

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Atherton Baptist Home		STREET ADDRESS, CITY, STATE, ZIP CODE 214 South Atlantic Blvd. Alhambra, CA 91801	
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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide supervision for two of three sampled residents (Residents 12 and 18) under the accidents care area in accordance with facility policy when: 1. Resident 12 was observed sliding off the wheelchair unattended in the activity room and unsupervised during a fall on 1/12/2026 in the resident's bedroom. 2. Resident 18 was observed unattended in the activity room. This deficient practice placed Resident 12 and 18 at risk for accident and/or injury which had the potential to result in harm like fractures (break in bone), hospitalization, and death. Findings: 1. During a review of Resident 12's admission Record, the admission Record indicated the facility initially admitted Resident 12 on 3/29/2022 and was readmitted on [DATE] with diagnoses that included but not limited to dementia (a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life), repeated falls (an unintentional coming to rest on the ground or another surface, which can cause injury), reduced mobility (having difficulty moving around freely, easily, or without pain), unsteadiness on feet (feeling of being wobbly, off balance, or unstable while walking or standing), generalized muscle weakness (widespread decrease in physical strength affecting most or all muscles), difficulty walking (having abnormal or uncontrolled way of moving on foot), and osteoporosis (bone disease that makes bones weak, brittle, and more likely to fracture). During a review of Resident 12's Minimum Data Set (MDS-a resident assessment tool), dated 10/22/2025, the MDS indicated Resident 12 had intact cognitive (mental abilities that help us think, learn, remember, and solve problems) skills for daily decision making. The MDS indicated Resident 12 used a walker (mobility aid, a frame with wheels or legs that provides support for people with difficulty walking) and a wheelchair (chair with wheels) for mobility. The MDS indicated Resident 12 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity) with eating, oral and personal hygiene. The MDS indicated Resident 12 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs but provides less than half the effort) with toileting hygiene, upper and lower body dressing, putting on/taking off footwear, from sitting to standing position from chair, wheelchair or side of the bed, toilet transfer (ability to get on and off a toilet or commode) and walking 10 feet (ft. - unit of measure used for measuring height, length and distance), walking 50 feet with two turns, and walking 150 feet. The MDS also indicated Resident 12 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathing self. During a review of Resident 12's Care Plan initiated 12/24/2025, the Care Plan indicated Resident 12 is at risk for falls related to history of falls. The care plan indicated interventions including anticipating and meeting the resident's needs and reviewing information on past falls, attempting to determine cause of falls and alter or remove any potential causes. During a review of Resident 12's Progress Notes, dated 1/12/2026, the Progress Notes indicated that Resident 12's bed alarm (safety device designed to alert staff when a resident attempts to leave the bed without assistance. It typically consists of a sensor pad placed on the bed or under the mattress that detects changes in pressure or movement. When the resident gets up or shifts in a way that indicates they may exit the bed, the alarm sounds or sends a signal to staff.) (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
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent any accidents (a person cannot control when they pass urine or stool). During an interview on 1/16/2026 at 9:05 AM with LVN 3, LVN 3 stated residents should not be left on their own, unsupervised in the activity room. LVN 3 stated the residents may need something and might try to move/stand that can cause them to fall and sustain injuries. During an interview on 1/16/2026 at 9:35 AM, the DON stated there should be staff present when residents are in the activity room to ensure the safety of residents who were fall risks and should be included in the policy and procedure for the Activity Program. During a review of the facility's policy and procedures (P&P) titled Safety and Supervision of Residents, revised 7/2017, the P&P indicated: The facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. During a review of the facility's P&P titled Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P indicated that resident conditions that may contribute to the risk of falls include, but not limited to: Delirium and other cognitive impairment Lower extremity weakness Functional impairments incontinence		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, the facility failed to ensure the physician reviewed and took timely action on a medication regimen review (MRR, consists of a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) irregularity (includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) identified by the facility's pharmacy consultant for two of five sampled residents (Resident 24 and 58) under unnecessary medications care area by failing to:1 a. Consider a gradual dose reduction (GDR, a periodic attempt to manage a resident's behavioral issues with a lower dose of medication) with the goal of discontinuing Resident 24's Escitalopram (Lexapro, medication