STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555330	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Postacute Care	8781 Lakeview Avenue Riverside, CA 92509

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure seven of 39 residents reviewed (Residents 118, 106, 8, 153, 163, 108, and 69) were free from significant medication error when:1.Resident 118 did not receive her medication Lacosamide (anticonvulsant medication used to treat seizures) from December 17, 2025, to January 15, 2026.This failure had the potential to place Resident 118 at high risk for seizure and other complications;2. Resident 106 did not receive five doses of the medication Acyclovir (antiviral medication to treat infection) from February 22 to February 23, 2026.This failure had the potential to jeopardize Resident 106's health status by leaving a skin infection untreated, leading to delayed healing and increased risk of viral spread;3. Resident 8 did not receive the medications Atorvastatin (medication used to lower bad cholesterol), Olanzapine (medication used to treat mental disorder), Risperdal (medication used to treat mental disorder) , Allopurinol (medication used to lower uric acid level in the blood), on multiple occasions in January 2026 and February 2026.This failure had the potential to jeopardize Resident 8's health and safety for not managing and treating the medical conditions, overall long-term health, and well-being of the resident.4. Resident 153 did not receive her medication Lacosamide in December 1 and 2, 2025.This failure had the potential to place Resident 153 at high risk for seizure and its complications;5. Resident 108 did not receive the medication Methimazole (medication used to reduce thyroid hormone production in the body) on multiple occasions in December 2025, and January 2026.This failure had the potential to jeopardize Resident 108's health and safety by not managing and treating the medical condition, overall long-term health and well-being of the resident;6. Resident 163 did not receive the medication Glipizide (medication used to diabetes {treat high blood sugar}) on multiple occasions in December 2025.This failure had the potential to jeopardize Resident 163's health and safety for not managing and treating the diabetes that could result to unmanaged high blood sugar levels and even death; and7. Resident 69 did not receive the medications Divalproex sodium, Gabapentin, Buspirone, Keppra (medication used to treat epilepsy), Xarelto (blood thinning medication), Levothyroxine (medication used to replace thyroid hormones), and Atorvastatin on multiple occasions in December 2025, and January 2026.This failure had the potential to jeopardize Resident 69's health and safety for not managing and treating the medical conditions, overall long-term health and well-being of the resident;On March 2, 2026, at 5:39 p.m., the facility Administrator and Director of Nursing were verbally notified of the system failure which resulted in an Immediate Jeopardy (IJ). The system failure resulted in a delay in receiving necessary medications to manage epilepsy, diabetes, treat infection, and to treat other medical condition of the residents.On March 3, 2026, at 1:31 p.m., the Administrator presented an acceptable plan of action which included the following:- Residents 118, 106, 8,153,163,108, and 69's primary physicians were notified of the missed medication doses, physician recommendations were implemented, such as laboratory orders, and resident care plans were updated to address any adverse effects of the missed medications;- Residents 118, 106, 8,153,163,108, and 69's medication were checked and all medications were available for administration;- A triple medication check was conducted by the pharmacist to ensure that residents' medication was available for medication administration; and-An in-service was provided to licensed (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	nurses on how to communicate missing medications to the pharmacy and the Attending Physician; complete medication errors report when medication is passed late and proper documentation of medication administration.On March 3, 2026, at 3:45 pm, the immediate jeopardy was removed in the presence of the Administrator, upon verification and implementation of the plan of actions. The facility was notified an extended survey would be conducted due to substandard quality of care issues.Noncompliance for F760 remained at the lower scope and severity of E no actual harm with potential for more than minimal harm.Findings:1.On February 24, 2026, at 11:01 a.m., an observation with a concurrent interview was conducted with Resident 118. Resident 118 was in bed, alert, and interviewable. Resident 118 stated that she ran out of her seizure medication about a month ago.On February 24, 2026, Resident 118's medical records were reviewed. Resident 118 was admitted to the facility on [DATE], with diagnoses including epilepsy (chronic neurological disorder manifested by recurrent, unprovoked seizures caused by sudden, excessive electrical discharges in the brain).The document titled, ANNUAL HISTORY AND PHYSICAL, dated March 19, 2025, indicated Resident 118 had intermittent (fluctuating) capacity to make decisions.The physician's order dated March 19, 2024, indicated to give two tablets of Lacosamide Oral Tablet 50 milligrams (mg- unit of measurement) by mouth two times a day for seizure.The electronic Medication Administration Record (eMAR) dated December 1, 2025, to December 31, 2025, indicated the physician's order to give two tablets of Lacosamide Oral Tablet 50 milligrams by mouth two times a day at 9 a.m., and 5 p.m., for seizure. The eMAR indicated the medication Lacosamide was signed by the licensed nurses as not administered from December 17 to 31, 2025.The document titled, .Orders-Administration Note . dated December 17, 2025, signed by a licensed nurse, indicated, .Lacosamide Oral Tablet 50 MG .Give 2 tablet oral by mouth two time a day for .SEIZURE .med not in cart, already ordered .The document titled, .Orders-Administration Note . dated December 18, 2025, signed by the licensed nurse, indicated, .Lacosamide Oral Tablet 50 MG .Give 2 tablet oral by mouth two time a day for .SEIZURE .med not in cart. already called pharmacy, stating need to get order from Dr to refill .There was no documented evidence between December 17 to 31, 2025 that Resident 118's physician was notified of the missed doses and that the medication Lacosamide needed a refill medication order.The eMAR dated January 1 to 31, 2026, indicated a physician's order to give two tablets of Lacosamide Oral Tablet 50 milligrams by mouth two times a day at 9 a.m. and 5 p.m. for seizure. The eMAR indicated the medication Lacosamide was signed by the licensed nurses as not administered from January 1 to 15, 2026. The care plan dated March 20, 2024, indicated, .Focus .(Name of Resident) has a seizure disorder .Goal .The resident will be/remain free of seizure activity .Intervention/Tasks .Give medication Lacosamide Oral Tablet 50 MG .as ordered .Monitor effectiveness and side effect .There was no documented evidence Resident 118's physician was notified of the Lacosamide missed doses from January 1 to 15, 2026. In addition, there was no documented evidence Resident 118 has been monitored for change of condition or seizure activity between December 17, 2025, to January 15, 2026. On February 25, 2026, at 2:25 p.m., an interview with a concurrent record review was conducted with the Director of Nursing (DON). The DON stated:-Resident 118's medication Lacosamide Oral Tablet 50 mg by mouth two times a day for seizure was not administered as ordered by the physician from December 17, 2025, to January 15, 2026, because the medication was not available;-The medication was ordered from the pharmacy, but since it was considered a narcotic medication (controlled drug) the pharmacy needed a physician's signature first before they can refill the medication;-The licensed nurses failed to contact the primary physician regarding the medication refill for Lacosamide, which required a physician's signature. The DON stated the licensed nurses should have followed up with Resident 188's physician;- Resident 118's physician was only notified of the missed Lacosamide doses in January 15, 2026. The DON stated the licensed nurses should have notified the physician after the initial missed dose on December 17, 2025, and monitored the resident since it was considered as COC (Change of Condition).-Resident 118 was not monitored for possible seizure activity or COC since she started missing the dose on December 17, 2025, until January 15, (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2026. The DON stated this should have been done; and- Resident 118 was at high risk to experience seizure activities due to the missed Lacosamide medication doses.The facility's policy and procedure titled, .Administering Medications ., dated January 2018, indicated .Medications are administered in accordance with prescriber orders, including any required time frame .The facility's policy and procedure titled, .Change of Condition . dated August 2017, indicated, .It is the facility's policy that it shall promptly notify the resident, his or her Attending Physician, and representative .of changes in the resident's medical/mental condition and/or status .PROCEDURE .Acute medical changes or any sudden or serious change in condition manifested by a marked change in physical, mental and psychosocial status .Licensed nurse will notify physician .If unable to contact attending physician or alternate physician, notify the Medical Director . 2. On February 25, 2026, Resident 106's record was reviewed. Resident 106 was admitted to the facility on [DATE].The physician's order dated February 19, 2026, indicated to give Acyclovir Oral Tablet 800 milligrams (mg - unit of measurement) one tablet by mouth four times a day for shingles (painful, blistering rash caused by a virus) for seven days to start February 19, 2026.The electronic Medication Administration Record (eMAR) dated February 1 to 28, 2026, indicated the medication Acyclovir was documented as not administered by the licensed nurses on February 22 at 8 p.m., February 23 at 8 a.m., 12 p.m., 4 p.m., and 8 p.m.The eMAR progress notes indicated the following entries by the licensed nurses:- February 23, 2026 at 12:36 a.m., .Acyclovir Oral Tablet 800 mg .Pharmacy did not send enough .I faxed pharmacy .;-February 23, 2026, at 8:34 a.m., .Acyclovir Oral Tablet 800 mg .Medication not on hand. Did not give. Contacted pharmacy .;-February 23, 2026, at 12:35 p.m., .Acyclovir Oral Tablet 800 .Medication not on hand. Did not give. Contacted pharmacy .; and-February 23, 2026, at 9:59 p.m., .Acyclovir Oral Tablet 800 .awaiting delivery from pharmacy .The care plan dated February 18, 2026, indicated, Focus .The resident has infection of the skin R/T (related to) fluid filled vesicles to the left back and hip .Intervention .Administer anti-viral as ordered .On February 25, 2026, at 2:27 p.m., an interview with concurrent record review of Resident 106's medical record was conducted with the Director of Nursing (DON). The DON stated the following:-Resident 106's medication Acyclovir was not administered on February 22, 2026, at 8 a.m., and February 23, 2026, at 8a.m., 12 p.m., 4 p.m., and 8 p.m.,;- The medication was not administered by the licensed nurses because it was not available. The DON stated the pharmacy did not deliver enough Acyclovir medication to complete the seven days order;- The pharmacy was notified to deliver the rest of the medications but it was not delivered until February 24, 2026.-Resident 106's missed antibiotic doses meant his medication regimen treatment was incomplete and this may not effectively treat the current infection.3.On March 2, 2026, Resident 8's record was reviewed. Resident 8 was admitted to the facility on [DATE], with diagnoses including diabetes (high blood sugar), schizophrenia (type of behavioral disorder), gout (type of arthritis caused by high level of uric acid in the blood forming needle-like crystals in joints causing pain), hyperlipidemia (having high level of cholesterol in the blood), and Congestive Heart Failure (CHF - chronic condition where the heart muscle is too weak to pump blood efficiently).The facility document titled, .HISTORY AND PHYSICAL NOTE . dated July 10, 2024, indicated Resident 8 had fluctuating capacity to make decisions.The physicians' order indicated to give:-Allopurinol tablet 100 milligrams (mg- unit of measurement) by mouth one time a day for gout, date ordered February 4, 2026;-Atorvastatin Calcium Tablet 40 mg one tablet by mouth at bedtime for hyperlipidemia, date ordered June 20, 2025;-Risperdal Oral Tablet 1 mg one tablet by mouth two times a day for schizophrenia, date ordered June 20, 2025, discontinued February 3, 2026, and re-ordered on February 3, 2026; and-Olanzapine Oral Tablet 2.5 mg one tablet at bedtime for schizophrenia, ordered January 12, 2026 and discontinued January 20, 2026.The care plans dated:-December 13, 2024, indicated, Focus .AT RISK FOR (acute/chronic pain) r/t (related to) .GOUT .Interventions .Adminsiter (sic.) Allopurinol per MD (Medical Doctor) orders for gout .;-July 8, 2025, indicated, Focus .The resident uses psychotropic medications (risperdal) r/t Schizophrenia m/b (manifested by) episode of visual hallucination .Interventions .Administer PSYCHOTROPIC medications as ordered by physician (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	.';and-September 7, 2025, indicated, Focus .The resident has hyperlipidemia .Interventions .Administer statin drug(Atorvastatin) per MD orders .The electronic Administration Record (eMAR) dated January 1 to 31, 2026, indicated the following physician's order were not signed as administered by the licensed nurses:- Atorvastatin Calcium Tablet 40 mg one tablet by mouth at bedtime for hyperlipidemia on January 12, 15, 16, 17, 18, and 20, 2026, at 9:00 p.m.;-Olanzapine Oral Tablet 2.5 mg one tablet at bedtime for schizophrenia on January 12, 13, 14, 15, 16, 17, and 18, 2026, at 9:00 p.m.; and-Risperdal Oral Tablet 1 mg one tablet by mouth two times a day for schizophrenia, on January 28 and 31 at 9:00 a.m., and on January 8, 9, 12, 15, 17, and 18, 2026, at 5:00 p.m.;The eMAR dated February 1 to 28, 2026, indicated the following physician's order were not signed as administered by the licensed nurses:-Allopurinol tablet 100 mg by mouth one time a day for gout on February 6, 7, 8, 11, and 15, 2026, at 9:00 a.m.; and-Risperdal Oral Tablet 1 mg one tablet by mouth two times a day for schizophrenia on February 2, 3, 6, and 8, 2026, at 9:00 a.m.On March 2, 2026, at 3:05 p.m., an interview with a concurrent record review of Resident 8's medical record was conducted with the Assistant Director of Nursing (ADON). The ADON stated:- Resident 8's medications Atorvastatin, Olanzapine, Risperdal, and Allopurinol, were not administered as ordered by the physician on multiple occasions in January 2026 and February 2026; and-The licensed nurses did not administer these medications because they were unavailable. The ADON stated these medications should have been available and administered as ordered by the physician; and-Resident 8 was not getting the desired therapeutic effect of the medications to address the diagnosis or health condition because of the missed doses.On March 2, 2026, at 4:20 p.m., an interview was conducted with the Pharmacy Consultant (PC), The PC stated:- She conducted review of the residents' medical records including the residents' eMAR monthly in December 2025 and January 2026. Included in her monthly review was to review the residents' eMAR to identify and report medication discrepancies such medications not administered as ordered by the physician;-She did not identify and report the medication discrepancies in the residents' eMAR when the licensed nurses documented that medications were not administered as ordered due to unavailability for Residents 153, 163, 108, 69, 8, 118, and 106;-The expectation from the licensed nurses was to notify the residents' physician as soon as possible and report the missed medication dose and monitor the residents for a change in condition or adverse effects from the missed medication.4. On March 2, 2026, Resident 153's medical record was reviewed. The licensed nurses documented in the eMAR Resident 153 did not receive her medication Lacosamide (medication used to treat seizures) on December 1 and 2, 2025, for the 9 a.m. and 5 p.m. doses.Resident 153 was admitted to the facility on [DATE], with diagnoses which included epilepsy (a brain disorder characterized by seizures) with simple partial seizures (convulsions, altered consciousness). - The medication was not administered by the licensed nurses because it was not available. - Resident 153's missed Lacosamide doses meant her medication regimen treatment was incomplete and this had the potential to place Resident 153 at high risk for seizure and its complications. 