STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555473	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Gardens Care Center	13075 Blackbird Street Garden Grove, CA 92843

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility's P&P review, the facility failed to ensure the residents or their representatives were informed in advance of the proposed treatment regarding the use of psychotropic medications (medications affecting brain activity) for five of five residents reviewed for unnecessary medication (Residents 9, 25, 28, 38, and 47). * The facility failed to ensure the informed consent was obtained from Resident 28 or their representative before administering the sertraline (antidepressant medication) medication to Resident 28. In addition, the facility failed to ensure the informed consent was obtained from Resident 28 or their representative when the Ativan (antianxiety medication) medication was changed to be administered routinely (once a day from as needed). * The facility failed to ensure the informed consent was obtained from Resident 47 or their representative when the duration of the hydroxyzine (used to relieve anxiety and tension) medication used for inability to relax was changed. In addition, the facility failed to ensure the informed consent was obtained from Resident 47 or their representative before the administration of the prazosin (used to treat high blood pressure but a common off-label treatment for PTSD (Post Traumatic Stress Disorder)-associated nightmares) medication prescribed for nightmares. * The facility failed to ensure the informed consent for the Risperdal (antipsychotic medication) medication indicated the non-pharmacologic measures for Resident 25. * The facility failed to ensure the informed consent for the Zoloft (antidepressant) medication indicated the non-pharmacologic measures for Resident 9. * The facility failed to ensure the informed consent for the escitalopram (antidepressant) medication included the indication and manifested behaviors for Resident 38. These failures had the potential to compromise the resident's right, or the right of her designated representative, to be fully informed regarding the psychotropic medication, its indication, the manifested behaviors, possible non-pharmacological interventions, and its potential side effects, in order to make an informed decision.Findings: Review of the facility P&P titled Psychotropic Medication Use dated 2/2025 showed prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: - non- pharmacological alternatives; - the indications and rational for the recommendation; - the potential risk and benefits (including possible side effects, adverse consequences, and black box warnings); and - the resident's/representative's right to accept or decline the treatment. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Medical record review for Resident 28 was initiated on 2/11/26. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 9/23/25, showed Resident 28 had the capacity to understand and make decisions. Review of Resident 28's Physician's Order Summary showed the following physician's orders: - dated 9/17/25, to administer sertraline (antidepressant medication) HCL (hydrochloride) oral tablet 25 mg one tablet by mouth one time a day for depression as manifested by verbalizing sadness. - dated 1/20/26, to administer Ativan oral tablet 1 mg one tablet by mouth one time a day for anxiety, restlessness as manifested by overly concern about health. Further review of the physician's order showed the informed consent was obtained by the physician from Resident 28 after explanation of risk and benefits of medication. a. Review of Resident 28's Psychotropic Medication Administration Disclosure (Anti-Depressant) showed sertraline 25 mg per oral every day for depression as manifested by verbalizing sadness. The document showed the medication benefits, potential adverse reactions, and special concerns were explained. Further review of the document showed that the informed consent was obtained on 9/23/25, which was five days after the medication was started. b. Review of Resident 28's Psychotropic Medication Administration Disclosure (Anti-Anxiety) dated 12/22/25, showed Ativan 1 mg once a day as needed for anxiety as manifested by verbalization of anxiousness (overly concern about health) for 30 days. The document showed the medication benefits, potential adverse reactions, and special concerns were explained. However, further review of Resident 28's medical record did not show documentation the informed consent was obtained from Resident 28 or their representative when the Ativan medication was changed from as needed to once daily. On 2/18/26 at 0824 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 2. RN 2 verified Resident 28's sertraline medication was ordered on 9/17/25, with the start date of 9/18/25. RN 2 verified the informed consent was obtained on 9/23/25 (five days after the medication was started). RN 2 also verified Ativan 1mg medication order was changed from as needed to once daily on 1/20/26, for Resident 28. RN 2 stated she was not able to find the documentation to show if the informed consent was obtained when the frequency of the Ativan medication administration was changed from as needed to once daily. 2. Medical record review for Resident 47 was initiated on 2/11/26. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's H&P examination dated 6/23/25, showed Resident 47 had the capacity to understand and make decisions. Review of Resident 47's Order Summary Report showed the following physician's orders: - dated 2/11/26, to administer prazosin HCL one capsule by mouth at bedtime for nightmares. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 12/9/25, to administer hydroxyzine pamoate 25 mg oral capsule by mouth three times a day for agitation/anxiety as manifested by inability to relax. a. Review of Resident 47's Psychotropic Medication Administration informed consent dated 10/27/25, showed the antianxiety medication hydroxyzine pamoate 25 mg every eight hours for 30 days for agitation/anxiety as manifested by inability to relax. The document showed the medication benefits, potential adverse reactions, and special concerns. However, further review of Resident 47's medical record did not show documentation the informed consent was obtained when the duration of the hydroxyzine pamoate 25 mg medication was changed from 30 days to a routine order with no stop date. b. Review of Resident 47's medical record did not show if the informed consent was obtained from Resident 47 or their representative before the administration of the prazosin medication prescribed for nightmares. On 2/18/26 at 0917 hours, an interview and concurrent medical record review for Resident 47 was conducted with RN 2. RN 2 verified Resident 47 was receiving the hydroxyzine pamoate 25 mg medication and the medication order was changed from 30 days to a routine order with no stop date on 12/9/25. RN 2 verified the informed consent for the hydroxyzine medication was not obtained when the medication was changed from 30 days to a routine with no stop date. In addition, RN 2 verified she could not find the documentation to show if the informed consent for the prazosin medication used for nightmares was obtained for Resident 47. On 2/18/26 at 1147 hours, an interview and concurrent medical record review for Residents 28 and 47 was conducted with the DON. The DON stated the prazosin medication was used off-label as a psychotropic medication and the informed consent should have been obtained. The DON further stated the informed consent should have been obtained before the administration of the psychotropic medication, and when the frequency and duration of the medication was changed. The DON was informed and acknowledged the above findings. 3. Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the facilities may use the CDPH (California Department of Public Health) Psychotherapeutic Drug Informed Consent Form or use their own in-house form as long as the in-house form contains all the data elements on the CDPH form. The form must be in use by January 1, 2026, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the CDPH 9168 document titled Psychotherapeutic Drug Informed Consent Form dated 12/2025 showed to include the following psychotherapeutic drug information: drug category, drug name, dosage prescribed, frequency, duration, administration method, caution and earning summary, reason for use of the psychotherapeutic drug and benefits, the probable side effects and significant risks associated with the use of the psychotherapeutic drug, and the reasonable alternative mode(s) of treatment or possible non-pharmacological approaches that could address the resident's needs. Medical record review for Resident 9 was initiated on 2/11/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 5/5/25, showed Resident 9 had no capacity to (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understand and make medical decisions. Review of Resident 9's Order Summary Report showed a physician's order dated 11/26/25, to administer Zoloft 25 mg tablet by mouth one time a day for anxiety manifested by defecating on the floor. Further review of the physician's order showed the informed consent was obtained by the physician with the resident representative. Review of Resident 9's Psychotropic Medication Administration Disclosure (Antianxiety) showed for the Zoloft 25 mg medication, Resident 9's responsible party was informed on 11/24/25. However, further review of the form failed to show the list of possible non pharmacological approaches that could address the resident's behavior related to the use of Zoloft medication. On 2/18/26 at 1016 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 4. LVN 4 verified the Psychotropic Medication Administration Disclosure (Antianxiety) for the Zoloft 25 mg medication for Resident 9 did not show the list of the possible non pharmacological approaches that could address the resident's behavior related to the use of Zoloft medication. On 2/18/26 at 1511 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. Medical record review for Resident 25 was initiated on 2/11/26. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 12/8/25, showed Resident 25 had no capacity to understand and make medical decisions. Review of Resident 25's Order Summary Report showed a physician's order dated 3/31/25, to administer Risperdal 0.5 mg one tablet by mouth at bedtime for psychosis as manifested by aggressive behavior and striking out. Further review of the physician's order showed the informed consent was obtained by the physician from the resident representative after explanation of possible risk and benefits. Review of Resident 25's Psychotropic Medication Administration Disclosure dated 10/13/25, for Risperdal 0.5 mg at bedtime did not show the list of the possible non pharmacological approaches that could address the resident's behavior related to the use of Risperdal medication. On 2/18/26 at 1020 hours, an interview and concurrent medical record review for Resident 25 was conducted with RN 2. RN 2 verified the above findings and stated the Psychotropic Medication Administration Disclosure for the Risperdal 0.5 mg medication did not include the list of the possible non pharmacological interventions to address the resident's behaviors related to the use of Risperdal medication. On 2/18/26 at 1512 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. Medical record review for Resident 38 was initiated on 2/11/26. Resident 38 was admitted to the facility on [DATE]. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 38's Order Summary Report dated 2/17/26, showed a physician's order dated 1/8/26, to administer escitalopram 20 mg one tablet by mouth one time a day for anxiety manifested by unable to keep still. Review of Resident 38's Psychotropic Medication Administration Disclosure showed for the escitalopram 20 mg daily, Resident 38's responsible party was informed on 1/8/26. However, further review of the form failed to show the indication and behavior manifestations for the use of the escitalopram medication. On 2/17/26 at 1033 hours, an interview and concurrent medical record review for Resident 38 was conducted with LVN 4. LVN 4 verified Resident 38's informed consent for the escitalopram medication did not include the indication and manifested behaviors. On 2/17/26 at 1514 hours, an interview was conducted with the DON. The DON stated for the residents prescribed with psychotropic medications, the informed consent should include the type of medication, name, dose, route, frequency, duration of use, indications and manifested behaviors. On 2/18/26 at 1453 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure five of five final sampled residents (Residents 3, 9, 28, 38,and 47) reviewed for the unnecessary medications were free from the unnecessary psychotropic medications. * The facility failed to ensure Resident 47 was monitored for the number of episodes of nightmares related to the use of prazosin (medication used to treat high blood pressure; also widely used as off-label medication to manage nightmares and sleep issues). * The facility failed to ensure the nonpharmacological interventions were provided to Resident 28 when Resident 28 had six behavior episodes related to the use of Ativan (medication used to relieve anxiety). * The facility failed to ensure Resident 38 who was on the aripiprazole (antipsychotic) medication was monitored for orthostatic hypotension [a sudden drop in blood pressure, greater than or equal to 20mmHg for the systolic (upper blood pressure reading) or greater than or equal to 10 mmHg for the diastolic (lower blood pressure reading) occurring within three minutes of standing when compared with blood pressure from the sitting or laying on their back]. * The facility failed to ensure Resident 3's orthostatic blood pressure was monitored and accurately documented for the use of the Seroquel (antipsychotic) medication. * The facility failed to ensure the monthly summary of behaviors targeted for the use of Zoloft (medication to treat depression and antianxiety) medication was completed for Resident 9. These failures had the potential for adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dosage of psychotropic medications.Findings: Review of facility's P&P titled Psychotropic Medication Use dated 2/2025 showed resident do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction. Further review of the P&P showed residents receiving psychotropic medication are monitored and the response to treatment is documented. Monitoring may include lab results, vital signs, progress notes, behavior flow sheet, medication administration records, and the drug regimen review from the consultant pharmacist. 1. Medical record review for Resident 47 was initiated on 2/11/26. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's H&P examination dated 6/23/25, showed Resident 47 had the capacity to understand and make decisions. Review of Resident 47's Order Summary Report showed a physician's order dated 2/11/26, to administer prazosin HCL (hydrochloride) 1 mg capsule by mouth at bedtime for nightmares. Review of Resident 47's medical record did not show if the behavior of nightmares related to the use of the prazosin medication was monitored. On 2/18/26 at 0917 hours, an interview and concurrent medical record review for Resident 47 was conducted with RN 2. RN 2 verified the physician's order for the prazosin medication, prescribed for nightmares for Resident 47. RN 2 also verified there was no documented evidence to show the monitoring of nightmares related to the use of prazosin medication was completed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Medical record review for Resident 28 was initiated on 2/11/26. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 9/23/25, showed Resident 28 had the capacity to understand and make decisions. Review of Resident 28's Physician's Order Summary showed the following orders: - dated1/20/26, to administer Ativan oral tablet 1 mg by mouth one time a day for anxiety, restlessness as manifested by overly concern about health. Further review of the order showed informed consent was obtained by physician from Resident 28 after explanation of risk and benefits of medication. - dated 1/20/26, for anti-anxiety, to monitor episodes of restlessness and tally by hashmarks, and to document nonpharmacological intervention use. Review of Resident 28's MAR dated 2/1 to 2/28/26, showed on 2/9/26 in the evening shift (1500 hours- 2300 hours), Resident 28 had six episodes of the behavior of restlessness related to the use of Ativan medication. Further review of the document did not show if the nonpharmacological interventions were provided when Resident 28 had six episodes of the behavior related to the use of Ativan medication. On 2/18/26 at 0824 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 2. RN 2 verified the physician's order for Ativan medication, which included monitoring for behaviors of restlessness related to Ativan use and providing the nonpharmacological interventions as needed. RN 2 verified on 2/9/26 during the evening shift, Resident 28 exhibited six episodes of restlessness related to Ativan use. RN 2 also verified there was no documented evidence to show the nonpharmacological interventions were provided during these episodes. On 2/18/26 at 1147 hours, an interview and concurrent medical record review for Residents 28 and 47 was conducted with the DON. The DON stated the prazosin medication was used as off-label as a psychotropic medication for Resident 47 and acknowledged the behavior of nightmare related to the use of prazosin medication should have been monitored. The DON further stated the nonpharmacological interventions should be provided when a resident exhibited behaviors related to the use of psychotropic medications. 3. Medical record review for Resident 38 was initiated on 2/11/26. Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's H&P examination dated 1/9/26, showed Resident 38 had no capacity to understand and make decisions. Review of Resident 38's Plan of Care showed a care plan problem dated 1/8/26, addressing the Black Box Warning (BBW- the most stringent safety alert required by the FDA (Food and Drug Administration) for prescription medications) for the use of the Abilify (brand name for aripiprazole) medication. The side effects included orthostatic hypotension. Review of Resident 38's Order Summary Report dated 2/17/26, showed a physician's order dated 1/15/26, to administer aripiprazole 2 mg two tablets by mouth one time a day for agitation manifested (continued on next page)

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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 food safety and sanitation guidelines were followed. * Food items in the refrigerator and dry storage area used for residents' food were not properly labeled and dated. * Expired food were not discarded. * Food contact surfaces were not clean or in a cleanable condition. * The facility failed to ensure the refrigerated food item brought in by visitors was properly labeled and dated. In addition, the refrigerator was not clean and the temperature for the freezer and the refrigerator was not consistently monitored. * The ice machine was not clean. * The hair restraint was not worn by one staff member entering the kitchen. * Hand hygiene practices were not completed prior to wearing gloves. * The blender was not washed in between the preparation of each pureed food. These failures had the potential to contaminate the food which could lead to foodborne illnesses in a medically vulnerable resident population who consumed food prepared in the kitchen. Findings: Review of the facility's Diet Type Report dated 2/12/26, showed 114 of 118 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Food Storage: Cold Foods revised 2/2023 showed all Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will beappropriately stored in accordance with guidelines of the FDA Food Code. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Review of the facility's P&P titled Food Storage: Cold Foods revised 2/2023 showed all dry goods will be appropriately stored in accordance with guidelines of the FDA Food Code. Storage area will be neat, arranged for easy identification, and date marked as appropriate. On 2/11/26 at 0745 hours, during the initial tour of the kitchen with the DSS, the following was observed:- one rectangular plastic container of fresh peeled garlic in the refrigerator with no open date;- one tray of pinto beans covered with aluminum foil observed with a hole with unreadable date;- one opened cereal bag not properly sealed closed with no open date;- multiple bags of cookies not properly stored or sealed in an open aluminum basin; and- one container of sage not properly labeled with use by date. The DSS verified the above findings. The DSS stated the garlic, pinto beans, cereal bag, and the cookies prepared and opened by the kitchen staff should have been stored, dated, and labeled accordingly. 