used to treat depression and generalized anxiety disorder) 20 milligrams (mg, unit of measurement) and adjusting the medication administration time to the daily time (instead of at bedtime)b. Clarify and add parameter to the Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) instructions for Resident 24's use of Hydrocodone/Acetaminophen (Norco, a combination medication that contains an opioid [sometimes called narcotics, are medication prescribed by physicians to treat persistent to severe pain] and an analgesic).2. Indicate the reason for disagreeing with the pharmacist recommendation for Resident 58 to have a gradual dose reduction for the use of Ativan (Lorazepam - a medication used for anxiety (an emotion characterized by feelings of fear, dread, and uneasiness, often as a reaction to stress). These deficient practices increased the risk that Residents 24 and 58 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to their medication therapy possibly leading to impairment or decline in their mental, functional, and psychosocial wellbeing.Findings: 1. During a review of Resident 24's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE], with the diagnoses including but not limited to dementia (progressive brain disorder that slowly destroys memory and thinking skills) with psychotic (mental health disorder which a person loses touch with reality) disturbance, depression (severe feelings on sadness and hopelessness), pain in right hip, and anxiety disorder (a feeling of nervousness, panic, and fear). During a review of Resident 24's Care Plan, revised on 4/7/2025, the Care Plan indicated Resident 24 used antidepressant medication Escitalopram related to major depressive disorder. The nursing staff interventions were to administer antidepressant medications as ordered by the physician and monitor/document side effects and effectiveness every shift. During a review of Resident 24's Care Plan, revised 4/7/2025, the Care Plan indicated Resident 24 had potential for alteration in comfort related to pain. The nursing staff interventions were to administer Norco oral tablet 5-325 milligrams (mg &ndash; unit of measurement) 0.5 tablet by mouth at bedtime for pain management. Not to exceed three (3) grams/24 hours and observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease range of motion, withdrawal or resistance to care. During a review of Resident 24's Order Summary Report, the Order Summary Report indicated as follows: (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/2025, Hydrocodone-Acetaminophen oral tablet 5-325 mg: Give 0.5 tablet by mouth every eight hours as needed for moderate-severe pain (four to ten) not to exceed 3 grams/24 hours on all acetaminophens. On 4/28/2025, Escitalopram 20 mg tablet: Give 1 tablet by mouth at bedtime for major depressive disorder manifested by verbalization of sadness. During a record review of Resident 24's Minimum Data Set (MDS, a resident assessment and tool), dated 10/13/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 24 required partial/moderate assistance (helper does less than half the effort) for shower/bathe self and tub/shower transfer. The MDS indicated Resident 24 received scheduled pain medication regimen. The MDS also indicated Resident 24 did not have any mood or behaviors and was taking medications such as an antidepressant, antipsychotic (drugs that work by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking), and opioid. During a record review of Resident 24's MAR for the month of December 2025, the MAR indicated Resident 24 did not have any verbalizations of sadness for all three shifts for the month of December. During a review of the Consultant Pharmacist's (CP) Medication Regimen Review for recommendations between 12/10/2025 and 12/11/2025, the MRR indicated Resident 24 had two medications for review: Hydrocodone/Acetaminophen and Escitalopram. The CP indicated for Hydrocodone/Acetaminophen to: Clarify and add this parameter to the MAR instructions: Hold if respiratory rate is less than 12 (and notify physician) and Add a space on the MAR (above the dose) to document the respiratory rate. The CP indicated Escitalopram 20 mg at bedtime for depression manifested by verbalizing sadness (ordered April) does not appear to be showing behaviors to: 1. Consider a dose reduction to 10 mg daily with the goal of discontinuance. 'Irritability' and 'anger' are listed as possible side effects and Resident 24 was also receiving Seroquel (an atypical [second-generation] antipsychotic [drug that treats a form of mental illness] medication used in the treatment of schizophrenia [a chronic and severe mental disorder that affects how a person thinks, feels, and behaves], bipolar disorder [mental disorder characterized by episodes of mania (extreme highs) and depression (extreme lows)] , and major depressive disorder] at bedtime for 'aggressive behavior'. 