5. On February 26, 2026, at 3:01 p.m., an interview was conducted with Resident 108 inside her room. Resident 108 stated that she did not receive her thyroid medication for more than two days.On February 26, 2026, Resident 108's medical records were reviewed. Resident 108 was admitted to the facility on [DATE], with past medical history of hyperthyroidism (an overactive thyroid condition).The facility document titled, HISTORY AND PHYSICAL, dated March 28, 2025, indicated Resident 108 had the capacity to make decisions.A review of the physicians order indicated, .Methimazole oral tab 5 MG (milligram-unit of measurement) give 0.5 tablet by mouth one time a day for Hyperthyroidism .A review of the electronic Medication Administration Record (eMAR) for December 2025 and January 2026 indicated multiple doses of Methimazole 5 mg were documented by the licensed nurses not administered according to the physicians order on the following dates:-December 20, 2025, med not on hand;-December 21, 2025, pending delivery;-December 22, 2025, med not in cart;-December 27, 2025, med not on hand;-December 28, 2025, med not in cart;-December 29, 2025, med not in cart;-January 2, 2026, med not in hand;-January 3, 2026, med not in hand;-January 4, 2026, med not in cart; (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and-January 5, 2026, med not in cart.Further review of the Resident 108's medical record did not indicate documentation nursing staff had reordered the medication or contacted the pharmacy or physician to ensure the medication was available for administration.On March 2, 2026, at 5:20 p.m., a concurrent interview and record review was conducted with the DON. The DON stated if the medication was not available in the medication cart, then the licensed nurse would be responsible for following up with the pharmacy and to find out the reason why the medication was not delivered, notify the physician for the missed doses, document a change of condition, and initiate a care plan. The DON further stated Resident 108's health and safety was affected for not managing and treating her medical condition.6. On March 2, 2026, Resident 163's record was reviewed. Resident 163 was admitted to the facility on [DATE], with diagnoses which included Type 2 Diabetes Mellitus (high blood sugar).The facility document titled, .Brief Interview for Mental Status (BIMS- a cognitive assessment tool) . dated December 12, 2025, indicated Resident 163 had a score of 15 (cognitively intact).A review of the physician order for Resident 163 indicated, .Glipizide oral tablet 2.5mg, give 1 tablet by mouth three times a day for DM 2 administer with meals .A review of the eMAR for December 2025 indicated multiple doses of Glipizide were documented by the licensed nurses as not administered according to the physician's orders on the following dates:-December 6, 2025, med not on hand;-December 7, 2025, med not on hand;-December 11, 2025, med not on hand;-December 12, 2025, med not on hand; and-December 14, 2025, awaiting delivery from pharmacy.Further review of the medical record did not indicate documentation that the nursing staff had reordered the medication or contacted the pharmacy or physician to ensure the medication was available for administration.On March 2, 2026, at 5:20 p.m., a concurrent interview and record review was conducted with the DON. The DON stated if the medication was not available in the medication cart, then the licensed nurse was responsible for following up with the pharmacy to find out the reason why the medication was not delivered, notify the physician regarding the missed doses, document a change of condition, and initiate a care plan. The DON further stated Resident 163 not receiving the ordered Glipizide, may result in unmanaged high blood sugar levels.7. On March 2, 2026, Resident 69's record was reviewed. Resident 69 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (severe, chronic mental disorder that interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others), bipolar disorder (chronic mental health condition characterized by extreme, long-lasting mood swings that ranges from high-energy mania to low depressive episodes), and atrial fibrillation (heart rhythm disorder characterized by a rapid, irregular heartbeat).A review of Physician's Order, indicated the following:- Atorvastatin Calcium Oral tablet 20mg (milligrams - a unit of measurement), give one tablet in the evening for peripheral vascular disease, hyperlipidemia and diabetes;- Levothyroxine Sodium Oral tablet, 100 mcg (micrograms - a unit of measurement), give 1 tablet by mouth one time a day for hypothyroidism;- Xarelto oral tablet, 20mg, give one tablet by mouth at bedtime for acute embolism and thrombosis of left popliteal vein;- Keppra oral tablet, 500 mg, give one tablet by mouth two time a day for seizures;- Buspirone Hydrochloride oral tablet 10 mg, give one tablet by mouth three times a day for anxiety M/B (manifested by) angry outburst towards others AEB (as evidenced by) being verbally abusive;- Divalproex Sodium oral tablet Delayed Release 500mg, give one tablet by mouth three times a day for Schizo-affective disorder, bipolar type M/B mood swings of being calm and then getting angry; and- Gabapentin oral capsule 300mg, give one capsule by mouth three times a day for neuropathy.A review of the eMAR for December 2025 and January 2026 indicated Atorvastatin Calcium oral tablet 20mg was not available and not administered on the following dates:- December 15, 16, 17, 22, 23, 24, 25, 26, 27, 28, 29,; and- January 1, 2, 3, 4.A review of the eMAR for December 2025 and January 2026 indicated Levothyroxine Sodium oral tablet 100mcg was not available and not administered on the following dates:- December 19, 20, 21, 22, 24, 26, 28, 29, 30, 31; and- January 1, 2, 3, 4.A review of the eMAR for December 2025 and January 2026 indicated Xarelto oral tablet 20mg was not available and not administered on the following dates:- December 22, 23, 24, 26, 27, 28, 29, 30; and- January 1, 2, 3, (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	medications that requires special processing .order at least (seven days) in advance of need .The facility's undated policy and procedure titled, .CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS . indicated, .Regular and reliable consultant pharmacist services are provided to residents .The consultant pharmacists agrees to render the required service in accordance with local, state, and federal laws, regulations, and guidelines; facility policies and procedures; community standards of practice; and professional standards of practice .Assisting in identification and evaluation or medication-related issues, including prevention and reporting of medication errors .Collaborating with facility leadership in setting standards and developing, implementing, and monitoring policies and procedures for the safe and effective distribution, control, and use of medications .Developing mechanisms for communicating, addressing, and resolving issues related to pharmaceutical services

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to have a written Quality Assurance Performance Improvement (QAPI - a systematic, interdisciplinary, comprehensive, and data-driven approach to maintain and improve safety, quality of care, and quality of life of the residents) plan in place to address the facility's systemic process issues related to timely response to call lights. This failure resulted in delayed response to residents' call lights and placed residents at risk of not achieving their highest physical, mental, psychosocial well-being.A recertification survey was conducted between February 23, 2026, and March 3, 2026. During the survey, systemic issues were identified with timely response to residents' call lights (Cross Reference F725). On February 27, 2026, at 2:26 p.m., an interview and a concurrent record review was conducted with the Administrator (ADM) and the Director of Nursing (DON) to discuss facility's QAPI program. The ADM stated the QAPI committee consists of the ADM, DON, Medical Director, Infection Preventionist, Director of Staff Development and the heads of the facility departments. The ADM stated he was aware of the late response to residents' call lights from the residents' council meetings. The ADM stated the facility did not have a QAPI program which identified, corrected, and improved the issues related to timely response to call lights for their residents. A review of the facility document titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated August 2017, indicated, .It is the policy of the facility to establish and maintain an ongoing, systematic and proactive facility wide process and data driven information to plan to measure and assess as well as to carry out the plan and improve resident care, outcomes and safety based on its mission, strategic goals and objectives .The QAPI program is also designed to provide an integrated collaborative and comprehensive program that will monitor, assess and improve the quality of resident care delivered at this facility .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure equipment in the kitchen was maintained in a safe operating condition when the kitchen steam table (appliance designed to hold prepared food at safe, hot serving temperatures using heated water or steam) was not fully functional from December 19, 2025, to February 3, 2026.This failure had the potential to place vulnerable population of residents who receive food from the kitchen at risk for not receiving quality food.Findings:On February 24, 2026, at 1:06 p.m., Resident 89 was observed lying in bed, awake and alert. In a concurrent interview with Resident 89, he stated he received his food cold and believed the food would come out of the kitchen cold.Resident 89's record was reviewed. Resident 89 was admitted to the facility on [DATE], with diagnosis which includes diabetes (high blood sugar). Resident 89's history and physical, dated July 21, 2025, indicated Resident 89 had the capacity to understand and make decisions. On February 26, 2026, at 3 p.m., during an interview with the Registered Dietician (RD), she stated she conducted monthly audits. The RD stated she did not send her monthly audit reports on time as expected. She stated the fourth steam table wells were not fully functional in her December 2025 and January 2026 kitchen audits. She stated the expectation was to always maintain all kitchen equipment fully functional. She also stated hot foods should stay hot so when delivered to the residents it will remain hot. A review of the two-month kitchen audit by the RD indicated the following:- December 19, 2025, indicated, .98 degrees Fahrenheit (F - a unit of measurement) of the fourth well of the steam table (an equipment used for holding hot food).; and- January 23, 2026, indicated, .Steam well #3 does not reach the appropriate temperature, 180(F) to ensure food meets and stays at temp (temperature) during serving.The RD's email sent to the Administrator (ADM) and the Director of Nursing on February 6, 2026, was reviewed. The email indicated, .The main, most important finding is the temperature, >180F. This did impact my test tray as two items did not reach the appropriate temperature.On February 26, 2026, at 3:44 p.m., during an interview with the Maintenance Director (MND), he stated he was not aware of the steam table problem in the kitchen until late January 2026.The facility policy and procedure, titled, SANITATION, dated 2023, indicated, .The Food & Nutrition Services Department shall have equipment of the type.for the preparation, serving, and storing of food.All equipment shall be maintained as necessary and kept in working order.Employees are to alert the FNS (Food and Nutrition Services) Director immediately to any equipment needing repair.Correct temperatures for the storage and handling of foods are used.The facility policy and procedure, titled, Maintenance Service, dated January 2026, indicated, .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure staff knocked and received permission prior to entering multiple resident rooms for six out of 14 sampled residents (Residents 15,18, 87, 67, 81, and 183). This failure had the potential to compromise resident's rights to dignity, respect, and privacy for Residents 15, 18, 87, 67,81, and 183 .Findings: On February 24, 2026, at 1:10 p.m., a concurrent observations and interview were conducted with Certified Nursing Assistant (CNA). CNA1 was observed entering Resident 15 and Resident 18's rooms without knocking and/or obtaining permission prior to entry. CNA1 stated that he should have knocked prior to entering the resident's room for privacy, to let them know, and for dignity. On February 24, 2026, at 1:12 p.m., a concurrent observation and interview was conducted with CNA 2. CNA 2 was observed entering Resident 87's room without knocking and/or obtaining permission prior to entry. CNA 2 stated that she should have knocked prior to entering the resident's room. On February 25, 2026, 1:20 p.m., a concurrent observation and interview was conducted with Maintenance Director (MND). The MND was observed entering the rooms of Resident's 67, 81, and 183 without knocking and/or obtaining permission prior to entry. The MND stated that he should have knocked prior to entering the resident's room for respect and privacy. On February 26, 2026, at 3:57 p.m., an interview was conducted with Resident 81 in his room. Resident 81 stated that he did not like that the MND entered his room earlier without knocking. He further stated that the MND did not respect his privacy. On February 27, 2026, at 2:01 p.