STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555397	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Los Angeles	340 South Alvarado Street Los Angeles, CA 90057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide reasonable accommodation for resident needs (the facility's efforts to individualize the resident's physical environment) by failing to: 1. Ensure two of five sampled residents (Resident 1 and Resident 185) had a communication board (a visual tool that uses pictures, symbols, or letters to help people with limited speech express their thoughts) at the bedside as indicated in the facility's Policy and Procedures (P&P) titled Communication Barriers, last reviewed 4/14/2026 and the facility's P&P titled ADL (Activities of Daily Living - activities such as bathing, dressing and toileting a person performs daily) Provided for Dependent Residents, last reviewed 4/14/2026. 2. Ensure one of five sampled residents (Resident 93) had a call light (a device used by a resident to signal his or her need for assistance) that was easy for Resident 93 to activate as indicated in the facility's P&P titled Resident Call System last reviewed 4/14/2026. 3. Ensure two of five sampled residents' (Resident 104 and Resident 138's) call light was within reach and accessible as indicated in the facility's P&P titled Resident Call System, last reviewed 4/14/2026. These failures had the potential for Resident 1, Resident 93, Resident 104, Resident 138, and Resident 185 to experience a delay in care and services, including inability to effectively communicate their needs to facility staff.Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/13/2025 with diagnoses that included paralytic syndrome unspecified (loss of ability to move or control certain muscles in the body, but the doctor has not specified the exact cause or the specific name of the condition in the medical record), senile degeneration of the brain (the physical breakdown of brain tissue in older adults, which causes a steady loss of memory, thinking, and daily living skills), Diabetes Mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, dysphagia (difficulty swallowing), suicide attempt, muscle weakness, and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident's History and Physical (H&P), dated 1/6/2025, the H&) indicated Resident 1 had the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool) dated 3/15/2026, the MDS indicated Resident 1 usually had the ability to make himself (Resident 1) understood and usually had the ability to understand others. The MDS indicated Resident had unclear speech (slurred or mumbled words). The MDS indicated Resident 1 had moderately impaired cognition (ability to think, read, learn, remember, reason, express thoughts, and make decisions). During a concurrent observation and interview on 5/11/2026 at 10:54 AM with Certified Nursing Assistant 5 (CNA 5) in Resident 1's room, Resident 1 was observed trying to communicate, mumbling words, and was missing a communication board. CNA 5 stated he (CNA 5) could sometimes figure out (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what Resident 1 was trying to say. CNA 5 stated he would get Resident 1 a communication board. Resident 1 nodded his head yes when he was asked if he wanted a communication board. During a concurrent observation and interview on 5/11/2026 at 11:08 AM with Licensed Vocational Nurse 7 (LVN 7), in Resident 1's room, Resident 1 was observed to nod yes when asked if he wanted a communication board to be able to point to what his needs were. LVN 7 stated it would be better if Resident 1 had a means of communicating directly instead of staff guessing what Resident 1 needed. During a concurrent interview and record review on 5/15/2026 at 5:00 PM with the Director of Nursing (DON), the DON reviewed the facility's policy and procedure (P&P) titled ADL (Activities of Daily Living - activities such as bathing, dressing and toileting a person performs daily) Care Provided for Dependent Residents, last reviewed 4/14/2026, The DON stated the facility should have provided Resident 1 with a communication board. During a review of the facility's P&P titled ADL (Activities of Daily Living - activities such as bathing, dressing and toileting a person performs daily) Care Provided for Dependent Residents, last reviewed 4/14/2026, the P&P indicated ADL (Activities of Daily Living - activities such as bathing, dressing and toileting a person performs daily) Care Provided for Dependent Residents, last reviewed 4/14/2026, The DON stated the P&P indicated Speech, Language or other Functional Communication Systems: The resident's (in general) ability to effectively communicate requests, needs, opinions, and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture, behavior, or a combination of these (e.g., a communication board or electronic augmentative communication device). During a review of the facility's P&P titled, Communication Barriers, last reviewed 4/14/2026, the P&P indicated Facility Staff will inform residents of TTY/TDD availability, as indicated. A. In addition to TTY/TDD devices, the Facility may use other electronic devices, written materials and communication boards to address communication barriers. 2. During a review of Resident 93's admission Record, the admission Record indicated the facility admitted the resident on 1/2/2026, with diagnoses that included rhabdomyolysis (a serious medical condition where damaged muscle tissue rapidly breaks down and dies), transverse myelitis (a rare neurological disorder caused by inflammation across one section of the spinal cord), and hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) affecting the left side of the body. During a review of Resident 93's MDS dated [DATE], the MDS indicated the resident needed touching assistance (helper provides verbal cues or steadying as resident completed activity) from facility staff to complete activities of daily living ADLs. During a review of Resident 93's Fall Risk Evaluation, dated 1/2/2026, the evaluation indicated the resident was a high risk for falls. During a review of Resident 93's care plan report titled, ADL: Resident requires assistance, revised on 1/5/2026, the care plan indicated an intervention of Call light within reach and answered promptly. During a concurrent observation and interview on 5/11/2026 at 12:20 PM with Resident 93, in Resident 93's room, Resident 93 was observed sitting upright in bed while holding a basin (a plastic open container) on his lap. Yellowish brown fluid was observed on Resident 93's chin, mouth, chest (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area, and on the resident's bed linens. Resident 93 stated, The call light doesn't work and asked if someone could help clean up the throw up. During a concurrent observation and interview on 5/11/2026 at 12:24 PM with Restorative Nurse Assistant (RNA) 1, in Resident 93's room, RNA 1 pressed the call light but the call light did not alarm. RNA 1 stated there was watery, brown throw up in the basin. During a concurrent observation and interview on 5/11/2026 at 12:26 PM with Maintenance Staff (MS) 1, in Resident 93's room, Resident 93's call light cord was not fully plugged into the wall socket. MS 1 was observed pushing the call light cord completely into the wall socket. MS 1 stated the call light was the only device residents could use to call for help. MS 1 stated that call light cords had to be fully plugged into a working electrical wall socket to work. During a concurrent observation and interview on 5/11/2026 at 12:38 PM with Resident 93, in Resident 93's room, Resident 93 pressed the call light multiple times. The call light did not alarm. Resident 93 stated the call light was still not working. During an interview on 5/11/2026 at 12:39 PM with RNA 1, RNA 1 stated residents could feel scared and frustrated when they were unable activate the call light to call for help. During a concurrent observation and interview on 5/11/2026 at 12:47 PM with LVN 6, in Resident 93's room, LVN 6 pressed Resident 93's call light and activated the alarm. LVN 6 stated Resident 93 could not apply enough pressure on the call light button to activate the alarm. LVN 6 stated without a way to call for help, residents could try to get up unassisted and fall. During a concurrent interview and record review on 5/14/2026 at 5:30 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Resident Call System and Reasonable Accommodation of Needs – Preferences, revised on January 2026, was reviewed by the DON. The DON stated the P&P was not followed because Resident 93 was not able to easily access and activate the call light. The DON stated staff should have assessed residents to determine if they cannot use a standard call light due to limitations in functional extremities. The DON stated care could be delayed and Resident 93 could have aspirated. During a review of the facility's P&P titled, Resident Call System, revised on January 2026, the P&P indicated Some residents may need a specialized call light, such as a call pad to request assistance. During a review of the facility's P&P titled, Reasonable Accommodation of Needs - Preferences, revised on January 2026, the P&P indicated Each resident shall have access to the resident call system within reach and to the ability the resident is able to use it if desired. During a review of Resident 185's Administration Record, the Administration Record indicated the facility admitted the resident on 4/30/2026 with diagnoses that included DM2, hyperlipidemia (high levels of cholesterol in the blood), chronic kidney disease (a condition in which the kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood), congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and hypertension (high blood pressure). During a review of Resident 185's Care Plan Report dated 5/1/2026, the Care Plan Report indicated the resident was a Spanish speaker. The Care Plan Report indicated an intervention to provide (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 185 with a Spanish communication board at bedside. During a review of Resident 185's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (loss of memory and the ability to think, understand, and reason that is severe enough to interfere with daily life). The MDS indicated Resident 185 was dependent on facility staff for help with toileting hygiene and personal hygiene. The MDS indicated Resident 185 required substantial/maximal assistance (helper does more than half the effort) with putting on/taking off footwear. The MDS indicated Resident 185 required partial/moderate assistance (helper does less than half the effort) with showering/bathing self and putting on/taking off footwear. The MDS indicated Resident 185 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, and oral hygiene. During an observation on 5/11/2026 at 10:08 AM in Resident 185's room, the resident was observed lying in bed and watching a Spanish language channel on television (TV). There was no Spanish communication board observed at Resident 185's bedside. During a concurrent observation and interview on 5/11/2026 at 10:14 AM with CNA 4 in Resident 185's room, CNA 4 stated Resident 185 spoke Spanish. CNA 4 stated Resident 185 did not have a communication board at bedside. CNA 4 stated there should have been a communication board at Resident 185's bedside. During an interview on 5/14/2026 at 9:55 AM with Registered Nurse 3 (RN 3), RN 3 stated the facility had communication boards for residents (in general) that did not speak English. RN 3 stated the residents who did not speak English could use the communication board by pointing to pictures when they communicated with staff (in general). RN 3 stated Resident 185 spoke Spanish. RN 3 stated Resident 185 should have had a communication board at bedside. RN 3 stated there was potential for Resident 185 to have not been able to communicate the resident's needs to staff (in general) if the resident did not have a communication board at bedside. During a concurrent interview and record review on 5/14/2026 at 3:14 PM with the Director of Nursing (DON), Resident 185's Care Plan Report dated 5/1/2026 was reviewed. The DON stated Resident 185's Care Plan Report indicated the resident was a Spanish speaker and had an intervention to provide the resident with a Spanish communication board at bedside. The DON stated that if Resident 185's Care Plan Report indicated the resident needed a Spanish communication board at bedside, a Spanish communication board should have been provided. The DON stated a communication board was a way for residents (in general) who did not speak English to communicate with the staff (in general) about the residents' (in general) needs. The DON stated that if Resident 185 did not have a communication board there was potential for the Resident 185 to have not been able to communicate the resident's needs. The DON stated there was potential for Resident 185 to not have the resident's needs met. During a review of the facility's P&P titled Communication Barriers reviewed 4/14/2026, the P&P indicated Facility Staff will inform residents of TTY (Text telephones/TTD (telecommunications devices for the deaf) availability as indicated. In addition to TTY/TTD devices, the facility may use other electronic devices, written materials and communication boards to address communication barriers. During a review of the facility's P&P titled ADL Care Provided for Dependent Residents reviewed (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/14/2026, the P&P indicated The facility provides assistance for residents unable to carry out activities of daily living.Speech, Language or other Functional Communication Systems: The resident's ability to effectively communicate requests, needs, opinions, and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture, behavior, or a combination of these (e.g., a communication board or electronic augmentative communication device).The interdisciplinary team develops and implements interventions in accordance with the resident's assessed needs, goals for care, preferences, and recognized standards of practice that address the identified limitations in ability to perform ADLs. During a review of Resident 138's admission Record (Face Sheet), the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (paralysis and weakness on one side of the body following a stroke), functional quadriplegia (complete immobility due to severe physical disability), type 2 diabetes mellitus with hyperglycemia (high blood sugar due to the body not properly using insulin), cognitive communication deficit (difficulty understanding or expressing thoughts), essential hypertension (chronic high blood pressure), acute and chronic respiratory failure with hypoxia (inability to maintain adequate oxygen levels) and muscle weakness (reduced muscle strength affecting mobility and physical function). During a review of Resident 138's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 138 had severely impaired cognitive skills for daily decision-making, memory problems with short-term and long-term memory, and required extensive staff assistance for activities of daily living (ADLs), including personal hygiene, toileting hygiene, dressing, bathing, transfers, and mobility.During an observation on 05/13/2026 at 9:08 a.m., Resident 138 was observed receiving morning care from Certified Nursing Assistant 1 (CNA 1). The resident's call light was observed on the floor and not within the resident's reach.During a review of Resident 104's admission Record, the admission Record indicated the Resident 104 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN - elevated blood pressure), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and muscle weakness (reduced muscle strength affecting mobility and physical function). During a review of Resident 104's Minimum Data Set (MDS - a resident assessment tool), dated 5/3/2026, the MDS indicated Resident 104 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and with varying assistance from set up (helper sets up or cleans up; resident completes activity) to being dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During an observation on 5/13/2026 at 8:26 a.m., inside Resident 104's room, Resident 104's call light was observed on the floor and not within Resident 104's reach. During a concurrent interview on 5/13/2026 at 8:26 a.m., Resident 104 stated, It fell earlier and no one came to help me get it.During a concurrent interview on 05/18/2026 at 2:32 p.m., the Director of Nursing (DON) stated it is important for the resident's call light to remain within reach at all times to ensure the resident has immediate access to call staff for assistance when needed. The DON further stated that failure to keep the call light within reach may place the resident at risk for delayed assistance, unmet needs, and inability to promptly call staff during an emergency. During a record review of the facility's policy and procedure (P&P), titled Reasonable Accommodations of Needs – Preferences, revised January 2026, the policy indicated each resident shall have access to the resident call system within reach and to the ability the resident is able to use it if desired.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure grievances and recommendations voiced through the Resident Council (an independent group of nursing home residents or family, who meet on a regular basis to discuss concerns and suggestions and to plan activities that are important to them) meetings were acted upon and responded to for two out of five residents (Resident 75 and 147) reviewed for resident council concerns who attended a group meeting with the nurse surveyor (Healthcare official that conducts inspections, investigations, surveys and evaluations of health facilities). By failing to follow through with the steps taken to investigate the grievance, provide the residents a summary of the pertinent findings and/or conclusions regarding the concern and a statement as to whether the grievance was confirmed or not confirmed and corrective actions taken as a result of the grievance as indicated by the facility's Policy and Procedure (P&P), titled, Grievance Policy, last reviewed 4/14/2026. This deficient practice resulted in multiple and unresolved residents' grievances related to delay in answering residents' call light and had the potential to affect residents' ability to receive timely assistance, care, and services.Findings: During a review of Resident 75's admission Record, the admission Record indicated the facility admitted the resident on 11/6/2024 with diagnoses that included dysarthria (difficulty in speaking /slurred speech), cerebral infraction (also called stroke, a result of inadequate blood flow to the brain) and diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]). During a review of Resident 75's Minimum Data Set (MDS: standardized assessment tool) dated 2/6/2026, the MDS indicated Resident 75 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 147's admission Record, the admission Record indicated the facility originally admitted the resident on 2/12/2015 and re-admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), chronic kidney disease (CKD-a longstanding disease of the kidneys leading to kidney failure) and generalized muscle weakness. During a review of Resident 147's History and Physical (H&P) dated 11/3/2025, the H&P indicated Resident 147 had the capacity to understand and make decisions. During a review of Resident 147's MDS, dated [DATE], the MDS indicated Resident 147 had moderately impaired (lacking full function or ability) cognition for daily decision-making and with varying assistance from set up (helper sets up or cleans up; resident completes activity) to maximal assistance (helper does more than half the effort) from staff for ADLs. A review of the Facility's Resident Council Minutes (RCM), dated 8/6/2025, Facility's RCM indicated a resident identified long call light waiting during the 11 AM-7 AM shift (night shift). A review of the Facility's Grievance/Complaint Resolution Report (GCRR), dated 8/7/2025, Facility's GCRR indicated under steps taken to investigate grievance/complaint was grievance and one to one (1:1) in-service started. Facility's GCRR indicated under summary of pertinent findings or conclusion regarding resident's concern was education needed. A review of the Facility's RCM dated 9/9/2025, Facility's RCM indicated a resident identified an extremely long call light waiting during the 3 PM-11 PM (evening shift) and 11 AM-7 AM shifts. A review of the Facility's GCRR, dated 9/10/2025, Facility's GCRR indicated under steps taken to investigate grievance/complaint was grievance and 1:1 in-service started. Facility's GCRR indicated under summary of pertinent findings or conclusion regarding resident's concern was education needed on finding. A review of the Facility's RCM dated 1/13/2026, Facility's RCM indicated a resident identified long call light waiting during the 3 PM-11 PM and 11 AM-7 AM shifts. A review of the Facility's GCRR, dated 1/16/2026, Facility's GCRR indicated under steps taken to investigate grievance/complaint was grievance copy to the Director of Staff Development (DSD) and in-service was completed. Facility's GCRR indicated under summary of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 develop and implement a comprehensive care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) that meets the needs for three of 33 sampled residents (Resident 4, 169 and 190) by failing to: 1. Ensure a pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid) care plan was developed on 5/8/2026 when Resident 4 received a physician's order for Ertapenem Sodium (antibiotic medication) one gram (1 gm) via intravenously (IV-administering fluid medication through a needle or tube inserted into a vein) one time a day for PNA for 10 days.2. Ensure a care plan was implemented for diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) when a nurse did not provide education on diet management to Resident 169.3. Ensure a care plan was implemented for hemodialysis (HD-filtering the blood of a person whose kidneys are not working normally), when a case manager (CM) 2 failed to schedule transportation at prescribed pick-up time for one of one resident (Resident 190). These deficient practices had the potential to have a negative impact on Resident 4, 169 and 190's health and safety, as well as the quality of care and services received. 2. Findings: During a record review of face sheet of Resident 169, Resident 169 was admitted to the facility on [DATE] with a diagnoses of Essential hypertension (chronic high blood pressure); type 2 diabetes mellitus (DM, chronic disorder of persistent high blood sugar levels); chronic kidney disease, stage 4 (late stage of kidney damage, affecting the body's ability to remove excess water and wastes in urine); peripheral vascular disease (slow, progressive disorder of blood vessels, reducing blood flow and oxygen to the limbs, most often the legs and feet), right 3rd toe ray amputation (a surgical procedure that involves removal of dead tissue/part of extremity). During a record review of Resident 169's Minimum Data Set (MDS, resident assessment tool), dated 3/1/2026, the MDS indicated the resident was cognitively intact, evidenced by had Brief Interview for Mental Status score of 15 (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident). The MDS also indicated that Resident 169's primary language was Spanish, but no need for interpreter services in communications with healthcare staff. The MDS indicated the functional abilities (abilities to perform activities of daily living like eating, dressing, walking, toileting) of Resident 169 required set up/clean up assistance for eating and oral hygiene, partial/moderate assistance (helper does less than half the effort) with upper body dressing, sit to stand, chair/bed transfers, and maximal assistance with lower body dressing, toileting and showering). During an initial observation and interview on 05/11/2026 at 2:13 p.m. with Resident 169, Resident 169 was observed in his room sitting in a wheelchair. Resident 169 stated he was supposed to have food low in sugar, but was served sweet juice, or ice cream, and had too much finger poking and insulin injections. Resident 169 stated she informed the charge nurse last night. During a concurrent interview and record review on 5/13/2026 12:36 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that Resident 169's friend brought him extra food. LVN 2 reviewed the Order Summary for diet, dated 2/26/2026, and LVN 2 stated Resident 169 was on Consistent Carbohydrate diet (CCHO, a diet with controlled amount of sugars in each serving of food). LVN 2 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the nurse provided education and explained risks and benefits of the diet. During a review of the electronic medical chart for Resident 169, undated, LVN 2 did not find a documentation about Resident 169 being educated on diet or any note of noncompliance with the diet. During a concurrent interview and record review 5/13/2026 at 2:39 p.m. with a Case Manager (CM) 1, Resident 169's care plan for Hypoglycemic medication/Insulin Use (medications to lower blood sugar level), dated 2/26/2026, the care plan indicated an intervention Providing resident education on diabetes management, including meal planning, exercise. CM 1 did not find any documentation in the chart that this care plan was implemented. CM 1 stated It would be important to document education of resident, especially with DM, comorbidities (two or more medical conditions in the same person) and wounds, because not documented means not done. CM 1 stated it would be a challenge to send Resident 169 home. The residents' friend was not aware about diet compliance for the resident. During a record review of Situation, Background, Assessment and Recommendation Change of Condition (SBAR COC, communication tool between a nurse and a doctor), dated 4/20/2026, the SBAR document did not indicate resident 169's noncompliance with or resident 169's education on diet. During a concurrent interview and record review on 5/14/2026 at 10:53 a.m. with Director of Nursing (DON), DON stated, He is on CCHO diet, he is not eating too much sugar, he has half of the carbs (carbohydrates, sugars in the food) compared to normal food for healthy people. DON reviewed dietitian's assessment and did not find documentation about resident diet education or doctor's notification about the resident noncompliance. DON sated It is important to educate the Residents to their benefit to follow recommendations. If it is beneficial to gain weight, especially with elderly, diet is not concerning, mostly medication is the concern to control his blood sugar. During a record review of Resident 169's care plan for hypoglycemic medications /insulin use, dated 2/26/2026, the care plan indicated the following interventions: Providing resident education on diabetes management, including medication administration, monitoring blood glucose levels, meal planning, exercise, and recognizing signs of hyperglycemia or hypoglycemia. 