STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555462	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Valencia Healthcare Center	25000 Calle DE Los Caballeros Laguna Hills, CA 92653

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **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 provide the reasonable accommodations to meet the needs of three nonsampled residents (Residents 16, 46, and 346). The facility failed to ensure Residents 16, 46, and 346's call lights were within the residents' reach. These failures had the potential to negatively impact the residents' psychosocial well-being or result in a delay in receiving care. Findings: 1. Review of the facility's P&P titled Call Light Answering revised 1/2025 showed it is the policy to provide the resident a means of communication with the nursing staff, to leave the resident comfortable and to place the call device within the resident's reach before leaving the room. On 5/13/25 at 1224 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with Resident 346. Resident 346 was observed awake, lying in bed in her room. Resident 346 stated during the graveyard shift (2300 to 0700 hours), he used his call light because he felt pain on his left leg and wanted to reposition his legs. Resident 346 stated he pressed his call light; however, he waited for two to three hours for someone to assist him. Resident 346 could not recall exactly what the time was at night. Resident 346 stated he kept track of the time by checking his mobile phone. Resident 346 stated he could not wait any longer, so he started yelling for help, and further stated, my voice was probably scary, so somebody showed up, and they tried to calm me down and I told them I needed help. Medical record review for Resident 346 was initiated on 5/13/25. Resident 346 was admitted to the facility on [DATE]. Review of Resident 346's H&P examination dated 4/25/25, showed Resident 346 had the capacity to make decisions. Review of Resident 346's MDS assessment dated [DATE], showed Resident 346 was cognitively intact, with no impairment to upper and lower extremities, and dependent on facility to staff members for toileting, personal hygiene and bed mobility. On 5/14/25 at 1038 hours, Resident 346 was observed asleep and in bed. Resident 346's call light was observed on the floor and not within the resident's reach. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 1043 hours, a concurrent observation and interview for Resident 346 was conducted with RN 1. RN 1 verified Resident 346's call light was observed on the floor and not within the resident's reach. 2. On 5/15/25 at 0620 and 0704 hours, Resident 46 was observed asleep and in bed. Resident 46's call light was observed on the floor and not within the resident's reach. On 5/15/25 at 0707 hours, a concurrent observation and interview for Resident 46 was conducted with CNA 2. CNA 2 verified Resident 46's call light was observed on the floor and not within the resident's reach. CNA 2 stated the call light should be within reach so the resident could call for help or assistance. Medical record review for Resident 46 was initiated on 5/13/25. Resident 46 was admitted to the facility on [DATE]. Review of Resident 46's H&P examination dated 5/14/25, showed Resident 46 had the capacity for medical decision-making. 3. On 5/15/25 at 0622 and 0705 hours, Resident 16 was observed asleep and in bed. Resident 16's call light was observed hanging on the left side of the bed and not within the resident's reach. On 5/15/25 at 0710 hours, a concurrent observation and interview for Resident 16 was conducted with RNA 1. RNA 1 verified Resident 16's call light was observed hanging on the left side of the bed and not within the resident's reach. RNA 1 stated Resident 16 could use the call light. Medical record review for Resident 16 was initiated on 5/13/25. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 4/13/25, showed Resident 16 had the capacity to understand and make decisions. Review of Resident 16's MDS assessment dated [DATE], showed Resident 16 had severe cognitive impairment, with no impairment to upper and lower extremities, and needed supervision or touching assistance with personal hygiene, partial/ moderate assistance with mobility, and substantial/maximal assistance with toileting hygiene.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, and medical record review, the facility failed to provide services to attain or maintain the highest practicable well-being for one nonsampled resident (Resident 30). * Resident 30 had a physician's orders to administer Synthroid (man-made thyroid hormone) and Ajovy (used to prevent migraines in adults) medications from the acute care hospital. However, these orders were omitted during the admission process to the facility. This failure posed the risk of the resident not being able to take the prescribed medications and could potentially cause adverse effects to Resident 30 due to missing the prescribed medications. Findings: According to GoodRx.com's article titled Thyroid Hormone Medication dated 2/11/25, showed the thyroid hormone medications provide thyroid hormone when the body does not have enough such as in hypothyroidism. Thyroid hormones play an important role in growth and development. It also regulates your metabolism and body temperature. Levothyroxine is the hypothyroidism medication prescribed the most, and it is the first-choice medication for people with the condition. After missing several doses of the thyroid medication in a row, symptoms of low thyroid levels will be noticeable, such as constipation, feeling weak or tired, muscle and joint pain, weight gain, and sensitivity to cold. Levothyroxine levels in the body start to drop significantly after about six or seven days, and will likely notice symptoms of hypothyroidism if the medication was missed a week or more. If the medication is not restarted, the levels will continue to drop, and more severe symptoms are possible. In severe cases, untreated hypothyroidism can result in a condition known as myxedema coma. Medical record review for Resident 30 was initiated on 5/13/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 30's H&P evaluation dated 4/17/25, showed the resident may make own medical needs known. Review of Resident 30's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of the acute care hospital's Discharge to Post-Acute/ SNF AVS Report dated 4/17/25, under the Reconciled Home Medications section, showed the following physician's orders: - levothyroxine (Synthroid) 125 mcg tablet daily before breakfast; and - fremazumab-vfrm (Ajovy) 225 mg/1.5 ml syringe, inject under the skin. Review of Resident 30's Order Summary Report dated 4/17/25, failed to show the physician's orders for the Synthroid and Ajovy medications. Review of Resident 30's Progress Notes dated 4/17/25 at 2347 hours, showed Resident 30 brought some medications on hand, and all the orders were faxed to the facility. There was no documentation the licensed nursing staff had clarified with the physician nor any of the resident's family member about the Synthroid and Ajovy medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 30's MAR for April and May 2025 showed Resident 30 was administered the Synthroid medication on 4/27 to 5/15/25. Resident 30 was administered with the Synthroid medication 10 days after admission to the facility. On 5/15/25 at 0949 hours, an interview and concurrent medical record review for Resident 30 was conducted with RN 1. RN 1 stated for Resident 30's initial admission on [DATE], she, started queuing the physician's orders into the electronic health record using the Discharge to Post-Acute/SNF AVS Report from the acute care hospital. RN 1 further stated when she was done entering the physician's order into the electronic health record, she would place a checkmark on the report form to identify the medications were entered. RN 1 verified the Discharge Post-Acute/SNF AVS Report included the Synthroid and Ajovy medications; however, they were not checked on the report. RN 1 stated she missed the Synthroid medication and did not enter the Ajovy medication because the order on the report did not include a frequency. RN 1 acknowledged she did not verify the frequency of the Ajovy medication from the resident, family member, nor the physician. On 5/15/25 at 1332 hours, an interview and concurrent medical record for Resident 30 was conducted with LVN 1. LVN 1 stated Resident 30 spoke with her about the medication, and she informed the physician on 4/26/25. LVN 1 stated Resident 30 did not tell her that she felt weak at that time. LVN 1 stated Resident 30 was not monitored for any change of condition, nor laboratory tests were ordered because she did not have a change of condition. When LVN 1 was informed that Resident 30 stated she felt weak several days after admission to the facility, LVN 1 stated, weakness has nothing to do with not taking the Synthroid medication. On 5/16/25 at 0920 hours, a telephone interview and concurrent medical record review for Resident 30 was conducted with RN 3. RN 3 stated for Resident 30, RN 1 entered the physician's orders into the electronic health record using the Discharge to Post-Acute/SNF AVS Report from the acute care hospital. RN 3 further stated when Resident 30 was transferred to the facility, RN 3 activated her medications into the electronic health record. When asked if she double checked all the medications from the medication list report from the acute care hospital were transcribed and entered into the facility's electronic health record, RN 3 answered no.

