STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555375	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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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 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:1. For Residents 24 and Resident 123, manufacturer's specification for dosing diclofenac (for pain relief) topical gel for application was followed. This deficient practice could have resulted in either an overdose or underdose of the topical pain medication diclofenac, potentially leading Resident 24 and Resident 123 to experience adverse reactions (unwanted or harmful effects from a medicine) or inadequate pain relief.2. A Licensed Vocational Nurse (LVN) 9 did not sign the shift change audit (a brief review of medication and documentation at the end of a work shift) and narcotic accountability (records used to track and verify the handling of controlled medications [medications with a high potential for harm, misuse or abuse]) forms in advance, while not in the presence of both the outgoing nurse and the incoming nurse on Station 3.This deficient practice increased the risk for lack of controlled medication accountability. 3. The facility's Cubex Policy and Procedures, for a blind count prior to the removal of a medication was followed. The deficient practice had the potential for inaccuracy of both controlled and noncontrolled medication inventory, by not requiring personnel to physically count items without knowing the expected quantity in the system.Findings:1a. During a review of Resident 24's admission Record, the admission Record indicated the facility admitted Resident 24 on 2/25/2025 with diagnoses including Osteoarthritis (joint disease causing pain and stiffness), Psoriatic Arthritis Mutilans (severe form of joint inflammation that can destroy joints and bones), Prurigo Nodularis (skin condition with itchy, hard lumps), and Acne Keloid (raised, thick scars from acne).During a review of Resident 24's History and Physical (H&P), dated 11/21/2025, the H&P indicated the resident does not have the capacity to understand and make decisions.During a review of Resident 24's Minimum Data Set ([MDS] a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 24's cognitive (thinking and understanding abilities) skills was moderately impairment. The MDS indicated Resident 24 required setup or clean-up assistance for eating, oral hygiene, dressing, toileting, supervision or touch assistance for showering, personal hygiene, and walking.During a review of Resident 24's Order Summary, dated 4/1/2026, the Order Summary indicated Resident 24's orders included the following:Diclofenac Sodium External (Topical) Gel one (1) percent (%), instructions indicated, apply to affected area topically every 6 hours as needed for breast pain and joint pain, apply two (2) grams (gm, unit of mass), order date 3/8/2025Diclofenac Sodium External Gel 1 %, instructions indicated, apply to chest keloids topically two times a day for chronic keloid pain, order date 8/18/2025, with a discontinued date of 4/7/2026 timed at 11:09 AM. During a review of Resident 24's Care Plan, revision date 3/5/2026, the Care Plan focus indicated Resident 24 was at risk for pain or discomfort due to: generalized osteoarthritis.prurigo nodularis.acne keloid. Resident 24's Care Plan goal indicated, pain will be relieved to tolerable level as indicated by resident, using verbal or nonverbal communication.Interventions indicated, administer treatment as ordered.Pain management as indicated. Resident 24's Care plan included a black box warning for Diclofenac, which indicated may cause an increased risk of serious cardiovascular thrombotic events (heart and blood vessel problems caused by blood clots) events and gastrointestinal (stomach and (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intestines) bleeding.This risk may occur early in treatment and may increase with duration of use.During a record review of Resident 24's Nursing Notes, dated 4/7/2026, timed at 9:02 AM, the Nursing Notes indicated, .resident stated her skin itches when gel is applied.During a concurrent medication pass observation and interview on 4/7/2026 between 9:24 AM to 9:54 AM, with a Licensed Vocational Nurse (LVN) 1, LVN 1 was observed preparing morning medications for Resident 24 on Station 4 at Medication Cart (MedCart) 4B, that included but was not limited to Diclofenac Sodium Topical Gel. LVN 1 was observed squeezing Diclofenac Sodium Topical Gel from the tube directly into a medication cup. LVN 1 stated Resident 24 was ordered to receive 2 gm of Diclofenac Sodium Topical Gel. Observed inside of the Diclofenac packaging that was labeled for Resident 24 was a medication guide and a measuring dosing card still glued to the inside of the carton, unused. During a concurrent observation and interview on 4/7/2026, at 9:56 AM, with LVN 1 and Resident 24, inside of the resident's room. Resident 24 stated the Diclofenac Gel itches so badly, and it comes off and does not help. LVN 1 stated that Resident 24 does not want the Diclofenac gel, because she is not in pain and the medication causes itching.During a concurrent observation, interview, and review of the manufacturer's labeling for Diclofenac Sodium Topical Gel on 4/7/2026, at 10:13 AM, with LVN 1, LVN 1 stated that more than three-fourths of the Diclofenac Sodium Topical Gel had been used for Resident 24. LVN 1 stated the manufacturer's measuring dosing card was not being used to measure out the 2 gm as ordered. LVN 1 stated that she usually squeeze out an amount from the Diclofenac Sodium Topical Gel medication tube into a medication cup and applies the full amount onto the resident's chest. LVN 1 reviewed the manufacturer's labeling and stated adverse reactions from Diclofenac Topical Gel includes skin redness and irritation. LVN 1 used the manufacturer's medication dosing card and measured out 2 gm of Diclofenac Sodium Topical Gel and placed it into a medication cup and compared the amount to the medication cup that she squeezed out earlier and LVN 1 stated the amount she measured out without using the medication dosing card was over twice as much as prescribed.During a concurrent interview, record review, and review of manufacturer instructions for Diclofenac Sodium Topical Gel on 4/7/2026, at 12:55 PM, with the Assistant Director of Nursing (ADON), the ADON stated the licensed nurses must use the dosing card provided by the manufacturer to measure the correct amount of medicine. The ADON stated it is not acceptable for nurses to estimate the 2 gm dose by putting the gel into a medication cup. The ADON stated if the dosing card is not used the dose for diclofenac could be under or over the required dose. The ADON stated the resident could be under medicated, the pain management would not be as effective or the resident could be over medication. The ADON stated that over medication of Diclofenac Sodium Topical Gel, could lead to side effects, increase systemic absorption, cause skin reactions, particularly in the elderly, gastrointestinal bleeding, ulcers and potentially causing serious cardiovascular reactions. 1b. During a review of Resident 123's admission Record, the admission Record indicated the facility admitted Resident 123 on 5/13/2024 and the resident was readmitted on [DATE] with diagnoses including Osteoarthritis (joint disease that causes pain and stiffness), Right and Left Shoulder and Neuropathy (nerve pain), and Pain due to nervous system prosthetic device, implants.During a review of Resident 123's History and Physical (H&P), dated 3/26/2026, the H&P indicated the patient does not have the capacity for medical decision making due to: chronic encephalopathy (long-lasting brain damage that causes problems with thinking, memory, or understanding) from Cerebrovascular Accident (CVA, or stroke, is a medical emergency caused by a sudden interruption of blood flow to the brain). During a review of Resident 123's MDS, dated [DATE], the MDS indicated Resident 123's cognitive skills was moderately impairment. The MDS indicated Resident 123 required setup or clean-up assistance for eating and oral hygiene, supervision or touch assistance for showering, dressing, and walking, and partial to moderate physical staff assistance with toileting and personal hygiene.During a review of Resident 123's Order Summary, dated 3/1/2026, the Order Summary indicated Resident 123's orders included an order for Diclofenac Sodium External Gel 1%, instructions indicated, apply to both shoulders topically two times a day for pain management, apply two (2) gm, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order date 9/17/2025.During a review of Resident 123's Care Plan, dated 11/11/2025, the Care Plan focus indicated Resident 123 has alteration in musculoskeletal status related to pain due to internal orthopedic devices, Osteoarthritis multiple sites: bilateral knees and shoulders. Resident 123's Care Plan goal indicated, the resident will remain free from pain or at a level of discomfort acceptable to the resident through the review date. Interventions included instructions, to give analgesics as ordered by the physician.During a review of Resident 123's Care Plan, dated 2/11/2025, the Care Plan focus indicated Resident 123 has bilateral pain related to diagnosis of osteoarthritis, chronic shoulder pain. Resident 123's Care Plan goal indicated, pain will be relieved to a tolerable level as indicated by resident, using verbal or nonverbal communication to the extent possible. Interventions indicated, administer medications as ordered.Notify physician if resident experiences unmanageable or intolerable pain. Offer nonpharmacological interventions to relieve discomfort or pain.During a record review of Resident 123's Nursing Notes, dated 2/17/2026, the Nursing Note indicated, Obtained clarification of order from Dr. (doctor) to apply 2 gm Diclofenac gel 1 % for bilateral shoulders per pharmacy recommendation. Order noted and carried out.During a concurrent medication cart inspection, interview, and record review, on 4/7/2026, at 3:50 PM with LVN 6 on Station 2 at MedCart 2B, observed in the bottom drawer was a tube of Diclofenac Sodium Topical Gel 1 % labeled for Resident 123. LVN 6 reviewed Resident 123's order and administration detail report and stated the resident was scheduled to be administered Diclofenac Topical Gel twice a day at 9 AM and 9 PM and the resident last dose was administered on 4/7/2026 at 8:23 AM by LVN 2 that works on Station 2 at MedCart 2A. The medication guide and medication dosing card was observed intact glued inside of the Diclofenac Sodium Topical Gel packaging, unused.During a concurrent medication cart inspection, interview, and record review on 4/7/2026, at 4:03 PM with LVN 2, Resident 123's order and administration detail report were reviewed. Resident 123's had an order to have Diclofenac Sodium Topical Gel 1 % applied to both shoulders twice a day for pain management. LVN 2 stated she applied Resident 123 Diclofenac Sodium Topical Gel 1 % this morning, 4/7/2026, for the scheduled 9 AM administration. LVN 2 stated she squeezed into a medication cup the topical gel and then apply to Resident 123 whatever amount she puts into the medication cup to both shoulders of the resident. LVN 2 stated she does not use a medication dosing card to measure out the Diclofenac Sodium Topical Gel. LVN 2 opened the Diclofenac Sodium Topical Gel carton and stated that the dosing card was still taped inside of the medication packaging unused, and that she did not know there was a dosing card inside. LVN 2 stated it is important to give an accurate dose of Diclofenac Sodium Topical Gel to Resident 123 to prevent side effects, not to overdose, and to ensure the effectiveness of the medication. LVN 2 stated that giving too little of the topical gel will not be effective in pain relief and too much could cause Resident 123 to experience adverse effects.During an interview on 4/8/2026 at 1:44 PM, with the Director of Nursing (DON), the DON stated she was made aware of how the facility's nurses were measuring out the Diclofenac Sodium Topical Gel into a medication cup. The DON stated the licensed nurses must use the medication dosing card to measure either 2 gm or 4 gm per physician order to ensure accurate administration to the residents as prescribed.A review of the facility's policy and procedures (P&P) titled, Administering Medications, dated 1/2026, the P&P indicated, Medications are administered in accordance with prescriber ordersA review of the facility's P&P titled, Administration Procedures for All Medications, dated 5/2022, indicated, To administer medications in a safe and effective manner.If unfamiliar with the medication, consult a drug reference, manufacturer package insert, or pharmacist for more information.A review of the manufacturer's package insert for Diclofenac Sodium Topical Gel, 1 %, User Guide indicated, Before you use Diclofenac Sodium Topical Gel read the Drug Facts Label, which appears on the carton.Remove the dosing card from the inside of the carton. You should always use the dosing card to measure out the correct dose of Diclofenac Sodium topical Gel.Measuring the correct amount using the dosing card.Wash the dosing card with water. Store enclosed dosing card with your Diclofenac Sodium Topical Gel. The dosing card is re-usable.Stop using Diclofenac Sodium Topical Gel and ask a doctor (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if pain gets worse or lasts more than 21 days.skin irritation occurs.Questions and Answers.Can I apply Diclofenac Sodium Topical Gel without measuring it out on the dosing card first? No. Use the dosing card to make sure you are getting the correct amount of medicine. 