42 preferred to receive her insulin on the arm. LVN 4 then injected insulin into the fatty tissue of left arm after discussing the medication with the resident. On 3/5/26 at 1145 hours, during an interview, LVN 4 stated she checked the insulin pen's name, and expiration date, primed the pen with 2 units insulin before giving insulin dose. LVN 4 also stated to wipe insulin pen with alcohol swab prior to attaching new needle. LVN 4 confirmed she did not wipe the insulin pen tip with alcohol prior to attaching the new needle and administering to resident. LVN 4 stated wiping the insulin pen tip will keep the pen from any contaminants which can enter resident's skin and cause infection. 5. Medical record review for Resident 102 was initiated on 3/4/26. Resident 102 was admitted on [DATE]. Review of Resident 102's H&P examination dated 2/18/26, showed Resident 102 had the capacity to understand and make decisions. Review of Resident 102's MDS assessment dated [DATE], showed Resident 54 had a BIMS score of 13, meaning the resident was cognitively intact. Review of Resident 102's Order Recap Report showed an order dated 3/9/26, for sacrococcyx pressure injury, cleanse with NS (normal saline0, pat dry, apply Medihoney (a sterile, medical-grade Leptospermum (Manuka) honey that helps in wound healing by providing a moist environment, lowering the wound's pH, and offering strong antimicrobial action) and cover with DD (dry dressing) every day shift for 30 days. On 3/9/26 at 0950 hours, a wound treatment observation for Resident 102 and concurrent interview was conducted with LVN 8. During the preparation of wound treatment supplies at Resident 102's bedside, LVN 8 kept Resident 102's water pitcher and a box of open tissue paper together with the wound treatment supplies. When asked if another bedside table should be used, LVN 8 stated there was no available bedside table and was not able to find one. LVN 8 verified the findings. 6. Medical record review for Resident 146 was initiated on 3/11/26. Resident 146 was readmitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 146's H&P examination dated 1/23/26, showed Resident 146 had the capacity to make decisions. On 3/6/26 at 1537 hours, during an observation, Resident 146 sitting on the wheelchair with two connected straws. The straws were tied to the wheelchair hand grip and were touching the wheel of the wheelchair. On 3/6/26 at 1605 hours, an observation and concurrent interview was conducted with LVN 6. When asked about Resident 146's use of the two connected straws, LVN 6 approached Resident 146. Resident 146 grabbed the two connected straws and used it to drink from his water pitcher. LVN 6 walked away from Resident 146. LVN 6 did not provide new straws or water to the resident. On 3/6/26 at 1605 hours, an interview was conducted with RN 1. RN 1 stated staff should have provided new straws to the resident because the original straws were touching the wheel of the wheelchair, and provide education.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, and facility P&P review, the facility failed to ensure the grievances presented to the facility were thoroughly investigated for two of two nonsampled residents (Residents 54 and 165) reviewed for grievances. * The facility failed to clarify and address Resident 54's grievance about the facility's inventory process. * The facility failed to address and thoroughly investigate the grievance for Resident 165 when the resident was transported to the wrong appointment location. These failures had the potential for the residents to cause the residents to feel hopeless and may negatively affect their emotional well-being and overall care. Findings: Review of the facility's P&P titled Resident Rights- Grievances revised 11/2007 showed the purpose of the policy is to assure that concerns are quickly and thoroughly evaluated and acted upon in order to resolve issues which affect the quality of life and care for the residents in the facility. Section 4 of the procedures showed the the SSD or Administrator/Designee evaluates and investigates the concern and takes appropriate action to resolve the concern and prevent further occurrences. Review of the facility's grievance log for February 2026 showed two grievance reports were received: - dated 2/5/26, for Resident 165 when the resident's son filed a grievance and requesting an explanation about transport coordination when the resident was dropped off to the wrong address for an appointment and waited for three hours to return to the facility; and - dated 2/12/26, for Resident 54 who would like to have social services clarify the facility's inventory process Further review of the grievance forms and documents showed Residents 54 and 165 had resolution documented. However, there was no documentation to show on how the grievances were evaluated and investigated. Medical record review for Resident 54 was initiated on 3/4/26. Resident 54 was admitted to the facility on [DATE]. Closed medical record review for Resident 165 was initiated on 3/11/26. Resident 165 was admitted to the facility on [DATE]. On 3/11/26 at 1230 hours, an interview and concurrent facility document review was conducted with the Social Services Director (SSD). When asked about how Resident 54's grievance was investigated, the SSD stated the concern was brought forth during the Resident Council meeting held in February 2026. The SSD further stated Resident 54 brought up the concern about the inventory update. When asked about Resident 54's concern regarding inventory, the SSD stated she asked Resident 54 and the resident did not have concerns. There was no documentation to show if the SSD asked Resident 54 during the investigation on what initiated the grievance regarding the inventory. The SSD was not able to provide documentation on how the grievance was evaluated and investigated for Resident 54. When asked about the grievance received for Resident 165 when the resident was dropped off at the wrong address by the transportation services set up by the facility, the SSD was not able to provide documentation on how the grievance was investigated. There was no documentation to include if the facility attempted to find out where the error started in arranging the transportation for the resident's appointment, who were involved in the process, and how the error occurred resulting for Resident 165 to get dropped off at the wrong address for her appointment and waited for three hours to return to the facility from an appointment On 3/11/26 at 1218 hours, an interview and concurrent facility documentation review was conducted with the Administrator. When asked to show documentation about how Resident 54 and 165's grievances were evaluated and investigated, the Administrator verified the facility was missing the investigation element on the grievance forms. The Administrator acknowledged the grievance investigation should be documented. On 3/11/26 at 1636 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 a copy of the advance directive was obtained and maintained in the medical record and the POLST was complete for three of twelve final sampled residents (Residents 5, 130, and 135) reviewed for advance directives and POLSTs. * The facility failed to ensure Resident 5's advance directive was in her medical record. * The facility failed to ensure Resident 130's POLST was completely filled out. * The facility failed to ensure Resident 135's POLST was completely filled out. These failures had the potential for the residents' wishes related to the provision of the medical treatment and services to not be followed if the residents were unable to make medical decisions for themselves.Findings: Review of the facility's P&P titled Documentation revised 5/2007 showed the resident's clinical record is a concise and accurate account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. It is also necessary to include data needed for identification and communication with family and friends. Complete history of the resident and present illness is required under current law and regulations at the time of admission. Review of the facility's P&P titled Advance Directives revised 11/2019 showed the facility recognized and respected the resident's rights to choose his or her treatment and make decisions about care to be received at the end of life. Furthermore, should the resident have an advance directive, the facility will require that a copy of such directive will be included in the medical record. 1. Medical record review for Resident 5 was initiated on 3/5/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's POLST dated 1/5/26, showed under Section D, Resident 5's advance directive was not available. Review of Resident 5's Social Services Assessment / Evaluation V 3 dated 1/6/26, showed Resident 5 had executed an advance directive and a copy would be included in the resident's record. Review of Resident 5's H&P examination dated 1/7/26, showed Resident 5 had the capacity to understand and make decisions. Further review of Resident 5's medical record failed to show a copy of the advance directive was obtained and maintained in the medical record. On 3/5/26 at 1519 hours, an interview and concurrent medical record review for Resident 5 was conducted with the SSD. The SSD verified Resident 5 did not have an advance directive in her medical record. On 3/10/25 at 1249 hours, a follow-up interview was conducted with the SSD. The SSD stated she followed up with Resident 5's family member last week and they stated they would provide a copy of Resident 5's advance directive when they could. The SSD verified she did not follow up with Resident 5's family prior to 3/5/26. The SSD further stated the facility should have followed up on Resident 5's advance directive with Resident 5's family earlier. On 3/11/26 at 1600 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 130 was initiated on 3/5/26. Resident 130 was admitted to the facility on [DATE] and readmitted in 2/12/26. Review of Resident 130's POLST dated 4/25/24, showed section C for Artificially Administered Nutrition was left blank. The POLST further showed under section D for Information and Signatures, the physician's name, phone number, license number, and signature were left blank and undated. On 3/10/26 at 1535 hours, an interview and concurrent medical record review for Resident 130 was conducted with RN 3. RN 3 verified the findings and stated the POLST is the residents' wishes and should have been completed and signed by the physician to verify residents' wishes and code status. 