STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555445	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record and facility P&P review, the facility failed to ensure two of 20 final sampled residents (Residents 3 and 6) and one nonsampled resident (Resident 56) were treated with respect and dignity. * The facility failed to ensure the video with Residents 3, 6, and 56 on it was not posted in the social media . This failure posed the risk to negatively affect the residents' psychosocial well-being.Findings: Review of the facility's P&P titled Compliance and Ethics Program-Code of Conduct and Statement of Purpose dated 12/2020 showed the objectives of the compliance and ethics program included the following:- to formulate effective, internal controls to ensure compliance with current statutes, regulations and rules;- demonstrate to employees and the community at large our facility's commitment to responsible corporate conduct;- obtain an accurate assessment of employee and contractor behavior; and- increase the likelihood of identifying and preventing unlawful and unethical behavior. Medical record review for Resident 3 was initiated on 5/18/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 3/10/26, showed Resident 3 had the capacity to understand and make decisions. Review of Resident 3's Consent for Photographs (undated) showed The undersigned hereby authorizes the Facility and the Resident's physician(s) to photograph or permit other persons to photograph the Resident for the following specific purpose(s) other than staff identification or health care of the Resident. The photograph shall be used for only the following specific purpose(s): social media, brochure and flyer. The term photograph, as used in this agreement, shall mean motion picture or still photography in any format, as well as videotape, video disc, digital recordings and any other mechanical means of recording and reproducing images. The form showed Resident 3's name; however; the form had no resident or resident's representative signature and date. On 5/20/26 at 0828 hours, an interview was conducted with the Administrator. The Administrator stated an entertainer was hired to entertain the residents during an event. The Administrator stated during the event in the dining room on 2/23/26, Entertainer 1 used her cellphone to record the event. The Administrator stated to her knowledge all the residents had signed the consents to be photographed except for one resident who was not in the dining room at that time. The Administrator further stated when Entertainer 1 had to perform, she (Administrator) continued with the video recording using Entertainer 1's cellphone. The Administrator stated approximately a week later she received a report of the video uploaded on a social media platform and requested Entertainment 1 to remove the video from her social media post. The Administrator stated Entertainer 1 refused to remove the video in social media and requested the facility to provide a financial offer in exchange for taking the video from social media. When asked if she was aware Entertainer 1 would be posting the video recording on social media, the Administrator responded, there was a possibility. On 5/21/26 at 0748 hours, an interview was conducted with the Activities Director. When asked if she was present in the dining room when the video was recorded on , the Activities Director stated, yes; however, she was busy transporting and attending to the residents. On 5/21/26 at 0949 hours, an interview was conducted with the DON. When asked about the video recording posted in social media, the DON stated it is a (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mistake, the social media consent was not done on Resident 3, she should have not been there. The DON further stated, we have to protect the residents before a recording is done, no more videos. On 5/21/26 at 1004 hours, an interview with the Admissions Director was conducted. The Admissions Director stated she obtains consents from the residents or responsible parties on admission including the consents to be photographed for the social media, brochure, and flyer use. The Admissions Director stated Resident 3's Responsible Party signed the consent to be photographed for the face sheet, dietary cards, and medical records only. The Admissions Director further stated they revised the consents to be photographed for social media, brochure, and flyer use last year and Resident 3's responsible party did not give the consent. The Admissions Director was asked whether the residents who attended the video recorded event had signed consents. The Admissions Director stated, No, I was not asked. On 5/21/26 at 1310 hours, an interview was conducted with Resident 3's responsible party. Responsible Party 2 stated he did not sign any consent for Resident 3 to be photographed or to be posted on the social media. Responsible Party 2 stated he received information of his wife in social media and people were making fun of her. Responsible Party 2 further stated, I don't want humiliation, this is my dignity, my daughter came home crying because of this, we did not tell my wife because she will feel bad about it. Additionally, Responsible Party 2 stated he was aware the entertainer asked the facility for money to remove the social media posting and have been following up with the Administrator. Responsible Party 2 added the police department was called to have the social [NAME] post removed but felt he was going nowhere. On 5/21/26 at 1358 hours, an interview was conducted with Resident 6. Resident 6 was in the video recorded event and was asked how she felt when she learned the video recording was posted on social media. Resident 6 stated, I didn't want my picture posted, I was humiliated when someone showed it to me a couple of days after it happened. On 5/21/26 at 1403 hours, an interview was conducted with Resident 56. Resident 56 stated he was in the video recorded during the event but did not know it would be posted on social media. Resident 56 further stated, I was humiliated, so embarrassed, it's not a nice feeling seeing that online, I am not happy at all. Additionally, Resident 56 stated he cannot remember if he signed the consent to be photographed on admission, since he was just admitted . Resident 56 further stated, it is a different humiliation when it is already posted, had I known it will be posted online, I won't be there attending the event. On 5/21/2026 at 1529 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings. Cross reference to F607.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure four of five final sampled residents (Residents 2, 8, 49, and 83) reviewed for unnecessary medications and one of 20 final sampled residents (Resident 1) were free from unnecessary psychotropic medications. * The facility failed to ensure the monitoring of meal intake related to the use of the mirtazapine medication was accurate for Resident 1. The facility failed to ensure the monitoring of Resident 1's meal intake in the MAR matched the CNA documentation when the resident ate less than 50%. *The facility failed to consistently monitor Resident 2's behaviors related to the use of the trazodone (antidepressant medication), sertraline (antidepressant medication) and Seroquel (antipsychotic medication) medications. In addition, the facility failed to ensure the nonpharmacological interventions were implemented prior to the use of the trazodone, Seroquel, and sertraline medications, and the facility failed to monitor the side effects related to the use of the sertraline, Seroquel, and trazodone medications for Resident 2. * The facility failed to ensure the nonpharmacological interventions and side effects for the bupropion (antidepressant medication) and sertraline (antidepressant medication) were separately monitored for Resident 8. * The facility failed to ensure the nonpharmacological interventions were implemented prior to the use of the duloxetine (antidepressant and nerve pain medication) medication for Resident 49. * The facility failed to ensure the monitoring of meal intake related to the use of the mirtazapine medication was accurate for Resident 83. The facility failed to ensure the monitoring of Resident 83's meal intake in the MAR matched the CNA documentation when the resident ate less than 50%. In addition, the monthly behavior summary was not accurate to reflect the CNA documentation of Resident 83's meal intake of less than 50%. Furthermore, the facility failed to ensure nonpharmacological interventions were attempted prior to the administration of the mirtazapine (antidepressant medication). Furthermore, the facility failed to ensure the monitoring for side effects related to the use of the mirtazapine medication was accurate for Resident 8 when the resident was documented to be on dialysis, and hospitalized . These failures had the potential to result in ineffective care, failure to identify medication-related adverse effects, delayed interventions, and increased risk for decline in residents' health and well-being.Findings: 1. Review of the facility's P&P titled Psychotropic Medication Use/ Informed Consent dated 3/2024 showed the following: - Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes adequate monitoring for efficacy and adverse consequences; and - Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible Medical record review for Resident 83 was initiated on 5/19/26. Resident 83 was readmitted to the facility on [DATE]. Review of Resident 83's Order Summary Report showed the physician's orders: - dated 2/13/25, to monitor for depression manifested by poor oral intake less than 50% during (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mealtimes every shift for use of mirtazapine after meals. To document 1 if less than 50%, and 0 if more than 50% of meals; - dated 2/13/25, to monitor for side effects for antidepressant medication (mirtazapine) every shift; - dated 3/25/25, to administer mirtazapine 7.5 mg two tablets by mouth at bedtime for depression manifested by poor oral intake less than 50% during mealtimes (discontinued 5/19/26); and - dated 5/19/25, to administer mirtazapine 7.5 mg one tablet by mouth at bedtime for depression manifested by poor oral intake less than 50% during mealtimes a. Review of Resident 83's MARs for April and May 2026 showed the following: - Resident 83 was administered two tablets of mirtazapine 7.5 mg medication from 4/1 to 5/18/26 at 2100 hours; - Resident 83 was administered one tablet of mirtazapine 7.5 mg medication from 5/19 to 5/21/26 at 2100 hours; - Resident 83's monitoring for side effects related to the use of mirtazapine was documented with 3 and 5 on 5/1/26 on the day shift. The Chart Codes section showed 3 meant hospitalized , while 5 meant hospitalized ; - Resident 83 was not provided with non-pharmacological interventions prior to the administration of the mirtazapine medication; and - Resident 83 had episodes of eating less than 50% meals on 4/6, 4/17, and 4/20, and 5/19/26 during dinner, on 5/20/26 during lunch and dinner, and 5/21/26 during breakfast. b. Review of Resident 83's medical records did not show Resident 83 was provided with nonpharmacological interventions prior to the administration of the mirtazapine medication. Further review of Resident 83's medical records did not show Resident 83 was on dialysis nor hospitalized on [DATE]. c. Review of Resident 83's Documentation Survey Report v2 for April 2026 showed the following: - Resident 83 consumed 0 to 25% of her meals on 4/6 and 4/8/26 during dinner (total of two episodes); and - Resident 83 consumed 26 to 50% of her meals on 4/23/26 during breakfast, on 4/5 and 4/21/26 during lunch, and on 4/3, 4/5, 4/14, 4/16, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25, 4/26, 4/28, 4/29, and 4/30/26 during dinner (total of 18 episodes). Review of Resident 83's Documentation Survey Report v2 for May 2026 showed the following: - Resident 83 consumed 0 to 25% of her meals on 5/11/26 during dinner; - Resident 83 consumed 26 to 50% of her meals on 5/3 and 5/16/26 during lunch, and on 5/1, 5/2, 5/3, 5/7, 5/9, 5/10, 5/12, 5/13, 5/16, 5/19, and 5/20/26 during dinner. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Review of Resident 83's Psychoactive Summary for April 2026 showed there were only three episodes of behavior per shift (oral intake of less than 50% of meals) related to the use of mirtazapine medication. On 5/20/26 at 1454 hours, an interview and medical record review for Resident 83 was conducted with RN 1. When asked about nonpharmacological interventions, RN 1 verified there were no documented evidence nonpharmacological interventions were provided to Resident 83 prior to the administration of the mirtazapine medication. When asked about the monitoring of the side effects related to the use of the mirtazapine medication, RN 1 verified Resident 3 was documented in the MAR to be on dialysis and hospitalized on [DATE], per the chart code. RN 1 further verified Resident 83 was never on dialysis and hospitalized on 5/1/26. When asked about the monitoring of the resident's meal intake, RN 1 stated the licensed nurses documented the resident's meal intake in the MAR, in coordination with the CNAs. RN 1 stated the licensed nurses asked the CNAs about the resident's meal intake before documenting in the MAR. RN 1 verified the monitoring of the resident's meal intake in the MAR by the licensed nurses did not match the resident's meal intake monitoring in the Task documentation by the CNAs. When asked about the monthly behavior summary, RN 1 verified it did not match the CNA documentation of when Resident 83 ate less than 50%. RN 1 further stated they had to clarify the range because when the resident eats 50%, it would still be in the 26-50% range, which could lead to inaccurate monitoring and inaccurate psychoactive summary documentation. 2. Medical record review for Resident 8 was initiated on 5/19/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed the following physician's orders: - dated 4/25/26, to monitor side effects for anti-depressant medications (bupropion and sertraline) every shift; - dated 4/25/26, for non-pharmacological behavioral interventions, to pick the intervention(s) that best works to alleviate the behavior, every shift, for the use bupropion and sertraline medication; - dated 4/25/26, to administer bupropion 150 mg one tablet by mouth one time a day for depression manifested by verbalization of sadness; and - dated 4/28/26, to administer sertraline 50 mg one tablet by mouth one time a day for depression manifested by tearfulness. Review of Resident 8's MAR for April and May 2026 showed the following: - Resident 8 was administered the bupropion 150 mg medication from 4/26 to 5/21/26 at 0900 hours; - Resident 8 was administered the sertraline 50 mg medication from 4/26 to 5/21/26 at 0900 hours. - Resident 8 was monitored for side effects related to the use of the bupropion and sertraline medications from 4/26 to 5/20/26 on day, evening and night shifts; and - Resident 8 was provided non-pharmacological interventions for the use of the bupropion and sertraline medications from 4/26 to 5/20/26 on day, evening and night shifts. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/26 at 1425 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 1. When asked about the nonpharmacological interventions and monitoring for side effects related to the use of bupropion and sertraline medications for Resident 8, RN 1 stated these were documented in Resident 8's MAR. RN 1 verified the non-pharmacological interventions and the monitoring for side effects for the bupropion and sertraline medications for Resident 8 were not separated for each of medications, or behaviors manifested for the resident. When asked how they monitor the effectiveness of nonpharmacological interventions for each psychotropic medication or behavior for Resident 8, RN 1 stated they would not know because the nonpharmacological interventions were documented together, and not separately. RN 1 stated if the nonpharmacological interventions and side effect monitoring were not documented separately, we would not know which specific antidepressant medication may be causing the side effects, and which specific antidepressant medication the non-pharmacological interventions relates to. On 5/21/26 at 0817 hours, an interview for Residents 8 and 83 was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Review of the facility's P&P titled Psychotropic Medication Use dated 7/2022 showed a psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. The consideration of the use of any psychotropic medication is based on a comprehensive review of the resident, which includes an evaluation of the resident's signs and symptoms in order to identify the underlying causes. Nonpharmacological approaches were used, unless contraindicated, to minimize the need for medications, permit the lowest possible dose, and allow for the discontinuation of medications when possible. Residents receiving psychotropic medications are monitored for adverse consequences including anticholinergic effects, cardiovascular effects, and psychosocial effects. Medical record review for Resident 49 was initiated on 5/18/26. Resident 49 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 49's Order Summary Report showed the following orders:- dated 5/1/26, to administer duloxetine hydrocholoride 30 mg delayed release particles one capsule by mouth one time a day for neuropathic pain; and- dated 5/1/26, to provide non-pharmacological interventions to best alleviate the behavior every shift for the use of duloxetine medication, to document the corresponding number of all intervention attempted, and to document the effectiveness of the intervention. The interventions included to code 0-No intervention attempted, 2-Redirect, 3- Remove from situation/ensure Resident safety, 4- Provide a calm environment (low lighting, quiet), 5- Meaningful activity, 6- Reapproach, 7- 1:1 8-Offer food/drink, 9- Toileting, 10- Provide comfort (massage, reposition, heat/cold), 11-Relaxation techniques, and 12- Resident refused. Review of Resident 49's H&P examination dated 5/4/26, showed Resident 49 had the capacity to make his own medical decisions. Review of Resident 49's MAR for May 2026 showed the following:- the duloxetine medication was administered from 5/2 to 5/9/26 and 5/11 to 5/19/26; and- a discontinued order on 5/1/26, to provide nonpharmacological interventions for the use of the duloxetine medication. Further review of Resident 49's medical record failed to show documented evidence Resident 49 was provided nonpharmacological interventions prior to the use of the duloxetine medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/26 at 1504 hours, an interview and concurrent medical record review for Resident 49 was conducted with LVN 7. LVN 7 stated Resident 49 had an order for duloxetine for their neuropathic pain. When asked if Resident 49's psychotropic medication had documented evidence of nonpharmacological interventions prior to administration of the medication, LVN 7 stated the duloxetine medication was a routine medication and nonpharmacological interventions did not need to be provided unless it was a PRN medication. On 5/20/26 at 1542 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 1. RN 1 stated nonpharmacological interventions should be provided prior to administration of psychotropic medications. RN 1 verified the above findings. On 5/21/26 at 1413 hours, an interview was conducted with the DON. The DON stated nonpharmacological interventions should be provided prior to administration of psychotropic medications to assess if the interventions were effective for the resident. The DON was informed and acknowledged the above findings. 4. Medical record review for Resident 2 was initiated on 5/18/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 5/4/26, showed Resident 2 had the capacity to make his own medical decisions. Review of Resident 2's Order Summary Report showed the following physician's orders: - dated 3/27/26, to monitor for depression manifested by verbalization of sadness every shift;- dated 3/27/26, to monitor the side effects of the sertraline medication every shift;- dated 3/27/26, to monitor the side effects for the trazodone medication every shift;- dated 3/27/26, to provide nonpharmacological interventions to best alleviate the behavior every shift for the use of the sertraline medication, to document the corresponding number of all intervention attempted, and to document the effectiveness of the intervention;- dated 3/27/26, to provide nonpharmacological interventions to best alleviate the behavior every shift for the use of the trazodone medication, to document the corresponding number of all intervention attempted, and to document the effectiveness of the intervention;- dated 3/28/26, to administer sertraline 50 mg one tablet one time a day for depression manifested by verbalization of sadness;- dated 3/28/26, to administer trazodone 25 mg one tablet by mouth at bedtime for insomnia; - dated 3/28/26, to monitor the hours of sleep every evening and night shift for the use of trazodone;- dated 4/16/26, to administer Seroquel 100mg one tablet by mouth at bedtime for schizoaffective disorder manifested by persecutory delusions as evidence by stating someone was trying to get him;- dated 4/16/26, to monitor Resident 2's schizoaffective disorder manifested by persecutory delusions as evidence by stating someone was trying to get him every shift for his use of the Seroquel medication; and- dated 4/16/26, to provide non-pharmacological interventions to best alleviate the behavior every shift for the use of the Seroquel medication, to document the corresponding number of all intervention attempted, and to document the effectiveness of the intervention. Review of Resident 2's MAR for May 2026 showed the following:- from 5/1 to 5/20/26, the Seroquel, sertraline, and trazodone medications were administered;-on 5/10/26 during the 11 pm to 7 am shift, sleep monitoring entries for the use of the trazodone medication were missing; and- on 5/15 to 5/16/26 during the 11 pm to 7 am shift, entries were missing for sleep monitoring for the use of the (continued on next page)