2. During a concurrent medication storage area inspection and interview on 4/8/2026 at 10:56 AM of Station 3 MedCart 3B with LVN 9, two different forms for the month of 4/2026 were reviewed, the two forms were titled, Controlled Drugs Count Record and Narcotic Accountability. form. The space for nurses signature on each form that indicated Outgoing from the 7 AM to 3 PM shift on 4/8/2026 was initialed/signed. LVN 9 stated that she accidentally signed the shift change (Controlled Drugs Count Record) and the Narcotic Accountability forms ahead of time before the end of the shift, without a witness or the incoming nurse present. LVN 9 stated that she should have waited and signed together with the incoming nurse to prevent any discrepancies with controlled medications.During an interview and record review on 4/8/2026 at 5:38 PM, with the DON, the April 2026, Controlled Drugs Count Record and Narcotic Accountability. forms, for Station 3, Medcart 3B were reviewed. The DON stated two nurses at the same time must endorse (formally handing over responsibility for) the shift change and narcotic accountability forms together prior to the incoming nurse assuming responsibility of the medication cart. The DON stated the outgoing and incoming nurse are required to review the medication cart and controlled medications together to prevent the risk of controlled drug diversion (misuse or abuse) and enhance the checks and balance system for accountability.A review of the facility's P&P titled, Controlled Substances, dated 1/2026, indicated, Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. 3. During a medication area storage inspection on 4/8/2026, at 10:31 AM, with LVN 8, Station 4 medication room's Cubex was reviewed. LVN 8 demonstrated the use of the Cubex, and the available quantity of medication was displayed on the screen. LVN 8 stated the Cubex is not a blind count, and the license nurse can see what quantity of medication is in the Cubex station before the count to verify what was on hand.During an interview on 4/8/2026, at 4:31 PM, with the Director of Nursing (DON), the DON stated the Cubex is used for emergency medication and first dose. The DON stated there is no blind count for the medications inside of the Cubex station for controlled or noncontrolled medications. The DON stated the licensed nurses are supposed to match the available quantity displayed in the Cubex station with the physical count once the Cubex station opens to remove a dose for a resident.During a telephone interview and review of the Cubex policy on 4/9/2026 at 11:14 AM, with the facility's Cubex Pharmacist Manager (Pharm 1), Pharm 1 stated the Cubex station located inside of Station 4 medication room is electronically managed. Pharm 1 stated the Cubex policy and the facility practice do not match. Pharm 1 stated the Cubex policy indicates a blind count prior to removal of medications from the Cubex station. Pharm 1 stated the pharmacy is not doing a blind count, the quantity on hand of medications stored in the Cubex is displayed prior to the nurse removing the medication from the Cubex and the policy would have to be updated.A review of the facility's P&P titled, Cubex Policy and Procedures, dated 9/2023, indicated, Blind Count - Prior to removing a medication, the user will be asked to enter the inventory count of the medication being removed. If the count entered by the nurse and the count kept by the Cubex Station do not match, a discrepancy will be logged by the station and a message electronically sent to the pharmacy. Only authorized individuals have the access to research a discrepancy and correct inventory count. Correcting the inventory count for any medication will create a permanent record and document the individual who adjusted the count, and it will log the date, and time of the inventory adjustment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to:a. Ensure dietary staff were wearing hair restraints appropriately while working in the kitchen.b. Maintain the ice machine in a sanitary condition to prevent contamination of consumable ice.c. Ensure proper hand hygiene and glove use during food preparation to prevent cross contamination.These failures had the potential to result in contamination of food and ice, placing residents at risk for foodborne illnesses (an illness that comes from eating contaminated food) including Legionella (type of bacteria found in water environments).Findings: a. During a concurrent observation and interview on 4/6/2026 at 8:51 a.m. with the Dietary Supervisor (DS) in the kitchen area, dietary staff were observed working in the kitchen without wearing hair restraints appropriately. The DS stated, [NAME] 1's (CK) 1 hair net did not cover the sides of the head, CK 2's hair net did not cover sides and back of the head, Dietary Aid (DA) 1's hair net did not cover sides and back of the head and DA 2's hair net did not cover sides of the head. b. During a concurrent observation and interview on 4/6/2026 at 9:23 a.m. with the DS in the kitchen area, the ice machine was inspected. The upper interior surface of the ice machine was observed to have brown and pink discoloration. The DS stated the substance was dirt, the ice produced by the machine was used for all residents and staff upon request, and contaminated ice could cause food borne illness.During a concurrent interview and record review on 4/6/2026 at 9:37 a.m. with the Maintenance Supervisor (MS), the MS stated failure to maintain the ice machine in a clean condition could result in bacterial growth, including Legionella and place residents at risk for illness, as the ice is consumed facility wide.c. During a concurrent observation and interview on 4/7/2026 at 10:28 a.m. with the DS in the kitchen, food preparation area, CK1 was observed wearing gloves while preparing sandwiches. CK 1 placed 4 slices of bread and added ham. [NAME] 1 then turned to refrigerator B, touched the handle, opened the refrigerator, and retrieved a container of margarine placing it next to the bread. [NAME] 1 then continued preparing the sandwiches by placing the bread over the ham without changing gloves or performing hand hygiene. The DS stated [NAME] 1 should change gloves and perform hand hygiene after touching non-food contact surfaces, and this failure to do so could result in foodborne illness, as the food may become contaminated when handled the surface not clean. During an interview on 4/9/2026 at 3:27 p.m. with the Registered Dietitian (RD), the RD stated dietary staff should wear hair restraint properly while working in the kitchen to prevent the hair from contaminating food. The RD stated the ice machine should be cleaned and maintained in a sanitary condition to prevent the buildup of bacteria and mold. The DS stated dietary staff should perform hand hygiene and change gloves during food preparation to prevent cross contamination. The RD stated these practices could result in foodborne illness.During a review of the facility's policy and procedure (P&P) titled, Dress Code, dated 2023, the P&P indicated staff should dress properly hair net for hair, if hair is long cover the ears or longer. During a review of the facility's P&P titled, Sanitation, dated 2023, the P&P indicated 14. Ice which is used in connection with food or drink shall be from sanitary sources.During a review of the facility's P&P titled, Hand Washing Procedure, dated 2023, the P&P indicated when hands need to be washed: before and after handling foods with the hands (cutting, peeling, missing, etc.)During a review of the facility's P&P titled, Food Handling, dated 2023, the P&P indicated food will be prepared and served in a safe and sanitary manner:All food and nutrition services personnel will wash their hands prior to handing all food.Food & Nutrition services personnel should never use bare hand contact with any food, ready to eat or otherwise.This includes food preparation. Gloves should be changed before handling washed food items.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to provide documented evidence of for 32 out of 32 licensed practitioners, COVID-19 (a highly contagious respiratory disease) vaccination (medications used to prevent diseases usually given by injection or by mouth) status, provision of education on benefits and potential side effects for 32 out of 32 licensed practitioners for the 2025 to 2026 COVID-19 vaccine.This failure had the potential to result in staff and residents contracting COVID-19 which can cause serious illness, hospitalization, and death.Findings:During a concurrent interview and record review on 4/8/2026 at 1:20 p.m., with the Infection Prevention Nurse (IPN), the facility's binders for COVID-19 Staff Vaccination Status were reviewed. The IPN stated there was no documented evidence for licensed practitioners' education on benefits and side effects was provided. The IPN stated COVID-19 vaccination status for licensed practitioners should also be obtained because they have direct access to residents.During an interview on 4/9/2026 at 11 a.m. with the Director of Nursing (DON), the DON stated all staff need to be educated and offered the current COVID-19 vaccine because vaccines minimize sickness and protects residents in the facility.During a review of the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19) - Vaccination of Staff, revised 1/2026, the P&P indicated staff are educated about the benefits, risks, and potential side effects of the COVID-19 vaccine. The P&P indicates the staff meant individuals who provide any care, treatment, or other services for the facility and/or its residents, regardless of clinical responsibility or resident contact.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two out of eight sampled residents (Resident 29 and 76) were treated with respect and dignity by failing to:a. Cover Resident 29's back during ambulation.b. Provide scheduled showers for Resident 76.These deficient practices had the potential to have a negative impact on the psychosocial well-being of the residents and affect their self-worth and self-esteem.Findings:a. During an observation on 4/7/2026 at 8:07 a.m., Resident 29 was observed walking in front of Nursing Station 3 with the back of his gown open, exposing his back and adult brief. There were multiple staff in and around Nursing Station 3 that observed Resident 29's back and adult brief exposed.During a review of Resident 29's admission Record, the admission Record indicated Resident 29 was originally admitted to the facility on [DATE] and was admitted on [DATE] with diagnoses including encephalopathy (any damage or disease that affects the brain), generalized muscle weakness, and cognitive communication deficit.During a review of Resident 29's history and physical (H&P) dated 11/17/2025, the H&P indicated Resident 29 has fluctuating capacity to make medical decisions.During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 3/23/2026, the MDS indicated Resident 29 had mild cognitive impairment. The MDS indicated Resident 29 required supervision for all aspects of 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 29 had no impairments both sides of the upper (arms/shoulders) and lower (hips/legs) extremities and utilized a walker and wheelchair.During an interview on 4/7/2026 at 8:08 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she saw Resident 29's gown open in the back and indicated it was not acceptable for his back to be exposed.During an interview on 4/7/2026 at 8:27 a.m. with CNA 2, CNA 2 stated she saw Resident 29 walking in the hallway with his back exposed and indicated she saw other staff that witnessed the back exposure. CNA 2 stated the staff should cover his back immediately and bring him back to his room to protect his privacy.During an interview on 4/9/2026 at 12:29 p.m. with the DON, the DON stated it is not acceptable for residents to be walking in the hallway with their back exposed as their dignity would not be protected and should always be covered.b. During a review of Resident 76's admission Record, the admission Record indicated Resident 76 was originally admitted to the facility on [DATE] and was admitted to the facility on [DATE] with diagnoses including a history of healed traumatic fracture (break in a bone caused by a high-energy incident, such as a fall, car accident, or direct blow, resulting in significant force), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) on left knee, and abnormalities of gait and mobility.During a review of Resident 76's H&P dated 2/9/2026, the H&P indicated Resident 76 has the capacity to understand and make decisions.During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 had mild cognitive impairment. The MDS indicated Resident 76 required substantial assistance (Helper does more than half the effort) for oral hygiene, toileting hygiene, bathing, upper body (waist above) and lower body (waist below) dressing, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toileting transfer, shower transfer, and required supervision for eating. The MDS indicated Resident 76 had an impairment on one side of the lower extremity. The MDS indicated Resident 76's preference for customary routine and activities indicated it is very important for Resident 76 to be able to choose between a tub bath, shower, bed bath, or sponge bath.During a review of the Resident Shower Schedule, the resident shower schedule indicated Resident 76's shower days are Mondays and Thursdays during the 3:00 p.m. to 11:00 p.m. shift.During an interview on 4/6/2026 at 10:03 a.m. with Resident 76, Resident 76 stated she has a hard time getting showers and indicated she is supposed to get showers on Monday and Thursdays and today 4/6/2026 was her shower day. Resident 76 stated last Monday 3/30/2026 was her last (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower day. Resident 76 indicated the staff brings her a basin so that she can clean herself and indicated she used to take showers when she used to live at home and would like to shower.During a review of Resident 76's Documentation survey Report dated Apr-26, the bathing task indicated the following:4/2/2026 (Thursday): Bed bathDuring a review of Resident 76's Documentation survey Report dated MAR-26, the bathing task indicated the following:3/26/2026 (Thursday): Bed bath3/23/2026 (Monday): Bed bath3/12/2026 (Thursday): Bed bath3/9/2026 (Monday): Bed bath3/2/2026 (Monday): Bed bathDuring a review of Resident 76's Documentation survey Report dated FEB-26, the bathing task indicated the following:2/26/2026 (Thursday): Bed bath2/23/2026 (Monday): Bed bath2/16/2026 (Monday): Bed bathDuring a concurrent interview and record review o 4/8/2026 at 4:27 p.m. with CNA 6, CNA 6 stated Resident 76 required assistance with her ADLs. CNA 6 stated Resident 76 is scheduled to get showers on Monday and Thursday and indicated it is the residents' right to get their showers. CNA 6 stated that despite the residents getting a shower on their non-shower days, they would still be able to get their shower on their scheduled shower days. CNA 6 stated bed baths count as shower days if the resident refuses the shower. CNA 6 stated Resident 76's Documentation survey Report dated MAR-26 task sheet indicated on 3/9/2026, it does not indicate Resident 76 refused her shower day. CNA 6 stated Resident 76 had gotten a bed bath on 3/9/2026, 3/12/2026, 3/23/2026, 3/26/2026, and 4/2/2026 with no showers. CNA 6 stated it is important for residents to receive showers to eliminate skin issues. CNA 6 stated if residents did not receive their shower, it would not make them feel good and they would be upset.During a concurrent interview and record review on 4/9/2026 at 12:26 p.m. with the Director of Nursing (DON), the DON stated showers are important as it is body hygiene and residents can still get showers outside of their shower days. The DON stated if the residents do not get their showers, they would be frustrated and upset. The DON stated a bed bath is not the same as showers and indicated on Resident 76's Documentation survey Report dated MAR-26, Resident 76 received a bed bath on 3/2/2026 and 3/9/2026.During a review of the facility's policy and procedure (P&P) titled, Dignity, revised January 2026, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues through the resident's facility stay. When assisting with care, residents are supported in exercising their rights. For example, residents are allowed to choose when to sleep, eat and conduct activities of daily living. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents.During a review of the facility's P&P titled, Resident Rights, revised January 2026, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence, be supported by the facility in exercising his or her rights, and privacy and confidentiality.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure ongoing assessment and evaluation for the continued use of a sensor pad alarm (a device designed to detect moisture or movement, alerting someone immediately) for one of one sample resident (Resident 142).This failure has the potential to result in restricting the residents' movement, loss of dignity, sleep disturbance due to the sound of alarm, confusion, fear, agitation, and anxiety or irritation.Findings:During a review of Resident 142's admission Record, the admission Record indicated the facility admitted Resident 142 on 11/7/2024, and readmitted on [DATE] with diagnoses including anoxic brain damage (occurs when the brain is totally cut off from oxygen, causing brain cells to die within minutes), cognitive communication deficit (difficulties with communication that arise from underlying problems with thinking skills, rather than primary language or speech disorders), and abnormalities of gait and mobility (an abnormal working pattern).During a review of Resident 142's History and Physical (H&P), dated 12/9/2025, the H&P indicated, Resident 142 did not have the ability to understand and make decisions.During a review of Resident 142's Minimum Data Set (MDS- a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 142' cognitive (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired. The MDS indicated Resident 142 required moderate assistance (helper does less than half the effort to complete the task) with personal hygiene, supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, toileting hygiene, showering, lying to sitting on side of bed, sitting to stand, chair/bed-to chair transferring, toilet transferring and walking.During a review of Resident 142's Order Summary Report, dated 4/6/2026, the Order Summary Report indicated starting 1/8/2026, Resident 142 may have a sensor pad alarm in bed and wheelchair to alert staff when Resident 142 tries to get up unassisted.During a review of Resident 142's Fall Risk Observation/Assessment, dated 12/21/2025 and 1/4/2026, and 2/3/2026 the assessments indicated Resident 142 wasa high risk for falls.During a review of Resident 142's Restraint- physical (initial Evaluation), dated 1/4/2026, the evaluation indicated the facility placed the sensor pad alarm to alert staff when resident tries to get up unassisted. The evaluation did not indicate alternatives attempted to reduce risk of harm to the resident or others prior to the application of the sensor pad alarm.During a concurrent observation and interview on 4/6/2026 at 12:33 p.m. in Resident 142's room with Certified Nurse Assistant (CNA) 7, a sensor pad alarm with blue light on under the resident's mattress and another alarm with light off in the wheelchair were observed. CNA 7 stated Resident 142 needed the sensor pad alarm because he was at high risk for fall and the resident got out of bed without requesting assistance to go to the restroom.During an interview on 4/9/2026 at 10:15 a.m. with CNA 8, CNA 8 stated Resident 142 a sensor pad alarm that was loud enough to be heard anywhere in the nursing station and the alarm sound could startle or upset Resident 142.During a concurrent interview and record review on 4/9/2026 at 10:41 a.m. with Registered Nurse Supervisor (RNS) 2, Resident 142's Restraint- physical (initial Evaluation), dated 1/4/2026 was reviewed. RNS 2 stated the facility should evaluate more than once to assess the psychological effect of a bed alarm and determine whether it limits the Resident 142's free movement. RNS 2 stated a one-time assessment is not sufficient to determine that a bed alarm does not have a psychological or restrictive effect.During a concurrent interview and record review on 4/9/2026 at 12:21 p.m. with the Assistant Directive of Nursing (ADON), Resident 142's Restraint- physical (initial Evaluation), dated 1/4/2026 was reviewed. The ADON stated he assessed the Resident 142 on 1/4/2026 approximately for 30 minutes, and the facility identified the bed alarm as a safety device not a restraint. The ADON stated the facility did not implement a consent and restraint -related requirements including attempting alternatives to reduce risk of harm to the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident or others prior to the application of the sensor pad. The ADON stated, the determination was based on a single observation, indicating the resident continued attempting to get out of bed. The ADON stated there was no further evaluation to assess the potential psychological impact or restrictive effect over time, including whether the alarm limited the resident's voluntary movement.During a review of the facility's P&P titled Sensor Alarms/Tab Alarms/Pad Alarms, dated January 2026, the P&P indicated1. Assess residents for appropriateness of using position change alarm, either in bed and/or in the wheelchair. Select residents may be appropriate for a position change alarm for limited use aimed at assisting staff to assess patterns and routines of the resident.2. Staff will consider the negative potential outcomes which could result from position change alarm use when determining necessity:-Loss of dignity-Decreased mobility-Bowel and bladder incontinence-Sleep disturbances due to the sound of alarm or because afraid to move-Confusion, fear, agitation, anxiety or irritation in response to the sound of alarm. During a review of the facility's policy and procedures (P&P) titled Use of Restraints, dated January 2026, the P&P indicated: -Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted. -Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. -The following safety guidelines shall be implemented and documented while a resident is in restraints: A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record.

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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 one of three sampled residents (Resident 14) was free of unnecessary psychotropic medications (any drug that affects brain activity related to mental processes and behavior) by failing to:1.Ensure Resident 14's Lexapro (a prescription medication that helps keep more serotonin available in the brain which helps improve mood, anxiety (constantly feeling worried and nervous), and emotional stability) order had the correct indication for anxiety as indicated by the physician.This failure had the potential to place Resident 14 at risk for unnecessary exposure to psychotropic medications and adverse drug reactions (a harmful or unwanted effect caused by a medication when taken normally and correctly), which could result in impairment or decline in the residents' physical and functional condition, and mental and psychosocial status.Findings:During a review of Resident 14's admission Record, the admission Record indicated the facility admitted Resident 14 on 3/30/2018 and was readmitted on [DATE] with diagnoses including bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs) and anxiety disorder.During a review of Resident 14's History and Physical (H&P) dated 3/27/2025, the H&P indicated Resident 14 had the capacity to understand and make decisions. The H&P did not indicate a diagnosis of depression (a mental health condition where someone feels very sad, empty, or loses interest in things for a long time).During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 7/14/2025, the MDS indicated Resident 14 had an intact cognition (ability to think or make decisions). The MDS indicated Resident 14 needed setup or clean-up assistance (helper assists only prior to or following the activity) with eating, moderate assistance (helper does less than half the effort to complete the activity) with oral and toileting hygiene, upper body dressing, and personal hygiene, and maximum assistance (helper does more than half the effort to complete the activity) with showering, lower body dressing, and putting on or taking off footwear. The MDS indicated Resident 14 had active diagnosis of bipolar and schizophrenia (a mental illness that is characterized by disturbances in thought). The MDS did not indicate Resident 14 had an active diagnosis of depression. The MDS indicated Resident 14 was taking antipsychotic [a drug that helps reduce symptoms of hallucinations (seeing, hearing, or feeling something that is not actually there), delusions (strong beliefs that are not true) or severe confusion] and antidepressant (a drug that helps with the feeling of sadness and improves an individual's mood) medications.During a review of Resident 14's Order Summary Report dated 4/9/2026, the order summary report included the following physician orders:-Lexapro Oral Tablet 5 mg (milligrams - metric unit of measurement) one tablet by mouth one time a day for Depression manifested by (m/b) episodes of tearfulness order dated 5/20/2025, with a start date of 5/21/2025.During a concurrent interview and record review on 4/9/2026 at 8:21 a.m. with the Assistant Director of Nursing (ADON), Resident 14's diagnosis information in the admission record, order summary report, and psychiatry follow-up note dated 5/20/2025 were reviewed. The ADON stated Resident 14's diagnosis list did not indicate Resident 14 had a diagnosis of anxiety. The ADON stated the order summary report indicated Lexapro oral tablet 5 mg give 1 tablet by mouth one time a day for depression m/b episodes of tearfulness ordered on 5/20/2025 and was started on 5/21/2025. The ADON stated the psychiatry follow-up notes dated 5/20/2025 indicated a plan to start Resident 14 on Lexapro 5 mg by mouth in the morning for generalized anxiety disorder manifested by inability to relax and continue the remaining psychiatric regimen. The ADON stated the psychiatry follow-up note did not indicate a diagnosis of depression. The ADON stated the importance of making sure the indication for the medication matched the psychiatrist plan was to ensure the resident was monitored and treated for correct signs and symptoms of anxiety. The ADON stated if the medication did not have the correct indication as indicated by the psychiatrist, there would be increased risk for Resident 14 to receive medications (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that was not needed.During an interview on 4/2026 at 12:07 p.m. with the Director of Nursing (DON), the DON stated nurses should clarify the correct indication for the medication with the psychiatrist. The DON stated the importance of making sure the medication had the accurate indication was to ensure Resident 14 received the correct treatment plan. The DON stated if the medication did not have the correct indication as indicated by the psychiatrist, Resident 14 would be at risk for unnecessary use of psychotropic medication for non-diagnosed depression.During a review of the facility's policy and procedures (P&P) titled Psychotropic Medication Use dated 2001, the P&P indicated Adequate indication for use, refers to the identified, documented clinical rationale for administering medications that is based on: a. an assessment of the residents' condition and therapeutic goals. The P&P did not indicate procedures regarding clarification of orders psychotropic medications.During a review of the facility's policy and procedures (P&P) titled Unnecessary Medications revised 1/2026, the P&P indicated .1. The facility will ensure to conduct regular medication reviews for all residents and to assess the appropriateness of each medication prescribed. The review will consider the resident's medical condition, goal of care, potential drug interaction, and adverse effects.

