STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555306	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kei-Ai South Bay Healthcare Center	15115 S Vermont Ave Gardena, CA 90247

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to label a container of dehydrated mashed potatoes with a use by date and failed to properly sanitize (the process of keeping places free from dirt, infection, disease) cookware. This failure had the potential to result in the preparation and provision of expired food for the residents and the potential to result in the use of improperly sanitized cookware used to prepare food for the residents. Findings:During an observation on 1/20/2026, at 8:25 a.m., in the kitchen, on the counter, near the sink, a clear container labeled Mashed Potatoes did not have a use by date. During an interview on 1/20/2026, at 8:27 a.m., with DS1, DS1stated there should be a use by date once opened. DS1 stated they will throw it away because we won't know when it will expire and the residents could get sick from the food if the use by date is not on the opened product.During an observation on 1/20/2026, at 8:35 a.m., in the kitchen, at the sanitation sink, multiple cookware items were not submerged (completely covered) in the sanitized solution at the sanitizer sink.During an interview on 1/20/2026, at 8:37 a.m., at the sanitation sink, with DS2, DS2 stated, sanitized items should be fully submerged in the water that has a sanitation solution, if the items are not submerged in the water, they are not properly sanitized and can cause an illness. During an interview on 1/23/2026, at 9:10 a.m., with the DSS, in the DSS office, the DSS stated for cookware sanitation, the items must be completely submerged in the sanitizing fluid and there should be an open date and a use by date for all dry food products.During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating Foods (Date Marking), dated 2020, the P&P indicated that expiration dates on commercially prepared, dry storage food items will be followed.During a review of the facility's policy and procedure (P&P) titled, Dishwashing: Manual, dated 2020, the P&P indicated, the pots and pans will be washed in a hot detergent solution in the first compartment, rinsed in clean warm water in the second compartment, and sanitized by either heat or chemicals in the third compartment.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Ensure one of seven sampled residents (Resident 61) Certified Nursing Assistant (CNA) 1 was seated while feeding Resident 61. This deficient practice of CNA 1 was not seated while feeding Resident 61 had the potential to make her feel uncomfortable.During a review of Resident 61's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 61 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 61's diagnoses dysphagia (difficulty swallowing), hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body), and gastro-esophageal reflux disease ([GERD]- a chronic condition of frequent backflow of stomach acid into the esophagus). During a review of Resident 61's History and Physical (H&P), dated 7/31/2025, the H&P indicated Resident 61 did not have the capacity to make decisions. During a review of Resident 61's Minimum Data Set ([MDS] a resident assessment tool), dated 12/8/2025, the MDS indicated Resident 61's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 61 was dependent (helper does all the effort) on staff for eating, showering, and dressing. The MDS indicated Resident 61 had a swallowing disorder with complaints of difficulty with swallowing. During a review of Resident 61's care plan, Impaired nutritional and hydration, dated 11/20/2025, the care plan indicated the interventions assist resident during mealtime. During a review of Resident 61's physician order, Order Summary Report, dated 12/15/2025, the physician order indicated regular small portions diet with pureed texture and mildly thick consistency. During an observation on 1/20/2026 at 12:40 p.m., in Resident 61's room, CNA 1 was standing over and feeding Resident 61 during lunch time. During an interview on 1/20/2026 at 12:53 p.m., with CNA 1, CNA 1 stated she was standing over and feeding Resident 61 during lunch time on 1/20/2026. CNA 1 stated she should have been sitting at eye level feeding Resident 61. CNA stated the purpose of seating with the resident so the resident would feel connected to the process of eating. CNA 1 stated it would make Resident 61 feel more dignified. During an interview on 1/21/2026 at 1:48 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when feeding residents the staff should be sitting. LVN 1 stated standing over Resident 61 while feeding could make her feel rushed to eat and could affect her well-being. During a review of facility's policy and procedures (P&P) titled, Quality of Life-Dignity, dated 8/2009, the P&P indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The P&P indicated demeaning practices and standards of care that compromise dignity was prohibited, staff shall promote dignity and assist residents as needed. During a review of facility's policy and procedures (P&P) titled, Assisting the Impaired Resident with In-Room Meals, dated 9/2013, the P&P indicated the purpose of this procedure was to provide appropriate support for residents who need assistance with eating. The P&P indicated if you were going to be seated during feeding, position a chair where it will be convenient for you and the resident.