3. Medical record review for Resident 135 was initiated on 3/5/26. Resident 135 was admitted to the facility on [DATE]. Review of Resident 135's POLST dated 10/7/25, showed under section D for Information and Signatures, the physician's name, phone number, license number and signature were left blank and undated. On 3/10/26 at 1349 hours, an interview and concurrent medical record review for Resident 135 was conducted with RN 3. RN 3 verified the findings and stated the POLST was the residents' wishes and should have been completed and signed by the (continued on next page)

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Mainplace Post Acute	1835 West LA Veta Avenue Orange, CA 92868

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician to verify residents' wishes and code status. On 3/11/26 at 1630 hours, the DON was informed of and acknowledged the above findings.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain a clean, sanitary, and homelike environment for five residents' room (Rooms A, B, C, D, and E) of the facility. * Room A window was missing four vertical blinds.* Room B window had two broken blind slats.* Room C window had one broken blind slat.* Room D window was missing one blind slat, and the restroom faucet sink was leaking.* Room E wall paint below the overhead light was peeling off and the restroom baseboard behind the toilet and below the sink was coming off. These had the potential for the residents to be at risk for living in an unkempt environment.Findings: Review of the facility's P&P titled Physical Environment, Environmental Conditions/Homelike Environment revised 11/2019 showed it is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public through monthly environmental rounds. Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. On 3/4/26 at 0800 hours, a tour of the facility was initiated. Room A was observed with four missing vertical blinds. Room B was observed with two broken window slats. Room C was observed with one broken window slats. Room D was observed with missing one blind slat and the restroom faucet sink was leaking. Room E was observed with wall paint below the overhead light was peeling off and the restroom baseboard behind the toilet and below the sink was coming off. On 3/6/26 at 1428 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. When asked about the environmental findings, the Maintenance Director reviewed the maintenance log for the past two months and could not find the documentation that the environmental findings were reported. On 3/6/26 at 1539 hours, an interview and observation was conducted with the Maintenance Director and CNA 2 in Room B. When CNA 2 was asked about the window two broken blind slats, CNA 2 stated it was not reported. The Maintenance Director verified that it was not on the maintenance log. On 3/6/26 at 1542 hours, an interview and observation was conducted with the Maintenance Director and CNA 2 in Room A. When CNA 2 was asked about the missing vertical window slats, CNA 2 stated it was reported to the facility nursing supervisor two days ago. The Maintenance Director verified that it was not on the maintenance log. On 3/6/26 at 1545 hours, an interview and observation was conducted with the Maintenance Director and CNA 2 in Room C. When CNA 2 was asked about the window one broken blind slats, CNA 2 stated it was not reported. The Maintenance Director verified that it was not on the maintenance log. On 3/6/26 at 1549 hours, an interview and observation was conducted with the Maintenance Director and CNA 2 in Room D. When CNA 2 was asked about the window missing one blind slats, the CNA 2 stated it easily comes off and it was not reported. When the Maintenance Director was asked about the leaking restroom faucet sink, the Maintenance Director attempted to fully turn the faucet knob and the faucet sink continued to leak. The Maintenance Director verified that it was not on the maintenance log. On 3/6/26 at 1603 hours, an interview and observation was conducted with the Maintenance Director and CNA 3 in Room E. When CNA 3 was asked about the wall paint below the overhead light that was peeling off and the restroom baseboard behind the toilet and below the sink that was coming off, CNA 3 stated it was not notice and it was not reported. The Maintenance Director verified that it was not on the maintenance log. On 3/11/26 at 1636 hours, the DON acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview, medical record review, and facility P&P review, the facility failed to ensure two of five final sampled residents (Residents 4 and 163) reviewed for unnecessary medications were free from unnecessary psychotropic medications. * The facility failed to ensure the nonpharmacological interventions were implemented prior to the use of trazodone HCl (hydrochloride) (antidepressant) medication for Resident 4. * The facility failed to monitor the orthostatic hypotension for Resident 163 related to the use of risperidone (Risperdal, antipsychotic medication). These failures had the potential for the residents to experience potential harm from the adverse consequences from the use of the psychotropic medications.Findings: Review of the facility's P&P titled Psychotropic Medications revised 2/2024 showed psychotropic medications shall 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. 1. Medical record review for Resident 4 was initiated on 3/4/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's care plan for the use of trazodone medication for depression revised 3/30/25, showed the interventions included to provide nonpharmacological interventions for Resident 4. Review of Resident 4's H&P examination dated 10/27/25, showed Resident 4 had the capacity to make decisions. Review of Resident 4's Order Summary Report showed a physician's order dated 1/27/26, to administer trazodone HCl 50 mg, two tablets by mouth at bedtime for depression manifested by difficulty sleeping at night. Review of Resident 4's MAR for February 2026 showed Trazodone HCl 50 mg was administered to the resident daily at 2100 hours. There was no documented evidence nonpharmacological interventions were attempted prior to the administration of the medication. Review of Resident 4's MAR for from 3/1-3/9/26 showed the following: - from 3/1-3/9/26, Trazodone HCl 50 mg was administered at 2100 hours; - dated 3/9/26, showed to document nonpharmacological interventions done every shift for Resident 4's trazodone medication use and to code the interventions provided to the resident: 0. Back rub, 1. Redirection, 2. Speak to and approach in a calm manner, 3. Reposition, 4. Offer snacks / fluids / milk, 5. Assess for pain, 6. Provide a quiet environment, 7. Encourage to express feelings, 8. Take to activities, and 9. Provide reassurance. Further review of Resident 4's MAR for March 2026 failed to show documented evidence the licensed nurses documented nonpharmacological interventions implemented for Resident 4's trazodone medication use prior to 3/9/26. On 3/11/26 at 1341 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 9. LVN 9 verified the above findings. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/26 at 1404 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 1. RN 1 stated nonpharmacological interventions should be provided to Resident 4 prior to the administration of the trazodone medication. RN 1 reviewed Resident 4's MAR for for February and March 2026 and verified there was no documented evidence Resident 4 was provided nonpharmacological interventions prior to 3/9/26. On 3/11/26 at 1600 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility P&P titled Psychotropic Medications revised 2/2024 showed the licensed nurse shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the attending physician. Review of the drug label information for Risperdal dated 1/2025 showed the adverse reactions included orthostatic hypotension. Medical record review for Resident 163 was initiated on 3/4/26. Resident 163 was admitted to the facility on [DATE]. Review of Resident 163's Order Summary Report showed the following physician's orders: - dated 2/27/26, to administer Risperdal 1 mg one tablet by mouth every 12 hours as needed for dementia with psychosis manifested by sudden anger outburst. This order was discontinued on 3/1/26; - dated 2/27/26, to administer Risperdal 1 mg one tablet by mouth for dementia with psychosis manifested by sudden anger outburst. This order was discontinued on 3/1/26; - dated 3/1/26, to administer Risperdal 1 mg one tablet by mouth for psychosis manifested by sudden anger outburst; - dated 2/27/26, to monitor for atypical antipsychotic common side effects such as drowsiness, dry mouth, blurred vision, constipation, transient nausea, weight gain, increased saliva, and sweating; less common side effects such as edema, postural hypotension, urinary retention, stiff or tight muscles, shakiness, and serious blood disorders; and rare side effects such as extra pyramidal tardive dyskinesia, jaundice, allergic reaction, increased photosensitivity, and allergic dermatitis for risperidone medication every shift; - dated 2/27/26, to monitor and document number of dementia with psychosis features manifested by sudden angry outburst for risperidone medication every shift; - dated 2/27/26, for nonpharmacological interventions: 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, provide reassurance for risperidone medication every shift; - dated 2/27/26, to monitor for side effect: Tardive dyskinesia or facial/tongue movement for risperidone medication every shift; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 2/27/26, to monitor for side effect: Akathesia or inability to sit still risperidone medication every shift; - dated 2/27/26, to monitor for side effect: Parkinsonism or tremors, drooling or rigidity risperidone medication every shift; and - dated 2/27/26, to monitor for side effect: Cognitive/ behavior impairment or decrease in mental function risperidone medication every shift. Review of Resident 163's MAR for February and March 2026 showed Resident 163 was administered the risperidone medication on 2/20, 2/22, 2/28, and from 3/2 to 3/5/26 at 2100 hours. Review of Resident 163's medical record did not show Resident 163 was monitored for orthostatic hypotension. On 3/9/26 at 1414 hours, an interview and concurrent medical record review for Resident 163 was conducted with Unit Manager 1. Unit Manager 1 stated the residents on the antipsychotic medications were monitored for tardive dyskinesia, akathisia, parkinsonism, cognitive or behavior impairment, and orthostatic blood pressure. Unit Manager 1 stated the orthostatic blood pressure was monitored once a week, on Sundays. Unit Manager 1 verified Resident 163 was not monitored for orthostatic hypotension while on risperidone medication. On 3/11/26 at 1215 hours, the DON was informed and acknowledged the above findings.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **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 implement the P&P for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act when the facility did not report an allegation of verbal abuse to the CDPH, L&C Program, Ombudsman Office, and local law enforcement agency for two of four nonsampled residents (Resident 54 and 154) reviewed. * Resident 54 reported during resident's council meeting on 2/11/26, about allegation of verbal abuse against CNA 4. * Resident 154 reported during resident's council meeting on 2/11/26, about allegation of verbal abuse against CNA 4. This failure had the potential for Residents 54 and 154 to be vulnerable to further abuse and emotional distress.Findings: Review of the facility's P&P titled Abuse: Prevention of and Prohibition Against revised 1/2021 showed It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation. Further review of the P&P, under the section H. Reporting//Response showed: 1. All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator.2. Allegation of abuse, neglect, misappropriation of resident property, or exploitation will be reported to outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations. Medical record review for Resident 54 was initiated on 3/6/26. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's H&P examination dated 7/23/25, showed Resident 54 had no capacity to understand and make decisions. Review of Resident 54's MDS dated [DATE], showed Resident 54 had a BIMS score of 14, cognitively intact. Medical record review for Resident 154 was initiated on 3/6/26. Resident 154 was admitted to the facility on [DATE]. Review of Resident 154's H&P examination dated 2/16/25, showed Resident 154 had the capacity to understand and make decisions. Review of Resident 154's MDS dated [DATE], showed Resident 154 had a BIMS score of 15, cognitively intact. On 3/5/26 at 1402 hours, a resident council meeting was conducted in the dining room with the Ombudsman. When the residents were asked about the facility treating them with respect and dignity, Resident 154 stated no. Resident 154 further stated CNA 4 was rude and cursed at her. When Resident 154 was asked about reporting CNA 4, Resident 154 stated it was reported from last month's resident council meeting. Resident 4 stated CNA 4 was also rude and cursed at Resident 54. Resident 4 further stated the allegation of abuse was reported during the resident's council last month. On 3/5/26 at 1515 hours, an interview was conducted with the Ombudsman. When the Ombudsman was asked about the allegations of abuse against CNA 4, the Ombudsman stated she was present during the resident's council meeting last month and she was aware of the allegations. When asked if it was reported to the Facility, the Ombudsman stated she was not a mandated reporter, and the Activity Director was present during the meeting and the Activity Director was a mandated reporter. On 3/5/26 at 1530 hours, an interview and concurrent facility document review was conducted with the Activity Director, DON, and Administrator. When asked to show documentation on the resident council minutes on 2/11/26, about the allegations of abuse, the Activity Director could not show documentation that it was reported to the Administrator. The Activity Director stated she did not recall the allegations of abuse being reported during the resident's council meeting. When the DON and Administrator was asked about the allegations, the DON stated they were not aware of the allegations of abuse from last month's resident's council meeting. On 3/5/26 at 1714 hours, a telephone interview was conducted with the Ombudsman. The Ombudsman confirmed that the Activity Director was in the resident council on 2/11/26, and the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Activity Director was taking notes. On 3/5/26 at 1530 hours, an interview was conducted with the facility Administrator. When asked about the expectations surrounding abuse allegations, the Administrator stated the staff must report the allegation of abuse to the Administrator and to conduct investigation. On 3/11/26 at 1636 hours, the DON acknowledged the Activity Director should have reported the allegations of abuse to the Administrator and to the appropriate agencies.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, and facility P&P review, the facility failed to investigate an allegation of abuse for two of four nonsampled residents (Residents 54 and 154). * Resident 54 reported during the resident's council meeting on 2/11/26, about allegation of verbal abuse against CNA 4. * Resident 154 reported during resident's council meeting on 2/11/26 about allegation of verbal abuse against C.NA 4. This failure had the potential for Residents 54 and 154 to be vulnerable to further abuse and emotional distress.Findings: Review of the facility's P&P titled Abuse: Prevention of and Prohibition Against revised 1/2021 showed It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation. Further review of the P&P, under the section F. Investigation showed:1. All allegations of abuse, neglect, and misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee. Medical record review for Resident 54 was initiated on 3/6/26. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's H&P examination dated 7/23/25, showed Resident 54 had no capacity to understand and make decisions. Review of Resident 54's MDS dated [DATE], showed Resident 54 had a BIMS score of 14, indicating cognitively intact. Medical record review for Resident 154 was initiated on 3/6/26. Resident 154 was admitted to the facility on [DATE]. Review of Resident 154's H&P examination dated 2/16/25, showed Resident 154 had the capacity to understand and make decisions. Review of Resident 154's MDS dated [DATE], showed Resident 154 had a BIMS score of 15, indicating cognitively intact. On 3/5/26 at 1402 hours, a resident council meeting was conducted in the dining room with the Ombudsman. When the residents were asked about the facility treating them with respect and dignity, Resident 154 stated no. Resident 154 further stated CNA 4 was rude and cursed at her. When Resident 154 was asked about reporting CNA 4, Resident 154 stated it was reported from last month's resident council meeting. Resident 4 stated CNA 4 was also rude and cursed at Resident 54. Resident 4 further stated the allegation of abuse was reported during the resident's council last month. On 3/5/26 at 1530 hours, an interview was conducted with the DON and Administrator. When the DON and Administrator were asked about the allegations of abuse, the DON stated they were not aware of the allegations of abuse from last month's resident's council meeting. On 3/5/26 at 1530 hours, an interview was conducted with the Administrator. When asked about the expectations surrounding abuse allegations, the Administrator stated the staff must report the allegation of abuse to the Administrator and to conduct investigation. On 3/11/26 at 1636 hours, the DON acknowledged the allegations of abuse reported on 2/11/26, during the resident council meeting should be investigated. *Cross reference to F609.