2. Consider adjusting the administration time to the daily time (instead of at bedside). The CP also indicated if a gradual dose reduction was contraindicated, to specify why. During a concurrent review and interview on 1/16/2026 at 10:46 AM with Licensed Vocational Nurse 1 (LVN 1) of Resident 24's Order Summary Report and Nursing Notes were reviewed. LVN 1 stated the Director of Nursing (DON) was in charge of the MRR. LVN 1 stated neither an indication that the physician was notified nor any changes regarding Resident 24's MRR were done. LVN 1 stated MRR (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was conducted to ensure if residents were receiving the right medications and if there were contraindications to other medications. LVN 1 stated it was important to follow up with the CP's MRR recommendations to ensure safety in terms of medication for adverse reactions. During an interview on 1/16/2026 at 12:01 PM with the DON, the DON stated the physician usually likes the MRR presented to the physician when the physician comes to the facility. The DON stated the facility did not have a specific time frame to complete the MRR. The DON stated that the CP said the MRR could be completed in a few weeks but there was no specific time frame. The DON stated the MRR should at least be completed within the month. The DON stated there needed to be a follow up to see if the physician agreed with the CP's recommendations. The DON stated it was important to follow up with the MRR to avoid any adverse reactions. The DON stated the CP recommendations were for regulations and were not specific to the residents' needs. The DON stated the MRR was to avoid unnecessary use or avoid any adverse reactions. The DON stated the MRR was a collaboration and looks after a specific area for the resident medications. During a concurrent review and interview on 1/16/2026 at 12:13 PM with the DON, Resident 24's Order Summary Report and Nursing Notes were reviewed. The DON stated there were no notes to indicate whether the physician was notified and if the physician wanted to follow or decline the CP's MRR on 12/11/2025 (37 days after monthly MRR). The DON stated the importance of adding respiratory rate parameters were due to respiratory rate depression that could occur when a resident took Hydrocodone-Acetaminophen. The DON also stated it was important to follow up with the physician for a GDR to avoid any adverse reactions that could result in the resident such as drowsiness, dyskinesia (movement disorder that often appears as uncontrolled shakes, tics, or tremors), and confusion. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review (Monthly Report), dated December 2016, the P&P indicated the recommendations are acted upon and documented by the facility staff and or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit. During a review of the facility's P&P titled, Tapering Medications and Gradual Drug Dose Reduction, revised July 2022, the P&P indicated the physician will review periodically whether current medications are still necessary in their current doses; for example, whether an individuals' conditions or risk factors are sufficiently prominent or enduring that they require medication therapy to continue in the current dose, or whether those conditions and risks could potentially be equally well managed or controlled without certain medications, or with a lower dose. 2. During a review of Resident 58's admission Record, the admission Record indicated the resident was admitted on [DATE] with the following but not limited to diagnoses of dementia, depression, anxiety and impulse disorder (a mental health condition marked by a persistent inability to resist strong urges or impulses that lead to repetitive, harmful behaviors, causing significant distress and problems in daily life). During a review of Resident 58's MDS, dated [DATE], the MDS indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS also indicated Resident 58 required substantial/ maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, lower body dressing, putting on/taking off footwear, and personal hygiene but required partial/moderate assistance with shower/bathe self and upper body dressing. The MDS indicated Resident 58 has anxiety disorder and (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is taking antianxiety medication. Resident 58 did not have mood or behavior symptoms. During a review of Resident 58's Care Plan with focus Risk for Adverse reactions related to polypharmacy (the use of multiple medications, typically defined as five or more at once), revised on 4/28/2025, the Care Plan indicated to review pharmacy consult recommendations and follow up as indicated. During a review of Resident 58's Physician Orders, dated 9/12/2025, the Physician Orders indicated the following: Lorazepam Give 0.25 mg by mouth in the afternoon (1 PM) for anxiety as manifested by self-report of constant worrying. Lorazepam tablet 1 mg by mouth in the evening (6 PM) for Anxiety as manifested by self-report of constant worrying. During a review of Resident 58's MRR, dated 12/11/2025, the MRR indicated Resident 58 is taking Lorazepam 0.25 mg PM (1PM) and 1 mg PM (6PM). The MRR indicated to consider a dose reduction, discontinuing the 1 PM dose or decreasing the 6 PM dose to 0.5 mg. The MRR also indicated if a gradual dose reduction is contraindicated, please specify why. During an interview on 1/15/2026 at 4:02 PM, the facility's MRR, dated 12/11/2025, was reviewed. The DON stated the MRR with the GDR for Resident 58 was not but should have been addressed by the resident's primary care physician. The DON also stated Resident 58 can experience adverse drug reactions. During an interview on 1/16/2025 at 10:39AM, the facility's P&P titled, Consultant Pharmacist Reports, dated 12/2016 was reviewed. The DON stated the GDR for Resident 58 needs to be reported to the physician within a week. The DON also stated the P&P does not have a time frame but should indicate a time frame of a week. During a review of the facility's P&P titled, Consultant Pharmacist Reports, dated 12/2016, the P&P indicated recommendations are acted upon and documented by the facility staff and or the prescriber. P&P also indicated physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit.		