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Ensure one of seven sampled residents (Resident 103) had a consent (when a patient agrees to a treatment or procedure understanding of the risk and benefits of treatment) for the antipsychotic medication Seroquel (medication to manage schizophrenia, bipolar, and major depressive disorder). This deficient practice of not obtaining consent antipsychotic medication Seroquel had the potential for Resident 103 not to be educated on the risk and benefits of the medication.During a review of Resident 103's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 103 was admitted to the facility on [DATE]. Resident 103's diagnoses osteoarthritis (a chronic degenerative joint disease the breakdown of articular cartilage causing pain, stiffness, and reduce mobility), muscle weakness (reduction in muscle strength that cause difficulty doing specific task), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 103's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 103's cognition (ability to learn, reason, remember, understand, and make decisions) had no cognitive impairment. The MDS indicated Resident 103 was dependent (helper does all the effort) on staff for eating, showering, and dressing. The MDS indicated Resident 103 was on antipsychotic mediation. During a review of Resident 103's physician order titled, Order Summary Report, dated 10/27/2025, the physician order indicated Seroquel 25 milligrams ([mg] - a metric unit of mass) to give 0.5mg tablet by mouth at bedtime for schizophrenia. During a concurrent interview and record review on 1/23/2026 at 12:10 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 103's consent documents were reviewed. There was no consent for Seroquel 25mg to give 0.5mg tablet by mouth at bedtime for schizophrenia. LVN 1 stated the Seroquel 25mg was being administered at bedtime. LVN 1 stated the purpose of the consent was for Resident 103 to agree with taking the medication and understand the potential side effects. During a concurrent interview and record review on 1/23/2026 at 12:45 p.m., with Assist Director of Nursing (ADON), Resident 103's consent documents were reviewed. There was no consent for Seroquel 25mg to give 0.5mg tablet by mouth at bedtime for schizophrenia. The ADON stated there was no consent for Seroquel 25mg and should have been consented. The ADON stated it was a requirement to get consent for antipsychotic medication. The ADON stated the purpose of getting consent to educate the residents of the medication side effects. During a review of facility's policy and procedures (P&P) titled, Informed Consent Policy, dated 1/2024, the P&P indicated it was to involve residents in their care decisions by facilitating information and obtaining consent for the use of psychotropics drugs. The P&P indicated when there was new or an increase in psychotropic drug the facility was to obtain an informed consent.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure one of seven sampled residents (Resident 112) was weighed on and after admission. This deficient practice of not weighing Resident 112 upon admission and after had the potential to not keep track of weight loss.During a review of Resident 112's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 112 was admitted to the facility on [DATE]. Resident 112's diagnoses benign prostatic hyperplasia (enlargement of the prostate gland), dermatitis (chronic skin inflammation), and gastro-esophageal reflux disease ([GERD]- a chronic condition of frequent backflow of stomach acid into the esophagus). During a review of Resident 112's Minimum Data Set ([MDS] a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 112's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 112 was partial/moderate dependent (helper does less than half the effort) on staff for toileting hygiene, showering, and dressing. During a review of physician orders titled, Order Summary Report, dated 1/15/2026, the physician orders indicated Resident 112 was to have weekly weights every Monday for 30 days. During a review of Resident 112's Weights and Vitals Summary, dated 1/20/2026, the vital signs indicated no documentation of weight. During a concurrent interview and record review on 1/21/2026 at 2:24 p.m., Resident 112's with Restorative Nurse Assistant (RNA) 1, Order Summary Report, dated 1/15/2026 was reviewed. The physician orders indicated Resident 112 was to have weekly weights every Monday for 30 days.RNA 1 stated Resident 112 was not weighed on admission [DATE]) and was not weighed on Monday 1/19/2026. RNA 1 stated the facility had no way of knowing if the resident was gaining or losing weight. RNA 1 stated it was important to weigh the resident to know If the food provided was appropriate to prevent weight loss. During a concurrent interview and record review on 1/21/2026 at 2:30 p.m., Resident 112's Weight and Vitals Summary, was reviewed. The vital signs indicated no documentation of current weight. LVN 1 stated when the residents were admitted the residents were to be weighed. LVN 1 stated Resident 112 was admitted on admission [DATE]) and was not weighed after admission. LVN 1 stated not having the weight the staff will not be able to keep track if the residents were to become malnourished or if there was an emergency and needed to use certain medications requiring weight. During a review of the facility's policy and procedures (P&P) titled, admission Assessment, dated 10/2022, the P&P indicated the purpose of the procedure was to gather information and to conduct a physical assessment of the resident including vital signs.