3. Findings: During a review of face sheet of Resident 190, dated 4/29/2026, the face sheet indicated the resident 190 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia (sudden difficulty breathing and oxygen exchange due to damage in lungs), and end stage renal disease (irreversible loss kidney function), renal hemodialysis dependance (HD, a long term treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed). During a review of Minimum Data Set (MDS, resident assessment tool) dated 5/5/2026, the MDS indicated the Resident 190's cognitive patterns were intact (able to comprehend complex concepts, memory intact, and verbalize own needs), as evidenced by Brief Interview for Mental Status score of 14 (BIMS score, an assessment tool to screen and identify memory, orientation, and judgement status of the resident). The MDS indicated that Resident 190's functional abilities (abilities to perform activities of daily living, such as eating, dressing, walking, toileting) required supervision/touching assistance for eating, partial/moderate assistance (helper does less than half the effort) with oral hygiene, substantial/maximal assistance with dressing, rolling in bed, dependence with sit to stand, chair/bed transfers, and toileting and showering. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/12/2026 at 8:08 a.m. with Resident 190, Resident 190 stated there were issues with scheduling of the transportation for HD. Resident 190 stated on 5/11/2026 the ambulance came one hour late to pick him up, and 45 minutes (min.) late to bring me back to the facility. On 5/11/2026 it was most notable, but they were late several times. Resident 190 stated there seems to be a problem in scheduling the HD center staff made me sign some paper about the shorter session. During a concurrent observation and interview 5/13/2026 at 9:07 a.m. with Resident 190, Resident 190 was still in his room waiting for his transportation for HD. Resident 190 stated they were running late again, and no one has told me anything. It is wrong, my dialysis time gets shortened, and other residents' dialysis would be delayed or shortened too. Nurses at the HD clinic get upset too. HD clinic made me sign the paper that my session is cut short. During a concurrent observation and interview on 5/13/2026 at 9:14 a.m. with the emergency medical technician (EMT) 1 stated, the dispatch sends us information about who and where to pick up, and destination, but not exact pick-up time. During an observation on 5/13/2026 at 9:29 am Resident 190 left the facility. During a concurrent phone interview and record review on 5/13/2026 at 9:36 a.m. with a Case Manager (CM) 2, scheduled the transportation, CM 2 stated Resident 190's HD start time was at 9:30 a.m., pick up time 8:30 a.m. or 9 a.m. CM 2 stated did not know the Physician's order for Resident 190's dated 4/29/2026, the pick-up time was at 8:15 a.m. CM 2 stated Resident 190's was being late and HD time would be shortened. During an interview on 5/13/2026 at 10:20 a.m. with RN 3, RN 3 stated that CM 2 had to follow the order for dialysis arrangement of transportation. During a concurrent interview and record review on 5/14/2026 at 10:11 a.m. with Licensed Vocational Nurse (LVN) 2 dialysis communication record dated 5/11/26 was reviewed, LVN 2 stated the facility usually notifies the dialysis center if transportation was late. LVN 2 stated the dialysis record did not have time indicating when HD treatment started and ended. LVN 2 stated she was not aware Resident 190's dialysis was cut short on 5/11/2026. LVN 2 stated, If we were aware about HD was being cut short, I would notify the physician. During an interview on 5/14/2026 at 10:45 a.m. Director of Nursing (DON), the DON stated the facility communicates with HD center mainly via phone. If dialysis center cut HD session short, they should have communicated with us. During a concurrent interview and record review on 05/14/2026 at 12:50 p.m. with Assistant Director of Nursing (ADON) 1, an Early Termination of Treatment Against Medical Advice form (AMA, a form signed by residents declining recommended medical treatment), dated 5/11/2026 was reviewed. The AMA form indicated the shortened dialysis treatment by 24 minutes (min) (prescribed dialysis treatment time was195 min) due to coming late. During an interview on 5/14/2026 at 5:15 p.m. with DON, DON stated CM 2 did not follow resident's care plan or order for dialysis. The DON stated CM 2 should have followed care plan and orders. DON stated if Resident 190 was running late due to transportation, facility should have communicated to CM 2, and to dialysis center to ask if they can still accommodate so Resident 190 can get the full (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment. The DON stated dialysis facility should have alerted and called the facility that the resident did not receive the full dialysis treatment. The DON stated staff should have alerted the physician that the resident's dialysis was cut short. DON stated there was potential for Resident 190 to have fluid retention, fluid overload, shortness of breath, altered laboratory test results and might require a transfer to the hospital. During a record review of the facility's policy and procedure titled Dialysis Management, dated 3/2023, the P & P indicated: The facility has an agreement with contracted Dialysis Unit(s) which operates in accordance with current standards of practice, including communication and collaboration. The P &P indicated the Dialysis Unit(s) and facility staff coordinate the development and implementation of the dialysis care plan, including the ongoing provision of assessment of the resident and care plan revision, as necessary. The P & P indicated the facility has a qualified social services representative who assists the dialysis resident and their representative with dialysis related transportation needs. During a record review of Nursing Home Dialysis Transfer Agreement, dated 4/28/2025, indicated Transportation of designated resident: facility shall have the responsibility for arranging suitable transportation of the Designated Resident to and from Center. Findings: During a review of Resident 4's admission record, the admission record indicated the facility originally admitted Resident 4 on 3/17/2025 and re-admitted the resident on 1/7/2026 with diagnoses including gastrostomy tube (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and dependence on ventilator (a machine or device used medically to support or replace the breathing of a person, unable to breath on their own). During a review of Resident 4's History and Physical (H&P), dated 1/14/2026, the H&P indicated Resident 4 did not have the capacity to understand and/or make decisions. During a review of Resident 4's Minimum Data Set (MDS-standardized assessment tool), dated 3/13/2026, the MDS indicated Resident 4 had impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and was dependent (helper does all the effort) on staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 4's situation background assessment and recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) Change in Condition dated 5/7/2026, the SBAR: Change in Condition indicated Resident 4 had a fever (high body temperature) and tachycardia (heart rate faster than normal). During a review of Resident 4's Order Summary Report, dated 5/8/2028, the Order Summary Report indicated that Resident 4 had an order for Ertapenem Sodium gm via intravenously one time a day for PNA for 10 days. During a review of Resident 4's complete care plan, the care plan review indicated a care plan for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4's antibiotic (ertapenem) use was not created. During a concurrent interview and record review on 5/14/2026 at 9:54 AM, with Director of Nursing (DON), Resident 4's care plan was reviewed. Resident 4's care plan indicated a missing PNA care plan for antibiotic (ertapenem) use. The DON stated that when a resident started an antibiotic medication, nursing staff had to develop a care plan for the diagnosis of the antibiotic use. The DON stated a care plan for antibiotic use and a care plan for PNA should have been developed when ertapenem on 5/8/2026 was ordered to be able to provide proper care and interventions for Resident 4. During a review of the facility's policy and procedure (P&P), titled, Develop-Implement Comprehensive Care Plans, reviewed on 4/14/2026, the P&P indicated that each resident was to have a person-centered comprehensive care plan that was developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide skin and pressure ulcer (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin) prevention care consistent with professional standards of practice and per physician's orders for three of five sampled residents (Resident 1, 4, and 9) on Low Air Loss Mattresses (LALM, a specialized medical support surface designed to prevent and treat skin breakdown and pressure ulcers [localized damage to the skin and/or underlying tissue usually over a bony prominence]). By failing to 1. Ensure Resident 1 and Resident 9's LALMs were set to the correct setting as indicated by the facility's Policy and Procedures (P&P) titled Low Air Loss Mattress, last reviewed 4/14/2026 and the product manufacturer guidelines titled Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System Operator's Manual, revised 3/22/2021.2. Ensure Resident 4's LALM was plugged in and working as indicated by the facility's P&P titled Low Air Loss Mattress, last reviewed 4/14/2026 and the product manufacturer guidelines titled, User-Service Manual Roerns(R) Support Surfaces P.R.O. Matt(R) Plus, dated 2024. This failure had the potential for Resident 1, Resident 4, and Resident 9 to develop or worsen existing pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence).Findings: During a review of Resident 1'a admission Record, the admission Record indicated the facility admitted Resident 1 on 11/13/2025 with diagnoses that included paralytic syndrome unspecified (a person has lost the ability to move or control certain muscles in their body, but the doctor has not specified the exact cause or the specific name of the condition in the medical record), senile degeneration of the brain (the physical breakdown of brain tissue in older adults, which causes a steady loss of memory, thinking, and daily living skills), Diabetes Mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, dysphagia (difficulty swallowing), suicide attempt, muscle weakness, and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident's History and Physical (H&P), dated 1/6/2025, the H&P) indicated Resident 1 had the capacity (ability) to make decisions. The H&P indicated Resident 1 had an unstageable sacral ulcer (a severe, deep bed sore located directly over the tailbone), bilateral (both) knees with open wound, bilateral toes (toes on both feet), right arm with skin tear, right groin with skin fold wound, and occiput (the back part of the head) pressure sore (localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 1's Care Plan Report titled, Resident 1 has high risk/or at risk for delayed wound healing dated 2/13/2026, the Care Plan Report indicated an intervention for LALM for wound management. During a review of Resident 1's Care Plan Report titled Low air loss mattress: the resident (Resident 1) requires the use of a low air loss mattress to relieve pressure and support the maintenance of skin integrity (the overall health, wholeness, and strength of your skin), the Care Plan report indicated an intervention for facility staff to regularly check the mattress's inflation to ensure it is maintaining the correct pressure level and air flow. During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool) dated 3/15/2026, the MDS indicated Resident 1 usually had the ability to make himself (Resident 1) understood and usually had the ability to understand others. The MDS indicated Resident had unclear (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	speech (slurred or mumbled words). The MDS indicated Resident 1 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 (a score of 12 is usually a signal for the care team to monitor the person's mental status closely, help them with daily cues if needed). During a review of Resident 1's Order Summary Report dated 5/13/2026, the Order Summary Report indicated Resident 1 had a physician order for LALM for skin and wound management. During a concurrent observation and interview on 5/11/2026 at 11:08 AM with Licensed Vocational Nurse 7 (LVN 7), Resident 1's LALM was observed set for a weight of 120 pounds. LVN 7 stated that the facility's environmental services were responsible for setting up Resident 1's LALM. LVN 7 stated Resident 1 did not have any bed sores. LVN 1 stated she was not sure what the facility's LALM policy was. During a concurrent interview and record review on 5/12/2026 at 2:17 PM with the facility's Infection Preventionist Nurse (IPN) and Registered Nurse 4 (RN 4), Resident 1's electronic medical record (EMR - a digital version of a patient's paper medical chart) was reviewed. The IPN and RN 4 verified Resident 1 weighed 155 lbs. During a concurrent observation and interview at 5/12/2026 at 2:17 PM with the facility's IPN and RN 4, Resident 1's LALM was observed to be set at the same setting, observed on 5/11/2026 at 11:08 AM. The IPN stated the facility's nurses (in general) should have set Resident 1's LALM based on Resident 1's weight. RN 4 stated Resident 1 had a sacrococcyx pressure injury (bed sore located on your lower tailbone and the flat bone connecting to it) and the LALM should have been set to the correct setting based on Resident 1's weight. RN 4 stated Resident 1's sacrococcyx pressure injury could be negatively affected if Resident 1's LALM was not set to the correct weight. During an interview on 5/14/2026 at 5:00 PM with the Director of Nursing (DON), the DON stated the facility should have set Resident 1's LALM based on Resident 1's weight. During a review of the facility's policy and procedure (P&P), titled Low Air Loss Mattress, last reviewed 4/14/2026, the P&P indicated 12. For maintenance, cleaning, settings, and care, the facility shall follow the manufacturer's guidelines. During a review of the manufacturer's guidelines titled Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System Operator's Manual, revised 3/22/2021, the manufacturer's guidelines indicated Step 6 Determine the patient's (resident in general) weight and set the control knob to that weight s setting on the control unit. During a review of Resident 9's admission record, the admission record indicated the facility originally admitted Resident 9 on 12/31/2014 and re-admitted the resident on 4/13/2026 with diagnoses including gastrostomy (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and metabolic encephalopathy (a condition in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood). During a review of Resident 9's Braden Scale (pressure ulcer risk predictor tool) for predicting pressure ulcer risk (BSPPUR) dated 12/25/2025, the BSPPUR indicated Resident 9 was at risk for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure ulcer development. During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 9 was at risk of developing pressure ulcers/injuries with treatment for pressure reducing devices for bed. During a review of Resident 9's care plan revised on 4/13/2026, the care plan indicated Resident 9 was at risk for developing pressure ulcers and needed specialized pressure-reducing care. Resident 9's care plan indicated under interventions to ensure LALM was in place, plugged in and functioning properly, and maintaining the correct level and air flow. During a review of Resident 9's H&P dated 4/20/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's order summary report dated 5/12/2026, the order summary report indicated Resident 9 had an order for a LALM for skin management every shift for wound and skin management. During a review of Resident 9's Weights and Vitals Summary Report, on 5/13/2026, Resident 9's weight indicated the following: 5/11/2026 161 pounds (lbs.) 4/27/2026 159 lbs. 3/6/2026 155 lbs. During an observation on 5/11/2026 at 9:59 a.m., inside Resident 9's room, Resident 9's LALM setting was observed set at 280 lbs. During an interview with Treatment Nurse 2 (TX 2) on 5/13/2026 at 12:01 PM, TX 2 stated Resident 9's LALM should have been set at 180 lbs. to prevent pressure ulcer for Resident 9. TX 2 also stated importance of following the manufacturer's manual for the use of LALM. During an interview on 5/13/2026 at 12:13 PM, the DON stated that Resident 9's LALM should have been set according to Resident 9's weight. The DON stated the importance of having LALM set at the right setting to be able to prevent pressure ulcers/injury to high-risk residents of having skin breakdown. During a review of facility's P&P, titled, Treatment Services to Prevent/Heal Pressure Ulcers, reviewed on 4/14/2026, P&P indicated that support surfaces and pressure redistribution devices that are used by the facility are most likely to reduce pressure effectively if they are used in accordance with the manufacturer's instructions. During a review of the LAL Operator's Manual 1 (LAL OM 1), undated, LAL OM 1 indicated the facility needed to determine the patient's weight and set the control knob to the specific weight setting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 4's admission record, the admission record indicated the facility originally admitted Resident 4 on 3/17/2025 and re-admitted the resident on 1/7/2026 with diagnoses including gastrostomy, chronic respiratory failure and dependence on ventilator (a machine or device used medically to support or replace the breathing of a person, unable to breath on their own). During a review of Resident 4's care plan dated 1/8/2026, care plan indicated Resident 4 was at risk for developing pressure ulcers, requiring specialized care and pressure relief using LALM. Resident 4's care plan indicated under interventions to ensure LALM was in place, plugged in and functioning properly, maintaining the correct level and air flow. During a review of Resident 4's H&P, dated 1/14/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had impaired cognition for daily decision-making and was dependent on staff for ADLs. The MDS also indicated Resident 4 was at risk of developing pressure ulcers/injuries with treatment for pressure reducing devices for bed. During a review of Resident 4's Braden Scale for predicting pressure ulcer risk (BSPPUR) dated 3/13/2026, the BSPPUR indicated Resident 4 was at risk for pressure ulcer development. During a review of Resident 4's order summary report dated 3/20/2026, the order summary report indicated that Resident 4 had an order for a LALM for skin management every shift. During a concurrent observation and interview on 5/11/2026 at 10:49 AM, with Registered Nurse 2 (RN 2) inside Resident 4's room, Resident 4's LALM machine was observed turned off. RN 2 stated that the LALM machine was unplugged and disconnected from a power wall outlet. RN 2 stated that LALM should have been turned on. RN 2 stated importance of using the LALM to Resident 4 due to Resident 4's high risk of skin breakdown. During an interview with Treatment Nurse 1 (TX 1) on 5/13/2026 at 9:48 AM, TX 1 stated LALM should have been plugged in and turned on to provide the intended use, which was reducing pressure to the skin. During a review of facility's P&P, titled, Treatment Services to Prevent/Heal Pressure Ulcers, reviewed on 4/14/2026, P&P indicated that support surfaces and pressure redistribution devices that are used by the facility are most likely to reduce pressure effectively if they are used in accordance with the manufacturer's instructions. During a review of the LAL Operator's Manual 2 (LAL OM 2), undated, LAL OM 2 indicated to ensure the system is operating correctly, the mattress and control unit should be checked by facility.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure 19 pureed diets (foods that do not require chewing and are easily swallowed. All food should be smooth and pureed to the consistency of pudding) meal trays received bread texture in the form that met their needs and in accordance with international Dysphagia Diet Initiative IDDSI (IDDSI-a framework made up of levels and describes food textures and drink thickness) Level Four (pureed foods and extremely thick drinks) when on 5/11/2026 kitchen staff served bread that was lumpy, not smooth and had small pieces of bread grains present that required chewing before swallowing on pureed diet trays. This deficient practice had the potential to result in meal dissatisfaction and increased choking risk for the residents on the pureed diet.Findings:During an observation of the facility's kitchen's tray line (tray line- a system of food preparation, in which trays move along an assembly line) service for lunch on 5/11/2026 at 12:00PM, the pureed bread looked lumpy, and not smooth while in a pan on the steam table (table having openings to hold containers/Pans of cooked food over steam or hot water circulating beneath them). Cook1 stated kitchen staff used the robot coupe (commercial strength food processing machine a kitchen appliance designed for quickly chopping, slicing, shredding, grating, pureeing and mixing foods using interchangeable blades and discs within a close bowl) to make the pureed bread. Cook1 stated kitchen staff added some butter and milk to the bread and pulsed the machine a couple of times until it was mixed. During a concurrent interview and taste test of the pureed bread with the ADS, Cook1 and the RD on 5/11/2026 at 1:15PM, the pureed bread was observed to have a lumpy texture. There were small pieces of bread, and it was not smooth. During a tasting of the pureed bread, the pureed bread was grainy and with some residue remaining in the mouth requiring chewing before swallowing. During the same taste test with the ADS, Cook1 and the RD, Cook1 stated the bread looked minced and it was lumpy. Cook1 said it was because I didn't leave it in food processor until it was smooth. Cook1 stated pureed food had to be smooth and if not prepared correctly, it could cause swallowing problems with residents who were on pureed diets. The ADS agreed that the pureed bread texture was not smooth and said the bread was more like a bread pudding. The RD stated the pureed bread looked lumpy. During a review of the facility recipe titled Pureed Bread or Roll (PU4) (dated 2026) the recipe indicated, place required portions of Soft Bread from regular prepared recipe (remove hard, crispy crusts) into a food processor and pulse until a fine consistency. Gradually add liquid.only use enough liquid needed to achieve a smooth consistency. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test. During a review of the facility policy and procedures (P&P) titled, Menus (dated 1/2025) the P&P indicated, Residents receive food in the amount, type, consistency and frequency to maintain normal body weight and acceptable nutritional values.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a fortified diet (diet enhanced to increase caloric content of food) for 18 out of 112 meal trays requiring a fortified diet. This deficient practice had the potential to result in decrease caloric intake and lead to undesirable weight loss.Findings: During an observation of the kitchen tray line (tray line- a system of food preparation, in which trays move along an assembly line) service for lunch on 5/11/2026 at11:56AM, meal trays indicating fortified diet received the same food as the meal trays that did not have fortified diet orders. Dietary Aide (DA2) was observed not communicating to the cooks the fortified diet orders written on the meal tray cards (a printed sheet that includes resident diet order, preferences and dislikes). A review of tray cards on the meal carts indicated orders for fortified diets. However, DA2 did not read out loud the fortified diet and cook (Cook1) did not add any additional food items. During an interview with DA2 on 5/11/2026 at 1:00PM, DA2 stated that fortified diets were to add extra calories to the food. DA2 stated fortified diets were for residents who were losing weight so they can have more calories. DA2 stated I think residents on fortified diets receive special soup. DA2 stated I didn't communicate the fortified diets to the cook, so no one received anything extra. During an interview with cook1 on 5/11/2026 at 1:10PM, cook1 said the cooks would add melted butter to fortified diets. Cook1 confirmed not adding any melted butter to any tray on date of interview (5/11/2026) during lunch service. Cook1 said DA2 would let the cooks know that the trays were for fortified diets so the cooks could add melted butter. Cook1 said DA2 did not read out the fortified diet during the lunch service on 5/11/2026. Cook1 said the fortified diet is for residents who are losing weight. Cook1 stated fortified diets were to get additional butter on the vegetables or starch to add extra calories. During an interview with the Registered Dietitian (RD) on 5/11/2026 at 1:15PM, the RD stated fortified diets were recommended for residents who were at risk of weight loss. [NAME] RD stated fortified diets required an additional 500 calories per day, spread out over three meals. The RD stated residents on fortified diets would receive either melted butter over the vegetables and starches, high protein and calorie mashed potato, or creamy soup. The RD stated regular soups or high calories shakes were separate requests and were not part of the fortified diets. During a review of facility Guideline and procedures Manual titled, Fortified Foods, Supplements, and Snacks (dated 2020) the manual indicated, Residents who cannot consume adequate amounts of regular foods at meals to meet their nutritional needs may be considered for fortified foods, snacks, or supplements to increase nutritional intake. Residents will be evaluated by the Registered Dietitian when additional nutritional intervention is warranted. Fortified foods, house supplements, or snacks will be provided within the specifications of the diet order. During a review of facility's Guideline and procedures Manual titled, Fortified Enhanced power Foods Protocol (FEP) (dated 2020), the manual indicated, A protocol such as the Fortified Foods Protocol (FEP) may be utilized to increase calories and or protein in the foods serves as a part of the meal. The FEP Protocol is based on the regular diet, with foods enhanced, substituted or added to boost the calorie and protein content of meals. FEP foods are designed to provide additional calories and protein. FEP foods are foods that are enhanced in calories and protein. All power foods provide a minimum of 180 to190 calories and 5 to 6 grams of protein per serving. The FEP foods include, but are not limited to : Cheesy eggs, fortified hot chocolate, milk shake, fortified soup, power potatoes, super cereal and pudding.

