STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555348	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Granada Post Acute	3565 E Imperial Hwy Lynwood, CA 90262

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, facility failed to ensure the low-temperature dishwashing machine reached the required sanitizing water temperature of 120 degrees Fahrenheit (F, unit of temperature) prior to washing soiled dishes, and ensure dietary staff adhered to proper food safety practices when a cook was observed performing meal preparation without a beard net. These failures had the potential to result in improperly sanitized dishware and food contamination, which could increase the risk of foodborne illness, cross-contamination, and the transmission of infectious organisms potentially affecting all residents receiving meals and food services from the facility. Findings: 1. During a concurrent observation and interview on 6/15/2026 at 8:24 a.m., with the Dietary Assistant Supervisor (DAS), the low-temperature dishwashing machine was observed in operation and actively washing dishware. The machine's temperature gauge was observed with a buildup of dried water residue on the thermometer, obstructing the visibility of the temperature reading. Once the residue was removed, the thermometer registered a water temperature of 108 degrees Fahrenheit (F, unit of temperature) during the active wash cycle. The DAS stated that the machine should be allowed to run through two or three cycles prior to washing dishware to ensure the water temperature reached the facility's required operating range of 120 to 140 F . The DAS stated that staff were responsible for verifying the machine achieved the appropriate temperature before loading and washing dishes. The DAS stated that a wash temperature of 108 F was below the acceptable operating range and stated that dishware washed at this temperature may not be adequately cleaned and sanitized. The DAS stated that failure to achieve the required water temperature could result in food-contact surfaces not being properly disinfected, increasing the risk of bacterial contamination and the potential transmission of foodborne pathogens to residents. The DAS stated that dishware should not be washed until the machine reached the required temperature and agreed that the machine was being utilized before achieving the appropriate operating temperature.2. During a concurrent observation and interview on 6/15/2026 at 11:50 a.m., in the kitchen, with [NAME] (CK) 1, CK 1 was observed actively preparing and serving resident meals. CK 1 was not wearing a beard net. CK 1 had visible facial hair extending beyond the chin area while handling food and meal trays intended for resident consumption. CK 1 stated that dietary staff were expected to wear appropriate hair restraints while preparing and serving food. CK 1 stated that beard nets should be worn by staff with facial hair to prevent hair from falling into food and to maintain sanitary food handling practices in the kitchen. CK 1 stated that the purpose of a beard net was to minimize the risk of contaminating food with hair or other particles from facial hair. CK 1 stated that failure to wear the required beard restraint could compromise food sanitation.During an interview on 6/15/2026 at 12:15 p.m., with the Dietary Supervisor (DS), the DS stated that the low-temperature dishwashing machine had been observed operating with a wash-cycle temperature of 108 F , which was below the facility's expected operating range of 120 to 140 F . The DS stated that dietary staff were responsible for ensuring the dishwashing machine reached the appropriate temperature before washing dishware and that the machine should run through three or more cycles prior to use to achieve the required temperature. The DS stated that staff should routinely monitor and verify (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dishwasher temperatures to ensure proper cleaning and sanitization of dishes, utensils, and food-contact surfaces. The DS stated that utilizing the machine before it reached the appropriate temperature could result in dishware not being adequately sanitized and could increase the risk of contamination. The DS stated that the thermometer should remain clean and readily readable at all times to allow staff to accurately monitor dishwasher temperatures during operation. The DS stated that the facility's personal hygiene and food safety practices require dietary staff with facial hair to wear beard nets while preparing, handling, or serving food. The DS stated that beard restraints were intended to prevent hair from contaminating food and to maintain sanitary food handling conditions. The DS stated that dietary staff have received training regarding the dishwashing settings and regarding the use of hair and beard nets. The DS stated that both the failure to ensure proper dishwasher temperatures and the failure to wear required beard restraints were not consistent with facility policies designed to protect residents' health and safety. During s review of the facility's policy and procedure (P&P) titled Sanitation and Infection Control - Dishwashing Procedures Dishmachine) dated 2011, the P&P indicated Chemical low temperature dishmachines must maintain a water temperature of 120 F - 140 F. Dishmachine Temperature Logs must be documented prior to the start of washing at each meal to ensure proper sanitation of all dishware and trays.During a review of the facility's P&P titled Sanitation and Infection Control-Personal Hygiene dated 2011, the P&P indicated A hair net and/or head covering which completely covers all hair should be worn during meal preparation and service. Beards and/or mustaches should be closely cropped and neatly trimmed or must be covered during meal preparation and service.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure repositioning and turning documentation was completed timely and accurately for five out of five sampled residents (Resident 32, Resident 7, Resident 95, Resident 4, and Resident 64). These failures resulted in documentation that could not be relied upon to verify care and services provided for Residents 32, 7, 95, 4, and 64. Cross reference F686.Findings: a. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 32's diagnoses included muscle weakness, contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right lower leg, unstageable pressure ulcer (a severe wound where the true depth and tissue damage cannot be seen because it is completely obscured by dead tissue) of the sacral region (near tailbone), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 32's Minimum Data Set ([MDS], a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 32's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 32 was entirely dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 32's History and Physical (H&P), dated 3/16/2026, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's Braden Scale for Predicting Pressure Sore Risk Assessment (an evidence-based clinical assessment tool used to predict a patient's risk of developing pressure injuries [localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence]), dated 4/27/2026, the assessment indicated Resident 32 was at very high risk for the development of a pressure ulcer. During a review of Resident 32's Care Plan titled, Skin Integrity Impaired, initiated 5/10/2026, the care plan indicated to turn and reposition Resident 32 at least every two hours. During a concurrent interview and record review on 6/17/2026 at 10:50 a.m. with the Director of Staff Development (DSD), Resident 32's Turning and Repositing Flow Sheet, dated 6/2026, was reviewed. The record did not indicate Resident 32 was repositioned on 6/3/2026 at 11:00 p.m., 6/4/2026 at 11:00 p.m., 6/5/2026 at 11:00 p.m., 6/9/2026 at 11:00 p.m., and 6/11/2026 from 7:00 a.m. to 1:00 p.m. The DSD stated that the Certified Nursing Assistants (CNAs) were expected to document the repositioning and turning of residents every two hours, document repositioning after care was provided, and document resident refusals when applicable. The DSD stated documentation should be completed timely to accurately reflect care provided. The DSD stated that because the repositioning was not documented as completed every two hours, there was potential for Resident 32 to develop a pressure ulcer. The DSD stated documentation was not completed timely and confirmed the medical record could not verify whether repositioning occurred during the time periods. During a concurrent interview and record review on 6/18/2026 at 9:47 a.m. with Registered Nurse (RN) 1, Resident 32's ADL Task Flow Sheet, dated 6/2026, was reviewed. The flow sheet indicated charting for the 3:00 p.m. to 11:00 p.m. shift was entered at 10:52 p.m. on 6/15/2026, and at 8:30 p.m. on 6/16/2026. RN 1 stated staff were expected to document care at the time the task was completed. RN 1 stated documentation was not completed timely and stated late entries reduced the reliability of the record. RN 1 stated the documentation did not identify the position to which Resident 32 was repositioned and confirmed the medical record could not verify whether repositioning interventions were performed during the identified time periods due to untimely documentation. b. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7's diagnoses included muscle weakness, pressure ulcer of unspecified site, adult failure to thrive (a (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and multiple sclerosis (MS, a chronic autoimmune disease of the central nervous system). During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 7 was entirely dependent on staff for ADLs. During a review of Resident 7's Braden Scale for Predicting Pressure Sore Risk Assessment, dated 6/14/2026, the assessment indicated Resident 7 was at high risk for the development a pressure ulcer. During a review of Resident 7's Care Plan titled, Incontinent of Bowel (undated), the care plan indicated to reposition and turn Resident 7 every two hours and as needed. During observations made on 6/16/2026 at 9:46 a.m., 12:34 p.m., and 2:01 p.m., in Resident 7's room, Resident 7 was observed on his back. During observations made on 6/17/2026 at 8:49 a.m. and 1:06 p.m., in Resident 7's room, Resident 7 was observed on his back. During a concurrent interview and record review on 6/17/2026 at 9:03 a.m. with Certified Nursing Assistant (CNA) 2, Resident 7's Turn and Repositioning Flow Sheet, dated 6/2026, was reviewed. The Flow Sheet did not indicate Resident 7 was repositioned on 6/16/2026 at 12:00 p.m. and 2:00 p.m. CNA 2 confirmed that she was Resident 7's assigned CNA on 6/16/2026. CNA 2 stated Resident 7 was not repositioned because the resident refused. CNA 2 stated her documentation should have indicated that Resident 7 refused to accurately depict the care was not provided and so that the charge nurse would be made aware of the resident's refusals. c. During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 95's diagnoses included muscle weakness, gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 95's MDS, dated [DATE], the MDS indicated Resident 95's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 95 required maximal assistance (helper does more than half the effort) for toileting, showering, and lower body dressing. During a review of Resident 95's Braden Scale for Predicting Pressure Sore Risk Assessment, dated 6/14/2026, the assessment indicated Resident 95 was at risk for the development of a pressure ulcer. During a concurrent interview and record review on 6/17/2026 at 10:50 a.m. with the DSD, Resident 95's Turning and Repositing Flow Sheet, dated 6/2026, was reviewed. The flow sheet did not indicate Resident 95 was repositioned on 6/12/2026 at 2:00 p.m. and 6/14/2026 from the hours of 12:00 a.m. to 6:00 a.m. d. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4's diagnoses included muscle weakness, muscle wasting and atrophy (loss of muscle tissue), palliative care (compassionate care for people who are near the end of life), and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the right hip. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 4 had range of motion impairments on both lower extremities. During a review of Resident 4's Care Plan titled, ADLs, initiated 3/8/2024, the care plan indicated to turn and re-position Resident 4 at least every two hours and as often as needed. During a review of Resident 4's Braden Scale for Predicting Pressure Sore Risk Assessment, dated 6/11/2026, the assessment indicated Resident 4 was at moderate risk for the development of a pressure ulcer. During observations made on 6/16/2026 at 12:20 p.m. and at 2:02 p.m., in Resident 4's room, Resident 4 was observed positioned on her back. During a concurrent interview and record review on 6/18/2026 at 9:47 a.m. with RN 1, Resident 4's ADL Task Flow Sheets, dated 6/2026, were reviewed. The flow sheets did not indicate a designated section for the documentation of repositioning for Resident 4. RN 1 stated the facility's practice was to reposition residents every two hours according to the facility turning schedule, and document the intervention after completion. RN 1 stated that if there was no (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation in place for Resident 4's repositioning, then the intervention could not be verified as completed. e. During a review of Resident 64's admission Record, the admission Record indicated Resident 64 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 64's diagnoses included muscle weakness, muscle wasting and atrophy, and dementia (a progressive state of decline in mental abilities).During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64's cognitive skills for daily decision making were intact. The MDS indicated Resident 64 required maximal assistance for toileting, showering, and putting on footwear. During a review of Resident 64's Care Plans titled, ADLs, initiated 7/25/2022, and At Risk for Pressure Sore (undated), the care plan indicated to turn and reposition Resident 64 at least every two hours and as often as needed. During a concurrent interview and record review on 6/17/2026 at 10:50 a.m. with the DSD, Resident 64's Turning and Repositing Flow Sheet, dated 6/2026, was reviewed. The flow sheet did not indicate Resident 64 was repositioned on 6/10/2026 at 4:00 a.m. and 6:00 a.m., and on 6/11/2026 at 6:00 a.m. During a review of the facility's P&P titled, Charting and Documentation, revised 7/2025, the P&P indicated the facility was to ensure documentation in the medical record would be complete, and accurate.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure behavior episodes and the number of hours of sleep were monitored for two of five sampled residents (Resident 2 and Resident 11) receiving psychotropic medication (any drug that changes brain function resulting in alteration to mood, thoughts, feelings or behavior).These failures had the potential to place Resident 2 and 11 at risk for unnecessary psychotropic medication use and unidentified and unaddressed changes in behavior.Findings:1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included chronic obstructive pulmonary disorder (COPD, a chronic lung disease causing difficulty in breathing), pneumonia (an infection/inflammation in the lungs), and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 2's History and Physical (H&P) dated 6/4/2026, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 4/28/2026, the MDS indicated Resident 2 had moderate cognitive skills for daily decision making (ability to think and understand). The MDS indicated Resident 2 was dependent on staff for toileting, bathing and required setup assistance for eating.During a concurrent interview and record review on 6/16/2026 at 12:02 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 2's medical record and physician orders dated 6/2/2026 were reviewed. The physician order indicated, Quetiapine Fumarate (Seroquel, medication used to treat schizophrenia by improving thinking, mood and behavior) Oral Tablet 25 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount). Give 1 tablet by mouth every 12 hours for schizophrenia manifested by visual hallucinations of seeing people in the ceiling. The physician order also indicated, Monitoring of behavior episodes of schizophrenia manifested by sudden angry outburst as evidenced by increased agitation and aggressiveness every shift for Seroquel. The medical records did not indicate there was a physician order for the behavior monitoring of Resident 2's visual hallucinations. LVN 2 stated the behavior monitoring order for Seroquel was incorrect, and monitoring of Resident 2's visual hallucinations should have been ordered instead. LVN 2 stated monitoring Resident 2's visual hallucinations was important to ensure effectiveness of medication regimen and to determine the need of physician reassessment.During a concurrent interview and record review on 6/16/2026 at 12:27 p.m. with the Quality Assurance (QA) Nurse, Resident 2's Psychotherapeutic Drug Informed Consent Form dated 6/1/2026 and medical records were reviewed. Resident 2's Psychotherapeutic Drug Informed Consent Form for Seroquel indicated a behavioral manifestation of visual hallucination of seeing people in the ceiling. Resident 2's medical records did not indicate there was a physician order for the behavior monitoring of Resident 2's visual hallucinations. The QA Nurse stated failure to ensure the correct behavior manifestation was being monitored placed resident at risk of inadequate monitoring and unidentified and unaddressed changes in behavior.2. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE]. Resident 11's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), and depression (mental health condition that causes deep feelings of sadness and loss of interest in activities).During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 had no cognitive impairment. The MDS indicated Resident 11 required substantial assistance from staff for toileting, bathing, and setup assistance for eating.During a concurrent interview and record review on 6/17/2026 at 10:08 a.m. with Registered Nurse (RN) 1, Resident 11's physician orders dated 5/18/2026 and medical records were reviewed. The physician orders indicated, trazadone hydrochloride (medication used to regulate mood and sleep) oral tablet 50 mg. Give 1.5 tablet by (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth at bedtime for depression manifested by verbalization of difficulty in sleeping due to current health condition. The medical records did not indicate there was a physician order for monitoring Resident 11's hours of sleep. RN 1 stated Resident 11's hours of sleep should have been monitored to ensure the medication was effective. RN 1 stated monitoring the effectiveness of medications was important to ensure resident's issues were being properly addressed and physician was notified if any changes in regimen were needed.During an interview with the Director of Nursing (DON) on 6/18/2026 at 10:03 a.m., the DON stated monitoring for the indicated behavior of psychotropic medications was important to ensure the medication was effective in treating the manifested behavior. The DON stated failure to monitor the indicated behavior placed Resident 11 at risk of improper medication management as staff would not be able to assess if the medication was treating the behavior, and therefore would not be able to notify the physician for adjustments in medication regimen.During a review of the facility's Policy and Procedure (P&P), titled, Behavioral Assessment, Intervention and Monitoring revised 3/2019, the P&P indicated, when medications were prescribed for behavioral symptoms, documentation would include specific target behaviors, expected outcomes, monitoring for efficacy and adverse consequences.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set ([MDS]- a resident assessment tool) for a significant change status was completed for one of two sampled residents (Resident 3) after the resident experienced a fall resulting in a fracture (a broken bone) on 1/28/2026. This failure resulted in delayed assessment and delayed transmission of Resident 3's significant change in condition to the Centers for Medicare and Medicaid Services (CMS, a federal agency within the U.S. Department of Health and Human Services (HHS) that administers major healthcare programs) and had the potential to negatively affect the resident's care planning, and delivery of necessary care and services related to the fall and fracture. Cross reference F657Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), fracture of the right fibula (broken calf bone), and muscle weakness (loss of muscle strength). During a review of Resident 3's History and Physical (H&P), dated 10/23/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set ([MDS]- a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 3's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 3 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 3 required supervision or touching (helper provides verbal cues and/or contact guard assistance as resident competes activities) assistance for sitting on the side of the bed and/or standing position. During a concurrent interview and record review on 6/15/2026 at 6/15/2026 at 9:14 a.m., at Resident 3's bedside, with Resident 3, Resident 3 was observed lying in bed. Resident 3 stated she had a fall at the facility in 1/2026, which resulted in a left ankle fracture. Resident 3 stated prior to the fall, she was able to walk. Resident 3 stated currently she could not walk and/or get out of bed without staff assistance. During a concurrent interview and record review on 6/17/2026 at 9:16 a.m., with MDS Nurse (MDSN) 1, Resident 3's situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 1/28/2026, was reviewed. The SBAR indicated on 1/28/2026 at 2:55 p.m., Resident 3 was walking in the hallway with two staff members when she lost her balance, twisted her left ankle, and fell backward to the floor. MDSN 1 stated the SBAR indicated Resident 3 complained of left ankle pain rated at 7out of 10, on a pain scale (0= no pain, 1-3= mild pain, 4-6= moderate pain, 7-10= severe pain). MDSN 1 stated the SBAR indicated Resident 3 was transferred to the general acute care hospital (GACH) for evaluation due to a fall and pain. During a concurrent interview and record review on 6/17/2026 at 10:00 a.m., with MDSN 1, Resident 3's records, including a progress note, dated 1/28/2026, were reviewed. The progress note indicated Resident 3 returned to the facility from the GACH on 1/28/2026. The progress note indicated Resident 3 had an acute (a sudden) fracture to the medial malleolus (bony bump on the inner side of the ankle) and distal fibula (a bony bump on the outside of the ankle). MDSN 1 stated she was responsible for completing the MDS assessments for the facility. MDSN 1 stated Resident 3's fall with fracture, hospital transfer, increased pain, and decline in ability to ambulate (walk) independently should have prompted the facility to evaluate Resident 3 for a significant change in status assessment. MDSN 1 stated the MDS assessment process was used to identify changes in a resident's condition and ensure the resident's care plan accurately reflected the resident's current needs. MDSN 1 stated when a resident had a significant change in condition, the facility was required to complete a significant change in status assessment after the significant change was identified. MDSN 1 stated there was no documented evidence that a significant change MDS assessment was (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed after Resident 3's fall with fracture on 1/28/2026. MDSN 1 stated the facility should have completed the assessment to evaluate Resident 3's current needs related to mobility, fall risk, pain, ADL assistance, and care planning after the fracture. During an interview on 6/17/2026 at 1:00 p.m., with the Director of Nursing (DON), the DON stated residents who experience a fall with injury should be assessed to determine whether the resident had a significant change in condition. The DON stated a significant change in status MDS should be completed when the resident's condition declined and the change required review and revision of the resident's care and services. The DON stated the interdisciplinary team (IDT- a coordinated group of healthcare professionals who collaborate and evaluate comprehensive care for a resident) should have evaluated Resident 3's fall, left ankle fracture, and need for additional safety, care and services approaches. The DON stated failure to complete a significant change in status MDS assessment may have delayed identification of the resident's current needs, and negatively affect care planning and the delivery of necessary care and services. The DON stated this placed Resident 3 at risk for continued falls, injury, weakness, decline in ADLs, and further decline in overall condition. During a review of the facility's policy and procedure (P&P) titled Resident Assessment, revised 10/2023, the P&P indicated the facility was mandated to complete a comprehensive MDS assessment for any significant change in resident's status.