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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 and record review, the facility failed to follow its policy to ensure resident's drug regimen was free from unnecessary medication use for one (1) of five (5) sampled residents (Resident 2), under unnecessary medications care area, by failing to have a specific indication for Resident 2's use of Seroquel (quetiapine- an antipsychotic medication to treat mental condition by helping balance certain chemicals in the brain). This deficient practice had the potential to increase the risk for Resident 2 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medication (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), possibly leading to impairment or decline in the resident's mental, functional or psychosocial status. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (progressive decline in mental ability severe enough to interfere with daily life), depression (a common, serious mental health condition characterized by a persistent low mood, loss of interest in activities, and a sense of numbness or emptiness), and anxiety disorder (a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear, worry, or dread that interferes with daily life). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 10/31/2025, the MDS indicated Resident 2 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 required setup or clean-up assistance with eating and oral hygiene. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, upper/lower body dressing, personal hygiene, roll left and right, sit to lying, sit to stand, and toilet transfer. Resident 2 did not have any mood or behavior symptoms. During a review of Resident 2's Order Summary Report, dated 12/24/2025, the Order Summary Report indicated a physician order for the following: Seroquel oral tablet 25 milligrams (mg-unit of measurement) give 1 tablet by mouth two times a day for psychosis (significant loss of contact with reality) manifested by (m/b) periods of paranoia (an intense, irrational distrust and suspicion of others, often with the unfounded belief that people are trying to harm, deceive or conspire against them), with a start date of 1/2/2025. Monitor behavior of psychosis m/b periods of paranoia behavior every shift, with a start date of 1/29/25. During a review of Resident 2's Care Plan, dated 1/29/2025, the care plan indicated Resident 2 used psychotropic medications Seroquel related to (r/t) psychosis. The care plan indicated interventions to monitor/record occurrence of target behavior (a specific observable, and measurable action selected for change, assessment, or intervention) symptoms periods of paranoia and document per facility protocol. During a concurrent interview and record review on 1/16/2026, at 9:59 AM, with Licensed Vocational Nurse 1 (LVN 1), Resident 2's physicians orders were reviewed. LVN 1 stated Resident 2 was ordered Seroquel for psychosis and paranoia. LVN 1 stated Resident 2's paranoid behavior included seeing things that were not there, saying that someone took her daughter or was going to hurt her or take her away from her place. LVN 1 stated Resident 2's behavior of seeing things were hallucinations and not paranoia. LVN 1 stated Resident 2's specific paranoid behavior was not indicated in Resident 2's physician order. LVN 1 stated Resident 2's order for behavior monitoring for Seroquel did not and should have indicated the specific paranoid behavior that needed to be monitored. LVN 1 stated this will ensure all the licensed nurses are monitoring the same behavior which will ensure accurate evaluation if the medication is effective or not. During an interview on 1/16/2026, at 10:31 AM, with LVN 2, LVN 2 stated Resident 2's behavior was being monitored because she was taking Seroquel for paranoia. LVN 2 stated Resident 2's paranoid behavior included agitation, aggressive behavior, and accusing staff of (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taking her things away. LVN 2 stated Resident 2's behavior monitoring order did not indicate the specific type of paranoia that needed to be monitored by facility staff. LVN 2 stated that the specific paranoid behavior should be specified in Resident 2's physician's order so that Resident 2's behavior could be managed. LVN 2 stated it was important to monitor Resident 2's specific paranoid behavior to determine if her Seroquel medication needed to be reevaluated by the physician. During an interview on 10/16/2026, at 3:04 PM, with the Director of Nursing (DON), the DON stated Resident 2's Seroquel was ordered for episodes of seeing things that are not there. The DON stated Resident 2's Seroquel order should indicate the specific paranoid behavior that needed to be monitored. The DON stated the specific behaviors of residents on antipsychotic medications should be monitored to make sure that the medication was working and to provide interventions when the resident displayed the behavior. During a review of the facility's policy and procedure (P&P), titled, Antipsychotic Medication Use, revised on 7/2022, the P&P indicated the following: Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavior symptoms have been identified and addressed. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The attending physician and facility staff will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications.		