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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 provide accurate information in the Minimum Data Set ([MDS], a resident assessment tool) for two of four sampled residents (Resident 17 and Resident 40) when:a. Resident 17 was taking an anti-anxiety medication (medication to treat symptoms such as feelings of fear, dread, uneasiness, and muscle tightness) for anxiety (constantly feeling worried and nervous).b. Resident 40 was taking an anti-coagulant medication (medications that prevent harmful blood clots from forming) for diagnosis of atrial fibrillation (irregular heart rate that can cause poor blood flow).This deficient practice had the potential to result in inaccurate assessment and services for the residents due to the inaccurate MDS assessment and care screening tool practices.Findings:a. During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), anxiety disorder (constantly feeling worried and nervous), and dementia (a progressive state of decline in mental abilities).During a review of Resident 17's history and physical (H&P), dated 9/2/2025, the H&P indicated Resident 17 had fluctuating capacity to understand and make decisions. During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 was moderately impaired in cognitive (thought process) functioning for daily decision making. The MDS indicated Resident 17 required supervision (helper provides verbal cues as resident completes the task) to maximal assistance (helper does more than half the effort to complete the task) with self-care abilities such as eating, hygiene and dressing. The MDS indicated Resident 17 was not taking an anti-anxiety medication. During a review of Resident 17's Order Summary Report, dated 10/22/2025, the Order Summary Report indicated Buspirone (medication used for anxiety) 15 milligrams ([mg] metric unit of measurement) by mouth three times a day for anxiety manifested by verbalizing feeling anxious.During a concurrent interview and record review on 4/8/2026 at 1:04 p.m. with the MDS Nurse (MDSN) 1, the MDS dated [DATE] and Order Summary Report dated 10/22/2025 were reviewed. The MDS indicated that Resident 17 was not taking an anti-anxiety medication, but the Order Summary Report indicated Resident 17 was taking an anti-anxiety medication since 10/22/2025. MDSN 1 stated the MDS assessment for medication use should have been coded that Resident 17 was taking an anti-anxiety medication. MDSN 1 stated the importance of having an accurate MDS assessment was to have an impact on the overall care for the residents, the medications the residents are taking, and the treatments and services being provided to the residents in the facility.b. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including DM, atrial fibrillation and dementia.During a review of Resident 40's MDS dated [DATE], the MDS indicated Resident 40 was moderately impaired in cognitive functioning for daily decision making. The MDS indicated Resident 40 required supervision assistance with self-care abilities such as eating, and hygiene. The MDS indicated Resident 40 was taking anticoagulant, but no active diagnosis indicated for the anticoagulant. During a review of Resident 40's Order Summary Report dated 7/9/2023, the Order Summary Report indicated Eliquis (anticoagulant medication) 2.5 mg, two times a day for atrial fibrillation. During a concurrent interview and record review on 4/9/2026 at 9:58 a.m. with MDSN 1, the MDS dated [DATE] and Order Summary Report dated 7/9/2023 were reviewed. MDSN 1 stated the MDS assessment should have indicated the diagnosis of atrial fibrillation because the MDS assessment showed what the resident has and the care the staff are providing for the residents. MDSN 1 stated Resident 40 was taking anti-coagulant medication for the diagnosis of atrial fibrillation. MDSN 1 stated the MDS assessment gets transmitted to CMS, and CMS would need to see the reason Resident 40 was taking anti-coagulant for the diagnosis of atrial fibrillation. MDSN 1 stated that the medication could be deemed an unnecessary medication if no diagnosis indicated the reason (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the medication use. MDSN 1 stated the importance of accurate MDS was because it was a comprehensive assessment of the residents, their cognitive functioning, medical status, mobility and the diagnosis of atrial fibrillation should have been on the list of active diagnosis. During an interview on 4/9/2026 at 12:32 p.m. with the Director of Nursing (DON), the DON stated the MDS assessment was an overall assessment of the resident, and the MDS assessment indicates what the resident has from diagnosis, cognitive functioning, medications and treatments. The DON stated the importance of accurate MDS assessment was so there would be proper interventions and care planning in place for the residents based on what the MDS assessment indicators are. The DON stated the staff would not be able to monitor the residents accordingly if the assessment was not done correctly. During a review of the facility's policy and procedure (P&P) titled Resident Assessments, revised January 2026, indicated, a comprehensive assessment of each resident is completed as required. the resident assessment coordinator is responsible for ensuring the interdisciplinary team conducts timely and appropriate resident assessments.all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. 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 policy and procedure (P&P) titled Certifying Accuracy of the Resident Assessment revised November 2019, indicated, any person completing a portion of the Minimum Data Set/MOS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. any person who completes any portion of the MOS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment. the MDS Coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the MDS Coordinator, who is a registered nurse.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of five sampled residents (Residents 14 and Resident 19) Preadmission Screening and Resident Review (PASARR- a federal assessment requirement to help ensure that individuals who have a mental disorder -MD- are placed in facilities that can provide the appropriate care) were reassessed appropriately by:1.Failing to ensure a PASARR level 1 resident review screening was resubmitted for Resident 14's and Resident 19's new mental health diagnosis and medications.This deficient practice placed Resident 14 and Resident 19 at risk of not receiving necessary care and services needed for mental illness or developmental disability. Findings:During a review of Resident 14's admission Record, the admission Record indicated the facility admitted Resident 14 on 3/30/2018 and was readmitted on [DATE] with diagnoses including bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional high) and anxiety disorder (constantly feeling worried and nervous).During a review of Resident 14's History and Physical (H&P) dated 3/27/2025, the H&P indicated Resident 14 had the capacity to understand and make decisions. The H&P did not indicate a diagnosis of depression (a mental health condition where someone feels very sad, empty).During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 7/14/2025, the MDS indicated Resident 14 had an intact cognition (ability to think or make decisions). The MDS indicated Resident 14 needed setup or clean-up assistance (helper assists only prior to or following the activity) with eating, moderate assistance (helper does less than half the effort to complete the activity) with oral and toileting hygiene, upper body dressing, and personal hygiene, and maximum assistance (helper does more than half the effort to complete the activity) with showering, lower body dressing, and putting on or taking off footwear. The MDS indicated Resident 14 had active diagnosis of bipolar and schizophrenia (a mental illness that is characterized by disturbances in thought). The MDS did not indicate Resident 14 had an active diagnosis of depression. The MDS indicated Resident 14 was taking antipsychotic (a drug that helps reduce symptoms of hallucinations [seeing, hearing, or feeling something that is not actually there]), delusions (strong beliefs that are not true) or severe confusion] and antidepressant (medication that helps with the feeling of sadness and improves an individual's mood) medications.During a review of Resident 14's Order Summary Report dated 4/9/2026, the order summary report included the following physician orders:1. Lexapro Oral Tablet 5 MG [milligrams - metric unit of measurement), one time a day for depression manifested by (m/b) episodes of tearfulness.During a concurrent review and interview on 4/8/2026 at 11:07 a.m. with the Assistant Director of Nursing (ADON), Resident 14's PASRR dated 3/19/2025 and 3/24/2025 were reviewed. The ADON stated Resident 14's PASRR level 1 screening dated 3/19/2025 did not indicate mental illness diagnoses or medications. The ADON stated Resident 14's PASARR level 1 resident review screening dated 3/24/2025 indicated diagnoses including paranoid schizophrenia (a mental illness that affects how a person thinks and understands what is real), bipolar disorder and anxiety disorder. The ADON stated Resident 14 did not have another PASARR level 1 screening submitted after the resident started treatment with Lexapro (antidepressant medication) for depression. The ADON stated it was important to submit another PASARR level 1 screening when Resident 14 had a new diagnosis or was prescribed a new medication for a mental illness diagnosis to ensure the resident would be evaluated and provided the appropriate treatment plan. The ADON stated there would be potential for Resident 14 not to receive the proper guidance for treatment and care.During a review of Resident 19's admission Record, the admission Record indicated the facility admitted Resident 19 on 11/14/2001 and was readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) bipolar disorder, depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder.During a review (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident 19's H&P dated 1/23/2026, the H&P indicated Resident 19 does not have the capacity to understand and make decisions.During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 had severe cognitive impairment. The MDS indicated Resident 19 needed moderate assistance (helper does less than half the effort to complete the activity) with eating, maximal assistance (helper does more than half the effort to complete the activity) with oral hygiene and upper body dressing, and was dependent on staff with toileting hygiene, showering, lower body dressing, and putting on or taking off footwear. The MDS indicated Resident 19 had active diagnoses of anxiety disorder, depression, and bipolar disorder.During a concurrent interview and record review on 4/8/2026 at 10:48 a.m. with the ADON, Resident 19's PASARR level 1 screening dated 1/23/2026 was reviewed. The ADON stated Resident 19's PASARR level 1 screening indicated the mental illness diagnosis of bipolar disorder and dementia. The ADON stated Resident 19's PASARR level 1 screening did not indicate mental illness diagnosis of depressive disorder, mood disorder, or anxiety disorder. The ADON stated he should have included the diagnoses of depressive disorder, mood disorder, and anxiety disorder upon submission of the PASARR level 1 screening dated 1/23/2026. The ADON stated it was important to include the mental illness diagnoses to ensure the facility was able to provide the services Resident 19 needed. The ADON stated if the PASARR level 1 screening did not include the mental health diagnoses, Resident 19 would lack the appropriate care and treatment.During an interview on 4/9/2026 at 11:55 a.m. with the Director of Nursing (DON), the DON stated it was important to submit another PASARR level 1 screening upon start of a new medication for a new mental illness diagnosis to ensure residents were evaluated to develop a plan of care. The DON stated if a PASARR level 1 screening was not resubmitted, there would be potential for the residents not to receive the appropriate plan of care and not be able to follow through any recommendations indicated during the evaluation.During a review of the facility's policy and procedures (P&P) titled PASARR dated 1/2026, the P&P did not indicate procedures regarding resubmission of a PASRR level 1 resident review screening when the resident had a new mental illness diagnosis or prescribed a new medication to treat a new mental illness diagnosis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a person-centered care plan was implemented for two of four sampled residents (Resident 17 and Resident 1) when:a. Resident 17 who was receiving a psychotropic medication (a medication that alters chemical levels in the brain, affecting mood, perception, thoughts, and behavior). b. addressing Resident 1's arteriovenous (AV) (connection or interaction between arteries and veins) shunt (a direct connection between an artery and a vein, bypassing the capillary network, which can be natural or surgically created for medical access).These deficient practices had the potential to negatively affect the quality of life and wellbeing for Resident 17 and Resident 1 to prevent them from achieving their highest practical well-being. Findings: a. During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), anxiety disorder (constantly feeling worried and nervous), and dementia (a progressive state of decline in mental abilities). During a review of Resident 17's history and physical (H&P), dated 9/2/2025, the H&P indicated Resident 17 had fluctuating capacity to understand and make decisions. During a review of Resident 17's Minimum Data Set ([MDS], a resident assessment tool) dated 1/2/2026, the MDS indicated Resident 17 was moderately impaired in cognitive (thought process) functioning