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Granada Post Acute	3565 E Imperial Hwy Lynwood, CA 90262

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the minimum data set (MDS- a resident assessment tool) was accurately completed for one of one sampled residents (Resident 1), when Resident 1's MDS did not include his active diagnosis of dementia (a progressive state of decline in mental abilities).This failure had the potential to place Resident 1 at risk of not receiving comprehensive care that addressed his diagnosis of dementia.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included pneumonia (an infection/inflammation in the lungs), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities).During a review of Resident 1's History and Physical (H&P) dated 5/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Aet (MDS- a resident assessment tool), dated 4/24/2026, the MDS indicated Resident 1 had no cognitive impairment (ability to think and understand). The MDS indicated Resident 1 required partial assistance from staff for personal hygiene. The MDS indicated Resident 1 required substantial assistance with toileting and setup assistance for eating.During a concurrent interview and record review on 6/17/2026 at 12:05 p.m. with MDS Nurse (MDSN 1), Resident 1's MDS dated [DATE] and diagnosis list were reviewed. Resident 1's diagnosis list indicated a diagnosis of dementia. Resident 1's MDS Section I (MDS section dedicated to documenting the resident's active diagnoses) did not indicate a diagnosis of dementia. MDSN 1 stated she should have included Resident 1's diagnosis of dementia when she completed the MDS assessment. MDSN 1 stated all active diagnoses should be documented in the MDS assessment, because it drives the care plans and interventions implemented for residents. MDSN 1 stated failure to include Resident 1's diagnosis of dementia placed the resident at risk of not receiving comprehensive care that addressed dementia specific needs.During an interview on 6/18/2026 at 10:03 a.m. with the Director of Nursing (DON), the DON stated accurate MDS assessments were important to ensure the residents' plan of care were comprehensive and the resident's specific needs were addressed.During a review of the facility's policy and procedure (P&P), titled, Resident Assessments last revised 10/2023, the P&P indicated, Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews.During a review of the facility's Resident Assessment/Care Plan Coordinator (MDS) Job description, indicated, Inform all assessment team members of the requirements for accuracy and completion of the resident assessment (MDS).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR- a federal assessment requirement to help ensure individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care and referred to special services as needed) Level 2 evaluation was completed for one of one sampled residents (Resident 1).This failure had the potential to result in inappropriate placement and unidentified specialized services for Resident 1.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included pneumonia (an infection/inflammation in the lungs), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's History and Physical (H&P) dated 5/12/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/24/2026, the MDS indicated Resident 1 had no cognitive impairment (ability to think and understand). The MDS indicated Resident 1 required partial assistance from staff for personal hygiene. The MDS indicated Resident 1 required substantial assistance with toileting and setup assistance for eating.During a review of Resident 1's Preadmission Screening and Resident Review (PASARR) level 1 screening dated 1/26/2024, the PASARR indicated the need for a Level 2 PASARR evaluation.During a concurrent interview and record review on 6/17/2026 at 12:19 p.m. with the Social Services Director (SSD), Resident 1's PASARR Level 2 Determination Letter dated 1/26/2024 and medical records were reviewed. Resident 1's medical records indicated a PASARR Level 2 evaluation had not been completed. The PASARR Level 2 Determination Letter indicated Resident 1 required a level 2 PASARR evaluation, but it was not completed because the individual was unable to participate in the evaluation. The SSD stated, Resident 1 either refused to participate or was not in the facility when the PASARR Level 2 evaluation was attempted. The SSD stated staff should have submitted another PASARR Level 1 screening to prompt another PASARR level 2 evaluation. The SSD stated PASARR evaluations were important to ensure residents were appropriately screened for mental illnesses, ensure resident placement was accurate, and referrals were made to appropriate programs and services.During an interview with the Director of Nursing (DON) on 6/18/2026 at 10:03 a.m., the DON stated PASARR evaluations were important to ensure resident placement was appropriate and resources such as programs and services were coordinated depending on resident needs.During a review of the facility's Policy and Procedure (P&P), titled, Preadmission Screening and Resident Review dated 4/2017, the P&P indicated, Level 2 full evaluation shall be conducted by a Department of Health Care Services (DHCS) Contractor for determination when the Level 1 screen identifies the resident having Mental Illness (MI) or Intellectual Disability (ID).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the care plan for one of two sampled residents (Resident 3) after the resident experienced a fall on 1/28/2026, which resulted in a fracture (a broken bone). This failure had the potential to result in ineffective care, treatment, and services for Resident 3, and placed the resident at increased risk for additional falls, injury, and unmet care needs. Cross reference F637Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), fracture of the right fibula (calf bone), and muscle weakness (loss of muscle strength). During a review of Resident 3's History and Physical (H&P), dated 10/23/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set ([MDS]- a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 3's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 3 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).The MDS indicated Resident 3 required supervision or touching (helper provides verbal cues and/or contact guard assistance as resident competes activities) assistance from staff for sitting on the side of the bed and/or standing position. During a concurrent interview and record review on 6/15/2026 at 9:14 a.m., at Resident 3's bedside, with Resident 3, Resident 3 was observed lying in bed. Resident 3 stated she had a fall at the facility in 1/2026, which resulted in a left ankle fracture. Resident 3 stated prior to the fall, she was able to walk. Resident 3 stated currently she could not walk and/or get out of bed without staff assistance. During a concurrent interview and record review on 6/17/2026 at 9:16 a.m., with MDS Nurse (MDSN) 1, Resident 3's situation, background, assessment, recommendation ([SBAR]- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 1/28/2026, was reviewed. The SBAR indicated on 1/28/2026 at 2:55 p.m., Resident 3 was walking in the hallway with two staff members when she lost her balance, twisted her left ankle, and fell backward to the floor. MDSN 1 stated the SBAR indicated Resident 3 complained of left ankle pain rated at 7out of 10, on a pain scale (0= no pain, 1-3= mild pain, 4-6= moderate pain, 7-10= severe pain). MDSN 1 stated the SBAR indicated Resident 3 was transferred to the general acute care hospital (GACH) for evaluation due to a fall and pain. During a concurrent interview and record review on 6/17/2026 at 10:00 a.m., with MDSN 1, Resident 3's records, including a progress note, dated 1/28/2026, were reviewed. The progress note indicated Resident 3 returned to the facility from