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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** 2. Medical record review for Resident 344 was initiated on 5/13/25. Resident 344 was admitted to the facility on [DATE]. Review of Resident 344's Order Summary Report showed the following physician's orders dated 5/3/25: - To check the right upper arm midline site every shift; - To perform dressing change of PICC line site every day shift every seven days and record external catheter measurement in every dressing change; and - To perform dressing change of PICC line site as needed and record external catheter measurement in every dressing change Review of Resident 344's plan of care showed the following: - A care plan problem dated 5/5/25, to address Resident 344's IV therapy related to poor oral intake and high risk for infection on the right upper arm midline IV site. The interventions included observing IV site for redness, tenderness, swelling, puffiness, infiltration, and occlusion. Review of Resident 344's IV record for May 2025 showed the dressing change and external catheter measurement of PICC line site were documented on 5/9/25. The record did not show the resident's right upper arm circumference was measured. Further review of Resident 344's medical record did not show the resident's right upper arm circumference was measured upon admission. On 5/16/25 at 0940 hours, an interview and concurrent interview and medical record review for Resident 344 was conducted with RN 1. RN 1 verified Resident 344 had a midline catheter on his right upper arm. RN 1 stated the nurses assessed the midline catheter during the dressing change included measuring the catheter length and comparing it to the initial length upon admission. RN 1 verified the orders for the dressing change weekly and as needed were for PICC line site. RN 1 acknowledged the orders should be for midline catheter and not for PICC line. On 5/16/25 at 0956 hours, an observation and concurrent interview for Resident 344 was conducted with RN 1. RN 1 verified Resident 344 was lying in bed, and the dressing on the right upper arm midline catheter was observed with bleeding on the insertion site which was covered with a Biopatch protective disk (a polyurethane foam disc dressing impregnated with chlorhexidine gluconate or CHG, used to reduce infections around central venous or arterial catheter insertion sites) site. When asked to identify the label, RN 1 could not read the writing on the label of the dressing on the resident's right upper arm. On 5/16/25 at 1047 hours, a follow-up interview for Resident 344 was conducted with RN 1. When asked about the measurement of the arm circumference for the residents with midline catheter, RN 1 acknowledged the nurses did not measure the arm circumference upon admission. RN 1 stated the nurses only checked the site every shift, flushed the catheter before and after medication administration, changed the dressing, and measured the external catheter every seven days. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous accesses for two of two final sampled residents (Residents 5 and 344) reviewed for IV catheter devices. * The facility failed to ensure Resident 5's right upper arm circumference was measured for the use of the PICC line. * The facility failed to ensure Resident 344's right upper arm circumference with a midline catheter was measured upon admission per the facility's P&P. These failures had the potential to delay the identification of catheter related complications for the residents. Findings: According to the NIH, external length is measured at the time of insertion and used for future measurement comparison. If a PICC line is in place, arm circumference is also measured each shift and results compared to previous readings. Review of the facility's P&P titled Midline Catheter Dressing Change dated 3/2023 showed the catheter dressing changes are to be performed by RNs and IV certified LVNs according to state law and facility policy. The Policy section showed to measure the upper arm circumference (three inches or 10 centimeters above insertion site) upon admission. Medical record review for Resident 5 was initiated on 5/13/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Review of Resident 5's Order Summary Report dated 4/30/25, showed a physician's order dated 4/17/25, to check the right upper arm PICC line site every shift. Review of Resident 5's Care Plan Report dated 5/14/25, showed a plan of care dated 4/17/25, addressing the resident's potential for IV related complications such as infection, swelling, venous thrombosis, drainage and/or fever, hemorrhage related to dislodgment/broken/disconnection. The interventions included to measure the upper arm circumference 10 cm superior to the insertion site; specify in cm. Further review of Resident 5's medical record failed to show documented evidence the measurement of Resident 5's right upper arm circumference was obtained upon admission to the facility. On 5/13/25 at 0928 hours, an observation and concurrent interview was conducted with the ADON. The ADON verified Resident 5's use of the PICC line on the right upper arm with a transparent dressing dated 5/8/25. The ADON stated Resident 5 used the PICC line for his IV antibiotic. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/25 at 0719 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified there was no documentation of the measurement for Resident 5's right upper arm circumference. RN 1 stated Resident 5's right upper arm circumference should have been measured to make sure there was no infiltration or complication. On 5/16/25 at 1337 hours, the Administrator and DON were informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Medical Record review for Resident 26 was initiated on 5/13/25. Resident 26 was admitted to the facility on [DATE]. On 5/13/25 at 0830 hours, Resident 26 was observed to have a nebulizer mask and tubing stored inside the bedside table drawer, touching the base of the drawer, and not bagged. Resident 26 stated she received a breathing treatment via nebulizer two times a day. On 5/13/25 at 0945 hours, an observation for Resident 26 and concurrent interview was conducted with RN 2. Resident 26's nebulizer tubing and mask were found to be unbagged and undated. RN 2 stated the nebulizer should be properly bagged and dated. RN 2 verified the findings. Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care services for two of two final sampled residents (Residents 26 and 344) and one nonsampled resident (Resident 21) reviewed for respiratory care services * The facility failed to ensure Resident 21's CPAP mask was stored properly when not in use. In addition, the facility failed to ensure the CPAP mask was cleaned per the facility's P&P, and the resident's care plan. * The facility failed to ensure Resident 344's nasal cannula tubing was stored inside a set-up bag when not in use. * The facility failed to ensure Resident 26's nebulizer mask and tubing were stored inside a set-up bag when not in use. These failures posed the risk for the residents' respiratory supplies and equipment to become contaminated which had the potential to negatively affect the residents' medical conditions. Findings: 1. Review of the facility's P&P titled CPAP/BiPAP Support revised 3/2015, under General Guidelines for Cleaning section, showed the following: - For machine cleaning, wipe the machine with warm, soapy water and rinse at least once a week and as needed; - For humidifier (if used), use clean, distilled water only in the humidifier chamber, clean humidifier weekly and air dry, and to disinfect, place vinegar-water solution (1:3 ratio) in clean humidifier, soak for 30 minutes and rinse thoroughly; - For filter cleaning, rinse the washable filter under running water once a week to remove dust and debris, replace the filter at least once a year, and replace disposable filters monthly; - For masks, nasal pillows and tubing, clean daily by placing in warm, soapy water and soaking/ agitating for five minutes. Mild dish detergent is recommended. Rinse with warm water and allow air dry between uses; and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- For the headgear (strap), wash with warm water and mild detergent as needed, and allow to air dry. Medical record review for Resident 21 was initiated on 5/13/25. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's Order Summary Report showed a physician's order dated 3/31/25, for the CPAP per home setting, and CPAP schedule to start at 2100 hours and discontinue at 0800 hours. Review of Resident 21's MAR for May 2025 showed Resident 21 was administered with CPAP on 5/1 to 5/13/25. Review of Resident 21's plan of care showed a care plan problem dated 3/20/25, to address Resident 21's needing special care related to CPAP machine use and risk for complications. The interventions included cleaning the CPAP tubing weekly and as needed and cleaning the CPAP headgear weekly and as needed when soiled. Further review of Resident 21's medical record failed to show documented evidence of cleaning the CPAP machine, humidifier, filter, masks, nasal pillows and tubing, and headgear. On 5/13/25 at 1135 hours, during the initial tour of the facility, Resident 21 was not in the room. A CPAP mask was observed on the nightstand, and there was no set-up bag to store the CPAP mask. On 5/13/25 at 1430 hours, an observation for Resident 21 and concurrent interview was conducted with RN 2. RN 2 verified Resident 21 was asleep in bed, and his CPAP mask was on the nightstand and not in a set-up bag when not in use. On 5/16/25 at 0951 hours, an interview and concurrent medical record review for Resident 21 was conducted with RN 1. RN 1 stated the night shift nurses applied the CPAP mask to Resident 21. When asked about cleaning the CPAP, RN 1 stated she was not sure about cleaning the CPAP machine and mask. RN 1 stated there was no order to clean the CPAP machine and mask. On 5/16/25 at 0959 hours, an observation for Resident 21 and a concurrent interview was conducted with RN 1. RN 1 acknowledged Resident 21 was in bed and currently using the CPAP mask. 2. Medical record review for Resident 344 was initiated on 5/13/25. Resident 344 was admitted to the facility on [DATE]. Review of Resident 344's Order Summary Report showed a physician's order dated 5/5/25, to administer oxygen at two liters per minute via nasal cannula at bedtime. Review of Resident 344's MAR for May 2025 showed Resident 344 was administered with oxygen at two liters per minute via nasal cannula on 5/5 to 5/15/25 at 2100 hours. On 5/13/25 at 1132 hours, during the initial tour of the facility, Resident 344 was observed asleep in bed. A nasal cannula tubing was observed on top of the oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 1426 hours, an observation for Resident 344 and concurrent interview was conducted with RN 2. RN 2 verified Resident 344 was asleep in bed, and a nasal cannula tubing was on top of the oxygen concentrator and not stored in a set-up bag. RN 2 stated the nasal cannula should be stored inside the set-up bag when not in use.