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Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility P& review, the facility failed to ensure two of 20 final sampled residents (Residents 3 and 6) and one nonsampled resident (Resident 56) were free from abuse or exploitation as per the facility's P&P. * The facility failed to ensure the facility's protocols were discussed prior to providing activities to Residents 3, 6 and 56 who were in the video posted in the social media. This failure put the residents at risk for potential abuse and exploitation. Findings: Review of the facility's P&P titled Abuse Prevention Program dated 12/2024 showed the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. As part of the resident abuse prevention, the administration will: - protect the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteer, staff from other agencies, family members, legal representatives, friends, visitors or any other individual; and- develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Review of the facility's P&P titled Compliance and Ethics Program- Code of Conduct and Statement of Purpose dated 12/2020 showed the objectives of the compliance and ethics program included the following:- to formulate effective, internal controls to ensure compliance with current statutes, regulations and rules;- demonstrate to employees and the community at large our facility's commitment to responsible corporate conduct;- obtain an accurate assessment of employee and contractor behavior; and- increase the likelihood of identifying and preventing unlawful and unethical behavior. Medical record review for Resident 3 was initiated on 5/18/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 3/10/26, showed Resident 3 had the capacity to understand and make decisions. On 5/20/26 at 0828 hours, an interview was conducted with the Administrator. The Administrator stated an entertainer was hired to entertain the residents during an event. The Administrator stated during the event in the dining room on 2/23/26, Entertainer 1 used her cellphone to record the event. The Administrator stated to her knowledge all the residents had signed the consents to be photographed except for one resident who was not in the dining room at that time. The Administrator further stated when Entertainer 1 had to perform, she continued with the video recording using Entertainer 1's cellphone. The Administrator stated approximately a week later she received a report of the video uploaded on social media and requested Entertainment 1 to remove the video from her social media post. The Administrator stated Entertainer 1 refused to remove the video in social media and requested the facility to provide a financial offer in exchange for taking the video from social media. When asked if she was aware Entertainer 1 would be posting the video recording on social media, the Administrator responded, there was a possibility. On 5/21/26 at 0748 hours, an interview was conducted with the Activities Director. When asked if the facility had any contract/agreement formulated or files for the entertainer, the Activity Director stated the facility did not keep a file folder for the entertainer but would only keep the vouchers. When asked if the background check and in-services regarding abuse prevention were being done, the Activity Director stated, no. When asked if she was present in the dining room when the video was recorded, the Activities Director stated, yes; however, she was busy transporting and attending to the residents. On 5/21/26 at 0949 hours an interview was conducted with the DON. When asked about the video recording posted in social media, the DON stated, it is a mistake, the social media consent was not done on Resident 3, and she should have not been there. The DON further stated, we have to protect the residents before a recording is done, no more videos. On 5/21/26 at 1004 hours, an interview with the Admissions Director was conducted. The Admissions Director stated she would obtain the consents from the residents or responsible parties on admission including the consents to be photographed for social media, brochure, and flyer use. The Admissions Director stated Resident 3's responsible party signed the consent to be photographed for the face sheet, dietary cards, and medical records only. The (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Admissions Director stated they revised the consents to be photographed for the social media, brochure, and flyer use last year and Resident 3's responsible party did not give the consent. The Admissions Director was asked whether the residents who attended the video recorded event had signed consents. The Admissions Director stated, No, I was not asked. On 5/21/26 at 1310 hours, an interview was conducted with Resident 3's responsible party. Responsible Party 2 stated he did not sign any consent for Resident 3 to be photographed or to be posted on social media. Responsible Party 2 stated he received information of his wife in social media and people were making fun of her. Responsible Party 2 further stated, I don't want humiliation, this is my dignity, my daughter came home crying because of this, we did not tell my wife because she will feel bad about it. Additionally, Responsible Party 2 stated he was aware the entertainer asked the facility for money to remove the social media posting and have been following up with the Administrator. Responsible Party 2 added the police department was called to have the social [NAME] post removed but felt he was going nowhere. On 5/21/26 at 1358 hours, an interview was conducted with Resident 6. Resident 6 was in the video recorded event and was asked how she felt when she learned the video recording was posted on social media. Resident 6 stated, I didn't want my picture posted, I was humiliated when someone showed it to me a couple of days after it happened. On 5/21/26 at 1403 hours, an interview was conducted with Resident 56. Resident 56 stated he was in the video recorded during the event but did not know it would be posted on social media. Resident 56 further stated, I was humiliated, so embarrassed, it's not a nice feeling seeing that online, I am not happy at all. Additionally, Resident 56 stated he cannot remember if he signed the consent to be photographed on admission, since he was just admitted . Resident 56 further stated, it is a different humiliation when it is already posted, had I known it will be posted online, I won't be there attending the event. On 5/21/2026 at 1529 hours, an interview with the DON was conducted. DON was informed and acknowledged the findings. Cross reference to F550.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was developed and implemented to reflect the individual care needs for four of 20 final sampled residents (Residents 17, 23, 49, and 68). * The facility failed to develop a care plan problem to address Resident 17's new diagnosis of prurigo nodularis (a chronic, debilitating skin condition characterized by the eruption of intensely itchy, firm, and hard bumps (nodules) on the skin). * The facility failed to develop a care plan problem to address Resident 23's use of CPAP machine at the bedside. * The facility failed to implement bilateral floor mats per Resident 49's care plan for falls. In addition, the facility failed to monitor Resident 49's urinary output per his care plan for the use of an indwelling urinary foley catheter. * The facility failed to develop a care plan problem to address Resident 68's use of a blood sugar monitoring device. These failures had the potential for the residents to not be provided with appropriate, consistent, and individualized care.Findings: Review of the facility P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed 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. 1. Medical record review for Resident 49 was initiated on 5/18/26. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's H&P examination dated 5/4/26, showed Resident 49 had the capacity to make his own medical decisions. Resident 49 had a diagnosis of chronic kidney disease, hydronephrosis (the swelling of one or both kidneys caused by a backup of urine), urinary retention (inability to pee) and used a chronic indwelling foley catheter. Review of Resident 49's Care Plan Report showed the following care plans:- a care plan problem revised 5/19/26, addressed his chronic kidney disease and hydronephrosis diagnosis. The interventions included to monitor, document, and report signs and symptoms of acute renal failure such as oliguria (abnormally low urine output) with a urine output of 400 ml per 24 hours or the diuretic phase of a urine output greater than 500 ml within 24 hours; and - a care plan problem revised 5/19/26, addressed his risk for falls with injury related to his limited mobility. The interventions included to provide bilateral floor mats beside his bed. a. Review of Resident 49's Order Summary Report showed a physician's order dated 5/2/26, for an indwelling urinary foley catheter due to his neurogenic bladder (loss of bladder control caused by nerve damage). Review of Resident 49's Documentation Survey Report v2 for 5/2026 did not show documented evidence Resident 49's urinary output was monitored. On 5/19/26 at 1557 hours, an interview and concurrent medical record review for Resident 49 was conducted with LVN 3. LVN 3 stated Resident 49 did not have orders to monitor the urinary output. When asked how to monitor the signs and symptoms of acute renal failure per Resident 49's care plan, LVN 3 stated they should monitor and document Resident 49's urinary output. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/26 at 1627 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 5. RN 5 stated the fluid intake and output should be monitored for 30 days for residents who were newly admitted with an indwelling urinary foley catheter. RN 5 verified the above findings. b. On 5/18/26 at 0821 hours, Resident 49 was observed awake in bed. There were no floor mats observed by his bedside. On 5/19/26 at 0846, Resident 49 was observed awake in bed. There were no floor mats observed by his bedside. On 5/19/26 at 1557 hours, an interview, observation, and concurrent medical record review for Resident 49 was conducted with LVN 3. LVN 3 verified the above findings. On 5/19/26 at 1627 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 5. RN 5 verified the above findings. On 5/21/26 at 1413 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 23 was initiated on 5/18/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's admission Record dated 5/19/26, showed Resident 23 was admitted to the facility with the diagnosis of obstructive sleep apnea. Review of Resident 23's plan of care failed to show documented evidence a care plan was developed to address Resident 23's use of CPAP machine at the bedside. On 5/19/26 at 1435 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 1. RN 1 verified Resident 23's use of CPAP machine at bedside. RN 1 was asked about the care plan for the use of CPAP machine. RN 1 reviewed the plan of care and was unable to find a care plan formulated for the use of CPAP machine. 3. Medical record review for Resident 68 was initiated on 5/18/26. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68's admission Record dated 5/19/26, showed Resident 68 was admitted to the facility with the diagnosis of diabetes mellitus. Review of Resident 68's plan of care failed to show documented evidence a care plan was developed to address Resident 68's use of blood sugar monitoring device (Dexcom G7 blood sugar monitoring device). On 5/19/26 at 1117 hours, an interview and concurrent medical record review for Resident 68 was conducted with LVN 10. LVN 10 verified Resident 68's use of the blood sugar monitoring device. LVN 10 was asked if there was a care plan formulated for the use of the Dexcom G7 blood sugar monitoring device. LVN 10 verified there was no care plan developed for the use of the Dexcom device. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/26 1346 hours, an interview and concurrent medical record review for Residents 23 and 68 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F684, example #3. 4. Medical record review for Resident 17 was initiated on 5/19/26. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's Physician's Progress Record dated 5/15/26, showed prurigo nodularis coupled with self-inflicted picking. Review of Resident 17's Progress Notes showed a Skin/Wound Note dated 5/15/26 at 1509 hours, showed the resident came back from dermatology appointment with a diagnosis of prurigo nodularis with self-inflicted scratching/picking. Review of Resident 17's plan of care did not show a care plan was developed to address the new diagnosis of prurigo nodularis. On 5/20/26 at 1409 hours, an interview and concurrent medical record review for Resident 17 was conducted with RN 1. RN 1 verified Resident 17 was diagnosed with prurigo nodularis from his dermatology appointment. RN 1 could not show a care plan was developed to address Resident 17's diagnosis of prurigo nodularis. On 5/21/26 at 0917 hours, an interview for Resident 17 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, the facility failed to provide the necessary care and services to ensure four of 20 final sampled residents (Residents 8, 17, 37, and 68) attained and maintained their highest practicable physical well-being. * The facility failed to ensure Resident 17's treatments were updated and directed towards Resident 17's newly identified diagnosis of prurigo nodularis rather than continued treatment for a dermatological rash. In addition, the facility failed to ensure the physician's order for therapeutic shampoo was followed. * The facility failed to ensure insulin injection sites were rotated per the physician's order for Residents 8 and 37. * The facility failed to ensure a physician's order was obtained, the assessment was completed, and the appropriate instructions were obtained to maintain the appropriate care of a blood glucose monitoring device for Resident 68. These failures had the potential to result in ineffective treatment, worsening skin conditions, altered medication effectiveness, impaired insulin absorption and tissue damage which could lead to negative resident outcomes.Findings: 1. Medical record review for Resident 17 was initiated on 5/19/26. Resident 148 was readmitted to the facility on [DATE]. Review of Resident 17's Order Summary Report showed the following physician's orders: - dated 12/11/25, to use therapeutic shampoo 3% coal tar on shower days, every evening shift every Tuesday and Friday for scalp seborrheic dermatitis (a common, chronic inflammatory skin condition affecting sebum-rich areas. It causes itchy, scaly, greasy patches and stubborn flaking (dandruff) on the scalp); - dated 5/8/26, right lower extremity dermatologic rash (open lesions) – cleanse with normal saline, pat dry, apply manuka honey (a topical wound care product), and cover with dry dressing every day shift; - dated 5/8/26, right lower extremity dermatologic rash (open lesions) – cleanse with normal saline, pat dry, apply manuka honey, and cover with dry dressing every evening shift every Tuesday and Friday. Reinforce dressing after shower; - dated 5/8/26, right lower extremity dermatologic rash (open lesions) – cleanse with normal saline, pat dry, apply manuka honey, and cover with dry dressing as needed if soiled or dislodge; - dated 5/8/26, right upper extremity to torso, and back area dermatological rash – cleanse with normal saline, pat dry, apply Gentamicin Sulfate (antibiotic) external ointment 0.1% to open areas, Triamcinolone Acetonide (synthetic corticosteroid) external cream 0.1% and ketoconazole (antifungal) external cream 2% to intact skin, and cover with dry dressing every day shift; - dated 5/8/26, right upper extremity to torso, and back area dermatological rash – cleanse with normal saline, pat dry, apply Gentamicin Sulfate external ointment 0.1% to open areas, Triamcinolone Acetonide external cream 0.1% and ketoconazole external cream 2% to intact skin, and cover with dry dressing every evening shift every Tuesday and Friday. Reinforce dressing after shower; - dated 5/8/26, right upper extremity to torso, and back area dermatological rash – cleanse (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with normal saline, pat dry, apply Gentamicin Sulfate external ointment 0.1% to open areas, Triamcinolone Acetonide external cream 0.1% and ketoconazole external cream 2% to intact skin, and cover with dry dressing as needed if soiled or dislodge; and - dated 5/13/26, to administer Doxycycline (antibiotic) 100 mg one tablet by mouth two times a day for impetigo for 10 days. Review of Resident 17's Physician's Progress Record dated 5/15/26, showed prurigo nodularis coupled with self-inflicted picking. Review of Resident 17's Progress Notes showed a Skin/Wound Note dated 5/15/26 at 1509 hours, showed the resident came back from dermatology appointment with a diagnosis of prurigo nodularis with self-inflicted scratching/picking. Further review of Resident 17's medical record did not show Resident 17's treatments were updated and directed towards Resident 17's newly identified diagnosis of prurigo nodularis rather than continued treatment for a dermatological rash. On 5/20/26 at 1142 hours, an inspection of the treatment cart, and concurrent interview and medical record review for Resident 17 was conducted with LVN 4. When asked to show the therapeutic shampoo used for Resident 17, LVN 4 showed a therapeutic shampoo with 0.5% coal tar. LVN 4 verified the physician's order showed to use therapeutic shampoo with 3% coal tar. When asked about Resident 17's open lesions, LVN 4 stated Resident 17 came back from his dermatology appointment on 5/15/26, and he was diagnosed with prurigo nodularis. When asked about the treatment towards Resident 17's new diagnosis of prurigo nodularis, LVN 4 was not able to show documented evidence the treatments were updated and directed towards Resident 17's newly identified diagnosis of prurigo nodularis. On 5/20/26 at 1409 hours, an interview and concurrent medical record review for Resident 17 was conducted with RN 1. RN 1 verified Resident 17 was diagnosed with prurigo nodularis from his dermatology appointment. RN 1 was not able to show documented evidence the treatments were updated and directed towards Resident 17's newly identified diagnosis of prurigo nodularis. When asked about Resident 17's antibiotic treatment for impetigo, RN 1 verified Resident 17 was on antibiotic treatment for impetigo, but could not find any physician's progress notes or diagnosis of impetigo. RN 1 also could not find any documentation by the licensed nurses of clarification of the diagnosis of impetigo from the physician. 2. According to Taylor's Clinical Nursing Skills seventh edition, the various sites used for subcutaneous injections are the outer aspect of the upper arm, the abdomen (from below the costal margin to the iliac crest), the anterior aspect of the thigh, the upper back, and the upper ventral (front upper) or dorsogluteal area (buttocks). It is necessary to rotate sites or areas for injections to prevent buildup of fibrous tissue and permit complete absorption of the medication. a. Medical record review for Resident 8 was initiated on 5/19/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed a physician's order dated 4/25/26, to inject regular insulin (short-acting insulin) subcutaneously before meals and at bedtime, per sliding scale, and to rotate sites. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 8's Blood Glucose Monitoring for April and May 2026 showed the injection sites to administer the insulin injections were not rotated for Resident 8. For example: - On 4/26/26 at 1630 and 2100 hours, and on 4/27/26 at 1630 hours, regular insulin was injected on the left arm; and - On 5/7/26 at 1608 hours, on 5/8/26 at 1130 hours, on 5/9/26 at 1630 hours, and on 5/10/26 at 1630 hours, regular insulin was injected on the left lower abdominal quadrant. On 5/20/26 at 1425 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the licensed nurses should have checked which site was used from the previous insulin administration and rotated the insulin injection sites. RN 1 also verified there was no documentation to show Resident 8 preferred the left lower quadrant of the abdomen nor the left arm. On 5/21/26 at 0817 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. b. Medical record review for Resident 37 was initiated on 5/18/26. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's H&P examination dated 5/1/26, showed resident did not have the capacity to understand and make decisions. Review of Resident 37's Order Summary Report dated 5/21/26, showed the following physician's orders: - dated 4/30/26, to administer Humulin-R insulin (a short-acting, insulin designed to manage high blood sugar), inject as per sliding scale (amount of insulin to be administered based on the blood sugar results) subcutaneously before meals and at bedtime and to rotate injection sites; and - dated 5/1/26, to administer insulin glargine (a long-acting, insulin designed to manage blood sugar), inject 30 unit subcutaneously in the morning and to rotate injection sites. Review of Resident 37's Location of Administration Report for May 2026 showed the regular insulin, and insulin glargine was administered consecutively on the same injection sites on the following dates and times: - on 5/1/26 at 0918 hours, insulin glargine was administered to the LLQ (lower left quadrant) of the abdomen; - on 5/1/26 at 1200 hours, Humulin-R insulin was administered to the LLQ of the abdomen; - on 5/4/26 at 0748 hours, insulin glargine was administered to the LLQ of the abdomen; - on 5/4/26 at 0748 hours, Humulin-R insulin was administered to the LLQ of the abdomen; - on 5/4/26 at 1159 hours, Humulin-R insulin was administered to the LLQ of the abdomen; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 5/16/26 at 0731 hours, insulin glargine was administered to the LLQ of the abdomen; and - on 5/16/26 at 0730 hours, Humulin-R insulin was administered to the LLQ of the abdomen. On 5/20/26 at 1056 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 1. RN 1 verified the above findings and stated the insulin injection site should be rotated with each insulin administration. On 5/21/26 at 1330 hours, an interview was conducted with the DON. The DON stated the expectation from the licensed nurses was to rotate the insulin injection sites. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 68 was initiated on 5/18/26. Resident 68 was admitted to the facility on [DATE]. On 5/18/26 at 0816 hours, during the initial tour of the facility, an observation and concurrent interview with Resident 68 was conducted. A box of Dexcom G7 blood sugar monitoring device was observed at Resident 68's bedside table. Resident 68 was asked about the device and stated the device probe was on his right upper arm and able to show the device with a transparent dressing. Resident 68 stated he changed the device probe every 18 days and the nurses helped him to put the dressing. Resident 68 was able to show the device monitor which shows the result of his blood sugar. Review of Resident 68's Order Summary Report showed a physician's order dated 4/22/26, to administer Lispro insulin (fast acting insulin) solution per sliding scale subcutaneously before meals for DM as follows: if the blood sugar result = 80 to 150 mg/dl, give 3 units of insulin; if the blood sugar result = 151 to 200 mg/dl, give 5 units of insulin; if the blood sugar result = 201 to 250 mg/dl, give 7 units of insulin; if the blood sugar results = 251 to 300 mg/dl, give 9 units of insulin; if the blood sugar results = 301 to 350 mg/dl, give 12 units of insulin. However, further review of the order summary report failed to show a physician's order for the use of the blood glucose monitoring device and care for the monitor probe placed on the resident skin was obtained and documented. Review of Resident 68's H&P examination dated 4/23/26, showed Resident 68 had the capacity to understand and make decisions. Further review of Resident 68's medical record failed to show documented evidence for the use of the blood glucose monitoring device. On 5/19/2026 at 1117 hours, an interview and concurrent medical record review for Resident 68 was conducted with LVN 10. LVN 10 verified Resident 68 had the Dexcom G7 blood sugar monitoring device and have a separate monitor to show the result of the blood sugar, but they were still checking the blood sugar via finger stick and compare. LVN 10 was asked if there was a physician's order for the use of the Dexcom blood sugar device. LVN 10 verified there was no physician's order for the use of the blood sugar monitoring device. On 5/19/26 at 1445 hours, an interview and concurrent medical record review for Resident 68 was conducted with RN 1. RN 1 was asked about the Dexcom G7 blood sugar monitoring device use of the Resident 68. RN 1 reviewed the medical records, verified and acknowledged there was no physician's order for the use of Dexcom G7 and care of the skin where the probe was placed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/26 at 1346 hours, an interview and concurrent medical record review for Resident 68 was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F656, example # 3.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the appropriate care and services for the use of the GT for three of three final sampled residents (Residents 5, 11, and 81) reviewed for GT care. * The facility failed to ensure Resident 5 and 11's free flush water bag was labeled with the resident's name, date, and start time. Additionally, the facility failed to label the piston syringe with the resident's name, date, and time the syringe was changed. * The facility failed to ensure Resident 81's enteral free water bag via enteral pump was labeled with resident's name, date, time, and initials by the nurse. These failures had the potential to place Residents 5, 11, and 81 at risk for complications related to the use of the GT. Findings: 1. Medical record review for Resident 5 was initiated on 5/18/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's Order Summary Report dated 5/21/26, showed the following physician's orders: - dated 5/6/26, to administer enteral feeding: Diabetisource 1.2 (a type of enteral feeding formula) at the rate of 65 ml per hour; to start feeding at 1400 hours until 1300 ml have infused. - dated 5/6/26, to administer enteral free water via enteral pump at 55 ml/hour to provide 1100 ml in 24 hours; to start at 1400 hours. a. On 05/18/26 at 0752 hours, Resident 5 was observed lying in bed and GT feeding was observed infusing Diabetisource 1.2 at 65 ml/hr. The enteral free water was observed hanging and was connected to the enteral feeding with no label of Resident 5's name, date, and the time the water bag was hang. On 5/18/26 at 0755 hours, a concurrent interview and observation was conducted with LVN 6. LVN 6 stated when hanging a new enteral feeding bag, the enteral free water bag should be labeled with the resident's name, the date and time the enteral free water was started. LVN 6 further stated the enteral free water bag should be discarded after 24 hours. When asked when Resident 5's current enteral free water was started LVN 6 verified the enteral free water bag was not labeled and stated she did not know when the enteral free water was started. b. On 05/18/26 at 0753 hours, a piston irrigation syringe in a plastic bag was observed hung at Resident 5's enteral pole. The resident's name, the date, and the time was not documented in the plastic bag when the piston irrigation syringe was changed. On 5/18/26 at 0757 hours, a concurrent interview and observation was conducted with LVN 6. LVN 6 stated when changing the piston irrigation syringe, the nurse should label the plastic bag with the resident's name, the date and time. LVN 6 further stated the piston irrigation syringe should be changed every night shift. On 5/21/26 at 1325 hours, an interview was conducted with the DON. The DON stated the licensed (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurses were expected to label the enteral free water bag with the resident's name, the ordered rate, and start date and time. The DON further stated the piston syringe should be changed daily and should be labeled accordingly. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 11 was initiated on 5/18/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's Order Summary Report dated 5/21/26, showed the following physician's orders: - dated 4/30/25, to administer enteral feeding: Diabetisource 1.2 (a type of enteral feeding formula) at the rate of 75 ml per hour for 20 hours; to start feeding at 1400 hours until 1500 ml have infused. - dated 7/14/25, to administer enteral free water via enteral pump at 60 ml/hour for 20 hours to provide 1200 ml in 24 hours; to start at 1400 hours. a. On 05/18/26 at 0758 hours, Resident 11 was observed lying in bed and GT feeding was observed infusing Diabetisource 1.2 at 75 ml/hr. The enteral free water was observed hanging and was connected to the enteral feeding with no label of Resident 11's name, date and the time the water bag was hung. On 5/18/26 at 0800 hours, a concurrent interview and observation was conducted with LVN 6. LVN 6 stated when hanging a new enteral feeding bag, the enteral free water bag should be labeled with the resident's name, the date and time the enteral free water was started. LVN 6 further stated the enteral free water bag should be discarded after 24 hours. When asked when Resident 11's current enteral free water was started LVN 6 verified the enteral free water bag was not labeled and stated she did not know when the enteral free water was started. b. On 05/18/26 at 0759 hours, a piston irrigation syringe in a plastic bag was observed hung at Resident 5's enteral pole. The resident's name, the date, and the time was not documented in the plastic bag when the piston irrigation syringe was changed. On 5/18/26 at 0801 hours, a concurrent interview and observation was conducted with LVN 6. LVN 6 stated when changing the piston irrigation syringe, the nurse should label the plastic bag with the resident's name, the date and time. LVN 6 further stated the piston irrigation syringe should be changed every night shift. On 5/21/26 at 1320 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to label the enteral free water bag with the resident's name, the ordered rate, and start date and time. The DON further stated the piston syringe should be changed daily and should be labeled accordingly. The DON was informed and acknowledged the above findings. 3. On 5/18/26 at 0636 hours, during the facility initial tour, an observation of Resident 81 in the resident's room was conducted. Resident 81 was observed lying on his bed with free water flush via enteral pump. The free water bag was observed with no resident's name, infusion rate, date, time, and nurse's initial. Medical Record Review for Resident 81 was initiated on 5/18/26. Resident 81 was admitted to the facility on [DATE]. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 81's H&P examination dated 2/15/26, showed Resident 81 lacks decision making capacity. Review of Resident 81's Order Summary Report showed a physician order dated 4/7/26, for free water via enteral pump at 60 ml/hour x 20 hours to provide 1200 ml in 24 hours or until total volume infused. On 5/18/26 at 0649 hours, an observation and interview were conducted with LVN 2. LVN 2 verified Resident 81's free water bag was not labeled as above. LVN 2 stated the free water bag should have been labeled by the nurse when it was hung. LVN 2 further stated she will get a new free water bag to hang and make sure she will label the bag. On 5/21/26 at 1404 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the respiratory care and services were provided in accordance with professional standards for four of 20 final sampled residents (Residents 5, 23, 35, and 89) and two nonsampled residents (Residents 57 and 74). * The facility failed to ensure the oxygen was administered as ordered for Resident 5. In addition, the facility failed to ensure Resident 5's nasal cannula was labeled. * The facility failed to ensure Resident 23's oxygen tubing was labeled and dated. In addition, the facility failed to ensure a physician's order was obtained and the appropriate instructions were obtained to maintain the appropriate care of Resident 23's CPAP machine, mask and tubing. * The facility failed to ensure Resident 35's nasal cannula was labeled. * The facility failed to ensure the oxygen was administered as ordered for Resident 57. In addition, the facility failed to ensure Resident 57's nasal canula attached to the oxygen concentrator was labeled, and the nasal cannula attached to the oxygen tank on the wheelchair was labeled and stored in a bag when not in use. * The facility failed to ensure Resident 74 was administered with oxygen as ordered by the physician. In addition, the facility failed to ensure Resident 74's oxygen humidifier was replaced as ordered by the physician. * The facility failed to ensure Resident 89's nasal canula was labeled. In addition, the facility failed to ensure Resident 89's nebulizer mask was labeled and stored in a bag when not in use. These failures had the potential for the residents to receive inadequate respiratory care and increased risk for infection. Findings: Review of the facility's P&P titled Oxygen Administration revised 2/2024 showed verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 1. Medical record review for Resident 5 was initiated on 5/18/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's H&P examination dated 3/13/26, showed resident had no capacity to understand and make decisions. Review of Resident 5's Order Summary Report dated 5/21/26, showed a physician's order dated 3/24/26, to change the oxygen nasal cannula every week on Sunday and as needed (label with name and date) every night shift every Sunday and administer oxygen at a rate of 2 liter per minute via nasal cannula continuously every shift to keep oxygen saturation greater than 92%. Review of Resident 5's plan of care showed a care plan problem for the resident's risk for altered cardiovascular status dated 3/17/26. The interventions included to administer oxygen per physician's order. a. On 5/19/26 at 1215 hours, Resident 5 was observed in her room laying on her bed. Resident had oxygen being administered at a rate of 1.5 liters per minute via nasal cannula. On 5/19/26 at 1220 hours, a concurrent observation of Resident 5 and interview was conducted with LVN 7. LVN 7 verified Resident was receiving oxygen at a rate of 1.5 liters per minute. LVN 7 stated she will inform the RN supervisor to adjust the prescribed oxygen for the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/26 at 0727 hours, a follow up observation was conducted for Resident 5. Resident 5 was observed in her room laying on her bed. Resident had oxygen being administered at a rate of 2.5 liters per minute via nasal cannula. On 5/20/26 at 0728 hours, a concurrent observation of Resident 5 and interview was conducted with LVN 7. LVN 7 verified Resident was receiving oxygen at a rate of 2.5 liters ER minute. LVN 7 stated she will inform the RN supervisor to adjust the prescribed oxygen for the resident. On 5/21/26 at 1339 hours, an interview was conducted with the DON. The DON was informed and acknowledged the finding as above. b. On 5/18/26 at 0739 hours, during the initial tour of the facility, Resident 5 was observed in her room. Resident had oxygen at a rate of 2 liters per minute via nasal cannula. Resident 5's nasal cannula was observed not labeled with a date. A plastic bag was observed hanging on the resident's oxygen concentrator dated 5/10/26. On 5/18/26 at 0755 hours, a concurrent observation of Resident 5 and interview was conducted with LVN 6. LVN 6 verified Resident 5's nasal canula was not labeled. LVN 6 stated the plastic bag hanging on the oxygen concentrator was for the storage of the nasal cannula when not in use. LVN 6 stated the nasal cannula and the bag should have been changed on Sunday and should have been labeled when it was changed. On 5/21/26 at 1340 hours, an interview was conducted with the DON. The DON was informed and acknowledged the finding as above. 2. Medical record review for Resident 35 was initiated on 5/18/26. Resident 35 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 35's H&P examination dated 8/25/26, showed the resident had no capacity to understand and make decisions. Review of Resident 35's Order Summary Report dated 5/21/26, showed a physician's order for the following: - dated 8/23/24, to administer oxygen at 3 LPM via nasal cannula continuously every shift to keep oxygen saturation greater than 92%; and - dated 9/27/24, to change oxygen nasal cannula every week on Sunday and as needed (label with name and date) every night shift every Sunday. On 5/18/26 at 0707 hours, during the initial tour of the facility, Resident 35 was observed in her room. Resident 35 had oxygen at a rate of 3 liters per minute via nasal cannula. Resident 35's nasal cannula was observed not labeled with a date. A plastic bag was observed hanging on the resident's oxygen concentrator dated 5/10/26. On 5/18/26 at 0714 hours, a concurrent observation of Resident 35 and interview was conducted with RN 1. RN 1 verified Resident 35's nasal cannula was not labeled. RN 1 stated the nasal cannula, and the bag should have been changed and labeled on Sunday. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/26 at 1340 hours, an interview was conducted with the DON. The DON was informed and acknowledged the finding as above. 3. Medical record review for Resident 57 was initiated on 5/18/26. Resident 57 was admitted to the facility on [DATE] and was readmitted on [DATE]. Review of Resident 57's H&P examination dated 2/23/26, showed the resident had the capacity to understand and make decisions. Review of Resident 57's Order Summary Report dated 5/21/26, showed a physician's order for the following: - dated 3/25/26, to administer oxygen at a rate of 3 liters per minute via nasal cannula continuously every shift to keep oxygen saturation greater than 92%; and - dated 4/18/26, to change oxygen nasal cannula every week on Saturdays and as needed (label with name and date) every night shift every Sunday. Review of Resident 57's Care Plan Report showed a care plan problem for at risk for cardiac distress revised on 4/3/26. The interventions included to administer oxygen inhalation as ordered. Further review of Resident 57's Care Plan Report showed a care plan problem for at risk for respiratory distress revised on 4/3/26. The interventions included to administer oxygen inhalation as ordered. On 5/18/26 at 0702 hours, during the initial tour of the facility, Resident 57 was observed in her room asleep, lying in the bed with oxygen at a rate of 4 liters per minute via nasal cannula. Resident 57's nasal cannula was observed not labeled with date. A plastic bag dated 5/10/26, was observed hanging on the resident's oxygen concentrator. A wheelchair was observed by the resident's bed with an oxygen tank. A nasal cannula was attached to the oxygen tank without a label and exposed to air. There was no bag observed to store the nasal cannula when not in use. On 5/18/26 at 0708 hours, a concurrent observation of Resident 57 and interview was conducted with RN 1. RN 1 verified Resident 57's oxygen was set at a rate of 4 liters per minute via nasal cannula. RN 1 verified Resident 57's nasal cannula attached to the oxygen concentrator was not labeled, the bag hanging by the oxygen concentrator was dated 5/10/26, the nasal canula connected to the oxygen tank was not labeled and was exposed to air and there was no bag to store the nasal canula when not in use. RN 1 stated the nasal cannula, and the bag should have been changed and labeled either Saturdays or Sundays. RN 1 further stated the nasal cannula should have been stored in a plastic bag when not in use. On 5/18/26 at 1012 hours, a concurrent interview and record review for Resident 57 was conducted with RN 1. RN 1 verified the resident's physician order dated 3/25/26, showed to administer oxygen at a rate of 3 liters per minute via nasal cannula continuously every shift to keep oxygen saturation greater than 92% and to change oxygen nasal cannula every week on Saturdays and PRN (label with name and date) every night shift every Sunday. RN 1 verified Resident 57's Care Plan Report showed a care plan problem for risk for respiratory distress revised on 4/3/26, with intervention to administer oxygen inhalation as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/26 at 1336 hours, an interview was conducted with the DON. The DON stated the oxygen should be administered as ordered by the physician. Resident 57 oxygen should be set at a rate of 3 liters per minute via nasal cannula. The DON stated the nasal cannula should be changed every week and Resident 57's nasal cannula should have been dated, changed weekly, and stored in a named and dated plastic bag when not in use. The DON was informed and acknowledged the finding as above. 4. On 5/18/26 at 0705 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with Resident 89. Resident 89 was observed in the room lying on her bed. A nebulizer was observed on the resident's bedside table with the nebulizer mask unlabeled and exposed to air. There was no bag observed by the nebulizer to store the nebulizer mask when not in use. Resident 89 stated she uses the nebulizer two times a day. Resident 89 further stated the mask was left by the nurse on top of the bedside table. An oxygen tank was observed beside Resident 89's bed. A nasal cannula was attached to the oxygen tank, and was on the floor. The nasal cannula was not labeled with a date and there was no labeled plastic bag by the oxygen tank to store the nasal canula when not in use. Resident stated she had not used oxygen for a while. Resident 89 stated she does not know when the nasal cannula was changed. On 5/18/26 at 0720 hours, a concurrent observation of Resident 89 and interview was conducted with RN 1. RN 1 verified the oxygen tank was for Resident 89. RN 1 verified the nasal cannula was on the floor and was not labeled with date. RN 1 verified a nebulizer was observed on the resident's bedside table with the nebulizer mask unlabeled and exposed to air and there was no bag observed by the nebulizer to store the nebulizer mask when not in use. RN 1 stated the nasal cannula, nasal mask, and the bag should have been changed and labeled either Saturdays or Sundays. RN 1 further stated the nasal cannula, and the nebulizer mask should have been stored in a plastic bag when not in use. Medical record review for Resident 89 was initiated on 5/18/26. Resident 89 was admitted to the facility on [DATE]. Review of Resident 89's H&P examination dated 5/9/26, showed the resident had the capacity to understand and make decisions. Review of Resident 89's Order Summary Report dated 5/21/26, showed a physician's order dated 5/14/26, to administer budesonide (a medication works by decreasing inflammation of the airway, making it easier to breath) inhalation suspension 0.5 ml/2ml, give 2 ml inhale orally every four hours as needed for shortness of breath for 30 days rinse the mouth with water after using nebulizer, and to administer budesonide inhalation suspension 0.5 mg/2ml, give 2 ml inhale orally two times a day 7 days rinse the mouth with water after using nebulizer. Further review of Resident 89's Order Summary Report dated 5/21/26, failed to show a physician's order for the use of oxygen. Review of Resident 89's MAR for May 2026 showed the budesonide inhalation suspension 0.5 mg/2ml was administered to the resident two times a day since 5/15/26. On 5/21/26 at 1339 hours, an interview was conducted with the DON. The DON stated the nasal cannula, and nebulizer mask should be changed every week and Resident 89's nasal cannula and nebulizer mask should have been dated, changed weekly, and stored in a named and dated plastic bag when not in use. The DON was informed and acknowledged the finding as above. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the facility's P&P titled Oxygen Administration dated September 2024 showed the following: - to turn on the oxygen, unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. - adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. - check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. - observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated. On 5/18/26 at 0631 hours, during the initial tour of the facility, Resident 74 was sleeping in bed with oxygen administered via nasal cannula at a rate between 3-3.5 liters per minute. The oxygen concentrator was adjacent to Resident 74's bed had an oxygen humidifier in use dated 5/9/26. On 5/18/26 at 0656 hours, an observation was conducted with CNA 1. CNA 1 verified the oxygen was being administered at a rate between 3-3.5 liters per minute and the date on the oxygen humidifier was 5/9/26. On 5/18/26 at 0812 hours, an observation was conducted with Resident 74. Resident 74 was observed receiving oxygen at a rate of 3 liters per minute via nasal cannula. On 5/18/26 at 1422 hours, a follow-up observation was conducted with Resident 74. Resident 74 was observed receiving oxygen at a rate of 2 liters per minute via nasal cannula. On 5/18/26 5/18/26 at 1430 hours, an observation and concurrent interview and medical record review were conducted with LVN 5. LVN 5 verified the oxygen administered via nasal cannula was at a rate of 2 liters per minute. LVN 5 was made aware of the previous observations of oxygen being administered at a rate between 3-3.5 liters per minute at 0631 and 0812 hours. LVN 5 verified Resident 74's current order for oxygen was at a rate of 4 liters per minute. LVN 5 was asked if she checked the oxygen being administered earlier, LVN 5 stated she's hospice. When asked if it matters if the resident is on hospice or not, LVN 5 stated I don't touch the oxygen, the RN has to do the rounds and monitor the oxygen, I will let the RN know. LVN 5 acknowledged the oxygen humidifier was dated 5/9/26 earlier and stated, it should be changed daily by the day shift, I changed it already this morning. Medical record review for Resident 74 was initiated on 5/18/26. Resident 74 was admitted on [DATE]. Review of Resident 74's H&P examination dated 2/28/25, showed Resident 74 does not have the capacity to understand and make decisions and can make needs known but cannot make decisions. Review of Resident 74's Order Summary Report dated 5/19/26 showed the following orders - dated 3/24/26, to change oxygen humidifier every week on Sunday and PRN when consumed every night shift every Sunday; and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 5/18/26, oxygen at two to four liters/min via nasal cannula continuously to keep oxygen saturation at more than 92% every shift for comfort measures related to hospice care (ordered after the above observation). On 5/21/26 at 930 hours an interview was conducted with the DON. The DON acknowledged the above findings. 6. Medical record review for Resident 23 was initiated on 5/18/26. Resident 23 was admitted to the facility on [DATE]. a. On 5/18/26 at 0731 hours, during the initial tour of the facility, Resident 23 was observed in bed receiving oxygen via nasal cannula from the oxygen concentrator. Resident 23's oxygen nasal cannula was observed unlabeled. Review of Resident 23's Order Summary Report dated 5/19/26, showed a physician's order dated 3/23/26, to administer oxygen at a rate of 3 liters per minute via nasal cannula continuously every shift. On 5/18/26 at 1235 hours, an observation and concurrent interview with RN 1 at Resident 23's bedside. RN 1 stated the night shift nurses would change the oxygen tubing once a week on Sunday night. RN 1 stated the licensed nurse would change the oxygen tubing, label and place it on a clear plastic bag. RN 1 verified the oxygen tubing was unlabeled and undated. b. On 5/18/26 at 0731 hours, during the initial tour of the facility, Resident 23 was observed in bed asleep. A CPAP machine was observed on top of the bedside table and the mask and tubing was inside the clear plastic bag. Review of Resident 23's Order Summary Report dated 5/19/26, showed the following physician's order: - dated 4/23/26, CPAP setting at 5 cm H20-20 cm H2O: On QHS, off when resident awakens. Empty water reservoir (if present on unit), rinse, wipe clean, and replace distilled water prior to use. May use mask of choice. Connect CPAP mask to oxygen delivery source and deliver 3 liters per minute continuously at bedtime for obstructive sleep apnea, and - dated 4/23/26, for the CPAP machine container: may rinse with soap and water, may air dry every day shift every Saturday. However, further review of the Order Summary Report failed to show a physician's order was obtained for the care and maintenance of the CPAP mask and tubing as per the manufacturer's recommendation. On 5/18/26 at 1135 hours, an observation and concurrent interview with Resident 23 was conducted. Resident 23 stated she uses oxygen and taking off when she eat cause the tubing will touch her food. Resident 23 was asked about her CPAP machine at bedside. Resident 23 stated she uses CPAP every night. Resident 23 stated she would put the mask on and turn the machine on herself and would take it off at 0500 hours. Resident 23 stated the staff clean the CPAP machine once a week including the mask and tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/26 at 1435 hours, a follow up interview and concurrent medical record review for Resident 23 was conducted with RN 1. RN 1 verified Resident 23's use of CPAP machine with physician's order for the setting. RN 1 was asked about the care for Resident 23's CPAP mask and tubing as per the manufacturer recommendation, RN 1 verified there was no physician's order. On 5/21/2026 at 1346 hours, an interview and concurrent medical record review for Resident 23 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility P&P review, the facility failed to ensure food safety were followed in the facility's kitchen. * Expired food was not discarded. * Food was not properly dated and labeled. These failures posed the risk for food borne illnesses in a highly susceptible resident population of 69 residents who received food prepared in the kitchen.Findings: Review of the facility's P&P titled Food Receiving and Storage revised 10/2017 showed all foods stored in the refrigerator or freezer will be covered, labeled, and dated with a use-by date. 1. On 5/18/26 at 0618 hours, an observation and concurrent interview was conducted with the DSS by the reach-in refrigerator in the kitchen. A clear plastic container filled with sauerkraut had the best if used by date of 5/17/26. On 5/19/26 at 0819 hours, an observation and concurrent interview was conducted with the DSS in the walk-in refrigerator in the kitchen. The following were observed:- two carrots in a clear plastic bag dated 4/15/26; - one red cabbage dated 4/22/26;- one red cabbage dated 5/12/26; and - parsley in a clear plastic bag dated 4/4/26.The DSS verified the above findings and confirmed the food was expired. 2. On 5/18/26 at 0615 hours, an observation and concurrent interview was conducted with the DSS by the reach-in refrigerator in the kitchen. The following were observed:- an opened container of soy bean paste, without a date opened or use by date; - an opened container of hot pepper paste, without a date opened or use by date; - an opened container of pineapple chunks, dated and labeled 5/8/26; - two opened bags of white bread; without a date opened or use by date; and - one opened bag of wheat bread; without a date opened or use by date. On 5/19/26 at 0819 hours, an observation and concurrent interview was conducted with the DSS in the walk-in refrigerator in the kitchen. Four green cabbages were not dated or labeled. The DSS verified the findings and stated the food should be properly dated with a use by date and a date opened date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure complete and accurate medical records for six of 20 final sampled residents (Residents 2, 7, 9, 10, 13, and 49). * The facility failed to accurately document the prescribed dosage of Trazodone, an antidepressant medication, on Resident 2's signed consent form. Furthermore, the facility failed to ensure that Resident 2's Do Not Resuscitate (DNR) status was maintained within his electronic medical record. * Resident 7's shift monitoring for left upper extremity edema did not match the weekly nursing progress note. * The facility failed to ensure the POLST for Residents 9 and 49 were completed. * The facility failed to ensure Resident 10's medical record had the completed POLST Form of the resident on file. * The facility failed to ensure accurate and complete documentation of the incident for Resident 13 that occurred on 4/24/26. These failures resulted in medical records that contained incomplete or inaccurate information, which could negatively affect continuity of care and clinical decisionˆmaking. Findings: Review of the facility's P&P titled Charing and Documentation revised 7/2017 showed all services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition shall be documented in the resident's medical record. Documentation in the medical record will be objective, complete, and accurate. 1. a. Medical record review for Resident 49 was initiated on 5/18/26. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's POLST dated 5/1/26, showed Section D for the advance directive (a legal document that states a person's wishes about receiving medical care if that person is no longer able to make decisions) was not completed. Review of Resident 49's H&P examination dated 5/4/26, showed Resident 49 had the capacity to make his own medical decisions. b. Medical record review for Resident 9 was initiated on 5/18/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's POLST dated 1/24/25, showed Section D for the advance directive was not completed. Review of Resident 9's H&P examination dated 1/31/26, showed Resident 9 had no capacity to make his own medical decisions. On 5/20/26 at 0918 hours, an interview and concurrent medical record review for Residents 9 and 49 were conducted with the SSD. The SSD verified the above findings. The SSD further stated the POLST should be fully completed to reflect the residents' wishes. On 5/21/26 at 1413 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Medical record review for Resident 2 was initiated on 5/18/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 5/4/26, showed Resident 2 had the capacity to make his own medical decisions. a. Review of Resident 2's POLST dated 3/28/26, showed Resident 2 had a Do Not Resuscitate (DNR) code status to allow a natural death. Review of Resident 2's Order Summary Report and Code Status on his electronic medical record failed to show Resident 2's DNR status. On 5/20/26 at 0918 hours, an interview and concurrent medical record review for Resident 2 was conducted with the SSD. The SSD verified the above findings. On 5/20/26 at 1146 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 1. RN 1 stated if there was no code status ordered for a resident, the resident would be considered full code. RN 1 verified the above findings. b. Review of Resident 2's Order Summary Report dated 3/28/26, showed a physician's order to administer trazodone 25 mg one tablet by mouth at bedtime for insomnia. Review of Resident 2's Facility Verification of Informed Consent dated 3/27/26, showed an informed consent was obtained for trazodone hydrocholoride 50 mg oral tablet. Review of Resident 2's Informed Consent – Psychoactive Medication – V3 dated 3/27/26, showed an informed consent was obtained for trazodone hydrocholoride 25 mg oral tablet. On 5/21/26 at 1333 hours, an interview and concurrent medical record review was conducted with LVN 12. LVN 12 stated informed consents were provided to residents to ensure they were aware of which psychotropic medications they were receiving. LVN 12 verified the conflicting dosages for Resident 2's trazodone informed consent documents. On 5/21/26 at 1413 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON stated the documentation in the resident's medical records were expected to be accurate. The DON verified the above findings. 3. Medical record review for Resident 13 was initiated on 5/18/26. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's MDS assessment dated [DATE], showed a BIMS (Brief Interview for Mental Status – a cognitive screening tool) Summary Score of 00, which indicated Resident 13 had severely impaired cognitive patterns. Review of Resident 13's Post-Fall Review dated 4/24/26, showed an incomplete status on the electronic medical record. Section 1 Fall Data showed Resident 13 had an unwitnessed and assisted fall on 4/24/26 at 1230 hours. In addition, Resident 13 was found on the floor mattress right side lying on the pillow and a skin tear noted on his right cheek. Section 3 of the Care Plan showed Resident 13's physician and family member were notified of Resident 13's fall and included the immediate (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	actions taken by the facility. Section 4 of the IDT Review and Summary of Root Cause was completed. Review of Resident 13's Progress Note dated 4/24/26 at 1522 hours, showed the DON documented Resident 13 was seen by a rehabilitation staff member trying to reach something by his bedside table. Resident 13's arms were holding onto the table, but his legs were positioned on the bed. The rehabilitation staff member repositioned Resident 13 onto his bed. Resident 13's family member was by his bedside and stated the resident was okay. On 5/20/26 at 1146 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 1. RN 1 confirmed he initiated the Post-Fall document on 4/24/26. When asked what occurred during the incident, RN 1 stated he was not sure because the incident occurred a month ago. On 5/20/26 at 1542 hours, a follow-up interview and concurrent medical record review for Resident 13 was conducted with RN 1. RN 1 stated he spoke with the physical therapy department staff and Resident 13 did not have a fall incident on 4/24/26. When asked why there was an assessment, interventions taken, and an IDT summary documented in Resident 13's medical record regarding the fall incident, RN 1 stated he made a mistake creating the Post-Fall document because the fall did not occur. On 5/20/26 at 1600 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON stated Resident 13 did not have a fall and she assessed the resident on 4/24/26, and documented her assessment in Resident 13's progress note. The DON stated she struck out the fall incident on the Risk Management section. The DON confirmed the Risk Management documentations were not included in Resident 13's medical record. When asked why the Post-Fall document was not struck out on Resident 13's medical record, the DON stated she was unable to strike out the document because the Risk Management had locked the documents. When asked how there was documentation of an assessment, interventions implemented, and an IDT meeting regarding the fall incident on 4/24/26, the DON stated she was not sure because the incident did not occur. Review of Resident 13's Post-Fall Review dated 3/4/26 at 1900 hours, with the DON showed the same documentation for Section 1 questions 3 to 16, Section 3, and Section 4. The DON confirmed the documentation were identical and stated RN 1 might have used the 3/4/26 Post-Fall Review as a template for the 4/24/26 Post-Fall Review. 4. Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Medical Record Review for Resident 7 was initiated on 5/18/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 3/10/26, showed Resident 7 had the capacity to understand and make decisions. Review of Resident 7's Order Summary Report showed a physician's order dated 1/13/25 – (Treatment) LUE 4+ pitting edema : Monitor edema and document by grade scale as follows: 1+ =2 mm or less with slight pitting, no distortion and disappears rapidly; 2+ =2-4 mm indentation with no readably detectable distortion, somewhat deeper pit and disappears 10-25 seconds; 3+ = 4-6 mm (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indentation with pit and may last more than 1 minute, appears swollen and fuller; 4+ = 6-8 mm indentation with very deep pit and lasts for 2-5 minutes, appears grossly distorted one time a day. Review of Resident 7's Treatment Administration Record for April 2026 and May 2026 showed LUE (left upper extremity) edema was 4+ from 4/1/26 to 5/20/26. However, the review of Resident 7's Weekly Nursing Progress Note – V2 showed the following: -dated 4/4/26 showed Edema a. None -dated 4/11/26 showed Edema a. None -dated 4/18/26 showed Edema a. None -dated 4/25/26 showed Edema a. None -dated 5/2/26 showed Edema b. 1+ -dated 5/16/26 showed Edema a. None On 5/20/26 at 0915 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 7 has +4 edema on his left upper extremity, and a +4 edema would not resolve in a day. On 5/20/26 at 1439 hours, an interview and concurrent medical record review were conducted with the DON. The DON stated Resident 7 has edema on his left upper extremity. The DON verified the documentation on the treatment administration record did not match the weekly nursing progress note. The DON further stated the weekly nursing progress note should show Resident 7's left upper extremity edema. 5. Medical record review for Resident 10 was initiated on 5/18/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's Physician Orders for Life-Sustaining Treatment (POLST) for m dated 12/12/25, under section D for Information and Signatures, Resident 10 had a legally recognized decision maker. However, the advance directive section was incomplete. Review of Resident 10's Social Service Review dated 12/17/25, showed Resident 10 had an advance directive and a copy was requested to be included in the resident medical record. Review of Resident 10's H&P examination dated 5/5/26, showed Resident 10 had no capacity to understand and make decisions. On 5/20/2026 at 0919 hours, an interview and concurrent medical record review for Resident 10 was conducted with the SSD. The SSD was asked about the POLST and advance directive of Patient 10. The SSD was able to show the POLST for Resident 10. The SSD verified the POLST section for advance directive was incomplete. The SSD was asked if Resident 10 have an advance directive on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the medical record. The SSD was able to show an advance directive for Resident 10 dated 6/24/22. On 5/21/2026 at 1346 hours, an interview and concurrent medical record review for Resident 10 was conducted with the DON. The DON was informed and verified the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection prevention control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to maintain an accurate infection control surveillance program for November 2025 through April 2026. The facility conducted surveillance only on the residents who exhibited signs and symptoms of an infection and were prescribed antimicrobial medications. The facility failed to ensure the residents exhibited signs and symptoms of an infection but were not prescribed antimicrobial medications were included in the facility's infection control surveillance log, and in the monthly infection surveillance report. These failures posed the risk for not identifying resident infections and thereby, preventing the implementation of interventions to control the potential transmission of communicable diseases to other residents in the facility. * The facility failed to ensure the facility's water management plan has to include the intervention for the testing of legionella in the event a water main break from the water source. * The facility failed to ensure the staff use appropriate infection control practices when one RN did not remove the gloves from passing medication and complete hand hygiene prior walking to the hallways, and one CNA failed to clean or sanitized the call light which was on the floor prior giving back to Resident 73. * The facility failed to protect the residents' clean personal clothing inside a storage closet from contamination when Resident 59 was observed touching and handling the residents' clean personal clothing. * The facility failed to ensure Resident 25 and 74's thickened water pitchers were changed daily. These failures posed the risk for transmission of disease-causing microorganisms and infections. Findings: 1. Review of the facility's P&P titled Surveillance for Infections dated September 2017 showed the infection preventionist will conduct ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Infections that may be considered in surveillance include those with limited transmissibility in healthcare environment and or limited prevention strategies. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from November 2025 through April 202, showed the following infection surveillance data for HAIs and CAIs: - 11/2025, CAI - 9, HAI - 13, and Total of Infections = 22 - 12/2025, CAI - 12, HAI - 16 and Total of Infections = 28 - 1/2026, CA I -14, HAI - 10 and Total of Infections = 24 - 2/2026, CAI - 8, HAI - 15 and Total of Infections = 23 - 3/2026, CAI - 17, HAI - 10 and Total of Infections = 27 - 4/2026, CAI - 15, HAI - 18 and Total of Infections = 33 Further review of the facility's monthly Infection Prevention and Control Surveillance Logs from (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	November 2025 through April 2026, showed documentation that all the residents included in the facility's infection surveillance program were determined to have either a HAI or CAI (with prescribed antimicrobial medications or having been diagnosed with an infection). The Infection Prevention and Control Surveillance logs failed to show any residents that did not met McGeer's criteria. On 5/21/26 at 1140 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's resident infection surveillance program. The IP stated when a resident was prescribed antimicrobial medications or was diagnosed with an infection the facility would then initiate a McGeer's Criteria and/or Loeb's Criteria form. The IP stated the McGeer's Criteria was utilized to determine if a resident had a true infection. The IP stated Loeb's Criteria was utilized to determine whether a resident met the minimum criteria for the use of antibiotics. The IP verified between November 2025 through April 2026, no resident in the facility was classified as having not met McGeer's Criteria. The IP was asked when a resident at the facility exhibited signs and/or symptoms of infection and was not prescribed antimicrobial medications (or was not diagnosed with an infection) if the facility initiated the McGeer's criteria form, and included these residents in the facility's infection surveillance program. The IP stated the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications (or were not diagnosed with an infection). The IP was asked how many residents had met McGeer's criteria and were not prescribed antimicrobial medications, from November 2025 through April 2026 (excluding residents who were diagnosed with an infection). The IP stated she was uncertain, as the facility did not initiate the McGeer's criteria form for residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications (or had not been diagnosed with an infection). On 5/21/26 at 1316 hours, the DON was informed and verified the above findings. 2. Review of the facility's Legionella Water Management Program and Legionella Detection and Surveillance (undated), showed the facility shall establish an infection control program that will prevent, detect and control water-borne contaminants, including Legionella which is overseen by the water management team. However, further review of the water management program failed to show documented evidence a water testing for Legionella was included in the plan when there was a water main break from the water source. On 5/21/26 at 0900 hours, an interview and concurrent facility document review was conducted with the Maintenance Director. The Maintenance Director was asked for the water management plan for the facility. The Maintenance Director was able to show the last testing for Legionella was conducted on the year 2023. The Maintenance Director was asked what was the facility's plan was in the event there was a main water break from the municipal water supply. The Maintenance Director stated he will test right away the water for Legionella and sent for analysis. When asked if the plan he mentioned was included on the Water Management Program, the Maintenance Director verified and acknowledged the testing of the water was not included in the plan. On 5/21/26 at 1346 hours, the Administrator was informed and verified the above findings. 3. a. On 5/18/26 at 0615 hours, during the initial tour of the facility, a concurrent observation and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview was conducted with RN 4. RN 4 was observed in the hallway with the medication cart going in and out of the resident's room with gloves on. RN 4 was not observed to remove the gloves and complete hand hygiene upon leaving the room and walked to the hallway to the conference room with gloves on. RN 4 verified she administered the medications and walked to the hallway. RN 4 stated she did not to touch the keys with her hands. b. On 5/18/26 at 0655 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with Resident 73. Resident 73 was observed laying on the bed. Resident stated she needs help. Resident's call light was observed on the floor. On 5/18/26 at 0700 hours, a concurrent observation of Resident 73 and an interview was conducted with CNA 6. CNA 6 verified Resident 73's call light was on the floor. CNA 6 stated she must have dropped it. CNA 6 was observed to had picked up the call light from the floor and gave to Resident 73 without cleaning or sanitizing the call light. CNA 6 stated she should have sanitized the call light prior giving it to the resident. On 5/21/26 at 1333 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. a. On 5/18/26 at 0615 hours, during the initial tour of the facility, Resident 25 was observed lying in bed, with water pitcher on top of the night stand dated 5/15/26 at Resident 25's bedside. Review of Resident 25's medical record was initiated on 5/18/26. Resident 25 was admitted on [DATE]. Review of Resident 25's MDS dated [DATE], showed to have short- and long-term memory problems and Cognitive Skills for Decision Making were coded as severely impaired (never/rarely made decisions). b. On 5/18/26 at 0625 hours, during the initial tour, Resident 74 was observed to have water pitcher on top of the night stand dated 5/15/26 at Resident 74's bedside. Review of Resident 74's medical record was initiated on 5/18/26. Resident 74 was admitted on [DATE]. Review of Resident 74's H&P examination dated 2/28/25, showed Resident 74 had no capacity to understand and make decisions and can make needs known but cannot make decisions. Review of Resident 74's Order Summary Report dated 5/19/26, showed a diet order dated 4/28/26, for fortified, high protein diet pureed, moderately thick consistency liquid. On 5/18/26 at 0656 hours, an interview was conducted with CNA 1. CNA 1 verified Resident 25 and 74's thickened water pitchers were dated 5/15/26, and were used for thickened water. CNA 1 further stated the morning shift changes the thickened water pitchers daily. On 5/19/26 at 1504 hours, an interview was conducted with the IP. The IP stated the thickened water (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pitchers were changed every day as the kitchen prepares it and gives the thickened water pitchers to the nurses/CNAs. The IP acknowledged both Resident 25 and 74's thickened water pitchers were dated 5/15/26. The IP further stated, the thickened water pitchers must be changed every day, the CNAs should see this and report to the charge nurse if not changed. On 5/21/26 at 0930 hours, an interview was conducted with the DON. The DON acknowledged the thickened water pitchers were observed to have labeled dates of 5/15/26. The DON stated, we are supposed to change the thickened water pitchers every 24 hours, but they did not change these for three days. 5. According to CDC, under the Linen and Laundry Management section dated 9/19/24, the best practices for management of clean linen included sorting, packaging, transporting, and storing clean linen in a manner that prevents risk of contamination. On 5/19/26 at 1202 hours, Resident 59 was observed handling the residents' personal clothing inside the storage closet. RN 1 verified the above findings. RN 1 was observed asking two other staff to provide assistance to Resident 59. Medical record review was conducted with Resident 59. Resident 59 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 11/29/25, showed the resident had the capacity to understand and make decisions. On 5/19/26 at 1215 hours, an interview was conducted with RN 1. RN 1 stated the storage closet was used to store residents' clean personal clothing. On 5/19/26 at 1220 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the storage closet used to store the residents' clean personal clothing should be locked at all times. The Maintenance Director stated he did not know why the storage closet was left open. On 5/19/26 at 1226 hours, an interview for Resident 59 was conducted with CNA 8. CNA 8 verified he assisted Resident 59 earlier while the resident was handling the residents' personal clothing inside the storage closet. CNA 8 stated Resident 59 was looking for his jacket. On 5/21/26 at 0817 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of five sampled residents for unnecessary medications (Residents 8 and 83) reviewed for informed consents were provided the right to self-determination regarding the use of the psychotropic medications and treatments. * The facility failed to ensure Resident 83's informed consent for the mirtazapine (antidepressant medication) showed nonpharmacological approaches used. Additionally, the prescribing physician did not sign the informed consent form. * The facility failed to ensure Resident 8's informed consents for the alprazolam (antianxiety medication), bupropion (antidepressant medication) and sertraline (antidepressant medication) showed whether the medications had caution and warning summary, FDA-approved use, and a black warning label. In addition, the facility failed to ensure the informed consent for alprazolam medication was signed by the prescribing physician. These failures posed the risk of the residents and their representatives to not having informed decision-making regarding treatment risks, benefits, alternatives, and attempted nonpharmacological interventions related to the use of psychotropic medications.Findings: 1. Review of the facility's P&P titled Psychotropic Medication Use/Informed Consent dated 3/2024 showed the following:- Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtained informed written consent signed by the resident or resident's representative along with the signature of the healthcare professional declaring the required material information has been provided . The personal exam and signatures of the prescriber, resident or representative can be completed and signed using remote technology; and- Before initiating treatment with psychotherapeutic drugs, the facility staff must verify that the resident's health record contains written informed consent with the required signatures. Review of the AFL 25-27 titled AB 48 - Nursing Facility Resident Informed Consent Protection Act of 2023 dated 10/7/25, showed the prescriber must share the material information a reasonable person in the resident's condition and circumstances would consider necessary for the resident or representative to make a decision about the treatment. Material information, that the provider shall provide, includes but is not limited to possible nonpharmacologic approaches that could address the residents' needs, whether the drug has a current boxed warning, and precautions required by the FDA. The AFL also showed the facility must check the medical record for proper informed consent prior to an initial administration. Review of the AFL 25-38.1, titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed effective 1/1/26, the Psychotherapeutic Drug Informed Consent Form or equivalent in-house form must be used for new residents, residents being prescribed a new psychotherapeutic drug, or residents having a psychotherapeutic drug dosage change. The Psychotherapeutic Drug Informed Consent Form Instruction Sheet showed the form will be completed by. entering the drug category, caution and warning summary, providing alternative modes or possible nonpharmacological approaches, and the prescriber and the resident or resident's representative are required to read and sign. Medical record review for Resident 83 was initiated on 5/19/26. Resident 83 was readmitted to the facility on [DATE]. Review of Resident 83's Order Summary Report showed a physician's order dated 3/25/25, to administer mirtazapine 7.5 mg two tablets by mouth at bedtime for depression manifested by poor oral intake less than 50% during mealtimes. Review of Resident 83's Informed Consent - Psychoactive Medication - V2 dated 1/6/26, under the Interventions and Assessment of Psychoactive Medication(s) section, did not show non-pharmacological approaches were attempted. In addition, the form, under the Informed Consent Verification section, did not show the e-signatures (electronic signature) the physician. Review of Resident 83's MARs for April and May 2026 showed Resident 83 was administered two tablets of mirtazapine 7.5 mg medication from 4/1 to 5/19/26 at 2100 hours. On 5/20/26 at 1454 hours, an interview and concurrent medical record review for Resident 83 was conducted with RN 1. RN 1 verified the informed consent form for the mirtazapine medication did not (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	show the boxes for the non-pharmacological approaches were checked to show which non-pharmacological approaches were attempted to Resident 83. RN 1 further verified the informed consent form for the mirtazapine medication did not show the e-signature from the prescribing physician. RN 1 stated the informed consent should show the e-signature of the physician's should appear at the bottom of the printed page. 2. Medical record review for Resident 8 was initiated on 5/19/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed the following physician's orders:- dated 4/25/26, to administer bupropion 150 mg one tablet by mouth one time a day for depression manifested by verbalization of sadness;- dated 4/25/26, to administer alprazolam 2 mg by mouth two times a day for anxiety manifested by verbalization of anxiousness (discontinued 5/6/26);-dated 4/28/26, to administer sertraline 50 mg one tablet by mouth one time a day for depression manifested by tearfulness; and- dated 5/6/26, to administer alprazolam 3 mg by mouth two times a day for anxiety manifested by verbalization of anxiousness. Review of Resident 8's Informed Consent - Psychoactive Medication - V3 dated 4/25/26, failed to show whether the alprazolam, bupropion, and sertraline medications were off-label use, FDA-approved use or had a black box warning label under Caution and Warning Summary section. Review of Resident 8's Informed Consent - Psychoactive Medication - V3 dated 5/6/26, for the alprazolam medication, showed the boxes for anti-anxiety and antidepressant medications were checked. The form also did not show, under Caution and Warning Summary section, whether the medications were off-label use, FDA-approved use or had a black box warning label. In addition, the form did not show the e-signature from the prescribing physician. Review of Resident 8's MARs for April and May 2026 showed Resident 8 was administered the following medications:- alprazolam 2mg medication from 4/27 to 5/5, and 5/20/26 at 0900 and 1700 hours, and on 5/6 and 5/21/26 at 0900 hours,-alprazolam 3 mg medication on 5/6/26 at 1700 hours and from 5/7 to 5/19/26 at 0900 and 1700 hours;- bupropion 150 mg medication from 4/26 to 5/21/26 at 0900 hours; and- sertraline 50 mg medication from 4/26 to 5/21/26 at 0900 hours. On 5/20/26 at 1425 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 1. RN 1 verified the informed consent for the alprazolam, bupropion, and sertraline medications did not show whether the medications were off-label use, FDA-approved use or had a black box warning label. RN 1 also verified the informed consent for the alprazolam medication, showed the boxes for anti-anxiety and antidepressant medications were checked, and the form did not show whether the medications were off-label use, FDA-approved use or had a black box warning label. RN 1 further verified the informed consent form for the alprazolam medication did not show the e-signature from the prescribing physician. On 5/21/26 at 0817 hours, an interview for Residents 8 and 83 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were safely administered for one of 74 residents (Resident 64). * Resident 64 had the Zoryve Cream 0.3% (a prescription medication used to treat inflammatory skin conditions) at bedside. However, Resident 64 did not have a physician's order to keep the medication at the bedside. This failure had the potential for the resident to administer the medication inaccurately, develop adverse reactions, and negatively affect the resident's well-being.Findings: Review of the facility's P&P titled Medication Labeling and Storage revised 2/2023 showed the facility stores all the medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Review of the facility's P&P titled Administering Medications revised 4/2023 showed the residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined the resident had the decision making capacity to do so safely. On 5/18/26 at 0648 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 64 in the resident's room. The Zoryve Cream 0.3% was observed in a plastic bag beside the resident in the bed. Resident 64 stated she applies the Zoryve cream to herself daily. Resident 64 further stated the cream was from home and was given back to her by the nurse. On 5/18/26 at 0650 hours, an observation of Resident 64 and concurrent interview was conducted with LVN 6. LVN 6 verified Resident 64 had the Zoryve Cream 0.3% beside the resident on the bed. LVN 6 stated the resident should not have the Zoryve Cream 0.3% at bedside. Medical record review for Resident 64 was initiated on 5/18/26. Resident 64 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 64's Medical Provider SOAP Note dated 3/2/26, showed the resident had the capacity to make decisions. Review of Resident 64's Order Summary Report showed a physicians order dated 4/17/26, to apply Zoryve External Cream 0.3% to general body topically one time a day. Family to provide medication. Further review of Resident 64's Order Summary Report dated 5/26/26, failed to show a physician's order for self-administration of the Zoryve External Cream 0.3%. Review of Resident's TAR for May 2026 showed Zoryve External Cream 0.3% was applied to the resident one time a day. Further review of Resident 64's medical record failed to show any documentation of an IDT assessment for self-administration of medication. On 5/19/26 at 1446 hours, a follow up interview and concurrent medical record review for Resident 64 was conducted with LVN 8. LVN 8 verified Resident 64's physicians order dated 4/17/26, showed to apply Zoryve External Cream 0.3% to general body topically one time a day. LVN 8 verified Resident 64's medical record failed to show a physician's order for self-administration of the Zoryve External Cream 0.3%. LVN 8 verified the resident's medical record failed to show any documentation of an IDT assessment for self-administration of medications. On 5/21/26 at 1335 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to obtain and maintain a copy of the Advance Directive for one of seven final sampled residents (Resident 12) investigated for Advance Directives. * Resident 12's Advance Directive was not in the medical record. This failure had the potential to result in the resident's wishes regarding medical treatment and services not being followed if they became unable to make their own medical decisions.Findings: Review of the facility's P&P titled Advance Directives dated 9/2022 showed on admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive. In the event the resident is unable to formulate an advanced directive due to cognitive impairment or deemed by the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the resident representative. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive. Upon admission, should the resident have an advanced directive, copies will be made and placed on the chart as well as communicated to the staff. Medical record review for Resident 12 was initiated on 5/18/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 10/1/25, showed Resident 12 could make needs known but could not make medical decisions. Review of Resident 12's Social Service Review dated 12/8/25, showed Resident 12 had issued an advance directive about his care and treatment. A copy of the advance directive was requested. Further review of Resident 12's medical record failed to show a copy of the advance directive was obtained and maintained in the medical record. In addition, the medical records failed to show documented evidence the facility staff followed up with the resident or their family representative. On 5/20/26 at 0934 hours, an interview and concurrent medical record review for Resident 12 was conducted with the SSD. The SSD stated when the resident was unable to make health care decision, the facility would ask the family for a copy of the advance directive and upload it to the medical records. The SSD reviewed Resident 12's medical record and verified Resident 12 had an advance directive based on the Social Service Review form. The SSD was unable to locate a copy of Patient 12's advance directive. In addition, the SSD acknowledged there was no follow up documented in the medical record. On 5/21/26 at 1346 hours, an interview and concurrent medical record review for Resident 12 was conducted with DON. The DON was informed and verified the above findings.