the GACH on 1/28/2026. The progress note indicated Resident 3 had an acute (a sudden) fracture to the medial malleolus (bony bump on the inner side of the ankle) and distal fibula (calf bone). MDSN 1 stated Resident 3's care plan should have been revised with updated and individualized nutritional interventions to address the significant change of a fall with injury. MDSN 1 stated new updated interventions were necessary to help prevent falls, injury, and ADL decline. During a concurrent interview and record review on 6/17/2026 at 10:15 a.m., with MDSN 1, Resident 3's care plan titled Risk for falls, dated 10/21/2025, was reviewed. The care plan did not indicate additional or revised interventions after Resident 3's fall and left ankle fracture were identified. MDSN 1 stated Resident 3 had a care plan that addressed the resident?s risk for fall; however, the care plan was not revised with additional individualized interventions after Resident 3's fall on 1/28/2026 which resulted in a left ankle fracture. During an interview on 6/17/2026 at 1:00 p.m., with the Director of Nursing (DON), the DON stated residents who experience falls and injuries should have their comprehensive care plans reviewed and revised to include updated interventions based on the resident's current condition (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and needs. The DON stated licensed staff should have evaluated Resident 3's fall and left ankle injury and updated the care plan with resident centered interventions to address the resident's risk for falls and injury. The DON stated these updated interventions would guide staff in providing consistent care for Resident 3 and help ensure staff were aware of the resident's current fall risks and care needs. The DON stated failure to revise the care plan after a fall with injury placed Resident 3 at risk for inadequate care and services, further falls, injury, and decline in ADLs. During a review of the facility's policy and procedure (P&P) titled Care Plan- Comprehensive Person- Centered, dated 1/2025, the care plan indicated a comprehensive care plan was developed for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. The P&P indicated the care plans were revised as needed on changes in resident's conditions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of four staff-dependent sampled residents' (Resident 25 and Resident 39) fingernails were trimmed and maintained in a clean manner. This failure had the potential to result in a negative impact on Resident 25 and Resident 39's quality of life and self-esteem and had the potential to result in sustaining an injury from scratching and developing an infection.Findings: a. During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 25's diagnoses included hypertension (HTN- high blood pressure), anxiety (a feeling of fear), and muscle weakness (loss of muscle strength). During a review of Resident 25's History and Physical (H&P), dated 2/16/2026, the H&P indicated Resident 25 had fluctuating capacity to understand and make decisions. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 4/30/2026, the MDS indicated Resident 25's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 25 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). During a review of Resident 25's care plan titled ADLs, dated 7/25/2025, the care plan indicated the staff would keep Resident 25's fingernails clean and short. During an observation on 6/15/2026 at 9:14 a.m., at Resident 25's bedside, Resident 25's fingernails were observed long and untrimmed with dark brown debris underneath the nail bed. During a concurrent observation and interview on 6/17/2026 at 1:35 p.m., in Resident 25's room, with Certified Nursing Assistant (CNA) 1, Resident 25's fingernails were observed. Resident 25's fingernails were long and untrimmed. CNA 1 stated Resident 25's fingernails were sharp, long and required trimming. CNA 1 stated nail care was one of the responsibilities of the CNA which included trimming and cleaning the resident's fingernails when they became long and dirty. CNA 1 stated residents' nails should be checked daily to ensure the nails remained clean and neat. CNA 1 stated residents sometimes scratched their skin, and if they scratched hard enough, they could break the skin and create an open wound. CNA 1 stated if a resident had dirty fingernails and scratched themselves, this increased the risk of infection. b. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), HTN, and muscle weakness. During a review of Resident 39's H&P, dated 5/7/2026, the H&P indicated Resident 39 had fluctuating capacity to understand and make decisions. During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39's cognitive skills for daily decision making was intact. The MDS indicated Resident 39 was dependent (helper does all the effort) on staff for ADLs. During a review of Resident 39's care plan titled ADLs, dated 5/6/2026, the care plan indicated staff would keep the resident's fingernails clean and short. During a concurrent observation and interview on 6/15/2026 at 10:28 a.m., at Resident 39's bedside, with Resident 39, Resident 39 was observed with long fingernails. Resident 39's fingernails were untrimmed with visible black debris underneath the fingernails. Resident 39 stated staff had not assisted with trimming or cleaning the nails. During an interview on 6/17/2026 at 1:45 p.m., with CNA 1, CNA 1 stated Resident 39 required staff assistance with personal hygiene and ADL care, including nail care. CNA 1 stated Resident 39's nails should be checked daily to ensure the nails remained clean and neat. During an interview on 6/17/2026 at 1:58 p.m., with the Director of Nursing (DON), the DON stated staff were expected to provide assistance with ADL care and keep residents' fingerprints clean and short. The DON stated nail care should be assessed daily. The DON stated residents who required assistance with cleaning or trimming their nails should be assisted by the CNA's or licensed nurses. The DON stated fingernails were a source of bacteria, and dirty or untrimmed nails could contribute to the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	spread of infection, especially among residents who may not be able to maintain their own hygiene. The DON stated routine nail care was an essential part of both personal hygiene and infection control. The DON stated the facility failed to ensure residents' fingernails were kept clean and trimmed. The DON stated this placed Residents 25 and 39 at risk for poor hygiene, discomfort, skin breakdown, and infection. During a review of the facility's policy and procedure (P&P) titled Fingernails/Toenails, Care of, revised 2/2018, the P&P indicated residents' nails will be kept clean and trimmed to prevent infection, scratches, and injuries.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pressure ulcer (PU- localized damage to the skin and/or underlying tissue usually over a bony prominence) prevention interventions were implemented for two of two sampled residents (Residents 32 and 52), by failing to: 1. Ensure Resident 32 received timely repositioning. 2. Ensure Resident 52's low air mattress (LAM- a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) was set according to the resident's weight. These failures had the potential to place Residents 32 and 52 at risk for pressure ulcer development and/or worsening skin integrity. Findings: a. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 32's diagnoses included muscle weakness, contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right lower leg, unstageable pressure ulcer (a severe wound where the true depth and tissue damage cannot be seen because it is completely obscured by dead tissue) of sacral region (near tailbone), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 32's Minimum Data Set ([MDS], a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 32's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 32 was entirely dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 32's History and Physical (H&P), dated 3/16/2026, the H&P indicated Resident 32 did not have the capacity to understand and make decisions. During a review of Resident 32's Care Plan titled, ADLs, initiated 1/30/2025, the care plan indicated to check Resident 32 at least every two hours for wetness or soiling and as needed. During a review of Resident 32's Braden Scale for Predicting Pressure Sore Risk Assessment (an evidence-based clinical assessment tool used to predict a patient's risk of developing pressure injuries [localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence]), dated 4/27/2026, the assessment indicated Resident 32 was a very high risk for the development of a pressure ulcer. During a review of Resident 32's Care Plan titled, Skin Integrity Impaired, initiated 5/10/2026, the care plan indicated to turn and reposition Resident 32 at least every two hours. During an observation on 6/16/2026 at 9:33 a.m., in Resident 32's room, observed Resident 32's Turning Schedule (undated) posted at head of the bed. The schedule directed staff to reposition Resident 32 every two hours by alternating the resident's position between the back and side-facing positions. During an observation on 6/16/2026 at 2:03 p.m., Resident 32 was observed lying on her back in bed. The turning schedule indicated Resident 32 was to be positioned facing the window. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 6/16/2026 at 8:10 a.m. with Family Member (FM) 1, FM 1 stated, on 6/15/2026, during the 3:00 p.m. to 11:00 p.m. shift, the certified nursing assistant (CNA) did not change and reposition Resident 32 from the hours of 2:30 p.m. and 6:30 p.m. FM 1 stated that Resident 32 was changed around 2:30 p.m. by the previous shift and Resident 32 soiled herself shortly after. FM 1 stated Resident 32 was not changed until 6:30 p.m. FM 1 stated that the CNAs were supposed to reposition Resident 32 every two hours because she had a history of pressure sores and needed to be changed timely. During a phone interview on 6/16/2026 at 12:35 p.m. with CNA 3, CNA 3 stated she was assigned to Resident 32 during the 3 p.m. to 11 p.m. shift on 6/15/2026. CNA 3 stated she recalled being unable to reposition Resident 32 at 4 p.m. because she was assisting another resident. CNA 3 stated it was crucial for Resident 32 to be cleaned and repositioned promptly given Resident 32's risk of developing a pressure ulcer. During a concurrent interview and record review on 6/17/2026 at 10:50 a.m. with the Director of Staff Development (DSD), Resident 32's Turning and Repositing Flow Sheet, dated 6/2026, was reviewed. The flow sheet did not indicate Resident 32 was repositioned on 6/3/2026 at 11:00 p.m., 6/4/2026 at 11:00 p.m., 6/5/2026 at 11:00 p.m., 6/9/2026 at 11:00 p.m., and 6/11/2026; 7:00 a.m. to 1:00 p.m. The DSD stated the CNAs were expected to document the repositioning and turning of residents every two hours, document repositioning after care, and document resident refusals when applicable. The DSD stated documentation should be completed timely to accurately reflect care provided. The DSD stated that because the repositioning was not documented as completed every two hours, there was potential for Resident 32 to develop a pressure ulcer. The DSD stated Resident 32's documentation was not completed timely. The DSD stated Resident 32's medical record could not verify whether repositioning was performed. During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, revised 7/2023, the P&P indicated to choose a frequency for the residents' repositioning based on the resident's risks factors, and to reposition all residents with or at risk of pressure injuries on an individualized schedule. During a review of the facility's P&P titled, Repositioning, revised 7/2024, the P&P indicated the facility staff were to check the care plan, assignment sheet or the communication system to determine resident-specific positioning needs. During a review of the facility's P&P titled, Charting and Documentation, revised 7/2025, the P&P indicated the facility was to ensure documentation in the medical record would be complete, and accurate. b. During a review of Resident 52's admission Record, the admission Record indicated Resident 52 was admitted to the facility on [DATE] with diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), and muscle weakness (loss of muscle strength). During a review of Resident 52's H&P, dated 1/15/2026, the H&P indicated Resident 52 had the capacity to understand and make decisions. During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52's cognitive skills for daily decision making was intact. The MDS indicated Resident 52 was dependent (helper (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	does all the effort) on staff for ADLs. During a review of Resident 52's physician order, dated 4/15/2026, the physician order indicated Resident 52 was to have a low air loss mattress (LAM) with the setting adjusted to 210-pound (Lbs., a unit of measuring weight). During a review of Resident 52's care plan titled LAM, dated 1/14/2026, the care plan indicated Resident 52 required a low air mattress with the setting maintained at 210 Lbs. The care plan indicated the intervention as a part of Resident 52's pressure ulcer prevention and skin integrity management. During a review of Resident 52's record titled Weights and Vitals Summary, dated 6/1/2026, the record indicated on 6/1/2026, Resident 52's weighed 198 pounds. During an observation on 6/15/2026 at 10:43 a.m., and 6/15/2026 at 2:45 p.m., at Resident 52's bedside, Resident 52 was observed lying on a LAM. The LAM setting was observed at 280 pounds. During an interview on 6/16/2026 at 1:45 p.m., with the Director of Nursing (DON), the DON stated Resident 52's weight was 198 pounds. The DON stated the LAM should have been set according to the resident's weight and the physician order to provide appropriate pressure redistribution. The DON stated staff were expected to check the mattress setting and ensure it matched the physician order and care plan. The DON stated Resident 52's mattress was not set according to the resident's weight and ordered 210-pound setting. The DON stated this failure had the potential to reduce the effectiveness of pressure redistribution provided by the LAM and placed Resident 52 at risk for increased pressure to bony prominences, skin breakdown, pressure ulcer development, and/or worsening skin integrity. During a review of the facility's P&P titled Air Mattress, undated, the P&P indicated the purpose of using special air mattresses was to decrease pressure from the resident's weight in bed, and to promote the healing of or the prevention of pressure ulcers. The P&P further indicated to monitor the mattress to assure that it is functioning properly, and that air level assures that the resident's body does not touch the bed. During a review of the facility's record titled, Drive: Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System Operating Manual, undated, the record indicated to determine the resident's weight and set the control knob to that weight setting on the control unit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to implement and follow physician orders for orthostatic blood pressure (the measurement of blood pressure changes that occur from a sitting or lying position to a standing position) monitoring and recording for one of three sampled residents (Residents 24). This failure had the potential to place Resident 24 at risk for undetected orthostatic hypotension, dizziness, syncope (fainting), falls, injury, delayed medical intervention, and adverse cardiovascular complications related to changes in blood pressure upon position changes.Findings: During a review of Resident 24's admission Record, the admission Record indicated the facility admitted Resident 24 on 2/14/2024. Resident 24's diagnoses included depressive disorder (a serious mood disorder characterized by a persistent low mood, loss of interest and low energy, lasting at least two weeks), muscle weakness, dysphagia (difficulty in swallowing), hepatic encephalopathy (a serious decline in brain function due to severe liver disease), hypotension (low blood pressure), and orthostatic hypotension (a sudden drop in blood pressure that occurs when you stand up after sitting or lying down). During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool), dated 5/22/2026, the MDS indicated Resident 24's mental capacity was intact. The MDS indicated that Resident 24 was partially dependent (helper does less than half