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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 record review, the facility failed to develop and implement a comprehensive, resident-centered care plan (a document that outlines a resident's care goals and the activities that will be performed to achieve those goals) for one (1) of 18 sampled residents (Resident 8) by failing to address Resident 8's central venous catheter (CVC, a type of access used for hemodialysis [HD-a procedure removing excess fluid and metabolic waste and products or toxic substances from the bloodstream]), in accordance with the facility's care plan policy. This deficient practice had the potential to not be able to provide specific interventions to address risk for having a CVC, such as accidental dislodgement (displacement/removal of a device thought to be securely in position), which could result in serious harm to Resident 8. Findings: During a review of Resident 8's admission Record, the admission Record indicated the facility initially admitted the resident on 6/25/2011 and was readmitted on [DATE] with diagnoses that included but not limited to end stage renal disease (ESRD-condition in which the kidneys stop functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life) with dependence on renal (kidney) dialysis (a treatment that removes waste and excess fluid from the blood when the kidneys are no longer functioning properly), and hypertension (high blood pressure). During a review of Resident 8's Minimum Data Set (MDS-a resident assessment tool) dated 12/29/2025, the MDS indicated Resident 8 had intact cognitive (ability to think, remember, and make decisions) skills for daily decision making. The MDS indicated Resident 8 was independent (residents complete the activity by themselves with no assistance from a helper) with eating, oral/toileting/personal hygiene, upper and lower body dressing, rolling left and right, sit to lying, lying to sitting on side of the bed, sit to stand, chair/bed to chair transfer, toilet transfer, and walking 10 feet (ft.- unit of measure used for measuring height, length and distance), walking 50 feet with two turns, and walking 150 feet. The MDS indicated Resident 8 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with putting on/taking off footwear and tub/shower transfer. The MDS indicated Resident 8 required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with showering/bathing self. The MDS further indicated Resident 8 was on dialysis and had intravenous access (a medical technique that involves inserting a small, flexible tube [catheter] or needle into a vein to create a direct, temporary, or long-term, route into the bloodstream. During an observation and interview on 1/13/2026 at 4:03 PM in Resident 8's room, Resident 8 was observed sitting on her recliner chair. Resident 8 stated she was on HD every Monday-Wednesday-Friday and had a CVC for her access. Resident 8 stated there was an emergency kit (E-Kit, a portable collection of essential, sterile supplies used to temporarily manage, secure, or repair a catheter line if it becomes damaged, leaks, or if the dressing falls off. It is designed to be kept immediately available to prevent infection and stop air from entering the bloodstream before professional medical help is reached) on the shelf next to her bedside table. Resident 8 was observed pointing to the shelf right next to her bedside table on the right side of the bed. During a concurrent interview and record review on 1/15/2025 4:44 PM with the Director of Nursing (DON), the policy and procedures (P&P) titled, Access and Care of Hemodialysis Catheters, revised 2/2023 and Care of a Resident with End Stage Renal Disease, revised 9/2010 were reviewed. The DON stated the P&Ps did not specifically address care of the CVC when accidental dislodgement occurs. The DON stated that for best practice, the P&P should include how to manage the CVC in the event it gets dislodged or damaged. During the same concurrent interview and record on 1/15/2025 at 4:44 PM with the DON, the care plans focused on: Potential for complications of HD related to ESRD, revised on 7/22/2025 and Resident 8's ESRD care (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan, revised 1/9/2026, were reviewed. The DON stated Resident 8 has a CVC on the right upper chest. The DON stated Resident 8 did not have and should have a care plan developed specifically for CVC to address the potential risks and complications and its interventions. The DON stated there should be a care plan for care of the CVC addressing not only risk of infection but also dislodgement. The DON stated the care plan should guide the staff on what interventions to perform in the event of an accidental dislodgement. The DON stated the failure to develop a care plan for the CVC represented a lack of comprehensive planning which could result in staff not knowing how to manage and care for Resident 8 if the CVC was accidentally pulled out and resulted in hemorrhage (bleeding).During a review of the care plan focused on Resident 8 has