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record, and facility P&P review, the facility failed to ensure one of 20 residents reviewed for functional assessments (Resident 3) was completely assessed. * The facility failed to ensure Resident 6's use of transfer pole was assessed and documented. This failure had the potential to result in unnecessary use of, ineffective and/ or lack of monitoring of transfer pole use which could negatively affect resident's practicable mental, physical, and psychosocial well-being.Findings: Review of the facility's P&P titled Managing Falls and Fall Risk dated 2/7/24, showed resident centered approaches to managing falls and fall risk includes use of non-restraining approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear changing the lighting and transfer poles, etc. On 5/18/26 at 0607 hours, during initial tour to the facility, Resident 6 was observed lying in bed with bilateral poles at bedside, at the upper part of the bed. Review of Resident 6's medical record was initiated on 5/19/25. Resident 6 was admitted on [DATE]. Review of Resident 6's accident prevention care plan dated 7/14/25, showed the use of transfer pole. Review of Resident 6's H&P examination dated 1/27/26, showed Resident 6 was paraplegic (lost voluntary movement and sensation in the lower half of their body, typically affecting both legs and the lower torso). Review of Resident 6's OT Evaluation and Plan of Treatment with certification period dated 1/28/26 - 2/25/26, failed to show the use of transfer poles however, the OT Evaluation and Plan of Treatment showed Clinical Impression of Resident 6 was expected to benefit significantly from occupational therapy services aimed at improving their overall level of functional independence, enhancing safety awareness, and increasing their ability to perform activities of daily living (ADLs) with greater efficiency and confidence. Review of Resident 6's PT Evaluation and Plan of Treatment with certification period dated 1/28/26- 2/25/26, showed a new goal for Resident 6 will safely perform bed mobility tasks with maximum assist in order to decrease risk for skin breakdown, participate in edge of bed activities and facilitate posture when upright with target date of 2/25/2026. Resident 6's OT and PT Evaluation and Plan of Treatment documentations failed to reflect the use of transfer pole, including its benefit, clinical justification, or appropriateness for Resident 6's use. Review of Resident 6's MDS dated [DATE], showed Resident 6 has a BIMS summary score of 14 (intact cognition). It also showed Resident 6's functional abilities as follows:- impairments of both sides of the lower extremities,- uses wheelchair,- substantial / maximal assistance to roll from left to right and return to back lying position, and- dependent on staff on sit to lying, lying to sitting side of bed, chair/ bed to chair transfer, and tub/ shower transfer Review of Resident 6's Interdisciplinary Resident Screen dated 3/17/26, showed a quarterly rehab screen which showed no significant decline in ROM (range of motion), mobility or ADL performance compared to prior level of function, skilled PT/OT services are not indicated at this time. Recommended the continuation of the current Restorative Nursing Assistant (RNA) program to maintain functional status, however, the RNA order is dedicated to the lower extremity PROM (passive range of motion) exercises and failed to show PROM exercises to the upper extremities. On 5/19/26 at 1517 hours, an interview was conducted with Resident 6. Resident 6 stated she uses the transfer poles when in bed. Resident further stated, when I turn from side to side, I am paralyzed from the waist down and it helps me especially when I am being changed. On 5/19/26 at 1614 hours, an interview and concurrent medical record review were conducted with the DOR. The DOR stated the PT or OT did the assessment on the residents' transfer pole use. Review of Resident 6's PT and OT evaluation from 1/28/26, latest quarterly assessment dated [DATE], failed to show Resident 6's use of transfer pole. The DOR stated the process for utilizing transfer poles is initiated when the rehab assessment identifies the resident could benefit from the transfer pole to promote safety and ease during the transfers. The DOR further stated, if the resident was on therapy, it was part of the evaluation, to evaluate the use of transfer poles, or do the (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	screening if the resident actually need the transfer pole if the resident was not on therapy. The DOR verified Resident 6's PT/ OT Evaluation notes for period dated 1/28/26- 2/25/26 and Quarterly Screen dated 3/17/26, did not reflect the use of the transfer poles. The DOR stated it should have been addressed and documented on the Rehab evaluation and screening. On 5/20/26 at 1442 hours, an interview and concurrent medical record review were conducted with the MDS Coordinator. The MDS Coordinator stated the transfer poles were assistive devices to assist in the bed mobility. The MDS Coordinator stated when she did her quarterly assessments, she asked the resident for any signs and symptoms of physical and psychological distress noted related to the pole use and documents it in the MultiCare Conference Assessment and care plan. The MDS Coordinator was asked if Resident 6's functional assessment was completed and documented, if Resident 6 was benefiting with the use of the transfer pole, and if Resident 6 was assessed to continue with the transfer pole use. The MDS coordinator stated I should have done that part of the assessment and documented the transfer pole use on the MultiCare Conference Assessment and care plan, I will document starting now. On 5/21/26 at 914 hours, an interview was conducted with the DON. The DON acknowledged the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the risk and development of pressure injuries for one of one final sampled resident (Resident 49) reviewed for pressure injuries. * The facility failed to provide a low air loss mattress for Resident 49 per the physician's order. This failure posed Resident 49 at risk for the development or worsening of pressure injuries.Findings: Review of the facility's P&P titled Support Surfaces Guidelines revised 2/2024 showed a guideline for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. Individuals at risk for developing pressure ulcers should be placed on a redistribution support surface such as a foam, gel, static air, alternating air, or air-loss when lying in bed. On 5/18/26 at 0821 and 1355 hours, Resident 49 was observed in his bed. A low air loss mattress was not observed. On 5/19/26 at 0846 hours, Resident 49 was observed in his bed. A low air loss mattress was not observed. Medical record review for Resident 49 was initiated on 5/18/26. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's Order Summary Report showed a physician's order dated 5/2/26, to provide a low bed position while the resident was on a low air loss mattress for wound management. Review of Resident 49's Skin Issues dated 5/2/26, showed Resident 49 had an unstageable pressure injury measured at 3 cm x 3 cm located at his sacrum. Review of Resident 49's H&P examination dated 5/4/26, showed Resident 49 had the capacity to make his own medical decisions. Review of Resident 49's SW - Skin Issues dated 5/14/26, showed Resident 49 had a stage 3 pressure injury measured at 1 cm x 0.5 cm located at his sacrum. The additional care documented included to provide a moisture barrier, pressure reducing device for the bed and for the chair. On 5/19/26 at 1557 hours, an interview, observation, and concurrent medical record review for Resident 49 was conducted with LVN 3. LVN 3 reviewed Resident 49's medical record and confirmed Resident 49 had a pressure injury located at his sacrum. LVN 3 verified Resident 49 was not provided with a low air loss mattress. On 5/19/26 at 1627 hours, an observation, interview and concurrent medical record review for Resident 49 was conducted with RN 5. RN 5 verified the above findings. RN 5 stated a low air loss mattress was an intervention to prevent pressure injuries from worsening. On 5/21/26 at 1413 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided for two of three final sampled residents (Residents 13 and 79) reviewed for accidents. *Resident 13 had an unwitnessed fall incident on 5/7/26. Resident 13's post-fall neurological assessment was incomplete. * The facility failed to ensure the safe smoking practices were followed for one resident who smoked in the facility as evidenced by Resident 79 who was assessed as requiring supervision while smoking and with a history of non-compliance with the facility's smoking P&P was permitted to keep the cigarettes, lighters, and other smoking articles/materials in his possession. These failures had the potential for adverse outcomes related to accidents.Findings: Review of the facility's P&P titled Neurological Assessment (Routine) revised 10/2023 showed a routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury. The steps in the procedure included to conduct the neurological check as frequently as ordered. The following information included should be recorded in the resident's medical record: date and time the procedure was performed, all assessment data obtained during the procedure, and if the resident refused the procedure. 1. Medical record review for Resident 13 was initiated on 5/18/26. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's MDS assessment dated [DATE], showed a BIMS of 00, which indicated Resident 13 had severely impaired cognitive patterns. Review of Resident 13's Post-Fall review dated 5/7/26, showed Resident 13 had an unwitnessed fall incident. Resident 13 was assessed and had a lip abrasion with light bleeding. The physician's recommendations included to conduct the neurological assessments for 72 hours. Review of Resident 13's neurological flowsheet dated 5/7/26, showed the neurological assessment for the scheduled entries of Q15x2 (every 15 minutes times two), Q15x3, Q15x4, Q30x1, Q30x2, Q4x2 and Q8x2 were missing. On 5/20/26 at 1146 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated neurological assessments were ordered to monitor the resident's neurological condition after the unwitnessed fall and to determine whether the resident remained at their baseline. On 5/21/26 at 1413 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON verified the above findings. The DON stated the purpose of the neurological assessments were to monitor residents for any significant level of consciousness changes. The DON stated she expected every entry of the scheduled neurological assessment to be completed. 2. Review of the facility's P&P titled Smoking Policy - Residents dated 1/2024 showed the facility shall establish and maintain safe resident smoking practices. The residents will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the revaluation will (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include their ability to smoke safely with or without supervision. The staff shall consult with the attending physician and DON to determine if safety restrictions need to be placed on a resident's smoking privileges. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. Any smoking-related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. Only residents who have independent smoking privileges are permitted to keep cigarettes and other smoking articles in their possession. Residents are not permitted to give smoking articles to other residents. Residents without independent smoking privileges may not have or keep any smoking articles. On 5/18/26 at 0755 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 79. Resident 79 was observed in bed awake, alert and respond to questions well. Resident 79 stated he could ambulate and smoke cigarettes. Resident 79 stated he could hold his own cigarette and smoke at the smoking area in the building. There was a box of cigarettes observed inside his front shirt pocket. Medical record review for Resident 79 was initiated on 5/18/26. Resident 79 was admitted to the facility on [DATE]. Review of Resident 79's H&P examination dated 1/24/26, showed Resident 79 had the capacity to understand and make decisions. Review of Resident 79's Smoking assessment dated [DATE], showed Resident 79 smoked three to five times a day. Resident 79 was able to return smoking materials to storage and needed a supervision to smoke safely. On 5/18/26 at 0908 hours, a follow up observation for Resident 79 was conducted at the facility's designated smoking area patio with other residents who smoke. Resident 79 was observed standing and holding a lighter and he light up the other residents cigarette. A white box with smoking materials was observed on top of the table and the aprons were available inside the box for use. A facility staff was observed monitoring the residents who smoke in the patio. On 5/20/26 at 0841 hours, an observation and concurrent interview was conducted with CNA 10 at Resident 79's bedside. Resident 79 was observed in bed asleep. A box of cigarettes were observed inside Resident 79's front shirt pocket. CNA 10 verified Resident 79 goes to the patio to smoke. When asked where the resident kept his smoking material, CNA 10 stated there was a box where they stored all the smoking materials for the resident. CNA 10 verified the resident's pocket showed the box of cigarettes. On 5/20/26 at 1115 hours, an observation and concurrent interview was conducted with CNA 11. Resident 79 was observed out to the patio sitting in the smoking area with other resident. CNA 11 stated Resident 79 was independent in smoking and had no difficulty in holding his cigarette. CNA 11 verified the resident kept his cigarettes in his pocket. CNA 11 was asked if Resident 79 kept his own lighter. CNA 11 stated no, they kept the lighter in the storage box for smoking materials. On 5/20/26 at 1210 hours, an interview for Resident 79 was conducted with LVN 10. LVN 10 was asked about Resident 79 and verified the resident was a smoker and required supervision. LVN 10 was asked if the resident kept his own smoking material. LVN 10 stated yes and stated the resident kept cigarettes in his shirt pocket. LVN 10 was uncertain if the resident kept his own lighter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/26 at 0825 hours, an interview and concurrent medical record review for Resident 79 was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 79 was a smoker and goes to the smoking patio with staff supervision. The MDS Coordinator stated the resident was compliant, knew the location of smoking area and followed the rules of smoking. The MDS Coordinator stated in the beginning, Resident 79 did not keep his own smoking materials but lately he did not want to give the smoking materials and wanted to keep it himself. The MDS Coordinator verified Resident 79 needed supervision in smoking and was not an independent smoker. The MDS Coordinator verified and acknowledged only independent smoker residents could keep their own smoking materials per facility P&P for smoking. On 5/21/26 at 1346 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of two final sampled residents (Resident 49) reviewed for nutrition received an acceptable nutritional service. * The facility failed to monitor weekly weights for Resident 49 per physician's orders. This failure had the potential risk of nutritional interventions not being implemented in a timely manner.Findings: Review of the facility's P&P titled Weight Assessment and Intervention revised 3/2022 showed the resident weights were monitored for undesirable or unintended weight loss or gain. A weight loss of 5% within a month was significant, a weight loss greater than 5% within a month was severe. Residents were weighed upon admission and at intervals established by the interdisciplinary team. Medical record review for Resident 49 was initiated on 5/18/26. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's H&P examination dated 5/4/26, showed Resident 49 had the capacity to make his own medical decisions. Review of Resident 49's Weight Summary from April to May 2026 showed the following:- dated 4/1/26, a weight of 117 lbs.;- dated 4/7/26, a weight of 113 lbs.,- dated 4/12/26, a weight of 113 lbs.,- dated 4/26/26, a weight of 112 lbs.,- dated 5/2/26, a weight of 105 lbs., and- dated 5/5/26, a weight of 105 lbs.The weight loss from 4/1/26 to 5/5/26 was 10.26%. Review of Resident 49's IDT Weight Management Update dated 5/6/26, showed Resident 49's 12 lbs. weight loss in one month and the interventions included to monitor Resident 49's weekly weights for four weeks. Review of Resident 49's Order Summary Report showed a physician's order dated 5/10/26, to monitor weekly weights for four weeks. On 5/19/26 at 1613 hours, an interview and concurrent medical record review for Resident 49 was conducted with the DSD. The DSD verified Resident 49 had orders for weekly weights, however, the last weight taken for Resident 49 was 5/5/26. On 5/19/26 at 1626 hours, an interview and concurrent medical record review for Resident 49 was conducted with the DON. The DON verified the above findings and stated the weekly weight for the week of 5/12/26, was not obtained.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to maintain the intravenous (IV) accesses for one of one final sampled resident (Resident 68) reviewed for IV therapy. * The facility failed to ensure the midline line external catheter baseline measurements were obtained and documented for Resident 68. This failure had the potential to delay the identification of IV catheter related complications for the resident.Findings: Medical record review for Resident 68 was initiated on 5/18/26. Resident 68 was admitted to the facility on [DATE]. On 5/18/26 at 0615 hours, during an observation, Resident 68 was in bed asleep with a midline IV on the left upper arm with two lumen and a transparent dressing. Review of Resident 68's Order Summary Report showed the following physician's orders:- dated 4/22/26, an antimicrobial disc will be utilized for midline site and changed every seven days with dressing change, one time a day every Friday;- dated 4/22/26, to flush midline lumen with 10 ml saline before and after IV medications, every shift;- dated 4/22/26, to monitor midline site for signs of inflammation/ infiltration every shift;- dated 4/22/26, to measure arm circumference 5 cm above midline insertion site during dressing change every day shift every Friday and as needed;- dated 4/22/26, to change midline dressing, Stat-lock every day shift every Friday if gauze dressing was used change every 48 hours; and- dated 4/22/26, to measure midline external catheter length during dressing change every day shift every Friday and call Medical Doctor if 2 cm longer than initial length and as needed every day. Further review of Resident 68's medical record failed to show the baseline measurement of the length of the external catheter and arm circumference above the insertion site were obtained upon admission from the acute hospital where the midline catheter was inserted. Review of Resident 68's care plans failed to show a care plan was formulated to address Resident 68's use of midline IV. Review of Resident 68's IV Administration Record for April and May 2026 failed to show documented evidence the baseline arm circumference measurement and length of the catheter measurement was documented upon admission of Resident 68 to the facility. On 5/19/26 at 1445 hours, an interview and concurrent medical record review for Resident 68 was conducted with RN 1. RN 1 verified Resident 68 was on IV antibiotics for an infection and the midline was use for administration of IV antibiotic. RN 1 verified the dressing change of the midline once a week and stated the RNs were responsible for changing the dressing on the midline and at the same time the measurement of the arm circumference and length of the midline catheter was performed. RN 1 was asked about the measurements and able to show the documentation on the IV MAR. When asked if there was a baseline measurement available to compare on the previous measurement, RN 1 was uncertain and verified there was no baseline measurement of the arm circumference and length of the midline catheter copy from the acute care hospital. On 5/21/26 1346 hours, an interview and concurrent medical record review for Resident 68 was conducted with the DON. The DON was informed and verified the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure appropriate pain management for one of one final sampled residents (Resident 49) reviewed for pain management. * The facility failed to administer Resident 49's prescribed lidocaine patch (a topical adhesive patch containing the local anesthetic lidocaine, designed to deliver the medication directly through the skin to numb a specific area) per the physician's orders. In addition, the facility failed to ensure the nonpharmacological interventions were provided for Resident 49 prior to the administration of his pain medication and the side effects of the pain medication were monitored per Resident 49's care plan. These failures had the potential to result in ineffective pain management and unnecessary discomfort for Resident 49.Findings: Review of the facility P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed 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. Review of the facility's P&P titled Administering Medications revised 4/2023 showed the medications were administered in a safe and timely manner, and as prescribed. 