2.a. On 2/11/26 at 0749 hours, during the initial tour of the kitchen with the DSS, the following was observed:- an opened container of coleslaw dressing with a use by date of 2/1/26;- an opened bag of shredded cheese with a use by date of 1/5/26, and expiration date of 2/2/26;- a container of salt labeled with a use by date of 6/17/25; and- a container of sesame seed with a use by date of 11/20/25. The DSS verified the above findings and stated the above items should have been expired items, and should have been discarded. b. On 2/12/26 at 1030 hours, a concurrent observation of the emergency food supply and interview was conducted with the DSS. There were six cans of peaches labeled with a use by date of 5/10/24. The DSS verified the label on the six cans of peaches were expired. The DSS stated canned foods were only good for two years. 3.a. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C), nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. On 2/11/26 at 0753 hours, during the initial tour of the kitchen with the DSS, the following was observed:- two frying pans with inner deep scratches had lost non-stick surface exposing the underlying metal;- multiple dry spice containers were not properly closed. There was also grime on the caps and surrounding the plastic container; - the trays holding the liquid seasoning containers had oily and sticky residue;- a drawer containing utensils by the food preparation area had dry food particles; and- the can opener had food residue and brownish orange material resembling rust. The DSS verified the above findings. The DSS stated the kitchen staff should have kept the kitchen drawers and spice containers clean. b. Review of facility's P&P titled Environment revised 9/2017 showed all food preparation areas, food service areas, and dining areas (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will be maintained in a clean and sanitary condition. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting and ventilation. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces. On 2/12/26 at 0850 hours, two piles of clean plate were observed in the hot plate cart behind the oven. The oven motor was directly in between the two piles of plate with one pile not covered and another pile was partially covered. The oven motor had grayish, fuzzy residue resembling dust. On 2/12/26 at 0853 hours, an observation and concurrent interview was conducted with the DSS. The DSS verified the oven motor with grayish, fuzzy residue was directly in between the two piles of plate with one pile not covered and another pile was partially covered. The DSS wiped the grayish, fussy material with a paper towel and identified it was dust. The DSS stated the dust would contaminate the food placed on the clean plate. c. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, showed surfaces such as cutting blocks that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. On 2/11/26 at 0758 hours, during the initial tour of the kitchen with the DSS, five cutting boards were observed heavily marred and fuzzy with knife marks. The DSS verified the findings. 4. Review of the facility's P&P titled Foods Brought in by Visitors revised 3/28/24, showed refrigerator/freezer for storage of foods brought in by visitors will be properly maintained and: - equipped with working thermometers;- have temperature monitored daily for refrigeration less than 41 degrees F and freezer equal or less than 0 degrees Fahrenheit;- daily monitoring for refrigerated storage duration and discard any food items that have been stored for more than 2 days; and- cleaned daily. On 2/11/25 at 1030 hours, an observation of Refrigerator 1, facility document review, and concurrent interview was conducted with the DSS. The freezer had ice cream bars in a bag. There was no thermometer in Refrigerator 1. Review of the facility's Refrigerator Temperature Log for January 2026 failed to show the freezer temperatures were monitored. Further review of the log failed to show the refrigerator temperatures were monitored on the following date and times:- 1/3/26 for 0700 - 1900 hours;- 1/4/26 for 0700 - 1900 hours and 1900 hours to 0700 hours;- 1/5/26 for 0700 - 1900 hours;- 1/6/26 for 0700 - 1900 hours;- 1/9/26 for 1900 - 0700 hours;- 1/10/26 for 0700 - 1900 hours;- 1/11/26 for 0700 - 1900 hours and 0900 to 000 hours;- 1/16/26 for 1900 to 0700 hours;- 1/17/26 for 0700 - 1900 hours;- 1/18/26 for 0700 - 1900 hours;- 1/24/26 for 0700 - 1900 hours and 1900 to 0700 hours;- 1/25/26 for 1900 to 0700 hours;- 1/28/26 for 1900 to 0700 hours;- 1/29/26 for 1900 to 0700 hours;- 1/30/26 for 1900 to 0700 hours; Review of the facility's Refrigerator Temperature Log for 2/2026 failed to show the freezer temperatures were monitored. The DSS verified the above findings. The DSS stated nursing was responsible for cleaning and monitoring the residents' refrigerator. On 2/17/26 at 1321 hours, an observation of Refrigerator 2 was conducted with LVN 4. Refrigerator 2 was observed with the following: - ice buildup at the back panel inside the refrigerator;- brown sticky grime at bottom shelf of the refrigerator;- an opened box of organic soy not labeled with a name, open date or date brought in the facility; and- two packages of drinkable jelly with an expiration date of 12/27/25, and not labeled with name or date brought in the facility. On 2/17/26 at 1325 hours, an interview was conducted with LVN 4. LVN 4 stated the night shift nurses were responsible to clean the refrigerator. LVN 4 further stated the foods brought in by the family should be labeled with resident's name, room number, and the date the food or beverage was brought in. LVN 4 further stated the foods not consumed within the day should be thrown away. On 2/17/26 at 1508 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. According to the USDA Food Code 2022, Section 4-601.11 Food Contact Surfaces, Nonfood Contact Surfaces, and Utensils (A) Equipment, food contact surfaces and utensils shall be clean to sight and touch, (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. On 2/12/26 at 1040 hours, an observation of the ice machine and concurrent interview was conducted with the Director of Maintenance. The (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interior area of ice machine storage bin had black residue. The Director of Maintenance confirmed the findings and verified there should not be any residue inside the ice machine. 6. According to the USDA Food Code 2022, Section 2-402.11 Effectiveness (A), Food employees shall wear hair restraints such as hats, hair coverings 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, utensils. Review of the facility's P&P titled Infection Control for Dietary Employees (undated) showed to ensure the dietary department is maintained in a sanitary condition in order to prevent food contamination and growth of disease producing organisms and toxins all dietary employees will follow infection control policies as established and approved by the facility's infection control committee. Personal cleanliness is required in sanitary food preparation. Clean hair covered with effective hair restraint while in all kitchen and food storage areas and beard/ mustache covering when applicable. On 2/12/26 at 1100 hours, an observation and concurrent interview was conducted with the DSS. The DSS had a beard. The DSS was not wearing beard restraints. The DSS was in puree food preparation area. The DSS stated he should be wearing a beard net. 7. Review of the facility's P&P titled Infection Control for Dietary Employees not dated showed to ensure the dietary department is maintained in a sanitary condition in order to prevent food contamination and growth of disease producing organisms and toxins all dietary employees will follow infection control policies as established and approved by the facility's infection control committee. Proper handwashing by any or all personnel will be done as follows:- upon entering the kitchen;- immediately before engaging in food preparation, including working with non-prepackaged food, clean equipment and utensils, and unwrapped single-use food containers and utensils;- after touching bare human body parts other than clean hands and clean, exposed portions of arms;- after using the restroom;- after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking;- after handling soiled equipment or utensils;- during food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks;- when switching between working with raw food and working with ready-to-eat food;- before initially donning gloves for working with food;- before dispensing or serving food or handling clean tableware and serving utensils in the food service area; and- after engaging in any other activities that contaminate the hands. On 2/12/26 at 1056 hours, an observation of puree food preparation and concurrent interview was conducted with [NAME] 1. [NAME] 1 removed his gloves, opened a kitchen drawer, took a tong, and took a pair of gloves to wear without washing his hands. [NAME] 1 stated he should have washed his hands after touching the kitchen surfaces and before wearing new gloves. 8. On 2/12/26 at 1115 hours, an observation of pureed food preparation was conducted with [NAME] 1. [NAME] 1 pureed the pasta, emptied the pasta into a pan, put the cauliflower in the blender with some pasta left into the blender and then pureed the cauliflower. [NAME] 1 emptied the pureed cauliflower into a pan then proceeded to put the chicken into the blender to puree. On 2/12/26 at 1130 hours, an interview was conducted with [NAME] 1. [NAME] 1 stated he did not usually wash the blender in between the food items unless he pureed meat. On 2/12/26 at 1145 hours, a subsequent observation of pureed food preparation was conducted with [NAME] 1. [NAME] 1 pureed the rice, emptied the rice into a pan, and put pork into the blender. There was still some rice left in the blender when [NAME] 1 added the pork. On 2/18/26 at 1445 hours, an interview was conducted with the Dietary Services District Manager. The Dietary Services District Manager was informed of the above findings and stated the blender should have been washed in between food types to prevent cross contamination and allergy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program for the months of March 2025 through January 2026. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications met the facility's criteria for infection (utilizing McGeer's Criteria). The facility failed to include these residents in the facility's infection control surveillance program. * The facility failed to ensure two resident basins were labeled in a shared resident restroom. * CNA 5 was observed assisting two residents; however, CNA 5 failed to perform hand hygiene in between assisting each resident. * The facility failed to ensure LVN 1 disinfected Resident 94's call light after picking it up from the ground and before placing the call light on Resident 94's bed. These failures posed the risk of not identifying resident infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program (IPCP) dated 9/18/24, showed a IPCP is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The IPCP is coordinated and overseen by the Infection Preventionist. Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infections) are used as measures of the IPCP effectiveness. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. The information obtained from infection control surveillance activities is compared to acknowledged standards and used to assess the effectiveness of established infection prevention and control practices. Data analysis gathered during surveillance is used to oversee infections and spot trends. On 2/17/26 at 0946 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to describe the facility's resident infection surveillance program. The IP stated she coordinated and conducted oversight of the facility's infection control surveillance program. The IP stated the facility utilized McGeer's criteria surveillance tool, to determine if a resident had a true infection. The IP stated identifying resident infections was necessary to detect outbreaks, to ensure appropriate transmission-based precautions were implemented, for monitoring adherence to infection prevention and control practices, detecting unusual pathogens, and ensuring residents received treatment. The IP stated when a resident exhibited signs and/or symptoms of an infection and was prescribed an antimicrobial medication, the licensed nurse would then initiate the Antibiotic Surveillance Data Collection Form. The IP stated she would then review the Antibiotic Surveillance Data Collection Form and determine if a resident had met McGeer's Criteria. The IP stated she would include these residents in the facility's infection surveillance program. Review of the facility's Infection Control Monthly Summary from March 2025 through January 2026 showed the following infection surveillance data for HAIs, CAIs, and residents who did not meet McGeer's Criteria (DNMC): - for 3/2025, HAI – 9, CAI – 11, and DNMC – 2; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- for 4/2025, HAI – 3, CAI – 14, and DNMC – 1; - for 5/2025, HAI - 6, CAI – 10, and DNMC – 10; - for 6/2025, HAI - 15, CAI – 4, and DNMC – 3; - for 7/2025, HAI – 15, CAI – 8, and DNMC – 5; - for 8/2025, HAI - 9, CAI – 4, and DNMC – 2; - for 9/2025, HAI - 11, CAI – 6, and DNMC – 7; - for 10/2025, HAI - 23, CAI – 5, and DNMC – 7; - for 11/2025, HAI - 13, CAI – 4, and DNMC – 5; - for 12/2025, HAI - 13, CAI – 4, and DNMC – 4; and - for 1/2026, HAI - 15, CAI – 10, and DNMC – 8. The IP was asked when a resident at the facility exhibited signs and/or symptoms of infection and was not prescribed antimicrobial medications, if the facility initiated the McGeer's criteria form for these residents and included these residents in the facility's infection surveillance program. The IP stated the facility did not initiate the McGeer's criteria form for residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications. The IP stated only a change of condition assessment was performed for these residents. The IP was asked how many residents in the facility had infections (met McGeer's criteria) and were not prescribed antimicrobial medications (from March 2025 through January 2026). The IP stated she was uncertain as the facility did not initiate the McGeer's criteria form for residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications. 2. On 2/11/2026 at 0835 hours, during the initial tour of the facility, the restroom in Room A was observed with a stack of two basins, one gray and one pink. Inside the pink basin was a comb and yellow emesis basin with a toothbrush, toothpaste, and a drinking cup. The basins, toothpaste, and toothbrush were stored on top of the toilet tank unlabeled with the resident's name. Room A was occupied by Residents 13 and 18. Medical record review for Resident 13 was initiated on 2/11/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's H&P Examination dated 5/12/25, showed the resident had no capacity to understand and make decisions. Medical record review for Resident 18 was initiated on 2/11/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's MDS assessment dated [DATE], showed the resident had a BIMS score of 8, which meant the resident had moderate cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/2026 at 0837 hours, an observation and concurrent interview was conducted with RNA 1. RNA 1 verified the stack of two basins, one gray and one pink and inside the pink basin was a comb and yellow emesis basin with a toothbrush, toothpaste, and a drinking cup. RNA 1 also verified the basins, toothpaste and toothbrush were stored on top of the toilet tank unlabeled with resident's name. RNA 1 stated the room was occupied by Residents 13 and 18. RNA 1 further stated she would throw away the items since the items were not labeled. RNA 1 stated the personal hygiene items should be labeled with the resident's name and room number and stored in a bag. On 2/11/2026 at 0912 hours, an interview was conducted with LVN 4. LVN 4 stated the resident's personal hygiene items should be labeled with the resident's name and stored in a bag inside the resident's drawer. 3. On 2/11/26 at 1245 hours, during the dining room observation, CNA 5 was observed assisting Resident 30 to eat lunch by taking the resident's spoon with food and placing it in Resident 30's mouth. CAN 5 then proceeded to feed Resident 14 without performing hand hygiene in between helping the residents. On 2/11/26 at 1246 hours, an interview was conducted with CNA 5. CNA 5 verified she assisted Resident 30 to eat lunch by taking resident's spoon with food and placing it in Resident 30's mouth then proceeded to feed Resident 14 without performing hand hygiene in between helping the residents. On 2/11/26 at 1249 hours, CNA 5 was observed cleaning the food from Resident 30's hands and lap then proceeded to feed Resident 14 without performing hand hygiene in between residents. Medical record review for Resident 30 was initiated on 2/11/26. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's H&P examination dated 10/11/25, showed the resident had no capacity to understand and make decisions. Medical record review for Resident 14 was initiated on 2/11/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's MDS assessment dated [DATE], showed the resident had severely impaired cognitive skills for daily decision making. On 2/11/26 at 1250 hours, an interview was conducted with LVN 4. LVN 4 was informed of the above findings. LVN 4 stated CNA 5 should have performed hand hygiene in between the residents when assisting with meals. LVN 4 further stated she would explain to CNA 5 the importance of performing hand hygiene. 4. On 2/11/26 at 0933 hours, during the initial tour of the facility, Resident 94's call light was observed on the ground behind Resident 94's bed. On 2/11/26 at 0935 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated the call light should be placed within the resident's reach. LVN 1 verified the above findings and was observed picking up the call light and placing the call light on Resident 94's bed. LVN 1 was asked and verified she did not disinfect the call light prior to placing the call light on the resident's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed. LVN 1 stated she should have disinfected the call light before placing it back on the bed. On 2/17/26 at 1522 hours, an interview was conducted with the DON. The DON stated when the call lights fall on the ground, it should be disinfected prior to placing it on the resident's bed. On 2/18/26 at 1453 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **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 maintain a homelike environment for three of six residents interviewed (Residents 20, 22, and 66) during Resident Council meeting, and one nonsampled resident (Resident 109). * Residents 20, 22, 66, and 109 enjoyed watching television in their rooms; however, their televisions were not functioning. This failure had the potential to negatively impact the residents' quality of life. Findings: Review of the facility's P&P titled Homelike Environment revised 2021 showed residents are provided with a safe, clean, comfortable, homelike environment, and encouraged to use their personal belongings to the extent possible. Staff provides person-centered care that emphasizes the residents' comfort, independence, personal needs, and preferences. Review of the facility's P&P titled Activity Program revised 6/2028 showed the activity programs are designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. On 2/12/26 at 1000 hours, a Resident Council meeting was conducted with six residents who resided in the facility. Residents 20, 22, and 66 stated the televisions in their rooms were not functioning for several weeks. The residents stated the facility was aware; however, their televisions had yet to be fixed. 