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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 interview and record review the facility failed to ensure two of seven sampled residents (Residents 77 and 103) had comprehensive individualized care plans addressing:Resident 103's anti-psychotic medication Seroquel (a medication to treat [schizophrenia]- a mental illness that is characterized by disturbances in thought). 2. Resident 77's peripherally inserted central catheter ([PICC]- a long thin tube inserted into the upper arm to give medication) line.This deficient practice placed residents at risk for unrecognized medication side effects and PICC-related complications due to the absence of staff guidance in the care plan.Findings: A.During a review of Resident 103's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 103 was admitted to the facility on [DATE]. Resident 103's diagnoses osteoarthritis (a chronic degenerative joint disease the breakdown of articular cartilage causing pain, stiffness, and reduce mobility), muscle weakness (reduction in muscle strength that causes difficulty doing specific tasks), and schizophrenia. During a review of Resident 103's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 103's cognition (ability to learn, reason, remember, understand, and make decisions) had no cognitive impairment. The MDS indicated Resident 103 was dependent (helper does all the effort) on staff for eating, showering, and dressing. The MDS indicated Resident 103 was risk of pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). The MDs indicated for skin and ulcer/injury treatment Resident 103 was to have a pressure reducing devices. During a review of Resident 103's physician order titled, Order Summary Report, dated 10/27/2025, the physician order indicated Seroquel 25 milligrams ([mg] - a metric unit of mass) to give 0.5mg tablet by mouth at bedtime for schizophrenia. During a concurrent and record review on 1/22/2026 at 11:19 a.m., with Licensed Vocational Nurse (LVN) 7, Resident 103's physician order titled, Order Summary Report, dated 10/27/2025 was reviewed. The physician order indicated Seroquel 25 mg to give 0.5mg tablet by mouth at bedtime for schizophrenia. LVN 7 stated there was no care plan for Seroquel. LVN 7 stated there should be a care plan with goals and a list of interventions. LVN 7 stated the interventions should list what to monitor such as side effects and behaviors to report. LVN 7 stated the care plan was a guide to look for life threatening side effects so the staff could check if the interventions were effective. During a review of policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 1/2012, the P&P indicated a care plan was to be developed to include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The P&P indicated identifying problem areas and their causes and develop interventions that were targeted and meaningful to the resident. B.During a review of Resident 77's admission Record, the admission Record indicated Resident 77 was admitted to the facility on [DATE]. Resident 77's diagnoses included sepsis, methicillin-resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 77's MDS, dated [DATE], the MDS indicated the resident was assessed to have clear cognition (ability to think and reason). The MDS indicated Resident 77 required dependent assistance from staff for activities of daily living (ADLs) such as transferring, toileting, lower body dressing and was partially dependent on staff for positioning and upper body dressing. During a concurrent interview and record review on 1/21/2026 at 3:15 p.m. with Registered Nurse (RN) 1, Resident 77's Care Plans were reviewed. No care plan regarding PICC line for Resident 77 was found. RN 1 stated there was not a care plan for PICC line for Resident 77. RN 1 stated one should have been implemented. RN 1 stated that without a care plan there would not be a way to know if all the patient centered interventions were performed and monitored. During an interview on 1/23/2026 at 2:30 p.m., with the Director of Nursing (DON), the DON stated a care plan was a blueprint for the residents' care, needs, interventions and goals. The DON stated if a care plan was not created it was possible that we would not give the residents the complete care they need. During a review of the P&P titled, Care Planning, dated 1/1/2012, the P&P indicated, a comprehensive care plan will be developed for each resident. The care plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. Each resident's care plan will describe the following: services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Review, update, and/or revise the care plan to address use of Low Air Loss (LAL) mattress for two of three sampled residents (Residents 2 and 14). This deficient practice had the potential to affect the delivery of necessary care and treatments for Residents 2 and 14.Findings: a.