1. Medical record review for Resident 49 was initiated on 5/18/26. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's H&P examination dated 5/4/26, showed Resident 49 had the capacity to make his own medical decisions. Resident 49 had diagnoses such as sciatica (nerve pain from an injury) and fibromyalgia (chronic disorder characterized by widespread body pain). a. On 5/20/26 at 1130 hours, Resident 49 was observed awake and laying down on his bed. Resident 49 stated he had pain to his left hip and had been waiting for a lidocaine patch he had requested. Review of Resident 49's Order Summary Report showed a physician's order dated 5/19/26, to apply the lidocaine external patch 4% to Resident 49's left hip one time a day, and to remove after twelve hours. Review of Resident 49's MAR for 5/2026 showed the lidocaine patch was not provided on 5/20/26 at 0900 hours. The entry was coded 10 which indicated other (specify). Review Resident 49's Progress Note dated 5/20/26 at 1455 hours showed Resident 49's lidocaine patch was not available and was pending pharmacy delivery. On 5/20/26 at 1504 hours, an interview and concurrent medical record review for Resident 49 was conducted with LVN 7. LVN 7 stated Resident 49 had not received his lidocaine patch because the pharmacy had not delivered the medication. LVN 7 confirmed the lidocaine patch order was placed on 5/19/26 at 1028 hours. When asked what the facility's process when receiving routine medications from the pharmacy, LVN 7 stated if a medication was not delivered or available, a licensed staff member was expected to follow up with the pharmacy; routine medications should be delivered to the facility within 24 hours. On 5/20/26 at 1542 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 1. RN 1 stated for newly ordered routine medications, the medication should arrive to the facility prior to the first scheduled dose. If the medication did not arrive on time, a licensed staff member should follow up with pharmacy. RN 1 verified the above findings. On 5/21/26 at 1413 hours, an interview was conducted with the DON. The DON stated routine medications were delivered four times a day to the facility; if a new medication was ordered in the morning, the DON expected the medication to be delivered by night shift. If the medication was not delivered during the expected timeframe, she expected the licensed staff members to follow up with pharmacy. The DON was informed and acknowledged the above findings. b. Review of Resident 49's MAR for 5/2026 showed the following:- dated 5/4/26, and discontinued on 5/11/26, to administer hydrocodone-acetaminophen 5-325 mg one tablet by mouth every four hours as needed for moderate to severe pain (4 - 10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst); the medication was administered to Resident 49 on the following dates and times:- on 5/4/26 at 1430, 1900, and 2300 hours,- on 5/5/26 at 0404, 0827, 1230, 1635, and 2035 hours, - on 5/6/26 at 0425, 0830, 1230, 1630, and 2030 hours, - on 5/7/26 at 0031, 0449, 0850, 1300, 1700, and 2100 hours, - on 5/8/26 at 0930, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1430, and 1945 hours,- on 5/9/26 at 0022, 0422, and 1932 hours, - on 5/10/26 at 0057, 1230, 1655, and 2200 hours, and - on 5/11/26 at 0205, 0605, and 1009 hours.- dated 5/11/26, to administer hydrocodone-acetaminophen 5-325mg one tablet by mouth every four hours as needed for moderate pain (4 - 6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst); the medication was administered to Resident 49 on the following dates and times: - on 5/11/26 at 1640 and 2100 hours, - on 5/13/26 at 1430 hours, - on 5/14/26 at 0100, 1622, and 2115 hours, - on 5/15/26 at 1020 hours,- on 5/16/26 at 1830 and 2315 hours, - on 5/17/26 at 0410, 0810, and 2040 hours, - on 5/18/26 at 2050 hours, - on 5/19/26 at 1350 and 1805 hours, and - on 5/20/26 at 0029 hours.- dated 5/11/26, to administer hydrocodone-acetaminophen 10-325mg one tablet by mouth every four hours as needed for severe pain (7 - 10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst); the medication was administered to Resident 49 on the following dates and times: - on 5/12/26 at 0205, 1005, 1700, and 2100 hours, - on 5/13/26 at 0145, 0602, 1030, and 2100 hours, - on 5/14/26 0600 and 1035 hours, - on 5/16/26 at 0700 and 1228 hours, - on 5/17/26 at 1303 hours, - on 5/18/26 at 1005 and 1550 hours, - on 5/19/26 at 0045, 0445, 0915, and 2148 hours, and - on 5/20/26 at 0411 hours. Review of Resident 49's Care Plan Report revised 5/19/26, showed a plan of care for Resident 49's pain related to his nerve pain, generalized body pain, leg pain, back pain, and left hip pain. The interventions included to administer medications as ordered, monitor and document for side effects and the effectiveness of the medication, and to provide nonpharmacological interventions such as repositioning, massages, or a comfortable environment. Further review of Resident 49's medical record did not show documented evidence Resident 49 was provided nonpharmacological interventions prior to the administration of hydrocodone-acetaminophen medication and monitoring the side effects of the pain medication. On 5/20/26 at 1504 hours, an interview and concurrent medical record review for Resident 49 was conducted with LVN 7. LVN 7 stated nonpharmacological interventions such as repositioning should be provided to the resident prior to administering the pain medications. LVN 7 further stated side effects for hydrocodone-acetaminophen medication should be monitored for signs of overdose and should promptly be reported to the physician. LVN 7 verified the above findings. On 5/20/26 at 1542 hours, an interview and concurrent medical record review for Resident 49 was conducted with RN 1. RN 1 verified the above findings. On 5/21/26 at 1413 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care and services were provided for one of one final sampled resident (Residents 7) reviewed for dialysis care. * The facility failed to ensure the Dialysis Communication Forms for Resident 7 were completed and accurate on multiple dates. This failure had the potential of not identifying negative outcomes for Resident 7.Findings: Review of the facility's P&P titled Hemodialysis Catheters- Access and Care of revised 2/2023 showed the residents with end stage renal disease (ESRD) will be cared for according to currently recognized standards of care. On 5/18/26 at 0930 hours, an observation and interview were conducted with Resident 7. Resident 7 stated he received hemodialysis treatment three times a week. Resident 7 showed he has a Permacath on the right upper chest. Medical Record Review for Resident 7 was initiated on 5/18/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 3/10/26, showed Resident 7 has the capacity to understand and make decisions. Review of Resident 7's Order Summary Report dated 5/20/26, showed the following physician's order:- dated 1/13/25, to Monitor Dialysis site (RUC PERMACATH) for tenderness, redness or bleeding Q shift - Document findings outside of baseline and call MD every shift.- dated 4/17/26, for Resident 7 to receive the hemodialysis treatments every Monday, Wednesday, and Friday with Dialysis Center A. Review of Resident 7's Dialysis Communication Record showed inaccurate documentation on the following dates:- dated 4/27, 4/29, 5/1, 5/4, 5/6, 5/8, 5/11, 5/13, and 5/15/26, Before (Pre) dialysis assessment and After (Post) dialysis assessment section showed bruit and thrill were present. On 5/20/26 at 0915 hours, an interview and concurrent medical record review were conducted with LVN 1. LVN 1 stated Resident 7 had Permacath on his right upper chest wall and the Permacath was being monitored for redness, swelling, and bleeding. LVN 1 verified on Resident 7's Dialysis Communication Record showed bruit and thrill was present. LVN 1 further stated Permacath had no bruit and thrill. On 5/20/26 at 0935 hours, an interview and concurrent medical record review were conducted with RN 1. RN 1 stated Resident 7 had hemodialysis treatment every Monday, Wednesday, and Friday and Resident 7 had Permacath on his right upper chest wall. When asked how Resident 7's dialysis access was being monitored, RN 1 stated he checks for redness, bleeding, swelling, pain, bruit and thrill. On 5/20/26 at 1023 hours, an interview was conducted with RN 2. RN 2 stated Resident 7 had AV (arteriovenous) shunt on his right upper chest and the dialysis access was being monitor for bruit and thrill. On 5/20/26 at 1439 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings and stated Resident 7's dialysis access was a right upper chest (RUC) Permacath. The DON stated a bruit, and thrill would not be assessed for the residents with a Permacath.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, medical record review, and facility document review, the facility failed to ensure the facility staffs (RN 1, RN 2, and LVN 7) had specific competencies and standard of practice skill sets needed to provide the safe and efficient nursing care to the residents. * The facility failed to ensure RNs 1 and 2 were competent on assessing the Permacath (dialysis access) for Resident 7. * The facility failed to ensure LVN 7 demonstrated competency in the administration of the ophthalmic medication and nasal spray medication. These failures had the potential to put the residents at risks of the care not provided in a safe and competent manner. Findings: 1. Review of the facility's document titled Registered Nurse Supervisor job description undated showed the essential duties and responsibilities of a registered nurse supervisor includes assessment and development of resident care plans. Review of the facility's document In-Service training Lesson Plan titled Care for Dialysis patients and Documentation dated 2/12/26, showed the content of the in service included was following dialysis treatment and care of central dialysis catheters. Furthermore, the in-service training showed RNs 1 and 2 met the competency expectations for dialysis care. On 5/20/26 at 0935 hours, an interview and concurrent medical record review were conducted with RN 1. RN 1 stated Resident 7 had hemodialysis treatment every Monday, Wednesday, and Friday and Resident 7 had a Permacath on his right upper chest wall. When asked how Resident 7's dialysis access site was being monitored, RN 1 stated he checks for redness, bleeding, swelling, pain, bruit, and thrill. On 5/20/26 at 1023 hours, an interview was conducted with RN 2. RN 2 stated Resident 7 had AV (arteriovenous) shunt on his right upper chest, and the dialysis access was being monitor for bruit and thrill. On 5/20/26 at 1439 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 7's dialysis access was a right upper chest (RUC) Permacath. The DON stated a bruit and thrill would not be assessed for the residents with a Permacath. The DON acknowledged the above findings. Cross reference to F698. 2. Review of the facility's document titled Charge Nurse (undated) showed the duties and responsibilities of the LVN as charge nurse included preparing and administering medications as ordered by the physician. Review of the facility's document titled Skill Checklist – Licensed Nurse Medication Administration dated 2/12/26, showed LVN 7 met the competency on giving eye medications. The skills checklist did not include competency in giving nasal spray medications. Review of the facility's P&P titled Instillation of Eye Drops revised 1/2014 showed when administering two or more different eye drops, to allow three to five minutes between each (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	application. Review of the facility's P&P titled Nasal Inhaler, Spray and Pump Administration dated 4/2008 the procedures included to have the resident blow his/ her nose gently to clear the nostril before administering the nasal spray. On 5/20/26 at 0813 hours, a medication administration observation for Resident 53 was conducted with LVN 7. LVN prepared the following medications for Resident 53, including artificial tears eyedrops and Fluticasone Propionate (synthetic corticosteroid) nasal spray. During the medication administration, the following was observed: - While Resident 53 was in bed, LVN 7 asked Resident 53 to tilt his head. LVN 7 administered the artificial tears eyedrops to the resident's right eye. LVN 7 stated she had to wait before administering artificial teardrops to the resident's left eye. After three minutes, LVN 7 was observed administering artificial tears eyedrops to the resident's left eye; and - LVN 7 was also observed administering nasal spray to Resident 53. LVN 7 was not observed asking the resident to blow his nose before administering the nasal spray. On 5/20/26 at 0927 hours, an interview for Resident 53 was conducted with LVN 7. LVN 7 verified she waited three minutes between administering the same ophthalmic medication to each of the resident's eyes. LVN 7 stated we followed what was required, we were trained by the pharmacy consultant, and the pharmacy consultant told us to wait three to five minutes in between each eye, even if we are administering just one eyedrops, same eyedrops. LVN 7 further verified she did not ask Resident 53 to blow his nose before administering the resident's nasal spray. LVN 7 stated the pharmacy consultant told them to ask the residents to blow their nose fist, during the training. On 5/21/26 at 1021 hours, an interview and concurrent employee file review for LVN 7 was conducted with the DSD. The DSD stated the facility conducted an annual skills checklist, to which she showed LVN 7's skills checklist. The DSD verified the annual skills checklist did not include administering nasal spray medication. On 5/21/26 at 1300 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross-reference to F755, #2.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services to ensure accurate administration and reconciliation of the medications. * The facility failed to ensure LVN 7 administered eye drops and nasal spray correctly to Resident 53. * The facility failed to ensure Resident 66's hydrocodone-acetaminophen (an opioid medication used to manage moderate to severe pain) tablet was documented administered in resident's MAR when the Antibiotic or Controlled Drug Record showed hydrocodone-acetaminophen was taken from Medication Cart A narcotic drawer. * The facility failed to ensure LVN 11 flushed Resident 67's GT with 15 ml of warm water in between medication as per facility's P&P. In addition, the facility failed to ensure LVN 11 administered the correct Pro-Stat (supplement) to Resident 67. * The facility failed to ensure the controlled medication count during the change of shift was completed and the Controlled Med Reconciliation record was signed by two licensed nurses. These failures had the potential to affect the residents' well-being by not being given the prescribed medications and not administering the correct GT flushes. In addition, there was a potential risk for inaccurate reconciliation, and drug diversion of the controlled medications. Findings: 1. According to the manufacturer's Frequently Asked Questions, the main difference between standard Pro-Stat and Pro-Stat Sugar Free lies in their sugar and carbohydrate content, impacting calorie counts and glycemic response. The sugar-free version contains 0 gram of sugar, 0 gram of carbohydrates and yields 100 calorie's per fluid ounce, while the regular Pro-Stat contains 0 gram of sugar, and ranging from seven to 10 grams of carbohydrates per serving. Review of the facility's P&P titled Administering Medications Through an Enteral Tube dated 11/2018 showed if administering more than one medication, to flush with 15 ml warm purified water (or prescribed amount) between medications. On 5/19/26 at 0845 hours, a medication administration observation for Resident 67 was conducted with LVN 11. LVN 11 prepared the following medications for Resident 67: - insulin glargine (long-acting insulin) 100 unit/ml pen injector; - vitamin C (supplement) 500 mg/5 ml; and - Pro-Stat (protein supplement) 30 ml. LVN 11 was also observed pouring water into a cup, the water was from a pitcher where the bottom portion of the pitcher was submerged in ice. LVN 11 stated she would use the cold water to flush the GT. During the medication administration, LVN 11 added 10 ml of water to the vitamin C medication cup poured it in the syringe connected to Resident 67's GT. Then LVN 11 flushed the GT with 5 ml water and then poured the Pro-Stat medication. LVN 11 flushed the GT with 30 ml water before and after medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 67 was initiated on 5/19/26. Resident 67 was readmitted to the facility on [DATE]. Review of Resident 67's Order Summary Report showed the following physician's orders: - dated 12/3/25, to administer insulin glargine 100 unit/ml 20 units subcutaneously every 12 hours. Hold insulin if blood sugar is less than 100 mg/dl; - dated 1/30/26, to administer Pro-Stat Sugar Free 30 ml mix with 60 ml of water via GT; and - dated 4/20/26, to administer ascorbic acid (vitamin C, supplement) 500 mg/5ml, to give 5 ml via GT two times a day. On 5/19/26 at 1525 hours, an interview was conducted with LVN 11. LVN 11 verified she flushed Resident 67's GT with 5 ml of cold water in between medication administration. LVN 11 further verified she administered a regular Pro-Stat and not Pro-Stat Sugar-Free as per the physician's orders. 2. Review of the facility's P&P titled Instillation of Eye Drops revised 1/2014 showed when administering two or more different eye drops, to allow three to five minutes between each application. Review of the facility's P&P titled Nasal Inhaler, Spray and Pump Administration dated 4/2008 showed the procedures included to have the resident blow his/ her nose gently to clear the nostril before administering the nasal spray. On 5/20/26 at 0813 hours, a medication administration observation for Resident 53 was conducted with LVN 7. LVN 7 prepared the medications for Resident 53, including artificial tears eyedrops and Fluticasone Propionate (synthetic corticosteroid) nasal spray. During the medication administration, the following was observed: - While Resident 53 was in bed, LVN 7 asked Resident 53 to tilt his head. LVN 7 administered the artificial teardrops to the resident's right eye. LVN 7 stated she had to wait before administering artificial tears eyedrops to the resident's left eye. After three minutes, LVN 7 was observed administering artificial tears eyedrops to the resident's left eye; - LVN 7 was also observed administering the nasal spray to Resident 53. LVN 7 was not observed asking the resident to blow his nose before administering the nasal spray. Medical record review for Resident 53 was initiated on 5/19/26. Resident 53 was admitted to the facility on [DATE]. Review of Resident 53's Order Summary Report showed the following physician's orders: - dated 4/19/26, to administer Fluticasone Propionate 50 mcg nasal spray, one spray to both nostrils one time a day; and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 5/19/26, to administer artificial tears ophthalmic solution (1 – 0.3% propylene glycol glycerin). Instill one drop in both eyes two times a day for eye dryness. On 5/20/26 at 0927 hours, an interview for Resident 53 was conducted with LVN 7. LVN 7 verified she waited three minutes between administering the same ophthalmic medication to each of the resident's eyes. LVN 7 further verified she did not ask Resident 53 to blow his nose before administering the resident's nasal spray. LVN 7 stated the resident blows his nose all the time anyway. On 5/21/26 at 0817 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross-reference to F726, example 3. 3. Review of the facility's P&P titled Controlled Substances revised November 2022 showed the 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. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. Medical record review for Resident 66 was initiated on 5/18/26. Resident 64 was admitted to the facility on [DATE]. Review of Resident 66's H&P examination dated 4/30/26, showed the resident had capacity to make decisions. Review of Resident 66's Order Summary Report dated 5/21/26, showed a physicians order dated 4/29/26 to administer hydrocodone-acetaminophen 7.5-325 mg one tablet by mouth every six hours as needed for moderate to severe pain (4-10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst). Review of Resident 66's Antibiotic or Controlled Record for hydrocodone-acetaminophen 7.5-325 mg showed #41 on 5/15/26 at 0600 hours, and #37 on 5/17/26 at 0230 hours hydrocodone-acetaminophen 7.5-325 mg tablet was taken from the narcotic drawer of Medication Cart A. However, review of Resident 66's MAR for May 2026 failed to show any documentation the hydrocodone-acetaminophen 7.5-325 mg tablet was administered to the resident on 5/15/26 at 0600 hours, and on 5/17/26 at 0230 hours. On 5/18/26 at 1350 hours, an inspection of Medication Cart A, an interview and concurrent medical record review for Resident 66 was conducted with LVN 7. LVN 7 verified Resident 66's Antibiotic or Controlled Record for the hydrocodone-acetaminophen 7.5-325 mg showed #41 on 5/15/26 at 0600 hours, and #37 on 5/17/26 at 0230 hours hydrocodone-acetaminophen 7.5-325 mg tablet was taken from the narcotic drawer of Medication Cart A. However, Resident 66's MAR for May 2026 failed to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	show any documentation the hydrocodone-acetaminophen 7.5-325 mg tablet was administered to the resident on 5/15/26 at 0600 hours, and on 5/17/26 at 0230 hours. LVN 7 stated the resident's MAR should show a documentation when hydrocodone-acetaminophen 7.5-325 mg was taken out of the narcotic drawer and the hydrocodone-acetaminophen 7.5-325 mg was signed out from the Antibiotic or Controlled Record and given to the resident. If the medication was not given to the resident for any reason the nurse should have documented in the resident records and medication should have been wasted witnessed by two nurses. On 5/21/26 at 1318 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to sign out the medication from Antibiotic or Controlled Record, give the medication to the resident and document in the resident's MAR. The DON was informed and acknowledged the above findings. 