the effort) on staff to complete activities of daily living. During a review of Resident 24's History and Physical (H&P) dated 6/5/2026, the H&P indicated Resident 24 had the capacity to make medical decisions. During a review of Resident 24's physician order dated 4/10/2026, the order indicated to monitor and record Resident 24's orthostatic blood pressure. The order indicated to record the lying blood pressure, wait for 5 minutes and then have Resident 24 sit and check the sitting blood pressure in the morning every Sunday. Notify the medical doctor if the systolic blood pressure's difference is 20 millimeters of mercury (mmHg, a unit for measuring blood pressure) or if the diastolic blood pressure's difference is 10 mmHg or more, or if the resident complains of lightheadedness, dizziness, or vision changes. During a review of Resident 24's physician order dated 6/4/2026, the order indicated to monitor and record Resident 24's orthostatic blood pressure. The order indicated to record the lying blood pressure, then wait for 5 minutes, and then have the resident sit and check the sitting blood pressure, in the morning every Sunday. Notify the medical doctor if the systolic blood pressure's difference is 20 mmHg or if the diastolic blood pressure's difference is 10 mmHg or more, or the resident complains of lightheadedness, dizziness or vision changes. During a review of Resident 24's Weights and Vitals Summary record for the months of May and June 2026, the records did not indicate that on 5/3/2026, 5/10/2026, 5/17/2026, 5/24/2026, 6/7/2026 and 6/14/2026, Resident 24's orthostatic blood pressures were monitored. During a concurrent interview and record review on 6/17/2026 at 2:53 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 24's Physician Orders for May and June 2026, the Weight and Vital Summary records dated May and June 2026, were reviewed. The physician orders indicated orthostatic blood pressure monitoring. The Weight and Vital Summary records did not indicate orthostatic blood pressure readings were documented. LVN 1 stated that the absence of documented orthostatic blood pressure monitoring indicated that the ordered assessments were either not completed or not recorded. LVN 1 stated that it was important to follow the physician orders and consistently monitor orthostatic blood pressures as prescribed to assess for changes in Resident 24's cardiovascular status, identify symptoms such as dizziness or hypotension, and ensure timely intervention when abnormalities were identified. LVN 1 stated that failure to perform and document orthostatic blood pressure monitoring as ordered could place the resident at risk for undetected changes in condition, falls, injury, and delayed medical evaluation. During a concurrent interview and record review on 6/17/2026 at 3:24 p.m., with the Director of Nursing (DON), Resident 24's Physician Orders for May and June 2026 and the Weight and Vital Summary records for May and June 2026 were reviewed. The DON stated that there was a physician (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for orthostatic blood pressure monitoring to be completed as prescribed, including Sundays. Upon review of the records, the DON stated that orthostatic blood pressure readings were not documented on multiple Sundays and agreed that the facility was unable to demonstrate that the ordered monitoring had been completed. The DON stated that nursing staff were expected to follow all physician orders as written and accurately document completed assessments in the medical record. The DON stated that orthostatic blood pressure monitoring was an important assessment used to identify changes in blood pressure associated with position changes, monitor for symptoms of dizziness or hypotension, and evaluate a resident's risk for falls and injury. During a review of the facility's policy and procedure (P&P) titled, Physician Orders: Orders/Receiving/transcribing dated 7/2024, the P&P indicated, Physician Orders are obtained to provide a clear direction in the care of the resident. During a review of the facility's P&P titled Blood Pressure, Measuring dated 10/2025, the P&P indicated, to measure orthostatic blood pressure, follow steps to obtain blood pressure reading while sitting or lying down and immediately after helping the resident to a standing position. Note the changes in both the systolic and diastolic measurements compared to the reading taken while the resident was in a seated position. The P&P indicated the following information should be recorded in the resident's medical record:1. The date and time the blood pressure was measured.2. The name and title of the individual(s) who measured the blood pressure.3. The blood pressure reading.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Urologist (medical doctor who specializes in treating diseases of the urinary tract in both men and women, as well as the male reproductive system) was consulted in a timely manner as ordered on 1/19/2026, and upon readmission to the facility on 2/20/2026 for one of one sampled residents (Resident 5) with an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine). This failure had the potential to place Resident 5 at risk for indwelling catheter related complications such as urinary tract infections (UTI- an infection in the bladder/urinary tract) and sepsis (a life-threatening blood infection).Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included hydronephrosis (swelling of a kidney caused by a backup of urine), hypertension (HTN-high blood pressure), presence of urogenital implants (medical device surgically placed in the body to support or replace the function of the urinary and reproductive organs), and obstructive reflux uropathy (a blockage in the urinary tract and backward flow of urine from the bladder into the kidneys). During a review of Resident 5's History and Physical (H&P) dated 1/20/2026, the H&P indicated Resident 5 did not have the capacity to understand or make medical decisions. During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 5/18/2026, the MDS indicated Resident 5 had moderate cognitive (ability to think and understand) impairment. The MDS indicated Resident 5 required moderate assistance from staff for personal hygiene and substantial assistance for toileting and lower body dressing. The MDS indicated Resident 5 had an indwelling catheter. During a review of Resident 5's physician order dated 2/20/2026, the physician order indicated, Foley (indwelling urinary catheter) catheter diagnosis obstructive reflux uropathy. 1. During a concurrent interview and record review on 6/17/2026 at 9:41 a.m. with Case Manager (CM) 1, Resident 5's physician order dated 1/19/2026 was reviewed. The physician order indicated Urology consultation upon availability for possible suprapubic [(foley catheter) a flexible tube surgically inserted directly into the bladder through an incision in the lower abdomen] placement. CM 1 stated she called the urology office on 2/6/2026 and started the consult process by faxing Resident 5's face sheet. CM 1 stated she should have initiated the consult process sooner, within the week the urology consult order was placed. CM 1 stated typically the urology office would call within 72 hours of receiving the resident's face sheet to coordinate an appointment. CM 1 stated the urology office never called to coordinate an appointment, and then Resident 5 was hospitalized on [DATE]. CM 1 stated she should have followed up with the urology office to ensure the required documents were received and the urology consult appointment was scheduled. CM 1 stated a urologist would have been more knowledgeable about Resident 5's obstructive reflux uropathy and able to better manage his care. CM 1 stated failure to ensure the urologist was consulted for a resident with a chronic indwelling foley catheter placed the resident at risk for recurrent urinary tract infections and complications such as sepsis (a life-threatening blood infection). During an interview on 6/17/2026 at 9:58 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 5's urology consult should have been initiated and completed when the initial order was placed on 1/19/2026. RN 1 stated the urologist consult was important because of Resident 5's chronic indwelling catheter. 