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and last readmitted on [DATE]/2025. Resident 2's diagnoses included dementia (a progressive state of decline in mental abilities), sepsis (a life-threatening blood infection), and encephalopathy (any condition that causes the brain to function abnormally, leading to mental changes like confusion, memory loss, personality shifts, or drowsiness). During a review of Resident 2's History and Physical (H&P), dated 12/1/2025, the H&P indicated Resident 2 did not have the capacity to make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 12/23/2025, the MDS indicated the resident was assessed to have severe cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 2 required dependent assistance from staff for activities of daily living (ADLs) such as oral hygiene, toileting, showering, and positioning. The MDS indicated Resident 2 was at risk for developing pressure ulcers/injuries. b.During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE]. Resident14's diagnoses included malignant neoplasm of brain (brain cancer), epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body), and acute kidney failure (sudden loss of the ability of the kidneys to function). During a review of Resident 14's H&P, dated 12/11/2025, the H&P indicated Resident 14 could make needs known but could not make medical decisions. During a review of Resident 14's MDS, dated [DATE], the MDS indicated the resident was assessed to have moderate cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 14 required dependent assistance from staff for activities of daily living (ADLs) such as toileting, showering, dressing and positioning. The MDS indicated Resident 14 was at risk for developing pressure ulcers/injuries. During a concurrent interview and record review on 1/22/2026 at 3:10 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 2 and 14's Care Plans were reviewed. The care plan that focused on skin breakdown was not revised to show interventions regarding LAL mattress. LVN 3 stated the care plan should have been revised when the LAL was put into use. LVN 3 stated revising care plans were important they serve as a guide for the nursing staff, to make sure all patient centered care and interventions were not missed. During an interview on 1/23/2026 at 2:30 p.m., with the Director of Nursing (DON), the DON stated a care plan was a blueprint for the residents' care, needs, interventions and goals. The DON stated if a care plan was not revised it was possible that the residents would not get the complete and updated care they need. During a review of the policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated December 2016, the P&P indicated, assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The Interdisciplinary Team must review and update the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment. During a review of the policy and procedure (P&P) titled, Low Air Loss Mattress Use, dated 12/22/2025, the P&P indicated, the nursing staff and the wound care nurse will: incorporate low air loss (LAL) mattress use into the comprehensive care plan.

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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: 1. Ensure one of seven sampled residents (Resident 97) sling (an orthopedic appliance used to immobilize, support, or protect an injured limb) device was on his right arm.This deficient practice of not placing a sling to Resident 97's right shoulder placed him at risk for dislocation (when a bone is forced out of its normal position at a joint). During a review of Resident 97's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 97 was admitted to the facility on [DATE]. Resident 97's diagnoses cerebral infarction (the death of brain tissue caused by a lack of oxygen), muscle weakness (reduction in muscle strength), and abnormalities of mobility (any limitation in independent, purposeful physical movement, ranging from partial impairment to complete immobility). During a review of Resident 97's Minimum Data Set ([MDS] a resident assessment tool), dated 11/10/2025, the MDS indicated Resident 97's sometime had the ability to make self-understood. The MDS indicated Resident 97 was dependent (helper does all the effort) on staff for eating, showering, and dressing. During a review of Resident 97's physician orders titled, Oder Summary Report, dated 2/25/2025, the physician order indicated to provide a right shoulder sling at all times to prevent subluxation (when a bone is partially pulled or pushed out of place) and at risk for dislocation. During an observation on 1/20/2026 at 9:05 a.m., in Resident 97's room, Resident 97 did not have a sling on the right arm. During an observation on 1/20/2026 at 11:09 a.m., in Resident 97's room, Resident 97 did not have a sling on the right arm. During a concurrent interview and pictured record review on 1/21/2026 at 1:55 p.m. with, Restorative Nurse Assistant (RNA) 1, the picture of Resident 97 not wearing a sling to the right arm was reviewed. RNA 1 stated Resident 97 was to always wear a sling and did not have a sling placed on the right arm. RNA 1 stated the sling was to be worn to support his right shoulder. RNA 1 stated if the right shoulder was not being supported at all times, which placed Resident 97's at risk for his right shoulder to get worse. During a concurrent interview and pictured record review on 1/21/2026 at 3:04 p.m. with, Licensed Vocational Nurse (LVN) 1, the picture of Resident 97 not wearing a sling to the right arm was reviewed. LVN 1 stated Resident 97 was always to wear a sling to the right shoulder. LVN 1 stated the sling was to be placed to prevent any risk for dislocation of the right shoulder. During a review of facility's policy and procedures (P&P) titled, Certified Nursing Assistant, unknown date, the P&P indicated the purpose of the job description to provide to provide the residents with routine daily nursing care and services. The P&P indicated to assist with the application of slings, elastic bandages, and binders. During a review of facility's P&P titled, Assistive Devices and Equipment, dated 7/2017, the P&P indicated the facility provides, maintains, trains, and supervises the use of assistive devices and equipment for residents. The P&P indicated devices, and equipment will be maintained on schedule.

