STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555438	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kei-Ai Los Angeles Healthcare Center	2221 Lincoln Park Ave Los Angeles, CA 90031

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to: 1. Notify Resident 262's physician when Spironolactone (a blood pressure medication prescribed for congestive heart failure, or CHF-a condition in which the heart cannot pump blood effectively) was unavailable on 02/16/2026.2. Positively identify Residents 260 and 262 before giving medications, increasing the risk of medication errors and harm.3. Maintain accurate emergency medication kit (Ekit, a secured, organized container holding essential, often pre-packaged, drugs and supplies designed for rapid access to treat specific health conditions, emergencies, or, in hospice settings, to provide immediate comfort care) usage records for all residents, putting residents at risk of not receiving needed medications during emergencies.4. Ensure both incoming and outgoing nurses counted and signed for controlled drugs (medications regulated by the Controlled Substances Act [CS] due to their potential for abuse, addiction, or diversion [Schedules II-V]. Requiring strict, secure storage, precise, ongoing inventory counts, and documented administration by licensed staff) together during shift change, increasing the risk of drug loss or misuse. These failures could lead to residents, including Residents 260 and 262 or any resident needing Ekit medications, receiving the wrong medication, missing doses, or experiencing adverse health outcomes such as hospitalization, serious injury, or misuse of controlled drugs.Findings: 1. During a review of Resident 262's admission record, the admission record indicated that Resident 262 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hypertensive heart disease (heart problems caused by long-term high blood pressure). During a review of Resident 262's Minimum Data Set (MDS, a resident assessment tool) dated 11/28/2025, the MDS indicated that Resident 262's cognitive skills (ability to think and reason) were intact. During a review of Resident 262's History and Physical (H&P) dated 12/19/2025, the H&P indicated the resident did not have the capacity to make healthcare decisions. During a review of Resident 262's current Order Review History Report, printed on 02/17/2026 and electronically signed by the prescriber, the report included an active medication order for Spironolactone 50 milligram (mg, unit of measure by weight) Oral Tablet, instructions indicated to give one tablet by mouth one time a day for CHF, order date 1/30/2026 During a review of Resident 262's Medication Administration Record (MAR, a document used to track the administration of prescribed medications to residents) for the month of 2/2026, the MAR indicated that Resident 262's Spironolactone ordered dose on 2/16/2026 scheduled for the 9:00 AM medication administration was initialed by a licensed nurse and was marked with 4, and according to the MAR legend, 4 indicated the medication was held/other reason/ or see progress notes. During a medication pass observation, interview, and record review on 2/17/2026 at 9:00 AM, with a Licensed Vocational Nurse (LVN) 3, LVN 3 was preparing morning medications for Resident 262, at Station D-Wing, MedCart B. LVN 3 after searching MedCart B stated the Spironolactone for Resident 262 was not available. LVN 3 reviewed Resident 262's MAR for 2/16/2026 and confirmed that Resident 262's Spironolactone was also not available the day prior, 2/16/2026. During an interview on 2/17/2026 at 9:04 AM with LVN 3, LVN 3 stated she did not notify the pharmacy on 2/16/2026 regarding Resident 262 being out of Spironolactone, resulting in the (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident missing a dose. During a concurrent interview and record review on 2/17/2026 at 2:26 PM, with LVN 3, Resident 262's MAR and nursing progress notes for the month of 2/2026 were reviewed. The nursing progress note dated 2/16/2026, timed at 9:13 AM, indicated that Spironolactone was Not available. LVN 3 stated that she did not notify the prescriber or document that Resident 262 missed a dose of Spironolactone on 2/16/2026. During a concurrent interview and record review on 2/19/2026 with the Director of Nursing (DON), Resident 262's physician order, nursing progress notes, and MAR for the month of 2/2026 were reviewed. The DON stated Resident 262's MAR for 2/16/2026, regarding the scheduled 9:00 AM dose of Spironolactone, was marked with the code 4, indicating that the medication was held. After reviewing Resident 262's nursing progress notes for 2/16/2026 and 2/17/2026, the DON stated there were no notes documented to indicate the reason Spironolactone was held on 2/16/2026, and there was no documentation that the physician was notified that the resident did not receive the medication. The DON stated the physician should have been notified. A review of the facility's undated policy and procedures (P&P) titled, Medication Ordering and Receiving, indicated, Note: Communication between nursing and pharmacy is crucial to ensure resident does not experience a missed dose. A review of the facility's P&P titled, Administering Medications, dated 4/2025, indicated, Medications are administered in accordance with prescriber orders, including any required time frame. 2a. During a review of Resident 262's admission record, the admission record indicated that Resident 262 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Hypertensive heart disease (heart problems caused by long-term high blood pressure). During a concurrent medication pass observations and interview on 2/17/2026 at 9:04 AM, with LVN 3, on Station D-Wing, MedCart B, LVN 3 prepared morning medications for Resident 262. LVN 3 stated she prepared three medications for Resident 262. LVN 3 entered Resident 262's room, stated the resident's name and administered the medications. LVN 3 was not observed verifying the resident's identity before administering the following medications: Apixaban (an oral anticoagulant used to prevent blood clots) 5 mg, one tablet. Escitalopram (a medication used to treat depression and anxiety) 10 mg, one tablet. Benztropine (a medicine that helps control shaking or stiffness from Parkinson's disease or certain mental health medicines) 1 mg, one tablet. During an interview on 2/17/2026 at 9:10 AM with LVN 3, LVN 3 stated that she already knew the resident. LVN 3 stated she asked Resident 262 her name, but the resident could not hear LVN 3. LVN 3 stated she did not know that Resident 262 had a hearing problem, and that Resident 262 was complaining that she could not hear.2b. During a review of Resident 260's admission record, the admission record indicated Resident 260 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included HTN and hyperlipidemia (high cholesterol in the blood). During a concurrent medication pass observations and interview on 2/17/2026 at 10:15 AM, with LVN 6, on Station 2, MedCart B, LVN 6 prepared morning medications for Resident 260. LVN 6 stated she prepared a total of seven medications, then entered the resident's room, stated the resident's name and administered the medications. LVN 6 was not observed verifying the resident's identity before administering the following medications:Labetalol (treat high blood pressure) 100 mg one tablet. Lisinopril (treat high blood pressure) 40 mg, one tablet. Vitamin C (vitamin supplement) 250 mg, one tablet. Cranberry (supplement to treat or prevent urinary tract infections) 450 mg, one tablet. Vitamin B12 (vitamin supplement) 1 mg, one tablet. Magnesium Oxide (used to help prevent and treat low levels of magnesium in the body) 400 mg, one tablet. Ferrous Gluconate (used to treat iron deficiency) 240 mg, one tablet. During an interview on 2/17/2026 at 10:21 AM with LVN 6, LVN 6 stated she should have checked Resident 260's identification name band before administering the medications to the resident. LVN 6 stated facility nurses were supposed to check resident identification prior to giving medications to be sure the correct resident was receiving the correct medication. A review of the facility's P&P dated 4/2025, titled, Administering Medications, the P&P indicated, The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. checking identification band;b. checking (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	photograph attached to medical record; andc. if necessary, verifying resident identification with other facility personnel. 3. During a medication storage area inspection and interview on 2/18/2026 at 11:36 AM, with a Registered Nurse (RN) 1, of Station 3 Medication Room and the Ekit usage was reviewed. RN 1 stated the facility did not keep a copy of the Ekit usage log. RN 1 stated the Ekit usage log was faxed to the pharmacy and then the form was put back inside of the Ekit and sent with the Ekit to the pharmacy. RN 1 stated the facility did not keep a copy of the Ekit usage which included both controlled Ekits, Injectable Ekits, and non-controlled Ekits, such as oral and antibiotic medications. During an interview on 2/18/2026 at 4:49 PM with the DON, the DON stated the facility did not have a process to monitor or track Ekit usage in the facility. A review of the facility's undated P&P titled, Emergency Medication Supply Procedures, indicated Medications will be available for administration to residents in emergency situations and situations requiring immediate administration of a medication 24 hours/ day, 7 days/week.Separate kits may be maintained according to routes of administration or storage needs.The nurse removing the medication from the emergency kit also enters a record of the medication withdrawn in the emergency medication administration record (log book) that is kept in the vicinity of the emergency kit. The record shall include the name and dose of each medication being used, the name of the resident to whom the medication is being administered, the time and date of medication administration, and the signature of the person who administers the medication. This emergency medication administration record must be retained as a permanent record .The pharmacist consultant monthly inspects the kits for expiration dating and integrity. Discrepancies are reported to the director of nursing services. 4a. During a concurrent medication storage area inspection and interview on 2/18/2026 at 3:39 PM of Station 1 MedCart B with LVN 4, a form titled, Controlled Drugs Inventory, was reviewed, and the spaces for nurses' signature In and Out for the 3 PM to 11 PM shift on 3/18/2026 was blank. LVN 4 stated that she was the incoming nurse and that she counted the controlled medications in the medication cart with the outgoing nurse for Station 1 MedCart B, but they both forgot to sign and the outgoing nurse had already left for the day. LVN 4 stated it was important to sign the Controlled Drugs Inventory form with two nurses to ensure the controlled count was correct, complete, and to prevent diversion (misuse) of controlled medications. 