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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 ensure safe and sanitary food storage and preparation practices in the kitchen when: 1.Three bags of frozen chicken were stored in the reach in freezer with no date or label. One medium container of expired left over chicken tortilla soup with use by date 5/9/2026 was stored in the walk-in refrigerator; Five bags of thawed raw chicken with use by dates of 5/6/2026; Three logs of ground beef with use by date of 5/10/2026 and two large bags of marinated chunks of beef with use by date of 5/8/2026 were stored in the walk in refrigerator exceeding storage periods for raw beef and poultry. 2. Nutrition shakes labeled store frozen with manufactures instruction to use within 14 days of thawing, were not marked with the date they were thawed to ensure expired shakes were discarded after the 14-day time frame. Two boxes containing 50 single serve cartons of chocolate flavored nutrition shakes and one box containing 50 single serve cartons of strawberry flavored shakes stored in the walk-in refrigerator with no thaw date. 3. One nutrition shake with manufacturers instruction to use within 14 days of thawing; one renal nutrition supplement and a can of soda were stored in the resident refrigerator located on the first floor's utility room with no date or label. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 112 out of 166 residents who receive food from the kitchen, including 20 residents who received nutrition shakes and residents who stored food in the resident refrigerator. Findings:1. During a concurrent observation and interview with Assistant Dietary Supervisor (ADS) on 5/11/2026 at 8:30AM, three large bags of chicken were observed stored in the facility's reach in freezer (is an upright, commercial-grade freezer they get their name from the fact that you simply open the front door and reach inside to grab your items, rather than walking into a large storage) with no date or label. The stated the bags of chicken were removed from the original packaging and should have been marked with the date they were opened. The ADS stated kitchen staff should have written the date the food items were delivered or the use by date, so kitchen staff would know when to use the chicken before the chicken reached the discard date. The ADS stated that kitchen staff were not sure how long the chicken had been stored in the freezer because there was no date on the chicken. During an observation in the walk-in refrigerator on 5/11/2026 at 10:00AM, t an open container of chicken tortilla soup was observed with a use by date of 5/9/2026 indicated the soup was expired and remained stored in the walk-in refrigerator. The ADS stated the chicken soup was leftover from the week prior and should have been discarded. The ADS stated expired food could cause residents to get sick. During the same observation in the walk in refrigerator on 5/11/2026 at 10:00AM five bags of thawed raw chicken were observed with a use by dates of 5/6/2026; Three logs of ground beef were observed with a use by date of 5/10/2026 and two large bags of marinated chunks of beef were observed with a use by date of 5/8/2026 stored in the walk in refrigerator exceeding storage periods for raw beef and poultry. During a concurrent interview and record review with the ADS on 5/11/2026 at 10:00AM, the ADS reviewed the menu for the week and stated there was no chicken on the menu for the week and since the chicken was already past the use-by date it would be discarded. The ADS stated the ground beef was a mistake and the cooks thawed more ground beef than needed. The ADS was then observed removing the items from the refrigerator to discard. The ADS stated the marinated chunks of beef did not belong to facility residents and was for staff use. The ADS stated staff belongings, including food, were not to be stored in the facility refrigerator. The ADS stated food brought in from outside could contaminate the refrigerator. The ADS was observed removing the marinated chunks of beef to discard. During an interview with the ADS and the registered dietician (RD) on 5/11/2026 at 10:15AM, the ADS stated raw chicken, and beef was thawed for 2 days and then an additional 2-3 days until preparation for a total of 5 days storage period. The ADS stated the chicken and ground beef were stored for longer (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	than 5 days. During a review of facility provided food storage guidelines titled, US Food and Drug administration's Refrigerator and Freezer storage chart (dated 3/2018) the guidelines indicted to store fresh poultry (chicken or turkey) for 1-2 days in the refrigerator and raw ground meat for 1-2 days in the refrigerator. During a review of facility's policy and procedures (P&P) titled, Food receiving and storage(dated 1/2026) the p&p indicated, When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping trach of when to discard perishable foods and covering, labeling, and dating all foods stored in the refrigerator or freezer as indicated. 2. During an observation in the kitchen on 5/11/2026 at 10:00AM there were two boxes of chocolate flavored nutrition shakes (high calorie shakes) and one box of strawberry-flavored nutrition shakes stored in the walk-in refrigerator with no thaw date. Each box contained 50 single serving cartons of nutrition shakes. The ADS stated the single serve cartons of nutrition shakes were frozen when they were delivered and then were stored directly in the refrigerator. The ADS said the expiration dates were already on the individual shakes. A concurrent observation and review of the manufacture's instruction for storage printed on the cartons of the nutrition shakes was done with the ADS. The ADS reviewed the instructions and stated the shakes were stored frozen and once thawed they were good for 14 days. The ADS stated that kitchen staff did not know that the shakes need to be monitored for expiration after thawing. The ADS stated the shakes were dairy based and could go bad and the residents could get sick when they received shakes that were expired. The ADS agreed there should have been a date on the supplements to monitor date of thaw. The ADS did not know when the shakes were thawed because there were no thaw dates on the shakes. 3. During an observation in the resident refrigerator located on the first floor in the utility room on 5/12/2026 at 11:15AM, one nutrition shake, one renal nutrition supplement and one soda were observed stored in the refrigerator with no date. The nutrition shake was thawed with no thaw date. During a concurrent observation and interview with the ADS and the Assistant Director of Nursing (ADON1), the ADS stated the nutrition shake was from the facility and once thawed its only good for 14 days. ADON1 stated that all food and beverages that were stored in the resident refrigerator had to have a date and label indicating to discard within 2 days. During an interview with the director of staff development (DSD) on 5/12/2026 at 11:45AM, the DSD stated everything that was brought from outside was checked in with nurses who would label and date the leftovers before storing them in the resident refrigerator. The DSD stated nursing staff would check dates to discard the food, or beverages once they reach the use by date. The DSD stated the nutritional shake was only good for 2 weeks once thawed, and if there was no date on the shakes facility staff would not know how long the shakes had been there. The DSD said if undated food was given to the residents the residents could get sick. During a review of facility's policy and procedures (p&p) titled Use and storage of food brought ot resident (dated 6/2025) the p&p indicated, The facility strives to support each resident's right to safe food storage, handling, and preparation. To ensure safe food practices and the prevention of foodborne illness, the facility shall provide safe and sanitary storage of food brought to residents by family and visitors for a period not to exceed 48 hours, and in accordance with the following guidelines.Perishable foods must be stored in the refrigerator, in a resealable containers with tightly fitting lids. Containers will be labeled with the resident's name, and the manufacturer use by date as applicable.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical records for two of five sampled residents (Resident 14 and Resident 190), by failing to accurately document on Resident 14's and Resident 190's Dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) Communication Record (a standardized medical document used to safely transfer critical patient information between a dialysis clinic and another care facility). This failure had the potential for nurses (in general) to misinterpret (to understand or explain something incorrectly) the documented information and lead to Resident 14 and Resident 190 receiving inappropriate care and services.Findings: 1.During a review of Resident 14's admission Record, the admission Record indicated the facility admitted the resident on 5/20/2025 with diagnoses that included End Stage Renal Disease (ESRD, irreversible kidney disease) and dependence on renal (kidney) dialysis. During a review of Resident 14's Care Plan Report dated 1/3/2026, the Care Plan Report indicated that the resident was at risk for complications to the right Internal Jugular (IJ, a major blood vessel in the neck) catheter (a soft hollow tube inserted into the IJ vein in the neck and tunneled under the skin to the chest) related to dialysis. During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool) dated 2/19/2026, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 14 received dialysis. During a review of Resident 14's Dialysis Communication Record dated 5/5/2026 at 11:35 AM, the Dialysis Communication Record indicated the resident had a right upper chest IJ catheter. The Dialysis Communication Record indicated a post-dialysis assessment was completed by Licensed Vocational Nurse 13 (LVN 13). The post-dialysis assessment indicated Resident 14's Arteriovenous (AV, a connection between arteries and veins) shunt (a surgically created connection between an artery and vein to provide high volume blood flow required for dialysis) was checked for bruit (a low-pitched, rushing or whooshing sound of blood flowing rapidly through a dialysis access) and thrill (a gentle, rhythmic buzzing or vibrating sensation felt on the skin over a dialysis access). During a review of Resident 14's Dialysis Communication Record dated 5/7/2026 at 11:31 AM, the Dialysis Communication Record indicated the resident had a right upper chest IJ catheter. The Dialysis Communication Record indicated a post-dialysis assessment was completed by LVN 13. The post-dialysis assessment indicated Resident 14's AV shunt was checked for bruit and thrill. During a review of Resident 14's Dialysis Communication Record dated 5/9/2026 at 10:23 AM, the Dialysis Communication Record indicated the resident had a dialysis catheter. The Dialysis Communication Record indicated a pre-dialysis assessment was conducted by LVN 14. The pre-dialysis assessment indicated Resident 14's AV Shunt was checked for the presence of bruit and thrill. The Dialysis Communication Record indicated a post-dialysis assessment was completed by LVN 13. The post-dialysis assessment indicated Resident 14's AV shunt was checked for bruit and thrill. During an interview on 5/13/2026 at 11:35 AM with Resident 14, Resident 14 stated she had a catheter (a flexible tube inserted into a large vein near the heart to filter blood) to her right upper chest for dialysis. Resident 14 stated she went to dialysis every Tuesday, Thursday, and Saturday. During an interview on 5/14/2026 at 1:54 PM with LVN 13, LVN 13 stated she (LVN 13) mistakenly documented that Resident 14's AV shunt was checked for bruit and thrill on the resident's Dialysis Communication Records dated 5/5/2026, 5/7/2026, 5/9/2026, and 5/9/2026. LVN 13 stated that bruit and thrill could only be checked on an AV fistula (a surgically made connection between an artery and a vein for dialysis) or AV shunt. LVN 13 stated Resident 14 had a catheter to her right chest for dialysis. LVN 13 stated that her (LVN 13) documentation on Resident 14's Dialysis Communication Records was not accurate. LVN 13 stated that documentation should be accurate. LVN 13 stated she (LVN 13) would be more careful with (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation in the future. 2. During a review of Resident 190's admission Record, the admission Record indicated the facility admitted the resident on 4/29/2026 with diagnosis that included ESRD and dependence on renal dialysis. During a review of Resident 190's MDS dated [DATE], the MDS indicated the resident was cognitively intact. The MDS indicated Resident 190 received dialysis. During a review of Resident 190's Dialysis Communication Record dated 5/8/2026 at 7:50 AM, the Dialysis Communication Record indicated the resident had a dialysis catheter. The Dialysis Communication Record indicated a pre-dialysis assessment was conducted by LVN 16. The pre-dialysis assessment indicated Resident 190's AV Shunt was checked for the presence of bruit and thrill. The Dialysis Communication Record indicated a post-dialysis assessment was completed by LVN 2. The post-dialysis assessment indicated Resident 190's AV shunt was checked for bruit and thrill. During a review of Resident 190's Dialysis Communication Record dated 5/11/2026 at 7:46 AM, the Dialysis Communication Record indicated the resident had a dialysis catheter. The Dialysis Communication Record indicated a pre-dialysis assessment was conducted by LVN 15. The pre-dialysis assessment indicated Resident 190's AV Shunt was checked for the presence of bruit and thrill. The Dialysis Communication Record indicated a post-dialysis assessment was completed by LVN 2. The post-dialysis assessment indicated Resident 190's AV shunt was checked for bruit and thrill. During a review of Resident 190's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 5/12/2026 to monitor the resident's right-side chest permacath (a long-term, specialized catheter inserted into a large blood vessel, typically in the neck or upper chest for dialysis) for redness, swelling, drainage and pain. During a review of Resident 190's Dialysis Communication Record dated 5/13/2026 at 5:42 AM, the Dialysis Communication Record indicated the resident had a dialysis catheter. The Dialysis Communication Record indicated a pre-dialysis assessment was conducted by LVN 15. The pre-dialysis assessment indicated Resident 190's AV Shunt was checked for the presence of bruit and thrill. The Dialysis Communication Record indicated a post-dialysis assessment was completed LVN 2. The post-dialysis assessment indicated Resident 190's AV shunt was checked for bruit and thrill. During a concurrent interview and record review on 5/14/2026 at 1:46 PM with LVN 2, Resident 190's Dialysis Communication Records dated 5/11/2026 and 5/13/2026 were reviewed. LVN 2 stated she mistakenly documented Resident 190's AV shunt was checked for the presence of bruit and thrill. LVN 2 stated that she did not mean to document that bruit and thrill were checked. LVN 2 stated Resident 190's dialysis access was a right upper chest permacath. LVN 2 stated that bruit and thrill were only checked for an AV fistula or an AV shunt. LVN 2 stated that documentation should be accurate and reflect Resident 190's status. LVN 2 stated there was potential for documentation to be misinterpreted if the documentation was not accurate. During a concurrent interview and record review on 5/14/2026 at 3:17 PM with the Director of Nursing (DON), Resident 14's Dialysis Communication Records dated 5/5/2026, 5/7/2026, and 5/9/2026 were reviewed. Resident 190's Dialysis Communication Records dated 5/8/2026, 5/11/2026, and 5/13/2026 were also reviewed with the DON. The DON stated the Dialysis Communication Records indicated that the AV Shunts for Resident 14 and Resident 190 were checked for the presence of bruit and thrill. The DON stated that the documentation that indicated Resident 14's and Resident 190's AV shunts were checked for bruit and thrill was not accurate. The DON stated Resident 14 had a right upper chest IJ catheter and Resident 190 had a right upper chest permacath. The DON stated checking for bruit and thrill was only done with an AV fistula or AV shunt. The DON stated bruit and thrill was not assessed on a resident (in general) with an IJ catheter or permacath for dialysis access. The DON stated documentation had to be accurate. The DON stated documentation had to reflect a proper assessment. The DON stated that inaccurate documentation could mislead the nurses (in general) to perform an assessment or provide an intervention that was not appropriate for Resident 14 or Resident 190. The DON stated the nurses (in general) had to accurately check, assess, and document. During a review of the facility's Policy and Procedure (P&P) titled Documentation Policy reviewed 4/14/2026, the P&P indicated It is the policy of this facility to document relevant findings in the clinical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facilityˆfailedˆtoˆmaintain infection control practices (the set of everyday habits and rules used to stop germs such as viruses and bacteria from spreading) necessary to prevent the spread of infections forˆfour of nine sampled residents (Resident 7, Resident 9, Resident 175, and Resident 186) by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 5 rinsed Resident 7' medication syringe after administering medications via 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) and before putting the syringe away as indicated by the facility's Policy and Procedures (P&P) titled Medication Administration Through Gastrostomy Tube, last reviewed 1/2026, and as indicated in the facility's P&P titled Enteral Feeding [a way of delivering liquid nutrition directly to your stomach] - Restore Eating Skills, last reviewed 4/14/2026.2. Ensure Treatment Nurse (a specialized nurse who focuses on hands-on, procedural care) 2 (TX 2) was wearing a personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) gown when providing g-tube dressing care for Resident 9, who was on enhanced barrier precautions (EBP - an infection control strategy used in nursing homes and skilled nursing facilities to prevent the spread of infection) as indicated by the facility's P&P titled Infection and Prevention and Control, last reviewed 4/14/2026.3. Ensure the enteral feeding tubes for Resident 175 and Resident 186 were capped (putting a plug or cover over the opening of the feeding tube when it is not being used to deliver food or medicine) and not open to air as indicated by the facility's P&P titled, Infection and Prevention and Control, last reviewed 4/14/2026 and as indicated by the facility's P&P titled, Enteral Feeding - Safety Precautions, last reviewed 4/14/2026.ˆ Cross reference F0693. This failure had the potential to increase the residents' risk of contamination (harmful germs like bacteria or fungus have gotten into the feeding tube or the liquid food) and had the potential to increase the residents' risk of infection.ˆFindings: 1. During a review of Resident 7's admission Record (a document containing demographic and diagnostic information) dated 5/13/2026, the admission record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to acute transverse myelitis in demyelinating disease of central nervous system (a brief but intense attack of inflammation [swelling] in the spinal cord that damages myelin [protective covering of nerve fibers]), encounter for attention to gastrostomy (g-tube) and gastro-esophageal reflux disease ([GERD] – a condition where stomach acid flows back up into the esophagus and causes heartburn) without esophagitis (swelling and irritation of tissues that line esophagus). During a review of Resident 7's History and Physical (H&P), dated 5/4/2026, the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set ([MDS], a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 7's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was moderately impaired. The MDS indicated Resident 7 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. The MDS indicated the function of eating was not attempted due to medical condition or safety reasons. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication administration observation on 5/13/2026 at 9:29 a.m. outside Resident 7's room, Licensed Vocational Nurse 5 (LVN 5) was observed preparing eight medications by crushing them individually using a crushing device and dissolving each medication in water separately into small individual medicine cups, to be administered to Resident 7 via g-tube and one injection syringe of enoxaparin (a prescription blood thinner used to prevent and treat harmful blood clots in your veins, legs, or lungs) , for a total of nine medications. LVN 5 entered Resident 7's room and placed the prepared medications on bedside cart without disinfecting the bedside cart. LVN 5 checked for Resident 7's g-tube placement (observing stomach contents, ensuring the measured length matches the recorded baseline, and confirming the skin-to-tube fit) and connected the 60 mL syringe to the g-tube to check for gastric residual volume (the amount of fluid remaining in the stomach of a person being fed through a feeding tube). LVN 5 stated there was very little, less than 1 mL[milliliter] residual in g-tube administration syringe. LVN 5 removed the 60 mL syringe from the g-tube and brought the medicine syringe near the medicine cups. LVN 5 pushed out a couple of droplets of the residual liquid onto the bedside cart with prepared medicines while removing the plunger from the 60 mL syringe. LVN 5 continued with a water flush and then administered the medications administration one by one via g-tube to Resident 7. After administering all medications for Resident 7, LVN 5 disconnected the 60 mL syringe and placed the syringe back in the syringe bag without rinsing and cleaning the syringe. During a follow up interview on 5/13/2026 at 10:04 a.m. with LVN 5, LVN 5 stated there would be a risk of infection because a few drops from residual volume pushed out from syringe onto Resident 7's bedside table before she (LVN 5) started administering medications. LVN 5 stated she should have rinsed out the syringe after g-tube administration before putting it away to keep the syringe clean and patent [intact]. During an interview on 5/14/2026 at 12:39 p.m. with the Director of Nursing (DON), the DON stated were to disinfect areas around the resident. The DON stated the syringe used to administer medications via g-tube should have been cleaned and disinfected to prevent spread of infection. The DON stated the nursing staff should have rinsed the syringe after g-tube administration of medications otherwise the g-tube syringe should have been replaced with a new clean syringe. During a review of the facility's P&P titled, Medication Administration Through Gastrostomy Tube, last reviewed 1/2026, the P&P indicated, Procedure. 25. Rinse the syringe utilized for medication instillation and store in a clean manner. During a review of the facility's P&P titled, Infection and Prevention and Control, last revised 1/2026, the P&P indicated, The facility has an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. During a review of Resident 9's admission record, the admission record indicated the facility originally admitted Resident 9 on 12/31/2014 and re-admitted the resident on 4/13/2026 with diagnoses including gastrostomy tube, respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and metabolic encephalopathy (a condition in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood). During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had impaired cognition for daily decision-making and dependent (helper does all the effort) from staff for activities (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 9 was at risk of developing pressure ulcers/injuries with treatment for pressure reducing devices for bed. During a review of Resident 9's care plan initiated on 4/13/2026, care plan indicated Resident 9 was on EBP related to gastrostomy with intervention to promote importance of EBP including proper hand hygiene and wearing PPE during high contact resident activities. During a review of Resident 9's H&P dated 4/20/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's order summary report, dated 5/12/2026, the order summary report indicated that Resident 9 had an order for an EBP due to gastrostomy. During a concurrent observation and interview with treatment nurse 2 (TX 2), on 5/13/2026 at 12:01 PM, Resident 9's room was observed with EBP signage indicating that providers and staff (general) had to wear gloves and a gown for high contact resident care activities such as ADLs (dressing, grooming, bathing, changing bed linens), toileting and changing incontinence briefs, caring for devices and giving medical treatments, wound care, mobility assistance and preparing to leave room and cleaning the environment. TX 2 was observed not wearing a gown during the gastrostomy tube site dressing change. TX 2 verbalized having forgotten to wear a gown. TX 2 stated that it was important to wear both the gloves and gown during a gastrostomy tube site dressing change for Resident 9 due to Resident 9 being high risk for infection. During an interview on 5/13/2026 at 12:13 PM, with the Director of Nursing (DON), the DON stated the treatment nurse should have been wearing gloves and gowns when doing any type of wound care dressing to prevent any infections to the residents in EBP. During a review of facility's P&P, titled, Infection and Prevention and Control, reviewed on 4/14/2026, the P&P indicated that facility had an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. The P&P indicated facility staff had to ensure EBP were used in conjunction with standard precautions and expanded the use of PPE to donning (putting on) of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO (multi-drug-resistant organism-bacteria that have become resistant to certain antibiotic medications) to staff hands and clothing. 3a. During a review of Resident 175's admission Record, the admission Record indicated the facility originally admitted Resident 175 on 5/23/2025 and readmitted Resident 175 on 1/16/2026 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (the person survived a stroke, which left them with weakness or paralysis [the loss of the ability to move or feel in all or part of the body] on the left side of their body), dysphagia (difficulty swallowing), muscle weakness, type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), acquired absence of other specified parts of digestive tract (a part of the digestive system was surgically removed), and reduced mobility. During a review of Resident 175's Care Plan Report, titled The Resident (Resident 175) has enteral feeding and must maintain nutritional status via feeding tube r/t (related to) inability to swallow, dated 2/11/2025, the Care Plan Report indicated an intervention to use clean technique when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administering tube feedings. During a review of Resident 175's Care Plan Report, titled Gastrostomy tube feeding: Resident (Resident 175) has is on gastrostomy tube (GT - gastrostomy tube -a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) feeding. At risk for aspiration (means food, liquid, or stomach contents go down the wrong pipe and enter your lungs), dehydration (a condition that occurs when the body loses more fluid than it takes in), weight fluctuation, weight gain, weight loss, nausea and vomiting, abdominal distention (stomach is visibly swollen, stretched, or sticking out further than usual), diarrhea, constipation (hard, dry, or difficult to pass stool), intolerance to feeding r/t dysphagia, dated 2/11/2025, the Care Plan Report indicated an intervention to change tubing per policy or as ordered. During a review of Resident 175's Care Plan Report, titled Enhanced Barrier Precautions (EBP - an infection control strategy used in nursing homes and skilled nursing facilities to prevent the spread of multidrug-resistant organisms that requires facility staff to use gown and gloves during high contact resident care activities) related to gastrostomy tube, dated 2/11/2025, the Care Plan Report indicated a goal for the facility to minimize risk and complications of infection. The Care Plan Report indicated an intervention to promote EBP. During a review of Resident 175's H&P dated 3/4/2026, the H&P indicated Resident 175 did not have the capacity (ability) to understand and make decisions. The H&P indicated Resident 175 had an intact GT. The H&P indicated Resident 175 was s/p (status post - condition after) urinary tract infection (UTI- an infection in the bladder/urinary tract) with sepsis (a life-threatening blood infection). The H&P indicated Resident 175's prognosis (a medical prediction about how an illness, disease, or injury will progress over time) was poor. During a review of Resident 175's MDS dated [DATE], the MDS indicated Resident 175 had no speech (absence of spoken word), rarely/never could make himself (Resident 175) understood, and rarely/never had the ability to understand others. During a review of Resident 175's Order Summary Report dated 5/13/2026, the Order Summary Report indicated Resident 175 had a physician order for enteral feeding (the delivery of liquid nutrients directly into the stomach or small intestine through a GT). The Order Summary Report Resident 175 had a physician order for enhanced barrier precautions due to gastrostomy tube. During a concurrent observation and interview on 5/11/2026 at 11:44 AM with LVN 7 in Resident 175's room, Resident 175's enteral feeding tube was observed to be uncapped and open to air. A photo was taken of the uncapped enteral feeding tube. LVN 7 verified Resident 175's enteral feeding tube was uncapped and stated Resident 175 could have been at risk for infection if staff connected the uncapped enteral feeding tube to Resident 175. LVN 7 stated she (LVN 7) would need to change Resident 175's enteral tube feeding system. During an interview on 5/13/2025 at 10:22 AM with Registered Nurse 3 (RN 3), RN 3 stated there could be an infection control issue if Resident 186's enteral feeding tube was uncapped and left open to air. During a concurrent interview and record review on 5/14/2026 at 5:09 PM, with the DON, the DON reviewed the facility's P&P titled Infection and Prevention and Control, last reviewed 4/14/2026. The DON stated the facility should have capped Resident 175's enteral feeding tube if the enteral feeding (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had been disconnected from Resident 175's gastrostomy tube for infection control. 3b. During a review of Resident 186's admission Record, the admission Record indicated the facility originally admitted Resident 186 on 3/9/2026 and readmitted Resident 186 on 4/27/2026 with diagnoses that included epilepsy (a brain disorder that causes repeated, unprovoked seizures), aphasia (a disorder that makes it difficult to speak), type 2 Diabetes Mellitus, muscle weakness, dysphagia (difficulty swallowing), and essential hypertension (HTN-high blood pressure). During a review of Resident 186's MDS dated [DATE], the MDS indicated Resident 186 had unclear speech (slurred or mumbled words), rarely could make himself (Resident 186) understood, and rarely had the ability to understand others. During a review of Resident 186's Care Plan Report, titled At risk for infection – GT: Resident at risk for infection due to gastrostomy tube site, dated 4/27/2026, the Care Plan Report indicated a goal for the facility to minimize risk for infection at the GT site. The Care Plan Report indicated an intervention for the facility to change tubings per policy or as ordered. During a review of Resident 186's Care Plan Report, titled Enhanced Barrier Precaution: Enhanced Barrier Precaution related to Gtube (GT), dated 4/27/2026, the Care Plan Report indicated a goal to minimize risk and complications of infection. During a review of Resident 186's H&P dated 5/6/2026, the H&P indicated Resident 186 did not have capacity to understand and make decisions. The H&P indicated Resident 186 was s/p fever of unknown etiology (having a high temperature without a clear cause) and s/p c-diff (clostridium difficile - a highly contagious bacteria that causes severe diarrhea) colitis, (swelling or inflammation of the inner lining of your large intestine). During a review of Resident 186's Order Summary Report, dated 5/13/2026, the Order Summary Report indicated Resident 186 had a physician order for enteral feeding. The Order Summary Report indicated Resident 186 had a physician order for EBP. The Order Summary Report indicated Resident 186 had a physician order to monitor the GT site for signs and symptoms of infection. During a concurrent observation and interview on 5/11/2026 11:45 AM with LVN 7 in Resident 186's room, Resident 186's enteral feeding tube was observed to be uncapped and open to air. LVN 7 verified Resident 186's enteral feeding tube was uncapped and stated Resident 186 could be at risk for infection if staff connected the uncapped enteral feeding tube to Resident 186. LVN 7 stated she (LVN 7) would need to change Resident 186's enteral tube feeding system. During an interview on 5/13/2025 at 10:22 AM with RN 3, RN 3 stated there could be an infection control issue if Resident 186's enteral feeding tube was uncapped and left open to air. During a concurrent interview and record review on 5/14/2026 at 5:09 PM, with the DON the facility's P&P titled Infection and Prevention and Control, last reviewed 4/14/2026, the DON stated the facility should have capped Resident 186's enteral feeding tube if the enteral feeding had been disconnected from Resident 186's gastrostomy tube for infection control. During a review of the facility's P&P titled Enteral Feeding – Safety Precautions, last reviewed 4/14/2026, the P&P indicated the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. 3. Staff maintains clean technique when working with enteral nutrition systems and formulas. During a review of the facility's P&P titled Infection and Prevention and Control, last reviewed 4/14/2026, the P&P indicated The facility has an infection prevention and control program designed to provide a safe, sanitary (clean), and comfortable environment and to help prevent the development and transmission of communicable diseases and infections (spread of germs like viruses, bacteria, or fungus). The P&P indicated Standard Precautions: The infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions (fluids made and released by your organs, glands, and cells), excretions (the ways your body gets rid of waste and extra fluids) except sweat, regardless of whether they contain visible blood, non-intact skin (any area where the skin's natural, protective outer barrier is broken, damaged, or missing), and mucous membranes (the moist, inner lining of some organs and body cavities such as the nose, mouth lungs, and stomach) may contain transmissible infectious agents (germs or pathogens, are microscopic organism such as viruses, bacteria, fungi, and parasites that can invade your body, multiply, and cause illness). Furthermore, equipment or items in the resident's environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 17) who could not self-administer medications did not self-administer Vitamin C (a supplement used to support immune health [body's ability to defend itself against harmful bacteria and viruses], collagen [protein in the body] production, and antioxidant defenses [substances that may prevent or delay some types of cell damage]). This failure had the potential for Resident 17 to self-medicate and result in unsafe medication administration. Findings: During a review of Resident 17's admission Record, the admission Record indicated the facility readmitted the Resident on 9/15/2025, with diagnoses that included pneumonia (an infection/inflammation in the lungs), larynx (commonly called the voice box, a hollow organ in the neck located just about the windpipe) cancer, and gastronomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 17's History and Physical (H&P) dated 9/15/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 17's Self Administration of Medication assessment dated [DATE], the Self Administration of Medication Assessment indicated the resident was not a candidate for safe self-administration of medications. The Self Administration of Medication Assessment indicated no physician orders to self-administer medications were obtained nor was a care plan for self-administration of medication implemented. During a review of Resident 17's Speech-Language Pathologist Discharge summary dated [DATE], the Speech-Language Pathologist Discharge Summary indicated oral intake was not safe for Resident 17. The Speech-Language Pathologist Discharge Summary indicated Resident 17 needed to see an ear, nose, and throat (ENT, a physician specializing in medical conditions of the ear, nose, throat, and neck) doctor for further evaluation. During a review of Resident 17's Rehab Dysphagia [difficulty swallowing] Screen dated 11/4/2025, the Rehab Dysphagia Screen indicated Resident 17 had severe dysphagia and to continue nothing by mouth (NPO, a safety measure used to instruct a resident to not eat or drink anything) with current orders of enteral feeding (a feeding tube that delivers liquid nutrition directly to the stomach or small intestine). During a review of Resident 17's Ear, Nose, Throat, and Allergy medical records dated 2/26/2026, the medical records indicated Clearance for oral intake to be determined by speech therapy based on swallow evaluation. During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2026, the MDS indicated the resident was cognitively intact (able to independently make decisions regarding tasks of daily life). The MDS indicated that the resident needed touching assistance (helper provides verbal cues or steadying as resident completes activity) from facility staff to complete activities of daily living (ADLs, activities a person performs daily such as bathing, dressing, and toileting). During a review of Resident 17's Order Summary Report dated 5/13/2026, the Order Summary Report did not indicate any physician orders to self-administer medications. During a review of Resident 17's Care Plan Report dated 5/13/2026, the Care Plan Report did not indicate any focus, goal, nor interventions for self-administration of medications. During a concurrent observation and interview on 5/11/2026 at 10:19 AM with Resident 17 in Resident 17's room, Resident 17 used a key to unlock his closet to retrieve an unsealed bottle of Vitamin C supplements. The bottle label indicated the following information: Nature Made, [Vitamin] C extra strength 1000 mg [milligram, a metric unit of measurement, used for medication dosage and/or amount], and 100 tablets. Resident 17 stated he (Resident 17) would take one Vitamin C supplement by mouth every other day in the morning. During an interview on 5/13/2026 at 11:46 AM with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated she (CNA6) was unaware if Resident 17 kept medications at bedside. CNA 6 stated licensed nurses (in general) were responsible for medication administration. During an interview on 5/13/2026 at 11:50 AM with Licensed Vocational Nurse 11 (LVN 11), LVN 11 stated residents (in general) were allowed (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain dignity (providing care that respects a resident's self-esteem, identity, and personal choices) and respect for one of one sampled resident (Resident 83) when the resident's chest was left exposed with the privacy curtain (a fabric partition used to block the line of sight between beds) pulled open. This failure had the potential to violate Resident 83's right to personal dignity, privacy, and respect, and could negatively affect Resident 83's psychosocial well-being and have impact on Resident 83's self-esteem (sense of personal worth and value).Findings: During a review of Resident 83's admission Record, the admission Record indicated the resident was a [AGE] year old woman who was admitted to the facility on [DATE] with diagnoses that included quadriplegia (paralysis from the neck down, including legs and arms, usually due to a spinal cord injury), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), bed confinement status (when a resident is unable to safely leave their bed without significant or total assistance), dementia (a progressive state of decline in mental abilities), unspecified intellectual disabilities (a condition characterized by significantly below-average intelligence and limitations in daily living skills), and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle of the right shoulder, left shoulder, right hand, and left hand. During a review of Resident 83's Minimum Data Set (MDS, a resident assessment tool) dated 5/1/2026, the MDS indicated the resident had severely impaired (never/rarely made decisions) cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 83 was dependent on facility staff for help with oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 5/11/2026 at 10:21 AM, in Resident 83's room, the resident was observed lying in bed. Resident 83's gown was observed bunched up around the resident's upper chest and neck. Resident 83's abdomen and chest were exposed. Resident 83's privacy curtain was observed pulled open. Staff (in general) were observed passing by Resident 83's room. During a concurrent observation and interview on 5/11/2026 at 10:23 AM with Certified Nursing Assistant 3 (CNA 3), in Resident 83's room, CNA 3 confirmed by stating Resident 83's privacy curtains were pulled open and the resident had her (Resident 83) chest exposed. CNA 3 was observed pulling down Resident 83's gown to cover the resident's chest. CNA 3 stated Resident 83 should have been covered and provided with privacy to maintain Resident 83's dignity. During an interview on 5/14/2026 at 10:30 AM with Registered Nurse 3 (RN 3), RN 3 stated if staff (in general) passed by a resident's (in general) room and noted that the resident (in general) was exposed, the staff should have covered the resident (in general) and provided the resident (in general) with privacy using the privacy curtain. RN 3 stated Resident 83 should have been covered to maintain the resident's (in general) privacy and dignity. During an interview on 5/14/2026 at 3:06 PM with the Director of Nursing (DON), the DON stated Resident 83 could not verbalize the needs and was totally dependent on staff for care. The DON stated staff (in general) should have protected Resident 83's privacy and dignity even though the resident could not call for help or verbalize needs. The DON stated staff (in general) were expected to provide Resident 83 with privacy to maintain the resident's dignity. The DON stated staff should have ensured privacy by drawing Resident 83's curtain, covering the resident with the gown and blanket, and making sure the resident's clothing was secured. The DON stated that if Resident 83 was exposed there was potential for the resident's dignity to be affected. During a review of the facility's Policy and Procedure (P&P) titled Dignity and Respect dated 1/2026, the P&P indicated Each resident shall be cared for in a manner that promotes and enhances (continued on next page)

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	555397	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Los Angeles	340 South Alvarado Street Los Angeles, CA 90057

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quality of life, dignity, respect, and individuality.Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. During a review of the facility's P&P titled Privacy and Confidentiality last reviewed 4/14/2026, the P&P indicated During the delivery of personal care and services, staff prevent exposure of the resident's body parts by pulling privacy curtains or closing doors and providing clothing or draping to prevent public view.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Resident 138's privacy curtain was completely closed, and private area was exposed during morning care for one of one sampled resident.This deficient practice had the potential to result in compromised resident dignity, embarrassment, emotional distress, and loss of privacy during care.During a review of Resident 138's admission Record (Face Sheet), the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (paralysis and weakness on one side of the body following a stroke), functional quadriplegia (complete immobility due to severe physical disability), type 2 diabetes mellitus with hyperglycemia (high blood sugar due to the body not properly using insulin), cognitive communication deficit (difficulty understanding or expressing thoughts), essential hypertension (chronic high blood pressure), acute and chronic respiratory failure with hypoxia (inability to maintain adequate oxygen levels) and muscle weakness (reduced muscle strength affecting mobility and physical function). During a review of Resident 138's Minimum Data Set (MDS- a resident assessment tool), dated 04/12/2026, the MDS indicated Resident 138 had severely impaired cognitive skills for daily decision-making. The MDS indicated has memory problems with short-term and long-term memory and required extensive staff assistance for activities of daily living (ADLs), including personal hygiene, toileting hygiene, dressing, bathing, transfers, and mobility.During an observation on 05/13/2026 at 9:08 a.m. Resident 138 was observed receiving morning care from Certified Nursing Assistant 1 (CNA 1). The privacy curtain was observed halfway open and the lower part of Resident 138's body was exposed. CNA left Resident 138 partially exposed while she went to obtain assistance from another CNA. The resident's call light was also observed on the floor.During a concurrent interview on 05/13/2026 at 10:04 a.m., the Registered Nurse 1 (RN 1) Supervisor stated residents should be provided privacy during care and stated, RN1 stated If I were him, I would be upset.During a concurrent interview on 05/13/2026 at 10:18 a.m., the Director of Nursing (DON) stated that leaving a resident exposed during morning care may place the resident at risk for emotional distress, embarrassment, humiliation, loss of dignity, anxiety, and psychological discomfort. During a record review of the facility's policy and procedure (P&P), titled Privacy and Confidentiality, revised 03/2023, the P & P indicated residents have the right to personal privacy during personal care. The P & P indicated staff shall prevent exposure of the resident's body parts during the delivery of personal care and services by pulling privacy curtains or closing doors and providing clothing or draping to prevent public view.