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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 and record review, the facility failed to:Ensure low air loss (LAL- aim to improve comfort, and circulation, and reduce the risk of pressure ulcers) mattresses were set to the appropriate weight settings for three of eight sampled residents (Residents 2, 14 and 103). This deficient practice placed residents at risk for ineffective pressure redistribution, discomfort, pain, and pressure ulcer development or worsening. B.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and last readmitted on [DATE]. Resident 2's diagnoses included dementia (a progressive state of decline in mental abilities), sepsis (a life-threatening blood infection), and encephalopathy (any condition that causes the brain to function abnormally, leading to mental changes like confusion, memory loss, personality shifts, or drowsiness). During a review of Resident 2's History and Physical (H&P), dated 12/1/2025, the H&P indicated Resident 2 did not have the capacity to make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 12/23/2025, the MDS indicated Resident 2 was assessed to have severe cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 2 required dependent assistance from staff for activities of daily living (ADLs) such as oral hygiene, toileting, showering, and positioning. The MDS indicated Resident 2 was at risk for developing pressure ulcers/injuries. During an observation on 1/20/2026 at 9:56 a.m. in Resident 2's room, Resident 2's bed was equipped with a LAL mattress that was in place and operating. Weight settings were set at 450 pounds. During a review of Resident 2's weights and vitals summary, the weights and vitals summary indicated Resident 2's weight on 1/15/2026 was 98 pounds. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnoses included malignant neoplasm of brain (brain cancer), epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body), and acute kidney failure (sudden loss of the ability of the kidneys to function). During a review of Resident 14's H&P, dated 12/11/2025, the H&P indicated Resident 14 could make needs known but could not make medical decisions. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 was assessed to have moderate cognitive impairment in daily decision making. The MDS indicated Resident 14 required dependent assistance from staff for ADLs such as toileting, showering, dressing and positioning. The MDS indicated Resident 14 was at risk for developing pressure ulcers/injuries. During an observation on 1/20/2026 at 9:59 a.m. in Resident 14's room, Resident 14's bed was equipped with a LAL mattress that was in place and operating. Weight settings were set at 350 pounds. During a review of Resident 14's weights and vitals summary, the weights and vitals summary (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 14's weight on 12/4/2025 was 275 pounds. During an interview on 1/22/2026 at 3:10 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated nursing staff monitored LAL mattress setting based on residents' weight to ensure proper pressure redistribution and support wound management. LVN 3 stated incorrect settings could cause discomfort, ineffective pressure redistribution, and increased risk for pressure ulcers. During an interview on 1/23/2026 at 2:30 p.m., with the Assistant Director of Nursing (ADON), the ADON stated LAL mattress settings were based on the resident's weight and comfort to ensure effective pressure redistribution and wound management. The ADON stated incorrect settings reduced effectiveness and could cause the mattress to be too firm, increasing the risk for discomfort, pain, and pressure ulcers. During a review of the policy and procedure (P&P) titled, Low Air Loss Mattress Use, dated 12/22/2025, the P&P indicated, residents at risk for or currently experiencing pressure injuries receive appropriate pressure redistribution surfaces. Low air loss mattresses shall be used when clinically indicated, ordered by a physician or other licensed prescriber, and monitored for effectiveness and safety. Verify correct mattress setup and function per manufacturer's instructions. Confirm settings appropriate for residents' weight and comfort. During a review of Resident 103's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 103 was admitted to the facility on [DATE]. Resident 103's diagnoses osteoarthritis (a chronic degenerative joint disease the breakdown of articular cartilage causing pain, stiffness, and reduce mobility), muscle weakness (reduction in muscle strength that cause difficulty doing specific task), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 103's Minimum Data Set ([MDS] a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 103's cognition (ability to learn, reason, remember, understand, and make decisions) had no cognitive impairment. The MDS indicated Resident 103 was dependent (helper does all the effort) on staff for eating, showering, and dressing. The MDS indicated Resident 103 was at risk of pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). The MDs indicated for skin and ulcer/injury treatment Resident 103 was to have a pressure reducing devices. During a review of Resident 103's physician orders titled, Order Summary Report, dated 8/28/2022, the physician order indicated LAL mattress for skin maintenance. During a review of Resident 103's Weights and Vital Summary, dated 1/7/2026, the vital signs indicated Resident 103 weighed 242 pounds ([lbs.]