4b. During a concurrent medication storage area inspection and interview on 2/18/2028 at 4:10 PM of Station 1 MedCart A with LVN 5, a form titled Controlled Drugs Inventory,' was reviewed, and the space for nurses' signature Out for the 11 PM to 7 AM shift on 2/18/2026 was initialed/signed. LVN 5 stated that she accidentally signed the shift change (Controlled Drugs Inventory) form ahead of time before the end of the shift and before the next nurse arrived. LVN 5 stated it was important to sign together with the incoming nurse to prevent medication discrepancies especially for controlled medications. During a concurrent interview and review of the Controlled Drugs Inventory for Station 1, MedCart A, and Station 1, MedCart B on 2/18/2026 at 4:22 PM with the Assistant Director of Nursing (ADON), the ADON stated that when the next shift nurse arrives for Station 1 MedCart A, both the incoming and outgoing nurses were required to count the controlled medications together. The ADON stated that after counting, both nurses were required to sign the Controlled Drugs Inventory form together. The ADON stated that signing the Controlled Drugs Inventory form confirmed the controlled count was accurate and that the outgoing nurse was endorsing (formally handing over responsibility for) the medication cart to the incoming nurse. The ADON stated that failing to sign the form together could result in uncertainty about the accuracy of the controlled medications and could delay the discovery of any missing controlled medications. A review of the facility's P&P titled, Controlled Substances, dated 11/2025, indicated, Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count.The nurse coming on duty and nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure four of seven residents (Resident 260, 129, 8, and 83) were 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 assess Resident 260, 129, 8, and 83's systolic blood pressure (SBP - the pressure in the arteries when the heart beats [bpm]) and/or heart rate in accordance with physician's orders, with a parameter [specific, measurable instructions or limits that define exactly how, when, and under what conditions a medication should be given] to check BP and/or the heart rate (HR - how fast the heart beats, measured by taking the pulse, which is the throbbing of the arteries as blood is pushed through them) as a condition to give or hold blood pressure medications, manufacturer's specification, and the facility's policy and procedures (P&P) titled, Administering Medications dated 4/2025. This deficient practice increased the risk that Residents 260, 129, 8, and 83 experience adverse reactions (negative effects from medication), that include hypotension (low blood pressure [BP]) and bradycardia (a slower than normal heart rate), that could lead to a decline in the residents' condition, harm, or hospitalization.Findings: 1. During a review of Resident 260's admission record, the admission record indicated Resident 260 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertension (HTN, high blood pressure) and hyperlipidemia (high cholesterol in the blood). During a review of Resident 260's Minimum Data Set (MDS, a resident assessment tool) dated 1/16/2026, the MDS indicated Resident 260's cognitive skills (ability to think and reason) was moderately impaired.Review of Resident 260's Order Review History Report, printed on 02/17/2026 and electronically signed by the prescriber, included the following active medication orders for the resident:Labetalol (medication used to treat HTN) 100 milligrams (mg, unit of measurement by weight) tablet, instruction to give one tablet by mouth two times a day for HTN. Hold for SBP less than 110 millimeters of mercury (mmHg, a unit for measuring blood pressure, normal SBP range: 90-120 mmHg) or HR less than 60 bpm (normal HR range: 60-100 bpm), order date 7/28/2025.Lisinopril (medication used to treat HTN) 40 mg tablet, instruction to give one tablet by mouth one time a day for HTN. Hold for SBP less than 110, order date 7/28/2025. During a review of Resident 260's care plan initiated on10/21/2024, the Care Plan focus indicated Resident 260 was at risk for Cardiac Distress (a condition characterized by symptoms such as chest pain, shortness of breath, or irregular heartbeat; cardiac distress can increase the workload on the heart and may contribute to elevated blood pressure) related to hyperlipidemia and HTN. The care clan indicated Resident 260 would remain free from signs and symptoms of cardiac distress. The care plan interventions indicated to administer Labetalol and Lisinopril as ordered.monitor apical pulse (heartbeat heard at the chest with a stethoscope) and blood pressure (BP) as indicated in the medication parameter. During a medication pass observation on 2/17/2026 between 9:58 AM to 10:18 AM, with Licensed Vocational Nurse (LVN) 6, LVN 6 was observed preparing medications that included the following BP medications: Labetalol 100 milligrams (mg, unit of measurement), one tablet and Lisinopril 40 mg, one tablet. LVN 6 stated she prepared a total of seven medications, and then entered the resident's room, called the resident by name and administered the medications. LVN 6 was not observed checking Resident 260's blood pressure (BP) or heart rate (HR) prior to administering the two BP medications Ldabetalol and Lisinopril.During an interview on 2/17/2026, at 10:21 AM, LVN 6 stated the Certified Nurse Assistants (CNA) normally checked the residents' vitals (measurements of essential body functions, such as blood pressure, heart rate, temperature, and respiratory rate). LVN 6 provided a handwritten paper that included Resident 260's BP and HR and stated the vital sign readings were provided to LVN 6 by CNA 1. LVN 6 acknowledged the paper with residents' vital signs did not include the date or time the vital signs were taken. LVN 6 acknowledged the vital signs were taken two and one-half hours earlier by CNA 1, on 2/17/2026 between 7:30 AM to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7:45 AM. During an interview on 2/17/2026 at 10:28 AM with CNA 1, in the presence of LVN 6, CNA 1 stated Resident 260's vitals were taken between 7:30 AM to 7:45 AM on 2/17/2026. CNA 1stated he (CNA 1) checked the vital signs of eight residents, which included the vital signs for Residents 260, 129, 8, and 83 before breakfast and once done provided the results to LVN 6. During a review on 2/17/2026 at 10:30 AM, with CNA 1 and LVN 6, CNA 1 confirmed the handwritten paper was the vital signs he (CNA 1) had taken earlier that day, 2/27/2026 between 7:30 AM to 7:45 AM which included the following undated and untimed BP readings:Resident 260's BP was documented as 136/78 (mmHg) and HR as 80 (bpm). Resident 129's BP was documented as 151/87 (mmHg) and HR as 57 (bpm).Resident 8's BP was documented as 134/65 (mmHg) and HR as 79 (bpm).Resident 83's BP was documented as 132/68 (mmHg) and HR as 71 (bpm). During a follow up interview on 2/17/2026 at 10:31 AM, with LVN 6, LVN 6 stated she (LVN 6) usually relied on the vitals taken by the CNAs to determine to give or hold BP medications to the residents. LVN 6 stated she could not verify based on the undated and untimed form when the vitals, that included BP and HR were taken by CNA 1 on 2/17/2026. LVN 6 stated that it was important to recheck the residents BP and HR to make sure the BP and HR readings were accurate before administering BP medications with an ordered parameter. LVN 6 stated if BP medications were administered outside of the ordered parameters residents could experience symptoms that include low blood pressure, weakness, change in cognition and alertness, syncope (brief loss of consciousness), which could lead to hospitalization. 2. During a review of Resident 129's admission record, the admission record indicated Resident 129 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included HTN, hyperlipidemia (high cholesterol in the blood), and hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke, loss of blood flow to the brain) affecting left non-dominant side (left side of the body that is not primarily used). During a review of Resident 129's MDS, dated [DATE], the MDS indicated Resident 129's cognitive skills were moderately impaired. Review of Resident 129's Order Review History Report, printed on 02/17/2026 and electronically signed by the prescriber, the report included the following active medication orders for the Resident 129:Amlodipine (medication used to treat HTN) 10 mg tablet, instructions to give one tablet by mouth one time a day for HTN. Hold for SBP less than 110 or HR less than 60, order date 6/18/2023.Lisinopril 40 mg tablet, instruction to give one tablet by mouth one time a day for HTN. Hold for SBP less than 110, order date 10/23/2023. Metoprolol (medication used to treat HTN) 50 mg tablet, instruction to give one tablet by mouth two times a day for HTN. Hold for SBP less than 110 mmHg or HR less than 60 bpm. Give with food/snack, order date 2/18/2025During a review of Resident 129's Care Plan, initiated 7/2/2022, with next target date of 3/9/2026, the Care Plan focus indicated Resident 129 was at risk for Cardiac Distress related to atrial fibrillation (A-fib, an irregular and often rapid heartbeat) and cerebrovascular accident (CVA, stroke; sudden loss of blood flow to the brain), hyperlipidemia and HTN. Resident 129 Care Plan interventions indicated to, Administer prescribed medication.Monitor apical pulse and blood pressure as indicated in the medication parameter. During a concurrent interview and record review on 2/17/2026 at 10:38 AM, with LVN 6, Resident 129's Medication Administration Record (MAR, a document used to track and record the administration of medications to residents or patients) for 2/17/2026 was reviewed and documentation and licensed nurse initials indicated Resident 129 was administered the BP medications Amlodipine 10 mg, Lisinopril 40 mg, and Metoprolol 50 mg on 2/17/2026 at 9:36 AM, without reassessing the resident's BP and HR. LVN 6 acknowledged Resident 8' vital signs were checked about two hours earlier by CNA 1, on 2/17/2026 between 7:30 AM to 7:45 AM. 3. During a review of Resident 8's admission record, the admission record indicated Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included HTN, hyperlipidemia, and hyperlipidemia, and hemiparesis following cerebral infarction affecting left non-dominant side. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8's cognitive skills were moderately impaired. Review of Resident 8's Order Review History Report, printed on (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/17/2026 and electronically signed by the prescriber, included the following active medication orders for Resident 8: Lisinopril 20 mg tablet, instruction to give one tablet by mouth one time a day for HTN. Hold for SBP less than 110, order date 2/12/2026. During a review of Resident 8's Care Plan, initiated 1/3/2026, the Care Plan focus indicated Resident 8 was at risk for Cardiac Distress related to CVA with left sided weakness, A-fib, HTN, hyperlipidemia, and Coronary Artery Disease status post stent (CAD S/P stent - heart artery narrowing treated with a tube called a stent). Resident 8 Care Plan interventions indicated to administer Lisinopril Oral Tablet as ordered. Observe and notify MD for new onset of confusion, change in the level of consciousness, shortness of breath, coughing, congestion, puffy eyelids, edema (swelling from excess fluid in tissues), weakness and easy fatigability (getting tired more easily than usual) secondary to fluid overload (excess water in the body, which strains the heart and lungs). During a concurrent interview and record review on 2/17/2026 at 10:38 AM, with LVN 6, Resident 8's MAR for 2/17/2026 was reviewed and documentation and licensed nurse initials indicated Resident 8 was administered the BP medication Lisinopril 20 mg on 2/17/2026 at 9:52 AM, without reassessing the resident's BP. LVN 6 acknowledged Resident 8' vital signs were checked over two hours earlier by CNA 1, on 2/17/2026 between 7:30 AM to 7:45 AM. 4. During a review of Resident 83's admission record, the admission record indicated Resident 83 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included HTN and hyperlipidemia, peripheral vascular disease (poor blood flow in the legs and arms due to narrowed blood vessels), myocardial infarction type 2 (a type of heart attack caused by a lack of oxygen to the heart, not a blocked artery), and chronic kidney disease, stage 4 (serious loss of kidney function; kidneys are not working well). During a review of Resident 83's MDS, dated [DATE], the MDS indicated Resident 83's cognitive skills were severely impaired. Review of Resident 83's Order Review History Report, printed on 02/17/2026 and electronically signed by the prescriber, included the following active medication orders for the resident:Amlodipine 10 mg tablet, instruction to give one tablet by mouth one time a day for HTN. Hold for SBP less than 120, order date 7/12/2024 During a review of Resident 83's Care Plan, initiated 3/7/2024, the Care Plan focus indicated Resident 83 was at risk for Cardiac Distress related to, CAD, congestive heart failure (CHF, a condition where the heart cannot pump blood well), use of a diuretic (a medicine that helps the body get rid of extra fluid), hyperlipidemia, HTN, and myocardial infarction. Resident 83 Care Plan interventions indicated to administer Amlodipine as ordered. Observe and notify MD when resident is experiencing change in the level of consciousness, shortness of breath, chest pain, restlessness, cyanosis, weakness, palpitation, secondary to cardiac distress. Monitor apical pulse and blood pressure as indicated in the medication parameter. During a concurrent interview and record review on 2/17/2026 at 10:38 AM, with LVN 6, Resident 83's MAR for 2/17/2026 was reviewed and documentation and licensed nurse initials indicated