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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, and medical record review, the facility failed to ensure the comprehensive care plan was developed and implemented for two of 30 final sampled residents (Residents 1 and 7). * The facility failed to develop a care plan to address Resident 1's non-compliance with his prescribed fluid restriction. * The facility failed to implement a care plan intervention to provide an APP mattress for Resident 17, who was at risk for the development of pressure injuries. These failures placed the residents at risk of not being provided appropriate, consistent, and individualized care.Findings: 1. Medical record review for Resident 17 was initiated on 3/4/26. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Care Plan Report showed a care plan focus titled Potential for Pressure Ulcer Development related to CVA, aging process, and decreased mobility initiated on 2/14/26. The care plan interventions included an APP mattress for skin integrity maintenance, initiated on 3/1/26. On 3/4/26 at 0927 hours, an observation was conducted of Resident 17. Resident 17 was observed lying in his bed. Resident 17's bed did not have an APP mattress. On 3/4/26 at 1606 hours, an observation and concurrent interview was conducted with RN 1. Resident 17 was observed lying in his bed. Resident 17's bed did not have an APP mattress. RN 1 verified Resident 17 had a care plan specific to potential for pressure ulcer development related to CVA, aging process, and decreased mobility, initiated on 2/14/26. RN 1 verified the care plan interventions included an APP mattress for skin integrity maintenance, initiated on 3/1/26. RN 1 verified the care plan intervention for the APP mattress was not implemented. Cross reference F686 #2. 2. On 3/9/26 at 1042 hours, Resident 1 was observed in bed. A non-graduated pitcher of water was observed at the bedside. On 3/9/26 at 1044 hours, an observation of Resident 1 and concurrent interview was conducted with CNA 1. Resident 1 was observed in bed, with a non-graduated pitcher of water at bedside. Resident 1 was also observed drinking a bottle of cold coffee drink. CNA 1 verified the above findings. CNA 1 stated she was not aware Resident 1 was on fluid restriction, and stated the nurses did not tell me anything about him or any precautions or fluid restrictions. Medical record review for Resident 1 was initiated on 3/4/26. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed the following physician's orders: - dated 2/13/26, for a fluid restriction of 1000 ml per day. The nursing department was to provide 240 ml in the day shift, 240 ml in the evening shift, and 160 ml in the NOC shift, while the dietary department was to provide 120 ml in the day shift, 120 ml in the evening shift, and 120 ml in the NOC shift; and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 2/25/26, for dialysis every Tuesdays and Saturdays. Review of Resident 1's Fluid Intake record dated 2/13/26 to 3/8/26, showed Resident 1 had a fluid intake more than the prescribed dietary fluid intake of 360 ml per day. The record showed the following: - On 2/13/26, Resident 1 's total dietary fluid intake was 1425 ml; - On 2/14/26, Resident 1 's total dietary fluid intake was 800 ml; - On 2/15/26, Resident 1 's total dietary fluid intake was 1340 ml; - On 2/16/26, Resident 1 's total dietary fluid intake was 1060 ml; - On 2/17/26, Resident 1 's total dietary fluid intake was 650 ml; - On 2/18/26, Resident 1 's total dietary fluid intake was 1000 ml; - On 2/19/26, Resident 1 's total dietary fluid intake was 875 ml; - On 2/20/26, Resident 1 's total dietary fluid intake was 930 ml; - On 2/21/26, Resident 1 's total dietary fluid intake was 1000 ml; - On 2/22/26, Resident 1 's total dietary fluid intake was 900 ml; - On 2/23/26, Resident 1 's total dietary fluid intake was 1500 ml; - On 2/24/26, Resident 1 's total dietary fluid intake was 1700 ml; - On 2/25/26, Resident 1 's total dietary fluid intake was 1420 ml; - On 2/26/26, Resident 1 's total dietary fluid intake was 800 ml; - On 2/27/26, Resident 1 's total dietary fluid intake was 1240 ml; - On 2/28/26, Resident 1 's total dietary fluid intake was 1140 ml; - On 3/1/26, Resident 1 's total dietary fluid intake was 500 ml; - On 3/2/26, Resident 1 's total dietary fluid intake was 890 ml; - On 3/3/26, Resident 1 's total dietary fluid intake was 500 ml; - On 3/4/26, Resident 1 's total dietary fluid intake was 1000 ml; - On 3/5/26, Resident 1 's total dietary fluid intake was 700 ml; - On 3/6/26, Resident 1 's total dietary fluid intake was 940 ml; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/7/26, Resident 1 's total dietary fluid intake was 700 ml; and - On 3/8/26, Resident 1 's total dietary fluid intake was 890 ml. Review of Resident 1's plan of care did not show a care plan problem to address Resident 1's non-compliance with his fluid restrictions. On 3/9/26 at 1147 hours, an observation, interview and concurrent medical record for Resident 1 was conducted with Unit Manager 1. Unit Manager 1 verified Resident 1 was in bed and with a 600 ml water in a graduated pitcher at bedside. Unit Manager 1 stated the CNAs documented his dietary fluid intake or how much fluid Resident 1 drank from the meal tray and water pitcher at bedside under Task documentation. Unit Manager 1 verified Resident 1's dietary fluid intake was more than the prescribed dietary fluid intake. Unit Manager 1 stated Resident 1 was non-compliant with his fluid restrictions. Unit Manager 1 verified Resident 1's plan of care did not include a care plan problem to address Resident 1's non-compliance with his fluid restrictions. On 3/11/26 at 1225 hours, the DON was informed and acknowledged the findings. Cross reference to F698, #2.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the risk and development of pressure injuries for two of two final sampled residents (Residents 17 and 147) reviewed for pressure injuries. * Resident 17 was at risk for the development of pressure injuries. The facility failed to ensure Resident 17's physician's order dated 2/28/26, for an APP mattress for skin maintenance/prevention was implemented. * The facility failed to reposition Resident 147 at least every shift which potentially led to the development of his pressure injury after admission on 8/2025. These failures placed the residents at risk for the development or worsening of pressure injuries.Findings: Review of the facility's P&P titled Skin Management System revised 12/2019 showed any resident who entered the facility without pressure ulcers would have appropriate preventative measures taken to ensure that the resident does not develop pressure ulcers unless the resident's clinical condition made the development unavoidable. Review of the National Pressure Ulcer Advisory Panel's (NPIAP) Guideline titled Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline for 2025, showed under the Repositioning for Pressure Injury Prevention section, extended periods of lying or sitting on a particular part of the body without redistribution of the pressure could lead to a pressure injury. Furthermore, repositioning and mobilization were essential preventative measures for reducing pressure injury occurrences. 1. Medical record review for Resident 147 was initiated on 3/5/26. Resident 147 was admitted on [DATE], and readmitted on [DATE]. Review of Resident 147's Braden Scale for Predicting Pressure Sore Risk dated 8/9/25, showed the following: - for degree of physical activity, Resident 147 was documented as bedfast: confined to bed; - for ability to change and control body position, Resident 147 was documented as completely immobile: did not make even slight changes in body or extremity position without assistance; and - for friction and shear, Resident 147 required moderate to maximum assistance in moving, frequently slid down in bed or chair, and required frequent repositioning with maximum assistance. Review of Resident 147's Skin Ulcer Non-Pressure Weekly dated 8/11/25, showed Resident 147 had blanchable redness on his sacrococcyx area that was present on admission to the facility. Review of Resident 147's MDS assessment dated [DATE], showed Resident 147 was dependent on the staff members to roll left and right. Further review of the MDS showed to code the resident dependent when the resident did not provide any effort to complete the activity or the assistance of two or more helpers were required for the resident to complete the activity. Review of Resident 147's Skin Pressure Ulcer Weekly dated 8/28/25, showed Resident 147 had a non-blanchable redness size 4 cm (length) x 2 cm (width) on his sacrum. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 147's Skin Pressure Ulcer Weekly dated 9/3/25, showed Resident 147's sacrococcyx had a 3.7 cm x 3.6 cm Stage 2 pressure injury. The recommended interventions included to turn and to reposition Resident 147 every two hours. Review of Resident 147's Skin Pressure Ulcer Weekly dated 9/10/25, showed Resident 147's sacrococcyx had a 6.5 cm x 8.5 cm unstageable pressure injury. Resident 147's unstageable pressure injury had 10% slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds), 50% necrotic (dead) tissue, and 40% eschar (thick, dry, black or brown layer of dead tissue that forms over pressure ulcers). Review of Resident 147's Documentation Survey Report v2 for Turning and Repositioning for August and September 2025 showed Resident 147 was not turned or repositioned prior to his unstageable pressure injury during the following shifts: - on 8/10 – 8/12, 8/16 – 8/17, 8/26 – 8/29, and on 8/31/25 during the 2300 to 0700 hours shift; - on 8/30/25 during the 1500 to 2300 hours shift; and - on 9/2/25/25 during the 2300 to 0700 hours shift. Review of Resident 174's care plans showed a care plan problem initiated 7/16/19 and revised 9/11/25, for very high risk for further skin breakdown/potential/actual impairment to skin integrity related to poor mobility, cognitive loss, variable intake, incontinence of bowel and bladder. Interventions included to reposition the resident as often as possible, and to re-check and re-reposition as needed. Review of Resident 147's H&P examination dated 11/12/25, showed Resident 147 had no capacity to make decisions. Resident 147 had diagnoses including dysphagia, GT, and a sacral pressure ulcer. On 3/9/26 at 1106 hours, an interview and medical record review for Resident 147 was conducted with LVN 6. LVN 6 stated Resident 147's developed a pressure injury due to his contractures and nutritional status. LVN 6 stated Resident 147 was not able to turn himself in bed and CNAs were expected to turn and reposition him. LVN 6 verified the above findings. On 3/11/26 at 1243 hours, an interview and medical record review for Resident 147 was conducted with the DON. The DON stated the interventions to prevent development of Resident 147's pressure injuries included turning and repositioning and daily skin checks. The DON stated CNAs were expected to document they turned Resident 147 every shift. The DON verified the above finding. 2. Medical record review for Resident 17 was initiated on 3/4/26. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Order Summary Report showed a physician's order dated 2/28/26, for an APP mattress for skin maintenance/prevention. Review of Resident 17's Skin Issues dated 3/5/26, showed Resident 17 had an unstageable pressure injury on his left dorsum hallux, measuring 2 cm in length and 2 cm in width. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/26 at 0927 hours, an observation was conducted of Resident 17. Resident 17 was observed lying in his bed. Resident 17's bed did not have an APP mattress. On 3/4/26 at 1550 hours, an observation and concurrent interview was conducted with LVN 10. Resident 17 was observed lying in his bed. Resident 17's bed did not have an APP mattress. LVN 10 verified Resident 17 had a physician's order dated 2/28/26, for an APP mattress for skin maintenance/prevention, however, the facility failed to carry out the physician's order. On 3/4/26 at 1606 hours, an observation and concurrent interview was conducted with RN 1. Resident 17 was observed lying in his bed. Resident 17's bed did not have an APP mattress. RN 1 verified Resident 17 had a physician's order dated 2/28/26, for an APP mattress for skin maintenance/prevention, however, the facility failed to carry out the physician's order. RN 1 stated Resident 17 was at risk for pressure injuries, due to left side weakness and impaired mobility as a result of a CVA.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services for the use of the enteral feedings for one of one final sampled resident (Resident 147) reviewed for enteral feedings. * The facility failed to ensure the enteral water flush for Resident 147 was accurately programmed per the physician's order. In addition, the facility failed to change Resident 147's water bag and enteral feeding tubing after 24 hours of use. These failures posed the risk for developing dehydration complications and potential infections for Resident 147.Findings: Review of the facility's P&P titled Enteral Feeding Administration dated 3/2022 showed to administer the enteral feeding at a constant controlled infusion rate per the physician's orders. Review of the Cardinal Health user manual for the Kangaroo Omni Enteral Feeding Pump dated 2024 showed the Kangaroo OMNI Feeding Set included a water flush bag, feeding bag, and a feeding set connector. In addition, under the Cautions section, the Kangaroo OMNI Feeding Set should be replaced after 24 hours from initiation of feeding to prevent bacterial growth that could be a hazard to the patient. On 3/5/26 at 1042 hours, Resident 147 was observed lying in bed. Resident 147's Kangaroo OMNI enteral feeding pump was off and not connected to Resident 147. The enteral formula hung by Resident 147's bed was Jevity 1.5 cal (type of enteral feeding), dated and labeled 3/5, and hung at 0230 hours. The enteral formula's label also showed Resident 147's feed was initiated on 3/4/26 at 1200 hours. In addition, Resident 147's water bag was observed dated 3/4/26 at 1200 hours. Medical record review for Resident 147 was initiated on 3/5/26. Resident 147 was admitted on [DATE], and readmitted on [DATE]. Resident 147 had a diagnosis of dysphagia and a GT. Review of Resident 147's Order Summary Report showed the following physician's orders:- dated 11/11/25, a NPO (nothing by mouth) diet;- dated 12/20/25, to administer Jevity 1.5 via external feeding pump at 1200 hours and to infuse 70 ml/hr for 20 hours to provide 1400 ml and 1950 kcal; and- dated 3/4/26, to administer a continuous water flush of 40 ml/hr for 20 hours to provide 800 ml of water via external feeding pump. On 3/5/26 at 1540 hours, Resident 147 was observed lying in bed and was receiving the same enteral feeding formula from 1042 hours. Additionally, the water bag was still dated 3/4/26 at 1200 hours. On 3/5/26 at 1548 hours, an observation, interview and concurrent medical record review for Resident 147 was conducted with LVN 2. LVN 2 reviewed Resident 147's physician's orders and stated Resident 147 should receive a continuous water flush of 40 ml/hr for 20 hours. LVN 2 stated it was best practice to label and date the enteral feeding system which included the resident's formula bottle, water bag, enteral feed tubing and syringe when the enteral feeding system was initiated. In addition, to replace the enteral feeding system every 24 hours. LVN 2 further stated the process for administering enteral feedings included to ensure the resident was receiving the proper feeding and flush rate per the physician's order. LVN 2 verified Resident 147's water bag was dated 3/4/26, the enteral feeding tubing connected to Resident 147 was not dated, and the water flush rate was administering 35 ml per hour. On 3/11/26 at 1600 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care services for four of four final sampled residents (Residents 10, 45, 102 and 163) reviewed for respiratory services. * The facility failed to discard Resident 10's nasal cannula tubing dated 1/22/26. In addition, the facility failed to ensure the set-up bag for the nasal cannula for Resident 10 was dated. * The facility failed to ensure a physician's order was obtained when oxygen was administered to Resident 45. * Resident 102's nebulizer mask and tubing was not dated and changed once a week. * The facility failed to ensure the nebulizer mask was dated and labeled, and stored in a set-up bag for Resident 163. These failures had the potential for these residents not to receive appropriate respiratory care, and for increased risks of infection.Findings: Review of the facility's P&P titled Oxygen, Use of, revised 5/2021 showed the following: - The oxygen cannula or mask will be changed at least every seven days, as well as the disposable humidifier. Tubing, masks, humidifiers, and other disposables used for oxygen administration will be dated in an identifiable fashion; and - Labeled and dated bags should be provided for cannulas and masks to be placed in when not in use. Review of the facility's P&P titled Oxygen Therapy revised 2/2012 showed the date and time the procedure (oxygen administration) was ordered, the rate, of low, route and rationale, and the frequency and duration of the treatment, as part of the charting and documentation section. 