- unit of weight) During an observation on 1/20/2026 at 9:30 a.m., in Resident 103's room, the LAL mattress was set at 280lbs. During a concurrent interview and pictured record review on 1/21/2026 at 2:58 p.m., with Licensed Vocational Nurse (LVN) 1 reviewed. the picture indicated the LAL mattress was set at 280lbs. LVN 1 stated Resident 103 weighed 242 lbs. LVN 1 stated the LAL mattress was set incorrectly and should be set at the resident weight. LVN 1 stated not having the correct settings could increase the risk for Resident 103 for pressure injury and reduce her circulation. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/21/2026 at 3:23 p.m., with Assistant Director of Nursing (ADON), the ADON stated the LAL mattress should be set at weight of the resident. The ADON stated the purpose of the LAL mattress was to prevent pressure ulcers and to prevent worsening pressure ulcers. The review of the facility's policy and procedure titled, Low Air Loss Mattress use, dated 12/22/2025, the P&P indicated all residents identified as being at risk for or currently experiencing pressure injuries receive appropriate pressure redistribution surfaces. The P&P indicated a LAL mattress is a dynamic pressure redistribution support surface providing airflow to help manage moisture and heat at the skin interface. The P&P indicated to confirm LAL mattress settings appropriate for resident's weight and comfort.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of seven sampled residents (Resident 112) the physician was notified when there was sediment (the solid matter that settles to the bottom of a liquid, such as urine or blood) in the indwelling catheter (a medical device inserted into the bladder to drain urine continuously) tubing. This deficient practice not notifying the physician of the sediment in the indwelling catheter tubing had the potential to cause a urinary tract infection ([UTI]- an infection in any part of the urinary system).During a review of Resident 112's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 112 was admitted to the facility on [DATE]. Resident 112's diagnoses benign prostatic hyperplasia (enlargement of the prostate gland), dermatitis (chronic skin inflammation), and gastro-esophageal reflux disease ([GERD]- a chronic condition of frequent backflow of stomach acid into the esophagus). During a review of Resident 112's Minimum Data Set ([MDS] a resident assessment tool), dated 1/19/2026, the MDS indicated Resident 112's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 112 was partial/moderate dependent (helper does less than half the effort) on staff for toileting hygiene, showering, and dressing. The MDS indicated Resident 112 had an indwelling During an observation on 1/20/2026 at 9:15 a.m., in Resident 112's room, Resident 112 had sediment in the indwelling catheter. During a review of Resident 112's physician orders, Order Summary Report, dated 1/15/2025, the physician order indicated to monitor for redness, irritation, swelling, and signs/symptoms for UTI.During a concurrent observation and interview on 1/21/2026 at 2:18 p.m., with Licensed Vocational Nurse (LVN) 6, in Resident 112's room, Resident 112 had sediment in the indwelling catheter. LVN 6 stated there was sediment in Resident 112 foley catheter. LVN 6 stated assessment of the indwelling catheter should be done every shift. LVN 6 stated sediment in the urine could be an indication of UTI and the physician should be notified.During an interview on 1/21/2026 at 3:17 p.m., with Assistant Director of Nursing (ADON), the ADON stated it was important to monitor the indwelling catheter every shift especially during care for Resident 112. The ADON stated monitoring the indwelling catheter for early signs of an UTI such as sediment should be reported to the physician.During a review of facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated 9/2014, the P&P indicated the purpose of this procedure was to prevent catheter-associated urinary tract infections. The P&P indicated to observe the resident for complication's associated with urinary catheters. The P&P indicated observe for other signs and symptoms of urinary tract infection and to report findings to the physician or supervisor immediately.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1. Ensure a peripherally inserted central catheter ([PICC]- a long thin tube inserted into the upper arm to give medication) dressing was labeled with a date, time and initials for one of one sampled resident (Resident 77). This deficient practice had the potential for the PICC line insertion site to develop an infection and/or hospitalization for Resident 77.Findings: During a review of Resident 77's admission Record, the admission Record indicated Resident 77 was admitted to the facility on [DATE]. Resident 77's diagnoses included sepsis (a life-threatening blood infection), methicillin-resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). A review of Resident 77's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 1/13/2026, the MDS indicated the resident was assessed to have clear cognition (ability to think and reason). The MDS indicated Resident 77 required dependent assistance from staff for activities of daily living (ADLs) such as transferring, toileting, lower body dressing and was partially dependent on staff for positioning and upper body dressing. During an observation on 1/21/2026 at 10:00 a.m. in Resident 77's room, Resident 77 had a PICC line to the right upper arm, the dressing was not labeled. During an interview on 1/21/2026 at 3:15 p.m. with Registered Nurse (RN)1, RN 1 stated as soon as an IV or PICC line dressing was changed it was to be labeled with date, time, and initials. RN 1 stated IV or PICC line dressings were changed every seven days and as needed. RN 1 stated if not properly managed there could be a risk of infection. During an interview on 1/23/2026 at 2:30 p.m. with Assistant Director of Nursing (ADON), the ADON stated IV dressings needed to be labeled with the date, time and initials, if not done staff would not know when dressing was placed. The ADON stated there was a risk of infection to the IV site. During a review of the facility's policy and procedure (P&P) titled, Peripheral IV Dressing Changes, dated April 2016, the P&P indicated, the purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. Label dressing with date, time, and initials.