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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. Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 186) reviewed for unnecessary medications such as psychotropic (any drug that affects the mental function, behavior, and mood) medications had an end date (expiration date of the physician order) for the use of Ativan (help calm the nervous system) as needed (PRN). This failure had the potential for Resident 186 to become over-medicated, restrict mobility, and experience adverse side effects (unexpected or harmful consequences of medication) such as dizziness and sedation (decrease in awareness).Findings: During a review of Resident 186's admission Record, the admission Record indicated the facility originally admitted Resident 186 on 3/9/2026 and readmitted Resident 186 on 4/27/2026 with diagnoses that included epilepsy (a brain disorder that causes repeated, unprovoked seizures), aphasia (a disorder that makes it difficult to speak), type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, dysphagia (difficulty swallowing), and essential hypertension (HTN-high blood pressure). During a review of Resident 186's Minimum Data Set (MDS, a resident assessment tool) dated 3/15/2026, the MDS indicated Resident 186 had no speech, rarely could make himself (Resident 186) understood, and rarely had the ability to understand others. During a review of Resident 186's History and Physical (H&P), dated 5/6/2026, the H&P indicated Resident 186 did not have the capacity (ability) to understand and make decisions. During a concurrent interview and record review on 5/14/2026 at 2:38 PM with Licensed Vocational Nurse 9 (LVN 9) and Registered Nurse 3 (RN 3), Resident 186's Order Summary Report dated 5/13/2026 was reviewed. The Order Summary Report indicated Resident 186 had physician order for Ativan 2 milligrams (mg- metric unit of measurement), intramuscularly (giving a medication or vaccine by injecting it directly into a muscle) as needed for seizure with a start date of 4/27/2026. The Order Summary Report indicated Resident 186's order for Ativan 2mg intramuscularly as needed for seizure did not have an end date LVN 9 and RN 3 verified Resident 186's Ativan 2mg intramuscularly as needed for seizure did not have an end date. During a concurrent interview and record review on 5/14/2026 at 2:38 PM with LVN 9 and Registered Nurse 3 RN 3, the facility's policy and procedure (P&P) titled, Dignity and Respect Psychoactive Medications, last reviewed 4/14/2026, the P&P indicated the following: 3. Residents shall not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and PRN orders for psychotropic drugs shall be limited to 14 days. LVN 9 and RN 3 stated the facility did not follow their policy and the physician order for Ativan 2mg intramuscularly as needed for seizure should have been limited to 14 days. During a concurrent interview and record review on 5/14/2026 at 4:46 PM with the Director of Nursing (DON), 2:38 PM with Licensed Vocational Nurse 9 (LVN 9) and Registered Nurse 3 (RN 3), Resident 186's Order Summary Report dated 5/13/2026 was reviewed. The Order Summary Report indicated Resident 186 had physician order for Ativan 2mg intramuscularly as needed for seizure with a start date of 4/27/2026. The Order Summary Report indicated Resident 186's order for Ativan 2mg intramuscularly as needed for seizure did not have an end date. The DON verified Resident 186's Ativan 2mg intramuscularly as needed for seizure did not have an end date. The DON stated Resident 186's order for Ativan 2mg intramuscularly as needed for seizure should have had a 14-day end date.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide a written notice of transfer or discharge to the Office of the State Long-Term Care Ombudsman (LTC Ombudsman-an independent, neutral official who investigates and resolves complaints) for one of 10 sampled residents (Resident 3) on 5/11/2026, when Resident 3 was transferred to hospital (GACH) on 5/11/2026. This deficient practice had the potential to prevent the LTC Ombudsman from being informed of Resident 3's facility-initiated transfer and from identifying, monitoring, or addressing potential resident rights concerns related to the transfer.Findings: During a review of Resident 3's admission record, the admission record indicated the facility originally admitted Resident 3 on 3/14/2026 and re-admitted the resident on 4/3/2026 with diagnoses including acute and chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), and encephalopathy (a condition in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood). During a review of Resident 3's Minimum Data Set (MDS - a standardized assessment tool) dated 3/18/2026, the MDS indicated Resident 3 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and mostly dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 3's History and Physical (H&P) dated 4/6/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Resident Transfer Record (RTR) dated 5/11/2026, Resident 3's RTR indicated Resident 3 was transferred to GACH due to tachycardia (heart rate faster than normal) and having difficulty maintaining adequate oxygen saturation levels. During a review of Resident 3's Notice of Proposed Transfer and Discharge (NPTD-an official, written warning from a nursing home stating an intent to discharge or transfer the resident) dated 5/11/2026, the NPTD indicated that the discharge was necessary for Resident 3 due to the resident's need not being able to be met by the facility. During a concurrent interview and record review on 5/14/2026 at 8:20 AM, with Medical Record Assistant 1 (MRA1), Resident 3's NPTD Facsimile (fax) report was reviewed. Resident 3's NPTD fax report indicated NPTD was faxed on 5/13/2026 at 11:18 AM. MRA 1 stated no fax report was completed and indicated in Resident 3's medical record on 5/11/2026 (date of transfer). MRA 1 stated that she (MRA 1) faxed Resident 3's NPTD on 5/13/2026 since it was requested by the surveyor. During an interview on 5/14/2026 at 9:54 AM, with the Director of Nursing (DON), the DON stated that it was best practice to notify the LTC Ombudsman via fax as soon as possible when a resident was transferred to another facility so LTC Ombudsman could be made aware of resident's status. The DON stated that the NPTD fax report should have been maintained and kept in residents' medical records. During a review of facility's P&P, titled Documentation of Discharge or Transferring Resident reviewed on 4/14/2026, the P&P indicated when a resident was temporarily transferred on an emergency basis to an acute care facility a notice of transfer was to be provided to the resident and resident representative and the facility was to forward a copy of the notices to the Ombudsman. The P&P indicated that facility was to maintain evidence that the notice was sent to the Ombudsman.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) for the use of tobacco was accurately completed for one of two sampled residents (Resident 57).This deficient practice had the potential for Resident 57 to receive inadequate and improper care at the facility.Findings: During a review of Resident 57's admission Record, the admission Record indicated the facility admitted the resident on 3/7/2025 with diagnoses that included spondylosis (age related wear and tear of the spinal disks in the neck), type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), diverticulosis (the presence of small, bulging pouches in the lining of the large intestine), muscle weakness, and history of falling. During a review of Resident 57's Care Plan Report dated 9/9/2025, the Care Plan Report indicated the resident was a smoker. The Care Plan Report indicated Resident 57 was at risk for injury, non-compliance (failure or refusal to follow rules), and respiratory illness (any condition that affects the lungs and airways, making it hard to breathe). The Care Plan Report indicated Resident 57 was informed of the facility's smoking guidelines. The Care Plan Report indicated Resident 57 was provided with instructions on safe smoking. During a review of Resident 57's Smoking Risk Assessment (an evaluation used to determine if a resident can safely smoke tobacco) dated 2/23/2026, the Smoking Risk Assessment indicated the resident was a smoker at the time of the assessment. During a review of Resident 57's MDS, dated [DATE], the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 57 did not currently tobacco at the time of the assessment. During a review of the facility's Resident Smoking List dated 5/11/2026, the Resident Smoking List indicated Resident 57 was a smoker. During a concurrent interview and record review on 5/14/2026 at 10:05 AM with the Minimum Data Set Licensed Vocational Nurse (MDS 1), Resident 57's Smoking Risk assessment dated [DATE], Care Plan Report dated 9/9/2025, and MDS dated [DATE] were reviewed. MDS 1 stated Resident 57's Smoking Risk Assessment and Care Plan Report indicated the resident was a smoker. MDS 1 stated Resident 57's MDS dated [DATE] indicated the resident did not use tobacco. MDS 1 stated Resident 57's MDS was inaccurate and did not reflect the resident's smoking status. MDS 1 stated Resident 57's MDS should have indicated that the resident smoked. MDS 1 stated the MDS assessment should have been accurate. MDS 1 stated the MDS assessment reflected the care that Resident 57 had been receiving at the facility. MDS 1 stated that if the MDS was inaccurate there was potential for Resident 57's care at the facility to be affected. During an interview on 5/14/2026 at 10:25 AM with Resident 57, the resident stated he smoked one cigarettes daily. During a concurrent interview and record review on 5/14/2026 at 3:10 PM with the Director of Nursing (DON), Resident 57's Smoking Risk assessment dated [DATE], Care Plan Report dated 9/9/2025, and MDS dated [DATE] were reviewed. The DON stated Resident 57 was a smoker. The DON stated Resident 57's MDS dated [DATE] indicated the resident was not a smoker and did not use tobacco. The DON stated Resident 57's MDS was inaccurate. The DON stated Resident 57's MDS should have indicated the resident used tobacco. The DON stated the MDS should have captured all of Resident 57's necessary information. The DON stated the MDS should have been documented with accuracy. The DON stated the MDS determined the care that was being provided to Resident 57. The DON stated an inaccurate MDS would potentially mislead Resident 57's care. During a review of the facility's Policy & Procedure (P&P) titled Resident Assessment dated 1/2026, the P&P indicated Initially and periodically, the facility conducts a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to update and revise the End Stage Renal Disease (ESRD, irreversible kidney disease) and dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) care plan (a plan of care that summarizes a resident's health conditions, current treatments, and specific care and services facility staff (in general) need to provide a resident to promote healing and prevent a worsening of a condition) for one out of five sampled residents (Resident 14). By Failing to update Resident 14's care plan on 5/5/2026 when the resident's pick-up time for dialysis was changed. This failure had potential for Resident 14 to miss dialysis and receive care that was not in alignment with the resident's physician orders.Findings:During a review of Resident 14's admission Record, the admission Record indicated the facility admitted the resident on 5/20/2025 with diagnoses that included ESRD and dependence on renal (kidney) dialysis. During a review of Resident 14's Care Plan Report dated 11/14/2025, the Care Plan Report indicated the resident had potential for complications of ESRD and dialysis. The Care Plan Report indicated a goal for Resident 14 to remain free of complications related to renal disease or dialysis through the review date. The Care Plan Report indicated an intervention to assist Resident 14 in the coordination of the dialysis schedule as ordered. The Care Plan Report indicated Resident 14 had physician orders for dialysis every Tuesday, Thursday, and Saturday. The Care Plan Report indicated Resident 14 was to be picked up by transportation for dialysis at 1:15 PM. During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool) dated 2/19/2026, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 14 received dialysis. During a review of Resident 14's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 5/5/2026, for dialysis three times a week every week on Tuesday, Thursday, and Saturday at 12:15 PM. The physician order indicated Resident 14 was to be picked up by transportation for dialysis at 11:30 AM. During a concurrent interview and record review on 5/14/2026 at 9:50 AM with Registered Nurse 3 (RN 3), Resident 14's Care Plan Report dated 11/14/2025 and physician order dated 5/5/2026 were reviewed. RN 3 stated Resident 14 had physician orders for dialysis every Tuesday, Thursday, and Saturday. RN 3 stated Resident 14 was to be picked up by transportation for dialysis at 11:30 AM. RN 3 stated Resident 14's Care Plan Report did not reflect the resident's active physician orders for dialysis. RN 3 stated it was important that the care plan reflected Resident 14's active plan of care. RN 3 stated the care plan had to match the care Resident 14 was receiving. RN 3 stated Resident 14's care plan was inaccurate because the care plan did not match the resident's physician orders. RN 3 stated Resident 14's care plan needed to be revised to match the resident's physician orders. RN 3 stated there was potential for the staff (in general) to not know what Resident 14's current dialysis schedule was, and the staff (in general) could get confused about resident's dialysis schedule. During a concurrent interview and record review on 5/14/2026 at 10:14 AM with the MDS Licensed Vocational Nurse (MDS 1), Resident 14's Care Plan Report dated 11/14/2025 and physician order dated 5/5/2026 were reviewed. MDS 1 stated Resident 14 had a physician order for dialysis every Tuesday, Thursday, and Saturday at 12:15 PM. MDS 1 stated Resident 14's care plan did not reflect the resident's current physician orders for dialysis. MDS 1 stated Resident 14's care plan should have been revised on 5/5/2026 to include the resident's current physician order for dialysis. MDS 1 stated if Resident 14's care plan was not revised there was potential for the staff to not be aware of the residents' active physician orders for dialysis. During a concurrent interview and record review at 5/14/2026 at 3:17 PM with the Director of Nursing (DON), Resident 14's Care Plan Report dated 11/14/2025 and physician order dated 5/5/2026 were reviewed. The DON stated Resident 14 had physician orders for dialysis that indicated the resident was to have dialysis every Tuesday, Thursday, and Saturday at 12:15 PM. The DON (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the physician order indicated Resident 14 was to be picked up by transportation for dialysis at 11:30 AM. The DON stated Resident 14's care plan indicated to assist the resident in the coordination of dialysis every Tuesday, Thursday, and Saturday. The DON stated Resident 14's care plan indicated the resident was to be picked up by transportation for dialysis at 1:15 PM. The DON stated the dialysis order listed on Resident 14's care plan was from a previous physician order. The DON stated Resident 14's care plan should have reflected the resident's active physician order. The DON stated the care plan was supposed to reflect the care Resident 14 was to receive. The DON stated there was potential for confusion on the care Resident 14 was to receive if the resident's care plan was not revised. During a review of the facility's Policy and Procedure (P&P) titled Develop-Implement Comprehensive Care Plans dated 1/2026, the P&P indicated The comprehensive care plan describes the services that are to be furnished are to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.Care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow professional standards of practice (the everyday rules and behaviors that keep patients safe and ensure high-quality healthcare) for medication administration (the process of giving medicine to a resident) by failing to ensure subcutaneous (fatty tissue under the skin) injection sites were rotated for two of two sampled residents (Resident 80 and Resident 186):Specifically, the facility failed to:1. Ensure two of two sampled residents (Resident 80 and Resident 186's) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection sites were rotated (a method to ensure repeated injections are not administered in the same area).2. Ensure one of two sampled residents (Resident 186's) Enoxaparin (a prescription blood thinner) injections sites were rotated. This failure had the potential to cause skin breakdown, bruising, tissue damage, and/or ineffective medication absorption.Findings: During a review of Resident 80's admission Record, the admission Record indicated the facility originally admitted Resident 80 on 2/16/2026 and readmitted Resident 80 on 5/9/2026 with diagnoses that included type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing, muscle weakness, local infection of the skin and subcutaneous tissue unspecified (unspecified bacterial infection in the fatty layer of tissue directly underneath your skin), and long-term current use of insulin. During a review of Resident 80's Minimum Data Set (MDS, a resident assessment tool), dated 2/22/2026, the MDS indicated Resident 80 had the ability to understand others and had the ability to make himself (Resident 80) understood. During a review of Resident 80's History and Physical (H&P), dated 4/14/2026, the H&P indicated Resident 80 had the ability to understand and make decisions. During a review of Resident 80's care plan titled Diabetes Mellitus (DM): At risk for hypo (low)/hyperglycemia (high blood sugar) related to diagnosis of DM, dated 4/13/2026, the care plan indicated an intervention (any action a nurse takes to help a patient heal, manage symptoms, or stay comfortable) to give diabetes medication as ordered by doctor. During a concurrent interview and record review on 5/12/2026 at 1:55 PM with the facility's Infection Preventionist Nurse (IPN - implements best practices for halting the spread of viruses and bacteria) and Registered Nurse 4 (RN 4), Resident 80's Location of Administration Report, (report of when and where injections were administered) was reviewed. The Location of Administration Report indicated the facility did not rotate insulin injections for Humalog (a rapid-acting mealtime insulin prescribed to control high blood sugar) insulin as follows:4/17/2026 at 5:30 AM Humalog insulin given subcutaneously in Resident 80's left arm.4/17/2026 at 12:01 PM Humalog insulin given subcutaneously in Resident 80's left arm.4/17/2026 at 11:12 AM Humalog insulin given subcutaneously in Resident 80's left arm.4/18/2026 at 5:22 PM Humalog insulin given subcutaneously in Resident 80's abdomen LLQ (the bottom-left quarter of your belly, located below your belly button). 4/19/2026 at 4:46 PM Humalog insulin given subcutaneously in Resident 80's abdomen LLQ The IPN stated the nurse giving the Humalog insulin injection would be able to see where the previous injection was given because Resident 10's electronic medical record (EMR - a digital version of your paper medical chart) would show where the previous injection was given. During a concurrent interview and record review on 5/12/2026 at 1:55 PM with the IPN and RN 4, Resident 80's Order Summary Report, dated 5/12/2026, was reviewed via Resident 80's EMR. The Order Summary Report indicated a physician order for Humalog, inject subcutaneously (in the fatty layer of tissue directly underneath your skin) per sliding scale (a personalized chart from your doctor that tells you how much rapid-acting insulin to inject right before a meal or at bedtime) before meals and bedtime for DM2 (type 2 Diabetes Mellitus), rotate injection sites. Both the IPN and RN 4 stated the facility nurses (in general) should have rotated Resident 80's insulin sites. Both the IPN and RN 4 stated the nurses (in general) did not follow Resident 80's doctors order when they (facility nurses in general) did not rotate insulin injection sites. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/14/2026 at 4:48 PM with the Director of Nursing (DON), Resident 80's Location of Administration Report was reviewed. The DON verified the facility did not rotate Resident 80's insulin injection sites as follows: 4/17/2026 at 5:30 AM Humalog insulin given subcutaneously in Resident 80's left arm.4/17/2026 at 12:01 PM Humalog insulin given subcutaneously in Resident 80's left arm.4/17/2026 at 11:12 AM Humalog insulin given subcutaneously in Resident 80's left arm.4/18/2026 at 5:22 PM Humalog insulin given subcutaneously in Resident 80's abdomen LLQ (the bottom-left quarter of your belly, located below your belly button). 4/19/2026 at 4:46 PM Humalog insulin given subcutaneously in Resident 80's abdomen LLQ. During a concurrent interview and record review on 5/14/2026 at 4:48 PM with the DON, the facility's policy and procedure (P&P), titled Insulin Administration, last reviewed 4/14/2026 was reviewed. The P&P indicated 18. Injection sites should be rotated to reduce the risk of damaging the skin tissue. The DON stated the facility nurses (in general) did not follow the facility's P&P and should have rotated Resident 80's injection sites. During a review of Resident 186's admission Record, the admission Record indicated the facility originally admitted Resident 186 on 3/9/2026 and readmitted Resident 186 on 4/27/2026 with diagnoses that included epilepsy (a brain disorder that causes repeated, unprovoked seizures), aphasia (a disorder that makes it difficult to speak), type 2 Diabetes Mellitus, muscle weakness, dysphagia (difficulty swallowing), and essential hypertension (HTN-high blood pressure). During a review of Resident 186's MDS dated [DATE], the MDS indicated Resident 186 had unclear speech, rarely could make himself (Resident 186) understood, and rarely had the ability to understand others. During a review of Resident 186's H&P dated 5/6/2026, the H&P indicated Resident 186 did not have capacity to understand and make decisions.During a concurrent interview and record review on 5/12/2026 at 1:45 PM with the IPN and RN 4, Resident 186's Location of Administration Report was reviewed. The Location of Administration Report indicated the following:5/5/2026 at 8:55 AM Enoxaparin injection given subcutaneously in Resident 186's abdomen LLQ. 5/6/2026 at 8:34 AM Enoxaparin injection given subcutaneously in Resident 186's abdomen LLQ. 5/7/2026 at 6:14 AM NPH insulin (an intermediate-acting insulin to treat DM) given subcutaneously in Resident 186's abdomen LLQ. 5/7/2026 at 1:33 PM NPH insulin given subcutaneously in Resident 186's abdomen LLQ. 5/7/2026 at 6:14 AM Humalog insulin given subcutaneously in Resident 186's abdomen LLQ. 5/7/2026 at 1:33 PM Humalog insulin given subcutaneously in Resident 186's abdomen LLQ.The IPN and RN 4 verified Resident 186's Enoxaparin and insulin injections were not rotated. During a concurrent interview and record review on 5/12/2026 at 1:45 PM with the IPN and RN 4, Resident 186's Order Summary Report was reviewed. The Order Summary Report was reviewed via Resident 186's EMR. The Order Summary Report indicated Resident 186 had the following orders:Enoxaparin inject 40 mg subcutaneously one time a day to prevent blood clotting. Rotate injection site.Humalog insulin inject subcutaneously per sliding scale subcutaneously before meals and at bedtime for type 2 DM. Rotate injection site.NPH Insulin inject 5 units (a small, measured amount of medication used) subcutaneously every 8 hours for type 2 DM. Rotate injection site.The IPN and RN 4 both stated the facility's nurses (in general) should have rotated injection sites for Resident 186's Enoxaparin and insulin injections. Both the IPN and RN stated the facility's nurses (in general) did not follow Resident 186's physician orders for Enoxaparin and Insulin. During a concurrent interview and record review on 5/14/2026 at 4:54 PM with the DON, Resident 80's Location of Administration Report was reviewed. The DON verified the facility did not rotate Resident 80's insulin injection sites as follows:5/5/2026 at 8:55 AM Enoxaparin injection given subcutaneously in Resident 186's abdomen LLQ. 5/6/2026 at 8:34 AM Enoxaparin injection given subcutaneously in Resident 186's abdomen LLQ. 5/7/2026 at 6:14 AM NPH insulin (an intermediate-acting insulin to treat DM) given subcutaneously in Resident 186's abdomen LLQ. 5/7/2026 at 1:33 PM NPH insulin given subcutaneously in Resident 186's abdomen LLQ. 5/7/2026 at 6:14 AM Humalog insulin given subcutaneously in Resident 186's abdomen LLQ. 5/7/2026 at 1:33 PM Humalog insulin given subcutaneously in Resident 186's abdomen LLQ. During a concurrent interview (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 5/14/2026 at 4:54 PM with the DON, the facility's policy and procedure (P&P), titled Insulin Administration, last reviewed 4/14/2026 was reviewed. The P&P indicated 18. Injection sites should be rotated to reduce the risk of damaging the skin tissue. The DON stated the facility nurses (in general) did not follow the facility's P&P and should have rotated Resident 186's insulin injection sites. Additionally, the DON stated the facility should have rotated Resident 186's Enoxaparin injection sites.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interviews, and record reviews the facility failed to provide necessary services to maintain good oral care (oral hygiene, the practice of keeping the mouth, teeth, and gums clean and free of disease) for one of one sampled resident (Resident 83) who was dependent on staff for oral hygiene. This failure had potential to affect Resident 83's dignity (providing care that respects a resident's self-esteem, identity, and personal choices) and place the resident at risk for aspiration (accidentally breathing food, liquid, or saliva into the airway and lungs) and tooth decay (damage and destruction of teeth).Findings: During a review of Resident 83's admission Record, the admission Record indicated the facility admitted the resident on 7/25/2013 with diagnoses that included quadriplegia (paralysis from the neck down, including legs and arms, usually due to a spinal cord injury), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or the inability to move on one side of the body), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), bed confinement status (when a resident is unable to safely leave their bed without significant or total assistance), dementia (a progressive state of decline in mental abilities), unspecified intellectual disabilities (a condition characterized by significantly below-average intelligence and limitations in daily living skills), and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of muscle of the right shoulder, left shoulder, right hand, and left hand. During a review of Resident 83's Minimum Data Set (MDS, a resident assessment tool) dated 5/1/2026, the MDS indicated the resident had severely impaired (never/rarely made decisions) cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 83 was dependent on facility staff for help with oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 83's Care Plan Report dated 4/9/2026, the Care Plan Report indicated the resident required assistance with bed mobility, transfers, walking in the room/corridor, locomotion (movement) on/off the unit, dressing, eating, toilet use, personal hygiene, and bathing. The Care Plan Report indicated a goal for Resident 83 to have increased Activities of Daily Living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) participation and minimized functional decline by the next review date. The Care Plan Report indicated an intervention that included assisting Resident 83 with maintaining good personal hygiene every shift and as needed. During a concurrent observation and interview on 5/11/2026 at 10:30 AM with the Infection Preventionist Nurse (IPN), Resident 83 was observed lying in bed with white opaque (not transparent or translucent) fluids coming from the resident's mouth and onto the upper part of the resident's gown. Resident 83's mouth and lips were observed covered in the white opaque fluid. The IP stated Resident 83 needed oral care. The IP stated oral care was to be performed for Resident 83 as needed. The IP stated Resident 83 was confused and dependent on staff (in general) for care. The IP stated Resident 83 needed assistance with oral care. The IP stated there was potential for Resident 83 to aspirate (food, drink, saliva, or stomach acid accidentally goes down the wrong pipe into the windpipe and enters the lungs instead of the stomach) or have teeth decay if oral care was not provided. During an interview on 5/14/2026 at 3:06 PM with the Director of Nursing (DON), the DON stated Resident 83 could not verbalize needs and was totally dependent on staff for care. The DON stated Resident 83 needed total assistance from staff for oral care. The DON stated staff (in general) were expected to provide Resident 83 with oral care and ensure the resident was well groomed. The DON stated staff (in general) should have wiped Resident 83's mouth because it was an easy intervention to do. The DON stated it was important to keep Resident 83's mouth clean to maintain the resident's dignity. The DON stated that if oral care was not provided to Resident 83 there was potential for the resident's dignity to be affected. During a review of the facility's Policy and Procedure (P&P) titled ADL Care Provided for Dependent Residents dated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/2026 the P&P indicated The facility provides assistance for residents unable to carry out activities of daily living. To ensure facility staff provide necessary care and services that are based on the resident's comprehensive assessment, to ensure that a resident who is unable to carry out activities of daily living receive necessary services to maintain good nutrition, grooming, personal and oral hygiene.Oral Care: The maintenance of a health mouth, which includes not only teeth, but the lips, gums, and supporting tissues. This involves not only activities such as brushing teeth or oral appliances, but also maintenance of oral mucosa.Facility staff will assist each resident with bathing, grooming, eating, dressing, transferring and other activities of daily living as necessary.