1. On 3/4/26 at 0945 hours, Resident 45 was observed in bed, asleep. A nasal cannula tubing was observed placed on top of the oxygen concentrator and not inside the set-up bag. On 3/4/26 at 1300 hours, Resident 45 was observed in bed receiving oxygen at two LPM via nasal cannula. Medical record review for Resident 45 was initiated on 3/4/26. Resident 45 was admitted to the facility on [DATE]. Review of Resident 45's Order Summary Report showed a physician's order dated 2/26/26, to wean off oxygen and to discontinue if oxygen saturation equal or more than 92% room air. Further review of Resident 45's medical records did not show a physician's order to administer oxygen. Review of Resident 45's Discontinue Order dated 3/4/26, showed the physician's order to administer oxygen at two LPM via nasal cannula was discontinued by the MDS Resource on 3/4/26 at 1042 hours. On 3/4/26 at 1301 hours, an observation, interview, and concurrent medical record review for Resident 45 was conducted with LVN 1. LVN 1 verified Resident 45 was receiving oxygen at two LPM via nasal cannula. LVN 1 could not show a physician's order to administer the oxygen. LVN 1 stated he did not administer the oxygen to Resident 45 and did not discontinue the physician's order to administer the oxygen. LVN 1 verified the above findings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/26 at 1434 hours, an interview was conducted with RN 1. RN 1 stated she did her rounds in the morning and checked Resident 45's oxygen saturation and it was 92 to 93%, so she administered oxygen to Resident 45 at two LPM via nasal cannula tubing. RN 1 stated there was a current physician's order to administer the oxygen when she placed the nasal cannula tubing to Resident 45. RN 1 verified the physician's order to administer the oxygen to Resident 45 was discontinued. RN 1 stated the MDS Resource mistakenly discontinued the physician's order to administer the oxygen to Resident 45. On 3/11/26 at 1205 hours, an interview was conducted with the DON. The DON stated she was informed the MDS Resource accidentally discontinued the physician's order to administer the oxygen to Resident 1. The DON acknowledged the above findings. 2. On 3/4/26 at 0954 hours, Resident 163 was observed in bed asleep. A nebulizer mask was observed on top of the nightstand. The nebulizer mask was undated, unlabeled, and not stored in a set-up bag when not in use. Medical record review for Resident 163 was initiated on 3/4/26. Resident 163 was admitted to the facility on [DATE]. Review of Resident 163's Order Summary Report showed a physician's order dated 2/27/26, administer ipratropium-albuterol solution (bronchodilator) 0.5-2.5 mg/3 ml inhale orally every four hours as needed for shortness of breath or wheezing via nebulizer. Review of Resident 163's Order Summary Report showed Resident 163 was administered the ipratropium-albuterol medication on 3/3/26 at 2300 hours. On 3/4/26 at 1259 hours, an observation, interview and concurrent medical record review for Resident 163 was conducted with LVN 1. LVN 1 verified Resident 163's nebulizer mask on top of the nightstand was undated, unlabeled and not stored in a set-up bag when not in use. LVN 1 stated the nebulizer mask and tubing were supposed to be changed by the charge nurses on the night shift. On 3/11/26 at 1215 hours, an interview was conducted with the DON. The DON stated the facility follows the same policy as the oxygen, to change the nebulizer mask and tubing every seven days, to label with the date, and it should be in a set-up bag when not in use. The DON acknowledged the above findings. 3. On 3/4/26 at 0800 hours, during the initial tour, Resident 102's nebulizer mask and tubing were observed without a date. The mask and tubing was stored in a clear bag dated 2/24/26. Medical record review for Resident 102 was initiated on 3/4/26. Resident 102 was admitted on [DATE]. Review of Resident 102's Order Recap Report showed an order dated 2/20/26, for ipratropium-albuterol solution (a medication used to treat air flow blockage) 0.5-2.5 (3) mg/3 ml 1 ml inhalation inhale orally two times a day for COPD (Chronic Obstructive Pulmonary Disease). On 3/4/26 at 1533 hours, an interview with LVN 1 was conducted. LVN 1 verified the nebulizer and tubing were not dated and the clear bag was dated 2/24/26. LVN 1 stated it should have been changed on 3/1/26, and properly labeled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/26 at 1636 hours, the DON acknowledged the above findings. 4. On 3/4/26 at 1308 hours, during the initial tour of the facility, Resident 10 was observed sleeping in bed. The nasal cannula tubing was dated 1/22/26, and the set-up bag for the nasal cannula was observed undated. A nebulizer machine was observed by Resident 10's bed. Medical record review for Resident 10 was initiated on 3/5/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's Order Summary Report failed to show a physician's order to administer oxygen to Resident 10. On 3/4/26 at 1453 hours, an observation and concurrent interview for Resident 10 was conducted with LVN 9. LVN 9 verified the nasal cannula tubing was dated 1/22/26, the set-up bag for the nasal cannula was undated, and the nebulizer machine was beside Resident 10's bed. LVN 9 stated the set-up bags for nasal cannulas should be dated and the nasal cannula tubing should be changed every 15 days. LVN 9 verified the above findings. LVN 9 further stated she was not sure if Resident 10 currently used the nebulizer machine. On 3/4/26 at 1558 hours, a follow-up interview for Resident 10 was conducted with LVN 9. LVN 9 stated nasal cannulas should be changed every seven days. On 3/5/26 at 1017 hours, an observation and concurrent interview for Resident 10 was conducted with LVN 9. The nasal cannula tubing was dated 3/3/26, however, the set-up bag for the nasal cannula was undated. A nebulizer machine was observed by Resident 10's bed. LVN 9 verified the above findings.On 3/9/26 at 1638 hours, an interview and concurrent medical record review for Resident 10 was conducted with RN 1. RN 1 verified Resident 10 did not have a physician's order to administer oxygen or to use a nebulizer machine. RN 1 stated if a resident did not have an order for the use of a nebulizer machine, there should not be a nebulizer machine by the resident. On 3/11/26 at 1600 hours, the DON was informed and acknowledged the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure appropriate pain management for one of one final sampled resident (Resident 4) reviewed for pain management. * The facility failed to ensure the nonpharmacological interventions were provided to Resident 4 prior to the administration of hydrocodone hydrocholoride (HCl) (pain medication). This failure had the potential to put the resident at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medication. Findings: Review of the facility's P&P titled Management of Pain revised 4/2016 showed the facility will assist each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by interviewing or observing the resident to determine if pain is present, evaluating pain with the resident to develop a plan of care that considers their needs, and implementing a plan using non-pharmacological and/or pharmacological interventions to manage and / or prevent pain. Medical record review for Resident 4 was initiated on 3/4/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's H&P examination dated 10/27/25, showed Resident 4 had the capacity to make decisions. Review of Resident 4's Order Summary Report, showed the following physician's orders:- dated 10/23/25, to administer acetaminophen (pain medication) 325 mg two tablets by mouth every four hours as needed for mild pain (1-3 