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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 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, and facility document review, the facility failed to ensure the competency of one of two licensed nurses (LVN 2) observed in performing a calibration of a medical equipment . LVN 2 was unable to demonstrate competency in the calibration of a glucometer. This failure had the potential of not providing care to the residents in a safe and competent manner. Findings: Review of the glucometer manufacturer's information sheet titled Assure Platinum Blood Glucose Monitoring System Quality Assurance/ Quality Control Reference Manual (undated) under the Quality Checks section showed the following: - To perform a control solution test, before testing with the Assure Platinum System for the first time, when a new bottle of test strips was opened, whenever meter or test strips may not be functioning properly, if the test test results appear to be abnormally high or low, or are not consistent, when the test strip bottle has been left open or exposed to temperatures below 39 degrees F or above 86 degrees F, or humidity levels above 8%, to check technique, when the Assure Platinum Meter has been dropped or stored below 32 degrees F or above 122 degrees F, and each time the batteries are changed; and - The first two of six steps in performing a control solution test were: Step 1: Insert test strip into the blood glucose meter, and Step 2: Press the Back or Forward button one time to enter the control solution mode (a control solution bottle will appear at the top right of the screen). Review of the facility's document titled List of Residents on Blood Sugar Check (undated) for Medication Cart A showed six residents were the list for their blood sugar checks. On 5/15/25 at 0639 hours, an inspection of the glucometer in Medication Cart A, concurrent interview and facility document review was conducted with LVN 2. The container of the test strips showed the control solution ranges from 86 to 108 mg/dl for Level 1 and 215 to 269 mg/dl for Level 2. LVN 2 stated there was one glucometer for each cart. When asked about glucometer calibration, LVN 2 stated the night shift nurses performed the glucometer calibration nightly between 1900 to 0700 hours. When asked to show how to calibrate the glucometer, LVN 2 was observed dispensing a drop of the low control solution test on the surface of an inverted medication cup, then LVN 2 inserted a test strip into the upper port of the glucometer. The test strip was brought into contact with the drop of control solution and the glucometer displayed a result of 98 mg/dl. Then, LVN 2 was observed dispensing a drop of the high control solution test on the surface of the inverted medication cup, then LVN 2 inserted a test strip into the upper port of the glucometer. The test strip was brought into contact with the drop of control solution and the glucometer displayed a result of 384. LVN 2 stated it was out of range, and he proceeded to perform another high control test, and the glucometer displayed a result of 381 mg/dl, which was still out of range. LVN 2 was not observed pressing the back or forward button, and the control solution bottle did not appear on the top right of the screen while he performed the glucometer calibration. LVN 2 verified the above findings. When asked if he received an in-service training on glucometer quality control, LVN 2 stated he had a training on glucometer calibration when he was newly hired three years ago, and he did not have an annual skills check on glucometer calibration. (continued on next page)

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	555462	A. Building B. Wing	05/16/2025

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Villa Valencia Healthcare Center	25000 Calle DE Los Caballeros Laguna Hills, CA 92653

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/25 at 0818 hours, an interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP stated the glucometer calibration should be performed if a new glucometer was being used. The DSD/IP stated she provided an in-service training on glucometer calibration last January, to which she showed the Class Attendance Roster. Review of the facility document titled Class Attendance Roster for Assure Platinum Blood Glucose Meter dated 1/15/23, showed LVN 2 attended the class. Cross reference to F908, example #4.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, medical record review, and professional standards literature review, the facility failed to ensure one of three sampled residents (Resident 5) was free of significant medication errors as evidenced by: * RN 4 administered Resident 5's ciprofloxacin (antibiotic) eye drop into the wrong eye. This failure had the potential for poor health outcome for this resident. Findings: According to Kozier & Erb's Fundamentals of Nursing textbook, when preparing eye medications for the residents, the MAR is checked to verify which eye is to be treated. On 5/14/25 at 0845 hours, a medication pass observation for Resident 5 was conducted with RN 4. RN 4 was observed preparing medications for Resident 5. The medications prepared included ciprofloxacin 0.3% (antibiotic)eye drop solution. The label on Resident 5's ciprofloxacin showed the eye drop was to be administered to Resident 5's left eye for Resident 5's left eye infection. RN 4 was then observed administering an eye drop to Resident 5's right eye. During the concurrent observation and review of Resident 5's May 2025 Medication Administration Record (MAR) with RN 4, RN 4 verified Resident 5's ciprofloxacin eye drop was to be instilled into Resident 5's left eye for his left eye infection. Further review of Resident 5's May 2025 MAR showed Resident 5 had an order dated 5/8/25, for ciprofloxacin solution 0.3% one drop to the left eye four times daily for left eye infection. RN 4 verified the order for Resident 5's eye drop as shown on Resident 5's 2025 MAR. RN 4 acknowledged she administered Resident 5's eye drop into the right eye instead of Resident 5's left eye as ordered by the physician. On 5/14/25 at 0910 hours, an interview was conducted with Resident 5. When asked which eye RN 4 administered his eye drop, Resident 5 verified RN 4 administered Resident 5's antibiotic eye drop into his right eye. When asked which eye Resident 5 had his infection, Resident 5 verified he had an infection to his left eye.

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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** 2. Review of the facility's P&P titled Medication Storage in the Facility, ID 1: Storage of Medication dated 4/2008 showed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. The provider pharmacy dispenses medications in containers that meet legal requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Transfer of medication from one container to another is done only by pharmacy. Medical record review for Resident 31 was initiated on 5/13/25. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's Order Summary Report dated 4/30/25, showed the physician's orders dated 4/2/25, to administer the following medications: - Mithochondria nutrition PQQ one capsule oral two times a day for supplement - Neuroprotext Px one capsule two times a day for supplement - Stress Calm Px one capsule oral at bedtime for supplement - Joint support nutrients two capsules two times a day for supplement - Megaquin one capsule oral one time a day for supplement - Neurofocus one capsule oral in the morning for supplement before breakfast - Cognicare one capsule two times a day for supplement - Same 200 one capsule one time a day for supplement - SR progesterone (a female sex hormone) 300 mg three capsules oral at bedtime - Transfer factor Multi-Immune one capsule oral in the morning for supplement before breakfast - Vitamin B 12/Methyl Folate (supplements working together to help maintain the health of the gastrointestinal tract, nervous system and the metabolism of protein and fats) 1000 mcg/800 mcg one cap sublingual On 5/13/25 at 0920 hours, a tote bag was observed hanging on a pole from Medication Cart B. The tote bag contained various pills and tablets. Medication Cart B was stationed in the hallway in front of Resident 246's room. RN 2 who was responsible for Medicine Cart B was seen walking toward the nursing station, leaving the cart unsupervised and unsecured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 0945 hours, RN 2 was administering medication to Resident 246 behind a closed curtain. Medication Cart B with a tote bag with medications was observed to be unsupervised and unsecured. On 5/13/25 at 1005 hours, an observation, interview, and concurrent record review for Resident 246 was conducted with RN 2. When asked about the tote bag containing medications and supplements, RN 2 stated the tote bag belonged to Resident 31 and the resident's family member had brought in the medications upon admission. RN 2 stated they would retrieve the tote bag from the medication room at the beginning of their shift and return it at the end of the shift. RN 2 used the medications and supplements in the tote bag to administer them to Resident 31. During the observation, the tote bag contained the following medications and supplements: - one opened bottle of progesterone SR (used to help prevent changes in the wom in women who are taking estrogens after menopause) 300 mg contained 25 capsules - one opened bottle of Neuro Protex PX (supports focus and memory) - Three foil blister packs of Same 200 enteric-coated adenosyl L-methionine (helps maintain a stable mood and supports both joint and liver health) (one pack contained 10 caplets) - one opened bottle of Transfer Factor Multi Immune (daily supplement to promote and maintain immune system d) - one opened bottle of Cognicare (used for management of autism and learning disorders) - one opened bottle of Bowel Mover - one opened bottle of Mitochondria Nutrition (supports healthy mental performance) - one opened bottle of [NAME] joint support nutrients - one opened bottle of Megaquin Potasium 2 (supports bone, heart, nerve, and immune function) and vitamin D3 - one opened bottle of Stress Calm PX (used to alleviate occasional symptoms of stress) - one opened bottle of Methyl B12 with L-methylfolate (supports brain function, mood, and energy levels) - two loose, unidentified tablets at the bottom of the bag RN 2 stated there was no available space in Medicine Cart B for these supplements. RN 2 acknowledged all medications and supplements should be securely stored. RN 2 was informed of the observation regarding Medication Cart B was left unsupervised and unsecured. RN 2 verified these findings and organized the third drawer of Medication Cart B to accommodate the storage of Resident 31's medications and supplements. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and facility P&P review, the facility failed to ensure proper storage and labeling of medications as evidenced by: * The label was not readable for the Advair (inhaler) * One bottle of iodine liquid was leaking and one wound cleanser bottle with brownish drops, inside the treatment cart * Two expired Sanicloth wipes containers were observed inside a storage room * Two expired Glucerna GT feeding formulas were observed stored in the emergency food storage closet * The facility failed to ensure the medications were not left unattended in Medication Cart B for one sampled resident (Resident 31). * The facility failed to ensure the medications were safely and properly stored. * The facility failed to ensure Resident 645's albuterol medication was stored properly and safely. * The facility failed to ensure the semaglutide (used to treat type 2 diabetes and for chronic weight management) medication was not left on Resident 345's bedside table unattended. * The facility failed to ensure the magnesium (supplement) medication was not left on top of Resident 28's dresser unattended. These failures posed the risk for unsafe practices and unauthorized access to the medications. Findings: 1. Review of the facility's P&P titled Medication Ordering and Receiving from Pharmacy effective date April 2014 showed medication containers having soiled, damaged, incomplete, or illegible are returned to the dispensing pharmacy for relabeling. a. On 5/14/25 at 0845 hours, a medication pass observation for Resident 5 was conducted with RN 4. RN 4 was observed preparing medications for Resident 5. The medications prepared included Advair. The label (including the dosage information) on Resident 5's Advair inhaler was observed with the print faded and was not readable. Prior to entering Resident 5's room with Resident 5's prepared medications, concurrent observation and interview was conducted with RN 4. RN 4 verified the dosage information on Resident 5's Advair was faded and not readable. b. On 5/13/25 at 1231 hours, a treatment cart inspection was conducted with RN 1. One bottle of povidine iodine liquid was observed with brown liquid leaking down the side of the iodine bottle. Also, the spray nozzle on a bottle of wound cleanser was observed with drops of brown liquid on it. The findings were verified with RN 1. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Review of the facility's P&P titled Medication Storage in the facility effective 4/2008 showed the medication storage areas are to be kept clean, and conditions monitored and corrected when problems identified. On 05/13/25 at 1311 hours, an inspection of the central supply storage area was conducted with Central Supply 1. Two Sanicloth (brand) bleach wipes with an expiration date of 11/2024 and the other bleach wipes 3/2025 were observed inside the central supply storage area. Also, two Glucerna GT enteral feeding bottles with an expiration date of 5/1/25, were observed inside the emergency food storage area. Central Supply 1 verified the findings. 5. Review of the facility's P&P titled Medication Storage in the Facility dated 4/2008 showed the following: - Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier. The medications supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members who are lawfully authorized; and - Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. On 5/13/25 at 1109 hours, during the initial tour in the facility, Resident 345 was not in the room and a box of semaglutide (antidiabetic) medication was observed on top of the resident's bedside table. On 5/13/25 at 1118 hours, Resident 345 was in a wheelchair, and a box of semaglutide medication was observed on top of the resident's bedside table. When asked about the semaglutide medication, Resident 345 stated she took the medication herself, every morning, and the nurses were aware. Resident 345 further stated she had the semaglutide medication because the nurses ran out of the semaglutide medication on hand. On 5/13/25 at 1125 hours, an observation for Resident 345 and concurrent interview was conducted with RN 2. RN 2 verified Resident 345 was in a wheelchair, and a box of semaglutide medication was observed on top of the resident's bedside table infront of her. RN 2 stated Resident 345 had the semaglutide medication with her because she was supposed to give it to the nurses so they could use it to administer to the resident. Medical record review for Resident 345 was initiated on 5/13/25. Resident 345 was admitted to the facility on [DATE]. Review of Resident 345's H&P examination dated 4/24/25, showed Resident 345 had the capacity to understand and make decisions. Review of Resident 345's Order Summary Report showed a physician's order dated 4/22/25, to administer Rybelsius (semaglutide) 14 mg one tablet by mouth one time a day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 1019 hours, an interview and concurrent medical record review for Resident 345 was conducted with RN 1. RN 1 stated there should be an assessment and care plan to administer the resident's medication by herself, and to keep the medication at the bedside. RN 1 stated the assessment to self-administer the medications was conducted only when the resident requested to self-administer the medications. RN 1 verified Resident 345 was not assessed to self-administer the medication and keep medications safely. 6. On 5/13/25 at 1101 hours, during the initial tour of the facility, Resident 28 was sitting in bed, and a bottle of magnesium was observed on top of the dresser. Resident 28 stated she was not taking the magnesium medication. Resident 28 was observed placing the bottle of magnesium inside the dresser drawer. On 5/13/25 at 1128 hours, an observation for Resident 28 and concurrent interview was conducted with RN 2. RN 2 verified a bottle of magnesium was inside Resident 28's dresser drawer. Medical record review for Resident 28 was initiated on 5/13/25. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 3/19/25, showed Resident 28 may make own medical decisions. Review of Resident 28's Order Summary Report did not show a physician's order to administer magnesium medication, nor to keep the magnesium medication at the bedside. On 5/13/25 at 1249 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 2. RN 2 verified there was no physician's order to administer the magnesium medication, nor to keep the magnesium medication at the resident's bedside. 3. Review of the facility's P&P titled Medication Storage in the Facility, ID 1: Storage of Medication dated 4/2008 showed medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. The provider pharmacy dispenses medications in containers that meet legal requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Transfer of medication from one container to another is done only by pharmacy. On 5/15/25 at 0529 hours, an observation and concurrent interview was conducted at the Nursing Station with LVN 3. Three white round tablets and four pink capsule medications were observed on the floor in front of the Nursing Station. LVN 3 was asked what the medications were, LVN 3 was not able to provide the name of those medications, whose medication, and how long the medications were on the floor. On 5/15/25 at 0725 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the facility's P&P titled Self-Administration of Medications dated 12/2016 showed self-administered medication must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of the residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer unopened medication to the residents requests them. A reference review from mayoclinic.org for the albuterol (brochodilator) medication showed the recommended storage guidelines to keep the medicine in a foil pouch until ready to use it. Store at room temperature, away from heat and direct light. Do not freeze. According to WebMD.com, the albuterol nebulizer solution should be stored between 36 F to 77 F (2 C to 25 C). Protect from light. Store the albuterol vials in the foil pouch when not in use. Once the vial has been removed from the foil pouch, keep the vial for no more than two weeks. Protect from heat. Medical Record Review for Resident 645 was initiated on 5/13/25. Resident 645 was admitted to the facility on [DATE]. Review of Resident 645's H&P examination dated 5/3/25, showed the resident had the capacity to understand and make decisions. Review of Resident 645's Order Summary Report dated 5/15/25, showed an order for albuterol sulfate HFA inhalation aerosol solution 108 (90 Base) mcg/act, two puffs inhale orally every six hours as needed for wheezing/shortness of breath unsupervised self-administration. On 5/13/2 at 0932 hours, during the initial tour of the facility, a concurrent observation and interview was conducted with Resident 645. One albuterol sulfate HFA (hydrofluoroalkane) inhalation aerosol was observed at Resident 645's overbed table and was not stored in the medicine foil pouch. Resident 645 stated she had been taking the albuterol sulfate for her asthma since she was admitted to the facility. On 5/13/25 at 0958 hours, an observation and concurrent interview for Resident 645 was conducted with the DSD. The DSD was asked about the facility's process of storing the medications and leaving the medications at the bedside. The DSD stated no medication should be left at the resident's overbed table because there was a risk for the other residents to take and self-administer the medications. The DSD verified Resident 645's albuterol inhalation aerosol was on the resident's overbed table and was not stored in a safe and secure place. On 5/16/25 at 1325 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were 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, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the proper hand hygiene was followed during the food preparation. * The facility failed to ensure proper labeling and dating of food in the refrigerator. * The facility failed to ensure the hair restraints were worn by staff in the kitchen. * The facility failed to ensure the kitchen equipment was maintained in a sanitary condition. * The facility failed to ensure the food item in the walk-in freezer was dated and labeled. * The facility failed to ensure the ice cream freezer was in sanitary condition. These failures had the potential to cause foodborne illnesses for the 53 residents who consumed food prepared in the kitchen. Findings: Review of the Diet Order Tally Report dated 5/14/25, showed 53 of 54 residents received food prepared in the kitchen. 