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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** Based on observation, interview, and record review, the facility failed to provide care and services to prevent aspiration (when food, liquid, or stomach contents accidentally enter the airway or lungs instead of the stomach) for one of three sampled residents (Resident 17) investigated under the accidents care area by failing to: -Ensure to clarify the route of administration of two Boost (nutritional drinks and shakes designed to provide everyday nutritional support) supplement orders for Resident 17. -Ensure to implement a risk for aspiration care plan (a personalized roadmap that guides how facility staff will manage treatments, medication, therapy goals, and safety precautions for residents) for Resident 17. This failure had the potential to increase Resident 17's risk for aspiration.Findings: During a review of Resident 17's admission Record, the admission Record indicated the facility readmitted the Resident on 9/15/2025 with diagnoses that included larynx (commonly called the voice box, a hollow organ in the neck located just above the windpipe) cancer, gastronomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dysphagia (difficulty swallowing). During a review of Resident 17's History and Physical (H&P) dated 9/15/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 17's Speech-Language Pathologist Discharge summary dated [DATE], the Speech-Language Pathologist Discharge Summary indicated oral intake was not safe for the resident. The Discharge Summary indicated the resident needed to see an ear, nose, and throat (ENT, a physician specializing in medical conditions of the ear, nose, throat, and neck) doctor for further evaluation. During a review of Resident 17's Order Summary Report order date 10/14/2025, the Order Summary Report indicated, Boost three times a day for [one] Boost for supplement. During a review of Resident 17's Rehab Dysphagia Screen, dated 11/4/2025, the screening indicated the resident had severe dysphagia and to continue nothing by mouth (NPO, a safety measure used to instruct a resident to not eat or drink anything) with current orders of enteral feeding (a feeding tube that delivers liquid nutrition directly to the stomach or small intestine). During a review of Resident 17's Ear, Nose, Throat, and Allergy medical records, dated 2/26/2026, the medical records indicated Clearance for oral intake to be determined by speech therapy based on swallow evaluation. During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2026, the MDS indicated the resident was cognitively intact (able to independently make decisions regarding tasks of daily life). The MDS indicated that the resident needed touching assistance (helper provides verbal cues or steadying as resident completes activity) from facility staff to complete activities of daily living (ADLs, activities a person performs daily such as bathing, dressing, and toileting). During a review of Resident 17's Order Summary Report, order date 3/20/2026, the Order Summary Report indicated, Acknowledge diet as followed on Boost supplement TID [three times a day] and enteral feeding. During a review of Resident 17's Dietary Screening dated 4/10/2026, the Dietary Screening indicated, Boost supplement. During a review of Resident 17's Care Plan Report dated 5/13/2026, the Care Plan Report did not indicate any focus for risk for aspiration. The Care Plan Report indicated aspiration precautions under special instructions. During an observation on 5/11/2026 at 10:19 AM in Resident 17's room, there was an open bottle of Boost supplement on Resident 17's bedside table. During an observation on 5/13/2026 at 9:20 AM in Resident 17's room, there was a sealed bottle of Boost supplement on Resident 17's bedside table. During a concurrent interview and record review on 5/13/2026 at 11:50 AM with Licensed Vocational Nurse 11 (LVN11), Resident 17's Order Summary Report dated 5/13/2026 was reviewed. The Order Summary Report indicated two separate orders for Boost supplement. LVN 11 stated the Boost supplement orders did not have a route of administration. LVN 11 stated that the order should have been clarified to verify if the Boost supplement was to be given orally or through Resident 17's gastronomy tube (G-tube, a tube inserted through the belly that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delivers directly to the stomach). LVN 11 stated Resident 17 could aspirate if he drank the Boost supplement. During an interview on 5/13/2026 with Registered Nurse 3 (RN 3), RN 3 stated Resident 17 would drink the Boost supplement. RN 3 stated Resident 17 was at increased risk of aspiration when consuming the Boost supplement orally. During an interview on 5/14/2026 at 8:31 AM with Resident 17, Resident 17 stated he (Resident 17) received no more than three bottles of Boost supplements every day. Resident 17 stated he (Resident 17) would drink the Boost supplement and that the nurses (unidentified) did not administer it through his (Resident 17's) G-tube. During an interview on 5/14/2026 at 8:50 AM with LVN 12, LVN 12 stated Resident 17 was on aspiration precautions, and that Resident 17 should have a care plan for risk of aspiration. LVN 12 stated care plans outline the interventions for resident care and were implemented to ensure resident safety (in general). During a concurrent interview and record review on 5/14/2026 at 9:07 AM with Minimum Data Set Licensed Vocational Nurse (MDS) 1, Resident 17's Care Plan Report dated 5/14/2026 was reviewed. The Care Plan Report did not indicate any focus for risk for aspiration. MDS 1 stated there was no current plan for risk of aspiration and that there should be one because Resident 17 was diagnosed with dysphagia. During a concurrent interview and record review on 5/14/2026 at 10:12 AM with the Registered Dietitian (RD), Resident 17's Dietary/Nutritional Progress Notes, 10/28/2025 and 9/3/2025 were reviewed. The Dietary/Nutritional Progress Note dated 10/29/2025 indicated Boost supplement TID. The Dietary/Nutritional Progress Note dated 9/3/2025, indicated Boost supplement TID orally. RD stated the difference in the Boost supplement note was due to the Speech Therapist's (ST) assessment of Resident 17 to be unsafe for oral intake. During a concurrent interview and record review on 5/14/2026 at 11:08 AM with the ST, Resident 17's Ear, Nose, Throat, and Allergy medical records, dated 2/26/2026 was reviewed. The medical records indicated for Resident 17 to continue swallow therapy with the ST. The ST stated Resident 17 was high risk for aspiration due to left vocal cord paralysis. The ST stated that Resident 17 could choke or develop aspiration pneumonia (a seriously lung infection caused by inhaling foreign materials into your airways instead of your esophagus) from drinking the Boost supplement. During an interview on 5/14/2026 at 5:36 PM with the Director of Nursing (DON), the DON stated the route for the Boost supplement orders should have been clarified. The DON stated there was no care plan for risk for aspiration. The DON stated that lack of an aspiration risk care plan increased Resident 17's risk for hospitalization due to choking. During a review of the facility's policy and procedure (P&P) titled, Free of Accident Hazards/Supervision/Devices, revised on January 2025, the P&P indicated, A resident-specific modification is revising the care plan to reflect the resident's current condition and risk factors that may have changed since the previous assessment. During a review of the facility's P&P titled, Physician Medication Orders, revised on January 2025, the P&P indicated, orders for medications must include route of administration if other than oral.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to maintain gastrostomy tube (G-tube, is a tube inserted through the abdomen that delivers nutrition directly to the stomach) care for two of nine sampled residents (Resident 175 and Resident 186) reviewed for tube feeding by failing to: -Ensure the enteral feeding (a way of delivering liquid nutrition directly to your stomach or intestines) tubes for Resident 175 and Resident 186 were capped (covered) and not open to air as indicated by the facility's Policies and Procedures (P&Ps) titled, Infection and Prevention and Control, last reviewed 4/14/2026, and P&P titled Enteral Feeding - Safety Precautions, last reviewed 4/14/2026. This failure placed Resident 175 and Resident 186 at risk for infection.Cross reference F880 Findings:1.During a review of Resident 175's admission Record, the admission Record indicated the facility originally admitted Resident 175 on 5/23/2025 and readmitted Resident 175 on 1/16/2026 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (the person survived a stroke, which left them with weakness or paralysis [the loss of the ability to move or feel in all or part of your body] on the left side of their body), dysphagia (difficulty swallowing), muscle weakness, type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), acquired absence of other specified parts of digestive tract (a part of the digestive system was surgically removed), and reduced mobility. During a review of Resident 175's Care Plan Report dated 2/11/2025, the Care Plan Report indicated Resident 175 had an enteral feeding and must maintain nutritional status via feeding tube related to inability to swallow. The Care Plan Report indicated a nursing intervention was to use clean techniques when administering tube feedings. During a review of Resident 175's Care Plan Report dated 2/11/2025, the Care Plan Report indicated Resident 175 was on a G-tube feeding and was at risk for aspiration (is when something enters the airway or lungs putting you at risk for serious infections), dehydration (a condition that occurs when your body loses more fluid than it takes in), weight fluctuation (variation), weight gain, weight loss, nausea and vomiting, abdominal distention (your belly is visibly swollen, stretched, or sticking out further than usual), diarrhea (watery stools), constipation (stools are hard, dry, or difficult to pass, and you go less often than usual), and intolerance to feeding related to dysphagia. The Care Plan Report indicated a nursing intervention to change the tubing per policy or as ordered. During a review of Resident 175's Care Plan Report dated 2/11/2025, the Care Plan Report indicated Resident 175 was on Enhanced Barrier Precautions (EBP - an infection control strategy used in skilled nursing facilities to prevent the spread of multidrug-resistant organisms that requires facility staff to use gown and gloves during high contact resident care activities) related to gastrostomy tube. The Care Plan Report indicated a goal for the facility was to minimize risk and complications of infection. The Care Plan Report indicated an intervention to promote EBP. During a review of Resident 175's Minimum Data Set (MDS - a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 175 had no speech (absence of spoken word), rarely/never could make himself (Resident 175) understood, and rarely/never had the ability to understand others. During a review of Resident 175's History and Physical (H&P) dated 3/4/2026, the H&P indicated Resident 175 did not have the capacity (ability) to understand and make decisions. The H&P indicated Resident 175 was s/p (status post - condition after) urinary tract infection (UTI- an infection in the bladder/urinary tract) with sepsis (a life-threatening blood infection). The H&P indicated Resident 175's prognosis (a medical prediction about how an illness, disease, or injury will progress over time) was poor. During a review of Resident 175's Order Summary Report dated 5/13/2026, the Order Summary Report indicated Resident 175 had a physician order for enteral feeding. The Order Summary Report indicated Resident 175 had a physician order for enhanced barrier precautions due to gastrostomy tube. During a concurrent observation and interview on (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/11/2026 at 11:44 AM with Licensed Vocational Nurse 7 (LVN 7) in Resident 175's room, Resident 175's enteral feeding tube was observed to be uncapped and open to air. LVN 7 stated Resident 175's enteral feeding tube was uncapped and stated Resident 175 could be at risk for infection if the licensed nurses (in general) would connect the uncapped enteral feeding tube to Resident 175. LVN 7 stated she (LVN 7) would need to change Resident 175's enteral tube feeding system. During an interview on 5/13/2025 at 10:22 AM with Registered Nurse 3 (RN 3), RN 3 stated there could be an infection control (the set of practical policies, procedures, and actions used to prevent the spread of infectious diseases) issue if Resident 186's enteral feeding tube was uncapped and left open to air. During a concurrent interview and record review on 5/14/2026 at 5:09 PM, with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled Infection and Prevention and Control, last reviewed 4/14/2026, the P&P indicated The facility has an infection prevention and control program designed to provide a safe, sanitary (clean), and comfortable environment and to help prevent the development and transmission of communicable diseases and infections (spread of germs like viruses, bacteria, or fungus). The P&P indicated Standard Precautions: The infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions (fluids made and released by your organs, glands, and cells), excretions (the ways your body gets rid of waste and extra fluids) except sweat, regardless of whether they contain visible blood, non-intact skin (any area where the skin's natural, protective outer barrier is broken, damaged, or missing), and mucous membranes (the moist, inner lining of some organs and body cavities such as the nose, mouth lungs, and stomach) may contain transmissible infectious agents (germs or pathogens, are microscopic organism such as viruses, bacteria, fungi, and parasites that can invade your body, multiply, and cause illness). Furthermore, equipment or items in the resident's environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents. The DON stated the facility should have capped Resident 175's enteral feeding tube if the enteral feeding had been disconnected from Resident 175's gastrostomy tube for infection control. 2. During a review of Resident 186's admission Record, the admission Record indicated the facility originally admitted Resident 186 on 3/9/2026 and readmitted Resident 186 on 4/27/2026 with diagnoses that included epilepsy (a brain disorder that causes repeated, unprovoked seizures), aphasia (a disorder that makes it difficult to speak), type 2 Diabetes Mellitus, muscle weakness, dysphagia (difficulty swallowing), and essential hypertension (HTN-high blood pressure). During a review of Resident 186's MDS dated [DATE], the MDS indicated Resident 186 had unclear speech (slurred or mumbled words), rarely could make himself (Resident 186) understood, and rarely had the ability to understand others. During a review of Resident 186's Care Plan Report dated 4/27/2026, the Care Plan Report indicated Resident 186 was at risk for infection due to G-tube site. The Care Plan Report indicated a goal was to minimize risk for infection at the GT site. The Care Plan Report indicated a nursing intervention to change the tubing per policy or as ordered. During a review of Resident 186's Care Plan Report dated 4/27/2026, the Care Plan Report indicated Resident 186 was on Enhanced Barrier Precaution related to G-tube and the goal was to minimize risk and complications of infection. During a review of Resident 186's H&P dated 5/6/2026, the H&P indicated Resident 186 did not have capacity to understand and make decisions. The H&P indicated Resident 186 was s/p fever of unknown etiology (having a high temperature without a clear cause) and s/p c-diff (clostridium difficile - a highly contagious bacteria that causes severe diarrhea) colitis, (swelling or inflammation of the inner lining of your large intestine). During a review of Resident 186's Order Summary Report, dated 5/13/2026, the Order Summary Report indicated Resident 186 had a physician order for enteral feeding. The Order Summary Report indicated Resident 186 had a physician order for EBP. The Order Summary Report indicated Resident 186 had a physician order to monitor the GT site for signs and symptoms of infection. During a concurrent observation and interview on 5/11/2026 with LVN 7 in Resident 186's room, Resident 186's enteral feeding tube was observed to (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be uncapped and open to air. LVN 7 stated Resident 186's enteral feeding tube was uncapped and stated Resident 186 could be at risk for infection if staff connected the uncapped enteral feeding tube to Resident 186. LVN 7 stated she (LVN 7) would need to change Resident 186's enteral tube feeding system. During an interview on 5/13/2025 at 10:22 AM with RN 3, RN 3 stated there could be an infection control issue if Resident 186's enteral feeding tube was uncapped and left open to air. During a concurrent interview and record review on 5/14/2026 at 5:09 PM, with the DON the facility's P&P titled Infection and Prevention and Control, last reviewed 4/14/2026, the P&P indicated The facility has an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. The P&P indicated Standard Precautions: The infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infectious agents. Furthermore, equipment or items in the resident's environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents. The DON stated the facility should have capped Resident 186's enteral feeding tube if the enteral feeding had been disconnected from Resident 186's gastrostomy tube for infection control. During a review of the facility's P&P titled Enteral Feeding - Safety Precautions, last reviewed 4/14/2026, the P&P indicated the following: 1. Personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. 3. Staff maintains clean technique when working with enteral nutrition systems and formulas.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of 14 residents (Resident 80) sampled for respiratory care receive necessary respiratory care and services in accordance with professional standards of practice, by failing to ensure Resident 80's nasal cannula tubing (a device that gives you additional oxygen [an invisible, odorless, and tasteless gas that makes up about 21% of the air we breathe] through your nose) and oxygen humidifier (a water bottled attached to the oxygen machine that adds moisture to oxygen preventing your nose, throat and airways from drying out, cracking, or getting sore) were labeled and dated. This deficient practice had the potential for Resident 80 to experience an increased risk for respiratory infections (illnesses that affect the parts of your body involved in breathing, such as your nose, throat, and lungs).Findings: During a review of Resident 80's admission Record, the admission Record indicated the facility originally admitted Resident 80 on 2/16/2026 and readmitted Resident 80 on 5/9/2026 with diagnoses that included type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing, muscle weakness, local infection of the skin and subcutaneous tissue unspecified (unspecified bacterial infection in the fatty layer of tissue directly underneath the skin), heart failure unspecified (our heart muscle is not pumping blood efficiently, but the medical records haven't pinned down the exact type), anemia unspecified (the body doesn't have enough healthy red blood cells to carry oxygen through the body) and long-term current use of insulin. During a review of Resident 80's Minimum Data Set (MDS, a resident assessment tool), dated 2/22/2026, the MDS indicated Resident 80 had the ability to understand others and had the ability to make himself (Resident 80) understood. The MDS indicated Resident 80 was receiving oxygen therapy. During a review of Resident 80's History and Physical (H&P), dated 4/14/2026, the H&P indicated Resident 80 had the ability to understand and make decisions. During a review of Resident 80's Order Summary Report, dated 5/13/2026, the Order Summary Report indicated Resident 80 had a physician order for oxygen at 2 liters per minute (a unit that expresses flow rate) via nasal cannula for SOB (shortness of breath - the feeling of not being able to get enough air into the lungs)/wheezing (a continuous, high-pitched whistling or rattling sound produced while breathing that occurs when the airways in the lungs become narrowed, inflamed, or blocked, making it difficult for air to flow smoothly). The Order Summary Report indicated Resident 80 had a physician order to change Resident 80's oxygen tubing every 7 days on Sunday mornings and as needed. During a concurrent observation and interview on 5/11/2026 at 1:27 PM with Licensed Vocational Nurse 4 (LVN 4) in Resident 80's room, Resident 80's nasal cannula tubing and humidifier were observed missing a label and date. LVN 4 verified Resident 80's nasal cannula and humidifier were not labeled and dated. During a concurrent observation and interview on 5/11/2026 at 1:37 PM with the Infection Preventionist (IPN) and Registered Nurse 4 (RN 4) in Resident 80's room, Resident 80's nasal cannula tubing and humidifier were observed missing a label and date. RN 4 stated the facility would document on Resident 80's Medication Administration Record (MAR) when the nasal cannula tubing and humidifier were changed. RN 4 stated she could not locate the documentation for when Resident 80's nasal cannula tubing and humidifier were last changed in the MAR. RN 4 stated she (RN 4) Resident 80's nasal cannula tubing and humidifier were supposed to be changed every Sunday but could not guarantee if Resident 80's nasal cannula tubing and humidifier were changed on Sunday (5/10/2026) because the current nasal cannula tubing and humidifier were not labeled and dated. The IPN stated Resident 80's nasal cannula tubing and humidifier needed to be changed for infection control (the set of practical policies, procedures, and actions used to prevent the spread of infectious diseases). During a concurrent interview and record review on 5/14/2026 at 5:03 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Oxygen Therapy, last reviewed 4/14/2026 was reviewed. The P&P indicated 8. All oxygen tubing, humidifiers, masks. and cannulas used to deliver oxygen are for single resident use (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only, will be changed weekly and when visibly soiled, and will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. The DON stated the facility should have put a label and date on Resident 80's nasal cannula tubing and humidifier. During a review of the facility P&P titled, AMsure Amsino AS0352 Humidification, last reviewed 4/14/2026, the P&P indicated The facility shall ensure that oxygen humidification using AMSure (Amsino) bubble humidifiers is provided, maintained, and replaced in a manner that prevents infection, ensures proper device function, and complies with manufacturer Instructions and accepted standards of practice. The P&P indicated the intent was To establish standardized procedures for the use, cleaning, maintenance, and replacement of AMSure (Amsino) humidifiers used with oxygen delivery systems to reduce infection risk, prevent equipment malfunction; and ensure safe respiratory care. The P&P indicated the humidifier used sterile water (regular water that has been processed to kill or remove all living microorganisms, such as bacteria, viruses, fungi, and spores). During a review of the facility P&P titled, Infection and Prevention and Control, last reviewed on 4/14/2026, the P&P indicated The facility has an infection prevention and control program designed to provide a safe, sanitary (extremely clean and free from dirt, germs, or anything that could make you sick), and comfortable environment and to help prevent the development and transmission of communicable diseases and infections (spread of germs like viruses, bacteria, or fungus). The P&P indicated 28. The staff apply standard precautions (the basic, everyday safety rules used to prevent the spread of germs) to infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered. The P&P indicated 63. [NAME] infection prevention and control training begins with new hire orientation and occurs at least annually. The P&P indicated 64. Training includes but is not limited to facility policies and procedures for:a. Surveillance to identity possible communicable diseases or infections to reduce the potential for spreading infection.