Resident 83 was administered the BP medication Amlodipine 10 mg on 2/17/2026 at 9:39 AM, without reassessing the resident's BP. LVN 6 acknowledged Resident 8' vital signs were checked over two hours earlier by CNA 1, on 2/17/2026 between 7:30 AM to 7:45 AM. During an interview on 2/18/2026 at 5:09 PM with the Director of Nursing (DON), the DON stated residents' BP should have been checked prior to, and as close as possible to the medication administration time. The DON stated that if a resident's BP and heart rate (HR) were checked two hours before medication administration, the licensed nurse had to recheck the resident's BP and HR immediately prior to administering the BP medication when there were ordered parameters, in order to prevent a decline in the resident's condition. A review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2025, indicated, Medications are administered in accordance with prescriber orders.The following information is checked/verified for each resident prior to administering medications.b. Vital signs, if necessary. A review of the facility's undated P&P titled, Medication Administration Principles, indicated, Vital signs (blood pressure, pulse rate, respiration) or blood sugar levels required for medication orders with hold parameters are taken prior to the administration of the medication and recorded on the MAR. During a review of the Food (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and Drug Administration (FDA)- approved prescribing information (package insert), revised 8/2024, the package insert for Lisinopril indicated, Hypotension: Patients with other heart or renal diseases have increased risk, monitor blood pressure after initiation.Patients at risk of excessive hypotension include those with the following conditions or characteristics: heart failure with systolic blood pressure below 100 mmHg. During a review of the Food and Drug Administration (FDA)- approved prescribing information (package insert), revised 8/2024, the package insert indicated, Metoprolol tartrate tablets are contraindicated in severe bradycardia.systolic blood pressure less than 100.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record reviews, the facility failed to ensure safe and sanitary food storage practices when: 1. Seven packages of turkey breast exceeding storage period (the amount of time a food product remains safe to eat and keeps its best quality) were stored in the facility's Walk-in refrigerator. 2. The temperature of the resident refrigerator located next to the nurse's station on the first floor was not maintained in a safe temperature range and was not monitored for unsafe refrigerator temperatures. These deficient practices had the potential to result in harmful bacteria growth that could lead to foodborne illness in 275 out of 283 residents who received food from the facility and including residents who had food stored in the resident refrigerator.Findings: During a concurrent observation in the refrigerator storage area located outside of the kitchen and interview on 2/17/2026 at 9:30 AM, Seven packages of previously frozen, turkey breast were stored in the walk-in refrigerator marked with dates 2/8/2026-2/9/2026. The Turkey breast was removed from original box, and the individual packages of turkey did not have any marking or manufactures use by date (a safety marker indicating the last date recommended for consuming a product while it is at its peak quality). The turkey breasts were stored inside a large plastic container that was labeled by the facility 2/8/2026 -2/9/2026. The Dietary Supervisor (DS) and Dietary Lead (DL), DL stated they would discard the turkey because it was removed from freezer to thaw on 2/8/2026 and staff did not label and date correctly. The DL stated everything was thawed for 3 days and then cooked or used. The DL stated the turkey breast were previously frozen products, staff removed them from the freezer and the portion that was not used should have been discarded. During a concurrent observation and interview with the DS and the DL on 2/17/2026 at 9:40AM, the DS was observed removing the turkey remove the turkey from storage to discard. The DS stated the packages of turkey were not labeled correctly and could have been a potential for residents to get sick. During a review of facility policy and procedures titled Food Receiving and Storage with a revised date of 10/2017, the policy indicated All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). During a review of the 2022 U.S. Food and Drug administration Food Code 3-501.18 titled Ready-to-Eat, time/temperature control for safety food, disposition. Indicated, A food specified in code 3-501.17 (A) or (B) shall be discarded if it: 2) is in a container or package that does not bear a date or day; 3) is inappropriately marked with a date or date that exceeds a temperature and time combination During a review of 2022 U.S. Food and Drug administration Food Code 3-501.17 titled Ready-to-Eat, Time/Temperature Control for safety Food, Date marking indicated B) Ready to eat time/temperature control for safety food prepared and packaged by food processing plant shall be clearly marked at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations and 1)the day or date marked by the food establishment may not exceed a manufacturer's use by date if the manufacturer determined the use by date based on food safety. 2. During an observation of the resident refrigerator located next to the nurse's station on the first floor on 2/18/2026 at 10:30AM, the thermometer inside the refrigerator unit registered at 45 degrees Fahrenheit (F). During the same observation there was one facility prepared lunch sandwich, snacks for a resident (unidentified), juices, and high calorie nutrition shakes were also observed in the refrigerator. During a concurrent observation and interview with Nurse Supervisor (RN4) on 2/18/2026 at 10:30AM, RN4 stated the refrigerator temperature was checked by the dietary staff. RN4 stated the normal temperature for food refrigerator was 41 degrees (F) and below. RN4 stated the perishable sandwich and snacks for the residents and juices had to be discarded because they were not stored at the right temperature. During a review of the temperature monitoring log dated February 2026, the temperature of the refrigerator was above 41 degrees (F) eight times on:2/1/2026: 42degrees F2/3/2026: 42degreesF2/10/2026: 42degrees F2/11/2026: 42 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	degrees F2/12/2026: 46 degrees F2/13/2026: 48 degrees F2/14/2026: 46 degrees F2/18/2026: 42 degrees FDuring the same review of the temperature monitoring log dated February 2026, no corrective actions for the out-of-range temperature were documented. During an interview with the Dietary Lead (DL) and the Registered Dietitian (RD1) on 2/18/2026 at 12:00PM, the DL stated dietary staff were responsible for checking the temperature of the resident refrigerators. The DL stated there were several out-of-range temperatures in February 2026 that were not brought to the DL's attention. The DL stated food was not stored in safe temperatures and residents could get sick. During an interview with the Director of Nursing (DON) on 2/18/2026 at 12:40PM, the DON stated the refrigerator was not working and would be replaced immediately. The DON stated that when the refrigerator temperature was not in range staff had to notify the maintenance supervisor. A review of the temperature log titled HACCP Refrigerator temperature Log-One Form Per Month for refrigerator Location: Nursing Station 1st Floor, dated 2/2026, indicated Maintain refrigerator temperature at 40F or below during stable times; complete corrective action column if temperature are not in proper ranges. A review of facility policy and procedure titled Food receiving and Storage with a revised date of 2017, the policy and procedure indicated, Food items and snacks kept on the nursing units must be maintained as indicated below: All food items to be kept below 41 degrees F must be placed in the refrigerator located at the nurses station and labeled with a use by date; Refrigerators must have working thermometers and be monitored for temperature according to state specific guidelines.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interviews and record reviews the facility failed to renew psychotropic medications (drugs that alter brain chemistry) consents for one of two residents (Resident 13), As evidenced by: 1. Failing to renew Resident 13's Lamotrigine (medication used to stabilize moods to manage bipolar disorder [a mental health condition that causes extreme mood swings]) consent from 1/31/2023.2. Failing to renew Resident 13's Trazadone (medication used to improve mood and sleep).3. Failing to renew Resident 13's aripiprazole (medication used to treat mental health conditions like schizophrenia [a serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior] and bipolar disorder) consent from 12/10/2024. These failures had the potential for Resident 13 to be denied the opportunity to give informed consent, participate in the resident's own plan of care, and be informed of the medications.Findings: During a review of Resident 13's admission Record, the admission record indicated the facility admitted the resident on 10/5/2022 with diagnoses that included schizophrenia and bipolar disorder. During a review of Resident 13's Verification of Informed Consent for Psychotropic Medication dated 1/31/2023 for lamotrigine, the consent indicated the resident was provided information and the risks were discussed and reviewed. The consent had not been renewed since 2023. During a review of Resident 13's Verification of Informed Consent for Psychotropic Medication dated 2/21/2024 for trazadone, the consent indicated the resident was provided information and the risks were discussed and reviewed. During a review of Resident 13's Verification of Informed Consent for Psychotropic Medication dated 12/10/2024 for aripiprazole, the consent indicated the resident was provided information and the risks were discussed and reviewed. During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 13 was alert and oriented with good recall. The MDS indicated Resident 13 had bipolar disorder and schizophrenia. During a concurrent interview and record review on 2/19/2026 at 2:42 PM with Licensed Vocational Nurse (LVN) 8, Resident 13's consent for lamotrigine was reviewed. LVN 8 reviewed Resident 13's electronic chart for consent for lamotrigine but could not locate the document in the chart. LVN 8 stated consents were needed and the risk to Resident 13 would be the resident would not be informed of the risks and benefits of the medication. LVN 8 reviewed the consents for Trazadone and Aripiprazole and noted the consents had not been renewed. LVN 8 stated she (LVN 8) was unsure when consents needed to be renewed. During an interview on 2/19/2026 at 2:54 PM, with the Assistant Director of Nursing (ADON), the ADON stated that consents need to be renewed every six months. The ADON was not sure if the facility's policy indicated if consents needed to be renewed every six months. During an interview on 2/19/2026 at 3:45 PM with the Director of Nursing (DON), the DON stated that consents for psychotropic medications were a requirement and the resident and or their representative (unspecified) needed to be informed of the risks and benefits of the psychotropic medication. The DON stated that consents needed to be updated every six months. The DON stated Resident 13 could have been deprived of the opportunity to give consent and participate in the plan of care and be informed of the medications. A review of the facility's policy and procedures (P&P) titled, Informed Consent Policy, dated 4/2025, the P&P indicated no mention of the time frame when the psychotropic consent should be renewed. A review of the facility's policy and procedures (P&P) titled, Psychotropic Medication Use, dated 4/2025, the P&P indicated no mention of the time frame when the psychotropic consent should be renewed. A review of the All Facilities Letter (AFL, an official bulletin or memo sent by a government agency [most commonly the California Department of Public Health (CDPH)] to keep healthcare facilities informed about new rules, safety alerts, or changes in the law) dated 2/3/2026, the AFL indicated Facilities had to renew the Informed Consent form every six months during which the resident received a psychotherapeutic drug (used to manage mood, behavior, and thoughts).