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated it was the facility's expectation that staff knock and obtain permission before entering a resident's room for respect and dignity. The facility policy and procedure titled, Resident Rights, dated January 2018, indicated, .employees shall treat all residents with kindness, respect and dignity.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure four of 39 residents (Resident 5, 30, 87, and 162), had the call light within reach.This failure resulted in Resident 5, 30,87, and 162 not to have a means of contacting the staff for assistance.Findings: 1.On February 24, 2026, at 12:50 p.m., an observation and interview was conducted with Resident 162 inside her room. Resident 162 was yelling .help, help, help me please, please help me. Resident 162 was found lying in bed and stated that she needed to be changed. Resident 162 further stated that she could not see her call light. On February 24, 2026, at 12:55 p.m., a concurrent observation and interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated Resident 162's call light button was not within reach. CNA 3 further stated the call light should be within Resident 162's reach so she could call for help if she needed to. A review of Resident 162's record was conducted. Resident 162 was admitted to the facility on [DATE], with diagnoses which included dementia (a set of symptoms that can affect memory, language, and behavior), and blindness. Resident 162's care plan dated August 3, 2023, indicated, . Resident is at risk for falls r/t (related to) confusion, incontinence, poor communication/comprehension, blindness . be sure call light is within reach . the resident needs prompt response to all request for assistance. On February 27, 2026, at 3:25 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 162's call light should be within reach to be able to ask for assistance. 2. On February 25, 2026, at 12:41 p.m., an observation and interview was conducted with Resident 87 inside his room. Resident 87 stated that he had diarrhea and needed help. Resident 87 further stated he tried to press the call light but couldn't reach it. Resident 87's call light was observed hanging on the rail on the right side of his bed, out of his reach. On February 25, 2026, at 12:43 p.m., a concurrent observation and interview was conducted with Certified Nursing Assistant (CNA) 1. CNA1 stated Resident 87's call light was not within reach. CNA 1 further stated, the call light should be within Resident 87's reach so he could call for help. A review of Resident 87's medical record was conducted. Resident 87 was admitted to the facility on [DATE], with diagnoses which included anxiety disorder, and muscle weakness. A review of Resident 87's care plan dated, January 25, 2024, indicated, . Resident has an ADL (Activities of Daily Living) self-care performance deficit . be sure call light is within reach . encourage the resident to use bell to call for assistance. On February 27, 2026, at 3:25 p.m., an interview was conducted with the DON. The DON stated Resident 162's call light should be within reach to be able to ask for assistance. 3. On February 26, 2026, at 11:15 a.m., an observation was conducted inside Resident 30's room. Resident 30 attempted to speak but could not be understood. Resident 30's call light was observed to (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be on top of a suction machine on his bedside drawer, not within reach. On February 26, 2026, at 11:20 a.m., a concurrent observation and interview was conducted with the Quality Assurance Nurse (QA). The QA stated Resident 30's call light was not within reach. The QA further stated, the call light should be close to Resident 30 so he could call out for help. A review of Resident 30's record was conducted. Resident 30 was admitted to the facility on [DATE], with diagnoses which included vascular dementia (a decline in thinking, memory, and reasoning skills). On February 27, 2026, at 3:25 p.m., an interview was conducted with the DON. The DON stated Resident 162's call light should be within reach to be able to ask for assistance. 4. The following observations were conducted in Resident 5's room: On February 23, 2026, at 9 a.m., and 2:46 p.m., Resident 5's call light was not within reach and underneath the resident's bed; On February 24, 2026, at 12:30 p.m., the call light button was not within reach of Resident 5 and was underneath the resident's bed; On February 25, 2026, at 8:45 a.m., Resident 5 was observed sitting on her bed for breakfast. The call light was observed on the floor underneath the resident's bed; and On February 25, 2026, at 8:58 a.m., the surveyor observed the resident sitting for breakfast. The call light was observed on the ground underneath the resident's bed. On February 25, 2026, at 9:05, a.m., an interview was conducted with Resident 5. Resident 5 stated she was unaware of how to reach and/or call the nurse from her room. Resident 5 stated she had to go to the hallway to locate a nurse if she needed assistance. On February 26, 2026, at 10:46 a.m., an interview was conducted with DON. The DON stated facility policy required the call light to be within reach of the resident. The DON stated staff were expected to conduct rounds at the beginning of their shift to ensure residents' call lights were within reach. The DON further stated if a resident cannot reach the call light during an emergency, staff could not be notified, which could result in a potential negative outcome for the resident. On February 26, 2026, at 10:55 a.m., an interview and a concurrent observation was conducted with CNA 3. CNA 3 stated at the beginning of the shift she goes from room to room to check call light placement ensuring it was within reach of residents. CNA 3 stated if a resident did not have the call light within reach to call for assistance a serious injury could occur, and staff may not be aware. On February 26, 2026, Resident 5's record was reviewed. The resident's admission record indicated an admission date of May 28, 2025, which included diagnoses of chronic ulcer (a long-lasting open sore on the skin) to left foot, venous insufficiency (poor blood flow in the veins of the legs), muscle wasting and atrophy (loss of muscle strength and size) and dementia (a condition that causes memory loss and problems with thinking and decision-making). On February 26, 2026, a review of Resident 5's care plan dated July 26, 2020, indicated an ADL (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	self-care deficit related to dementia, impaired balance, limited mobility and indicated the resident . requires assistance with activities of daily living including bathing, dressing, and bed mobility. The History and Physical dated September 24, 2025, indicated that the resident can make needs known but cannot make medical decisions. The facility policy titled Answering the Call Light, dated January 2018, was reviewed. The policy indicated that the purpose of the procedure is to ensure timely responses to residents' requests and needs. The policy further indicated .be sure the call light is plugged in and functioning at all times. and .when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, 10 of 39 residents reviewed for Advance Directive (AD - written statement of a person's wishes regarding medical treatment) (Residents 1, 10, 14, 15, 30, 57, 89, 106, 156, and 176) the resident or their resident representative (RP) had been provided follow up information regarding the formulation of an AD.These failures had the potential to result in the ADs for Residents 1, 10, 14, 15, 30, 57, 89, 106, 156, and 176, not being readily accessible to staff and physicians, which could lead to the residents' wishes regarding medical treatment being unknown and ultimately not honored.Findings:1. On February 24, 2026, at 8:39 a.m., an interview was conducted with Resident 14. Resident 14 stated that she was unsure of having been asked by the facility about formulating an AD and that she would like to know more. Resident 14's record was reviewed. Resident 14 was admitted to the facility on [DATE]. The History and Physical Examination, (H&P) dated, February 20, 2024, indicated Resident 14 had the capacity to understand and make decisions. A review of the Social Services Quarterly form, dated September 2, 2025, indicated, .Advance Directive.describe.'blank'. A review of the Social Service Assessment dated, February 18, 2026, indicated, .Does resident have advance directives? .NO.reason for no advance directive.resident would like to formulate an Advance Directive for healthcare. Ombudsman emailed on December 3, 2024.Resident responsible party involvement.name of son listed. There was no documented evidence the resident or RP was provided follow up information about the right to formulate an AD from December 2024 to February 2026. 2. On February 24, 2026, at 4:45 p.m., an interview was conducted with Resident 156. Resident 156 stated she was unsure of any follow up from the facility regarding an AD. On February 27, 2026, Resident 156's record was reviewed. Resident 156 was admitted to the facility on [DATE]. The H&P dated, January 26, 2026, indicated Resident 156, .can make needs known but can not make medical decision. A review of the Social Service Quarterly dated, October 1, 2025, indicated, .Advance Directive. Resident currently does not have capacity . and is unable to formulate an Advance Directive at this time. Writer made contact aware that if they would wish to be residents legal decisions maker they would need to contact the Superior Court of California, County of Riverside.(phone number and address listed). A review of the Social Service Assessment dated, October 16, 2025, indicated, .relative/responsible party.husband.Does resident have advance directives? .YES.if yes, is the Advance Directive present if so please upload to Electronic Health Record (EHR).currently awaiting ombudsman visit to complete Advance Directive form.referral made to ombudsman. There was no documented evidence the resident or RP was provided follow up information about the right to formulate an AD, and there was no documented evidence a follow up correspondence was (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	made with the ombudsman from October 2025 to February 2026. 3. On February 24, 2026, at 9:12 a.m., an interview was conducted with Resident 176 in his room. When asked about an AD, he stated he would like to know more about it because he had not spoken to any staff members in the facility regarding his right to formulate an AD.Resident 176's record was reviewed. Resident 176 was admitted to the facility on [DATE]. A review of the H&P dated, March 6, 2025, indicated, Resident 176 had the capacity to understand and make decisions. A review of the Social Service Quarterly dated, August 8, 2025, indicated, .Advance Directive .changes over past quarter.describe.N/A. A review of the Social Service Assessment dated, February 17, 2026, indicated, .relative/responsible party.father.Does resident have advance directives? .NO.reason for no advance directive.Resident would like to formulate an Advance Directive for Healthcare. Ombudsman emailed December 2, 2024. There was no documented evidence the resident or RP was provided follow up information about the right to formulate an AD, and there was no documented evidence a follow up correspondence was made with the ombudsman from December 2024 to February 2026. 4. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE]. A review of the Advance Healthcare Directive dated April 17, 2025, indicated Resident 1 would like more information, and the social service director sent a referral to Ombudsman on April 17, 2025. A review of the H&P dated September 9, 2025, indicated Resident 1's decision making capacity was intact. A review of the Social Service Assessment, dated February 21, 2026, indicated, .Does resident have advance directives? .YES. There was no documented evidence that the resident or the RP was provided follow up information about the right to formulate an AD, and there was no documented evidence that a follow up correspondence was made with the ombudsman from April 12, 2025, to February 27, 2026. 5. Resident 89's record was reviewed. Resident 89 was admitted to the facility on [DATE]. A review of the Social Service Assessment, dated July 10, 2025, indicated, .Does resident have advance directives? .NO. A review of the Advance Healthcare Directive, dated July 10, 2025, indicated Resident 89 would like more information and a referral was sent to the Ombudsman on July 10, 2025. A review of the H&P dated July 21, 2025, indicated Resident 89 had the capacity to understand and make decisions. A review of the Social Services Quarterly Assessment, dated October 10, 2025, indicated, .current Advance Directive wishes, Resident wants to move forward with executing an Advance Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Currently awaiting ombudsman visit to complete Advance Directive form. There was no documented evidence that the resident or the RP was provided follow up information about the right to formulate an AD, and there was no documented evidence that a follow up correspondence was made with the ombudsman from July 10, 2025, to February 27, 2026. 6. Resident 106's record was reviewed. Resident 106 was admitted to the facility on [DATE]. A review of the History and Physical dated December 4, 2025, indicated the resident 106 decision-making capacity was intact. A review of the Social Services Quarterly assessment, dated September 24, 2025, indicated resident wished to formulate advance directive for Resident 106. A review of the Social Services Assessment, dated February 11, 2026, indicated, .Does the resident have advance directives? . NO.and .The assessment indicated the resident would like to formulate an Advance Directive for Healthcare. 7. On February 26, 2026, Resident 30's record was reviewed. Resident 30 was admitted to the facility on [DATE], with diagnosis which included Encephalopathy (altered brain function). A review of Resident 30's Minimum Data Set (MDS), dated [DATE], indicated, .Cognitive Skills for Daily Decision Making . severely impaired- never/rarely made decisions. A review of the Advance Healthcare Directive form, dated April 14, 2025, indicated, .I have not executed any advance directives.Per H&P, resident does not have capacity to make healthcare decisions. A review of the Social Service Quarterly dated, August 7, 2025, indicated, .Advance Directive. changes over past quarter.describe.N/A. A review of the Social Service Assessment dated, September 24, 2025, indicated, .relative/responsible party.son (name listed) .cousin (name listed) .Does resident have advance directives? NO.reason for no advance directive.resident does not have capacity to formulate. There was no documented evidence that the resident or (RP) was provided with follow up information about the right to formulate an AD. 8. Resident 10's record was reviewed. Resident 10 was admitted to the facility on [DATE], with diagnosis which included Cerebral Infraction due to embolism of left middle cerebral artery (stroke). A review of Resident 10's MDS, dated [DATE], indicated Resident 10 had BIMS score of 0 (severe cognitive impairment). A review of the Social Service Assessment dated, February 9, 2026, indicated, .relative/responsible party.son (name listed) .daughter (name listed) .Does resident have advance directives? NO.Per H&P resident has no capacity to make healthcare decisions or low BIMS. A review of the Social Service Quarterly dated, December 19, 2025, indicated, .Advance Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changes over past quarter.describe.no changes. There was no documented evidence that the resident or (RP) was provided with follow up information about the right to formulate an AD from December 15, 2025- February 9, 2026. 