4. Review of Controlled Med Reconciliation record for March to May 2026 of Station A, Cart A showed the following dates and time were not signed by a licensed nurse: - on 5/2/26, 11 PM in - on 5/7/26, 3 PM out - on 5/9/26, 7 AM in - on 5/10/26, 7 PM out - on 5/11/26, 3 PM out - on 5/11/26, 11 PM in - on 5/12/26, 7 AM out - on 5/13/26, 11 PM in - on 4/1/26, 3 PM out - on 4/3/26, 3 PM out - on 4/20/26, 3 PM out - on 3/30/26, 3 PM in On 5/18/26 at 1350 hours, an inspection of Medication Cart A, an interview and concurrent facility record review was conducted with LVN 7. LVN 7 verified the Controlled Med Reconciliation record for March to May 2026 had missing entry, and stated there should be a two license nurses signature during the change of shift to indicate the controlled drug count was completed at the end of the shift. On 5/21/26 at 1315 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to do narcotic drug count during the change of shift and were expected to sign the Controlled Med Reconciliation record. The DON was informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 2) reviewed for unnecessary medications were free from unnecessary medications. * The facility failed to monitor the side effects for the use of Eliquis (blood thinner medication) for Resident 2. This failure had the potential for adverse effects related to the medication use.Findings: Review of Daily Med, for Eliquis-apixaban tablet revised 2/2025 under the Warnings and Precautions section, showed the Eliquis medication increased the risk of bleeding and can cause serious, potentially fatal bleeding. Review of the facility P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed 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. Medical record review for Resident 2 was initiated on 5/18/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 5/4/26, showed Resident 2 had the capacity to make his own medical decisions. Review of Resident 2's Order Summary Report showed the physician's order dated 3/28/26, to administer Eliquis 5 mg one tablet by mouth two times a day for atrial fibrillation (irregular heart rhythm). Review of Resident 2's Care Plan Report revised 3/28/26, showed a plan of care for Resident 2's altered cardiovascular status at risk for hypertension (high blood pressure) or hypotension (low blood pressure). The interventions included to administer the anticoagulant medication per the physician's order, to monitor the signs of symptoms of bruising and bleeding, and to hold the anticoagulant medication and notify the physician if any of the following was observed each shift: blood in urine, blood in stool, unusual bleeding after shaving, bleeding from gums, bleeding from nose, excessive bleeding from wounds, large hemorrhagic area (a specific region in the body where blood has escaped from damaged blood vessels {arteries, veins, or capillaries}), or petechiae (the medical term for tiny, pinpoint-sized red, purple, or brown spots on the skin. They are caused by minor bleeding from broken capillaries (tiny blood vessels) just under the skin's surface). Review of Resident 2's medical record did not show documented evidence that Resident 2 was monitored for signs and symptoms of bruising or bleeding related to the resident's Eliquis medication use. On 5/21/26 at 1333 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 12. LVN 12 stated the possible side effects of Eliquis medication use included bleeding and bruising; and the resident on an anticoagulant should be monitored for these symptoms. LVN 12 confirmed Resident 2 had current orders for the Eliquis medication. LVN 12 reviewed Resident 2's medical record and verified there was no documented evidence Resident 2 was monitored for the side effects related to the Eliquis medication use. On 5/21/26 at 1413 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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 medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 7.69%. One of the four licensed nurses (LVN 7) who were observed during medication administration was found to have errors. * LVN 7 failed to ensure the sodium chlorine (mineral and electrolyte supplement) medication was administered to Resident 60 with meals as per the physician's order. * LVN 7 failed to administer the correct artificial tears eye drops to Resident 53. These failures created the risk for the residents to have potential side effects or complications related to the medications including gastrointestinal discomfort from improper sodium chloride administration, and ineffective or inappropriate treatment related to the administration of incorrect sodium ophthalmic medication formulation.Findings: 1. On 5/19/26 at 1138 hours, a medication administration observation for Resident 60 was conducted with LVN 7. LVN 7 prepared two tablets of one gram sodium chloride. Resident 60 was observed sitting in wheelchair. There was no meal tray or food items at bedside. LVN 7 was observed administering the sodium chloride medication to Resident 60 without any food, nor asking Resident 60 if he had eaten. Medical record review for Resident 60 was initiated on 5/19/26. Resident 60 was readmitted to the facility on [DATE]. Review Resident 60's Order Summary Report showed a physician's order dated 12/7/25, to administer sodium chloride two grams by mouth with meals. On 5/19/26 at 1158 hours, an interview and medical record review for Resident 60 was conducted with LVN 7. LVN 7 verified she administered the sodium chloride medication to Resident 60 without meals. LVN 7 stated Resident 60 had not eaten yet, and lunch comes at 12 to 1230 hours. 2. According to the National Institutes of Health's article titled Categorization of Marketed Artificial Tear Formulations Based on Their Ingredients:- The glycerin, Hypromellose and polyethylene glycol formulation is a robust, multi-polymer combination often found in thicker lubricant gels or premium restorative eyedrops. The Hypromellose is a cellulose derivative that creates a soothing, shield-like barrier over the cornea, thickening the tear film and preventing evaporation, the glycerin is a potent humectant that draws water to the eye surface and helps promote the growth of surface cells, and the Polyethylene glycol is a high-molecular-weight polymer that mimics mucins, providing slick, long-lasting lubrication with less blurring. This formulation is best for moderate to severe dry eye or overnight use, as the thicker consistency may cause temporary, minor blurring upon application; and- The Propylene Glycol (1%) and Glycerin (0.3%) formulation is a standard, lightweight combination typically found in fast-acting, aqueous-based drops. The propylene glycol is a dual-action demulcent and humectant that holds water on the eye and creates a protective layer to reduce inflammation and irritation, and the glycerin works synergistically with propylene glycol to lock in moisture and protect the eye from dryness. This formulation is best for mild to moderate dry eye, computer eye strain, or for users who need a light, refreshing drop that won't cause vision blur during the workday On 5/20/26 at 0835 hours, a medication administration observation for Resident 53 was conducted with LVN 7. LVN 7 prepared Resident 53's medications including a bottle of artificial tears containing the active ingredients glycerin, Hypromellose and Polyethylene glycol. On 5/20/26 at 0911 hours, LVN 7 was observed administering the artificial tears containing the active ingredients glycerin, Hypromellose and Polyethylene glycol to Resident 53. Medical record review for Resident 53 was initiated on 5/19/26. Resident 53 was admitted to the facility on [DATE]. Review of Resident 53's Order Summary Report showed a physician's order dated 5/19/26, to administer artificial tears ophthalmic solution (1- 0.3% propylene glycol glycerin). Instill one drop in both eyes two times a day for eye dryness. On 5/20/26 at 0927 hours, an interview and medical record review for Resident 53 was conducted with LVN 7. LVN 7 verified she administered the artificial tears containing the active ingredients glycerin, Hypromellose and Polyethylene glycol to Resident 53. LVN 7 further verified the artificial tears containing the active ingredients 1- 0.3% propylene glycol glycerin was ordered. On 5/21/26 at 0817 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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 facility P&P review, the facility failed to ensure safe medication storage in one of three medication carts (Medication Carts A) and one of one medication room inspected. * The facility failed to ensure Medication Room A was closed and locked at all times. * The facility failed to ensure internal and external medications were stored separately in Medication Room A. * The facility failed to ensure disposal of medication was signed by two nurses. These failures had the potential for the residents to be exposed to the expired medications and the potential to lead to medication errors and place the residents at risk of receiving the wrong type of medication. Findings: 1. Review of the facility's P&P titled Medication Labeling and Storage revised on February 2023 showed the facility stores all the medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. On 5/18/26 at 0540 hours, during the initial tour of the facility, Medication Room A in Station A was observed with a trash can propped to keep the door open. Inside the Medication Room A there was a medication emergency kit on the counter top, two refrigerators, medications and syringes on the shelves. The Medication Room A was located right next to the emergency door exit was open to enter the facility. There were no licensed nurse observed by the nursing Station A. On 5/18/26 at 0727 hours, an interview was conducted with the RN 4. RN 4 verified the Medication Room A in Station A had a trash can propped to keep the door open earlier. RN 4 stated the medication room should have not left open and propped with trash can. RN 4 further stated she was passing the medications this morning. On 5/21/26 at 1323 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected keep the medication room locked at all times. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Medication Labeling and Storage revised February 2023 showed the medications for external use, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from other medications. On 5/18/26 at 1425 hours, an inspection of Medication Room A, an interview and concurrent facility record review was conducted with LVN 7. The calcium carbonate (antacid or calcium supplement medication), diclofenac sodium gel (a medication applied directly to skin to relieve minor joint pain), budesonide and formoterol fumarate dihydrate (an inhalant medication to reduce lung inflammation) mineral oil (lubricant laxative used to treat constipation) enema, and saline (salt and water solution used to treat constipation) laxative enema were observed stored together in the lower shelf in Medication Room A. LVN 7 verified the medications as above were stored together. LVN 7 stated should have been stored separately. On 5/21/26 at 1316 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Review of the facility's P&P titled Discarding and Destroying Medications revised on November 2022, showed noncontrolled and Schedule V (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications. The medication disposition record contains, as a minimum, the following information: a. The resident's name; b. The name and strength of the medication; c. The prescription number (if any); d. The name of the dispensing pharmacy; e. Date medication destroyed; f. The quantity destroyed; g. Method of destruction; h. Reason for destruction; [NAME]. Signature of witnesses. Review of the facility's Drug Destruction Log for 2/14, 2/20, 3/4, 3/11, 4/27, 5/1, 5/11, and 5/16/26, showed only one nurse had signed. One Drug Destruction Log was undated with no signature of two nurses. On 5/18/26 at 1428 hours, an inspection of Medication Room A, an interview and concurrent facility record review was conducted with LVN 7. LVN 7 verified the facility's Drug Destruction Log for 2/14, 2/20, 3/4, 3/11, 4/27, 5/1, 5/11, and 5/16/26, showed only one nurse had signed. One Drug Destruction Log was undated with no signature of two nurses. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 7 stated the destruction of medication should have been witness by two nurses and should sign the Drug Destruction Log. On 5/21/26 at 1320 hours, an interview was conducted with the DON. The DON stated the disposal of the medications should have been witnessed by two licensed nurses were expected sign the Drug Destruction Log. The DON was informed and acknowledged the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, medical record, facility record review, and facility P&P review, the facility failed to ensure one of 69 residents served with meal trays (Resident 3) the recipe was followed and prepared appropriately. * The facility failed to ensure Resident 3's chopped meat diet as ordered by the physician is followed and prepared appropriately. This had the potential for the resident not receiving adequate nutrition, and appropriate servings.Findings: Review of the facility's P&P titled Therapeutic Diets dated October 2017 showed the following- diet will be determined in accordance with the residents' informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet.- a therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). The attending physician may delegate this task to a registered or licensed dietitian as permitted by state law.- diet order should match the terminology used by the food and nutrition services department.- if a mechanically altered diet is ordered, the provider will specify the texture modification. On 5/18/26 at 1221 hours, lunch observation was conducted on Resident 3. Resident 3 was about to be fed by CNA 3. The meat portion on Resident 3's plate appeared as ground meat. CNA 3 stated this is what she eats all the time. Review of Resident 3's medical record was initiated on 5/18/26. Resident 3 was admitted to this facility on 3/7/24. Review of Resident 3's H&P examination dated 3/10/26, showed Resident 3 had the capacity to understand and make decisions. Review of Resident 3's Outcome Summary Report dated 5/20/26, showed Resident 3's diet order of regular diet, regular consistency, chopped meat texture, thin liquids consistency, meat chopped, 1:1 (one resident to one staff) assistance, ordered on 11/18/25. Review of Resident 3's Speech Therapy Evaluation and Plan of Treatment for the period of 10/30/25 - 11/27/25, showed Resident 3 was at risk for aspiration, immobility and decreased ability to return to prior level of assistance. On 5/19/26 at 826 hours, an interview and concurrent record review were conducted with the DSS. The DSS acknowledged Resident 3's lunch served on 5/18/26, consisted of meat had a ground like appearance. The DSS stated the apricot glazed pork loin method, mechanical soft recipe was followed. The mechanical soft recipe showed grind portions needed from regular prepared recipe, served with gravy as needed. The DSS further stated the mechanical soft diet recipe was being followed for Resident 3. The DSS was asked if the physician's order matches with the food served, the DSS stated, I will speak to the Dietitian. On 5/20/26 at 737 hours, during breakfast dining observation, Resident 3 was observed to have a portion of meat with ground-like appearance, scrambled egg, half of a sliced toast on her breakfast plate. On 5/20/26 at 1418 hours, a phone interview was conducted with the Dietitian. The Dietitian stated the chopped meat was considered level 7 in IDDSI (International Dysphagia Diet Standardization Initiative Inc.) and it will clarify in the diet order. The Dietitian was asked if she knows the diet of Resident 3, the Dietitian stated Resident 3 is on Diet 7-easy to chew and 1.5 cm or greater soft and bite sized. The Dietitian also stated the DSS was correct in following the specific recipe but if the diet ordered was chopped meat, the Dietitian verified the preparation was inaccurate. The Dietitian further stated, it sounds like the resident's diet was not ordered right, if the meat particle goes through the fork, it was a level five- minced and moist, not chopped. On 5/21/26 at 934 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings. The DON stated it does not appear chopped to me referring to the meal served on 5/18/26 and 5/20/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555445	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and facility document review, the facility failed to ensure the residents' care equipment were maintained in a safe operating condition. * The facility failed to ensure to monitor the Assure Platinum Blood Glucose Monitor control for one of two Assure Platinum Blood Glucose Monitor machines for Medication Cart A. This failure had the potential to result in inaccurate blood glucose readings and compromised resident care. * The facility failed to ensure the medication refrigerator in Medication Room A was free from any ice buildup. This failure had the potential to affect the stability and integrity of temperatureˆsensitive medications.Findings: 1. Review of the Assure Platinum Blood Glucose Monitoring System Quality Assurance/ Quality Control Reference Manual revised [DATE] showed in section B Performing a Control Solution Test healthcare professionals perform control solution tests in accordance with the state regulatory guidelines. Check meter and test strips using Assure Dose control solutions to confirm the meter and test strips are working properly, or to check if testing correctly. In section C Regulatory Review and Guidelines for QA/QC Protocols showed Quality control procedures are performed at least once each day on each instrument used for resident testing. In Section D Policy: Quality Control Testing on Assure Platinum Meter showed quality control testing using the Assure Dose Control Solution will be performed to examine the performance of the Assure Platinum Blood Glucose Monitoring System. The Assure Dose Control Solution checks if the meter and test strips are working correctly as a system and if testing correctly. Perform a Control Solution Test before testing with the Assure Platinum System for the first time; when you open a new bottle of test strips; whenever you suspect the meter or test strips may not be functioning properly; if test results appear to be abnormally high or low or are not consistent with clinical symptoms; the test strip bottle has been left open or has been exposed to light, temperatures below 39 F (4 C) or above 86 F (30 C), or humidity levels above 80%; to check your technique; when the Assure Platinum Meter has been dropped or stored below 32 F (0 C) or above 122 F (50 C); and each time the batteries are changed. Review of facility's Assure Platinum Blood Glucose Monitoring System Quality Control Record for Medication Cart A dated May 2026 showed Assure Platinum meter serial number 1040-4507209 quality control being completed daily. Further review of facility's Assure Platinum Blood Glucose Monitoring System Quality Control Records for Medication Cart A failed to show Quality Control Record for Assure Platinum Meter serial number 1040-4427033. On 5/18/26 at 1355 hours, a concurrent medication storage inspection of Medication Cart A, review of Assure Platinum Blood Glucose Monitoring System Quality Control Record, and an interview was conducted with LVN 7. Medication Cart A was observed with two Assure Platinum Blood Glucose Meters: Assure Platinum Meter serial number 1040-4507209, and Assure Platinum Meter serial number 1040-4427033. LVN 7 stated she uses either of the Assure Platinum Meter to check the resident's blood sugar level. LVN 7 verified there was no documentation for Assure Platinum Meter serial number 1040-4427033 if control was being completed. LVN 7 stated Assure Platinum Meter serial number 1040-4507209 had been broken for a week. LVN 7 further stated the quality control for the Assure Platinum Meter should be performed every night for check if the meters are accurate. On 5/21/26 at 1322 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to make sure to complete control check to all Assure Platinum Meter being used to make sure the meter works properly. The DON was informed and acknowledged the finding as above. 2. On 5/18/26 at 1425 hours, a concurrent medication storage inspection of Medication Room A, and an interview was conducted with LVN 7. Medication Room A had two refrigerators. Both of the medication refrigerators was observed with ice buildup in the freezer of the medication refrigerators. LVN 7 verified the ice buildup in both medication refrigerators. LVN 7 stated usually the night shift defrost the refrigerators. On 5/21/26 at 1313 hours, an interview was conducted with the DON. The DON stated the licensed nurses were expected to make sure to keep the refrigerator clean and to had no ice buildup. The DON was informed and acknowledged the finding as above.