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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 two out of five sampled residents (Resident 49 and Resident 308) were accurate, by failing to: 1. Document a diagnosis of bipolar disorder (a mental health condition that causes extreme mood swings) on Resident 49's MDS dated [DATE].2. Ensuring Resident 308's MDS dated [DATE] accurately reflected Resident 308's discharge status. These deficient practice resulted in an inaccurate MDS assessments and had the potential to negatively impact Resident 49's plan of care and delivery of services as well as the submission of incorrect regulatory and reimbursement (the act of paying someone back money) data for Resident 308.Findings: During a review of Resident 49's admission Record, the admission record indicated the facility originally admitted Resident 49 on 10/31/2024 and readmitted Resident 49 on 1/21/2026 with diagnoses that included bipolar disorder, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and aftercare following joint replacement surgery. During a review of Resident 49's History and Physical (H&P) dated 1/22/2026, the H&P indicated Resident 29 had the capacity (ability) to make healthcare decisions. During a review of Resident 49's MDS dated [DATE], the MDS indicated Resident 49 had the ability to understand others and had the ability to make herself (Resident 49) understood. During a concurrent interview and record review on 2/19/2026 at 3:45 PM with the MDSRN, Resident 49's current admission Record progress note dated 11/25/2024 was reviewed. The progress note indicated Resident 49 had a medical history of bipolar disorder. During a concurrent interview and record review on 2/19/2026 at 3:45 PM with the Minimum Data Set Registered Nurse (MDSRN) and Minimum Data Set Licensed Vocational Nurse (MDSLVN), Resident 49's MDS dated [DATE] was reviewed. Resident 49's MDS indicated the box for bipolar disorder in Section I – Active Diagnoses was not checked. The MDSRN stated that the MDS was not accurate. The MDSLVN stated the MDS had to be accurate because the information was sent to CMS (Centers for Medicare and Medicaid Services - a federal agency within the U.S. Department of Health and Human Services that manages major government healthcare programs, including Medicare and Medicaid that ensures quality healthcare by setting safety standards for facilities and ensures they meet quality standards). During a concurrent interview and record review on 2/19/2026 at 3:50 PM with the Director of Nursing (DON), Resident 49's MDS dated [DATE] was reviewed. The MDS indicated the box for bipolar disorder in Section I – Active Diagnoses was not checked. The DON stated the MDS had to accurately represent the resident because the information was sent to CMS and it also affected the facility's reimbursement. The DON stated the MDS had to be accurate. During a review of Resident 308's admission Record, the admission Record indicated the facility originally admitted the resident on 10/7/2017 and readmitted the resident on 11/12/2025 with diagnoses that included dysphagia (difficulty swallowing), acute gastric ulcer (a sudden , open sore in the stomach lining caused when stomach acid damages the tissue faster than it can repair itself), and iron deficiency anemia (a common condition where a lack of iron prevents the body from making (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enough hemoglobin[red blood cells that carries oxygen]). During a review of Resident 308's History and Physical (H&P), dated 11/17/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 308's Order Summary Report dated 1/2/2026, the Order [NAME] report indicated to discharge Resident 308 to home on 1/2/2026 with family. During a review of Resident 308's Discharge Instructions dated 1/2/2026 at 1:41 PM, the Discharge Instruction indicated Resident 308 was discharged to home with medical equipment arrangements for a hospital bed with Low Air Loss mattress (a specialized therapeutic mattress used in healthcare to prevent and treat pressure ulcers), wheelchair, walker and bathroom handrails. During a review of Resident 308's nurses' notes dated 1/2/2026 at 5:23 p.m., the notes indicated Resident 308 was discharged home by Gurney (a wheeled cot, stretcher, used in hospitals and ambulances to transport patients who are unable to walk) and explained discharge instructions. During a concurrent interview and record review on 2/19/2026 at 2:25 p.m. with Minimum Data Set Licensed Vocational Nurse (MDSLVN), Resident 308's order summary report was reviewed. The MDSLVN stated the order dated 1/2/2026 indicated Resident 308's discharge orders were to home with family. Resident 308's nurses' notes dated 1/2/2026 were reviewed. The notes indicated Resident 308 was discharged home. The MDSLVN stated that Resident 308's daughter was given discharge instructions. The MDSLVN reviewed Resident 308's MDS and stated the MDS indicated Resident 308 was discharged to Short-Term General hospital (a medical center that specializes in the short-term medical treatment of patients). The MDSLVN confirmed by stating the discharge status of Resident 308 was incorrectly documented on the MDS. The MDSLVN stated the MDS should have indicated discharged to home instead of discharged to Short-Term General Hospital. The MDSLVN stated that MDS assessment had to be accurate. The MDSLVN stated it was an incorrect assessment and reimbursement submission. During an interview on 2/29/2026 at 3:13 p.m. with the Administrator (ADM), the ADM stated the MDS was an assessment process to determine the clinical picture of residents. The ADM stated the MDS needed to be accurate. The ADM stated the MDS reflected the quality of care and clinical status of Residents. During a concurrent interview and record review on 2/19/2026 at 3:18 p.m. with the ADM, Resident 308's MDS dated [DATE] and nurses' notes dated 1/2/2026 were reviewed. The ADM stated the MDS discharge status indicated that the resident was discharged to a short-term General Hospital. The ADM stated Resident 308 was discharged home on 1/2/2026. The ADM Stated the MDS did not reflect accurate discharge status of Resident 308. The ADM stated the inaccuracy potentially affected financial reimbursement and accurate assessment of Resident 308. During a review the facility's policy and procedure (P&P) titled, Certify Accuracy of the Resident Assessment, dated 4/2025, the P&P indicated Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. The P&P indicated The information captured on the assessment reflects the status of the resident during the observation period (the specific timeframe during which staff review a resident's care, treatments, and behavior to fill out their assessment accurately to identify the resident's usual condition and to guide care planning and reimbursement) for the assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review the facility failed to develop an individualized person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) to meet the needs for one of three sampled residents (Resident 193), by failing to create and implement a care plan for Resident 193's Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries, localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). These deficient practices had the potential for Resident 193 to receive inadequate care and/or supervision which could affect the residents' quality of care and cause the resident harm.Findings: During a review of Resident 193's admission Record, the admission Record indicated the facility initially admitted the resident on 9/8/2000, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) type 2 with other circulatory (the body's primary transport network) complications, age-related osteoporosis(weak and brittle bones due to lack of calcium and Vitamin D) without current pathological fracture (a broken bone caused by an underlying disease that weakens the bone structure), unspecified osteoarthritis(a progressive disorder of the joints, caused by a gradual loss of cartilage), unspecified site, muscle weakness(generalized),dysphagia (difficulty swallowing), monoplegia(the paralysis or severe weakness of a single limb[one arm or one leg]) of upper limb following nontraumatic subarachnoid hemorrhage (a life-threatening, sudden bleeding in the space between the brain and its surrounding membrane, not caused by a head injury) affecting left non-dominant (less used) side. During a review of Resident 193's Physician Progress Note dated 9/12/2025, the Physician Progress Note indicated Resident 193 was wheelchair and bedbound, and weakness prevented ambulation (walking or moving from place to place). The Physician Progress Note indicated Resident 193 had dementia (a progressive state of decline in mental abilities). During a review of Resident 193's Minimum Data Set (MDS, a resident assessment tool) dated 12/5/2025, the MDS indicated the resident had severe cognitive impairment (impaired ability to think, understand, and reason). The MDS indicated Resident 193 was dependent on the staff (helper does all of the effort) for toileting hygiene, lower body dressing, lying to sitting on the side of the bed, and chair/bed to chair transfer. The MDS indicated Resident 193 was at risk of developing pressure ulcers/injuries (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin). The MDS indicated Resident 193 utilized a pressure reducing device for bed. During a concurrent interview and record review on 2/19/2026 at 1:31 PM, with Licensed Vocational Nurse (LVN) 7, Resident 193's Order Summary Report and complete Care Plan Report were reviewed. LVN 7 confirmed there were no orders and no care plan for Resident 193's low air loss mattress. LVN 7 stated a care plan had focused goals and specific care interventions Resident 193 needed and should have been in place in the care plan. LVN 7 stated the use of a LALM mattress would have been part of a personalized care plan for Resident 193. LVN 7 stated Resident 193's LALM used to prevent skin breakdown since the resident's skin was fragile due to age. LVN 7 stated if there was no care plan there would be no guide on how to take care of Resident 193. LVN 7 stated the facility would not know where to start. LVN 7 stated the facility should have had a care plan for Resident 193's LALM and orders for her LALM for specific indication and settings. During a concurrent interview and record review on 2/19/2026 at 2:34 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Support Surface Guidelines dated 4/2025, was reviewed. The DON stated Resident 193 should have had a care plan for the use of a LALM. The DON stated the care plan documented the particular plan of care for a resident and had to be person centered and individualized. The DON stated a care plan had personalized interventions that had to be documented with goals to have mitigated (lessoned) problems to improve quality of care. The DON stated resident 193 should have had orders for her (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LALM to specify indications for the use of the LALM such as weight. During a review of the facility's policy and procedure (P&P) titled, Support Surface Guidelines dated 4/2025, the P&P indicated Review the resident's care plan to assess for any special needs of the resident. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated 4/10/2025, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated The comprehensive, person-centered care plan will incorporate risk factors associated with identified problems, reflect treatment goals, timetables and objectives in measurable outcomes. The P&P indicated The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). The P&P indicated Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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 observation, interview, and record review the facility failed to update and revise the range of motion (ROM - uses guided exercises to help joints move properly, reducing stiffness and increasing flexibility after injury, surgery, or illness) care plan for one out of one sampled resident (Resident 12). This deficient practice had the potential to prevent Resident 12 from receiving care to address their specific needs, which could lead to a decline in emotional and physical health. Findings: During a review of Resident 12's admission Record, the admission record indicated the facility admitted Resident 12 on 1/24/2022 with diagnoses that include bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs), acquired absence of right leg above the knee (leg removed surgically or lost due to an injury at a point above the knee joint), unspecified dementia (a progressive state of decline in mental abilities) and neuralgia and neuritis unspecified (nerve pain and irritation of unknown cause). During a review of Resident 12 Baseline Admission Screen (an initial health check done when entering a skilled nursing facility to establish your normal status) note dated 2/3/2022, the note indicated Resident 12 had a left lower extremity contracture (stiffening/shortening of the left leg joint, that reduces the joint's range of motion). During a review of Resident 12's history and physical (H&P) dated 11/17/2025, the H&P indicated Resident 12 did not have the mental capacity (ability) to understand or make decisions. The H&P indicated resident 12 had a lower extremity (lower leg - did not specify which leg) contracture. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool) dated 1/27/2026, the MDS indicated Resident 12 sometimes had the ability to make himself (Resident 12) understood and sometimes had the ability to understand others. During an interview on 2/19/2025 with Restorative Nurse Assistant 1 (RNA1, a specialized caregiver, often a certified nursing assistant [CNA], who helps patients regain or maintain their physical strength and independence after an illness or injury), RNA 1 stated she (RNA 1) only performed range of motion exercises on Resident 12's upper extremities (arm) because Resident 12 did not allow RNA 1 to touch the lower extremities (legs). During a concurrent interview and record review on 2/19/2025 with Licensed Vocational Nurse 1 (LVN 1) and Registered Nurse 3 (RN 3), Resident 12's Order Review History Report dated 2/19/2025 was reviewed. The Order review History Report indicated a physician order dated 2/19/2026 for active range of motion (ROM) of both upper extremities with RNA three times a week as tolerated. RN 3 stated there was only a physician order for an RNA (in general) to perform ROM on Resident 12's upper extremities. LVN 1 stated Resident 12 did not allow any staff to touch the left lower extremity. During a concurrent interview and record review on 2/19/2025 with Licensed Vocational Nurse 1 (LVN 1) and Registered Nurse 3 (RN 3), Resident 12's care plan titled High risk for further decline in range of motion related to impaired mobility and decreased strength for: Both Upper Extremities and Both Lower Extremities, dated 11/23/2022 was reviewed. The care plan indicated interventions to observe and document response to range of motion exercise for both upper and lower extremities. The care plan also had an intervention to observe for change in ROM of both upper and lower extremities. LVN 1 stated the facility's staff should have reviewed Resident 12's care plan quarterly (every three months) and as needed. RN 3 and LVN 1 stated if the RNAs (in general) were no longer providing ROM to Resident 12's left lower extremity, the facility should have revised Resident 12's care plan for the care plan to be person-centered (focusing on the whole person-their unique needs, choices, and strengths). RN 3 and LVN 1 stated Resident 12's care plan should have been accurate for the facility to be able to properly care for Resident 12. During a concurrent interview and record review on 2/19/2026 at 2:05 PM with Physical Therapist 1 (PT 1), Resident 12's progress note dated 10/10/2023 were reviewed. The PT note indicated Resident 12 had been refusing to participate with RNA for LLE (left lower extremities) with a recommendation to discontinue (stop) the RNA for LLE. The progress note indicated Resident 12's Nurse Practitioner was contacted, agreed to the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation, and discontinued the RNA for LLE. PT 1 stated Resident 12 had been refusing lower extremity therapy since 10/10/2023 and the therapy was discontinued in 2023 per Resident 12's request. During a concurrent observation and interview on 2/19/2026 at 3:00 PM with the Director of Nursing (DON), Resident 12's care plan High risk for further decline in range of motion related to impaired mobility and decreased strength for: Both Upper Extremities and Both Lower Extremities, dated 11/23/2022 was reviewed. The DON confirmed by stating the facility did not update Resident 12's care plan. The DON stated if Resident 12 was refusing to do lower extremity exercises, Resident 12's care plan should have been revised and updated. The DON stated the current care plan in place was no longer pertinent to Resident 12. During a review the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive (complete) Person-Centered, dated 3/2025, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The P&P indicated The interdisciplinary team reviews and updates the care plan:a. when there has been a significant change in the resident's condition;b. when the desired outcome is not met;c. when the resident has been readmitted to the facility from a hospital stay; andd. at least quarterly, in conjunction with the required quarterly MDS (Minimum Data Set - a resident assessment tool) assessment.The P&P indicated The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to maintain the appropriate Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries, localized damage to the skin and/or the he non-hardened, flexible area beneath your skin usually over a bony area) settings for two of six sampled residents (Resident 42 and Resident 193). This failure had the potential to increase the risk of skin breakdown (damage to the skin and underlying tissue, ranging from red, irritated skin to deep, open wounds/bedsores) and development of pressure ulcers/injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for Resident 42 and Resident 193.Findings: During a review of Resident 42's admission Record, the admission Record indicated the facility originally admitted Resident 42 on 8/3/2021 and readmitted Resident 42 on 4/11/2022 with diagnoses that included rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), bilateral primary osteoarthritis of hip (he protective cushioning in both hip joints has worn away, causing the bones to rub together, resulting in pain, stiffness, and decreased mobility in both sides), peripheral vascular disease unspecified (common condition in which narrowed arteries reduce blood flow to the arms or legs), other specified disorders of bone density and structure, unspecified site (where bones become weak, brittle, misshapen, or soft due to faulty rebuilding, genetic issues, or metabolic problems that can cause an increased risk of fracture and bone pain), muscle weakness, unsteadiness on feet, congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), repeated falls, dementia (a progressive state of decline in mental abilities), and neuralgia and neuritis (nerve pain and inflammation of a nerve). During a review of Resident 42's History and Physical (H&P) dated 5/2/2025, the H&P indicated Resident 42 could make her (Resident 42) needs known but could not make medical decisions. During a review of Resident 42's Minimum Data Set (MDS – a resident assessment tool) dated 1/30/2026, the MDS indicated Resident 42 sometimes had the ability to make herself (Resident 42) understood and sometimes had the ability to understand others. The MDS indicated Resident 42 needed substantial/maximal assistance (helper does more than half the effort) for toileting, upper/lower body dressing, personal hygiene (comb hair, washing/drying hands and face), moving from lying on back to sitting on the side of the bed, moving from sitting to lying flat on the bed, and transferring from bed to chair or wheelchair. The MDS indicated Resident 42 was dependent (helper does all the work) on facility staff for getting in and out of a tub/shower and for showering/bathing. During a review of Resident 42's Situation, Background, Assessment, Recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) dated 2/11/2026, the SBAR indicated Resident 42's weight on 2/1/2026 was 79 pounds. During a review of Resident 42's care plan titled, Low Air Loss Mattress for pressure redistribution (spreading out) and skin Management dated 2/14/2026 indicated a goal for Resident 42 not to have skin breakdown. During a review of Resident 42's Pressure Ulcer Risk Evaluation dated 2/17/2026, the Pressure Ulcer Risk Evaluation indicated Resident 42's sensory perception (the process of using your senses—sight, sound, smell, taste, and touch—to gather information from the world and make sense of it in your brain) was slightly limited. The Pressure Ulcer Risk Evaluation indicated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 42's was constantly moist, likely had inadequate nutrition and had a problem with friction (the surface burn caused by rubbing, like sliding on sheets), and shear (happens when skin stays put while deeper tissue shifts downward, like sliding down in a bed, causing internal tissue damage). The Pressure Ulcer Risk Evaluation indicated Resident 42's Braden score was 12 (scores patients from 6 to 23, a score of 12 indicated high risk for developing bedsores). During a review of Resident 42's nurses notes dated 2/18/2026, the nurses notes indicated Resident 42 had left buttocks (butt) scar tissue, right ischium (the lower, back part of your hip bone) with excoriation (a surface-level scrape, scratch, or abrasion where the top layer of skin has been removed), and left buttocks with MASD (moisture-associated skin damage is defined as the erosion [wearing away] and/or inflammation [the body's natural response to protect itself against harm] of the skin due to extended exposure to moisture as well as its content such as mucus [a clear, slippery, gel-like substance that's part of your immune system], sweat, saliva, poop, and urine). During a review of Resident 42's Order Review History Report dated 2/19/2026, the Order Review History Report did not indicate there was a physician order for a LALM. The Order Review History Report indicated a physician order for zinc oxide (white, powdery, natural mineral commonly used in skin products for sun protection and healing) to Resident 42's right ischium daily. During a concurrent observation and interview on 2/17/2026 at 11:32 AM with the Wound Care Nurse (WCN), Resident 42's LALM was observed set for a weight of 250 pounds. The WCN stated Resident 42's LALM should have been set according to Resident 42's weight of 79 pounds. The WCN stated the LALM could cause the resident's wound on her ischium and buttocks to worsen. During a concurrent interview and record review on 2/17/2026 at 11:46 AM with Registered Nurse 2 (RN 2), Resident 42's vital sign weight dated 2/1/2026 on Resident 42's electronic medical record (EMR - a digital, computer-based version of a patient's paper chart) was reviewed. The vital sign weight indicated Resident 42 weight 79 pounds. RN 2 stated setting Resident 42's LALM to 250 pounds was too high and could cause Resident 42's wounds to get worse. RN 