9. Resident 15's record was reviewed. Resident 15 was admitted to the facility on [DATE] with diagnosis which included Dementia (decline in brain function). A review of Resident 15's History and Physical, dated February 9, 2026, indicated Resident 15 has fluctuating capacity to understand and make decisions. A review of the Advance Healthcare Directive form, dated August 19, 2025, indicated, .requested AD, and referred to ombudsman . A review of the Social Service Assessment dated, December 24, 2025, indicated, .relative/responsible party.daughter (name listed) .self (name listed) .Does resident have advance directives? NO.reason for no advance directive.(Blank). There was no documented evidence that the resident or (RP) was provided with follow up information about the right to formulate an AD from August 19, 2025- February 9, 2026. 10. Resident 57's record was reviewed. Resident 57 was admitted to the facility on [DATE]. The H&P dated September 24, 2025, indicated Resident 57 can make needs known but cannot make medical decisions. A review of the Social Services Quarterly form, dated August 2, 2025, indicated, .Advance Directive.describe.'N/A (not/applicable)'. There was no documented evidence the resident or RP was provided follow up information about the right to formulate an AD from August 2025 to February 2026. On February 27, 2026, at 10:14 a.m. an interview was conducted with the Social Service Director (SSD) and the Social Service Assistant (SSA). The SSA stated the process for establishing an advance directive (AD) is that during admission if the resident can make decisions they would be asked if an AD was available and if they were not cognitively able then the RO would be asked. She stated if an AD was available then a physical copy would be available in the medical record. If there was no AD available then the facility would offer to assist the resident or representative in formulating one. The SSA stated AD requests would be sent to the ombudsman for verification. The SSA stated the Ombudsman was inconsistent with following up regarding the AD's. The SSA stated that she conducted a monthly audit to evaluated those residents interested in formulating an AD. The SSD stated the social service assessment would be conducted upon admission, then quarterly as well as annually and that the assessment would include updates regarding the AD. The SSD stated it was important to have an AD available so the facility could determine the resident needs and honor their medical care wishes. In a concurrent record review the SSA stated the following for all sampled residents, (Residents 1, 10, 14, 15, 30, 57, 89, 106, 156, and 176). For Resident 1, the SSA stated the social service assessment dated [DATE], was incorrect. The SSA stated Resident 1 did not formulate an AD. The SSA stated (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she could not identify any documentation that she submitted the AD requests to the Ombudsman for all sampled residents reviewed. The SSA stated the Ombudsman had not completed the AD requests since the first request made on December of 2024, and could not provide any email correspondence that would indicate the ombudsman was aware of the need for all sampled residents to formulate the AD. The SSA stated she did not follow up for all sampled residents to honor their requests for the right to formulate an AD and she should have. The SSA further stated there was a risk if residents did not have an AD then there was the potential for their rights for treatments to not be honored. A review of the facility policy and procedure titled, Advance Directives dated January 2018, indicated, .upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the residents' legal representative.information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.if the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives.the resident will be given the option to accept or decline the assistance.staff will document the resident's decision to accept or decline assistance.an ongoing review of the resident's decision-making capacity and communicate significant changes to the resident's legal representative.review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded.inquiries concerning advance directives should be referred to the.social service director.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide sufficient nursing staff to be able to provide for care and services for the residents of the facility. This failure caused delays in the response to multiple residents' (Residents 19, 39, 43, 62, 108, 121, 124, 128, 183, 148, 150, 97, 13, 87, 108, and 162) call lights which had the potential to put residents at risk for falls, accidents, late provision of care or care not being rendered at all.Findings: On February 24, 2026, Resident council meetings (independent, resident-led groups that typically meet monthly to discuss concerns, improve quality of life, and influence care) minutes for December 2025, January 2026, and February 2026 were reviewed. The minutes indicated residents complained to the facility that call lights were not being answered in a timely manner. On February 24, 2026, at 3:10 p.m., an interview was conducted with the residents who attended the residents' council. All residents who attended the residents' council (Resident 19, 39, 43, 62, 108, 121, 124, 128, 183, 148, and 150) stated it took too long for nursing to respond to residents' call light, on average 25 minutes or more. On February 26, 2026, at 3 p.m., an interview with Certified Nursing Assistant (CNA) 5 was conducted. CNA 5 stated facility was short staffed of CNAs, and it affected her being able to respond timely to residents' call lights. On February 26, 2026, at 3:18 p.m., a concurrent observation and interview was conducted with Resident 97. Resident 97 was observed in bed. Resident 97 was alert and oriented. Resident 97 stated she was dependent on nursing and needed total care. Resident 97 stated it took too long to get help after she pressed the call light. She stated one instance she wanted some fresh water and the CNA responded to her call light one hour later. Resident 97 stated facility was short staffed. Resident 97's record was reviewed. Resident 97 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke), contracture of right and left ankle, and left artificial hip joint (hip replacement). On February 26, 2026, at 3:38 p.m., a concurrent observation and interview was conducted with Resident 13. Resident 13 was observed in bed. Resident 13 was alert and oriented, and stated she was dependent on nursing for her care. Resident 13 stated she had to wait a long time to get help after she pressed the call light. Resident 13 stated one time she was incontinent (involuntary leakage) of urine, needed help for cleaning and waited about 30-45 minutes to get help after she used the call light. Resident 13 stated facility was short staffed. Resident 13's record was reviewed. Resident 13 was admitted to the facility on [DATE], with diagnoses which included parkinsonism (a disease causing slow movement, poor balance, tremors and stiffness), cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) affecting right side. On February 27, 2026, at 9:22 a.m., an interview was conducted with CNA 6. CNA 6 stated facility was short staffed for CNAs at times, and short staffing affected his timely response to residents' call lights. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 27, 2026, at 11:04 a.m., a concurrent interview and record review was conducted with the Director of Staff Development (DSD) and the Staffing Coordinator (SD). The DSD stated she was aware of residents' council staffing issue that came up in relation to call light response. The DSD stated she brought up the issue of using registry (staff personnel provided by a placement service on a temporary basis) to the Administrator (ADM) but was not allowed to use registry when short staffed. The SD stated facility needed both CNAs and Licensed Vocational Nurses (LVN) from registry to help with short staffing. On February 27, 2026, at 2:54 p.m., a concurrent interview and record review was conducted with the ADM and Director of Nursing (DON). The ADM stated facility did not use registry since he started as an Administrator. The ADM stated facility was not going to use registry when short staffed. On February 27, 2026, at 6:45 p.m., a concurrent interview and record review was conducted with the ADM. The ADM verified the staffing hours and stated the facility was short staffed on January 4, January 10, February 8, February 14, and February 15 of 2026. On February 23, 2026, at 1:34 p.m., a concurrent observation and interview was conducted with Resident 108. Resident 108 was observed sitting in her wheelchair. Resident 108 was alert and oriented. Resident 108 stated that there is not enough staff to do their job and felt that the CNAs could not do all their job. Resident 108 stated it took too long to get help after she pressed the call light. Resident 108's record was reviewed. Resident 108 was admitted to the facility on [DATE], with diagnoses which included anxiety disorder (mental disorder) and paraplegia (paralysis of legs and lower body). On February 24, 2026 at 12:50 p.m., a concurrent observation and interview was conducted with Resident 162. Resident 162 was observed in bed, yelling for help and stated that she needed help, and it takes them too long to come help her. Resident 162's record was reviewed. Resident 162 was admitted to the facility on [DATE], with diagnoses which included blindness and generalized anxiety disorder (mental disorder). On February 25, 2026, at 12:41 p.m., a concurrent observation and interview was conducted with Resident 87 in his room. Resident 87 was observed lying in bed and asked for help to get changed. Resident 87 stated that he could not find his call light and staff took too long to respond. Resident 87's record was reviewed. Resident 87 was admitted to the facility on [DATE], with diagnoses which included muscle weakness and anxiety disorder. On February 27, 2026, at 1:40 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated that she was asked to work extra hours multiple occasions when the facility was short staffed. CNA 5 further stated that she was assigned too many residents to provide safe and adequate care. On February 27, 2026, at 1:50 p.m., a concurrent observation and interview was conducted with the Registered Nurse (RN) 2. RN 2 was observed passing medications to the residents. In a concurrent interview, RN 2 stated that it was difficult to perform her role efficiently as a nurse supervisor if she was assigned medication cart to administer medications to the residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility document titled Facility Assessment Tool, dated August 2025, was reviewed. The facility assessment indicated, .The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs .Position Based on Average Census .171 .Licensed Vocational Nurses Providing Direct Care .Days: 8; Evening: 6; Nights: 5 .Certified Nursing Assistant .Days: 22; Evening: 17; Nights: 14 . The staffing schedule for February 2026 was reviewed. The staffing schedule indicated a shortage of staff for February 8, 2026, when there were 7 LVNs scheduled for day shift, 16 CNAs scheduled for day shift, 15 CNAs scheduled for evening shift, and 7 CNAs scheduled for night shift; for February 14, 2026, when there were 5 LVNs scheduled for day shift, 17 CNAs scheduled for day shift, 12 CNAs scheduled for evening shift, and 6 CNAs scheduled for night shift; and for February 15, 2026, when there were 5 LVNs scheduled for day shift, 17 CNAs scheduled for day shift, 15 CNAs scheduled for evening shift, and 8 CNAs scheduled for night shift. The facility policy titled Answering the Call Light, dated January 2018, was reviewed. The policy indicated, .The purpose of this procedure is to ensure timely response to the resident's requests and needs . The facility policy titled Staffing, dated January 2018, was reviewed. The policy indicated .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pharmacy services were provided in a timely manner, for 14 of 39 residents reviewed (Residents 118, 106, 8, 153, 13, 163, 108, 69, 182, 185, 184,186, 176, and 167) for pharmacy services, when:1. For Resident 118, 106, 8, 153, 13, 163, 108, and 69, medications were not administered as ordered by the physician on multiple occasions between December 2025, January 2026, and February 2026, due to medication unavailability. (Cross Reference F760).2. Residents 182, 185, 184, and 186, did not receive the PPD skin test (test to detect Tuberculosis {contagious lung infection}) as scheduled due to unavailability of the PPD solution;3. For Residents 176 and 167, the facility did not establish a system for receiving and ensuring Over-The Counter (OTC) medications are readily available for residents' use; and4. For Resident 106, the medication Albuterol Sulfate Inhalation (drug used for treat shortness of breath by relaxing airway muscles) was available when needed in the medication cart.These failures resulted in residents not receiving medications as ordered by the physician to manage and treat medical conditions, and over-all long-term health and well-being of the residents. Findings: 1.On February 24, 2026, Resident 118's medical record was reviewed. The licensed nurses documented in the electronic Medication Administration Record (eMAR) that Resident 118 did not receive her medication Lacosamide (anticonvulsant medication used to treat seizures) from December 17, 2025, to January 15, 2026.(Cross Reference F760 Finding #1). On February 25, 2026, at 2:49 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated: -Resident 118's Lacosamide medications were not administered as ordered by the physician from the period of December 17, 2025, to January 15, 2026, due to unavailability of the medication. -There was an issue with the ordering of the medication refill with the pharmacy and it was not identified and addressed until January 15, 2026. This resulted in Resident 118 not receiving the medication from December 17, 2025, to January 15, 2026. -Resident 118's missed Lacosamide medication doses were not discussed with the pharmacy or pharmacy consultant. The DON stated they had been encountering issues with the pharmacy delivery service, and the facility management was made aware; and -All residents' medication should be available and administered as ordered by the physician. On February 25, 2026, Resident 106's medical record was reviewed. The licensed nurses documented in the electronic Medication Administration Record (eMAR) that Resident 106 did not receive five doses of the medication Acyclovir (antiviral medication to treat infection) from February 22 to February 23, 2026.