out of 10, zero for no pain and 10 means worst) or for a fever of 101 degrees Fahrenheit;- dated 10/23/25, to administer hydromorphone HCl 2 mg one tablet by mouth every four hours as needed for mild to moderate pain (1-6);- dated 10/23/25, to administer hydromorphone HCl 2 mg two tablets by mouth every four hours as needed for severe pain (7/10);- dated 10/23/25, to monitor the resident's pain level every shift using the following scale: 0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, and 7-10 = severe pain; and- dated 10/23/25, to provide non-pharmacological interventions for pain as needed and to code the interventions provided to the resident: 1. Repositioning, 2. Dim light / quiet environment, 3. Relaxation, 4. Distraction, 5. Music, and 6. Massage. Review of Resident 4's MAR for March 2026 showed Resident 4 was administered hydromorphone HCl 2 mg two tablets by mouth on the following dates and times, with the following pain level:- dated 3/1/26 at 0958 hours, a pain level of 9;- dated 3/2/26 at 0555 and 2014 hours, 3/3/26 at 0500 and 2000 hours, 3/5/26 at 0554 hours, 3/6/26 at 0300 hours, and 3/7/26 at 0600 and 1300 hours, a pain level of 7;- dated 3/4/26 at 0552 hours, a pain level of 10; and - dated 3/6/26 at 0905 and 2255 hours, 3/8/26 at 0900 hours, 3/9/26 at 0615 hours, and 3/10/26 at 0000 hours, a pain level of 8. However, further review of the MAR failed to show nonpharmacological pain interventions were attempted prior to the administration of hydromorphone medication for the following dates and times:- dated 3/1/26 at 0958 hours;- dated 3/2/26 at 2014 hours;- dated 3/4/26 0552 hours;- dated 3/8/26 at 0900 hours; and- dated 3/9/26 at 0615 hours. On 3/11/26 at 1341 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 9. LVN 9 stated nonpharmacological interventions should be attempted prior to pain medication administration to assess if the resident's pain could be relieved without pain medication. LVN 9 verified the above findings. On 3/11/26 at 1600 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the pharmacy consultant's recommendations were acted upon for one of 30 final sampled residents (Resident 1) reviewed for drug regimen review. * The facility failed to follow-up the pharmacy consultant's recommendation to add a warning to the medication sheet regarding the handling of finasteride (medication used to treat benign prostatic hyperplasia or enlarged prostate) for Resident 1. This failure had the potential to put the licensed nurses at risk for adverse consequences related to the medication. Findings: Medical record review for Resident 1 was initiated on 3/4/26. Resident 1 was readmitted on [DATE]. Review of the Consultant Pharmacist's Medication Regimen Review for Resident 1 dated 2/19/26, showed women who are pregnant or may get pregnant must not handle/administer broken or crush Proscar (finasteride) tablets, the active ingredient could harm the unborn baby. Please advise the nurses to wear gloves when handling the tablets, and wear gloves and face mask if crushing is required, by adding the warning to the medication sheet. The review sheet showed a checkmark. Review of Resident 1's Order Summary Report showed a physician's order dated 1/28/26, to administer finasteride 5 mg one tablet by mouth in the afternoon. The physician's order did not show the consultant pharmacist recommendation to add the warning for the nurses regarding safe handling of the finasteride medication was added. Further review of Resident 1's medical record did not show the consultant pharmacist recommendation to add the warning for the nurses regarding safe handling of the finasteride medication was followed. On 3/9/26 at 1147 hours, an observation, interview and concurrent medical record review for Resident 1 was conducted with Unit Manager 1. Unit Manager 1 verified the above findings. Unit Manager 1 stated the unit managers followed up the Consultant Pharmacist's recommendations, and they asked the physician whether they agree or not. Unit Manager 1 stated if there was a checkmark on the review sheet, it meant it was done or followed up. Unit Manager 1 stated the pharmacist consultant's recommendations should be followed up within that week when the review sheets were printed by the medical records. When asked about the pharmacy consultation's recommendation to advise the nurses to wear gloves when handling the tablets, and wear gloves and face mask if crushing is required, by adding the warning to the medication sheet, Unit Manager 1 stated the warning should be added to the physician's order, and a sticker was to be placed on the bubble pack for finasteride medication, to which she showed the bubble pack for the finasteride medication for Resident 1. The bubble pack for the finasteride medication for Resident 1 showed a yellow sticker on the bubble pack. The sticker showed Caution: hazardous drug. Observe special handling, administration and disposal requirements. Unit Manager 1 verified the above findings. Unit Manager 1 stated the nurses were supposed to see the yellow sticker and then check the physician's order to see what the special handling was for the finasteride medication. On 3/11/26 at 1225 hours, an interview was conducted with the DON. The DON stated the Unit Managers and RNs were responsible to follow up the pharmacy consultant's recommendations within 72 hours, or a week. The DON was informed and acknowledged the findings. The DON stated the pharmacist consultant's recommendation about the special handling of the finasteride medication for Resident 1 should have been added to the physician's order.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 156) observed for the medication administration was free from significant medication errors. * The facility failed to ensure Resident 156 received Dorzolamide Ophthalmic Solution 2% (used to reduce high pressure inside the eye) as ordered when Resident 156 did not receive at least three doses of dorzolamide eye solution. This failure had the potential to have a negative impact on the resident resulting in poor eye pressure control and long-term vision loss.Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed medications are administered in accordance with prescriber's orders. On 3/4/26 at 0924 hours, a medication administration observation for Resident 156 was conducted with LVN 3. LVN 3 prepared and administered several medications to Resident 156 including four pills and cyclosporine 0.05% ophthalmic emulsion (used to increase tear production in patients with chronic dry eye disease or severe eye inflammation). Medical record review for Resident 156 was initiated on 3/4/26. Resident 156 was admitted to the facility on [DATE]. Review of Resident 156's Order Summary Report showed an order dated 2/27/26, for Dorzolamide hydrochloride Ophthalmic Solution 2%, to instill one drop in both eyes two times a day related to glaucoma (increased pressure within the eyeball causing gradual loss of sight) to be given at 0900 and 1700 hours. The Dorzolamide hydrochloride Ophthalmic Solution medication was not observed administered during the above medication administration On 3/4/26 at 1235 hours, during an interview, LVN 3 verified the Dorzolamide solution was not given because it was not available. LVN 3 stated she called the pharmacy for refill. LVN 3 was unable to provide documentation the pharmacy was called for refill. LVN 3 stated she did not document the call to the pharmacy. Review of Resident 156's medical record showed the Dorzolamide eye solution was documented as given on 3/4/26 at 1700 hours and on 3/5/26 at 0900 hours. On 3/5/26 at 1448 hours, an observation, interview and concurrent medical record review for Resident 156 was conducted with LVN 1. LVN 1 was unable to locate Resident 156's Dorzolamide eye solution in the medication cart. LVN 1 confirmed Dorzolamide eye solution was not available in the medication cart. LVN 1 stated the Dorzolamide eye solution was not administered on 3/5/26 at 0900 hours. LVN 1 verified it was documented as given on 3/4/26 at 1700 hours and on 3/5/26 at 0900 hours. LVN 1 stated missing Resident 156's Dorzolamide eye solution doses would make the symptoms worse. On 3/5/26 at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON further stated missed Dorzolamide eye solution doses could increase the eye pressure and cause pain. Cross reference to F759, example 3.