2 stated Resident 42's LALM should have been set according to Resident 42's weight. During an interview on 2/17/2026 at 12:09 PM with the Director of Nursing (DON), the DON stated if Resident 42's LALM was set to 250 pounds and Resident 42 weighed 79 pounds, the LALM was set too high and Resident 42 would not get the therapeutic benefit of the LALM. The DON stated the LALM should have been set based on Resident 42's weight. During a review of Resident 193's admission Record, the admission Record indicated the facility initially admitted the resident on 9/8/2000, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) type 2 with other circulatory (the body's primary transport network) complications, age-related osteoporosis(weak and brittle bones due to lack of calcium and Vitamin D) without current pathological fracture (a broken bone caused by an underlying disease that weakens the bone structure), unspecified osteoarthritis(a progressive disorder of the joints, caused by a gradual loss of cartilage), unspecified site, muscle weakness (generalized),dysphagia (difficulty swallowing), monoplegia (the paralysis or severe weakness of a single limb[one arm or one leg]) of upper limb following nontraumatic subarachnoid hemorrhage (a life-threatening, sudden bleeding in the space between the brain and its surrounding membrane, not caused by a head injury) affecting left non-dominant(less used) side. During a review of Resident 193's Physician Progress Note dated 9/12/2025, the Physician Progress (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note indicated Resident 193 was wheelchair and bedbound; weakness prevented ambulation (walking or moving from place to place). The Physician Progress Note indicated Resident 193 has dementia (a progressive state of decline in mental abilities). During a review of Resident 193's Minimum Data Set (MDS, a resident assessment tool) dated 12/5/2025, the MDS indicated the resident had severe cognitive impairment (impaired ability to think, understand, and reason). The MDS indicated Resident 193 was dependent on the staff (helper does all of the effort) for toileting hygiene, lower body dressing, lying to sitting on the side of the bed, and chair/bed to chair transfer. The MDS indicated Resident 193 was at risk of developing pressure ulcers/injuries. The MDS indicated Resident 193 utilized a pressure reducing device for bed. During a review of Resident 193's Weights and Vitals Summary, the Weights and Vitals Summary indicated the resident weighed 118 pounds (lbs., a unit of weight) on 2/17/2026. During a concurrent observation and interview on 2/17/2026 at 12:08 PM, with Licensed Vocational Nurse (LVN)1, in Resident 193's room, Resident 193 was observed on a Drive LALM with settings set between 320 and 350 lbs. LVN 1 confirmed Resident 193's LALM settings were set at 320 to 350 lbs. LVN 1 stated the LALM settings were based on the Resident 146's weight. LVN 4 stated Resident 146's LALM settings at 350 lbs. were incorrect. LVN 1 verified Resident 193' weight in the medical record and stated Resident 193 current weight was 118 lbs. and stated the resident could have developed a pressure injury due to the mattress having been too hard for the resident. During an interview on 2/18/2026 at 11:45 PM, with the Director of Nursing (DON), the DON stated LALMs were set up based on a resident's weight to provide appropriate pressure. The DON stated if the LALM was too firm or too soft it could have been uncomfortable for the residents. The DON stated residents that had potential for pressure injuries with a LALM set at the incorrect weight, and would impact the benefit of having a LALM in place. During a review of the facility's policy and procedure (P&P) titled, Support Surface Guidelines dated 4/2025, the P&P indicated Redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. During a review of the user manual titled Med-Aire Assure 5 Air +3 Foam Base Alternating Pressure and Low Air Loss Mattress System dated 3/22/2021, the user manual indicated .intended to help reduce the incidence of pressure ulcers while optimizing patient comfort. The user manual indicated Turn the pressure adjust knob to set a comfortable pressure level using the weight scale as a guide.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 79) identified as at risk for falls was free from risks of falling, by failing to ensure the resident's bed was placed in the lowest position. This deficient practice placed Resident 79 at increased risk for falls and complications related to fall injuries such as fractures, cuts, and internal bleeding.Findings: During a review of Resident 79's admission Record, the admission Record indicated the facility admitted Resident 79 on 6/28/2024 with diagnoses that included vascular dementia (a progressive state of decline in mental abilities), pain in right hip, pain in left hip, collapsed vertebra thoracolumbar region (one of the bones in the spine, located where the middle back meets the lower back, has broken and flattened, becoming shorter in height), malignant neoplasm of prostate (prostate cancer, a disease where cells in the walnut-sized male gland below the bladder grow uncontrollably and can spread), and pain in unspecified ankle and joints of unspecified foot. During a review of Resident 79's care plan titled, High risk for falls and injury related to perceived self as independent and will not call for assistance, history of falls, use of psychotropic medications (prescription drugs that change brain chemistry to affect mood, thoughts, behavior, or perception), hard of hearing, recent fall dated 6/24/2024, the care plan indicated a goal for Resident 79 to be able to follow safe technique when performing functional mobility (your ability to move around independently and safely in your daily life) and ADL (activities of daily living - the basic, everyday self-care tasks people do to live independently without assistance, such as bathing, dressing, eating, and moving around) to prevent falls and injury. The care plan indicated an intervention for Resident 79 to have a yellow nameplate on the door and to have a fall risk arm band that identified Resident 79 as a fall risk. During a review of Resident 79's History and Physical (H&P) dated 10/24/2025, the H&P indicated Resident 79 was mostly wheelchair and bedbound (a person is unable to leave their bed for most or all of the day due to severe illness, injury, or physical weakness). The H&P indicated Resident 79 had weakness and gait instability (an unsteady, unbalanced, or irregular walking pattern that makes you feel shaky on your feet and increases fall risk) that prevented safe ambulation (walking or moving from place to place). During a review of Resident 79's Interdisciplinary Team Meeting - Fall (a collaborative gathering of different specialists-such as doctors, nurses, therapists, and social workers-who meet to create a unified, whole-person care plan for a resident) dated 11/26/2025, the Interdisciplinary Team Meeting - Fall indicated Resident 79 had a fall while at the VA (Veterans Administration - a federal agency that provides lifelong support to military veterans, their families, and survivors) for an audiology (the healthcare science of hearing and balance, focusing on diagnosing, managing, and treating hearing loss) appointment. The Interdisciplinary Team Meeting - Fall indicated Resident 79 was a high risk for falls. During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool) dated 1/5/2026, the MDS indicated Resident 79 could make himself (Resident 79) understood and had the ability to understand others. During a review of Resident 79's Morse Fall Risk Screen (checklist used by facility staff to predict a resident's likelihood of falling) dated 1/5/2026, the Morse Fall Risk Screen indicated Resident 79 had a history of falling and had a fall risk score of 55 indicating Resident 79 was a high risk for falls.During a review of Resident 79's care plan titled, difficulty with bed mobility, unable to stand for transfer and gait, impaired balance with weakness BLE (bilateral lower extremities, both lower extremities) dated 1/13/2026 indicated an intervention for skilled physical therapy five times a week for neuromuscular reeducation (a specialized physical therapy technique that re-teaches your brain and muscles to communicate, restoring normal movement, balance, and coordination) and gait training (a form of physical therapy designed to improve how you walk, stand, and balance, helping you move more safely) due to Resident 79 being unsteady on feet. During a review of Resident 79's Nurses Weekly Progress Notes dated 2/7/2026, the Nurses Weekly Progress Notes indicated Resident 70 was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forgetful and confused. The Nurses Weekly Progress Notes indicated Resident 79 required 2-person transfer assistance (a safety technique where two trained caregivers move a person who cannot stand or move safely on their own). During a review of Resident 79's Order Review History Report dated 2/19/2026, the Order Review History Report indicated a physician order for Wander guard (a wearable electronic device, usually a bracelet, designed for seniors or people with memory loss to prevent them from wandering away from safe areas) placement on resident's (Resident 79) wheelchair secondary to: wandering, exit-seeking behavior. The Order Review History Report indicated to monitor for placement every shift. The Order Review History Report indicated a physician order to check for orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from a sitting or lying position that can cause dizziness, lightheadedness, fainting) every dayshift. During an observation in Resident 79's room and interview on 2/17/2026 at 12:43 PM with Certified Nurse Assistant 5 (CNA 5), Resident 79's bed was observed to be in a high position. CNA 5 stated Resident 79's bed was in a high position and Resident 79 could fall out of bed. During an interview on 2/172026 at 12:47 PM with Licensed Vocational Nurse 11 (LVN 11), LVN 11 stated if Resident 79's bed position was set too high, Resident 79 could be at risk for fall. During an interview on 2/17/2026 at 12:57 PM with Registered Nurse 2 (RN 2), RN 2 stated if Resident 79's bed was not in a low position, Resident 79 could fall and have an injury. RN 2 stated staff should have placed Resident 79's bed in a low position. During an interview on 2/19/2026 at 2:39 PM with the Director of Nursing (DON), the DON stated if Resident 79's bed was not in the low position, Resident 79 could fall and have an injury. The DON stated Resident 79's bed should have been positioned to the lowest position. During a review of the facility's policy and procedure (P&P) titled Falls - Clinical Protocol, dated 12/2025, the P&P indicated the facility would identify pertinent (relevant) interventions to try to prevent subsequent (following or additional) falls. During a review of the facility's policy and procedure (P&P) titled Safety and Supervision of Residents, dated 4/2025, the P&P indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. The P&P indicated risk factors included bed safety. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, dated 4/2025, the P&P indicated staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P indicated incorrect bed height, delirium (a sudden, temporary state of severe confusion and rapid mental decline) and other cognitive impairment (having trouble with thinking, memory, focus, or decision-making that is more noticeable than normal aging), lower extremity weakness, and balance and gait disorders as a factors that could contribute to a resident's (in general) risk for fall. The P&P indicated The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls.