(Cross Reference F760 Finding #2). On February 26, 2026, at 3:19 p.m., the Pharmacy Owner (PO) was interviewed. The PO stated their pharmacy technician made a refill balance error for Resident 106's Acyclovir, causing the delivery of medication delay and five missed doses. The PO stated their pharmacy technician did not follow the proper procedure for refilling medication at the facility, and this practice was unacceptable. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 2, 2026, Resident 8's medical record was reviewed. The licensed nurses documented in the eMAR that Resident 8 did not receive the medications Atorvastatin (medication used to lower bad cholesterol), Olanzapine (medication used to treat mental disorder), Risperdal (medication used to treat mental disorder) , and Allopurinol (medication used to lower uric acid level in the blood), on multiple occasions in January 2026 and February 2026. (Cross Reference F760 Finding #3). On March 2, 2026, Resident 153's medical record was reviewed. The licensed nurses documented in the eMAR Resident 153 did not receive her medication Lacosamide on December 1 and 2, 2025. (Cross Reference F760 Finding #4). On March 2, 2026, Resident 13's medical record was reviewed. The licensed nurses documented in the eMAR Resident 13 did not receive the medication Duloxetine (medication used to treat depressions) on December 16 and 23, 2026. On March 2, 2026, Resident 108's record was reviewed. The licensed nurses documented in the eMAR Resident 108 did not receive the medication Methimazole (medication used to reduce thyroid hormone production in the body) on multiple occasions in December 2025, and January 2026. (Cross Reference F760 Finding #5). On March 2, 2026, Resident 163's record was reviewed. The licensed nurses documented in the eMAR Resident 163 did not receive the medication Glipizide (medication used to treat diabetes {high blood sugar}) on multiple occasions in December 2025. (Cross Reference F760 Finding #6). On March 2, 2026, Resident 69's record was reviewed. The licensed nurses documented in the eMAR Resident 69 did not receive the medications Divalproex sodium, Gabapentin, Buspirone, Keppra (medication used to treat epilepsy), Xarelto (blood thinning medication), Levothyroxine (medication used to replace thyroid hormones), and Atorvastatin on multiple occasions in December 2025, and January 2026. (Cross Reference F760 Finding #7). On March 2, 2026, at 4:20 p.m., an interview was conducted with the Pharmacy Consultant (PC). The PC stated the missed medication doses due to unavailability for Residents 118, 106, 8, 153, 13, 163, 108, and 69, should have been identified and reported during her Drug Regimen Review for these residents in December 2026 and January 2026. The PC stated she was unaware that these residents missed their medications due to unavailability, as she had not received any reports from the facility about medication delivery issues. 2. On February 24, 2026, a concurrent interview and record review for Resident 182 was conducted with the Director of Nursing (DON). Resident 182 was admitted to the facility on [DATE]. The Physician's Order dated February 19, 2026, indicated to give the Step 1 PPD skin test 0.1 milliliter (ml- unit of measurement) intradermally (deliver medication or vaccine in the dermis{layer of skin}) on the evening of February 20, 2026. The eMAR progress notes, dated February 20, 2026, indicated the licensed nurse did not administer the Step 1 PPD test on Resident 182 because the PPD solution was not available. During a concurrent interview, the DON stated Resident 182 did not receive the Step 1 PPD skin test (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as ordered and scheduled on February 20, 2026 evening shift, due to the facility's lack of available PPD solution. On February 24, 2026, at 5:35 p.m., a concurrent interview and record review was conducted with the Infection Preventionist Nurse (IPN). The following resident records were reviewed: -Resident 185 was admitted to the facility on [DATE]. A Physician's Order dated February 20, 2026, indicated to give the Step 1 PPD skin test 0.1 ml intradermally on the evening shift (from 3:00 p.m. to 11:00 p.m.) of February 21, 2026. The eMAR dated February 21, 2026, evening shift indicated the licensed nurse did not administer the Step 1 PPD test due to medication unavailability. -Resident 184 was admitted to the facility on [DATE]. A Physician's Order dated February 20, 2026, indicated to give the Step 1 PPD skin test 0.1 ml intradermally on the evening shift of February 21, 2026. The eMAR dated February 21, 2026, evening shift indicated the licensed nurse did not administer the Step 1 PPD test due to medication unavailability; and - Resident 186 was admitted to the facility on [DATE]. A Physician's Order dated February 18, 2026, indicated to give the Step 1 PPD skin test 0.1 ml intradermally on the evening shift on February 19, 2026. The eMAR dated February 19, 2026, evening shift was blank and did not indicate if the licensed nurse administered the Step 1 PPD skin test as scheduled. In a concurrent interview, the IPN stated, Resident 186's licensed nurse probably did not administer the step 1 PPD Skin test to Resident 186 as scheduled because there was no PPD solution available. The IPN stated, she was notified by the licensed nurses on February 21, 2026, that the facility did not have PPD solution available to give to the residents. The IPN stated she ordered the PPD solution from the pharmacy on February 21, 2026, and it was still pending delivery until February 24, 2026. The IPN stated the facility should have a PPD solution supply readily available for the residents. 3. On February 24, 2026, at 9:12 a.m. an interview was conducted with Resident 176. Resident 176 stated he took melatonin for sleep and the facility had been out for several days and that he had a hard time sleeping. Resident 176's record was reviewed. Resident 176 was admitted to the facility on [DATE] with a diagnosis which included generalized anxiety disorder (uncontrollable fear or worry that impairs daily functioning). A review of the Physicians order summary indicated, .Melatonin (medication used to help with sleep) Oral Tablet 3 MG (milligrams - a unit of measurement), Give 3 tablet (sic) by mouth at bedtime for supplement. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the eMAR progress note indicated, .February 19, 2026 at 8:43 p.m .administration note.Melatonin oral tablet 3 mg give 3 tablet (sic) by mouth at bedtime for supplement medication not on hand, awaiting facility stock. A review of the eMAR for February 2026, indicated code 9 for the 8 p.m., administration time on February 19, 2026. The eMAR indicated a 9 code was for a missed dose. Resident 167's record was reviewed. Resident 167 was admitted on [DATE] with a diagnosis which included chronic pain syndrome. A review of the Physicians order summary indicated, .Melatonin Oral tablet 10 mg Give 1 tablet by mouth at bedtime for inability to sleep. A review of the eMAR progress note dated February 19, 2026 orders administration note indicated, .Melatonin Oral Tablet 10 MG Give 1 tablet by mouth at bedtime for inability to sleep med not on hand, awaiting facility stock. A review of the eMAR for February 2026, indicated code 9 for the 8 p.m., administration time February 19, 2026. The eMAR indicated a 9 code was for a missed dose. On February 26, 2026 at 8:21 a.m. an observation and interview was conducted with the IPN . Observed medication administration for Resident 167. The IPN indicated she could not locate one eye drop and one nasal spray which were considered over the counter (OTC) medications and should have been readily available. On February 26, 2026, at 8:29 a.m. the IPN indicated she could not locate the OTC medication for Resident 167 in the OTC stock room and would have to ask for assistance to find the medications as they were noted to have been administered on February 24, and 25, 2026. On February 26, 2026, at 12:30 p.m. a follow up interview was conducted with the IPN regarding OTC medication availability of Melatonin. The IPN indicated Melatonin was an OTC medication and that two forms of the doses of 3mg and 5mg were available on each medication cart. The IPN was asked to review the eMARs for both Residents 176 and 167. The IPN confirmed a missed of dose of Melatonin for each resident on February 19, 2026. An observation of the OTC stock room with the IPN revealed a shelf labeled 3mg/5mg. The IPN stated there was no melatonin in the OTC stock room. She stated she would need to order new stock if the shipment delivered this week did not have any and that she did not check the recent shipment received this week. The IPN stated Melatonin 3mg was not available in the medication cart but there was 5mg bottle available. The IPN stated she could not speak for the evening nurse who documented the missed dose of 3mg for Resident 176 and 5mg for Resident 167 on February 19, 2026. The IPN further stated she was made aware the OTC stock delivery was received but could not account for any staff as to when or if it was stocked. On February 26, 2026, at 2:43 p.m. an interview and record review was conducted with staff coordinator/central supply (SC) ordering clerk. She stated she was in charge of ordering central supply stock only and that a Certified Nursing Assistant (CNA) 7 performed the stocking of the items received weekly. She stated the process was that the staff would endorse to her the supplies needed by Monday of each week so that the orders could be placed by Tuesday. The SC indicated ordered items included OTC medications. The SC stated she would only order from the list that was provided to her by the corporate office and that she did not have a list that kept an active inventory of the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplies ordered. The SC stated she assumed the CNA assigned to restock would ensure that all supplies were made available. A review of the supply inventory list was conducted with the SC. The supply inventory list read the following: Supply Inventory list indicated, .item Melatonin.Restock level.5. SC stated the number 5 indicated the amount of OTC bottles that where received which included both 3mg and 5 mg. The SC stated she did not review the packing slips to match the inventory list provided but only ordered what was on the inventory list weekly and that she would add any additional needs communicated to her by the staff. A review of the Packing slip dated February 19, 20206, indicated the following stock items were delivered to the facility: Melatonin tab 3mg.shipped 5. Melatonin tab 5mg.shipped 5. A review of the Packing slip dated February 25, 2026, indicated the following stock items were delivered to the facility. Melatonin, tab 3mg.shipped 6.to follow.3. Melatonin, tab 5mg.shipped 10. A review of the Supply Inventory list, undated, indicated, .item Melatonin.Restock level.5. On February 26, 2026, at 12:55 p.m. an interview was conducted with the Registered Nurse (RN) 1. RN 1 stated was asked to provide access to the OTC stock room to review the medication storage. RN 1 identified one empty drawer labeled 'eye drops' and another empty shelf labeled Melatonin 3mg/5mg. RN 1 stated if the OTC stock was not available on the shelf, then it would be in the medication carts available for the licensed nurse (LVN) in each station. RN 1 was asked how she would ensure enough stock of OTC was available. RN 1 stated she would ask the staff in charge of central supply to provide it and that there were orders delivered each week. RN 1 stated she would not regularly check the OTC stock but check the medication carts and that her expectation was that the LVN's assigned to medication pass would also check for any needs or shortages and if found any missing items to communicate with central supply. RN 1 stated there was no designated person assigned to check the OTC stock in the medication storage. On February 26, 2026, at 3:17 p.m. a follow up interview was conducted with the IPN at medication cart number one. The IPN was asked to check to see if there was any Melatonin stocked in the OTC medication storage and if she was aware of any restocked OTC medications received. The IPN checked the shelf and there was no Melatonin. The IPN stated the CNA assigned to restocking had gone home for the day and did not communicate to her that any stock was available or needed to be distributed regarding OTC medications. On February 27, 2026, at 1:14 p.m. an observation and interview was conducted with CNA 7. CNA 7 stated she was assigned the duty to restock items received from central supply which included OTC medications. CNA 7 indicated there was no staff that communicated with her any inventory list and that she would put out the supplies for the CNA's such as diapers and that she would communicate (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the LVN's and RN's when the OTC medications were delivered so that they could open up the OTC supply room to place them in the designated spot because she did not have a key to access the area. CNA 7 stated there was no designated nurse who would account for the supplies delivered weekly from central supply and that she would tell who ever the supervisor was when central supply orders were received. CNA 7 stated the most recent shipment was received on February 25, 2026, and that the box of OTC medications were still in the supply room awaiting distribution and that it should be stocked by nursing. CNA 7 pointed to a large box in the supply room that was unlabeled that had another box stacked on top of it labeled diapers. CNA 7 was asked how the nurses would know where to find the OTC medications if the boxes were not labeled. CNA 7 responded, that is a good question. On February 27, 2026, at 1:54 p.m., an interview was conducted with the Pharmacy Consultant (PC). The PC was asked how she would ensure OTC oversight as it was identified to be on the pharmacist checklist during monthly medication regimen reviews. The PC stated she would randomly select a medication cart and look for expired medications and open dates and if one cart was found to have an issue she would check another one. The PC stated the spot checks conducted did not include inventory and that the facility did not communicate any concerns regarding a lack of OTC medications. The PC stated she was not made aware of any missing medications by the facility during her last visit in January. The PC further stated if there were any missing OTC's then the nurses should communicate with the pharmacy so that a quick resolution could be reached. On February 27, 2026, at 2:34 p.m. an interview was conducted with the DON regarding inventory for stock supplies and OTC meds. The DON Stated there was no system in place to keep inventory for OTC