2. During a concurrent interview and record review on 6/17/2026 at 10:17 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 5's physician order dated 6/3/2026 was reviewed. The physician order indicated, Urology consult when available, pending insurance authorization. LVN 3 stated Family Member (FM) 2 requested a urology consult for Resident 5. LVN 3 stated when she spoke with Resident 5's physician, he agreed with the necessity of the consult and ordered a urology consult. During an interview on 6/17/2026 at 9:41 a.m. with CM 1, CM 1 stated when Resident 5 was readmitted to the facility on [DATE], the urology consult order should have (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been placed. CM 1 stated Resident 5's physician wanted all of his previous orders reinstated, and the urology consult was never reordered. CM 1 stated she should have followed up on Resident 5's urology consult when the resident was readmitted to the facility. During an interview on 6/17/2026 at 9:58 a.m. with Registered Nurse (RN) 1, RN 1 stated although Resident 5 was hospitalized , the urology consult should still have been followed up on upon readmission to the facility. RN 1 stated the urologist consult was important because of Resident 5's history of having a chronic indwelling catheter, recurrent UTI's, and hospitalizations. RN 1 stated Resident 5's care would have been better managed if a urologist was overseeing his care. RN 1 stated failure to ensure the urologist was consulted placed Resident 5 at further risk for UTI's and sepsis. During an interview on 6/18/2026 at 10:03 a.m. with the Director of Nursing (DON), the DON stated the case manager should have followed up on the Urologist consult in a timely manner. The DON stated it was the facility's policy to facilitate and help coordinate resident access to medical specialists. During a review of the facility's Policy and Procedure (P&P) titled, Referral to Medical Specialist dated 1/2024, the P&P indicated, Purpose: to ensure timely, appropriate, and coordinated referral of residents to medical specialists when indicated by clinical condition, physician recommendation, or resident/family request.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the consultant pharmacist's Medication Regimen Review (MRR- a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication, to the physician) recommendation was reviewed, addressed, and followed up with the physician for pain management therapy and non-pharmacological interventions for one of two sampled residents (Resident 3). This failure had the potential to affect Resident 3's pain management, comfort, and quality of care.Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), fracture of the right fibula (calf bone), and muscle weakness (loss of muscle strength). During a review of Resident 3's History and Physical (H&P), dated 10/23/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set ([MDS]- a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 3's cognitive skills for daily decision making (the ability to think and process information) was intact. The MDS indicated Resident 3 was dependent (helper does all the effort) on staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 3's care plan titled Pain, dated 10/21/2025, the care plan indicated to administer Oxycodone-Acetaminophen (a medication used to treat pain) as ordered by the physician. The care plan indicated to monitor non-pharmacological interventions. During a review of Resident 3's physician order, dated 3/11/2026, the physician order indicated to administer Oxycodone-Acetaminophen 10-325 milligrams (mg, a unit of dose measurement), one tablet by mouth every four hours as needed (PRN) for severe pain 7-10 (pain scale 0=no pain, 1-3=mild pain, 4-6=moderate pain, 7-10= severe pain). During a concurrent interview and record review on 6/16/2026 at 1:30 p.m., with the Director of Nursing (DON), Resident 3's Medication Regimen Review (MRR) dated 5/1/2026 through 5/7/2026, was reviewed. The MRR indicated the consultant pharmacist recommended pain management therapy and documentation of non-pharmacological interventions prior to administering each as needed (PRN) dose of Oxycodone-Acetaminophen to Resident 3. The MRR did not indicate the physician was notified of the pharmacist's recommendation. The DON stated there was no documentation that the physician reviewed the MRR or addressed the recommendation. The DON stated Resident 3 did not have documented non-pharmacological interventions, and the consultant pharmacist's recommendation was not communicated to Resident 3's physician. The DON stated non-pharmacological interventions were necessary for Resident 3 to help manage pain prior to administering PRN pain medication. The DON stated non-pharmacological interventions may include repositioning, offering rest periods, applying comfort measures, and encouraging relaxation techniques, based on the resident's needs. The DON stated the facility failed to ensure the consultant pharmacist's drug regimen review recommendation was communicated to Resident 3's physician. The DON stated this failure had the potential to affect Resident 3's pain management, comfort, and quality of care. During a review of the facility's policy and procedure (P&P) titled Consultant Pharmacist Reports, dated 6/2021, the P&P indicated the consultant pharmacist informs the Director of Nursing (DON) about resident-specific medication irregularities and provides recommendations. The P&P indicated the DON was responsible for acting on these recommendations and reports to the physician.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu and standardized recipes for one of four sampled residents (Resident 31).This failure had the potential for affecting Resident 31's meal satisfaction. FindingsDuring a review of Resident 31's admission Record, the admission Record indicated the facility admitted the resident on 3/13/2026 with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness (loss of muscles strength), and hypertension (HTN-high blood pressure).During a review of Resident 31's History of Physical (H&P), dated 3/16/2026, the H&P indicated Resident 31 could make needs known but cannot make medical decisions.During a review of Resident 31's Minimum Data Set (MDS- a resident assessment tool), dated 4/6/2026, the MDS indicated Resident 31's cognition (the ability to understand and process information) was intact. The MDS indicated Resident 31 was dependent (helper does all the effort) on staff for activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 31's physician diet order, dated 4/2/2026, the physician's order indicated Resident 31 was to receive a regular texture consistent carbohydrate diet, with no salt added.During a concurrent observation and interview on 6/15/2026, at 12:34 p.m. at Resident 31's bedside, Resident 31's lunch tray was observed to contain a sandwich with meat and cheese. Resident 31 stated he did not request cheese with the sandwich.During an interview and record review on 6/17/2026 at 10:16 a.m. with the Dietary Supervisor (DS), the lunch menu recipe titled French Dip Sandwich for 6/15/2026 was reviewed. The DS stated the recipe included roast beef, salt, pepper, and a soft French roll. The DS stated the recipe did not include cheese. The DS stated the importance of following recipes consistently to avoid placing Resident 31 at risk for receiving food items that could cause food allergies, or items the resident dislikes.During a concurrent interview on 6/17/2026 at 3:13 p.m., with [NAME] 1, [NAME] 1 stated the facility was responsible for following the facility's established recipes. [NAME] 1 stated when residents request any addition to their meals, such as adding cheese, this should be indicated on the resident's meal ticket. [NAME] 1 stated the facility did not follow the French dip sandwich recipe on 6/15/2026 because Resident 1 did not request cheese. [NAME] 1 stated this had the potential to place Resident 31 at risk for may not liking his meal.During a review of the facility's policy and procedure (P&P) titled [NAME] Job Description undated, the P&P indicated [NAME] responsibilities were to review menus prior to preparation of food.prepare meals in accordance with planned menus.prepare food in accordance with standardized recipes.