for daily decision making. The MDS indicated Resident 17 required supervision (helper provides verbal cues as resident completes the task) to maximal assistance (helper does more than half the effort to complete the task) with self-care abilities such as eating, hygiene and dressing. The MDS indicated Resident 17 was maximal assistance to dependent (helper does all the effort) for mobility such as rolling, sitting, standing and transfers. During a review of Resident 17's Order Summary Report dated 10/22/2025, the Order Summary Report indicated Buspirone (medication used for anxiety) 15 milligrams ([mg] metric unit of measurement) by mouth three times a day for anxiety manifested by verbalizing feeling anxious. During a review of Resident 17's person centered care plan, dated 8/8/2025, the person-centered care plan indicated a focus that Resident 17 required anti-anxiety medication related to anxiety disorder manifested by verbalizing feeling anxious. The care plan goals indicated the medication use will result in the maintenance of the resident's functional status with interventions to administer the medication as ordered by the doctor, but no other interventions to monitor or maintain the effectiveness of the medication or no person-centered interventions were in place. During a concurrent interview and record review on 4/8/20265 at 1:04 p.m. with MDS Nurse (MDSN) 1, the person-centered care plan dated 8/8/2025 was reviewed. MDSN 1 stated a care plan was a plan of care for residents and how the staff would care for the residents in the facility based on their needs. MDSN 1 stated there was no person-centered care plan interventions for the anti-anxiety medication Resident 17 was taking. MDSN 1 stated there was a care plan for anti-anxiety medication, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but the interventions were not person centered and did not have monitoring in place to monitor the behaviors Resident 17 had and the effectiveness of the medication Resident 17 was taking for the targeted behaviors. During an interview on 4/9/2026 at 12:49 p.m. with the Director of Nursing (DON), the DON stated a care plan was an overall individualized patient centered plan of care for residents. The DON stated the importance of residents having a person-centered care plan was that each resident has different needs, treatment and services and so the care plan should be individualized to their needs and reflect the care the staff are providing to the residents. During a review of the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered revised on January 2026, indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. b. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 9/25/2019 and was re-admitted on [DATE] with diagnoses including end stage renal disease (ESRD -irreversible kidney failure) and dependence on renal dialysis (life-sustaining treatment for kidney failure that filters waste, salt, and excess water from the blood, acting as an artificial kidney). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1's cognition (ability to think) was severely impaired. The MDS indicated Resident 1 needed partial assistance (helper does less than half the effort to complete the task) when eating, substantial assistance (helper does more than half effort) with oral hygiene, and dependent on staff with toileting hygiene, showering, and personal hygiene. During a concurrent interview and record review on 4/8/2026 at 12:15 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated there was no care plan for Resident 1's AV shunt. LVN 4 stated a care plan for the AV shunt should be included because a care plan reflects the care that is provided to the resident. LVN 4 stated if there is no care plan they are not providing the individualized care the resident needs. During an interview on 4/9/2026 at 11:53 a.m. with the Director of Nursing (DON), the DON stated care plans need to be individualized to meet resident needs. During a review of the P&P titled, Care Plans, Comprehensive Person-Centered, revised 1/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan reflects currently recognized standards of practice for problem areas and conditions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure adequate supervision to prevent one of one sampled resident (Resident 27) from accessing and consuming food from another resident (Resident 25).This failure had the potential to result in choking, allergic reaction, consumption of food inconsistent with the resident's prescribed diet and exposure to contaminated food.Findings:During a review of Resident 27's admission Record, the admission Record indicated the facility admitted Resident 27 on 12/9/2024 and readmitted on [DATE] with diagnoses including metabolic encephalopathy (any damage or disease that affects the brain), dysphagia (difficulty swallowing) and respiratory failure (any condition that affects breathing function and results in lungs not functioning properly).During a review of Resident 27's History and Physical (H&P), dated 3/13/2026, the H&P indicated, Resident 27 did not have ability for medical decision making. During a review of Resident 27's Minimum Data Set (MDS- a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 27's cognition (ability to think) was moderately impaired. The MDS indicated Resident 27 required moderate assistance (helper does less than half the effort to complete the task) with eating, oral hygiene, dependent (helper does all the effort) with toileting hygiene, showering and personal hygiene. During an observation on 4/6/2026 at 2:46 p.m. in Resident 27's room, Resident 27 was observed sitting on the bed and eating a sandwich. The food container was labeled for Resident 25.During a concurrent observation and interview on 4/6/2026 at 2:48 p.m. in Resident 27's room with Licensed Vocational Nurse (LVN) 10, LVN 10 assessed the name on the food container. LVN 10 confirmed and stated the food was intended for Resident 25. LVN 10 stated the food had already been distributed to Resident 25 and may have been contaminated. LVN 10 stated Resident 27 could choke when consuming food not ordered for him.During a concurrent interview and record review on 4/6/2026 at 2:55 p.m. with LVN 10, Resident 25 and 27's diet order, as of 4/6/2026 were reviewed. LVN 10 stated Resident 27's diet order was soft and bite-sized, while Resident 25's diet order was regular. LVN 10 confirmed there was no care plan in place to address Resident 27's behavior of taking other residents' food. During a review of the facility's policy and procedure (P&P) titled Safety and Supervision of Residents, revised January 2026, the P&P indicated:1. When accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible.2. Employees shall be trained on potential accident hazards and demonstrate competence in how to identify and report accident hazards and try to prevent avoidable accidents.3. The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary.4. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.5. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.

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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 proper catheter management for three of three sampled residents (Resident 10, 50, and 184) with an indwelling catheter (flexible tube inserted into the bladder to drain urine) by failing to: a. Clean the catheter, assess urine for signs and symptoms of infection, and monitor the urine output for Resident 10 and 184. b. Ensure Resident 50 had an order for a suprapubic catheter (a tube inserted through the lower abdomen directly into the bladder to drain urine) and monitoring for a urinary tract infection ([UTI]- an infection in the bladder/urinary tract) were in place.These deficient practices had the potential for the residents to develop an UTI and result in fever, pain or blood in the urine.Findings: a. During a review of Resident 10's admission record, the admission record indicated Resident 10 was admitted to the facility on [DATE] with a diagnoses including hydronephrosis (swelling of one or both kidneys) with ureteropelvic junction obstruction (blockage where the kidney meets the ureter, disrupting urine flow), obstructive and reflux uropathy (conditions that block or reverse the normal flow of urine), benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, presence of urogenital implants (prosthetic devices used to treat urinary incontinence), and urinary retention. During a review of Resident 10's Minimum Data Set ([MDS] a resident assessment tool), dated 3/28/2026, the MDS indicated Resident 10's cognitive (thinking) skills indicated moderate cognitive impairment. The MDS indicated Resident 10 required partial assistance (helper does less than half the effort to complete the task) with eating, oral hygiene, substantial assistance (helper does more than half the effort to complete the task) with showering and toileting hygiene. During a review of Resident 10's Order Summary dated 3/3/2026, the order summary indicated an order for an Indwelling Urinary Catheter for Obstructive Uropathy. During a review of Resident 184's admission record, the admission record indicated Resident 184 was admitted to the facility on [DATE] with a diagnosis including Neuromuscular dysfunction of bladder (bladder control problems caused by nerve or muscle damage), infection and inflammatory reaction (the immune system's non-specific, immediate response to tissue injury) due to indwelling urethral (hollow tube that lets urine, a waste product, leave your body) catheter, and benign prostatic hyperplasia with lower urinary tract symptoms. During a review of Resident 184's MDS, dated [DATE], the MDS indicated Resident 184's cognitive skills indicated moderate cognitive impairment. The MDS indicated Resident 184 required partial assistance with eating, substantial assistance with oral hygiene, and resident was dependent on staff with showering and toileting hygiene. During a review of Resident 184's Order Summary dated 4/1/2026, the order summary indicated starting 4/1/2026, an order for an Indwelling Urinary Catheter for a neurogenic bladder (dysfunction caused by nerve damage). During a concurrent interview and record review on 4/7/2026 at 1:31 p.m., with the Infection Prevention Nurse (IPN), Resident 10 and184's medical records were reviewed. The IPN stated that there was no documentation of urinary care administered to Resident 10 and 184. The IPN stated (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was no documented evidence of monitoring the urine output in the indwelling catheter for signs and symptoms of infection. During an interview on 4/9/2026 at 11 a.m. with the Director of Nursing (DON), the DON stated residents with an indwelling catheter need to receive indwelling catheter care, assessed for signs and symptoms of infection and need to monitor urine output to prevent an UTI. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised 1/2026, the P&P indicated the facility need to prevent urinary catheter-associated complications including UTIs. The P&P indicated to observe residents' urine for unusual appearance, bleeding, complaints of burning, tenderness, or pain in urethral area. The P&P indicated to provide routine perineal hygiene. The P&P indicated to document all care rendered and assessment of characteristic of urine, any problems and assessment data. b. During a record review of Resident 50's admission Records, the admission Records indicated Resident 50 was originally admitted to the facility on [DATE] with a readmission date on 1/30/2026 with diagnoses including dementia (a progressive state of decline in mental abilities), diabetes mellitus ([DM],a disorder characterized by difficulty in blood sugar control and poor wound healing), and Guillain-Barre Syndrome ([GBS], a serious autoimmune disorder where immune system attacks the body). During a review of Resident 50's history and physical (H&P), dated 1/31/2026, the H&P indicated Resident 50 had the capacity to understand and make decisions. During a record review of Resident 50's MDS dated [DATE], the MDS indicated Resident 50 had intact cognitive (ability to think, understand, learn, and remember) status. The MDS indicated Resident 50 required setup assistance (helper sets up or cleans up but resident can complete the activity) for self-care abilities such as eating, and oral hygiene and was dependent (helper does all the effort) for hygiene, shower, and dressing. The MDS indicated Resident 50 was maximal assistance for mobility such as rolling left to right, sitting to lying position and dependent on transfers. The MDS indicated Resident 50 had a neurogenic bladder (a dysfunction of the bladder caused by nerve damage leading to an inability to empty the bladder) and indwelling catheter was in place. During a record review of Resident 50's Order Summary Report dated 7/6/2025, the Order Summary Report indicated to cleanse of the suprapubic catheter site daily. There was no order for the suprapubic catheter with the indication of use, and no monitoring in place to ensure suprapubic catheter was in place and Resident 50 was being monitored for UTI. During a concurrent interview and record review on 4/9/2026 at 10:14 a.m. with MDS Nurse (MDSN) 1, the Order Summary Report dated 7/6/2025 and MDS dated [DATE] were reviewed. MDSN 1 stated there were no orders for the suprapubic catheter but there should have been an order for it. MDSN 1 stated if the facility staff did not have orders before interventions were done for the residents, the facility staff were practicing medicine, and it was not within their scope of practice. MDSN 1 stated Resident 50 had a suprapubic catheter for neurogenic bladder and there should be monitoring in place for the suprapubic catheter use. MDSN 1 stated the importance of having a physician order for the suprapubic catheter was for facility staff to be aware that Resident 50 had the indwelling catheter and to monitor the resident with the suprapubic catheter, to make sure staff are monitoring for infection, bleeding, leaking, sediments. MDSN 1 stated there should be a physician order to monitor the Resident 50 for signs and symptoms of infection to reduce the risk of resident getting recurrent (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infections such as UTI. During an interview on 4/9/2026 at 1:03 p.m. with the Director of Nursing (DON), the DON stated there should have been a physician order for any type of indwelling catheter use with indication and monitoring in place for any residents with indwelling catheter. The DON stated if there was a physician order for the suprapubic catheter, the staff could monitor the residents to make sure the use of the indwelling catheter was appropriate and the indwelling catheter was monitored and cleaned as ordered. The DON stated the orders to monitor the residents for indwelling catheter was to ensure the residents do not develop infections and to monitor for clarity of the indwelling catheter and urine for foul smelling, bleeding, leaking, which could indicate that something was wrong with the indwelling catheter or resident and to notify the physician right away. During a review of the facility's policy and procedures (P&P) titled Catheter Care, Urinary, revised January 2026, indicated, the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. review and document the clinical indications for catheter use prior to inserting. nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place using a standardized tool for documenting clinical indications for catheter use. the following information should be recorded in the resident's medical record such as all assessment data obtained when giving catheter care, character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor, any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain, any problems or complaints made by the resident related to the procedure.