ESRD, revised 1/9/2026, the care plan interventions did not indicate presence and management of HD CVC access.During a review of the facility's P&P titled, Care of a Resident with ESRD, the P&P indicated residents with ESRD will be cared for according to currently recognized standards of care, education and training of staff specifically including how to recognize and intervene in medical emergencies such as hemorrhage and septic infections (a serious condition in which the body responds improperly to an infection).During a review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, revised 3/2022, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the care plan was implemented for one (1) of 1 sampled resident (Resident 47), under language and communication care area, by failing to put on the resident's hearing aid and provide a pencil and paper for communication. This deficient practice had the potential for Resident 47 from expressing her needs in a manner that the staff can understand, which could result in a delay in the provision of the resident's necessary care and services. Findings: During a review of Resident 47's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), muscle weakness, and need for assistance with personal care. During a review of Resident 47's Minimum Data Set (MDS - a resident assessment tool), dated 10/20/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 47 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with lower body dressing, shower/ bathe self and toileting hygiene but required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing, putting on/taking off footwear, personal hygiene and chair/bed to chair transfer. The MDS indicated Resident 47 has moderate difficulty (speaker has to increase volume and speak distinctly) in hearing. During a review of Resident 47's Care Plan with focus communication problem related to hard of hearing, revised 1/16/2025, the Care Plan indicated the following staff interventions: Provide assistive communication devices (hearing amplifier) and writing board. Resident requires staff to put on her hearing aid with communication. During a concurrent observation in Resident 47's room with Infection Preventionist Nurse (IPN) on 1/13/2026 at 8:44 AM, Resident 47 was observed sitting in her wheelchair and asked to be put back to bed. The IPN replied to Resident 47 and the resident yelled, I can't hear you. IPN stated and was observed attempting to look for a writing board. Resident 47 was noted to be without hearing aids and without a writing board/paper and pencil at bedside. During an interview on 1/16/2026 at 9:34 AM, the IPN stated on 1/13/2026, Resident 47 was not wearing any hearing aids and did not have any writing materials for communication. The IPN also stated Resident 47 should have hearing aids on and a writing board/pad, or pencil and paper, so the resident is able to communicate her needs with the staff. During an interview on 1/16/2026 at 10:22 AM, the facility's Policy and Procedure (P&P) titled, Care of Hearing-Impaired Resident, dated 2001, was reviewed. The Director of Nursing (DON) stated the resident should have a writing pad or pen and paper to write, if able, when communicating with the staff. The DON also stated that this makes communicating easier so the staff can meet the needs of the resident. During a review of the facility's P&P titled, Care of Hearing-Impaired Resident, dated 2001, the P&P indicated when interacting with the hearing impaired, staff will implement the following but not limited to providing pencil and paper or tablet to communicate in writing, if the resident is able. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Plans, dated 2001, the P&P indicated the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and are services provided for the resident.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor, assess, and inform the physician regarding a skin discoloration (bruises - an injury appearing as an area of discolored skin on the body, caused by a blow or impact rupturing underlying blood vessels) on the resident's left arm for one of one sampled resident (Resident 16) receiving anticoagulant medications (medications that prevent blood from clotting excessively) in accordance with professional standards of practice (authorized, authoritative guidelines established by professional bodies to define the expected behaviors, skills, ethics, and knowledge required for competent practice). This deficient practice had the potential to result in a lack of or delay in assessing for possible complications of Resident 16's skin discoloration which could lead to undetected bleeding and hospitalization. Findings: During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included transient cerebral ischemic attack (stroke-a temporary episode of blockage of blood flow to the brain), unspecified atrial fibrillation (afib-irregular, rapid heartbeat), and essential hypertension (high blood pressure). During a review of Resident 16's Minimum Data Set (MDS- a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 