medications and there should be. The DON indicated there was one staff who ordered from a list provided to her from the corporate office but that there was no assigned person to track, monitor, or evaluate the stock needs for OTC medications. The DON further stated there was one CNA who was the designated staff assigned to distributing the central supply stock weekly and that the shipment was received, but that it was the responsibility of the nurses to obtain any OTC stock for their medication carts as the CNA did not have a key to access the medication cart or the medication stock room. 4. On February 25, 2026, at 1:50 p.m., an inspection of the medication cart with a concurrent record review of Resident 106's record was conducted with Registered Nurse (RN) 1. Resident 106 had a physician's order to give Albuterol Sulfate Inhalation, two puffs inhale orally every four hours as needed for shortness of breath or wheezing (high pitched whistling sound caused by narrowed or obstructed airways). RN 1 was observed to check the medication cart for Resident 106's medication Albuterol Sulfate Inhalation and stated it was not available in the medication cart. On February 25, 2026, at 1:55 p.m., an observation with a concurrent interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated: - She was the licensed nurse assigned to give medication to Resident 106. LVN 1 stated, Resident 106's medication Albuterol Sulfate Inhalation, was taken out of the medication cart this morning because it was empty and it needed to be re-ordered; -She was not aware when the medication supply ran out or whether a reorder had been placed. She stated the licensed nurse should have ordered the medication before it ran out; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident 106 will not have a medication to use in case he will experience SOB or wheezing. LVN 1 stated no resident should be running out of medication. On February 25, 2026, Resident 106's medical record was reviewed. Resident 106 was admitted to the facility on [DATE], with diagnoses including heart failure, dyspnea (shortness of breath), pleural effusion (abnormal accumulation of excess fluid in the pleural space between the lungs and chest wall often causing shortness of breath, chest pain, and coughing); and asthma (chronic disease that causes inflammation, swelling, and narrowing of the airways in the lungs making it difficult to breathe). The physician's order dated January 28, 2026, indicated to give Albuterol Sulfate Inhalation Aerosol Powder Breath Activated 108 (90 Base) MCG (Microgram – unit of measurement) two puff inhale orally every four hours as needed for shortness of breath and wheezing. Resident 106's electronic Medication Administration Record (eMAR), dated February 1 to 28, 2026, indicated the medication Albuterol was last administered by the licensed nurse on February 20, 2026, at 1:04 a.m. The Care Plan dated December 9, 2024, indicated, Focus .The resident has asthma .Potential for ineffective breathing pattern .Goal .The resident will remain free from complications of asthma .Intervention .Give medications as ordered . The Care Plan dated, August 16, 2025, indicated, .Focus .The resident has diagnosis of Chronic Obstructive Pulmonary Disease .Ineffective Airway Clearance .Impaired Gas Exchange .Ineffective Breathing Pattern .Goal .The resident will display optimal breathing patterns .Interventions .Give aerosol or bronchodilators as ordered .

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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. Based on observation, interview, and record review, the Pharmacy Consultant (PC) failed, for eight of 39 residents reviewed for pharmacy services (Residents 118,106, 8, 153, 63,108, and 69), to identify drug irregularities when multiple licensed nurses were documenting in the electronic medication Administration Record (eMAR) prescribed medications were not administered on multiple occasions between December 2025, January 2026, and February 2026, due to medication unavailability. (Cross Reference F760).This failure resulted in these residents not receiving medications as ordered by the physician to manage and treat medical conditions. Findings:On February 24, 2026, Resident 118's medical record was reviewed. The licensed nurses documented in the eMAR that Resident 118 did not receive her medication Lacosamide (anticonvulsant medication used to treat seizures) from December 17, 2025, to January 15, 2026.(Cross Reference F760 Finding #1).On February 25, 2026, Resident 106's medical record was reviewed. The licensed nurses documented in the eMAR that Resident 106 did not receive five doses of the medication Acyclovir (antiviral medication to treat infection) from February 22 to February 23, 2026.(Cross Reference F760 Finding #2).On March 2, 2026, Resident 8's medical record was reviewed. The licensed nurses documented in the eMAR that Resident 8 did not receive the medications Atorvastatin (medication used to lower bad cholesterol), Olanzapine (medication used to treat mental disorder), Risperdal (medication used to treat mental disorder) , and Allopurinol, on multiple occasions in January 2026 and February 2026. (Cross Reference F760 Finding #3).On March 2, 2026, Resident 153's medical record was reviewed. The licensed nurses documented in the eMAR Resident 153 did not receive her medication Lacosamide on December 1 and 2, 2025. (Cross Reference F760 Finding #4).On March 2, 2026, Resident 108's record was reviewed. The licensed nurses documented in the eMAR Resident 108 did not receive the medication Methimazole (medication used to reduce thyroid hormone production in the body) on multiple occasions in December 2025, and January 2026. (Cross Reference F760 Finding #5).On March 2, 2026, Resident 163's record was reviewed. The licensed nurses documented in the eMAR Resident 163 did not receive the medication Glipizide (medication used to diabetes {treat high blood sugar}) on multiple occasions in December 2025. (Cross Reference F760 Finding #6).On March 2, 2026, Resident 69's record was reviewed. The licensed nurses documented in the eMAR Resident 69 did not receive the medications Divalproex sodium, Gabapentin, Buspirone, Keppra (medication used to treat epilepsy), Xarelto (blood thinning medication), Levothyroxine (medication used to replace thyroid hormones), and Atorvastatin on multiple occasions in December 2025, and January 2026. (Cross Reference F760 Finding #7).On March 2, 2026, at 4:20 p.m., an interview was conducted with the Pharmacy Consultant (PC), The PC stated:- She conducted review of the residents' medical records including the residents' eMAR monthly in December 2025 and January 2026. Included in her monthly review was to review the residents' eMAR to identify and report medication discrepancies such medications not administered as ordered by the physician;-She did not identify and report the medication discrepancies in the residents' eMAR when nurses documented that medications were not administered as ordered on multiple occasions due to unavailability for Residents 153,163,108, 69, 8,118, and 106, during the period between December 2025 to February 2026.;- The missed medication doses due to unavailability should have been identified and reported during her Drug Regimen Review for these residents in December 2026 and January 2026; and- She was unaware that Residents 118, 106, 8,153, 63,108, and 69) missed their medications due to unavailability, as she hadn't received any reports from the facility about delivery issues. The facility's undated policy and procedure titled, .CONSULTANT PHARMACIST SERVICES PROVIDER REQUIREMENTS . was reviewed. The policy indicated, .Regular and reliable consultant pharmacist services are provided to residents .The consultant pharmacists agrees to render the required service in accordance with local, state, and federal laws, regulations, and guidelines; facility policies and procedures; community standards of (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practice; and professional standards of practice .The consultant pharmacist provided consultation on all aspects of the provision of pharmacy services in the facility. In collaboration with facility staff, the consultant pharmacist help identify, communicate, address, and resolve concerns or issues related tot he provision of pharmaceutical services. This includes, but is not limited to .Working with the facility staff on the development, implementation, evaluation, and revision of pharmaceutical services procedures, helping assure that the procedures address the needs of the residents and reflect current standards of practice .Assisting in identification and evaluation or medication-related issues, including prevention and reporting of medication errors .Collaborating with facility leadership in setting standards and developing, implementing, and monitoring policies and procedures for the safe and effective distribution, control, and use of medications .Developing mechanisms for communicating, addressing, and resolving issues related to pharmaceutical services .Specific activities that the consultant pharmacist performs includes .Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings related to medication therapy .Reviewing medication administration record (MARs), treatment administration record (TARs) and physician orders (at least monthly) to ensure proper documentation of orders and administration of medication to residents .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper infection control measures were implemented when:1.For Resident 66, there was no EBP (Enhanced Barrier Precaution - an infection control strategy in nursing homes requiring staff to wear gowns and gloves during high-contact resident care, such as bathing, dressing, or device care) signage posted at the door outside Resident 66's room who had a urinary catheter (a flexible tube used to drain urine); 2. A kitchen staff was observed to touch the kitchen floor and continued with food handling without washing hands and changing gloves; 3. For Resident 106, the CNA attempted to reapply resident 106's nasal cannula after it had been on the floor; 4. The staff failed to hand sanitize in between meal tray pass; and 5. For Resident 30, the facility did not label his suction machine and discard the contents inside the canister in accordance with the facility policy. These failures had the potential to result in cross-contamination, increasing the spread of infection to an already vulnerable population of residents in the facility. Findings: 1. On February 23, 2026, at 2:02 p.m., Resident 66 was observed lying in bed awake and alert. Resident 66 was observed to have a urinary catheter. There was no EBP signage posted at the door outside Resident 66's room. On February 23, 2026, at 3:20 p.m., Registered Nurse (RN) 2 was observed to sanitize her hands with the alcohol-based hand rub (ABHR), don a pair of gloves and entered Resident 66's room, to administer an IV (Intravenous – administering fluids, nutrients, or medication directly into a vein) antibiotic (medication that fight bacterial infections). On February 23.2026, at 3:28 p.m., CNA 8 was interviewed in front of Resident 66's room. CNA 8 stated Resident 66 had a urinary catheter and there was no EBP signage posted at the door outside Resident 66's room. On February 23, 2026, at 3:33 p.m., RN 2 was observed to exit Resident 66's room, removed her gloves and sanitized her hands. In a concurrent interview with RN 2 she stated she hung IV antibiotic for Resident 66. RN 2 stated Resident 66 had a urinary catheter. RN 2 stated an EBP signage should have been posted at the door outside Resident 66's room. Resident 66's record was reviewed. Resident 66 was admitted to the facility on [DATE], with diagnoses which included extended spectrum beta lactamase (ESBL – a type of infection that is resistant to many common antibiotics) resistance, paraplegia (impairment or total loss of voluntary movement and sensation in the lower half of the body, including both legs and sometimes the abdomen). The facility document titled, Physician's Order, dated January 18, 2026, indicated, .Indwelling Catheter.for NEUROMUSCULAR DYSFUNCTION OF BLADDER loss of bladder control caused by nerve damage from diseases or injuries). On February 27, 2026, at 9:14 a.m., during an interview with the Infection Preventionist (IPN), she stated any resident with a medical device such as central line catheter, indwelling catheter (foley), feeding tubes and wounds should be placed on EBP. The IPN stated an EBP signage should have been posted at the door outside Resident 66's room because he had a urinary catheter (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy and procedure titled, Enhanced Barrier Precaution, dated, June 2022, indicated, .The purpose of this policy is to establish and provide guidelines for isolation precautions as well as to prevent transmission of infectious agents in the facility.Enhanced Barrier Precautions can be applied.to residents with any of the following.Wounds or indwelling medical devices, regardless of MDRO colonization status such as but not limited to central line, urinary catheter, feeding tubes.Infection or colonization with an MDRO.Post clear signage at the door or wall outside the resident room. 2. On February 26, 2026, at 1:04 p.m., during tray line observation, the Dietary Aide (DA), assisting in food handling, stated There was no meal ticket for this tray. The DA slightly pushed the meal cart, kneeled onto the kitchen floor, touched the floor with both hands with gloves on and looked under the meal cart. The DA got up on his feet and went back to continue to assist with food handling without removing his gloves and performing hand washing. On February 26, 2026, at 1:09 p.m., in a concurrent interview with the DA, the DA was immediately stopped before he could assist with food handling and was asked by the surveyor if he changed his gloves. The DA stated he did not change his gloves and had been using the same gloves from the start of the tray line. On February 26, 2026, at 3 p.m., during an interview with the RD, she stated all kitchen staff should perform handwashing and change gloves in-between tasks. She stated the DA should have removed his soiled gloves, performed handwashing, and don a new pair of gloves before he went back to assist with food handling. According to Food and Drug Administration (FDA – agency responsible for protecting public health by ensuring the safety of food supply) Food Code 2022, Section 2-301.14(I), titled. When to Wash, indicated, .FOOD EMPLOYEES shall clean their hands and exposed portions of their arms.After engaging in other activities that contaminate the hands. and Section 3-304.15 (A), titled, Gloves, Use Limitation, indicated, .If used, single used gloves shall be used for only one task.and discarded when damaged or soiled, or when interruptions occur in the operation. 