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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:Implement care plan for hemodialysis (HD, an invasive procedure to filter blood to remove waste and excess water through a machine, to replace kidney function), when a case manager (CM) 2 failed to schedule transportation at prescribed pick-up time for one of one resident (Resident 190).Ensure proper communication was implemented between the facility and hemodialysis center on one of one resident's (Resident 190) hemodialysis treatment and care.Ensure the transportation was not late during hemodialysis appointments for one of one resident (Resident 190).This deficient practices resulted in Resident 190's hemodialysis session shortened, and had a potential to cause fluid retention, shortness of breath, and altered laboratory test results.Findings:During a review of face sheet of Resident 190, dated 4/29/2026, the face sheet indicated the resident 190 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia (sudden difficulty breathing and oxygen exchange due to damage in lungs), and end stage renal disease (irreversible loss kidney function), renal hemodialysis dependance (HD, a long term treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed).During a review of Minimum Data Set (MDS, resident assessment tool) dated 5/5/2026, the MDS indicated the Resident 190's cognitive patterns were intact (able to comprehend complex concepts, memory intact, and verbalize own needs), as evidenced by Brief Interview for Mental Status score of 14 (BIMS score, an assessment tool to screen and identify memory, orientation, and judgement status of the resident). The MDS indicated that Resident 190's functional abilities (abilities to perform activities of daily living, such as eating, dressing, walking, toileting) required supervision/touching assistance for eating, partial/moderate assistance (helper does less than half the effort) with oral hygiene, substantial/maximal assistance with dressing, rolling in bed, dependence with sit to stand, chair/bed transfers, and toileting and showering.During a concurrent observation and interview on 5/12/2026 at 8:08 a.m. with Resident 190, Resident 190 stated there were issues with scheduling of the transportation for HD. Resident 190 stated on 5/11/2026 the ambulance came one hour late to pick him up, and 45 minutes (min.) late to bring me back to the facility. On 5/11/2026 it was most notable, but they were late several times. Resident 190 stated there seems to be a problem in scheduling the HD center staff made me sign some paper about the shorter session.During a concurrent observation and interview 5/13/2026 at 9:07 a.m. Resident 190 was still in his room, ready to be picked up by transportation for HD. Resident 190 stated they were running late again, and no one has told me anything. It is wrong, my dialysis time gets shortened, and other residents' dialysis would be delayed or shortened too. Nurses at the HD clinic get upset too. HD clinic made me sign the paper that my session is cut short.During a concurrent observation and interview on 5/13/2026 at 9:14 a.m. with the emergency medical technician (EMT) 1 stated, Dispatch sends us information about who and where to pick up, and destination, but not exact pick-up time.During an observation on 5/13/2026 at 9:29 am Resident 190 left the facility via gurney.During a concurrent phone interview and record review on 5/13/2026 at 9:36 a.m. with a Case Manager (CM) 2, scheduled the transportation, CM 2 stated Resident 190's HD start time was at 9:30 a.m., pick up time 8:30 a.m. or 9 a.m. CM 2 stated did not know the Physician's order for Resident 190's dated 4/29/2026, the pick-up time was at 8:15 a.m. CM 2 stated Resident 190's was being late and HD time would be shortened.During an interview on 5/13/2026 at 10:20 a.m. with RN 3, RN 3 stated that CM 2 had to follow the order for dialysis arrangement of transportation.During a concurrent interview and record review on 5/14/2026 at 10:11 a.m. with Licensed Vocational Nurse (LVN) 2 dialysis communication record dated 5/11/26 was reviewed, LVN 2 stated the facility usually notifies the dialysis center if transportation was late. LVN 2 stated the dialysis record did not have time indicating when HD treatment started and ended. LVN 2 stated she was not aware Resident 190's dialysis was cut short on 5/11/2026. LVN 2 stated, If we were aware (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about HD was being cut short, I would notify the physician.During an interview on 5/14/2026 at 10:45 a.m. Director of Nursing (DON), the DON stated the facility communicates with HD center mainly via phone. If dialysis center cut HD session short, they should have communicated with us.During a concurrent interview and record review on 05/14/2026 at 12:50 p.m. with Assistant Director of Nursing (ADON) 1, an Early Termination of Treatment Against Medical Advice form (AMA, a form signed by residents declining recommended medical treatment), dated 5/11/2026 was reviewed. The AMA form indicated the shortened dialysis treatment by 24 minutes (min) (prescribed dialysis treatment time was195 min) due to coming late.During an interview on 5/14/2026 at 5:15 p.m. with DON, DON stated CM 2 did not follow resident's care plan or order for dialysis. The DON stated CM 2 should have followed care plan and orders. DON stated if Resident 190 was running late due to transportation, facility should have communicated to CM 2, and to dialysis center to ask if they can still accommodate so Resident 190 can get the full treatment. The DON stated dialysis facility should have alerted and called the facility that the resident did not receive the full dialysis treatment. The DON stated staff should have alerted the physician that the resident's dialysis was cut short. DON stated there was potential for Resident 190 to have fluid retention, fluid overload, shortness of breath, altered laboratory test results and might require a transfer to the hospital.During a record review of the facility's policy and procedure (P & P) titled Dialysis Management dated 3/2023, the P & P indicated, the facility has an agreement with contracted Dialysis Unit(s) which operates in accordance with current standards of practice, including communication and collaboration. The P & P indicated the Dialysis Unit(s) and facility staff coordinate the development and implementation of the dialysis care plan, including the ongoing provision of assessment of the resident and care plan revision, as necessary. The P & P indicated the facility has a qualified social services representative who assists the dialysis resident and their representative with dialysis related, transportation needs.During a record review of Nursing Home Dialysis Transfer Agreement, dated 4/28/2025, indicated Transportation of designated resident: facility shall have the responsibility for arranging suitable transportation of the Designated Resident to and from Center.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 safe medication administration and accurate accountability of all controlled medications (medications with a high potential for abuse) for three of five sampled residents (Resident 7, Resident 98, and Resident 151) by failing to: 1.Clarify the physician's order for Resident 7'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) administration of pantoprazole (a medication used to treat gastro-esophageal reflux disease (GERD - a condition where stomach acid flows back up into the esophagus and causes heartburn) granules (crumbs). 2. Ensure one of four inspected medication carts (Station 4 Medication Cart 1) maintained accurate documentation of Resident 98's hydrocodone-acetaminophen (a controlled medication [medications that the use and possession of are controlled by the federal government] in combination with acetaminophen [APAP - a medication used to treat pain] used to treat severe pain) on count sheet/controlled drug record ([CDR] - a document indicating perpetual inventory and administration of controlled substances) after Licensed Vocational Nurse 4 (LVN 4) administered hydrocodone-acetaminophen. 3. Ensure one of four inspected medication carts (Station 4 Medication Cart 1) maintained accurate documentation of Resident 151's Lacosamide (a medication used to treat a subset of seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) on accountability record or CDR after LVN 4 administered lacosamide. These failures failed to administer medications in accordance with manufacturer's specifications or professional standards of practice, and maintaining accurate documentation of controlled medications, which had the potential to result in controlled medications misuse, diversion, g-tube clogging and complications, discomfort and hospitalization for Resident 7, Resident 98, and Resident 151.Findings:1. During a review of Resident 7's admission Record (a document containing demographic and diagnostic information) dated 5/13/2026, the admission Record indicated the facility originally admitted Resident 7 on 8/20/2024 and readmitted Resident 7 on 8/12/2025 with diagnoses that included but not limited to acute transverse myelitis in demyelinating disease of central nervous system (a brief but intense attack of inflammation [swelling] in the spinal cord that damages myelin [protective covering of nerve fibers]), encounter for attention to gastrostomy (g-tube) and GERD without esophagitis (swelling and irritation of tissues that line esophagus). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 7's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was moderately impaired. The MDS indicated Resident 7 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. The MDS indicated the function of eating was not attempted due to medical condition or safety reasons. During a review of Resident 7's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 4/1/2026 to 4/30/2026, the MAR indicated the pantoprazole granules were documented as administered with apple sauce via g-tube 56 times. During a review of Resident 7's History and Physical (H&P) dated 5/4/2026, the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's MAR dated 5/4/2026 to 5/13/2026, the MAR indicated pantoprazole granules were documented as administered to Resident 7 with apple sauce via g-tube 19 times. During a concurrent medication administration observation and interview on 5/13/2026 between 9:29 AM and 10:04 AM outside Resident 7's room with LVN 5, LVN 5 prepared nine medications that included but not limited to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pantoprazole sodium 40 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount) granules for suspension to be administered via g-tube. LVN 5 stated she (LVN5) was finding it difficult to administer medications via gravity, so she (LVN5) needed to push the plunger into the syringe a little to help medications pass through smoothly. LVN 5 administered seven g-tube medications and administered 40 mg pantoprazole via g-tube at the end. During a review of Resident 7's Order Summary Report (a document containing a summary of all active physician orders) dated 5/13/2026, the Order Summary Report indicated but not limited to the following physician order: Protonix Oral Packet 40 mg [Pantoprazole Sodium], give 1 packet via g-tube two times a day for GERD, do not crush. Mix granules with apple sauce, order date 5/3/2026, start date 5/4/2026. During the concurrent medication administration observation and interview on 5/13/2026 between 9:29 AM and 10:04 AM, LVN5 mixed one packet of pantoprazole 40 mg in apple sauce then mixed with water before administration via g-tube. LVN 5 stated that sometimes because of the powder particles, or because she (LVN5) started with cellcept (generic name - mycophenolate mofetil [a medication used to suppress immune response in transplant patients]) suspension and because it was thick, the medications were hard to push through, and the resident was gassy. LVN 5 stated she (LVN5) would usually administer Protonix at the end because of the granules. During a review of the undated manufacturer's product labeling for the pantoprazole granules, the document indicated, For patients who have a nasogastric tube [tube in the nose] or gastrostomy tube in place, Protonix [generic name - pantoprazole] for delayed-release oral suspension can be given as follows: Remove the plunger from the barrel of a 2 ounce [a unit of measurement for volume] [60 milliliters [mL - a unit of measurement for volume] catheter-tip syringe, Discard the plunger. Connect the catheter tip.tube. Hold the syringe attached.to prevent any bending of the tubing. Empty the contents of the packet into the barrel of the syringe. Add 10 mL [2 teaspoonfuls [tsp]] of apple juice and gently tap and/or shake the barrel.tube. Repeat at least twice using the same amount of apple juice [10 mL or 2 tsp] each time. No granules should remain in the syringe. During an interview on 5/13/2026 at 1:02 PM with LVN 5, LVN 5 showed the syringe used for g-tube administration and stated it was not clear if it was a 16-french syringe and was just 60 mL syringe. LVN 5 stated she (LVN5) added the pantoprazole granules in apple sauce then poured water into the mixture of granules and apple sauce. LVN 5 stated she (LVN5) had been administering pantoprazole granules in apple sauce via g-tube but needed to google [search engine to obtain information about someone or something on the World Wide Web] or find the package insert to look at the manufacturer's instructions or ask a supervisor. During an interview on 5/13/2026 at 2:27 PM with LVN 5, LVN 5 stated the package insert indicated to administer pantoprazole granules with apple juice during g-tube administration, not apple sauce. LVN 5 stated the g-tube clogged possibly because of the use of apple sauce instead of apple juice and that the order would be fixed with correct instructions. During a concurrent interview and record review on 5/14/2026 at 12:16 PM with the Director of Nursing (DON) the package insert of pantoprazole granules was reviewed. The DON stated the instructions from the package insert indicated the pantoprazole granules should be emptied in the barrel of syringe, then add the apple juice. The DON stated it was okay to give apple sauce if it was mixed with water and then given via g-tube. The DON stated, pantoprazole mixed with apple sauce and water would thin out the apple sauce when mixed and would be able to give pantoprazole via g-tube. The DON stated it was a pharmacy recommendation to administer pantoprazole granules with apple sauce via g-tube. The DON stated there would be a risk of clogging the g-tube and medications might not flow smoothly via the g-tube. The DON stated there might be discomfort for the resident (Resident 7) if some of the granules did not get delivered to the resident. The DON stated she (DON) would conduct an education with the person (unidentified) who created the order, clarify the order with the pharmacy, and inform the doctor. 2. During a review of Resident 98's admission Record dated 5/12/2026, the admission Record indicated Resident 98 the facility originally admitted Resident 98 on 9/26/2023 and readmitted the resident on 10/11/2024 with diagnosis that included but not limited to generalized muscle weakness. During a (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Los Angeles	340 South Alvarado Street Los Angeles, CA 90057

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 98's MDS dated [DATE], the MDS indicated that Resident 98 was dependent on facility's staff for ADLs such as oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated not applicable - not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury for eating. During a review of Resident 98's H&P dated 5/12/2026, the H&P indicated Resident 98 did not have the capacity to understand and make decisions. During a review of Resident 98's Order Summary Report dated 5/12/2026, the Order Summary Report indicated but not limited to the following physician order: Hydrocodone-acetaminophen oral tablet 10-325 mg, give 1 tablet via g-tube two times a day for pain management, hold for respiration rate (RR) less than 12, not to exceed (NTE) 3 grams of APAP in 24 hours from all sources, order date 5/7/2026, start date 5/8/2026. During a concurrent inspection, interview, and record review on 5/12/2026 at 3:17 PM with LVN 4 of Station 4 Medication Cart 1, Resident 98's hydrocodone-APAP 10-325 mg bubble pack (sealed card containing individual, daily, or weekly doses of medication in clear, push-through plastic bubbles), facility's CDR, and the medication administration details in electronic medical record (eMAR) for hydrocodone-APAP 10-325 mg were reviewed. Resident 98's hydrocodone-APAP bubble pack contained 21 tablets. The facility's CDR indicated a quantity of 22 tablets remaining with the last dose documented as administered on 5/11/2026 at 5:16 PM. The administration details in eMAR indicated the last dose of hydrocodone-APAP 10-325 mg was documented as administered on 5/12/2026 at 9:51 AM. LVN 4 stated she (LVN4) forgot to document in the book that she (LVN 4) administered hydrocodone-APAP to Resident 98. LVN 4 stated the controlled medications should be documented in the CDR or count sheet so that there would be a record of administration, and to prevent potential for misuse and risk for side effects. LVN 4 stated it was important to monitor these medications being administered because if hydrocodone-APAP was not given appropriately, there would be a risk for side effects of nausea, allergy reactions, respiratory depression related effects and difficulty breathing. During an interview on 5/14/2026 at 1:10 PM with the DON, the DON stated controlled substances should be documented in count sheet once they were removed from the medication card. The DON stated the licensed nursing staff (in general) should document the eMAR after medication was administered to prevent discrepancy and diversion of controlled medications. 3. During a review of Resident 151's admission Record dated 5/12/2025, the admission Record indicated the facility admitted Resident 151 to the facility on [DATE] with diagnoses that included but not limited to epilepsy (seizure), unspecified, not intractable (treatable), with status epilepticus (a seizure lasting more than five minutes). During a review of Resident 151's H&P dated 12/22/2025, the H&P indicated with a question mark that Resident 151 could make needs known but could not make medical decisions. During a review of Resident 151's Order Summary Report dated 5/12/2026, the order summary report indicated but not limited to the following physician order: Lacosamide oral tablet 50 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give 2 tablets by mouth every 12 hours for preventing and controlling seizures, order date 12/19/2025, start date 12/19/2025. During a concurrent inspection, interview and record review on 5/12/2026 at 3:17 PM with LVN 4 of Station 4 Medication Cart 1, Resident 151's lacosamide 100 mg bubble pack facility's-controlled medication count sheet (CDR) and the medication administration details in the eMAR for lacosamide 100 mg dose were reviewed. Resident 151's lacosamide bubble pack pharmacy label indicated Lacosamide 100 mg, take 1 tablet (100 mg) by mouth every 12 hours and it contained 51 tablets. The facility's CDR indicated a quantity of 52 tablets remaining with the last dose documented as administered on 5/11/2026 at 8:27 PM. The administration details in the eMAR indicated the last dose of two tablets (=100 mg) of lacosamide 50 mg was documented as administered on 5/12/2026 at 9:34 AM. LVN 4 stated she (LVN4) was supposed to sign the book (CDR) after removing the medication from the bubble pack, then click in the eMAR and save after medication was administered. LVN 4 stated when the CDR did not show accurate count of lacosamide, if another nurse (in general) looked at the paper and did not look at the computer, they would think Resident 151 did not receive lacosamide, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer it again and could increase the risk for medication errors. During a review of the facility's policy and procedure (P&P) titled, Safeguarding Controlled Substances, last reviewed 1/2026, the P&P indicated, Administration of Controlled Substance, 1. The licensed nurse will enter the following information immediately upon removing dose(s) from the controlled storage on the resident's individual controlled substance accountability reconciliation log. A. Date of medication removal. B. Time of medication removal. C. amount of medication removed. D. Amount of medication remaining. E. Signature of nurse removing the medication. During a review of the facility's P&P titled, Administering Medications, last reviewed 1/2026, the P&P indicated, Medications must be administered in accordance with state and federal guidelines. The P&P indicated, The licensed nurse must check the label.right time and right method (route) of administration before giving the medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, and record review, the facility failed to ensure the facility's pharmacy and consultant pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) addressed medication irregularities for one of five sampled residents (Resident 7) by failing to: -Ensure the medication administration instructions for Resident 7's pantoprazole (a medication used to treat gastro-esophageal reflux disease [GERD - a condition where stomach acid flows back up into the esophagus and causes heartburn]) granules (crumbs) via 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) were appropriate in accordance with the manufacturer's specifications. -Ensure drug to drug interaction (occurs when two or more drugs react with each other, which may lead to unexpected side effects or alter the effectiveness of the medications) between Resident 7's pantoprazole granules and mycophenolate mofetil (a medication used to suppress immune response in transplant patients) suspension were identified, reviewed, and clarified with a physician before the medications were administered concurrently via g-tube during medication pass. These failures resulted in Resident 7 receiving pantoprazole inappropriately and concurrently with mycophenolate mofetil via g-tube, possibly resulting in adverse (unwanted) consequences such as g-tube clogging and complications, low levels and less effectiveness of mycophenolate mofetil, resident discomfort, and hospitalization.Findings:During a review of Resident 7's admission Record (a document containing demographic and diagnostic information) dated 5/13/2026, the admission Record indicated the facility originally admitted Resident 7 on 8/20/2024 and readmitted the resident on 8/12/2025 with diagnoses that included but not limited to acute transverse myelitis in demyelinating disease of central nervous system (a brief but intense attack of inflammation [swelling] in the spinal cord that damages myelin [protective covering of nerve fibers]), encounter for attention to gastrostomy (g-tube) and gastro-esophageal reflux disease ([GERD] - a condition where stomach acid flows back up into the esophagus and causes heartburn) without esophagitis (swelling and irritation of tissues that line esophagus). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 7's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was moderately impaired. The MDS indicated Resident 7 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. The MDS indicated the function of eating was not attempted due to medical condition or safety reasons. During a review of Resident 7's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 4/1/2026 to 4/30/2026, the MAR indicated the pantoprazole granules were documented as administered 28 times with apple sauce via g-tube at 9 AM. During a review of Resident 7's MAR dated 4/1/2026 to 4/30/2026, the Cellcept (mycophenolate mofetil) oral suspension was documented as administered 28 times via g-tube at 9:00 a.m. During a review of Resident 7's History and Physical (H&P) dated 5/4/2026, the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's MAR dated 5/4/2026 to 5/13/2026, the MAR indicated the pantoprazole granules were documented as administered ten times with apple sauce via g-tube at 9 AM. During a review of Resident 7's MAR dated 5/4/2026 to 5/13/2026, the MAR indicated the Cellcept (mycophenolate mofetil) oral suspension was documented as administered ten times via g-tube at 9 AM. During a concurrent observation and interview of medication administration on 5/13/2026 between 9:29 AM and 10:04 AM outside Resident 7's room with Licensed Vocational Nurse (LVN) 5, LVN 5 prepared nine medications (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that included but not limited to pantoprazole sodium 40 milligrams (mg, a unit of measurement) granules for suspension and mycophenolate mofetil suspension to be administered via g-tube. LVN 5 stated she (LVN5) was finding it difficult to administer medications via gravity, so she (LVN5) needed to push the plunger into the syringe a little to help medications pass through smoothly. Observed one packet of pantoprazole 40 mg, mixed in apple sauce then mixed with water at bedside before administration via g-tube. Two and one-half (2.5) milliliters (mL - a unit of measurement for volume) (500 mg) of mycophenolate mofetil suspension 200 mg/mL. During a concurrent observation and interview of medication administration on 5/13/2026 between 9:29 AM and 10:04 AM, LVN 5 entered Resident 7's room, checked for g-tube placement and residual volume. LVN 5 continued with water flush and administration of medications one by one via g-tube to Resident 7. LVN 5 stated she (LVN5) was finding it difficult to administer medications via gravity, so she (LVN5) needed to push the plunger into the syringe a little to help the medications pass through smoothly. LVN 5 administered 40 mg pantoprazole via g-tube at the end. LVN 5 stated, sometimes the powder particles or because she (LVN5) started with cellcept (generic name - mycophenolate mofetil [a medication used to suppress immune response in transplant patients]) suspension and because it was thick, the medications were hard to push through, and the resident was gassy. LVN 5 stated she (LVN5) would usually administer Protonix at the end because of the granules. During a review of Resident 7's Order Summary Report (a document containing a summary of all active physician orders) dated 5/13/2026, the Order Summary Report indicated but not limited to the following physician orders for 9 AM: - Protonix Oral Packet 40 mg (Pantoprazole Sodium), give 1 packet via g-tube two times a day for GERD, do not crush. Mix granules with apple sauce, order date 5/3/2026, start date 5/4/2026. - Cellcept Oral Suspension Reconstituted 200 mg/mL (Mycophenolate Mofetil), give 2.5 mL via g-tube two times a day for acute transverse myelitis, give 2.5 mL = 500 mg, order date 5/3/2026, start date 5/4/2026.The facility did not provide or indicate lab values for mycophenolate mofetil levels for Resident 7. During a review of Resident 7's Progress Note dated 5/14/2026, the Progress Note indicated, Cellcept oral suspension reconstituted 200 mg/mL, give 2.5 mL via g-tube two times a day for acute transverse myelitis give 2.5 mL = 500 mg. Held waiting for GT (g-tube) replacement. During an interview on 5/13/2026 at 1:23 PM with LVN 5, LVN 5 stated she (LVN5) was not sure but found the interaction between pantoprazole and mycophenolate. LVN 5 stated pantoprazole and mycophenolate should not be administered together because it could lower mycophenolate levels and make it less effective and might indicate the need for more frequent blood levels. During an interview on 5/13/2026 at 2:27 PM with LVN 5, LVN 5 stated, the pharmacy changed administration times for pantoprazole granules to 6:00 a.m. and mycophenolate to 9 AM. During an interview on 5/14/2026 at 12:39 PM with the Director of Nursing, the DON stated the pharmacist discussed the drug-drug interaction between pantoprazole and mycophenolate mofetil with the quality assurance nurse and stated it was not a severe interaction, and was informed to practice just a caution, in case. During a concurrent interview and record review on 5/14/2026 at 12:39 PM with the DON the prescribing information of pantoprazole granules was reviewed. The DON stated the package insert indicated, pantoprazole decreases the pH (the value that indicates acidity and basicity) of gastric lining, only need to have caution - decrease absorption of mycophenolate? The DON stated the nursing staff (in general) should inform the physician about any changes in the order including time changes. During an interview on 5/14/2026 at 2:38 PM with the Consultant Pharmacist (RPH 1), RPH 1 stated pantoprazole granules should be administered with apple juice via g-tube so that it could move faster via g-tube. RPH 1 stated apple sauce was thicker in consistency and so it was better not to use apple sauce to prevent the risk of clogging of g-tube. RPH 1 stated according to the reference he (RPH1) checked the drug-drug interaction between cellcept, and pantoprazole only indicated cautionary advice, not a major interaction. RPH 1 stated pantoprazole could lower the absorption of cellcept but there were no interventions to be made. RPH 1 stated he (RPH1) did not need to inform or consult a physician regarding drug-drug interaction because it was a minor interaction.RPH 1 did not share documentation (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or reference with the surveyor that he (RPH1) referred to, for the drug-drug interaction between pantoprazole and mycophenolate mofetil. According to the manufacturer's product labeling, titled Highlights of Prescribing Information, for pantoprazole granules, the document indicated, For patients who have a nasogastric tube or gastrostomy tube in place, Protonix (generic name - pantoprazole) for delayed-release oral suspension can be given as follows: Remove the plunger from the barrel of a 2 ounce (a unit of measurement for volume) (60 milliliters (mL - a unit of measurement for volume) catheter-tip syringe, Discard the plunger. Connect the catheter tip.tube. Hold the syringe attached.to prevent any bending of the tubing. Empty the contents of the packet into the barrel of the syringe. Add 10 mL (2 teaspoonfuls [tsp]) of apple juice and gently tap and/or shake the barrel.tube. Repeat at least twice using the same amount of apple juice (10 mL or 2 tsp) each time. No granules should remain in the syringe. According to the manufacturer's product labeling, titled Highlights of Prescribing Information, for pantoprazole granules, the document indicated, Table 4: Clinically Relevant Interactions Affecting Drugs Co-Administered with Protonix and Interactions with Diagnostics, Clinical Impact: Drugs Dependent on Gastric pH for Absorption (e.g., mycophenolate mofetil and others) Pantoprazole can reduce the absorption of other drugs due to its effect on reducing intragastric acidity. Intervention: Mycophenolate mofetil (MMF): Co-administration of pantoprazole sodium in healthy subjects.receiving MMF has been reported to reduce the exposure to the active metabolite, mycophenolic acid (MPA) . During a review of the drug-drug interaction report between pantoprazole (or proton pump inhibitors [pantoprazole's pharmacologic category]) and mycophenolate mofetil on Micromedex (an evidence based drug information resource), dated 5/13/2026, the report indicated a major drug-drug interaction, with warning: Concurrent use of mycophenolate mofetil and proton pump inhibitors may result in reduced mycophenolic acid exposure.clinical management: concomitant use of .leading to decreased efficacy of mycophenolate mofetil. Monitor patients for alterations in efficacy when coadministration with a PPI is required. Obtaining MPA plasma levels before and after the initiation or discontinuation of concomitant medications may be necessary. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed date 1/2026, the P&P indicated, To provide employees with guidelines for the safe and timely administration of medications per physician order. The P&P indicated, Medications must be administered in accordance with state and federal guidelines. The P&P indicated, The licensed nurse must check the label.right time and right method (route) of administration before giving the medication. During a review of the facility's P&P titled, Unnecessary Drugs, last reviewed date 1/2026, the P&P indicated, Adverse Consequence: Unwanted, unintended, or dangerous effects that a drug may have,.psychosocial status. It may include various types of adverse drug reactions and interactions (e.g., medication-medication, medication-food, and medication-disease). The P&P indicated, the facility is cautious in determining .prescribing (including dose, duration, and type of medications).quality of life and functional capacity.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five residents (Resident 2) sampled for unnecessary medications (a medication that may be doing more harm than good or isn't needed for the resident's current condition) was administered medication in accordance with physician orders and professional standards of practice. By failing to ensure:1. Resident 2 was not administered Hydrocodone-Acetaminophen (a controlled medication [medications that the use and possession of are controlled by the federal government] in combination with acetaminophen [APAP - a medication used to treat pain] used to treat severe pain) tablet 7.5-325 mg, give 2 tablets by mouth every 4 hours as needed for severe pain (7-10) NTE 3 g/day, hold if RR<12 and call MD, order date 2/21/2026, when the Resident's pain level was out of the ordered parameters (the specific, measurable guidelines, dosages, and conditions that dictate how, when, and why a medication is administered). This deficient practice placed Resident 2 at risk for an overdose and adverse consequences such as liver toxicity, respiratory depression, breathing difficulties and hospitalization. (Cross-referenced with F760)Findings: During a review of Resident 2's admission Record (a document containing demographic and diagnostic information) dated 5/14/2026, the admission record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso) incomplete (with some shoulder, elbow, wrist and hand function) and personal history of other (healed) physical injury and trauma. During a review of Resident 2's History and Physical (H&P) dated 1/27/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 2/19/2026, the MDS indicated Resident 2's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated that Resident 2 needed setup or clean-up assistance from facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating and oral hygiene, and was dependent on facility's staff for ADLs such as toileting hygiene, showering, upper and lower body dressing and personal hygiene. During a review of Resident 2's Order Summary Report (a document containing a summary of all active physician orders), dated 5/14/2026, the order summary report indicated but not limited to the following physician orders: Monitor level of pain (0-10 scale): Document pain level as follows: 0 = None 1-3 = Mild Pain, 4-6 = Moderate Pain, 7-10 = Severe Pain every shift, order date 2/7/2026, start date 2/7/2026. Hydrocodone-Acetaminophen tablet 7.5-325 mg, give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6) NTE 3 g/day. Hold if respiratory rate (RR) less than (<) 12 and call Medical Doctor (MD), order date 2/21/2026, start date 2/21/2026. Hydrocodone-Acetaminophen tablet 7.5-325 mg, give 2 tablets by mouth every 4 hours as needed for severe pain (7-10) NTE 3 g/day, hold if RR<12 and call MD, order date 2/21/2026, start date 2/21/2026. Baclofen (a medication used to treat muscle spasms) oral tablet 5 mg, give 1 tablet by mouth every 6 hours for muscle spasms, order date 2/7/2026, start date 2/8/2026. Pregabalin (controlled medication [medications that the use and possession of are controlled by the federal government] used to treat fibromyalgia [pain in muscles and soft tissues] related pain, neuropathic (nerve related) pain) oral capsule 50 mg, give 1 capsule by mouth three times a day for neuropathic pain, order date 2/7/2026, start date 2/8/2026. During a review of Resident 2's MAR dated 4/1/2026 to 4/30/2026, the MAR indicated hydrocodone-APAP 7.5-325 mg, 2 tablets were documented as administered six times by two different licensed nurses, when the pain level did not fall within the indicated pain level parameter in accordance with physician orders as follows:a. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 6, on 4/15/2026 at 11:49 AM b. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for severe pain (7-10) for pain level of 0, on 4/20/2026 at 8:16 PM c. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 4/21/2026 at 9:54 PM d. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 4/23/2026 at 6:27 AM e. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 4/27/2026 at 9:43 AM f. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 4, on 4/28/2026 at 10:19 AM During a review of Resident 2's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 5/1/2026 to 5/14/2026, the MAR indicated hydrocodone-APAP 7.5-325 mg, 2 tablets were documented as administered four times by two different licensed nurses, when the pain level did not fall within the indicated pain level parameter in accordance with physician orders as follows: a. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 5/7/2026 at 9:39 AM b. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 6, on 5/10/2026 at 9:01 AM c. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 5, on 5/10/2026 at 2:04 PM d. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 6, on 5/11/2026 at 6:26 PM During a concurrent interview and record review on 5/14/2026 at 10:55 AM with Licensed Vocational Nurse (LVN) 9, the physician orders for Resident 2's hydrocodone-APAP 7.5-325 mg and MAR, dated 5/1/2026 to 5/14/2026 were reviewed. LVN 9 stated there were two physician orders for hydrocodone-APAP, one of which indicated to give 2 tablets every 4 hours as needed for severe pain (7-10) that could go up to 12 tablets which would be 3900 mg/day which exceeded the order limit of 3 g/day or 3000 mg/day. LVN 9 stated Resident 2 was also on 1 tablet of hydrocodone-APAP every 4 hours as needed for moderate pain (4-6), that would also add acetaminophen dose if taken throughout the day. LVN 9 stated the resident had to be monitored for respirations and pain level because hydrocodone could decrease respirations, lead to respiratory depression and resident could desat [oxygen levels drop dangerously low]. LVN 9 stated there would be a risk for hospitalization if resident desats. LVN 9 stated excessive APAP dose, and exceeding the 3g/day allowance increased Resident 2's risk for liver damage. LVN 9 stated the MAR indicated Resident 2 received two tablets of hydrocodone-APAP for pain level of 6 a few times when Resident 2should have received one tablet, according to the physician orders. LVN 9 stated Resident 2 was also on baclofen and pregabalin which increased Resident 2's risk for respiratory depression. During an interview on 5/14/2026 at 1:31 PM with the Director of Nursing (DON), the DON stated Resident 2 needed reassessment for pain as to how often the resident was taking hydrocodone-APAP and if the frequency needed to be adjusted. The DON stated, based on the orders, there was a risk of acetaminophen and liver toxicity because the orders could cause acetaminophen dose to go over 3 grams. The DON stated there was a side effect of sedation so the resident had to be monitored for respiratory depression, respiratory distress, otherwise Resident 2 could be at risk of hospitalization. The DON stated the nurse should have assessed pain and followed physician orders and given 1 tablet of hydrocodone-APAP instead of 2 tablets for the pain level of 6. During an interview on 5/14/2026 at 2:52 PM with the Consultant Pharmacist (RPH 1), RPH 1 stated if the resident was using a lot of prn [whenever necessary medications] hydrocodone-APAP, then RPH 1 would recommend the physician to change to a medication without acetaminophen. RPH 1 stated when orders had a different pain scale and nurses gave 2 tablets instead of 1 tablet, it would be considered a medication error. RPH 1 stated there would be a risk of drowsiness, falls, sedation, especially if the resident was on lot of medications such as baclofen and pregabalin. RPH 1 stated it was important to monitor the resident for respiratory depression, blood pressure and blood glucose.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed 1/2026, the P&P indicated, Medications must be administered in accordance with the orders. The P&P indicated, The licensed nurse must check the (continued on next page)

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	555397	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Los Angeles	340 South Alvarado Street Los Angeles, CA 90057

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	label.right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility's P&P titled, Pain Assessment and Management, last reviewed 1/2026, the P&P indicated, The facility provides pain management to residents who require such services, consistent with professional standards of practice.preferences. The P&P indicated, Opioids should be selected and dosed in accordance with current professional standards of practice and manufacturer's guidelines in order to optimize their effectiveness and minimize their adverse consequences. The P&P indicated, Use of Opioids for Pain Management. 3. The facility, with the guidance from the physician, uses the lowest possible effective dosage for the shortest amount of time possible. preferences and goals for care. The P&P indicated, Decisions of strength, frequency, duration and routine versus as needed administration, are based.and not part of the nurses' scope of practice. During a review of the facility's P&P titled, Unnecessary Drugs, last reviewed date 1/2026, the P&P indicated, The intent of these requirements is to ensure each resident's entire drug/medication regimen is managed and monitored to promote.well-being. The P&P indicated, Unnecessary Drug: Any drug when used in excessive dose (including duplicate drug therapy); or for excessive duration. Adequate indications for Use: The identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition.contraindicated. Also, adequate indication for use means that the medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for one of five sampled residents (Resident 7) by failing to: -Ensure Resident 7's pantoprazole (a medication used to treat gastro-esophageal reflux disease ([GERD] - a condition where stomach acid flows back up into the esophagus and causes heartburn) delayed-release granules were administered via 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) safely and in accordance with manufacturer's specifications. -Ensure drug-drug interaction between Resident 7's pantoprazole granules and mycophenolate mofetil (a medication used to suppress immune response in transplant patients) suspension was clarified and reviewed with a physician before they were administered concurrently during medication pass. These failures failed to administer medications in accordance with manufacturer's specifications and professional standards of practice, which resulted in a medication error rate of 8% which exceeded the 5% threshold, placed Resident 7 at risk for g-tube clogging and complications, discomfort, and hospitalization. Findings:During a review of Resident 7's admission Record (a document containing demographic and diagnostic information) dated 5/13/2026, the admission record indicated the facility admitted Resident 7 to the facility on 8/20/2024 and readmitted the resident on 8/12/2025 with diagnoses that included but not limited to acute transverse myelitis in demyelinating disease of central nervous system (a brief but intense attack of inflammation [swelling] in the spinal cord that damages myelin [protective covering of nerve fibers]), encounter for attention to gastrostomy (g-tube) and gastro-esophageal reflux disease ([GERD] - a condition where stomach acid flows back up into the esophagus and causes heartburn) without esophagitis (swelling and irritation of tissues that line esophagus). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 3/18/2026, the MDS indicated Resident 7's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was moderately impaired. The MDS indicated Resident 7 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on or taking off footwear and personal hygiene. The MDS indicated the function of eating was not attempted due to medical condition or safety reasons. During a review of Resident 7's Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 4/1/2026 to 4/30/2026, the MAR indicated the pantoprazole granules were documented as administered 28 times with apple sauce via g-tube at 9 AM. During a review of Resident 7's MAR dated 4/1/2026 to 4/30/2026, the MAR indicated the Cellcept (mycophenolate mofetil) oral suspension was documented as administered 28 times via g-tube at 9 AM. During a review of Resident 7's History and Physical (H&P), dated 5/4/2026, the H&P indicated Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's MAR dated 5/4/2026 to 5/13/2026, the MAR indicated the pantoprazole granules were documented as administered 10 times with apple sauce via g-tube at 9 AM. During a review of Resident 7's MAR dated 5/4/2026 to 5/13/2026, the MAR indicated the Cellcept (mycophenolate mofetil) oral suspension was documented as administered 10 times via g-tube at 9 AM. During a concurrent observation an interview of medication administration on 5/13/2026 between 9:29 AM and 10:04 AM outside Resident 7's room, LVN 5 prepared eight medications by crushing them individually using a crushing device and dissolving each medication in water separately into small individual medicine cups, to be administered to Resident 7 via g-tube and one injection syringe of enoxaparin, for a total of nine medications: a. One tablet of calcium carbonate (a medication used to treat bloating) 500 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount). b. One tablet of folic acid (a medication used to treat low levels of folic acid) 1 mg c. One tablet of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	famotidine (a medication used to treat GERD) 20 mg d. One packet of pantoprazole (a medication used to treat GERD) 40 mg, mixed in apple sauce then mixed with water at bedside before administration via g-tube e. One injection of enoxaparin (a medication used to prevent blood clots) 40 mg/0.4 milliliters ([mL] a unit of measurement for volume) under the skin f. One tablet of prednisone (a medication used to treat inflammation) 2.5 mg g. One tablet of simethicone (a medication used to treat bloating and gas) 80 mg h. Two and one-half (2.5) mL (500 mg) of mycophenolate mofetil (a medication used to suppress immune response in transplant patients) suspension 200 mg/mL i. Two tablets of acetaminophen (a medication used to treat pain and fever) 325 mg During a concurrent observation an interview of medication administration on 5/13/2026 between 9:29 AM and 10:04 AM, LVN 5 entered Resident 7's room and placed the prepared medications on the bedside cart. LVN 5 continued with water flush and administration of medications one by one via g-tube to Resident 7. LVN 5 stated she (LVN5) was finding it difficult to administer medications via gravity so needed to push the plunger into the syringe a little to help medications pass through smoothly. LVN 5 administered 40 mg pantoprazole via g-tube at the end. LVN 5 stated she (LVN5) stated, sometimes the powder particles or because she started with cellcept (generic name - mycophenolate mofetil [a medication used to suppress immune response in transplant patients]) suspension and because it was thick, the meds were hard to push through, and resident was gassy. LVN 5 stated she (LVN5) would usually administer Protonix at the end because of the granules. During a review of Resident 7's Order Summary Report (a document containing a summary of all active physician orders) dated 5/13/2026, the Order Summary Report indicated but not limited to the following physician orders for 9 AM: - Protonix Oral Packet 40 mg (Pantoprazole Sodium), give 1 packet via g-tube two times a day for GERD, do not crush. Mix granules with apple sauce, order date 5/3/2026, start date 5/4/2026. - Cellcept Oral Suspension Reconstituted 200 mg/mL (Mycophenolate Mofetil), give 2.5 mL via g-tube two times a day for acute transverse myelitis, give 2.5 mL = 500 mg, order date 5/3/2026, start date 5/4/2026. The facility did not provide or indicate lab values for mycophenolate mofetil levels for Resident 7. During an interview on 5/13/2026 at 1:23 PM with LVN 5, LVN 5 stated she (LVN5) was not sure but found the interaction between pantoprazole and mycophenolate. LVN 5 stated pantoprazole and mycophenolate should not be administered together because it could lower mycophenolate levels and make it less effective and might indicate the need for more frequent blood levels. During an interview on 5/13/2026 at 2:27 PM with LVN 5, LVN 5 stated, the pharmacy changed administration times for pantoprazole granules to 6 AM and mycophenolate to 9 AM During an interview on 5/14/2026 at 12:39 PM with the Director of Nursing, the DON stated the pharmacist discussed drug-drug interaction between pantoprazole and mycophenolate mofetil with the quality assurance nurse and stated it was not a severe interaction, and was informed to practice just a caution, in case. During a concurrent interview and record review on 5/14/2026 at 12:39 PM with the DON, the prescribing information of pantoprazole granules was reviewed. The DON stated the package insert indicated, pantoprazole decreases the pH (the value that indicates acidity and basicity) of gastric lining, only need to have caution - decrease absorption of mycophenolate? The DON stated the nursing staff (in general) should inform the physician about any changes in the order including time changes. During an interview on 5/14/2026 at 2:38 PM with the Consultant Pharmacist (RPH 1), RPH 1 stated pantoprazole granules should be administered with apple juice via g-tube so that it could move faster via g-tube. RPH 1 stated apple sauce was thicker in consistency and so it was better not to use apple sauce to prevent the risk of clogging of g-tube. RPH 1 stated according to the reference he (RPH 1) checked the drug-drug interaction between cellcept, and pantoprazole only indicated cautionary advice, not a major interaction. RPH 1 stated pantoprazole could lower the absorption of cellcept but there were no interventions to be made. RPH 1 stated he (RPH 1) did not need to inform or consult a physician regarding drug-drug interaction because it was a minor interaction. RPH 1 did not share documentation or reference that he (RPH 1) referred to, for the drug-drug interaction between pantoprazole and mycophenolate mofetil. During a review of the manufacturer's product (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	labeling, titled Highlights of Prescribing Information, for pantoprazole granules, the document indicated, For patients who have a nasogastric tube or gastrostomy tube in place, Protonix (generic name - pantoprazole) for delayed-release oral suspension can be given as follows: Remove the plunger from the barrel of a 2 ounce (a unit of measurement for volume) (60 milliliters (mL - a unit of measurement for volume) catheter-tip syringe, Discard the plunger. Connect the catheter tip.tube. Hold the syringe attached.to prevent any bending of the tubing. Empty the contents of the packet into the barrel of the syringe. Add 10 mL (2 teaspoonfuls [tsp]) of apple juice and gently tap and/or shake the barrel.tube. Repeat at least twice using the same amount of apple juice (10 mL or 2 tsp) each time. No granules should remain in the syringe. During a review of the manufacturer's product labeling, titled Highlights of Prescribing Information, for pantoprazole granules, the document indicated, Table 4: Clinically Relevant Interactions Affecting Drugs Co-Administered with Protonix and Interactions with Diagnostics, Clinical Impact: Drugs Dependent on Gastric pH for Absorption (e.g., mycophenolate mofetil and others) Pantoprazole can reduce the absorption of other drugs due to its effect on reducing intragastric acidity. Intervention: Mycophenolate mofetil (MMF): Co-administration of pantoprazole sodium in healthy subjects.receiving MMF has been reported to reduce the exposure to the active metabolite, mycophenolic acid (MPA) . During a review of the drug-drug interaction report between pantoprazole (or proton pump inhibitors [pantoprazole's pharmacologic category]) and mycophenolate mofetil on Micromedex (an evidence based drug information resource), dated 5/13/2026, the report indicated a major drug-drug interaction, with warning: Concurrent use of mycophenolate mofetil and proton pump inhibitors may result in reduced mycophenolic acid exposure.clinical management: concomitant use of .leading to decreased efficacy of mycophenolate mofetil. Monitor patients for alterations in efficacy when coadministration with a PPI is required. Obtaining MPA plasma levels before and after the initiation or discontinuation of concomitant medications may be necessary. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed date 1/2026, the P&P indicated, To provide employees with guidelines for the safe and timely administration of medications per physician order. The P&P indicated, Medications must be administered in accordance with state and federal guidelines. The P&P indicated, The licensed nurse must check the label.right time and right method (route) of administration before giving the medication. During a review of the facility's P&P titled, Unnecessary Drugs, last reviewed date 1/2026, the P&P indicated, Adverse Consequence: Unwanted, unintended, or dangerous effects that a drug may have,.psychosocial status. It may include various types of adverse drug reactions and interactions (e.g., medication-medication, medication-food, and medication-disease). The P&P indicated, the facility is cautious in determining .prescribing (including dose, duration, and type of medications).quality of life and functional capacity.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five residents (Resident 2) was free of a significant medication error (any preventable error in medication administration that can result in resident discomfort, jeopardizing health and safety, or requiring medical intervention). By failing to ensure: 1. Resident 2 was not administered Hydrocodone-Acetaminophen (a controlled medication [medications that the use and possession of are controlled by the federal government] in combination with acetaminophen [APAP - a medication used to treat pain] used to treat severe pain) tablet 7.5-325 mg, give 2 tablets by mouth every 4 hours as needed for severe pain (7-10) NTE 3 g/day, hold if RR<12 and call MD, order date 2/21/2026, when the Resident's pain level was out of the ordered parameters (the specific, measurable guidelines, dosages, and conditions that dictate how, when, and why a medication is administered). This deficient practice placed Resident 2 at risk for an overdose and adverse consequences such as liver toxicity, respiratory depression, breathing difficulties and hospitalization.(Cross-referenced with F757)Findings: During a review of Resident 2's admission Record (a document containing demographic and diagnostic information) dated 5/14/2026, the admission record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso) incomplete (with some shoulder, elbow, wrist and hand function) and personal history of other (healed) physical injury and trauma.During a review of Resident 2's History and Physical (H&P) dated 1/27/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool) dated 2/19/2026, the MDS indicated Resident 2's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated that Resident 2 needed setup or clean-up assistance from facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating and oral hygiene, and was dependent on facility's staff for ADLs such as toileting hygiene, showering, upper and lower body dressing and personal hygiene. During a review of Resident 2's Order Summary Report (a document containing a summary of all active physician orders), dated 5/14/2026, the order summary report indicated but not limited to the following physician orders: Monitor level of pain (0-10 scale): Document pain level as follows: 0 = None 1-3 = Mild Pain, 4-6 = Moderate Pain, 7-10 = Severe Pain every shift, order date 2/7/2026, start date 2/7/2026. Hydrocodone-Acetaminophen tablet 7.5-325 mg, give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6) NTE 3 g/day. Hold if respiratory rate (RR) less than (<) 12 and call Medical Doctor (MD), order date 2/21/2026, start date 2/21/2026. Hydrocodone-Acetaminophen tablet 7.5-325 mg, give 2 tablets by mouth every 4 hours as needed for severe pain (7-10) NTE 3 g/day, hold if RR<12 and call MD, order date 2/21/2026, start date 2/21/2026. Baclofen (a medication used to treat muscle spasms) oral tablet 5 mg, give 1 tablet by mouth every 6 hours for muscle spasms, order date 2/7/2026, start date 2/8/2026. Pregabalin (controlled medication [medications that the use and possession of are controlled by the federal government] used to treat fibromyalgia [pain in muscles and soft tissues] related pain, neuropathic (nerve related) pain) oral capsule 50 mg, give 1 capsule by mouth three times a day for neuropathic pain, order date 2/7/2026, start date 2/8/2026. During a review of Resident 2's MAR dated 4/1/2026 to 4/30/2026, the MAR indicated hydrocodone-APAP 7.5-325 mg, 2 tablets were documented as administered six times by two different licensed nurses, when the pain level did not fall within the indicated pain level parameter in accordance with physician orders as follows:a. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 6, on 4/15/2026 at 11:49 AMb. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 4/20/2026 at (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:16 PMc. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 4/21/2026 at 9:54 PMd. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 4/23/2026 at 6:27 AMe. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 4/27/2026 at 9:43 AMf. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 4, on 4/28/2026 at 10:19 AM During a review of Resident 2's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 5/1/2026 to 5/14/2026, the MAR indicated hydrocodone-APAP 7.5-325 mg, 2 tablets were documented as administered four times by two different licensed nurses, when the pain level did not fall within the indicated pain level parameter in accordance with physician orders as follows:a. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 0, on 5/7/2026 at 9:39 AMb. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 6, on 5/10/2026 at 9:01 AMc. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 5, on 5/10/2026 at 2:04 PMd. Hydrocodone-APAP 7.5-325 mg, 2 tablets by mouth every 4 hours as needed for severe pain (7-10) for pain level of 6, on 5/11/2026 at 6:26 PM During a concurrent interview and record review on 5/14/2026 at 10:55 AM with Licensed Vocational Nurse (LVN) 9, the physician orders for Resident 2's hydrocodone-APAP 7.5-325 mg and MAR, dated 5/1/2026 to 5/14/2026 were reviewed. LVN 9 stated there were two physician orders for hydrocodone-APAP, one of which indicated to give 2 tablets every 4 hours as needed for severe pain (7-10) that could go up to 12 tablets which would be 3900 mg/day which exceeded the order limit of 3 g/day or 3000 mg/day. LVN 9 stated Resident 2 was also on 1 tablet of hydrocodone-APAP every 4 hours as needed for moderate pain (4-6), that would also add acetaminophen dose if taken throughout the day. LVN 9 stated the resident had to be monitored for respirations and pain level because hydrocodone could decrease respirations, lead to respiratory depression and resident could desat [oxygen levels drop dangerously low]. LVN 9 stated there would be a risk for hospitalization if resident desats. LVN 9 stated excessive APAP dose, and exceeding the 3g/day allowance increased Resident 2's risk for liver damage. LVN 9 stated the MAR indicated Resident 2 received two tablets of hydrocodone-APAP for pain level of 6 a few times when Resident 2should have received one tablet, according to the physician orders. LVN 9 stated Resident 2 was also on baclofen and pregabalin which increased Resident 2's risk for respiratory depression. During an interview on 5/14/2026 at 1:31 PM with the Director of Nursing (DON), the DON stated Resident 2 needed reassessment for pain as to how often the resident was taking hydrocodone-APAP and if the frequency needed to be adjusted. The DON stated, based on the orders, there was a risk of acetaminophen and liver toxicity because the orders could cause acetaminophen dose to go over 3 grams. The DON stated there was a side effect of sedation so the resident had to be monitored for respiratory depression, respiratory distress, otherwise Resident 2 could be at risk of hospitalization. The DON stated the nurse should have assessed pain and followed physician orders and given 1 tablet of hydrocodone-APAP instead of 2 tablets for the pain level of 6. During an interview on 5/14/2026 at 2:52 PM with the Consultant Pharmacist (RPH 1), RPH 1 stated if the resident was using a lot of prn [whenever necessary medications] hydrocodone-APAP, then RPH 1 would recommend the physician to change to a medication without acetaminophen. RPH 1 stated when orders had a different pain scale and nurses gave 2 tablets instead of 1 tablet, it would be considered a medication error. RPH 1 stated there would be a risk of drowsiness, falls, sedation, especially if the resident was on lot of medications such as baclofen and pregabalin. RPH 1 stated it was important to monitor the resident for respiratory depression, blood pressure and blood glucose. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed 1/2026, the P&P indicated, Medications must be administered in accordance with the orders. The P&P indicated, The licensed nurse must check the label.right medication, right dosage, right time and right method (route) of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration before giving the medication. During a review of the facility's P&P titled, Pain Assessment and Management, last reviewed 1/2026, the P&P indicated, The facility provides pain management to residents who require such services, consistent with professional standards of practice.preferences. The P&P indicated, Opioids should be selected and dosed in accordance with current professional standards of practice and manufacturer's guidelines in order to optimize their effectiveness and minimize their adverse consequences. The P&P indicated, Use of Opioids for Pain Management. 3. The facility, with the guidance from the physician, uses the lowest possible effective dosage for the shortest amount of time possible. preferences and goals for care. The P&P indicated, Decisions of strength, frequency, duration and routine versus as needed administration, are based.and not part of the nurses' scope of practice. During a review of the facility's P&P titled, Unnecessary Drugs, last reviewed date 1/2026, the P&P indicated, The intent of these requirements is to ensure each resident's entire drug/medication regimen is managed and monitored to promote.well-being. The P&P indicated, Unnecessary Drug: Any drug when used in excessive dose (including duplicate drug therapy); or for excessive duration. Adequate indications for Use: The identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition.contraindicated. Also, adequate indication for use means that the medication administered is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals.