16 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 16 required setup or clean-up assistance with eating, oral/toileting hygiene, and personal hygiene. The MDS indicated Resident 16 required supervision or touching assistance with sit to lying, sit to stand, chair/bed-to-chair transfer, walking 150 feet (ft-unit of measurement), and toilet transfer. The MDS also indicated Resident 16 required partial/moderate assistance (helper does less than half the effort) with shower/bathe self, upper body dressing, and lower body dressing. During a review of Resident 16's Order Summary Report, dated 12/24/2025, the Order Summary Report indicated the following physician orders: Aspirin EC (medication used to prevent blood clots and lower the risk for a heart attack or stroke) Tablet Delayed Release 81 milligrams (mg- unit of measurement) give 1 tablet by mouth one time a day for cardiac (heart) protector, give with food, with a start date of 11/13/2025. Xarelto (rivaroxaban- a blood thinner used to prevent and treat dangerous blood clots) Oral Tablet 10 mg give 1 tablet by mouth in the evening for afib, give with meal, with a start date of 1/2/2025. Monitor for any signs and symptoms of bleeding related to (r/t) Xarelto and Aspirin- check every (q) shift for bleeding gums, nose bleeds, bruising, coughing up blood, stained mucus, black stools. If present report to physician (MD), with a start date of 1/2/2025. During a review of Resident 16's Care Plan, dated 4/22/2025, the Care Plan indicated Resident 16 was on anticoagulant therapy Xarelto r/t afib. The Care Plan intervention included the following: Administer anticoagulant medications as ordered by the physician. Monitor for side effects and effectiveness q shift. Daily skin inspection. Report abnormalities to the nurse. Monitor [NAME] any signs and symptoms of bleeding r/t Xarelto and aspirin- check q shift for bleeding gums, nose bleeds, bruising, coughing up blood stained mucus, black stools. If present report to MD. During a concurrent observation and interview on 1/13/2026, at 9:50 AM, with Resident 16 in Resident 16's room, Resident 16 was observed sitting on her chair watching television. Resident 16 stated she was taking Xarelto and Aspirin which would give her bruises. Resident 16 pulled up her left sleeve and stated she had a dark purple bruise on the resident's left upper arm. During a concurrent interview and record review on 1/14/2026, at 3:25 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 16's Point of Care (POC- the delivery and documentation of clinical services, such as nursing care, therapy, or diagnostics, directly at the resident's location (bedside, room) at the moment it occurs) Response History form (the detailed, real-time record of care documentation captured directly at the resident's bedside) dated 1/14/2026 was reviewed. LVN 1 stated Resident 16 bruised easily because the resident was taking Xarelto and Aspirin. LVN 1 stated Resident 16 was monitored for signs of (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bleeding every shift. LVN 1 stated Certified Nursing Assistants perform body checks when they assist the residents with their activities of daily living (ADL- basic self-care tasks like eating, bathing, dressing, and using the toilet). LVN 1 stated Resident 16's POC Response History form indicated Resident 16 had an old discoloration on 1/14/2026, at 9:52 AM. LVN 1 stated she was not aware that Resident 16 had a bruise on the resident's left arm. During an interview on 1/14/2026, at 4:18 PM, with the Infection Prevention Nurse (IPN), IPN stated Resident 16 had a bruise on the resident's left arm. During an interview on 1/15/2026, at 11:28 AM, with CNA 1, CNA 1 stated she reports new bruises she sees on residents during ADL care to the LVN. CNA 1 stated Resident 16 has had the bruise on her left lower arm for approximately three (3) months. CNA 1 stated she informed an unknown LVN three months ago about the bruise and was informed by the LVN that the bruise was already reported to the MD. CNA 1 stated she did not report the bruise on Resident 16's left lower arm anymore because CNA 1 thought it was an old bruise from 3 months ago that was already reported. CNA 1 stated it was important to report skin discoloration or bruises to the LVN so the MD can be notified and the cause of bruise can be investigated. During an interview on 1/15/2026 at 12:02 PM, with LVN 1, LVN 1 stated signs and symptoms of bleeding on a resident taking anticoagulants should be reported to the MD right away to make sure the resident was not bleeding internally. LVN 1 stated it was also important to find out the cause of the bleeding because sometimes it could also be a sign that the resident was abused (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) or had a fall. During an interview and record review on 1/15/2026, at 12:10 PM, with the IPN, Resident 16's Progress Notes dated from 10/25/2025 to 1/13/2026 were reviewed. The IPN stated there was no documentation of discoloration or bruising on Resident 16's left lower arm from 10/25/2025 to 