3. On February 24, 2026, at 9:35 a.m., an observation with a concurrent interview was conducted with Certified Nursing Assistant (CNA) 2. A nasal cannula was observed laying on the floor next to Resident 106's bed. CNA 2 was then observed to attempt to place the nasal cannula tubing that had been on the floor back on Resident 106. The resident refused the attempt. CNA 2 then placed the nasal cannula tubing that had been on the floor onto the resident's headboard for storage. On February 24, 2026, at 9:40 a.m., an interview was conducted with CNA 2. CNA 2 stated she was assigned to Resident 106 that day. CNA 2 stated according to facility policy the nasal cannula found on the floor should have been reported to the LVN, thrown away in the trash, and replaced with a new nasal cannula. CNA 2 stated the new nasal cannula per facility policy should be labeled with the resident's name and the date and time it was opened. CNA 2 also stated if the nasal cannula was not in use, it should be placed in a clean bag labeled with the resident's name and date/time and stored near the resident's headboard. CNA 2 further stated it was wrong to attempt to place the nasal cannula that had been on the floor back onto the resident because it could increase the risk of infection (illness caused by germs). On February 26, 2026, at 10:44 a.m., an interview was conducted with the IPN. The IPN stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	according to facility policy, a nasal cannula found on the ground must be discarded (thrown away) and a new nasal cannula must be obtained. The IPN stated the new nasal cannula should be labeled with the resident's name and date and time of opening. If the nasal cannula was not in use, it should be stored in a clean bag labeled with the date and time near the resident's headboard. The IPN stated the outcome of placing a contaminated nasal cannula back on Resident 106 placed the resident at risk for infection. On February 26, 2026, Resident 105's record was reviewed. Resident 106 was admitted to the facility on [DATE]. Diagnoses included chronic respiratory failure (long-term breathing problem), chronic obstructive pulmonary disease or COPD (lung disease that makes it hard to breathe), asthma (condition that causes swelling and narrowing of airways), hemiplegia (paralysis on one side of the body), atrial fibrillation (irregular heart rhythm), and heart failure (heart cannot pump blood effectively). On February 26, 2026, Resident 106's clinical record was reviewed. A physicians order dated January 5, 2026, indicated staff were to administer oxygen at two liters per minute via nasal cannula. The facility's policy and procedure titled, Cleaning and Disinfection of Environmental Surfaces, dated January 2018, indicated . environmental surfaces will be cleaned and disinfected according to CDC recommendations for disinfection of healthcare facilities and OSHA bloodborne pathogen standards.and .items that come in contact with contaminated surfaces must be cleaned and disinfected. The facility's policy and procedure titled, Oxygen Administration, dated January 2018, indicated .assess the equipment and supplies as needed. and .check the tubing connected to the oxygen cylinder to assure that it is free of kinks, discard used supplies in designated containers. 4. On February 24, 2026, at 1:10 p.m., a concurrent observation and interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 was observed passing meal trays to multiple residents without performing hand hygiene (Residents 15, 18 and 87). CNA 1 stated that he should have sanitized his hands for infection control. A review of Resident 15's medical record was conducted. Resident 15 was admitted to the facility on [DATE], with diagnoses which included immunodeficiency (condition where the immune system is weakened, compromised, or absent). A review of Resident 18's medical record was conducted. Resident 18 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis of one side of the body). A review of Resident 87's medical record was conducted. Resident 87 was admitted to the facility on [DATE], with diagnoses which included bacteremia (presence of bacteria in the bloodstream). On February 27, 2026, at 9:20 a.m., an interview with the IPN was conducted. The IPN stated her expectation was for all staff to hand sanitize in between while passing meal trays, to prevent cross contamination and prevent spread of infections. 5. On February 26, 2026, at 11:15 a.m., during an observation inside Resident 30's room, a suction machine with tubing was observed without a resident identifier label. The suction canister attached to the machine contained fluid and secretions that had not been discarded. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On February 26, 2026, at 11:20 a.m., a concurrent observation and interview was conducted with the Quality Assurance Nurse (QA) inside Resident 30's room. The QA acknowledged the suction machine was not labeled with the resident's identifier and confirmed contents in the suction canister should have been discarded. The QA further stated that it was an infection control issue. On February 27, 2026, at 9:20 a.m., an interview with the IPN was conducted. The IPN stated the suction machine tubing should have been labeled and dated and the fluid or bodily secretions inside the canister should have been discarded. The IPN further stated that this had the potential for cross contamination and infection control concerns. A review of the facility policy and procedure titled, Suctioning the Upper Airway (Oral Pharyngeal Suctioning, dated January 2018, indicated, .empty and rinse collection container if necessary or as indicated by facility protocol.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light system (a communication system that allow the residents to call for staff assistance) was fully functional when the call light system panel did not have an audible sound. This failure had the potential for the residents in the facility not to receive assistance from the staff in a timely manner. Findings: On February 25, 2026, at 12:48 p.m., while standing in the hallway at Station 3, between rooms [ROOM NUMBERS], the Maintenance Director (MND)was observed to approach room [ROOM NUMBER] and asked the resident if he needed help. The call light for room [ROOM NUMBER]A was observed on, without an audible sound. The call light panel located on the wall in Station 3 was observed with the light on for room [ROOM NUMBER] with no audible sound. There was no staff member present at the nurse's station. On February 25, 2026, at 12:50 p.m., the Maintenance Director (MND) was interviewed. He stated he worked at the facility for one year and was not aware if the call light system should have an audible sound. He stated he would check the call light panel to see if there was a problem with the wiring or why the call light system did not have the functionality for the sound. On February 25, 2026, at 1:03p.m., Certified Nursing Assistant (CNA) 10 was interviewed. CNA 4 stated she did not hear any sound coming from the call light panel since she started working at the facility. She stated she would respond to the call because she could see the light was on but there was no sound. On February 25, 2026, at 2:20 p.m., the Administrator (ADM) was interviewed. He stated the call light system should have both visual and audible notification, and was not aware that the call light system did not have an audible sound. On February 25, 2026, at 2:50 p.m., during an interview with the Director for Staff Development (DSD), she stated she did not hear any audible sound coming from the call light system when the call light was on since she started working at the facility in August 2025. On February 25, 2025, at 4:45 p.m., during an interview with the MND, he stated the call light panel wirings were fixed and the call light system panel now had sound when the light was on. The facility policy and procedure, titled, Maintenance Service, dated January 2026, indicated, .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of physical abuse was reported within two hours to the California Department of Public Health (CDPH - State Agency Licensing and Certification Program) for one of 39 residents reviewed (Resident 20).This failure had the potential to result in a delay in the investigation and reporting further allegations of abuse for Resident 20.Findings:On February 25, 2026, at 12:31 p.m., Resident 20 was observed lying in bed, awake and alert. In a concurrent interview with Resident 20, he stated he had a urinal hanging at the foot of his bed. Resident 20 stated his previous roommate, was in his wheelchair and asked him if the urinal was his and answered, yes. He stated his previous roommate took the urinal that was hanging at the foot of his bed and threw it at him. Resident 20 stated he got wet with urine, and did not report the incident to the nurse until the next day. He stated he could not recall the date of the incident. Resident 20 was asked if somebody saw what happened and he stated he had a sitter (a person who provides one-on-one supervision for residents) when the incident happened. Resident 20 stated Certified Nursing Assistant (CNA) 4 was the sitter when the incident happened.Resident 20's record was reviewed. Resident 20 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (total loss of motor function on one side of the body) and hemiparesis (neurological condition characterized by partial weakness, reduced coordination, or numbness on one entire side of the body).A review of the History and Physical (H&P), dated January 15, 2026, indicated Resident 20 had the capacity to make decisions.A review of the Minimum Data Set (MDS - an assessment tool), dated January 21, 2026, indicated a Brief Interview for Mental Status (BIMS - a cognitive assessment tool) score of 14 (cognitively intact).A review of the Physician's Order, dated January 17, 2026, indicated, .Pt (patient) must have 1 on 1 sitter until d/c (discharge) by MD (Medical Doctor) every shift for FALL RISK.A review of the Situation-Background-Assessment-Recommendation (SBAR - a structured, four-component communication technique used in nursing to improve patient safety) dated February 11, 2026, indicated.the resident came in the front of the nurses desk with his sitter and told the RN (Registered Nurse) supervisor that his roommate had thrown a urinal full of urine at him during the evening shift yesterday (February 10, 2026) while he was lying in bed, hitting his feet. The resident is alert and oriented x 3-4 (a medical term used to describe a patient's level of consciousness and cognitive awareness indicating the patient is awake, and responsive, and knows their name, current location, time/date, and situation) and able to express his needs .On February 11, 2026, at 9:51 p.m., CDPH received a voicemail from the facility RN supervisor reporting a resident-to-resident altercation without resident names provided.On February 12, 2026, at 8:53 a.m., CDPH received a written report from the facility.On February 25, 2026, at 1:20 p.m., during an interview with CNA 4, she stated she was the sitter when the incident happened between Resident 20 and his previous roommate. She stated Resident 20's previous roommate took the urinal that was hanging at the foot of bed and toss it at Resident 20's feet. She stated she did not report the incident because she did not think it was an abuse. CNA 4 stated she thought it was Resident 20's previous roommate's behavior and did not think it was an abuse.On February 25, 2026, at 2:50 p.m., during an interview with the Director for Staff Development (DSD), she stated CNA 4 should have reported the incident immediately to prevent the incident from happening again between Residents 20 and his previous roommate.On February 27, 2026, at 9 a.m., during an interview with the administrator (ADM), he stated he was informed of the incident after Resident 20 reported the incident to the RN. He stated there was a witness to the incident, who was the sitter, but did not report the incident because CNA 4 told him she did not think the incident was abuse. He stated he did not have any knowledge of the incident until February 11, 2026.A review of the Five Day Follow-up, dated February 16, 2026, indicated, .This correspondence shall serve as the facility's five-day written follow-up on a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident-to-resident physical altercation alleged to have occurred on February 10, 2026. The incident was first reported by the alleged Victim (Resident 20) on January 11, 2026.A review of the facility policy and procedure titled, Abuse prevention Program, dated January 2018, indicated, .Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse.A review of the facility policy and procedure titled, Abuse Investigation and Reporting, dated February 2024, indicated, .Reporting.All alleged violation of abuse, neglect, exploitation or mistreatment.will be reported to the proper agencies as guided per regulations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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 ensure for two of 39 residents reviewed for quality of care (Residents 47, and 108) the following:1. For Resident 47, the medications Equate (brand name) Multivitamins and Over-The-Counter (OTC) throat lozenges found at the bedside had a physician's order for use.This failure had the potential for Resident 47 to not be monitored for safe self-administration of medication and medication side effects; and2. For Resident 108, the facility did not ensure a laboratory order to monitor the effectiveness of the thyroid medication was in place.This failure had the potential for Resident 108 to not be monitored for complications related to hyperthyroidism (overactive thyroid). Findings: 1. On February 24, 2026, at 1:19 p.m., a concurrent observation and interview was conducted with Resident 47. Resident 47 was observed sitting in the wheelchair, in his room. A bottle of Equate Complete Multivitamins and a pack of throat lozenges were observed on top of Resident 47's bedside table. Resident 47 stated the multivitamins and throat lozenges were his own medications. He stated he took the multivitamins by himself and the lozenges when he needed them. Resident 47 could not recall when he started self-administering the multivitamins and the lozenges. He also stated the nurses were aware he was self-administering the multivitamins and the lozenges. On February 26, 2026, at 9:48 a.m., Resident 47 was observed in his room, sitting in the wheelchair. A pack of throat lozenges was observed on top of Resident 47's bedside table. He stated he kept the bottle of Equate Multivitamins in the drawer. On February 26, 2026, at 9:53 a.m., during an interview with the Quality Assurance (QA) nurse, he stated when a resident expressed a desire to administer his own medication, a Medication Self-Administration Assessment should be performed by the RN supervisor. He stated if the resident was assessed that he was capable of medication self-administration, then an order should be obtained from the resident's physician to self-administer the medications and a lock box should be provided to the resident to keep the self-administered medications from other residents. The QA nurse stated the facility was not aware Resident 47 had the Equate Multivitamins and the throat lozenges at his bedside. The QA nurse stated there was no documented evidence Resident 47 expressed a desire to administer his own medication. He further stated Resident 47 did not have a physician's order to self- administer the multiple vitamins and the throat lozenges. The QA nurse was observed removing the multivitamins and throat lozenges from Resident 47's room. Resident 47's record was reviewed. Resident 47 was admitted to the facility on [DATE], with diagnoses which included muscle weakness. A review of the Nursing admission Assessment, dated July 14, 2025, indicated, .Self-Medication Administration .Did the resident requested to self administer medications? .No .Assessment Results .Self Medication Assessment .Resident deemed unable to safely self- administer medications . A review of the history and physical, dated, September 22, 2025, indicated, .can make needs known but can not make medical decisions . A review of Quarterly Risk Assessment, dated January 23, 2026, indicated, .Self Medication Administration Assessment .Resident request self medication administration of medications? .NO . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that the OTC throat lozenges was ordered for Resident 47. There was no physician's order that Resident 47 could self-administer the multiple vitamins. 2. Resident 108's medical record indicated that Resident 108 was admitted to the facility on [DATE], with a past medical history of hyperthyroidism (an overactive thyroid condition). A review of the physician's orders dated April 25, 2025, indicated, Methimazole oral tablet 5 MG (milligram- unit of measurement), give 0.5 tablet by mouth one time a day for Hyperthyroidism. Resident 108's eMAR, dated February 1 to 28, 2026, indicated the medication Methimazole was last administered by the licensed nurse on February 25, 2026. A review of Resident 108's medical records did not identify any current or past laboratory results to evaluate the effectiveness or safety of the medication therapy. Further review of the medical record indicated there were no current or active laboratory orders in place for monitoring thyroid function levels (such as Thyroid Stimulating Hormone TSH or other thyroid laboratory studies) while Resident 108 was receiving Methimazole. On February 27, 2026, a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated there should be laboratory orders in place to monitor the effectiveness of the thyroid medication Methimazole. The DON further stated there were no orders in place, and this may place Resident 108 at risk of complications related to her hyperthyroidism. According to the drug reference information from DailyMed, provided by the National Library of Medicine, .Methimazole can cause hypothyroidism necessitating routine monitoring of TSH and free T4 levels with adjustments in dosing to maintain a euthyroid (normal) state . A review of the facility policy and procedure, titled, Self-Administration of Medications, dated January 2018, indicated, .As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT – a group of professionals from diverse fields working in the same setting to achieve shared, patient-centered goals) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.If it is deemed safe and appropriate for a resident to self administer medications, this is documented in the medical record and the care plan.Self-administered medications are stored in a safe and secure place, which is not accessible by other residents.Any medication found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. A review of the facility policy and procedure, titled, Administering Medications, dated January 2028, indicated, .Medications are administered in accordance with prescriber orders.Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. A review of the facility policy and procedure titled, .Medication and Treatment Orders . dated January 2018 indicated, .Drugs and biologicals that are required to be refilled must be re-ordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure the refills are readily available .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed for three of 39 residents reviewed for oxygen administration (Residents 29, 206, and 181) when:1.For Residents 29 and 106, respiratory care and treatment were not provided when the physician's order for oxygen administration was not followed.This failure had the potential to result in ineffective oxygen therapy, respiratory distress, and decline in the residents' health condition; and2. For Resident 181, the facility did not ensure the resident's oxygen tubing was labeled in accordance with the facility practice.This failure had the potential to result in cross-contamination, increasing the spread of infection to an already vulnerable population of residents in the facility. Findings: 1a.On February 24, 2026, at 9:28 a.m., a concurrent observation and interview was conducted with Resident 29. Resident 29 was observed in bed with oxygen (O2) via nasal cannula (NC - a tube used to deliver oxygen through the nose). Resident 29's oxygen administration was observed at 6 liters per minute (LPM - a unit of measurement). Resident 29 stated she needed O2 because she was short of breath. Resident 29 stated her nose was dry probably from the O2, and she did not know what her O2 should be. On February 24, 2026, at 9:57 a.m., a concurrent observation, interview and record review was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 confirmed the O2 level for Resident 29 was at 6 LPM. LVN 1 verified the physician order and stated the O2 level should be at 2 LPM, as per physician's order, and the physician's order was not followed. LVN 2 stated O2 at 6 LPM could cause dry nose for Resident 29. On February 27, 2026, at 8:21 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON confirmed the O2 level should have been 2 LPM, as per physician's order for Resident 29. The DON stated the physician's order was not followed. Resident 29's record was reviewed. Resident 29 was admitted to the facility on [DATE], with diagnoses which included acute bronchitis (a temporary inflammation of the airways), and chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing). The physician's order dated October 7, 2025, indicated, .Administer oxygen at 2LPM via nasal cannula . 1b.On February 24, 2026, the following observations were conducted with Resident 106 not using oxygen: - At 9:35 a.m., Resident 106 was in bed, alert and conversant. The oxygen nasal cannula was observed laying on the floor next to his bed; -At 10:38 a.m., Resident 106 was up in his wheelchair outside the back patio by the residents' designated smoking area; -At 10:43 a.m., a staff assisted Resident 106 in returning indoors and positioned him by the hallway near the back hall nurse station; and - At 11:25 a.m. Resident 106 was observed seated in his wheelchair in the activities dining room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 24, 2026, Resident 106's medical record was reviewed. Resident 106 was admitted to the facility on [DATE], which included diagnoses chronic respiratory failure with hypoxia (long-term breathing problems with low oxygen levels), and chronic obstructive pulmonary disease (COPD–a long-term lung disease). Record review of the care plan dated December 7, 2024, indicated Resident 106 had a focus related to oxygen therapy (a lung disease that makes it hard to breathe) for COPD, asthma, and congestive heart failure (when the heart is not strong enough to pump blood effectively). The care plan further indicated, intervention.administer O2 at 2L.staff to monitor O2 sat. Record review of the physician order dated January 1, 2025, indicated an order to administer oxygen continuous at two liters per minute via nasal cannula. The order indicated oxygen to be titrated to two–four liters per minute to maintain oxygen saturation equal to or greater than 92 percent and to monitor O2 sat with oxygen use every shift. On February 24,2026 at 11:29 a.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated she was the primary licensed nurse responsible for Resident 106 on February 24, 2026. LVN 1 stated Resident 106 had a current physician order to administer oxygen via NC 2LPM. She stated the oxygen flow could be increased up to 4 LPM to maintain oxygen saturation (oxygen level in the blood) at 92 percent or higher. LVN 1 stated the oxygen order was written as a continuous order (given all the time) and not as an as needed order (only when the resident has symptoms such as shortness of breath). LVN 1 stated Resident 106 was not wearing the oxygen as ordered by the physician. LVN 1 stated she should have ensured the oxygen was applied continuously as ordered and she should have checked the resident's oxygen saturation to ensure it remained at 92 percent or greater. LVN 1 stated failure to apply oxygen continuous as ordered and monitor oxygen saturation could place the resident at risk for respiratory complications (breathing problems). On February 26, 2026 at 10:23 a.m., an interview was conducted with DON. The DON stated Resident 106's physician orders directed the licensed nurses to administer oxygen continuous at two liters via nasal cannula to maintain O2 Sat at 92 percent or greater. The DON stated licensed nurses should monitor the O2 sat each shift while the resident was receiving oxygen therapy. The facility policy and procedure titled, Oxygen Administration, dated January 2018, was reviewed. The policy indicated, .The purpose of this procedure is to provide guidelines for safe oxygen administration.Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2.On February 23, 2026, at 3:02, p.m. an observation and interview was conducted with Resident 181. Resident 181 was alert, in bed with oxygen applied to his nose by way of nasal cannula (plastic tube that allows oxygen to be delivered to the nose from a machine). An oxygen concentrator (a machine that supplies oxygen) was at Resident 181's bedside in use. The oxygen meter had a flow rate of two liters (a unit of measurement). The oxygen tubing and clear bag hung on the oxygen concentrator was observed to be unlabeled. Resident 181 stated he required oxygen to be used continuously and that he was using oxygen since his admission for approximately three to five days. Resident 181's record was reviewed. Resident 181 was admitted to the facility on [DATE], with a diagnosis which included, Chronic Obstructive Pulmonary Disease (COPD – a lung disease (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	causing inflamed, damaged airways that restrict airflow, making it difficult to breath). The progress notes dated February 20, 2026, at 10:16 p.m. indicated, .patient continues on oxygen at 2 liters via nasal cannula as ordered from the hospital .saturation (the percentage of blood cells that are occupied by oxygen) 95% at 2 liters via nasal cannula . A review of the physician's order dated, February 22, 2026, indicated, .Administer oxygen at 2 LPM (liters per minute – a unit of measurement) via nasal cannula to keep saturations equal or more than 92%. Monitor oxygen saturation with oxygen use. The Care Plan titled, Risk for COPD complication dated February 24, 2026, indicated, .resident will remain free from secondary complications.monitor for signs and.monitor for signs and symptoms of infection. On February 25, 2026, at 3 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 4. LVN 4 was asked if she could describe how oxygen tubing should be monitored and what the process was for the application and use of oxygen tubing and oxygen concentrators. LVN 4 stated the tubing was observed to be in use by Resident 181 at the rate of two liters which was the ordered rate, but that it had not been labeled according to the facility process. LVN 4 stated residents who were admitted to the facility with a need for oxygen, the admitting nurse should apply a new oxygen tubing, check the correct flow rate according to the physician orders, and write the date it was applied along with the name of the resident on the tubing and clear storage bag. LVN 4 stated she did not see a date on the tubing or a date and name of the resident and it should have been done. LVN 4 stated oxygen tubing should be changed by the night shift nurses every week on Friday, and she could not identify if the tubing had been changed. LVN 4 stated the tubing should be changed weekly in order to prevent moisture from developing and labeled so staff could identify who the tubing belonged. LVN 4 further stated there was a potential for another resident to use the tubing and for infection related to moisture build up in the tubing. A review of the facility policy and procedure titled, Oxygen Administration dated, June 2018, indicated, .the purpose of this procedure is to provide guidelines for safe oxygen administration.verify there is a physician's order for this procedure.review facility protocol for oxygen administration.documentation.date.procedure was performed.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident's food preference was honored for one of three residents (Resident 108). This failure had the potential to result in the resident refusing meals and experiencing decreased nutritional intake.Findings:On February 23, 2026, at 1:34 p.m., an observation and interview were conducted with Resident 108 in her room as she was eating her lunch. Resident 108 was observed to have a lettuce salad on her plate. Resident 108 stated, I told them I don't want lettuce, and they still keep bringing me lettuce, I don't have teeth; I can't chew the lettuce, they don't listen. Resident 108's meal ticket was observed on the resident's table that read, .Notes: No lettuce.Dislikes: Vegetables (lettuce). Resident 108's meal ticket was observed to list the following: .Diet Order: Regular Texture, Regular Diet- Thin liquids.Notes: No lettuce.Dislikes. Vegetables (Lettuce). On February 24, 2026, Resident 108's record was reviewed. Resident 108 was admitted to the facility on [DATE], with diagnosis which included mild protein calorie malnutrition (poor nutritional status). A review of the Minimum Data Set (an assessment tool), dated January 1, 2026, indicated Resident 108 had a Brief Interview of Mental Status (a tool to assess cognitive function of an individual) score of 14 (intact cognitive response). On February 26, 2026, at 3:16 p.m., a concurrent interview and record review was conducted with the Dietary Supervisor (DS). The DS stated Resident 108 had an order preference of No Lettuce, and the expectation was to follow the residents' dietary preferences. The DS further stated, the preferences should be honored and staff should check the meal ticket for preferences prior to serving their meal. On February 26, 2026, at 3:45 p.m., a concurrent interview and record review was conducted with the Registered Dietitian (RD). The RD stated she was not aware that Residents 108's preferences were not being honored. The RD further stated it was the residents' rights to have preferences honored to ensure that the residents have adequate nutritional intake. A review of the facility's policy and procedure titled, Resident Food Preferences, dated January 2026, indicated, .Individual food preferences will be assessed upon admission and as soon as practicable.modifications to diet will only be ordered with the resident's or representative's consent .the dietician or nursing staff will identify a residents food preference.