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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 proper storage, labeling and disposal of medications in one of two inspected medication rooms (Station 3 Medication Room) and two of four inspected medication carts (Station 4 Medication Cart 1 and Controlled Care Unit Medication Cart Floor 2) as per manufacturer specifications and facility's policies and procedures (P&P) titled, Medication Storage in the Facility - Storage of Medications, dated 6/2016, Labeling of Biologicals and Storage of Biologicals, dated 1/2026 and Medication Destruction, dated 1/2026, by failing to: 1. Ensure Resident 1's lorazepam (a medication used to treat anxiety [feelings of worry and uneasiness) oral liquid was stored in a refrigerator at temperatures between 2-degree-Celsius [(C) is a unit of temperature] to 8 C or 36 Fahrenheit [(F) is a unit of temperature] to 46 F, as per manufacturer specifications, in Station 3 Medication Room Refrigerator. 2. Ensure Resident 119's discontinued ciprofloxacin (a medication used to treat bacterial infection) ophthalmic (eye) solution stored in Station 3 Medication Room was discarded and disposed of. 3. Ensure that Resident 23's Rocklatan ([generic name: netarsudil dimesylate-latanoprost] a medication used to treat high eye pressure) ophthalmic solution in Station 4 Medication Cart 1 medication label on the bottle matched with the label and medication inside. 4. Ensure Resident 130's Humulin R (a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication] used to treat high blood glucose [simple sugar- the body's primary source of energy from food]) and Resident 96's Humulin R stored in Controlled Care Unit Medication Cart Floor 2 were labeled with an open date (the exact day a medication is unsealed), according to manufacturer requirements. These deficient practices had the potential to result in Residents 1, 23, 96, 119 and 130 receiving medications that were discontinued, or that had become expired, ineffective or toxic due to improper storage and labeling possibly leading to medication errors and adverse effects such as eye complications and abnormal blood glucose levels.Findings: 1. During a review of Resident 1's admission Record (a document containing demographic and diagnostic information), dated 5/12/2026, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included encounter for palliative care and generalized anxiety disorder (a condition where a person worries constantly about everyday issues and situations). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 3/15/2026, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was moderately impaired. The MDS indicated Resident 1 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on or taking off footwear and personal hygiene. The MDS indicated eating was not attempted due to medical condition or safety concerns. During a review of Resident 1's Order Summary Report (a document containing a summary of all active physician orders) dated 5/12/2026, the order summary report indicated but not limited to the following physician order: Lorazepam concentrate 2 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) per milliliters ([mL] a unit of measurement for volume), give 0.5 mL sublingually (under the tongue) every 4 hours as needed for anxiety manifested by (m/b) restlessness and agitation for 14 days, order date 4/29/2026, start date 4/29/2026, end date 5/13/2026. During a concurrent inspection and interview on 5/12/2026 at 10:42 AM with Registered Nurse Resource Consultant (RNRC), Licensed Vocational Nurse (LVN) 6 and LVN 7 of Station 3 Medication Room, the medication refrigerator's thermometer indicated a temperature of 60 F and contained an open bottle of Resident 1's lorazepam oral concentrate liquid 2 mg/mL. RNRC stated the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lorazepam should have been removed from the refrigerator along with the other medications that were removed because the refrigerator was reading high temperatures, not working properly and facility had contacted maintenance. During an interview on 5/12/2026 at 11:11 AM with LVN 6, LVN 6 stated Resident 1's lorazepam oral liquid was not properly stored because the medication refrigerator's temperatures were high, the medication was cooking so the lorazepam might not be potent (strong). LVN 6 stated she was not sure of the side effects, but it would not be safe to administer the lorazepam liquid to Resident 1. According to the manufacturer's labeling, lorazepam oral concentrate 2 mg/mL had to be stored in refrigerator at 2 C to 8 C or 36 F to 46 F and opened bottles had to be discarded after 90 days. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/1/2026 to 5/12/2026, the MAR indicated lorazepam concentrate 2 mg/mL was administered to Resident 1 two times. During an interview on 5/14/2026 at 1:06 PM with the Director of Nursing (DON), the DON stated refrigerated medications had to be stored at manufacturer required temperatures, at 36 F to 46 F to ensure medication's potency (strength). The DON stated it would not be safe or effective to administer lorazepam oral liquid. 2. During a review of Resident 119's admission Record, the admission record indicated Resident 119 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included essential primary hypertension (HTN - high blood pressure). During a review of Resident 119's History and Physical (H&P), dated 7/21/2025, the H&P indicated Resident 119 did not have the capacity to understand and or decisions. During a review of Resident 119's physician order, dated 1/1/2026, the physician order indicated, ciprofloxacin hydrochloride (HCl) ophthalmic solution 0.3%, instill 2 drops in left eye four times a day for redness of the left eye for 7 days. During a review of Resident 119's MDS, dated [DATE], the MDS indicated Resident 119's cognition was moderately impaired. The MDS indicated Resident 119 needed setup or cleanup assistance from the facility's staff for ADLs such as eating and oral hygiene, moderate assistance for toileting hygiene, showering, upper body dressing, lower body dressing and personal hygiene, and needed maximal assistance for putting on or taking off footwear.During a review of Resident 119's Order Summary Report, dated 5/12/2026, the report indicated there were no physician orders for ciprofloxacin ophthalmic solution 0.3% (percent - a unit of measurement for dose or strength). During a concurrent inspection and interview on 5/12/2026 at 10:42 AM with LVN 7 of Station 3 Medication Room, a bottle of ciprofloxacin ophthalmic solution 0.3% was observed stored in a cabinet behind a brown door with Resident 119's name on the container. LVN 7 stated ciprofloxacin for Resident 119 was discontinued but could not find on which date the ciprofloxacin was discontinued. During a concurrent interview and record review on 5/12/2026 at 11:11 AM with LVN 6, Resident 119's MAR, dated 1/1/2026 to 1/31/2026 was reviewed. The MAR indicated ciprofloxacin ophthalmic solution 0.3% was administered to Resident 119 between 1/2/2026 and 1/8/2026. LVN 6 stated the ciprofloxacin eye drops should have been discarded soon after the medication was discontinued. LVN 6 stated it would be better to dispose of discontinued medications right away in the incineration bin, to prevent medication misuse. During an interview on 5/14/2026 at 1:06 PM with the DON, the DON stated the discontinued ciprofloxacin ophthalmic solution should have been disposed of within a week to prevent misuse and medication errors. 3. During a review of Resident 23's admission Record, dated 5/14/2026, the admission record indicated Resident 23 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis that included Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications. During a concurrent inspection and interview on 5/12/2026 at 2:42 PM with LVN 4 of Station 4 Medication Cart 1, a vial with an outside label with Resident 23's name, medication name as Rocklatan (netarsudil dimeylate -latanoprost) drops was observed and on the inside label, the vial had a label with Resident 23's name but the actual medication and medication name was Olapatadine drops. LVN 4 stated she did not work the evening shift, and the medication was for bedtime use, so she (LVN 4) was not sure how the inside bottle was placed in the incorrect (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bottle. LVN 4 stated she would need to reorder Resident 23's Rocklatan. During a review of Resident 23's Order Summary Report, dated 5/14/2026, the order summary report indicated the following physician orders: Pataday (a medication used to treat itchy eyes due to seasonal allergies) Ophthalmic Solution (Olapatadine HCl), instill one drop in both eyes in the evening for itchy eyes, order date 1/28/2025, start date 1/28/2025. Rocklatan (a medication used to treat high eye pressure) Ophthalmic Solution 0.02-0.005% (Netarsudil dimesylate-Latanoprost), instill 1 drop in both eyes at bedtime for cataract, order date 5/12/2025, start date 5/12/2025. During an interview on 5/14/2026 at 1:18 PM with the DON, the DON stated there was a risk for medication errors if the facility staff nurse gave the wrong medication based on the outside label. The DON stated the nursing staff should have checked both the inside and outside medication and labels. 4. During a concurrent inspection and interview on 5/13/2026 at 2:40 PM with LVN 8 of Controlled Care Unit Medication Cart Floor 2, the following medications were found in the medication cart without an open date:a. One vial of unopened Humulin R 100 units/mL for Resident 130 without an open date.b. One vial of unopened Humulin R 100 units/mL for Resident 96 without an open date. The manufacturer's product labeling was reviewed with LVN 8, the label indicated unopened Humulin R vials had to be stored in refrigerator at 2 C to 8 C or 36 F to 46 F and in-use or opened vials of Humulin R could be stored below 30 C (86 F) and discarded within 31 days if not used. LVN 8 stated the Humulin R vials should have been labeled with an open date when stored in the medication cart or stored in refrigerator when unopened. LVN 8 stated it would be difficult to determine expiration date after the insulin was stored in medication cart, without an open date. During an interview on 5/14/2026 at 1:18 PM with the DON, the DON stated it was important to store insulins in the refrigerator to maintain potency or label with the open date when not in the refrigerator, because the insulins have different expiration dates, 28 days, 31 days, etc. The DON stated the insulin might not properly treat blood sugar levels if not stored properly. During a review of the facility's P&P titled, Medication Storage in the Facility - Storage of Medications, dated 6/2016, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The P&P indicated, The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by.(USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medication to the original container. The P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers that are.are immediately removed from inventory, disposed of according to procedures for medication disposal.and humidity. The P&P indicated, Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 C (36 F) and 8 C (46 F) with a thermometer to allow temperature monitoring. The P&P indicated, Medications requiring refrigeration until opened: A. Insulin-once opened should be kept outside of refrigerator. All insulin except for those listed in 2 shall be discarded 28 days after opening. 2. The following insulins shall be discarded after opening as follows: Levemir (42 days). (56 days). The P&P indicated, All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining.manner.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the transportation was not late during hemodialysis appointments for one of one resident (Resident 190).This failure resulted in Resident 190's hemodialysis session shortened, and had a potential to cause fluid retention, shortness of breath, and altered laboratory test results.Findings:During a review of face sheet of Resident 190, dated 4/29/2026, the face sheet indicated the resident 190 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia (sudden difficulty breathing and oxygen exchange due to damage in lungs), and end stage renal disease (irreversible loss kidney function), renal hemodialysis dependance (HD, a long term treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed).During a review of Minimum Data Set (MDS, resident assessment tool) dated 5/5/2026, the MDS indicated the Resident 190's cognitive patterns were intact (able to comprehend complex concepts, memory intact, and verbalize own needs), as evidenced by Brief Interview for Mental Status score of 14 (BIMS score, an assessment tool to screen and identify memory, orientation, and judgement status of the resident). The MDS indicated that Resident 190's functional abilities (abilities to perform activities of daily living, such as eating, dressing, walking, toileting) required supervision/touching assistance for eating, partial/moderate assistance (helper does less than half the effort) with oral hygiene, substantial/maximal assistance with dressing, rolling in bed, dependence with sit to stand, chair/bed transfers, and toileting and showering.During a concurrent observation and interview on 5/12/2026 at 8:08 a.m. with Resident 190, Resident 190 stated there were issues with scheduling of the transportation for HD. Resident 190 stated on 5/11/2026 the ambulance came one hour late to pick him up, and 45 minutes (min.) late to bring me back to the facility. On 5/11/2026 it was most notable, but they were late several times. Resident 190 stated there seems to be a problem in scheduling the HD center staff made me sign some paper about the shorter session.During a concurrent observation and interview 5/13/2026 at 9:07 a.m. with Resident 190, Resident 190 was still in his room waiting for his transportation for HD. Resident 190 stated they were running late again, and no one has told me anything. It is wrong, my dialysis time gets shortened, and other residents' dialysis would be delayed or shortened too. Nurses at the HD clinic get upset too. HD clinic made me sign the paper that my session is cut short.During a concurrent observation and interview on 5/13/2026 at 9:14 a.m. with the emergency medical technician (EMT) 1 stated, the dispatch sends us information about who and where to pick up, and destination, but not exact pick-up time.During an observation on 5/13/2026 at 9:29 am Resident 190 left the facility.During a concurrent phone interview and record review on 5/13/2026 at 9:36 a.m. with a Case Manager (CM) 2, scheduled the transportation, CM 2 stated Resident 190's HD start time was at 9:30 a.m., pick up time 8:30 a.m. or 9 a.m. CM 2 stated did not know the Physician's order for Resident 190's dated 4/29/2026, the pick-up time was at 8:15 a.m. CM 2 stated Resident 190's was being late and HD time would be shortened.During an interview on 5/13/2026 at 10:20 a.m. with RN 3, RN 3 stated that CM 2 had to follow the order for dialysis arrangement of transportation.During a concurrent interview and record review on 5/14/2026 at 10:11 a.m. with Licensed Vocational Nurse (LVN) 2 dialysis communication record dated 5/11/26 was reviewed, LVN 2 stated the facility usually notifies the dialysis center if transportation was late. LVN 2 stated the dialysis record did not have time indicating when HD treatment started and ended. LVN 2 stated she was not aware Resident 190's dialysis was cut short on 5/11/2026. LVN 2 stated, If we were aware about HD was being cut short, I would notify the physician.During an interview on 5/14/2026 at 10:45 a.m. Director of Nursing (DON), the DON stated the facility communicates with HD center mainly via phone. If dialysis center cut HD session short, they should have communicated with us.During a concurrent interview and record review on 05/14/2026 at 12:50 p.m. with Assistant Director of Nursing (ADON) 1, an Early Termination of Treatment Against Medical Advice form (AMA, a (continued on next page)

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form signed by residents declining recommended medical treatment), dated 5/11/2026 was reviewed. The AMA form indicated the shortened dialysis treatment by 24 minutes (min) (prescribed dialysis treatment time was195 min) due to coming late.During an interview on 5/14/2026 at 5:15 p.m. with DON, DON stated CM 2 did not follow resident's care plan or order for dialysis. The DON stated CM 2 should have followed care plan and orders. DON stated if Resident 190 was running late due to transportation, facility should have communicated to CM 2, and to dialysis center to ask if they can still accommodate so Resident 190 can get the full treatment. The DON stated dialysis facility should have alerted and called the facility that the resident did not receive the full dialysis treatment. The DON stated staff should have alerted the physician that the resident's dialysis was cut short. DON stated there was potential for Resident 190 to have fluid retention, fluid overload, shortness of breath, altered laboratory test results and might require a transfer to the hospital.During a record review of the facility's policy and procedure titled Dialysis Management dated 3/2023, the P & P indicated: The facility has an agreement with contracted Dialysis Unit(s) which operates in accordance with current standards of practice, including communication and collaboration. The P &P indicated the Dialysis Unit(s) and facility staff coordinate the development and implementation of the dialysis care plan, including the ongoing provision of assessment of the resident and care plan revision, as necessary. The P & P indicated the facility has a qualified social services representative who assists the dialysis resident and their representative with dialysis related transportation needs.During a record review of Nursing Home Dialysis Transfer Agreement, dated 4/28/2025, indicated Transportation of designated resident: facility shall have the responsibility for arranging suitable transportation of the Designated Resident to and from Center.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review the facility failed to ensure the call light (a device used by a resident to signal his or her need for assistance) was within reach for one of four sampled residents (Resident 85). This deficient practice had the potential to result in staff delay in meeting Resident 85's needs for activities of daily living (ADLS, activities a person performs daily such as bathing, dressing, and toileting), prolonged distress and increased risk of falls for Resident 85.Findings:During a review of Resident 85's admission Record, the admission Record indicated the facility admitted Resident 85 on 2/21/2025 with diagnoses that included essential primary hypertension (HTN-high blood pressure), history of falling, gastro-esophageal reflux disease (stomach acid is rising into the esophagus, the hollow, muscular tube that carries food and liquid from your throat to the stomach), difficulty walking, reduced mobility, muscle weakness, and dementia (a progressive state of decline in mental abilities). During a review of Resident 85's Care Plan Report, titled The resident (Resident 85) is at risk for falls r/t (related to gait (the manner or pattern of walking)/balance problems, incontinence B&B (bowel and bladder incontinence - a problem holding your peeing or pooping), diagnoses of history of fall with left tibia fracture (breaking your shin bone), dementia, muscle weakness, HTN meds use for side effects, last revised on 2/21/2025, the care plan report indicated an intervention (purpose-driven actions nurses make to improve, maintain or restore a patient's health) for Resident 85's call light to be within reach and to encourage Resident 85 to use the call light for assistance as needed. The care plan indicated an intervention to promote safe environment with: (Example: even floors free from spills and/or clutter [a messy jumble of objects]; adequate, glare-free lights [designed to soften brightness and prevent harsh rays from shining directly into your eyes], a working and reachable call light, personal items within reach). During a review of Resident 85's Care Plan Report, titled Bowel and Bladder Incontinence: Poor candidate for bowel and bladder training due to ADL (Activities of Daily Living - activities such as bathing, dressing and toileting a person performs daily) due to cognitive impairment (having trouble with any aspect of mental functioning, such as remembering, learning new things, concentrating, or making decisions), last revised on 2/12/2024, the care plan report indicated an intervention to anticipate Resident 85's need for toileting. During a review of Resident 85's History and Physical (H&P), dated 3/4/2026, the H&P indicated Resident 85 did not have the capacity (ability) to understand and make decisions. During a review of Resident 85's Minimum Data Set (MDS - a resident assessment tool), dated 4/22/2026, the MDS indicated Resident 1 usually had the ability to make herself (Resident 85) understood and usually had the ability to understand others. The MDS indicated Resident 85 was dependent (helper does all of the effort to complete activity) on facility staff for toileting hygiene (ability to clean their private area and adjust clothes after peeing or pooping), shower/bathing self (Resident 85), putting on/taking off shoes, and for tub/shower transfer (ability to get in and out of the tub/shower). The MDS indicated Resident 85 needed partial/moderate assistance (helper helps with less than half the effort - helper lifts, holds, and supports chest area, arms, and legs) from facility staff for rolling left and right, going from sitting to lying, lying to sitting on the side of the bed. During a concurrent observation and interview on 5/11/2026 at 10:16 AM with Licensed Vocational Nurse 17 (LVN 17), in Resident 85's room, Resident 85's call light was observed to be lying on the floor, out of Resident 85's reach. LVN 17 verified Resident 85's call light was on the floor and out of Resident 85's reach. LVN 17 stated he (LVN 17) would sanitize (to free from dirt, germs, by cleaning or sterilizing) Resident 85's call light and would put the call light within Resident 85's reach so Resident could ask for help if needed. During a review of the facility's policy and procedure (P&P) titled, Resident Call System, last reviewed 4/14/2026, the P&P indicated The facility is adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from the residents' bedside, floor, or toileting facilities. The P&P indicated some residents (in general) may need a specialized call light, such as a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555397	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Los Angeles	340 South Alvarado Street Los Angeles, CA 90057

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call pad to request assistance. The P&P indicated resident call system shall be accessible to resident while in their bed or other sleeping accommodations within the residents' (in general) room.