1. According to the USDA Food Code 2022, Section 2-301.14, Food employees shall clean their hands and exposed portions of their arms as specified under section 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single -use articles and: (F) During food preparation, as often as necessary, to remove soil and contamination and to prevent cross contamination when changing tasks. (I) After engaging in other activities that contaminate the hands. On 5/13/25 at 0752 hours, during the initial tour of Kitchen B, an observation was conducted in Kitchen B with Dietary Aide1. Dietary Aide 1 was observed helping with the tray line preparation for breakfast with ungloved hands, left tray line preparation, and pushed the food cart with ungloved hands. Dietary Aide 1 then went back to help with the tray line without washing his hands. On 5/13/25 at 0756 hours, an observation with Dietary Aide 1 was conducted. During the tray line preparation, a packet of catsup had dropped on the floor, Dietary Aide 1 was observed picking up the packet of catsup and proceeded to continue with the tray line preparation without washing his hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 0805 hours, an interview and concurrent interview was conducted with the RD. The RD was informed of Dietary Aide 1's ungloved hands during the breakfast tray line preparation. The RD verified the above findings and stated all dietary staff needed to wear gloves when preparing food for residents to prevent cross contamination of food. On 5/16/25 at 0753 hours, an interview was conducted with the DSS. The DSS was informed of the above findings and stated all the dietary staff needed to wash hands when changing tasks and after picking the items from the floor. 2. Review of the facility's P&P titled Refrigerators and Freezer Storage revised 12/2004 showed all the food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. On 5/13/25 at 0810 hours, during the initial tour of Kitchen B, an observation and concurrent interview was conducted with Dietary Aide 1. The following was observed: - 17 bowls of salad, undated - nine bowls of fruit, undated - eight cups of iced tea, undated Dietary Aide 1 verified the above findings and stated the food needed to have a label with the date when the food was prepared. 3. According to the USDA Food Code 2022, Section 2-402.11 Hair Restraints, Effectiveness, Food employees shall wear hair restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, and utensils. Review of the facility's P&P titled Dress Code for women and men dated 2018 showed the beard and moustache (any facial hair) must wear beard restraint. On 5/13/25 at 0752 hours, an observation in Kitchen B and concurrent interview was conducted with [NAME] 1. [NAME] 1 was observed with uncovered facial hair. When asked if his facial hair should be covered, [NAME] 1 verified he needed to use a beard restraint. On 5/13/25 at 0805 hours, an interview was conducted with the RD. The RD was informed of [NAME] 1's uncovered facial hair. The RD verified the findings and stated any kitchen staff with facial hair or beard needed to use the hair restraints to prevent cross contamination of food. 4. Review of the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, food-contact surface and utensils shall be clean to sight and touch. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Valencia Healthcare Center	25000 Calle DE Los Caballeros Laguna Hills, CA 92653

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 0824 hours, during the initial tour of Kitchen A, an observation and concurrent interview was conducted with the CDM. The following was observed and verified by the CDM: - two green chopping boards (use to cut fruit and vegetables) with white and black residue, and - one nonstick pan with black residue on the coating. 5. Review of the facility's P&P titled Refrigerators and Freezer Storage revised 12/2004 showed all food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates(dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. On 5/13/25 at 0831 hours, during the initial tour of Kitchen A's walk in freezer, an observation and concurrent interview was conducted with the CDM. The following was observed: - one stainless pan container of mustard, undated. - one stainless pan container of sour cream, undated - one stainless pan container of cheese with preparation date 5/8/25, and use by date 5/11/25. The CDM verified the findings and stated all the food items should be dated and labeled. 6. On 5/13/25 at 0831 hours, during the initial tour of Kitchen A, an observation and concurrent interview was conducted with the CDM. A freezer containing an ice cream was observed with ice build up. The CDM verified the findings. When asked regarding the facility's process in maintaining the freezer to prevent ice buildup, the CDM responded by saying, We are just going to clean it. On 5/16/25 at 0753 hours, an interview was conducted with the DSS. The DSS was informed and acknowledged the above findings. On 5/16/25 at 1325 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the facility's garbage and refuse was properly disposed. This failure had the potential to cause unsafe sanitary conditions and potential to harbor pests and rodents. Findings: According to the USDA Food Code 2022, Section 5-501.113 Covering Receptacles: Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered. (B) With tight-fitting or doors if kept outside the food establishment. Review of the facility's P&P titled Food-Related Garbage and Refuse Disposal revised 10/2017 showed the outside dumpsters provided by garbage pickup services will be kept closed and free of the surrounding litter. On 5/14/25 at 0745 hours, an observation of the facility's outside dumpster located on the side of the facility was conducted. One of one dumpster was observed overflowing with trash, preventing the lid from fully closing. On 5/14/25 at 0804 hours, an observation and interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated the dumpster was collected six times a week, except on Sundays, and the dumpster was previously picked up by the city waste management on 5/13/25. The Maintenance Supervisor verified the above findings and stated the dumpster should be fully closed at all times to prevent attracting pests and rodents. On 5/16/25 at 1325 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged 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** 7. Medical Record review of Resident 26 was initiated on 5/13/25. Resident 26 was admitted to the facility on [DATE]. On 5/13/25 at 0830 hours, Resident 26's disposable gown hamper (dirty) was observed touching the PPE isolation cart. 8.a. Medical Record review of Resident 18 was initiated on 5/13/25. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's plan of care dated 4/21/25, showed a care plan problem addressing the resident's EBP due to GT and indwelling urinary catheter use. The interventions included to ensure proper PPE were donned before providing high contact activities. On 5/13/25 at 0830 hours, Resident 18's disposable gown hamper (dirty) was observed touching the PPE isolation cart. Resident 18 was observed with a GT and an indwelling urinary catheter hanging on the right side of the bed frame. On 5/13/25 at 0945 hours, an observation and concurrent interview was conducted with RN 2 for Residents 18 and 26. Residents 18 and 26's disposable gown hampers were observed touching the PPE isolation carts. RN 2 acknowledged the disposable gown hamper should not be in contact with the PPE isolation cart due to the potential risk of contamination. RN 2 verified the above findings. 8b. On 5/15/25 at 0515 hours, an observation and concurrent interview was conducted with CNA 4. CNA 4 was observed assisting Resident 18 with incontinent care and dressing. CNA 4 was observed without a gown while providing assistance to Resident 18. An EBP signage was observed outside of the resident's room. When asked about the EBP guidelines for Resident 18, CNA 4 walked outside of the resident's room and stated she should have worn the gown. CNA 4 verified the above findings. 5. On 5/13/25 at 1040 hours, during the initial tour of the facility, an EBP signage was observed posted outside the door of Resident 9's room, and a bin labeled Disposable Gown Hamper and an isolation cart containing gowns were observed on the entrance of the Resident 9's room. The hamper was observed to be full of soiled gowns, preventing the lid from fully closing. Additionally, the hamper was in direct contact with the isolation cart. On 5/13/25 at 1254 hours, an observation for Resident 9's room and concurrent interview was conducted with the DSD/IP. A bin labeled Disposable Gown Hamper and an isolation cart containing gowns were observed on the entrance of the Resident 9's room. The hamper was observed to be full of soiled gowns where the sleeves of the soiled gowns were observed hanging over the edge and falling over the side of the hamper, preventing the lid from fully closing. Additionally, the hamper was in direct contact with the isolation cart. The DSD/IP verified the above findings. The DSD/IP stated the soiled gown hamper and the isolation cart should not be in contact with each other, and must be separated by a clear gap. On 5/16/25 at 0647 hours, an interview was conducted with the Housekeeper. The Housekeeper stated he helped clean the room, and he constantly emptied the trash and hampers for the isolation gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 9 was initiated on 5/13/25. Resident 9 was initially admitted on [DATE], and was readmitted to the facility on [DATE]. Review of Resident 9's plan of care showed a care plan problem dated 4/14/25, to address placing the resident on EBP due to the indwelling urinary catheter and wound. 6. On 5/13/25 at 1106 and 1224 hours, an EBP signage was observed posted outside the door of Resident 346's room, and a bin labeled Disposable Gown Hamper and an isolation cart containing gowns were observed on the entrance of Resident 346's room. The hamper was in direct contact with the isolation cart and there was no clear gap between the hamper and isolation cart. On 5/13/25 at 1259 hours, an observation for Resident 346's room and concurrent interview was conducted with the DSD/IP. A bin labeled Disposable Gown Hamper and an isolation cart containing gowns were observed at the entrance of Resident 346's room. The hamper was in direct contact with the isolation cart, there was no clear gap between the hamper and isolation cart. The DSD/IP verified the above findings. Medical record review for Resident 346 was initiated on 5/13/25. Resident 346 was admitted to the facility on [DATE]. Review of Resident 346's plan of care showed a care plan problem dated 4/26/25, to address Resident 346's indwelling urinary catheter. The interventions included implementing EBP. Based on observation, interview, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure Resident 597's onset date of infection on the monthly Infection Prevention and Control Surveillance Log was accurate. * The facility failed to ensure Resident 599's onset date of infection on the monthly Infection Prevention and Control Surveillance Log was accurate. * The facility failed to ensure the pending cultures for Residents 8 and 598 were updated on the Infection Prevention and Control Surveillance Log's Organism for March 2025. In addtion, the facility failed to ensure Resident 8's pending culture was followed up. * The facility failed to ensure the pending culture for Resident 645 on the Infection Prevention and Control Surveillance Log's Organism on Culture column for April 2025 was updated. * CNA 3 failed to perform hand hygiene after delivering the food tray to Room C and before delivering the food tray to Room B. In addition, Room C had an EBP signage on the wall by the entrance door. * The facility failed to ensure the PPE cart was not touching the soiled disposable gown hamper in Room A. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* The facility failed to ensure the PPE cart was not touching the soiled disposable gown hamper in Room D. * The facility failed to ensure the soiled gown hamper was not in direct contact and separated by a clear, visible gap with the PPE isolation cart for Residents 9 and 345. In addition, the facility failed to ensure Resident 9's soiled gown hamper was not overflowing with soiled gowns preventing the lid from being fully closed. These failures posed the risk of not identifying infections and controlling the transmission of communicable disease to other resident through the facility. Findings: 1.a. According to HealthIT.gov, the date of onset often is the defining date for the beginning of a reportable condition and is used to classify cases and detect outbreaks and clusters. Exposures must be investigated in relation to the onset date. If the onset date is not captured as a distinct structural data point, public health staff must dig for it in notes or other parts of the medical record and it is inevitably vague and sometimes missing. Date of diagnosis is not the same as date of onset. Date of onset is defined as the first clinical symptom or sign for a particular condition. Review of the facility's P&P titled Infection Prevention and Control Program revised 3/6/25, showed the medical criteria and standardized definitions of infections are used to help recognize and manage infections. Review of Resident 597's Revised McGeer Criteria for Infection Surveillance Checklist showed the date of infection was 2/17/25. Review of the Infection Prevention and Control Surveillance Log for February 2025 showed the Onset Date column for Resident 597 was 2/18/25. On 5/15/25 at 0921 hours, an interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP verified Resident 597's onset date on the Infection Prevention and Control Surveillance log was 2/18/25, and the date of infection from the Revised McGeer Criteria for Infection Surveillance Checklist was 2/17/25. The DSD/IP stated the onset date on the surveillance log was the start of the Resident 597's antibiotic and not the start of the infection. The DSD/IP stated Resident 597's infection started on 2/17/25. On 5/15/25 at 1607 hours, an interview and concurrent facility document review was conducted with the DON. The DON acknowledged the above findings. The DON stated the onset date on the surveillance log was when the facility started the antibiotic and when it was ordered so they could identify if it was HAI or CAI. b. Review of the Infection Prevention and Control Surveillance Log for March 2025 showed the Onset Date column for Resident 599 was 3/8/25. Review of Resident 599's Revised McGeer Criteria for Infection Surveillance Checklist showed the date of infection was 3/6/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/25 at 1025 hours, an interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP verified Resident 599's onset date on the Infection Prevention and Control Surveillance log was dated 3/8/25, and the date of infection from the Revised McGeer Criteria for Infection Surveillance Checklist was on 3/6/25. The DSD/IP stated Resident 599's infection started on 3/6/25. The DSD/IP stated she would ask the IP consultant for the infection onset date and where to log the start of the residents' antibiotic. On 5/15/25 at 1637 hours, an interview and concurrent facility document review was conducted with the DON. The DON acknowledged above findings. 2.a. Review of the facility's P&P titled Infection Prevention and Control Program revised 3/6/25, showed the infection prevention and control committee is responsible for reviewing and providing feedback on the overall program. Surveillance data and reporting information is used to inform the committee of potential issues and trends. Some examples of committee reviews may include: - whether the information about culture results or antibiotic resistance is transmitted accurately and in timely fashion; and -whether there is appropriate follow-up of acute infections. Review of the Infection Prevention and Control Surveillance Log's Organism on Culture column for March 2025 showed pending cultures for Residents 8 and 598. On 5/15/25 at 1010 hours, an interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP verified the Infection Prevention and Control Surveillance Log's Organism on Culture column for March 2025 showed pending culture for Residents 8 and 598. The DSD/IP stated she should have updated the surveillance log when the laboratory results were received and reviewed from the acute care hospital. The DSD/IP stated if she never received the culture, it would be a pending culture. On 5/15/25 at 1403 hours, a follow-up interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP stated she followed up on Resident 598's pending culture and showed a positive urine culture result. The DSD/IP also acknowledged she did not follow-up on Resident 8's pending culture. The DSD/IP stated the urine culture for Resident 8 was canceled in the acute care hospital. The DSD/IP stated she did not remember how it was communicated and she did not find any communication notes for pending and cancelled culture in Resident 8's medical record. On 5/15/25 at 1629 hours, an interview and concurrent facility document review was conducted with the DON. The DON acknowledged the above findings. The DON stated the Infection Prevention and Control Surveillance Log form should have been completed. b. Review of the Infection Prevention and Control Surveillance Log's Organism on Culture column for April 2025 showed pending culture for Resident 645. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/25 at 1045 hours, an interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP verified the Infection Prevention and Control Surveillance Log's Organism on Culture column showed pending results from Hospital A for Resident 645. The DSD/IP stated Resident 645 had positive urine culture result but she forgot to update the log. The DSD/IP stated she should have updated the log for accuracy. On 5/15/25 at 1645 hours, an interview and concurrent facility document review was conducted with the DON. The DON acknowledged the above findings. 3. Review of the facility's P&P titled Handwashing/Hand Hygiene revised 8/2015 showed this facility considers hand hygiene the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situation: Before and after assisting a resident with meals. Review of the facility's P&P titled Enhanced Barrier Precaution (EBP) updated 6/20/24, showed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of the facility's EBP signage showed everyone must clean their hands, including before entering and when leaving the room. On 5/13/25 at 1227 hours, CNA 3 was not observed performing hand hygiene after delivering the food tray in Room C. Room C had an EBP signage on the wall by the entrance door. CNA 3 grabbed a meal tray from the meal cart and delivered the meal tray to Room B without performing hand hygiene. On 5/13/25 at 1237 hours, an interview was conducted with CNA 3. CNA 3 stated he put Resident 17's tray down on the side table and removed the cover of the plate when he was in Room C. CNA 3 verified he did not perform hand hygiene after delivering the food tray to Room C and before delivering the food tray to Resident 33 in Room B. CNA 3 stated he usually performed hand hygiene but forgot to perform hand hygiene at the time. CNA 3 stated he should have done hand hygiene to remain free from germs. On 5/14/25 at 1556 hours, an interview was conducted with the DSD/IP. The DSD/IP acknowledged the above findings. The DSD/IP stated CNA 3 should have sanitized his hands, grabbed the tray, placed the tray on the resident's bedside table, removed the lid of the plate, sanitized his hands after coming out of the room, grabbed another tray, and gave the tray to the other resident. 4.a. Review of the facility's P&P titled Infection Prevention and Control Program revised 3/6/25, showed the prevention of infection by instituting measures to avoid complications or disseminations. On 5/13/25 at 0815 hours, during the initial tour of the facility, a PPE cart was observed touching the soiled disposable gown hamper in Room A. On 5/13/25 at 1029 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified the PPE cart was touching the soiled disposable gown hamper in Room A. CNA 3 stated the PPE cart should be separated from the disposable gown hamper because it could cause cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/25 at 1223 hours, an observation and concurrent interview was conducted with the ADON. The ADON stated the facility's staff put the soiled disposable gown on the black hamper. The ADON verified the PPE cart was touching the disposable gown hamper in Room A. b. On 5/13/25 at 0835 hours, during the initial tour of the facility, a PPE cart was observed touching the soiled disposable gown hamper in Room D. On 5/13/25 at 1021 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified the PPE cart was touching the soiled disposable gown hamper in Room D. CNA 3 stated the PPE cart should be separated from the disposable gown hamper because it could cause cross contamination. On 5/13/25 at 1223 hours, an observation and concurrent interview was conducted with the ADON. The ADON verified the PPE cart was touching the disposable gown hamper in Room D. The ADON stated the PPE cart should not be close to the soiled disposable gown hamper but they were in a separate bin. On 5/14/25 at 1608 hours, an interview was conducted with the DSD/IP. The DSD/IP acknowledged the above findings. The DSD/IP stated the public health knew the PPE cart was close to the disposable gown hamper. The DSD/IP stated the consultant stated to continue providing little gap between the containers to avoid the PPE cart from touching the disposable gown hamper. On 5/15/25 at 0921 hours, a follow-up interview was conducted with the DSD/IP. The DSD/IP stated she called the Orange County PHN and she recommended a space between the clean PPE cart and the soiled gown hamper to avoid the dirty container touching a clean container. On 5/16/25 at 1337 hours, the Administrator and DON were informed and acknowledged the above findings.