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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. Based on observations, interviews, and record reviews, the facility failed to provide necessary respiratory care services for one of one sampled residents (Resident 120), by failing to ensure Resident 120's oxygen nasal cannula tubing (a lightweight, flexible plastic tube with two small prongs that sit just inside your nostrils to deliver supplemental oxygen) was not resting on the floor while Resident 120 was using the oxygen nasal cannula. This failure had the potential for Resident 120 to experience respiratory infections (infections of parts of the body involved in breathing) associated with using an unsanitary (dirty, unhealthy, or unclean in a way that could endanger health) oxygen nasal cannula tubing.Findings: During a review of Resident 120's admission Record, the admission Record indicated the facility originally admitted Resident 120 on 8/2/2021 and readmitted Resident 120 on 3/7/2022 with diagnoses that included personal history of COVID-19 (a contagious respiratory illness caused by the SARS-CoV-2 virus), dementia (a progressive state of decline in mental abilities), unspecified injury of head, dysphagia (difficulty swallowing), muscle weakness, and repeated falls. During a review of Resident 120's Minimum Data Set (MDS - a resident assessment tool) dated 12/10/2025, the MDS indicated Resident 120 rarely/never had the ability to make herself (Resident 120) understood and rarely/never had the ability to understand others. During a review of Resident 120's History and Physical (H&P) dated 10/17/2025, the H&P indicated Resident 120 was only oriented to person (means that a person knows who they are) due to dementia. During a review of Resident 120's care plan dated 1/18/2026, the care plan indicated Resident 120 had impaired (decrease in ability) respiratory function r/t (related to) desaturation (drop in your blood oxygen levels below normal), tachycardia (an abnormally fast resting heart rate, generally defined as exceeding 100 beats per minute), fever pneumonia per x-ray result. The care plan had an intervention to change tubing and oxygen humidifier bottle (small, reusable container filled with distilled water that attaches to an oxygen machine to prevent dry air from causing nosebleeds, throat irritation, and dry nasal passage) when in use per facility protocol (standardized set of rules, procedures, or instructions that dictate how communication, actions, or tasks are carried out, ensuring consistency and safety). During a review of Resident 120's Nurses Notes dated 2/3/2026, the Nurses notes indicated Resident 120 was S/P (status post - after or following) antibiotic for pneumonia (an infection/inflammation in the lungs). During a review of Resident 120's Order Review History Report dated 2/20/2026, the Order Review History Report indicated a physician order written on 1/18/2026 to change Resident 120's oxygen cannula tubing every 2 weeks on Sundays and as needed for soilage (the act of making something dirty, stained, or contaminated). During a concurrent observation in Resident 120's room and interview on 2/17/2026 at 2:47 PM with Licensed Vocational Nurse 6 (LVN 6) and Certified Nursing Assistant 1 (CNA 1), Resident 120's oxygen nasal cannula tubing was observed touching the floor while Resident 120 was using the oxygen nasal cannula. CNA 1 stated the oxygen nasal cannula tubing on the floor could cause a tripping hazard. LVN 6 stated Resident 120 could get an infection from the oxygen nasal cannula tubing touching the floor and Resident 120's oxygen nasal cannula tubing would need to be changed right away. During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, dated 1/2026, the P&P: indicated the facility would change oxygen tubing every 2 weeks or as needed. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike Environment, dated 4/2025, the P&P indicated the facility would provide residents (in general) with a clean, sanitary (free from germs), and orderly environment. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 3/27/2025, the P&P indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections (when germs are spread from one person to another). The P&P indicated the facility would educate staff on adhering (sticking) to proper infection prevention techniques and procedures. The P&P indicated the facility would institute (put into place) prevention of infection measures to avoid complications and dissemination (spread).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility's medication error rate (the percentage of errors observed during medication administration) was less than five percent (%). Two medication errors out of a total of twenty-six opportunities contributed to an overall medication error rate of seven-point six nine percent (7.69 %), affecting one of four sampled residents (Resident 260) who was observed during medication administration (med pass). The facility failure to assess Resident 260's systolic blood pressure (SBP - the pressure in the arteries when the heart beats [bpm]) and/or heart rate (HR - the number of times the heart beats per minute) prior to administering Labetalol and Lisinopril (medications used to treat hypertension [HTN - high blood pressure]) to the resident as ordered. The failure placed Resident 260 at risk for bradycardia (HR that is too slow) and/or hypotension (low blood pressure [BP]), which could lead to other complications and hospitalization.Findings:During a review of Resident 260's admission record, the admission record indicated Resident 260 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertension (HTN, high blood pressure) and hyperlipidemia (high cholesterol in the blood). During a review of Resident 260's Minimum Data Set (MDS, a resident assessment tool) dated 1/16/2026, the MDS indicated Resident 260's cognitive skills (ability to think and reason) was moderately impaired. During a review of Resident 260's Order Review History Report, printed on 02/17/2026 and electronically signed by the prescriber, included the following active medication orders for Resident 260:Labetalol (medication used to treat HTN) 100 milligrams (mg, unit of measurement by weight) tablet, instruction to give one tablet by mouth two times a day for HTN. Hold for SBP less than 110 millimeters of mercury (mmHg, a unit for measuring blood pressure, normal SBP range: 90-120 mmHg) or HR less than 60 bpm (normal HR range: 60-100 bpm), order date 7/28/2025.Lisinopril (medication used to treat HTN) 40 mg tablet, instruction to give one tablet by mouth one time a day for HTN. Hold for SBP less than 110, order date 7/28/2025. During a review of Resident 260's care plan initiated on10/21/2024, the Care Plan focus indicated Resident 260 was at risk for Cardiac Distress (a condition characterized by symptoms such as chest pain, shortness of breath, or irregular heartbeat; cardiac distress can increase the workload on the heart and may contribute to elevated blood pressure) related to hyperlipidemia and HTN. The care clan indicated Resident 260 would remain free from signs and symptoms of cardiac distress. The care plan interventions indicated to administer Labetalol and Lisinopril as ordered.monitor apical pulse (heartbeat heard at the chest with a stethoscope) and blood pressure (BP) as indicated in the medication parameter. During a medication pass observation on 2/17/2026 between 9:58 AM to 10:18 AM, with Licensed Vocational Nurse (LVN) 6, LVN 6 was observed preparing the following medications: Labetalol 100 milligrams (mg, unit of measurement), one tablet.Lisinopril 40 mg, one tablet. Vitamin C (vitamin supplement) 250 mg, one tablet. Cranberry (supplement to treat or prevent urinary tract infections) 450 mg, one tablet. Vitamin B12 (vitamin supplement) 1 mg, one tablet. Magnesium Oxide (used to help prevent and treat low levels of magnesium in the body) 400 mg, one tablet. Ferrous Gluconate (use to treat iron deficiency) 240 mg, one tablet. During a concurrent med pass observation and interview on 2/17/2026 at 10:15 AM, LVN 6 stated she prepared a total of seven medications, entered the resident's room, called the resident by name and administered the medications. LVN 6 was not observed checking Resident 260's blood pressure (BP) or heart rate (HR) prior to administering the two BP medications Labetalol and Lisinopril. During an interview on 2/17/2026, at 10:21 AM, LVN 6 stated the Certified Nurse Assistants (CNA) normally checked the residents' vitals (measurements of essential body functions, such as blood pressure, heart rate, temperature, and respiratory rate). LVN 6 provided a handwritten paper that included Resident 260's BP and HR and stated the vital sign readings were provided to LVN 6 by CNA 1. LVN 6 acknowledged the paper with residents' vital signs did not include the date or time the vital signs were taken. LVN 6 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged the vital signs were taken two and one-half hours earlier by CNA 1, on 2/17/2026 between 7:30 AM to 7:45 AM. During an interview on 2/17/2026 at 10:28 AM with CNA 1, in the presence of LVN 6, CNA 1 stated Resident 260's vitals were taken between 7:30 AM to 7:45 AM on 2/17/2026. CNA 1stated he (CNA 1) checked the vital signs of eight residents, which included the vital signs for Residents 260, 129, 8, and 83 before breakfast and once done provided the results to LVN 6. During a follow up interview on 2/17/2026 at 10:31 AM, with LVN 6, LVN 6 stated she (LVN 6) usually relied on the vitals taken by the CNAs to determine to give or hold BP medications to the residents. LVN 6 stated she could not verify based on the undated and untimed form when the vitals, that included BP and HR were taken by CNA 1 on 2/17/2026. LVN 6 stated that it was important to recheck the residents BP and HR to make sure the BP and HR readings were accurate before administering BP medications with an ordered parameter. LVN 6 stated if BP medications were administered outside of the ordered parameters residents could experience symptoms that include low blood pressure, weakness, change in cognition and alertness, syncope (brief loss of consciousness), which could lead to hospitalization. During an interview on 2/18/2026 at 5:09 PM with the Director of Nursing (DON), the DON stated residents' BP should have been checked prior to, and as close as possible to the medication administration time. The DON stated that if a resident's BP and heart rate (HR) were checked two hours before medication administration, the licensed nurse had to recheck the resident's BP and HR immediately prior to administering the BP medication when there were ordered parameters, in order to prevent a decline in the resident's condition. A review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2025, indicated, Medications are administered in accordance with prescriber orders.The following information is checked/verified for each resident prior to administering medications.b. Vital signs, if necessary. A review of the facility's undated policy and procedure titled, Medication Administration Principles, indicated, Vital signs (blood pressure, pulse rate, respiration) or blood sugar levels required for medication orders with hold parameters are taken prior to the administration of the medication and recorded on the MAR. During a review of the Food and Drug Administration (FDA)- approved prescribing information (package insert), revised 8/2024, the package insert for Lisinopril indicated, Hypotension: Patients with other heart or renal diseases have increased risk, monitor blood pressure after initiation.Patients at risk of excessive hypotension include those with the following conditions or characteristics: heart failure with systolic blood pressure below 100 mmHg.