1. Medical record review for Resident 22 was initiated on 2/12/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Recreation Comprehensive assessment dated [DATE], showed Resident 22 enjoyed watching television. Review of Resident 22's Care Plan Report showed a care plan focus initiated 1/20/26, which showed Resident 22 was at risk for limited and/or meaningful engagement related to dementia. The care plan goal showed Resident 22 would make choices related to self-directed meaningful activities. The care plan interventions showed Resident 22 enjoyed watching and listening to television. On 2/12/26 at 1000 hours, an interview was conducted with Resident 22 during the Resident Council meeting. Resident 22 stated the television in her room had not worked for approximately four weeks. Resident 22 stated she had poor vision and could not read well; therefore, she enjoyed watching television in her room. Resident 22 stated she enjoyed watching the news on her television to keep up with world events. 2. Medical record review for Resident 20 was initiated on 2/12/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's Recreation Comprehensive assessment dated [DATE], showed watching television was very important to Resident 20. Resident 20 enjoyed watching the news, comedies, nature programs, reality tv, the weather report, and the history channel. Review of Resident 20's Care Plan Report showed a care plan focus initiated 12/30/25, which showed Resident 20 participated in recreational activity programs of interest. Resident 20 continued to identify independent leisure interests of preference such as watching television. The interventions initiated 2/12/26, showed Resident 20 enjoyed watching and listening to television; however, his television was not functioning at this time. On 2/12/26 at 1000 hours, an interview was conducted with Resident 20 during the Resident Council meeting. Resident 20 stated the television in his room was not working. Resident 20 stated the facility had one television that functioned in the activities room; however, he preferred to watch the television in his room independently. 3. Medical record review for Resident 66 was initiated on 2/12/26. Resident 66 was admitted to the facility on [DATE]. Review of Resident 66's Recreation Comprehensive assessment dated [DATE], showed watching television was very important to Resident 66. Resident 66 enjoyed watching comedies, news, mysteries, classics, and action/adventure programs. Review of Resident 66's Care Plan Report showed a care plan focus initiated 1/21/26, which showed Resident 66 enjoyed watching television movies. The interventions initiated 4/20/25, showed Resident 66 enjoyed watching the news, movies, and educational films on television. On 2/12/26 at 1000 hours, an interview was conducted with Resident 66 during the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Council meeting. Resident 66 stated the television in his room was not functioning. Resident 66 stated he spoke to the facility's maintenance staff and was informed the antenna was malfunctioning. 4. Medical record review for Resident 109 was initiated on 2/12/26. Resident 109 was admitted to the facility on [DATE]. Review of Resident 109's Recreation Comprehensive assessment dated [DATE], showed Resident 109 enjoyed watching reality TV, comedies, soap operas, news, and the cooking channel. Review of Resident 109's Care Plan Report showed a care plan focus revised 11/18/25, which showed Resident 109 enjoyed watching Spanish television. The interventions initiated 2/12/26, showed Resident 109 enjoyed watching and listening to television; however, her television was not functioning at this time. On 2/12/26 at 1200 hours, an observation and concurrent interview was conducted with Resident 109. Resident 109 was observed in her room. Resident 109 stated she enjoyed watching television in her room. Resident 109 stated the television in her room did not work. Resident 109 stated she informed the facility staff approximately two weeks ago; however, her television has yet to be fixed. On 2/12/26 at 1222 hours, an interview was conducted with the Director of Maintenance. The Director of Maintenance verified Residents 20, 22, 66, and 109's televisions were not functioning. The Director of Maintenance stated there were currently 118 residents who lived in the facility and each resident had a television in their rooms. The Director of Maintenance stated currently only three of 118 residents had functioning televisions. The Director of Maintenance stated the facility was in the process of upgrading the facility's television system.

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	555473	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Gardens Care Center	13075 Blackbird Street Garden Grove, CA 92843

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three final sampled residents (Resident 105) reviewed for abuse was free from abuse. * The facility failed to protect Resident 105's right to be free from physical abuse by another resident (Resident 3). Resident 105 was blocking the hallway while Resident 3 was trying to get through. Resident 3 reached out his hand and slapped Resident 105 on the face. Resident 105 had some redness on the face and forehead. This failure had the potential for Resident 105 to be seriously injured or have psychosocial harm.Findings: Review of the facility's P&P titled Abuse Prohibition Policy and Procedure dated 2/23/21, showed health care centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. The Federal Definition section showed abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, injury, or mental anguish. On 2/6/26 at 1735 hours, the CDPH, L&C Program received an SOC 341 from the facility. The SOC 341 showed at approximately at 1440 hours, there was a resident to resident altercation in Station 2. Resident 3 attempted to get by Resident 105 who was in front of the Station 2 hallway. Resident 3 yelled and Resident 105 moved but not quick enough. Resident 3 swung with an open hand and hit Resident 105's face. Medical record review for Resident 105 was initiated on 2/11/26. Resident 105 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 105's MDS assessment dated [DATE], showed the resident was cognitively intact. Medical record review for Resident 3 was initiated on 2/11/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 105's eINTERACT Change in Condition Evaluation - V 5.1 dated 2/6/26, showed Resident 105 said he was blocking the hallway while the other resident (Resident 3) was trying to get through. The other resident (Resident 3) reached his hand out and slapped Resident 105's face. Resident 105 had some redness on the face and forehead. On 2/12/26 at 1531 hours, an observation and concurrent interview was conducted with Resident 3. Resident 3 was observed lying on his right side and was calm. Resident 3 stated he did not remember the alleged abuse incident, refused to answer any more questions and closed his eyes. On 2/11/26 at 1600 hours, an interview was conducted with Resident 105. Resident 105 stated he was sitting in his wheelchair in the hallway and was hit by the resident in the hallway. Resident 105 stated he were going opposite directions and he could not move out of the resident's way fast enough. Resident 105 stated the resident hit him in the face with a closed fist. On 2/13/26 at 1110 hours, an interview was conducted with RN 3. RN 3 stated she heard Resident 3 yelling ?get out of my way'. RN 3 stated both Residents 3 and 105 were in the hallway. RN 3 further stated Resident 3 wanted to pass by, but he could not because Resident 105 was blocking his way. RN 3 stated Resident 105 was not moving fast enough, so Resident 3 swung his hand to Resident 105's head and slapped him. On 2/13/26 at 1139 hours, an interview was conducted with the Social Services Assistant. The Social Services Assistant stated he was sitting in his office, and the office door was halfway open when he heard yelling. The Social Services Assistant stated he saw Resident 3 slap Resident 105's face. On 2/18/26 at 1052 hours, an interview was conducted with the Administrator. The Administrator stated the facility substantiated the physical abuse because the incident was witnessed and the body check showed redness on Resident 105's face. On 2/18/26 at 1403 hours, the Administrator and DON were informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop/implement the comprehensive plan of care to reflect the individual care needs for two of 24 final sampled residents (Resident 3 and 12). * The facility failed to develop a care plan problem to address Resident 3's risk of elopement. * The facility failed to develop a care plan intervention to offload Resident 12's heels and ankles. In addition, the physician's order to offload Resident 12's heels and ankles while in bed was not implemented. These failures posed the risk of not providing appropriate, consistent, and individualized care to Residents 3 and 12. Findings: Review of the facility's P&P titled Care Plan Comprehensive dated 8/25/21, showed an individualized comprehensive care plan that includes measurable objectives and timetable to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. The comprehensive care plan includes the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. Medical record review for Resident 3 was initiated on 2/11/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Elopement Evaluation dated 5/22/25, showed the licensed nurse documented yes to the following questions: - Resident 3 was able to ambulate or self-propel in the wheelchair independently, - Resident 3 had verbally expressed the desire to go home, packed belongings to go home, or stayed near an exit door, and - Resident 3 had been recently admitted or readmitted and is not accepting the situation. Further review of Resident 3's Elopement Evaluation showed Resident 3 was at risk for elopement. Review of Resident 3's H&P examination dated 5/23/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Plan of Care initiated on 5/23/35, failed to show a care plan problem was developed to address Resident 3's risk for elopement. On 2/17/26 at 0823 hours, Resident 3 was observed in his wheelchair and wheeling himself down the hallway using his left hand. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/17/26 at 1451 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON stated all the residents were evaluated for elopement upon admission to the facility, quarterly, and as needed. The DON stated if the elopement evaluation showed the resident was at risk for elopement, the staff would be responsible for observing the resident for any change of condition, signs of guarding the doors, or any exit seeking behaviors. The DON further stated, if the elopement evaluation showed the resident was at risk for elopement, there should be a care plan developed. The DON reviewed Resident 3's medical record and verified the above findings. On 2/18/26 at 1453 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 2/11/26 at 0859 hours, during the initial tour of the facility, Resident 12 was observed asleep and the resident's nonslip socks were touching the bed mattress. Medical record review for Resident 12 was initiated on 2/11/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 12's Order Summary Report dated 2/20/26, showed a physician's order dated 9/18/24, to offload heels and ankles while in bed every shift for wound management. Review of Resident 12's Care Plan Report dated 2/21/25, showed the resident was at risk for skin breakdown related to resident required assistance with mobility, had thin and fragile skin, incontinent to bowel and bladder function and required assistance with toileting needs (cleansing). Further review of the medical record for Resident 12 failed to show documented evidence of care plan intervention to offload heels and ankles of the resident. On 2/13/26 at 0857 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 12's heels were not offloaded. CNA 1 stated the purpose of the offloading was to keep heels off the bed. CNA 1 stated she would check with the licensed nurse if Resident 12's heels needed to be offloaded. On 2/13/26 at 1414 hours, Resident 12 was observed in bed asleep, and the heels were not offloaded. On 2/13/26 at 1417 hours, an observation, interview, and concurrent medical record review for Resident 12 was conducted with LVN 9. LVN 9 verified Resident 12's heels were touching the mattress. Moreover, LVN 9 verified there was no care plan intervention to offload the heels of Resident 12. On 2/18/26 at 0945 hours, Resident 12 was observed in bed with heels touching the mattress. On 2/18/26 at 0955 hours, an observation and concurrent interview for Resident 12 was conducted with was conducted with LVN 4. LVN 4 verified Resident 12's heels were not offloaded. On 2/18/26 at 1509 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 interview, medical record review, and facility P&P review, the facility failed to provide the treatment and care in accordance with the professional standards of practice for four of 24 final sampled residents (Residents 4, 7, 14, and 105). * The facility failed to ensure the neurological evaluation was completed after the fall incident of Resident 105. In addition, the facility failed to ensure the physician was notified and the resident was monitored when Resident 105 was found to have discoloration of the right eye. * The facility failed to ensure the insulin injection site was rotated for Resident 4. * The facility failed to ensure Resident 14's wheelchair was evaluated as ordered by the physician. Resident 14's wheelchair was observed too high and the resident's feet were dangling. * The facility failed to ensure the PT (Physical Therapy)/OT (Occupational Therapy) evaluations were conducted as per the physician's order and care plan following Resident 7's change of condition evaluation for the decline in functional abilities. These failures had the potential for residents not to receive appropriate care and treatment.Findings: 1. Review of the facility's P&P titled Neurological assessment dated [DATE], showed neurological evaluation will be performed as indicated or ordered. When a resident sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: - Every 15 minutes for two hours, then; - Every 30 minutes for two hours, then; - Every 60 minutes for four hours, then; and, - Every eight hours until at least 72 hours 1.a. On 2/11/26 at 1600 hours, an interview was conducted with Resident 105. Resident 105 stated he had experienced a fall in the facility and struck his head. Medical record review for Resident 105 was initiated on 2/11/26. Resident 105 was admitted to the facility on [DATE]. Review of Resident 105's MDS assessment dated [DATE], showed Resident 105 was cognitively intact. Review of Resident 105's Change in Condition Evaluation dated 2/7/26, showed on 2/7/26, at approximately 1200 hours, the resident was observed on the floor while still seated in his wheelchair. The wheelchair was observed tipped backward, with the back of the wheelchair resting on the floor. Resident 105's head was also observed resting against the floor. Under the section provider notification and feedback showed the above incident was notified to the primary care clinician and recommended to transfer Resident 105 to acute care hospital. Review of Resident 105's Care Plan dated 2/7/26, showed a care plan problem addressing the fall for Resident 105. The care plan goal showed Resident 105 would remain free from falls during the shift and will maintain stable neurological status with no change in level of consciousness following the fall. The interventions included monitoring of the vital signs and neurological status. (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 105's progress notes dated 2/7/26 at 1809 hours, showed Resident 105 returned from the acute care hospital. Resident 105 denied pain and to continue the neurological monitoring. Review of Resident 105's Neurological Evaluation Flow Sheet dated 2/7/26, showed the Neurological Evaluation was initiated on 2/7/26 at 1200 hours. The Neurological Evaluation Flow Sheet showed Resident 105 was transferred to the acute care hospital on 2/7/26 at 1300 hours and returned from the acute care hospital on 2/7/26 at 1800 hours. Further review of the Neurological Evaluation Flow Sheet did not show if neurological evaluation was completed on the following dates and times: - On 2/7/26 at 1800, 1900, and 2000 hours; - On 2/8/26 at 2000 hours; and - On 2/9/26 at 1200, and 2000 hours. 1.b. Review of the facility's P&P titled Acute Condition Changes- Clinical Protocol, undated, showed the physician will help identify individuals with a significant risk for having acute changes of condition during their stay; for example, an individual with an indwelling catheter who has had recurrent symptomatic urinary tract infections, or someone with unstable vital signs or recurrent pneumonia. The physician and nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complication. Review of Resident 105's Change in Condition Evaluation dated 12/12/25 at 0500 hours, showed the resident was heard yelling, Help, I fell down. The CNA and the charge nurse responded and observed the resident lying on the floor to the right side of the bed. The resident was assisted back to bed and was noted to have a small bump on his right forehead. The physician and the resident's representative were notified. Review of Resident 105's progress notes dated 12/17/25, showed Resident 105 had a documented fall on 12/12/25. On the morning of 12/17/25, skin discoloration was observed around the resident's right eye, with no evidence of skin breakdown. The resident's representative was notified of the discoloration. However, further review of Resident 105's medical record did not show documentation whether the physician was notified of the discoloration or if the area was monitored. On 2/17/26 at 1013 hours, an interview and concurrent medical record review for Resident 105 was conducted with the MDS Nurse. The MDS Nurse stated the neurological evaluation should be done for 72 hours as per the facility policy after an unwitnessed fall. The MDS Nurse stated Resident 105 had an unwitnessed fall on 2/7/26 at 1200 hours. The MDS Nurse verified Resident 105 returned from acute care hospital following the fall on 2/7/26 at around 1800 hours. The MDS Nurse verified the neurological evaluation was not completed on the above dates and times for Resident 105 after an unwitnessed fall and after Resident 105 returned from the hospital. The MDS Nurse verified Resident 105 was observed with skin discoloration around the resident's right eye, with no evidence of skin breakdown on the morning of 12/17/25. The MDS nurse verified there was no documented evidence whether the physician was notified of the discoloration or if the area was monitored. 2. Medical record review for Resident 4 was initiated on 2/11/26. Resident 4 was admitted to the facility on [DATE]. (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 4's Order Summary Report showed a physician's order with a start date of 1/30/26, and a discontinued date of 2/16/26 , for Humulin R injection (medication to lower blood sugar levels) solution 100 unit/ml (insulin regular human) to inject as per sliding scale (amount of insulin to be administered based on the blood sugar results): - for blood sugar of 70-150 mg/dl to give 0 unit; - for blood sugar of 151-200 mg/dl to give, 2 units; - for blood sugar of 201-250 mg/dl to give, 4 units; - for blood sugar of 251-300 mg/dl to give, 6 units; - for blood sugar of 301 to 350 mg/dl to give, 8 units; and - for blood sugar of 351 to 400 mg/dl to give, 10 units. The physician's order specified subcutaneous (under the skin) administration three times a day for diabetes management, with instructions to rotate sites, not share needles or pens, and to hold insulin and notify the physician if blood glucose was less than 70 mg/dl and more than 400 mg/dl. Review of Resident 4's Location of Administration record dated 2/1 through 2/28/26, showed the insulin Humulin R injection was administered consecutively on the same site [the right axilla (underarm)] on 2/3/26 at 0636 and 1203 hours, and on 2/4/26 at 1607 hours, as well as on 2/5/26 at 0630 and 1130 hours. Further review showed insulin Humulin R injection was also administered on the same site (the left axilla) on 2/3/26 at 1615 hours and on 2/4/26 at 1213 hours. On 2/17/26 at 1500 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 6. LVN 6 stated the insulin injection site should be rotated each time the insulin was administered. LVN 6 verified the above findings and stated the insulin site was not rotated each time the above insulin was administered for Resident 4. On 2/18/26 at1147 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON acknowledged and verified the above findings. 