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide three of three hemodialysis ([HD]a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents (Resident 1, 6, and 103) with dialysis care and services consistent with standards of practice when the facility failed to:a. Ensure a blood pressure (measures the force in arteries when heart beats and rests) reading was not obtained on Resident 6 and 103's left upper extremity where the arteriovenous (AV) shunt (a direct connection between an artery and a vein, bypassing the capillary network, which can be natural or surgically created for medical access) was located. b. Notify the physician on 2/17/2026 and 2/19/2026, educate Resident 6 regarding risk for missing HD, call the Dialysis center to reschedule the dialysis, and monitor Resident 6 for complications after Resident 6 missed HD.c. Ensure Resident 1's AV shunt on the right upper extremity was assessed, monitored, cared for and that the blood pressure was not obtained on Residents 1's right arm.These deficient practices had the potential to result in complications including fluid overload (excessive fluid buildup in the body), access site clotting (process that prevents excessive bleeding when a blood vessel is injured), bleeding or inaccurate blood pressure readings.Findings: a) and b) During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including end stage renal disease ([ESRD]irreversible kidney failure) and dependence on hemodialysis. During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 6's cognition (ability to think) was moderately impaired. The MDS indicated Resident 6 needed supervision with eating, partial assistance (helper does less than half the effort to complete the task) with oral hygiene, substantial assistance (helper does more than half the effort) with toileting hygiene, showering, and dependent (helper does all the effort) on staff with personal hygiene. During a review of Resident 6's Order Detail dated 5/20/2026, the order detail indicated: Do not take blood pressure on left upper extremity with AV shunt and on 10/25/2025 to start Dialysis- three days a week every Tuesday, Thursday, and Saturday. During a review of Resident 6's care plan titled Needs dialysis (hemodialysis) r/t renal failure, revised 12/30/2024, the care plan's intervention indicated not to take blood pressure in the arm with the graft. During a review of Resident 6's Weight and Vitals Summary, dated from 3/3/2026 to 4/9/2026, the summary indicated staff documented blood pressure measurements taken from the resident's left arm on following dates:3/3/2026 at 8:30 a.m., 3/5/2026 at 8:46 a.m., 3/6/2026 at 9:53 p.m., 3/7/2026 at 8:31 a.m., 3/10/2026 at 8:26 a.m., 3/12/2026 at 8:05 a.m., 3/13/2026 at 3:07 a.m., 3/14/2026 at 8:40 a.m., 3/17/2026 at 8:49 a.m., 3/21/2026 at 7:40 a.m., 3/24/2026 8:25 a.m., 3/26/2026 8:37 a.m., 3/28/2026 at 7:35 a.m., 3/31/2026 at 8:21 a.m., 4/2/2026 at 8:31 a.m., 4/4/2026 at 8:35 a.m., and 4/7/2026 at 8:48 a.m. (17 times). During a review of Resident 103's admission Record, the admission Record indicated Resident 103 was admitted to the facility on [DATE] with diagnoses including ESRD and dependence on hemodialysis. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 103's MDS dated [DATE], the MDS indicated Resident 103's cognition was severely impaired. The MDS indicated Resident 103 needed partial assistance when eating, substantial assistance with oral hygiene, showering, and dependent on staff with toileting hygiene. During a review of Resident 103's Order Detail, dated 3/17/2026, the order indicated: Do not take blood pressure on left upper extremity with AV shunt. During a concurrent interview and record review on 4/7/2026 at 2 p.m. with the Infection Prevention Nurse (IPN), Resident 103's blood pressure readings, 3/17/2026 to 4/7/2026, were reviewed and the IPN confirmed and stated Resident 103's blood pressure was taken in the left upper arm on several occasions. The IPN stated Resident 103's blood pressure should not be taken from the left upper arm. During a concurrent interview and record review on 4/8/2026 at 1:04 p.m. with Licensed Vocational Nurse (LVN) 5, Resident 6's blood pressure readings, dated from 5/24/2026 to 4/7/2026, were reviewed. LVN 5 stated Resident 6's blood pressure was taken in the left upper arm on several occasions. LVN 5 stated Resident 6's blood pressure should not be taken from the left upper arm with the AV shunt, as doing so could damage the access site. During a concurrent interview and record review on 4/8/2026 at 3:58 p.m. with the Assistant Director of Nursing (ADON), Resident 6's medical records were reviewed. The ADON confirmed Resident 6 did not attend scheduled dialysis treatment on 2/17/2026 and 2/19/2026. The ADON stated a Change of Condition (COC) assessment was not completed following the missed dialysis treatments including notifying the physician, assessing the resident for risks related to missed hemodialysis, contacting the dialysis center to reschedule, and monitoring the resident for potential complications after missing dialysis on the identified dates. The ADON stated missed dialysis placed the resident at risk for fluid overload, congestion, and other complications, and that failure to intervene was not safe. During an interview on 4/9/2026 at 11 a.m. with the Director of Nursing (DON), the DON stated blood pressure should not be taken from the arm with the AV shunt because it could cause bleeding. The DON stated when residents miss HD days the staff needed to do a COC; The staff need to notify the physician/ responsible party, assess, educate the resident regarding risk for missing HD, call the Dialysis center to reschedule the dialysis, and monitor the resident for complications. The DON stated resident with missed HD was at risk for fluid overload. During a review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with revised 1/2026, the P&P indicated Residents with ESRD will be cared for according to currently recognized standards of care and standards. c. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/25/2019 and was re-admitted on [DATE] with diagnoses including end stage renal disease (ESRD -irreversible kidney failure) and dependence on renal dialysis (life-sustaining treatment for kidney failure that filters waste, salt, and excess water from the blood, acting as an artificial kidney). During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 1's cognition (ability to think) was severely impaired. The MDS indicated Resident 1 needed partial assistance (helper does less than half the effort to complete the task) when eating, substantial assistance (helper does more than half effort) with oral hygiene, and dependent on staff with toileting hygiene, showering, and personal hygiene. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's General Acute Care Hospital (GACH) record titled, History and Physical (H&P) Notes, dated 2/12/2026 at 11:48 a.m., the H&P indicated Resident 1 had an AV shunt in the right upper arm which was inserted on 12/31/2024, a second AV shunt in the right upper arm was inserted on 1/2/2026, and a central line (flexible tube inserted into a large vein) in the left internal jugular (large vein in side of neck) was inserted on 12/31/2024. During a concurrent observation, interview and record review on 4/8/2026 at 11:00 a.m. with LVN 3, stated Resident 1 had an old AV shunt on his right arm and the dialysis site currently used is the perma catheter (tunneled, cuffed central venous catheter designed for long-term vascular access, primary used for hemodialysis) on his left upper chest. LVN 3 while reviewing the GACH record, stated the resident had an AV shunt on right upper arm placed on 12/24/2024 and a second AV shunt on right upper arm placed on 1/2/2026. At bedside, LVN 3 verified two different AV shunt on the resident's right upper arm. LVN 3stated he was not aware of the second AV shunt. Resident 1's blood pressure readings from 3/30/2026 to 4/8/2026, were reviewed. LVN 3 stated Resident 1's blood pressure was taken in the right arm on several occasions during from 3/30/2026 through 4/8/2026. LVN 3 stated resident's blood pressure should be taken on the leg because there was a doctor's order to not be taking blood pressure on the left arm. LVN 3 stated if blood pressure was taken on the right arm there is potential for the shunt to burst and cause the AV shunt to stop working, preventing an access site for dialysis. During a concurrent interview and record review on 4/8/2026 at 12:15 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated there was no documentation for the second AV shunt. LVN 4 stated assessments should include skin assessments acknowledging the presence of the second AV shunt. LVN 4 stated even if Resident 1 had an old AV shunt, care such as monitoring and assessing signs of bleeding should still be documented. During an interview on 4/9/2026 at 11:53 a.m. with the Director of Nursing (DON), the DON stated she was not aware Resident 1 had two AV shunts. The DON stated blood pressure should not be taken from the arm with the AV shunt because taking the blood pressure over an AV shunt site can cause a malfunction. The DON stated ensuring the AV shunt was assessed is important to ensure it the AV shunt was working, operational for dialysis, and to ensure the right care was being provided. During a review of the facility's policy and procedure (P&P) titled Care of arteriovenous fistula (AVF – connection between an artery and a vein created surgically for dialysis access to allow for rapid, long-term hemodialysis) and arteriovenous grafts (AVG – surgical connection between an artery and a vein using a synthetic tube to provide vascular access for hemodialysis), revised 1/2026, the P&P indicated After placement of the fistula or graft, the site cannot be accessed until it matures. Care involved the primary goals of preventing infection and maintaining patency of the catheter (preventing clots). Do not use the access arm to take blood pressure. Check patency of the site at regular intervals.