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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/or disposal of medications, by failing to ensure an open box of Advair Diskus (a medication that contains both an anti-inflammatory medicine (fluticasone propionate) and a long-acting bronchodilator (salmeterol) with a shorten expiration date (the medicine will become less effective or unsafe sooner than the date originally printed on the bottle) once opened, had an open date (the date the medication was first opened) for one of four sampled residents (Resident 334), as per the manufacturer's label for Advair Diskus dated 6/2023. The deficient practice increased the risks associated with Resident 334 chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) could have received expired or ineffective medications which could result in health complications, difficulty breathing, or hospitalization.During a review of Resident 334's admission record, the admission record indicated Resident 334 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included COPD. During a review of Resident 334's Minimum Data Set (MDS, a resident assessment tool), dated 11/5/2025, the MDS indicated Resident 334's cognitive skills (ability to think and reason) were intact. During a review of Resident 334's History and Physical (H&P) dated 2/16/2026, the H&P indicated the resident did not have the capacity to make healthcare decisions. During a review of Resident 334's Order Summary Report dated 2/18/2026, the Order Summary Report included an order for Advair Diskus (a medication that contains both an anti-inflammatory medicine (fluticasone propionate) and a long-acting bronchodilator (salmeterol), used to treat asthma and COPD) 250 micrograms ([mcg] - unit of measure of weight)/ 50 mcg, instructions indicated one inhalation orally two times a day for COPD, rinse mouth after each use, order date 2/13/2026. During a concurrent observation and interview on 1/18/2026 at 12:10 PM with a Licensed Vocational Nurse (LVN) 3 on Nursing Station 3, MedCart C was inspected, and one oral inhaler was observed inside of the MedCart open without an open date for Advair (used to treat breathing difficulty) 250-50 mcg. LVN 3 stated there was no open date on the Advair labeled for Resident 334. LVN 3 stated without an open date the nurses would not accurately know when the medication was due to expire, and if administered after expiration the efficacy (effectiveness) might not have been as effective and the resident could have had an adverse reaction that included shortness of breath or respiratory symptoms (breathing problems such as coughing, wheezing, or chest tightness). LVN 3 stated she (LVN 3) administered a dose of Advair 250-50 mcg to Resident 334 on the date of interview, 2/18/2026. During a concurrent interview and record review on 2/18/2026 at 12:31 PM with a Registered Nurse Supervisor (RN) 1, Resident 334's physician order dated 2/18/2026 and prescription label and packaging for Advair were reviewed. RN 1 stated there should have been an open date to know when the medication was first opened and used. RN 1 reviewed the manufacturer's labeling for Advair and stated, the medication expired one month after opening the foil pouch or when the counter read zero whichever comes first. During a review of the manufacturer's labeling for Advair Diskus, dated 6/2023, indicated, Safely throw away ADVAIR DISKUS in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first.Write the date you opened the foil pouch in the first blank line on the label.Write the use by date in the second blank line on the label.That date is 1 (one) month after the date you wrote in the first line.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain infection control measures necessary to prevent the spread of infections for two out of nine sampled residents (Resident 262 and Resident 292), by failing to: Ensure Licensed Vocational Nurse 3 (LVN 3) performed hand hygiene (cleaning your hands to remove dirt, viruses, and bacteria, primarily through washing with soap and water or using alcohol-based sanitizer) before administering medications and coming in direct contact (physically touching someone or interacting face-to-face, allowing for the potential for immediate transfer of germs) with Resident 262.Ensure Certified Nurse Assistant 2 (CNA 2) wore full personal protective equipment (PPE-mask, gown, eye protection, gloves) per facility policy and procedures (P&P) titled Enhanced Barrier Precautions (EBP) with an last reviewed date of 1/8/2026 before providing care and treatment to Resident 292, who required enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes). This deficient practice had the potential to result in the spread of disease and infection to all 289 residents, visitors, and staff.Findings: 1.During a review of Resident 262's admission record, the admission record indicated Resident 262 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included diabetes mellitus (DM—a disorder characterized by difficulty in blood sugar control and poor wound healing), paranoid schizophrenia (a mental illness that causes someone to hear or see things that are not real and believe others want to harm them), hypertension (HTN—high blood pressure), hyperlipidemia (high cholesterol), and bed confinement status (unable to get out of bed without assistance). During a review of Resident 262's Minimum Data Set (MDS—a resident assessment tool) dated 11/28/2025, the MDS indicated Resident 262's cognitive skills (ability to think and reason) were intact. The MDS indicated Resident 262 required setup or clean-up assistance for eating and oral hygiene, as well as substantial staff assistance for upper body dressing. The MDS indicated Resident 262 was dependent on facility staff and required physical assistance from two or more staff members for toileting, showering/bathing, lower body dressing, and personal hygiene. During a review of Resident 262's History and Physical (H&P) dated 12/19/2025, the H&P indicated the resident did not have the capacity to make healthcare decisions. During a concurrent medication pass observation on Station D at Medication Cart B and interview, on 2/17/2026 between 8:52 AM through 9:08 AM, with LVN 3, LVN 3 stated she had prepared a total of three morning medications for Resident 262 and placed the medications into a medication cup, the medications were: Apixaban (a medicine that helps prevent blood clots) 5 milligrams (mg, measurement by weight) one tablet. Benztropine Mesylate (a medicine that helps with tremors and stiffness) 1 mg, one tablet. Escitalopram (to treat depression, feeling sad, and anxiety, feeling anxious) 10 mg, one tablet. On 2/17/2025 at 9:06 AM, before entering Resident 262's room, LVN 3 was not observed performing hand hygiene prior to entering Resident 262's room. LVN 3 proceeded to enter the resident's room and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was observed administering medications to the resident, by mouth. During a follow up interview on 2/17/2026 at 9:10 AM with LVN 3, LVN 3 confirmed by stating she did not wash or sanitize her hands before entering Resident 262's room to administer the medications. LVN 3 acknowledged that she should have sanitized her hands before entering Resident 262's room to prevent the transmission of infections. During an interview on 2/17/2026 at 9:52 AM with LVN 11, LVN 11 stated that hand hygiene was important for infection control because hand hygiene prevented germs from being passed along to residents or staff, as hands were the dirtiest. During an interview on 2/18/2026 at 5:11 PM, the Director of Nursing (DON) stated that nurses were expected to perform hand hygiene as follows: - Before preparing medications - Before entering the resident's room to administer medications, and - After administering medications and before going to the next resident. During a review of the facility's policy and procedure (P&P), titled Infection Control Guidelines for All Nursing Procedures, revised 4/2025, the P&P indicated All employees must wash their hands for at least twenty seconds using antimicrobial soap and water under the following conditions . Before and after direct contact with residents.In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60 – 95 % ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents; b. Before donning sterile gloves; c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications. 2. During a review of Resident 292's H&P dated 1/12/2026, the H&P indicated the resident had the capacity to make healthcare decisions. During a review of Resident 292's care plan titled, At risk for infection initiated 2/16/2026, the care plan interventions included to implement Enhanced Barrier Precaution (EBP). During an observation outside of Resident 292's room on 2/17/202 at 11 AM, a sticker labeled EBP was observed next to Resident 292's name. During an observation in Resident 292's room on 2/18/2026 at 4:25 PM, CNA 2 was observed performing an incontinent brief change on Resident 292 wearing gloves, a mask, and no gown on. During an interview on 2/18/2026 at 4:28 PM with CNA 2 outside of Resident 292's room, CNA 2 stated the sticker labeled EBP next to the resident's name indicated the resident was on EBP. CNA 2 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated staff were required to wear PPE which included masks, gloves and gowns, when providing care to residents on EBP. CNA 2 stated wearing PPE helped protect residents from infection and prevented the spread of infection. CNA2 confirmed by stating she was not wearing a gown during the incontinent brief change of Resident 292. CNA2 stated she should have worn a gown. CNA 2 stated she failed to follow the infection control process and potentially could have spread infection. During an interview on 2/20/2026 at 10:55 AM with LVN 12, LVN stated the safe infection control practice of EBP was to check the label next to the resident's name and use PPE when providing care. LVN 12 stated Resident 292's safety was important. LVN 12 stated all staff had to wear PPE when residents were placed on EBP. During a concurrent interview and record review on 2/20/2026 at 2:21 PM with the Infection Preventionist (IP), the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 1/8/2026, was reviewed. The IP stated residents with EBP were at high risk of infection. The IP stated PPE including gowns and gloves were worn during high contact care. The IP stated the P&P indicated facility staff would wear a gown and gloves when performing high-contact resident care activities. The IP stated an incontinent brief change was considered a high contact care activity. The IP stated CNA 2 had potential contact with resident's soiled brief and CNA 2 should have worn the gown as indicated on the P&P. During a concurrent interview and record review on 2/20/2026 at 2:25 PM with the facility Administrator (ADM), the facility's P&P titled, Enhanced Barrier Precautions, dated 1/8/2026, was reviewed. The ADM stated the facility's priority was to practice and monitor infection control. The ADM stated the EBP P&P indicated to wear PPE for high-contact resident care activities. The ADM stated CNA 2 failed to wear the appropriate PPE and should have worn a gown when changing Resident 292's brief. The ADM stated there was a potential risk of spreading infection. During a review of the facility's P&P, titled Hand Hygiene, revised 10/2025, the P&P indicated To maintain the highest standards of infection prevention and control through hand hygiene adherence.Hand hygiene shall be performed under the conditions listed in, but not limited to, the attached hand hygiene reference table.before and after direct contact, after contact with surfaces or objects in immediate vicinity of patient. During a review of the facility's P&P, titled Administering Medications, dated 4/2025, the P&P indicated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for the administration of medications, as applicable. During a review of Resident 292's admission Record, the admission Record indicated the facility originally admitted Resident 292 on 12/31/2025 and re-admitted on [DATE] with diagnoses the included chronic left foot ulcer (an open, painful, crater-like sore that develops on the skin) and anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). During a review of the facility's P&P titled Enhanced Barrier Precaution, last reviewed on 1/8/2026, the P&P indicated EBP was used in with standard precautions and expanded the use of PPE to putting on a gown and gloves during high contact resident care activities. The P&P indicated facility staff were to perform hand hygiene and would put on a gown and gloves before performing the following high-contact resident care activities: Changing briefs or assisting with toileting.