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F 0881 Level of Harm - Potential for minimal harm Residents Affected - Some	Implement a program that monitors antibiotic use. **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 implement the antibiotic stewardship program. * The facility failed to ensure the McGeer criteria (criteria used by long-term care facilities to determine a true infection) for true infection was completed and accurate for one nonsampled residents (Resident 597) . This failure had the potential for inaccurately identifying the true infections and potentially inhibiting the residents from receiving the appropriate treatment and care. Findings: According to the CDC, antibiotics are some of the most commonly prescribed medications in nursing homes. Over the course of a year, up to 70% of nursing home residents get an antibiotic. Roughly 40% to 75% of antibiotics are prescribed incorrectly. In nursing homes, high rates of antibiotics are prescribed to prevent UTI and RTI. Prescribing antibiotics before there is an infection often contributes to misuse. Often residents are given antibiotics just because they are colonized with (carrying) bacteria that are not making the person sick. Prescribing antibiotics for colonization contributes to antibiotic overuse. When patients are transferred between facilities, for example from a nursing home to a hospital, poor communication between facilities about prescribed antibiotics (e.g., rationale, number of days) plus insufficient infection control practices can result in antibiotic misuse and the spread of antibiotic resistance. Antibiotic-related harms, such as diarrhea from C. difficile (a bacterium that can cause severe diarrhea and inflammation of the colon) can be severe, difficult to treat, and lead to hospitalizations and deaths, especially among people over age [AGE]. Review of the facility's P&P titled Antibiotic Stewardship Program (ASP) revised 6/2021 showed to establish an ASP to promote appropriate use of antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use. The Action - Changes in Policy and Procedures section showed the facility will utilize McGeer's criteria when making decision to use antibiotics empirically. Medical record review for Resident 597 was initiated on 5/15/25. Resident 597 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 597's MDS assessment dated [DATE], showed Resident 597 was cognitively intact. Review of Resident 597's Revised McGeer Criteria for Infection Surveillance Checklist dated 2/17/25, showed the UTI criteria was met. However, only one of the criterion was fulfilled for the UTI surveillance definitions. Review of Resident 597's Order Summary Report dated 5/15/25, showed a physician's order dated 2/18/25, to administer cephalexin (antibiotic) 250 mg one tablet by mouth three times a day for UTI for seven days. (continued on next page)

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F 0881 Level of Harm - Potential for minimal harm Residents Affected - Some	On 5/15/25 at 0926 hours, an interview and concurrent medical record review was conducted with the DSD/IP. The DSD/IP verified Resident 597's Revised McGeer Criteria for Infection Surveillance Checklist showed the box was checked for the UTI criteria met, even though only one criterion was fulfilled for the UTI surveillance definitions. Moreover, the Revised McGeer Criteria for Infection Surveillance Checklist showed Resident 597's signs and symptoms of UTI were fulfilled and the microbiologic criteria was not fulfilled. The DSD/IP acknowledged two criteria must be fulfilled for the McGeer criteria for the UTI to be met. The DSD/IP stated Resident 597's second McGeer criteria for UTI was fulfilled but she forgot to check the box. When asked how she determined a true infection, the DSD/IP stated it was a true infection if she checked the boxes that met the criteria in the Revised McGeer Criteria for Infection Surveillance Checklist. On 5/15/25 at 1607 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 2.a. On 5/13/25 at 1056 hours, an inspection of the facility's medication refrigerator was conducted with the DSD. The freezer compartment located inside this medication refrigerator was observed to have ice buildup. Some of the ice buildup was starting to melt and water drops were observed falling down onto the medication packages and medication bags stored directly below the freezer compartment. These findings were verified with the DSD. The DSD stated the nurses were responsible for doing a follow-up to defrost the refrigerators. Review of the temperature log showed LVN 4 last checked the medication refrigerator. On 5/20/25 at 1514 hours, a telephone interview was conducted with LVN 4. LVN 4 stated she did not remember when the medication refrigerator was last defrosted. When asked if any documentation was kept related to the last time the refrigerator was defrosted, LVN 4 stated there was no documentation kept related to defrosting the refrigerators. b. On 5/13/25, at 1111 hours, a central supply inspection was conducted with Central Supply 1. Inside the Central Supply Storage Room A, a specimen refrigerator was observed. When Central Supply 1 was asked to open the specimen refrigerator, ice buildup was observed inside the freezer compartment of the refrigerator. 5/14/25 at 1411 hours, the DON was shown the ice buildup observed inside the specimen refrigerator and inside the medication refrigerator. The DON was unable to explain the reason(s) for the ice buildup observed. c. On 5/15/25 at 1045 hours, a tour of the facility's rehabilitation area was conducted with PT 1. Inside the OT Room, OTA 1 was observed cleaning a velcro wrist blood pressure machine. The blood pressure machine was observed with two pieces of clear tape on the sides of the machine's face plate. The finding was verified with PT 1 and OTA 1. When asked what brand the machine was, both PT 1 and OTA 1 verified the machine did not have a name on it. When asked why the blood pressure machine's face plate had pieces of clear tape on it, OTA 1 verbalized the tape was used to hold the blood pressure machine together. 3. Review of the Assure Platinum Blood Glucose Monitoring System Quality Assurance/Quality Control Reference Manual (undated), under the Quality Checks section, showed the following: - To perform a control solution test, before testing with the Assure Platinum System for the first time, when a new bottle of test strips was opened, whenever meter or test strips may not be functioning properly, if the test results appear to be abnormally high or low, or are not consistent, when the test strip bottle has been left open or exposed to temperatures below 39 degrees F or above 86 degrees F, or humidity levels above 8%, to check technique, when the Assure Platinum Meter has been dropped or stored below 32 degrees F or above 122 degrees F, and each time the batteries are changed; and - The Step 5 in performing a control solution test showed to compare the result to the range printed on the test strip bottle. Make sure the result is within the acceptable range. If the result falls within range, the meter and test strip are working correctly. Do not use system if control solution result is out of range. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's document titled List of Residents on Blood Sugar Check (undated) for Medication Cart A showed six residents were on the list for the blood sugar checks. On 5/15/25 at 0639 hours, an inspection of the glucometer in Medication Cart A and concurrent facility document review and interview was conducted with LVN 2. LVN 2 stated there was one glucometer for each cart. When asked about glucometer calibration, LVN 2 stated the night shift nurses performed the glucometer calibration nightly between 1900 to 0700 hours. LVN 2 stated the glucometer calibration was documented in the quality control record. Review of the facility's document titled Assure Platinum Blood Glucose Monitoring System: Quality Control Record for May 2025 showed the following: - The serial number 1040-4047897 documented on the record did not match the serial number 1040-4340423 of the glucometer machine found inside Medication Cart A; - The normal control range of 84-104 mg/dl documented on the record from 5/7 to 5/12/25, and 5/14/25, did not match the Level 1 range of 86-108 mg/dl printed on the test strip bottle with lot number 634015U; and - The high control range of 201-251 mg/dl documented on the record from 5/7 to 5/12/25, and 5/14/25, did not match the Level 2 range of 215-269 mg/dl printed on the test strip bottle. LVN 2 verified the above findings. On 5/16/25 at 0818 hours, an interview and concurrent facility document review was conducted with the DSD/IP. The DSD/IP stated the glucometer calibration should be performed if a new glucometer was being used, and the nurses should write the serial number of the new glucometer on the quality control record. Cross reference to F726. Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain the essential equipment in a clean and safe operating condition when: * The ice machine located in Kitchen B was not clean and the manufacturer's guidelines for cleaning and sanitizing were not followed. * The wrist velcro blood pressure machine was held together with a clear tape * The medication refrigerator's freezer compartment was observed with ice build-up * The refrigerator used to store specimen was observed with ice build-up in the freezer compartment * The facility failed to ensure LVN 2 accurately calibrated the glucometer in Medication Cart A. These failures had the potential for the essential equipment not to function in the way it was intended and exposed residents to unsafe practices and may lead to negative outcomes. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings: 1. Review of the facility's census dated 5/13/25, showed 53 of 54 residents consumed food prepared in the kitchen. Review of the facility's P&P titled Ice Machine Cleaning procedure dated 2018 showed the ice machine (bin and internal components), will be cleaned monthly and the date recorded when cleaned. The Maintenance Supervisor can keep this record, or it can be posted on the ice machine. Information about the operation and care of the ice machine can be obtained from manual, the manufacturer and/or in the direction panel on the inside of the ice machine. Clean inside of ice machine with a sanitizing agent per manufacturer's instructions. Add instructions to your policies or use manufacturer procedures to clean and sanitize the machine. On 5/14/25 at 1322 hours, an interview was conducted with the DSS. The DSS stated the Maintenance Supervisor maintained the cleaning and sanitizing of the ice machine in Kitchen B. On 5/14/25 at 1411 hours, an observation of the ice machine in Kitchen B and concurrent interview with the Maintenance Supervisor, Regional RD, and DSS was conducted. The top front cover of the ice machine was removed. The ice machine was wiped with a clean white towel and brown residue was removed from the left side panel of the bin. The Maintenance Supervisor was asked when the ice machine cleaning was last completed. The Maintenance Supervisor stated the ice machine was cleaned every six months and was not able to provide documentation when the last time the ice machine was cleaned. When the Maintenance Supervisor was asked if he was aware of the brown buildup as identified during the ice machine inspection, the Maintenance Supervisor stated he was not aware. The Maintenance Supervisor, Regional RD, and DSS verified the above findings.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility P&P review, and facility document review, the facility failed to conduct a regular bed inspection as part of a regular maintenance program to identify areas of possible entrapment for two of two final sampled residents (Residents 17 and 344). This failure had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: 1. According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Proper Use of Side Rails revised 12/2016 showed when side rail usage is appropriate, the facility will assess between the mattress and side rails to reduce the risk for entrapment, the amount of safe space may vary, depending on the type of bed and mattress being used. Review of the facility's P&P titled Bed Safety revised 12/2007 showed to try to prevent death/ injuries from the beds and related equipment, including the frame, mattress, side rails, headboard, footboard and bed accessories, the facility shall promote the following approaches: - Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review gaps within the bed system are within the dimensions established by the FDA. Note: The review shall consider situations that could be caused by the resident's weight, movement or bed position; and - Identify additional safety measure for residents who have been identified as having a higher than usual risk for injury including entrapment such as altered mental status, restlessness, etc. A concurrent observation, medical record review, and facility document review for Residents 17 and 344 showed there were no regular bed inspection conducted as part of a regular maintenance program, and the residents' bed entrapment assessments were not conducted. For example: On 5/13/25 at 1132 and 1426 hours, on 5/14/25 at 1049 hours, on 5/16/25 at 0646 and 0800 hours, Resident 344 was observed asleep in bed. Bilateral halo rails were observed elevated. Medical record review for Resident 344 was initiated on 5/13/25. Resident 344 was admitted to the facility on [DATE]. Review of Resident 344's H&P evaluation dated 5/6/25, showed Resident 344 had the capacity to understand and make decisions; however, the mental clarity was fluctuated due to multiple comorbidities and medications. Review of Resident 344's Device Evaluation Tool V.2 dated 5/5/25, showed Resident 344 required a two-person extensive assistance for gait, bed mobility, and transfers. Review of Resident 344's Order Summary Report showed a physician's order dated 5/5/25, for bilateral grab rails for ease/comfort and promote independence in bed mobility, transfer, and repositioning as enabler. On 5/16/25 at 0824 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 344 was alert and oriented, but very weak. CNA 1 further stated Resident 344 could move his arms and roll to the side by using the halo rails. On 5/16/25 at 0956, an interview and concurrent medical record review for Resident 344 was conducted with RN 1. RN 1 stated if the resident or a family member requested for the side rails, the PT or rehabilitation staff needed to evaluate the resident first. RN 1 stated the nurses obtained a physician's order for the side rails, verified the consent for the side rails, completed the assessment, and initiated the care plan to address the use of the side rails. RN 1 stated if there was an indication for the side rails, the nurses verbally informed the maintenance staff to install the side rails. When asked about the entrapment assessment, RN 1 stated she was not sure about the entrapment assessment. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/25 at 1020 hours, an interview for Resident 344 was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated he was responsible for the monthly bed inspection in the facility, including checking the bed frame, foot board, headboard, bed remote control, call light system, side rails, and mattress, and also the repairs needed for the resident beds. When asked for any documentation of the monthly bed inspection conducted for any of the beds in the facility, the Maintenance Supervisor stated he had done the monthly bed inspection visually and could not provide any documentation. The Maintenance Supervisor stated the ADON verbally informed him if side rails needed to be installed, and the maintenance staff installed the side rails. When asked about the entrapment assessment, the Maintenance Supervisor stated he was familiar with the different zones of entrapment but did not perform any entrapment assessment as part of his monthly bed inspection. The Maintenance Supervisor further stated he had not seen any bed inspection logs, including entrapment assessments from the previous Maintenance Supervisor, and he did not have a measuring device to perform the entrapment assessment. 2. On 5/13/25 at 0826 hours, during the initial tour of the facility, Resident 17 was observed lying in bed with the bilateral grab bars elevated. Resident 17 stated she used the grab bar to get up from the bed. Medical record review for Resident 17 was initiated on 5/13/25. Resident 17 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 17's MDS assessment dated [DATE], showed Resident 17 was cognitively intact. Review of Resident 17's Order Summary Report dated 4/30/25, showed a physician's order dated 4/14/25, to apply bilateral grab rail for ease and comfort in bed mobility, transfer and repositioning as enabler every shift. Further medical record review and facility document review for Resident 17 failed to show documented evidence the entrapment assessment was completed for Resident 17's use of the bilateral grab rail. On 5/14/25 at 1359 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified Resident 17's bilateral grab bars were elevated. CNA 3 stated Resident 17 used the bilateral grab bars for turning side to side in bed. On 5/16/25 at 0812 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified he did not measure Resident 17's bed entrapment zones. Moreover, the Maintenance Supervisor stated he did not measure the bed's entrapment zones in the facility. The Maintenance Supervisor stated he did not measure the bed's entrapment zones because the residents were in the facility for a short term period. The Maintenance Supervisor stated he did not have the tool for measuring the bed's entrapment zones. The Maintenance Supervisor further stated he never asked for the tool for measuring the bed's entrapment zones because he was not sure if he had to use it in this facility. The Maintenance Supervisor stated the entrapment zones should have been measured for Resident 17's safety. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/25 at 0837 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON acknowledged Resident 17's bed had no entrapment assessment completed for the use of the bilateral grab rails. The ADON stated the facility staff did not specifically complete the entrapment assessment but did complete an assessment related to the use of the device. The ADON stated the entrapment assessment was important to determine if the assistive device could cause Resident 17 not to move freely or to be entrapped. On 5/16/25 at 0920 hours, an interview was conducted with the Administrator. The Administrator acknowledged the above findings. The Administrator stated the facility did not use the side rails but used grab bars or halo rail for repositioning. The Administrator stated before the Maintenance Supervisor started working in the facility, the facility borrowed the bed entrapment tool device from another facility to complete the entrapment assessment.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, facility document review, and facility P&P review, the facility failed to maintain an effective pest control program to prevent the presence of flies in the kitchen. This failure had the potential to lead to food borne illnesses (illness caused by food contaminated with bacteria, viruses, parasites or toxins) for the facility residents who consumed food prepared in the kitchen. Findings: Review of the Diet Order Tally Report dated 5/14/25, showed 53 of 54 residents consumed food prepared in the kitchen. According to the USDA Food Code 2022, 6-501.111, Controlling Pests, insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments. Review of the facility's P&P titled Pest Control revised 5/2008 showed the facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. Review of the facility's document titled Orkin Service Report dated 4/1/25, showed the following actions and observations from the previous service date of 3/25/25: - Flies were observed in the kitchen area(s) and drains. - The kitchen was checked for any pest activity and treated as needed. - The floor drains were serviced to control and/or prevent flies from breeding. Review of the facility's document titled Orkin Pest Control dated 5/13/25 at 0419 to 0526 hours, showed the kitchen area was inspected and treated. Food debris was found under the shelves, sinks, cooking area, and coolers. The recommendation showed to clean the areas for pest prevention. On 5/13/25 at 0824 hours, an observation and concurrent interview was conducted with the CDM. Flies were observed flying in Kitchen A area, where the dishwashing machine was located. The CDM acknowledged the presence of the flies in the kitchen and stated the stagnant water on the floor caused the flies to be present in the dishwashing area. On 5/16/25 at 1325 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.