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one (1) expired medication, fluticasone furoate Ellipta (a once-daily inhaled corticosteroid used for long-term maintenance treatment of asthma, which lowers swelling and helps the body fight inflammation) oral inhaler was not stored in one out of four (4) sampled medication carts (Medcart) 2A on Station 2 and administered to a resident (Resident 79) two times after expiration on [DATE] and [DATE]. These deficient practices had the potential for loss of potency of the medication and for Resident 79 to receive ineffective medication necessary to help maintain and/or improve the resident's breathing.Findings:During a review of Resident 79's admission Record, the admission Record indicated the facility admitted Resident 79 on [DATE] and readmitted on [DATE] with diagnoses including Asthma (a chronic condition where the airways become inflamed and narrow, making it hard to breathe), Chronic Obstructive Pulmonary Disease (COPD, a long-term lung disease that blocks airflow and makes breathing difficult), interstitial pulmonary disease (a group of disorders causing scarring of lung tissue, which affects oxygen flow), and acute respiratory failure with hypoxia (sudden inability of the lungs to provide enough oxygen to the blood).During a review of Resident 79's History and Physical (H&P), dated [DATE], the H&P indicated that Resident 79 has the capacity to understand and make decisions.During a review of Resident 79's Order Summary Report, dated [DATE], the Order Summary included an active order for Fluticasone Furoate Inhalation Aerosol Powder Breath Activated 50 micrograms (mcg, unit of mass) per actuation (medication per inhalation), ordered to inhale one (1) puff orally one time a day for shortness of breath, with an order date of [DATE]. During a concurrent observation and interview on [DATE] at 4:17 p.m. with a Licensed Vocational Nurse (LVN) 2 on Nursing Station 2, MedCart 2A was inspected, and one oral inhaler, fluticasone furoate Ellipta 50 mcg was observed inside of MedCart 2A with an open date of [DATE]. LVN 2 reviewed the manufacturer labeling for fluticasone furoate Ellipta inhaler 50 mcg and stated the inhaler for Resident 79 expires six (6) weeks after opening. LVN 2 stated Resident 79's inhaler expired on [DATE]. LVN 2 stated that she administered a dose of fluticasone furoate Ellipta inhaler 50 mcg to Resident 79 today, [DATE]. LVN 2 stated the fluticasone furoate Ellipta inhaler 50 mcg expired on [DATE] and a new inhaler was ordered but has not arrived yet.During an interview on [DATE] at 4:36 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 79's fluticasone furoate Ellipta inhaler 50 mcg expired on [DATE] and would have to be replaced. During a concurrent interview and record review on [DATE] at 1:55 p.m., with the Director of Nursing, Resident 79's Medication Administration Record (MAR, a permanent record that shows which medicine was given, how much, when, and by whom), Administration Detail Reports (a record that lists what was administered, the amount, the time, and by whom) were reviewed for 4/2026, and the fluticasone furoate Ellipta inhaler 50 mcg medication labeled for Resident 79, manufacturer's label was reviewed. The DON stated Resident 79's inhaler was marked as first opened on [DATE] and expired on [DATE]. The DON stated Resident 79 was documented in the MAR and Administration Detail Report to have been administered two doses of the inhaler after the expiration date, on [DATE] and [DATE].A review of the manufacturer's labeling for Fluticasone Furoate Ellipta, revised 3/2025, indicated, Fluticasone Furoate ELLIPTA should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard Fluticasone Furoate ELLIPTA 6 weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first.A review of the facility's policy and procedures (P&P), titled, Administering Medications, dated 1/2026, the P&P indicated, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recorded on the container.A review of the facility's P&P titled, Medication Labeling and Storage, dated1/2026, indicated, To administer medication in a safe and effective manner. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow up on a recommendation for an ultrasound ([US] equipment used to produce high-frequency sound waves that travel deep into tissue and create therapeutic heat) of the right thyroid nodule (unusual lump (growth) of cells on your thyroid gland [produces hormones and regulate metabolism, energy levels, growth]) for diagnostic testing for one of seven sampled residents (Resident 101).This deficient practice had the potential to delay necessary care and services.Findings:During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was originally admitted to the facility on [DATE] and was admitted on [DATE] with diagnoses including spondylosis with myelopathy in the cervical region (progressive spinal cord dysfunction caused by chronic, age-related degeneration that compresses the spinal cord in the neck), disorder of bone density and structure, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) in the left and right hand.During a review of Resident 101's History and Physical (H&P) dated 5/17/2025 the H&P indicated Resident 101 has the capacity to understand and make medical decisions.During a review of Resident 101's Minimum Data Set (MDS, a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 101 was cognitively intact. The MDS indicated Resident 101 is dependent on shower transfer, chair/bed-to-chair transfer, required substantial assistance (Helper does more than half the effort) for lower body dressing, personal hygiene, and required partial assistance (Helper does less than half the effort) for upper body dressing, bathing, toileting hygiene, oral hygiene, and required supervision for eating.During a review of Resident 101's Pacific Rehab Consultants Physical Medicine and Rehabilitation (PM&R) follow up indicated the following:-11/26/2025: Ultrasound was recommended due to (d/t) nodule (right thyroid) discussed with (d/w) nursing and will be scheduled.-12/4/2025: US was recommended d/t nodule, d/w nursing and will be scheduled.-12/19/2025: US was recommended d/t nodule, d/w nursing and will be scheduled.-1/27/2026: US was recommended d/t nodule, d/w nursing and will be scheduled.-3/10/2026: US was recommended d/t nodule, d/w nursing and will be scheduled.During a concurrent interview and record review on 4/9/2026 at 8:36 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the nurses read the PM&R follow up notes and if the there were any orders, it would be placed by the Physician Assistant (PA). The ADON stated during the review of the PM&R follow-up notes from 11/26/2025 to 3/10/2026, there were recommendations and they should have spoken with the doctor to clarify the recommendation and follow up to see if the recommended diagnostic testing had been completed. The ADON stated that if there were no follow-ups, the residents would miss their diagnostic testing.During an interview on 4/9/2026 at 12:33 p.m. with the Director of Nursing (DON), the DON stated if there was a recommendation, and indicated if the recommendation was not followed up, they would not be able to provide the right treatment and interventions for Resident 101.During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test, revised January 2026, the P&P indicated a nurse will determine whether the test was done as a routine screen or follow up.During a review of the facility's P&P titled, Facility Assessment, revised January 2026, the P&P indicated the facility would do an assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of seven sampled residents (Resident 101) received Restorative Nursing Assistant ([RNA] promotes a resident's ability to adapt and adjust to living independently and safely) services as ordered by the physician.This deficient practice had the potential to delay treatment and services for Resident 101 and placed Resident 101 at higher risk for further decline and weakness.Findings:During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was originally admitted to the facility on [DATE] and was admitted on [DATE] with diagnoses including spondylosis with myelopathy in the cervical region (progressive spinal cord dysfunction caused by chronic, age-related degeneration that compresses the spinal cord in the neck), disorder of bone density and structure, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) in the left and right hand.During a review of Resident 101's history and physical (H&P) dated 5/17/2025 the H&P indicated Resident 101 has the capacity to understand and make medical decisions.During a review of Resident 101's Minimum Data Set (MDS, a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 101 was cognitively intact. The MDS indicated Resident 101 is dependent on shower transfer, chair/bed-to-chair transfer, required substantial assistance (Helper does more than half the effort) for lower body (waist below) dressing, and personal hygiene.During a review of Resident 101's the order summary report dated 4/9/2026, the order summary report indicated the following:1. RNA for active assistive range of (residents using their own muscles to move a joint while receiving partial help from a therapist or machine) on both lower extremities (LE) once daily (QD) three (3) times a week as tolerated active 8/5/2025. 2. RNA for application of abductor wedge one (1) to two (2) hours or as tolerated with skin check one daily 3 times a week dated 3/26/2026.3. RNA program for right-resting hand splint for 2 to four (4) hours 3 times or as tolerated in the morning every Tuesday, Thursday, Saturday. During an interview on 4/9/2026 at 12:54 p.m. with the Director of Staff Development (DSD), the DSD stated it was important to provide RNA services to ensure the continuity of the residents range of motion (ROM, the extent of movement of a joint), continue activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and to promote movement. The DSD stated if the RNA services are not provided, the muscles will tighten and the resident can develop contracture and muscle weakness.During an interview on 4/9/2026 at 2:41 p.m. with Restorative Nursing Assistant(RNA) 1, RNA 1 stated it was important for the residents to get their RNA treatment to ensure the residents are making progress.During a concurrent interview and record review on 4/9/2026 at 3:30 p.m. with the DSD, the DSD stated on the Documentation Survey Report dated March 26 indicated the following:-3/7/2026 (Saturday): Documented as not applicable (NA) for order: RNA program for right resident hand splint for 2-4 hours 3 times a week or as tolerated Tuesday/Thursday/Saturday.During a concurrent interview and record review on 4/9/2026 at 3:33 p.m. with the DSD, the DSD stated on the Documentation Survey Report dated February (Feb) - 26 indicated the following:-2/14/2026 (Saturday): No documentation for order: RNA for active assistive range of motion on both upper extremity (UE) once a day 3 times a week as tolerated Tuesday/Thursday/Saturday or for RNA for active assistive range of motion on both lower extremity (LE) once a day 3 times a week as tolerated Tuesday/Thursday/Saturday.-2/21/2026 (Saturday): No documentation for order: RNA program for right resident hand splint for 2-4 hours 3 times a week or as tolerated Tuesday/Thursday/Saturday.-2/28/2026 (Saturday): No documentation for order: RNA for application of abductor wedge 1 to 2 hours or as tolerated with skin check once a day 3 times a week Tuesday/Thursday/Saturday.The DSD stated if it was not documented, then it is not done and indicated the RNAs are here every day and if the residents are not able to get the service, they can do it the following day to ensure all services are provided.During an interview on 4/9/2026 at 4:27 p.m. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the Director of Nursing (DON), the DON stated it is important that they receive their RNA services to prevent them from getting further decline and overall functional ability.During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Services, revised January 2026, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain consent for an arbitration agreement (legally binding contract where parties agree to resolve disputes through a private arbitrator rather than a public court trial) from the resident representative for one of three sampled residents (Resident 19), who did not have the capacity to make decisions.This failure had the potential to result in the resident signing a legal binding agreement while not comprehending his/her right to access court remedies. During a review of Resident 19's admission Record, the admission Record indicated the facility admitted Resident 19 on 11/14/2001 and was re-admitted on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by chemical imbalances).During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool), dated 10/30/2024, the MDS indicated Resident 19's cognition (ability to think) was severely impaired. The MDS indicated Resident 19 ability to understand others sometimes understood and often needs assistance with health literacy (ability of individuals to find, understand, and use information and services to make informed health-related decisions for themselves and others).During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2026, the MDS indicated Resident 19's cognition (ability to think) was severely impaired. During a review of Resident 19's History and Physical (H&P) dated 10/25/2024 indicated Resident 19 has fluctuating capacity to understand and make decisions. During a review of Resident 19's History and Physical (H&P) dated 1/23/2026 indicated Resident 19 does not have capacity to understand and make decisions.During a review of Resident 19's Arbitration Agreement dated 10/24/2024, the Arbitration Agreement indicated Resident 19's signature on the document.During an interview on 4/9/2026 at 11 a.m. with the admission Director (AD) and the admission Assistant (AA), the AD stated when the residents are admitted to the facility, the arbitration agreement is explained to them and the AD or the AA will verify the residents understand the agreement. The admission Assistant (AA) stated she recalled going into the resident's room and explained the arbitration agreement and the resident nodded. The AA stated she or the AA did not verify if the resident lacks capacity and did not verify with a nurse if they had the ability to make an informed decision (a choice made based on facts, data, and relevant information). The AD stated the importance of making the resident or responsible party aware of signing the arbitration agreement as they are giving up their rights to go to court. During an interview on 4/9/2026 at 12:30 p.m. with the Director of Nursing (DON), the DON stated ensuring residents understand the arbitration agreement was important, so they are aware of their rights to go to court. The DON stated if a resident lacks capacity, signing the arbitration will not be accurate. During a review of facility's policy and procedure (P&P) titled Binding Arbitration Agreement, dated 2001, last revised January 2026, the P&P indicated The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a form and manner that he or she understands, taking in to consideration the resident's (or representative's) language, literacy and stated preference for learning. After the terms and conditions of the agreement are explained, the resident representative must acknowledge that he or she understands the agreement before being asked to sign the document. A. A signature alone is not sufficient acknowledgement of understanding. The resident (or representative) must verbally acknowledge understanding, and the verbal acknowledgement documented by the staff member who explains the agreement.