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Obtain physician orders prior to initiating low air loss (LAL) mattress therapy for two of eight sampled residents (Residents 2 and 14). This deficient practice had the potential to result in unnecessary treatment and adverse outcomes. Findings:a.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included dementia (a progressive state of decline in mental abilities), sepsis (a life-threatening blood infection), and encephalopathy (any condition that causes the brain to function abnormally, leading to mental changes like confusion, memory loss, personality shifts, or drowsiness). During a review of Resident 2's History and Physical (H&P), dated 12/1/2025, the H&P indicated Resident 2 did not have the capacity to make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a standardized assessment and care planning tool), dated 12/23/2025, the MDS indicated Resident 2 was assessed to have severe cognitive (difficulty with thinking) impairment in daily decision making. The MDS indicated Resident 2 required dependent assistance from staff for activities of daily living (ADLs) such as oral hygiene, toileting, showering, and positioning. The MDS indicated Resident 2 was at risk for developing pressure ulcers/injuries. During an observation on 1/21/2026 at 9:56 a.m. in Resident 2's room, Resident 2's bed was equipped with a LAL mattress that was in place and operating. b. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnoses included malignant neoplasm of brain (brain cancer), epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body), and acute kidney failure (sudden loss of the ability of the kidneys to function). During a review of Resident 14's H&P, dated 12/11/2025, the H&P indicated Resident 14 could make needs known but could not make medical decisions. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 was assessed to have moderate cognitive impairment in daily decision making. The MDS indicated Resident 14 required dependent assistance from staff for ADLs such as toileting, showering, dressing and positioning. The MDS indicated Resident 14 was at risk for developing pressure ulcers/injuries. During an observation on 1/21/2026 at 9:59 a.m. in Resident 14's room, Resident 14's bed was equipped with a LAL mattress that was in place and operating. During a concurrent interview and record review on 1/22/2026 at 3:10 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 2 and 14's physician orders were reviewed. No physician orders for a LAL mattress were found. LVN 3 confirmed no orders were in the system and stated a physician order was required and should be verified before initiating the LAL mattress. During an interview on 1/23/2026 at 2:30 p.m., with the Assistant Director of Nursing (ADON), the ADON stated a physician order was required for a low air loss mattress. The ADON stated placing the LAL mattress without an order was outside the nursing scope of practice and could potentially harm the resident. During a review of the policy and procedure (P&P) titled, Low Air Loss Mattress Use, dated 12/22/2025, the P&P indicated, residents at risk for or currently experiencing pressure injuries receive appropriate pressure redistribution surfaces. Low air loss mattresses shall be used when clinically indicated, ordered by a physician or other licensed prescriber, and monitored for effectiveness and safety. Obtain a written or telephone order specifying Low Air Loss Mattress and clinical rationale.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Ensure one of seven sampled residents (Resident 99) eye drop medication Timolol (medication to treat high pressure inside the eye) was properly stored. This deficient practice of leaving the eye drop medication Timolol at bedside had the potential for the medication to be used by other residents.During a review of Resident 99's admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 99 was admitted to the facility on [DATE]. Resident 99's diagnoses hemiplegia (paralysis affecting one side of the body), chronic obstructive pulmonary disease ([COPD]- a chronic lung disease causing difficulty in breathing) and anxiety (an uneasy feeling of discomfort, apprehension, or dread to a non-specific or unknown threat). During a review of Resident 99's history and physical (H&P), dated 7/17/2025, the H&P indicated Resident 99 had the capacity to understand and make decisions. The H&P indicated Resident 99 had glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight). During a review of Resident 99's Minimum Data Set ([MDS] a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 99's cognition (ability to learn, reason, remember, understand, and make decisions) had no