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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 medication storage for two of six medication/treatment carts inspected (Medication Cart A and Treatment Cart B). * The facility failed to ensure an outdated insulin, unlabeled insulin, and opened undated insulin pens were removed from Medication Cart A. * The facility failed to ensure a partially used sterile wound dressing was removed from Treatment Cart B. These failures had the potential for unsafe medication administration/wound treatment and to negatively impact the residents' well-being.Findings: 1. Review of the facility's P&P titled Insulin Injection dated 2/2015 showed do not use if opened over 28 days. Review of the facility's P&P titled Medication Ordering and Receiving: Medication Labels dated 2/2015 stated if a label does not fit directly onto the product, the label may be affixed to an outside container or carton, but the resident's name at least, must be maintained directly on the actual product container. Review of the facility's P&P titled Administering Medication dated 4/2019 showed the expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. Insulin pens are clearly labeled with the resident's name or other identifying information. On 3/4/26 at 1454 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 5. During the inspection of Medication Cart A, the following was observed:- Resident 148's insulin Glargine pen 100 units/ml 3 ml was labeled with opened date 1/26/26, and expiration 2/23/26. The insulin was not discarded after 2/23/26;- Resident 12's insulin Lantus pen 100 units/ml 3 ml did not have an opened date; and- One opened Novolog insulin pen 100 units/ml 3ml was not labeled with the resident's name and the opened date. LVN 5 confirmed the above findings. 2. On 3/5/26 at 1025 hours, an inspection of Treatment Cart B was conducted with LVN 6. There was one partially used Bordered gauze (sterile wound dressing) observed in the treatment cart. LVN 6 verified the above findings. On 3/5/26 at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure food brought to the facility from outside sources for the resident consumption was properly labeled, dated, and stored one of 30 final sampled residents (Resident 108). * Resident 108's food was unlabeled, undated, and not properly stored. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consume food brought from outside sources.Findings: Review of the facility's P&P titled Bringing in food and/or beverages for residents (undated) showed food and/or beverages brought in should be labeled to monitor for food safety. The item should include: resident's name, room number, and date. Further review of the P&P showed perishable foods/beverages are encouraged for immediate consumption. If food is to be consumed at a later date, the food and/or beverage can be given to the nurse and stored in the resident's designated refrigerator. Unused food will be discarded after third day, or if frozen 30 days. Medical record review for Resident 108 was initiated on 3/9/26. Resident 108 was admitted on [DATE]. Review of Resident 108's H&P examination dated 2/9/26, showed Resident 108 had no capacity to make decisions. Review of Resident 108's MDS assessment dated [DATE], showed Resident 108 had a BIMS score of 14, indicating cognitively intact. On 3/4/26 at 0800 hours, during the initial tour, Resident 108 was observed with an opened fruity pineapple jam on the bedside table. The fruity pineapple jam was unlabeled and undated. The body of the bottle was sticky. On 3/4/26 at 0936 hours, an interview was conducted with CNA 5. CNA 5 stated the facility usually labels and dates the food brought by the family members. CNA 5 further stated the bottle was not clean and did not know when it was brought in by the family member. On 3/9/26 at 1300 hours, an observation was conducted in Resident 108's room. There was unlabeled and undated bread inside a clear bag, a bowl of ham, and a can of prune juice on the bedside table. On 3/9/26 at 1305 hours, an interview was conducted with Unit Manager 1. Unit Manager 1 verified the resident's outside food was unlabeled and undated. On 3/9/26 at 1331 hours, an interview was conducted with DSD. The DSD stated food is labeled with the resident's name, room number, and dated. The DSD further stated staff were expected to check for the right resident's diet, label, and date outside food brought by families or visitors. On 3/11/26 at 1636 hours, the DON acknowledged the above findings.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 one of four garbage dumpsters of the facility. * One garbage dumpster was observed with the lid partially propped open by garbage bags and boxes. This failure had the potential to attract pest/rodents that carried diseases.Findings: Review of the facility's P&P titled Miscellaneous Areas, Garbage and Trash dated 2023 showed the garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. 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 3/4/26 at 0739 hours, an observation was conducted of the facility's one of four outside garbage dumpsters. One garbage dumpster was observed with the lid partially propped open by the garbage bags and boxes, preventing the lid from fully closing. On 3/4/26 at 0902 hours, an interview was conducted with the Maintenance Director. The Maintenance Director was informed of the above observation with a photograph of the garbage dumpster taken on 3/4/26 at 0739 hours. The Maintenance Director verified the above findings and stated the dumpster lid should be fully closed at all times, to prevent pests from getting in and out of the trash and for infection control purposes. On 3/11/26 at 1630 hours, the DON was informed of and acknowledged the above findings.

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F 0552 Level of Harm - Potential for minimal harm Residents Affected - Some	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 completed prior to the use of a psychotropic medication for one of five final sampled residents (Resident 80) reviewed for informed consent. * The facility failed to ensure Resident 80's informed consent included the date and signature of the physician under the prescriber's section of the form. This failure had the potential to violate the residents' rights of not being fully informed of the medications and treatments. Findings: Review of the facility's P&P titled Informed Consent - CA revised date 2017 showed the following:- Physician's orders related to the use of psychotherapeutic drug, or chemical restraint should not be initiated until an informed consent (Anti-Psychotic Medications Consent or Psychotropic Medications, Verbal Consent for) is obtained. Material information is provided to the resident or resident's surrogate decision maker that is material to the resident's decision concerning whether to accept or refuse any proposed treatment or procedure by the: Prescribing physician, or Other health professionals; and- The facility shall verify with the resident's physician or other health professional, that the resident or his/her surrogate decision maker gave informed consent prior to the initiation of psychotherapeutic drugs, physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function. The resident's representative shall be informed when the resident lacks the ability to understand his/her rights and the nature and consequences of proposed treatment. This shall be documented in the resident's health record in the Physician's orders, or Informed Consent, Facility Verification of Form. Medical record review for Resident 80 was initiated on 3/5/26. Resident 80 was admitted to the facility on [DATE]. Review of Resident 80's H&P examination dated 7/20/25, showed the resident had fluctuating capacity to understand and make decisions. Review of Resident 80's Order Summary Report showed a physician's order dated 2/17/26, for Lorazepam (antianxiety medication) oral tablet 0.5 mg to give by mouth every 12 hours for anxiety manifested by verbalization of fear that someone will hurt him. Review of Resident 80's Psychotherapeutic Drug Informed Consent form dated 2/17/26, showed Lorazepam 0.5 mg orally every 12 hours. The consent form showed no signature and date from the physician under the prescriber's section of the form. Review of Resident 80's MAR for 3/1 to 3/9/26, showed the resident had been receiving the Lorazepam 0.5 mg medication twice a day. On 3/10/26 at 1549 hours, an interview and concurrent medical record review for Resident 80 was conducted with RN 3. RN 3 verified the above findings and stated the informed consent should have been signed by the physician to inform the family of the medication's purpose and side effects and to address any questions the spouse had. In addition, RN 3 stated informed consent should have been signed within 72 hours. On 3/11/26 at 1630 hours, the DON was informed and acknowledged the above findings.

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F 0574 Level of Harm - Potential for minimal harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. **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 one of five nonsampled residents (Resident 154) during the Resident Council Meeting was informed of how to contact the State Survey Agency and to communicate with them when needed. This failure had the potential to negatively impact the residents' rights to be informed.Findings: Review of the facility's P&P titled Resident Rights revised 05/2007 showed The Resident has the Right: 25. To a posting of names, addresses and telephone numbers of all pertinent state client advocacy groups such as survey and certification, licensing, ombudsman, protection and advocacy network, and Medicaid fraud control unit. Medical record review for Resident 154 was initiated on 3/6/26. Resident 154 was admitted to the facility on [DATE]. Review of Resident 154's H&P examination dated 2/16/25, showed Resident 154 had the capacity to understand and make decisions. Review of Resident 154's MDS dated [DATE], showed Resident 154 had a BIMS score of 15, indicating cognitively intact. On 3/5/26 at 1402 hours, a concurrent observation and interview was conducted during the resident council meeting in the dining room. The residents in attendance were asked regarding their rights in the facility and how to contact the State Survey Agency and to communicate with them as needed. Resident 154 stated they never know and they do not know how. On 3/5/26 at 1537 hours, an interview and concurrent resident council minutes review was conducted with the Activity Director, DON, and Administrator. When asked about the facility process on informing the residents about their rights, the Activity Director stated the resident rights were read in the beginning of the resident council meeting. When asked regarding how the residents are informed about how to contact the State Survey Agency, the Activity Director could not answer the question and was silent. The Administrator stated the contact information could be searched on the internet and it was on the admission packet. On 3/9/26 at 1533 hours, an interview and concurrent facility document review was conducted with the admission Coordinator. When asked to show admission packet documents for Resident 154, the admission Coordinator was not able to show documentation that Resident 154 was informed on how to contact the State Survey Agency. The admission Coordinator stated Resident 154 had been in the facility for a while and the admission packet could not be found. On 3/11/26 at 1636 hours, the DON acknowledged the above findings.