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	555375	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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's Quality Assurance and Performance Improvement (QAPI) Committee failed to identify and implement corrective action of systemic problems identified thereby affecting 173 of 173 residents by failing to:a. Ensure person-centered care plan was initiated and implemented for every resident in the facility.b. Ensure the Preadmission Screening and Resident Review ([PASARR], a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) was done in a timely manner. c. Ensure the Minimum Data Set ([MDS], resident assessment tool) was accurate according to the residents' needs and services.The deficient practices placed the residents at risk of not receiving the quality treatment necessary to adequately meet their highest practicable well-being.Findings: During an interview on 4/9/2026 at 4:50 p.m., with the Administrator (ADM), the ADM stated the following systemic issues identified were not identified by the QAPI committee and the facility failed to:a. Ensure person centered care plan was initiated and implemented for each residentb. Ensure the PASARR was done in a timely manner for the residents.c. Ensure the MDS assessment was accurate according to the residents' needs and services.The ADM stated there should have been a QAPI done for the deficiencies from the last survey process, so that the facility does not repeat the same deficiencies from last survey. The ADM stated he was not aware the QAPI committee had to do that but moving forward, the QAPI committee will implement a QAPI for each of the deficiencies from the last survey process to make sure the facility was complying and there was no repeat in deficiencies. During a record review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program, dated January 2026, indicated, shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents. provide a means to measure current and potential indicators for outcomes of care and quality of life.provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators.reinforce and build upon effective systems and processes related to the delivery of quality care and services.establish systems through which to monitor and evaluate corrective actions.Cross Reference F641, F644, F656

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control policies and procedure (P&P) when:a. The facility failed to provide documented evidence of 32 out of 32 licensed practitioners, Annual Influenza ([Flu] highly contagious respiratory infection) vaccine (medications used to prevent diseases usually given by injection or by mouth) status and the provision of education on benefits and potential side effects and offering of the 2025 to 2026 flu vaccine. b. The facility failed to ensure Licensed Vocational Nurse (LVN) 1 wore personal protective equipment ([PPE] clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when touching Resident 114's gastrostomy tube ([G-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), not disconnecting Resident 114's tube feeding from the g-tube when it was turned off, and Resident 46's indwelling catheter (flexible tube inserted into the bladder to drain urine). c. The facility failed to ensure Licensed Vocational Nurse (LVN) 1 wore PPE while assessing Resident 46's indwelling catheter (flexible tube inserted into the bladder to drain urine). d. The facility failed to ensure Resident 27's handheld nebulizer tubing (tubing connects the compressor [medical device that converts liquid medication into fine mist] to the medication cup), was changed weekly. These failures had the potential to result in staff and residents contracting infectious diseases which can cause serious illness, hospitalization, and death. Findings: a. During a concurrent interview and record review on 4/8/2026 at 1:20 p.m., with the Infection Prevention Nurse (IPN), the facility's binders for Staff Vaccination Status were reviewed. The IPN stated there was no documented evidence for physicians or licensed practitioners' education on benefits and side effects was provided and the offering of 2025 to 2026 Flu vaccine. The IPN stated Flu vaccination status for physicians should also be obtained because they have direct access to residents. During an interview on 4/9/2026 at 11 a.m. with the Director of Nursing (DON), the DON stated staff need to be educated and offered the current annual flu vaccine because vaccines minimize sickness and protects residents in the facility. During a review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, revised 1/2026, the P&P indicated all staff will be offered the flu vaccine annually and the facility will promote benefits associated with vaccination against the flu and IP will document the status of Flu vaccination of all staff. b. During a review of Resident 114's admission Record, the admission Record indicated Resident 114 was admitted to the facility on [DATE] with diagnoses including gastrostomy tube (G-tube), dysphagia (difficulty swallowing), and Type 2 Diabetes Mellitus (condition in which the body does not metabolize blood sugar correctly). During a review of Resident 114's history and physical (H&P) dated 1/28/2026, the H&P indicated Resident 114 did not have the capacity to understand and make medical decisions. During a review of Resident 114's Minimum Data Set (MDS, a resident assessment tool), dated 1/21/2026, the MDS indicated Resident 114 had moderate cognitive impairment. The MDS indicated Resident 114 is dependent (helper does all the effort) on staff for oral hygiene, toileting hygiene, bathing, dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/6/2026 at 10:25 a.m. in Resident 114's room with LVN 1, Resident 114's tube feeding was turned off with the tube feeding attached to Resident 114's G-tube. LVN 1 was observed assessing and having direct contact with Resident 114's g-tube without wearing proper PPE. LVN 1 stated she turned off the tube feeding at 8:00 a.m. c. During an observation on 4/6/2026 at 10:28 a.m. in Resident 46's room with LVN 1, LVN 1 was observed opening Resident 46's brief to assess Resident 46's foley catheter and additionally touched the foley bag that was attached to Resident 46's bed without wearing proper PPE. During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was originally admitted to the facility on [DATE] and was admitted to the facility on [DATE] with diagnoses including hydronephrosis, retention of urine, and neuromuscular dysfunction of bladder. During a review of Resident 46's H&P dated 1/27/2026, the H&P indicated Resident 46 has the capacity to understand and make decisions. During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46 had severe cognitive impairment. The MDS indicated Resident 46 is dependent on toileting hygiene, bathing, lower body dressing, chair/bed-to-chair transfer, shower transfer, required substantial assistance (Helper does more than half the effort) for upper body dressing, personal hygiene, required partial assistance (Helper does less than half the effort) for rolling left to right, sit to lying, lying to sitting on side of bed, required supervision for oral hygiene, and required set up for eating. The MDS indicated Resident 46 had no impairments on either side of the upper and lower extremities and utilized a wheelchair. During an interview on 4/6/2026 at 10:33 a.m. with LVN 1, LVN 1 stated PPE is worn when changing the foley, g-tube, feeding, or when touching the resident. LVN 1 stated if PPE is not worn, it could cause cross contamination and indicated she should have worn a gown when touching the g-tube and foley catheter. During an interview on 4/9/2026 at 12:19 p.m. with the Director of Nursing (DON), the DON stated Enhanced Barrier Precautions (EBP, infection control intervention designed to reduce transmission of multidrug resistant organisms) is implemented when a resident has a central line (long, flexible, thin tube inserted into a large vein to deliver medication, fluids, and nutrition), foley catheter, wound that is draining, has a tube feeding, or when you touch a resident. The DON stated wearing a gown prevents residents from getting an infection and prevents cross contamination and indicated not wearing PPE means they are not following their procedure guidelines. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised January 2026, the P&P indicated enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. Indwelling medical devices include central lines, urinary catheters, and feeding tubes. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: prolonged, high contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin; device care or use (urinary catheter, feeding tube). d. During a review of Resident 27's admission Record, the admission Record indicated the facility admitted Resident 27 on 12/9/2024 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, lung disease that causes obstruction of airflow and can limit normal breathing) , chronic pulmonary edema (a long-term, slow-developing condition where excess (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fluid continuously leaks into the air sacs of the lungs) and respiratory failure (any condition that affects breathing function and results in lungs not functioning properly). During a review of Resident 27's History and Physical (H&P), dated 3/13/2026, the H&P indicated, Resident 27 did not have ability for medical decision making. During a review of Resident 27's Minimum Data Set (MDS- a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 27's cognition (ability to think) was moderately impaired. The MDS indicated Resident 27 required moderate assistance (helper does less than half the effort to complete the task) with eating, oral hygiene, dependent (helper does all the effort) with toileting hygiene, showering and personal hygiene. During a review of Resident 27's Order Summary Report, dated 3/11/2026, the Order Summary Report indicated to give ipratropium-albuterol inhalation solution (a prescription medication used to open airways and treat breathing issues) 0.5-2.5(3) milligram/milliliter (a medication concentration) every four hours for COPD. During a review of Resident 27's Medication Administration Record (MAR), for month of March 2026 and April 2026, the MARs indicated Resident 27 received ipratropium-albuterol inhalation via nebulizer six times a day through a nebulizer from 3/11/2026 until 4/6/2026. During a concurrent observation and interview on 4/6/2026 at 2:46 p.m. in Resident 27's room, handheld nebulizer tubing was observed placed on the drawer next to the resident's bed. The tubing had a sticker indicating a date of 3/28/2026, and the plastic bag containing the nebulizer equipment was labeled with the same date. Resident 27 stated he had used the nebulizer approximately one hour prior to the observation. During a concurrent observation and interview on 4/6/2026 at 2:48 p.m. in Resident 27's room with Licensed Vocational Nurse (LVN) 10, LVN 10 assessed Resident 27's handheld nebulizer tubing, confirmed staff changed the tubing on 3/28/2026, and the facility continued to use the same tubing to administer breathing treatments up to the date of observation. LVN 10 stated the facility should change the nebulizer tubing set weekly to prevent infection control, as the equipment delivers medication directly into the resident's mouth and lungs. During an interview on 4/9/2026 at 3:45 p.m. with the Director of Nursing (DON), the DON stated it's essential to change the nebulizer tube weekly to prevent prolonged use and reduce the risk of infection from contamination. During a review of the facility's procedure and policy (P&P) titled, Departmental (Respiratory Therapy)-Prevention of Infection, revised 2026, the P&P indicated 7. Change the oxygen cannular and tubing every seven (7) days or per manufacturer's guidelines.