1/13/2026. The IPN stated the discoloration on Resident 16's left lower arm was a change in condition and the MD should have been notified as soon as possible or by the end of the shift. The IPN stated it was important to notify the MD of any signs and symptoms of bleeding in case the resident's anticoagulant medications need to be changed. During an interview on 1/16/2026, at 12:27 PM, with the Director of Nursing (DON), the DON stated the signs and symptoms of bleeding observed by the CNA should be reported immediately to the LVN. The DON stated LVNs should assess and provide the necessary interventions to prevent complications as soon as signs and symptoms of bleeding are observed or reported to the licensed nurse. The DON stated the MD should be notified immediately and no more than 24 hours after signs and symptoms of bleeding were reported. The DON stated if bleeding was not assessed and reported to the MD, the resident can have complications like hemorrhage (an escape of blood from a ruptured blood vessel) which was an emergency and could result in hospitalization. During a review of the facility's P&P, titled, Acute Condition Changes-Clinical Protocol, revised on 3/2018, the P&P indicated the following:Direct care staff, including nursing assistants will be trained to recognizing subtle but significant changes in the resident and how to communicate these changes to the Nurse. Nursing assistants are encouraged to use the Stop and Watch Early Warning Tool (a simple, visual communication aid used in healthcare to help staff quickly spot and report subtle signs of a resident's condition deteriorating to nurses or managers) to communicate subtle changes in the resident to the nurse. During a review of the facility's policy and procedure (P&P), titled, Anticoagulation-Clinical Protocol, revised on 11/2018, the P&P indicated the following:As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated; for example, those with a recent history of atrial fibrillation.Assess for any signs or symptoms related to adverse drug reactions due to the medications alone or in combination with other medications. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the personal belongings were documented in the inventory list (a comprehensive, itemized record of all goods, raw materials, and finished products of the resident) in accordance with the facility's Policy and Procedure (P&P) for one (1) of 1 sampled resident (Resident 18) under personal property care area. This deficient practice has the potential to cause Resident 18 to lose his personal belongings and prevent the facility from being able to replenish them. Findings: During a review of Resident 18's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of age-related physical debility (a state of profound weakness, lack of energy, and diminished strength), unsteadiness on feet, and muscle weakness. During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool), dated 10/24/2025, the MDS indicated the resident was moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 18 required partial/moderate assistance (helper does less than half the effort. Helper lifts or holds trunk or limbs but provides less than half the effort) with slower/bathe self, upper body dressing, lower body dressing and putting on/ taking off footwear but required supervision/touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with toileting hygiene, and personal hygiene. During a review of Resident 18's Inventory List, dated 11/10/2024, the inventory list indicated the resident has 1 extender (device that seizes, snatches, or picks up objects, often used for reaching items). During an observation on 1/13/2026 at 10:13 AM in Resident 18's room, Resident 18 stated he has two extenders, one long extender and one short extender. One of the extenders was observed on top of the bed and the other one was on the floor, in between the resident's bed and the wall. During a concurrent review and interview with the Social Services Director (SSD) on 1/15/2026 at 3:36 PM, Resident 18's inventory list, dated 11/10/2024, was reviewed. The SSD stated that when Resident 18 was readmitted on [DATE], the resident had two (2) extenders; however, the inventory list only indicated one extender. The SSD also stated that the facility needs to ensure all residents' belongings are accounted for on the inventory list. The SSD added that if residents' belongings go missing, the facility can replenish them. During an interview on 1/16/2026 at 10:32 AM, the facility's Policy and Procedure (P&P) titled, Personal Property, revised 11/2010, was reviewed. The Director of Nursing (DON) stated that residents' personal items are to be documented in the inventory. The DON also stated that this process ensures residents' personal items do not go missing, and if they do, the facility can address the issue. During a review of the facility's P&P titled, Personal Property, revised 11/2010, the P&P indicated the resident's personal belonging and clothing shall be inventoried and documented upon admission and as such items are replenished.		