cognitive impairment. The MDS indicated Resident 99 required substantial /maximal assistance (helper does more than half the effort to lift, and hold limbs) on the staff for eating, showering, and dressing. During a record review of Resident 99's physician orders titled, Order Summary Report, the physician order indicated Timolol Maleate Ophthalmic Solution (medication to treat high pressure inside the eye) 0.5% to instill one drop in both eyes two times a day for glaucoma. During an observation and interview on 1/20/2026 at 10:43 a.m., in Resident 99's room, there was eye medication Timolol on the nightstand. Resident 99 stated she does not self-administer her medications. Resident 99 stated the nurses were the ones who administered the medication to her. During an interview on 1/21/2025 at 2:50 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the Timolol eye drops were to be administered to Resident 99 and when finished with the medication; it was to be stored back in the medication cart. LVN 1 stated it was important not to leave the medication at the residents' bedside, because the medication could come up missing. LVN 1 stated the resident could mistakenly take the medication and overdose on the prescribed dosing. During an interview on 1/21/2026 at 3:22 p.m., with Assistant Director of Nursing (ADON), the ADON stated no medication should be left on the nightstand. The ADON stated the medication was to be prepared and given by the licensed nurses. The ADON stated that after the medication was given it was to be put back into the medication cart. The ADON stated leaving the medication was unsafe and the residents in the room could have improperly used it or even ingested the medication. During a review of the facility policy and procedures (P&P) titled, Storage Medication, dated 4/2007, the P&P indicated all drugs and biologicals shall be stored in a safe, secure, and orderly manner. The P&P indicated the nursing staff shall be responsible for maintaining medication storage.

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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 record review, the facility failed to ensure 3 of 4 outside trash bin lids were completely closed. This failure had the potential to result in odors attracting pests and scavengers (organisms that feed on dead matter) to the trash bins.Findings:During an observation on 1/20/2026, at 1:43 p.m., one trash bin had both covers open and another trash bin had one cover partially opened and no staff were in the immediate area. During an interview on 1/20/2026, at 1:44 p.m., with DS3, DS3 stated, trash cans should be covered and if trash is uncovered rain and animals can get into the trash. During an interview on 1/23/2026 at 9:10 a.m., with the DSS, the DSS stated that the lids on the trash bins should be closed at all times. During a review of the facility's policy and procedure (P&P) titled, Food-Related Garbage and Refuse Disposal dated October 2017, the P&P indicated, all garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the urinal bottle (handheld container for pee) for Resident 113 had a cover to prevent spillage of urine. This failure had the potential to result in urine spilling onto staff or Resident 113 during care.Findings: During a review of Resident 113's admission Record, dated 1/15/2026, the admission Record indicated Resident 113 has diagnoses for Cellulitis (a common, potentially serious bacterial skin infection) of the right lower limb, Local infection of the skin and subcutaneous (beneath the skin) tissue, and sepsis (a life-threatening medical emergency caused by the body's overwhelming, dysfunctional immune response to an infection, leading to tissue damage, organ failure, and potential death). During a review of Resident 113's Order Summary Report, dated 1/15/2026, the Order Summary Report indicated Resident 113 was on a Regular Diet, and on a 5150 hold due to episodes of agitation and verbally aggressive towards staff. During a review of Resident 113's History & Physical, dated 1/8/2026, the History & Physical indicated Resident 113 has a colostomy (a surgical opening created to allow waste products from bowel to pass from intestines), diabetes mellitus (a disease that result in too much sugar in the blood), hypertension (high blood pressure), and congestive heart failure (a chronic, progressive condition where the heart muscle cannot pump efficiently enough to meet the body's oxygen needs, leading to fluid backup in the lungs and body). During an observation on 1/20/2026, at 11:37 a.m., in room [ROOM NUMBER]C, a partially filled urinal bottle, without a top for containing the urine , was hanging from the upper left bedside railing. During an interview on 1/20/2026, at 11:37 a.m., with LVN2, LVN2 stated if the urinal bottle is uncovered it could spill on the floor and someone can be affected by the bacteria in the urine. During an interview on 1/23/2026 at 11:17 a.m., with IP, in the DON's office, IP stated urinal bottles should always have a cover. It could contaminate the area if it spills. Everyone is responsible for making sure urinal bottles are covered. Staff or visitors could be infected by the urine if it spills on them. If that happened, we would advise staff and visitors to go home, change their clothing, and seek medical help if the resident has an infection. During a review of the facility's policy and procedure titled, Bedpan/Urinal, offering/Removing, dated February 2018, the P&P indicated to cover the urinal immediately with a urinal cover or paper towel.