3. On 2/11/26 at 0837 hours, during the initial tour of the facility, Resident 14 was observed in the dining room sitting in a wheelchair with non-slip socks. However, Resident 14's wheelchair was observed without footrest, the wheelchair was high, and the resident's feet were dangling at approximately six inches. Medical record review for Resident 14 was initiated on 2/11/26. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's MDS assessment dated [DATE], showed the resident had severe cognitive impairment. Review of Resident 14's Order Summary Report dated 2/13/26, showed a physician's order dated 1/16/26, to evaluate for ULW (Upper Light-Weight) wheelchair height: 58 inches weight: 95 lbs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/26 at 0838 hours, an observation and concurrent interview for Resident 14 was conducted with the Activity Assistant. The Activity Assistant stated Resident 14 could not have footrest because the resident walked when the sister came to the facility. On 2/11/26 at 0846 hours, an observation and concurrent interview for Resident 14 was conducted with the Physical Therapy Assistant. The Physical Therapy Assistant verified Resident 14's wheelchair was too high. The Physical Therapy Assistant stated she would get another wheelchair for Resident 14. On 2/13/26 at 0846 hours, Resident 14 was observed in the activity room sitting in the wheelchair. Resident 14's feet were dangling and not touching the floor. On 2/13/26 at 0847 hours, an observation and concurrent interview for Resident 14 was conducted with the Activity Director. The Activity Director verified Resident 14's wheelchair was too high. On 2/13/26 at 0930 hours, an interview and concurrent medical record review for Resident 14 was conducted with the MDS Coordinator. The MDS Coordinator verified the evaluation for Resident 14's wheelchair has not been completed. The MDS Coordinator stated she would get Resident 14 another wheelchair. On 2/18/26 at 1513 hours, the DON was informed and acknowledged the above findings. 4. Review of the facility's P&P titled Acute Condition Changes- Clinical Protocol revised 3/2018 showed the physician will help identify individuals with a significant risk for having acute changes of condition during their stay. The physician will help identify and authorize appropriate treatments. Review of the facility's P&P titled Physician Orders dated 3/22/22, showed whenever possible, the licensed nurse receiving the order will be responsible for documenting and implementing the order. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline. Medical record review for Resident 7 was initiated on 2/11/26. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's H&P examination dated 3/11/25, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's Change in Condition Evaluation dated 11/23/25, showed for Resident 7's functional decline (worsening function and/or mobility) the licensed nurse's documentation showed Resident 7 was noted with new functional decline. The licensed nurse documented Resident 7's responsible party reported the resident was not able to sit up straight in the wheelchair due to the loss of strength and transferring the resident was more difficult, the resident used to help more before; new functional decline noted with the resident and the physician and responsible party were made aware. Further review of the Change in Condition Evaluation showed documentation the primary care physician was notified and recommended PT/OT evaluation. Review of Resident 7's Order Summary Report showed the following physician's orders dated 11/23/25 for: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Occupational Therapy (OT) Evaluation and treatment as recommended, and - Physical Therapy (PT) Evaluation and treatment as recommended. Review of Resident 7's Plan of Care showed a care plan problem dated 11/23/25, addressing Resident 7's functional decline. The interventions included notifying the physician and responsible part for any change of condition and PT/OT evaluation as per the physician's order. Review of Resident 7's medical record failed to show the documentation the PT/OT evaluation was conducted as per the physician's orders following the Change in Condition on 11/23/25. On 2/18/26 at 1050 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON stated the physician's orders should be carried out. The DON reviewed Resident 7's medical record and verified the above findings. The DON stated there was no documentation to show why the PT/OT evaluation was not done following Resident 7's Change in Condition Evaluation. The DON further stated Resident 7 should have been evaluated as per the physician's orders. On 2/18/26 at 1453 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries for one of three final sampled residents (Resident 12) reviewed for pressure injuries. * The facility failed to offload Resident 12's heels, as ordered by the physician, to prevent pressure injuries. This failure had the potential for Resident 12 to develop pressure injuries, complications, or worsening of the existing pressure injuries.Findings: Review of the facility's P&P titled Skin Integrity Management dated 5/26/21, showed to provide safe and effective care to prevent the occurrences of pressure ulcers, manage treatment, and promote healing of all wounds. Medical record review for Resident 12 was initiated on 2/18/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's MDS assessment dated [DATE], showed the resident had a BIMS score of 1, which meant the resident had severe impaired cognition. Review of Resident 12's H&P examination dated 1/30/26, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's Order Summary Report showed a physician's order dated 9/18/24, to offload the heels and ankles while in bed every shift for wound management. On 2/11/26 at 0859 hours, Resident 12 was observed lying in bed with non-slip socks on and the heels were touching the bed mattress. On 2/13/26 at 0858 and 1214 hours, Resident 12 was observed lying in bed with non-slip socks on and the heels not offloaded. On 2/13/26 at 1217 hours, an observation and concurrent interview for Resident 12 was conducted with LVN 9. LVN 9 verified Resident 12's heels were touching the mattress, and the heels were not offloaded. On 2/18/26 at 0945 hours, Resident 12 was observed lying in bed with the heels touching the mattress and not offloaded. On 1/18/26 at 0955 hours, an observation and concurrent interview for Resident 12 was conducted with LVN 4. LVN 4 verified Resident 12's heels were not offloaded. On 2/18/26 at 1509 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure two of three final sampled residents (Residents 18 and 25) reviewed for falls remained free of accident hazards. * The facility failed to ensure the bedside table was not placed on top of the floormat for Resident 18. * The facility failed to ensure the post fall assessment and IDT (Interdisciplinary Team) assessment were conducted after Resident 25 sustained a fall. These failures had the potential to put Residents 18 and 25 at risk for serious injuries. Findings: Review of facility's P&P titled Falls Clinical Protocol revision dated 3/2018, showed the staff and practitioner will review each resident's risk factors for falling and documented in the medical record; for an individual who has fallen, the staff and practitioner will begin to try to identify possible cause within 24 hours of the fall. 1. Medical record review for Resident 18 was initiated on 2/17/26. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 18's H&P examination dated 1/14/26, showed the resident had no capacity to understand and make medical decisions. Review of Resident 18's eINTERACT Change in Condition Evaluation V 5.1 dated 2/7/26, showed the resident had an unwitnessed fall on 2/7/26 at 1945 hours. The resident sustained a mid-forehead laceration, upper lip abrasion with slight bleeding and swelling, and right third finger skin tear. Review of Resident 18's Order Summary Report showed a physician's order dated 2/11/26, to have floor mats on both sides of bed every shift. On 2/13/26 at 0827 hours, Resident 18 was observed in her room awake with her right leg slightly off the bed. The resident's bed was in low position; however, the floormat on the right side of the bed was observed with the bedside table on top of it. On 2/13/26 at 0835 hours, an observation and concurrent interview for Resident 18 was conducted with CNA 1. CNA 1 verified Resident 18's bedside table was on top of the resident's floormat and the resident's leg was slightly off the bed. CNA 1 stated Resident 18 was at risk for fall and would remove the bedside table from the floormat. On 2/18/26 at 0800 hours, Resident 18 was observed lying in bed with the bedside table on top of the floormat. On 2/18/26 at 0806 hours, an observation and concurrent interview for Resident 18 was conducted with LVN 4. LVN 4 verified the resident's bedside table was on top of the floormat. LVN 4 stated the bedside table on top of the floormat was potential for harm to the resident when resident attempted to get out of bed. On 2/18/26 at 1505 hours, an interview was conducted with the DON. The DON stated the bedside table should not be on top of the floormat to prevent injury. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 25 was initiated on 2/17/26. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination date 12/8/25, showed the resident had no capacity to understand and make medical decisions. Review of Resident 25 's MDS assessment dated [DATE], showed Resident 25 had a BIMS score of 3, which meant the resident had severe cognitive impairment. Review of Resident 25's eINTERACT Change in Condition Evaluation dated 1/4/26, showed the resident has an unwitnessed fall and the resident was found lying on the floor on her left side of the bed. The resident was noted with a small bump on the left cheek. On 2/17/26 at 1413 hours, an interview and concurrent medical record review for Resident 25 was conducted with the MDS Nurse. Resident 25's IDT Care Conference dated 1/7/26, was reviewed with the MDS Nurse. The MDS Nurse verified the IDT Care Conference form was blank and incomplete for Resident 25. In addition, Resident 25's medical record failed to show documented evidence the fall risk assessment was completed for Resident 25 after the fall incident on 1/4/26. The MDS Nurse verified there was no post fall risk assessment documented in the resident's medical record. The MDS Nurse stated the IDT Care Conference and post fall risk assessment should have been completed to prevent further episodes of fall. On 2/17/26 at 1433 hours, an interview and concurrent medical record review for Resident 25 was conducted with the DON. The DON verified the post fall risk assessment and IDT Care Conference were not completed after Resident 25's fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident on 1/4/26. The DON stated the IDT assessment should have been completed to assess the resident's risk factors to prevent future falls. On 2/18/26 at 1507, a follow up interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the nutritional recommendations from the RD were followed for one of five final sampled residents (Resident 48) reviewed for nutrition. * The facility failed to follow the RD's recommendation for an appetite stimulant for Resident 48. This failure had the potential for adverse nutritional outcomes and to negatively affect the resident's well-being. Findings: Review of the facility's P&P titled Interdepartmental Notification of Diet (Including Changes and Report) revised 10/2017 showed the nursing services shall notify the physician and dietitian when a nutritional problem (e.g., weight loss, pressure ulcer, eating problem, etc.) has been identified and shall collaborate with the dietitian and physician to initiate an appropriate process of clinical review for causes of the nutritional problem. Physician notification will also include Registered Dietician's diet or nutritional recommendations for approval as indicated. Medical record review for Resident 48 was initiated on 2/17/26. Resident 48 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 48's H&P examination dated 1/12/26, showed the resident had no capacity to understand and make decisions. Review of Resident 48's MDS assessment dated [DATE], showed Resident 48 had a BIMS score of 2, which meant the resident had severe impaired cognition. Review of Resident 48's Weights and Vitals Summary in the EHR (Electronic Health Record) showed the following weights recorded for the resident:- dated 1/5/26, weight of 66 lbs;- dated 1/12/26, weight of 70 lbs;- dated 1/20/26, weight of 64 lbs;- dated 1/27/26, weight of 62 lbs;- dated 2/3/26, weight of 62 lbs;- dated 2/4/26, weight of 62 lbs; and - dated 2/10/26, weight of 62 lbs. Review of Resident 48's Nutritional assessment dated [DATE], showed the RD noted resident was severely underweight, had poor intake, and some refusal of meals. The RD recommended consulting the physician for an appropriate appetite stimulant due to poor intake. Review of Resident 48's Order Summary Report dated 2/17/26, did not show documented evidence Resident 48 had a physician's order for an appetite stimulant. On 2/17/26 at 1044 hours, an interview and concurrent medical record review for Resident 48 was conducted with RN 2. RN 2 verified the RD's recommendation for an appetite stimulant for Resident 48; however, there was no documented evidence the physician was notified of the RD's recommendation, or a physician's order was obtained for an appetite stimulant for Resident 48. On 2/17/26 at 1055 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain IV (intravenous-through the vein) access for one of one final sampled resident (Resident 48) reviewed for IV care. * The facility failed to label Resident 48's IV site with the date, time, and initials of the licensed nurse when the IV was inserted. This failure posed the potential risk for infection or phlebitis (inflammation of a vein) for Resident 48. Findings: Review of the facility's P&P titled Peripheral Venous Catheter Insertion dated 3/2023 showed under the procedure section, after inserting the peripheral IV then write date, time, and initials on the dressing label. On 2/11/26 at 0940 hours, Resident 48 was observed lying in bed with a peripheral IV line on the right hand. The IV site was not labeled with the date, time, and initials of the licensed nurse. On 2/11/26 at 0945 hours, RN 4 was summoned to Resident 48's room. An observation and concurrent interview for Resident 48 was conducted with RN 4. RN 4 was informed and verified there was no date, time, and initial on Resident 48's right hand IV site. Medical record review for Resident 48 was initiated on 2/17/26. Resident 48 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 48's H&P examination dated 1/12/26, showed the resident had no capacity to understand and make decisions. Reviewed of Resident 48's Order Summary Report dated 2/17/26, showed the following physician's orders:- dated 2/10/26, to insert short peripheral IV as needed, document location and label with date/time/initials; and - dated 2/10/26, to administer sodium chloride (known as salt solution to maintain fluid balance, nerve function, and muscle contraction in the body) intravenous solution at 75ml/hr intravenously every shift for poor PO for two liters. Review of Resident 48's Intravenous Therapy Medication Record showed documentation of the peripheral IV was inserted to the right hand on 2/10/26. On 2/18/26 at 1310 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure appropriate pain management were provided for two of two final sampled residents (Residents 18 and 28) reviewed for pain management. * The facility failed to ensure the nonpharmacological interventions for pain management were provided before the administration of the pain medication for Resident 28. In addition, the facility failed to ensure the pain medication was administered according to the physician's order for Resident 28. * The facility failed to ensure the pain medication was administered as ordered by the physician for Resident 18. These failures placed Residents 18 and 28 at risk for ineffective pain management. Findings: Review of the facility P&P titled Pain Management dated 8/25/21, showed to provide pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences are provided to residents who require such services. Resident receiving interventions for pain will be monitored for the effectiveness and side effects (e.g., constipation, sedation) in providing pain relief. Further review of the P&P showed to document the following: - non-pharmacological interventions and effectiveness. - effectiveness of PRN medication. - infectiveness of routine or PRN medication including interventions, follow-up, and physician notification 1. Medical record review for Resident 28 was initiated on 2/11/26. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 9/23/25, showed Resident 28 had the capacity to understand and make decisions. Review of Resident 28's Order Summary Report showed the following physician's orders dated 11/25/25, to administer: - hydrocodone-acetaminophen (controlled pain medication) oral tablet 10-325 mg, to give one tablet by mouth every six hours as needed for severe pain 8-10 (on a pain scale 0-10 with 0= no pain and 10=worst pain); and - hydrocodone-acetaminophen oral tablet 5-325 mg, to give one tablet by mouth every six hours as needed for moderate pain 4-7. Review of Resident 28's MAR dated 2/1 to 2/28/26, showed the following physician's orders dated 11/25/25: - to administer hydrocodone-acetaminophen oral tablet 10-325 mg one tablet by mouth every 6 hours as needed for severe pain 8-10. Further review of the MAR showed the above medication was administered on 2/10/26 at 0840 hours, for the pain level of 9, and on 2/16/26 at 1000 hours, for the pain level of 8. In addition, the above medication was administered on 2/15/26 at 1017 hours for the (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain level of 6, which was outside the prescribed parameters (8-10). - to administer hydrocodone-acetaminophen oral tablet 5-325 mg one tablet by mouth every six hours as needed for moderate pain 4-7. Further review of the MAR showed the above medication was administered on 2/3/26 at 1045 hours, for the pain level of 7. However, further review of Resident 28's MAR dated 2/1 to 2/28/26 and medical record did not show if the nonpharmacological interventions were provided prior to the administration of the above pain medication to Resident 28. On 2/18/26 at 0824 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 2. RN 2 verified the above findings and stated the nonpharmacological interventions should have been provided to Resident 28 when the hydrocodone-acetaminophen was administered on 2/10 at 0840 hours for a pain level of 9, on 2/16 at 1000 hours for a pain level of 8, and on 2/3/26 at 1045 hours for a pain level of 7. RN 2 also verified the hydrocodone-acetaminophen oral tablet 10-325 mg was prescribed for pain levels of 8–10; however, the medication was administered on 2/15/26 at 1017 hours for a pain level of 6 to Resident 28, which was outside the prescribed parameters. On 2/18/26 at 1147 hours, an interview and concurrent medical record review for Resident 28 was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical Review for Resident 18 was initiated on 2/17/26. Resident 18 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 18's H&P examination dated 1/14/26, showed Resident 18 had no capacity to understand and make decisions. Review of Resident 18's Order Summary Report dated 2/17/26, showed the following physician's orders: - dated 2/4/6, to administer tramadol (an opiod analgesic to treat moderate to severe pain) HCl (hydrochloride) oral tablet 25 mg one tablet by mouth every six hours as needed for moderate/severe pain (4-10); and - dated 2/6/26, to administer acetaminophen (Tylenol) (pain medication) tablet 325 mg two tablets by mouth every four hours as needed for mild pain (1-3), more than three doses in 48 hours, notify the physician/advance practice provider (do not exceed 3g/day of acetaminophen in 24 hours from all sources). Review of Resident 18's MAR for 2/2026 showed on 2/8/26 at 0827, 1500, and 2216 hours, acetaminophen 325 mg two tablets were administered for a pain level of four. On 2/17/26 at 1315 hours, an interview and concurrent medical record review for Resident 18 was conducted with LVN 4. LVN 4 stated for the pain level of 4, the licensed nurse should have administered the Tramadol instead of Tylenol medication because the physician's order for Tylenol was for a pain level of 1-3. LVN 4 reviewed Resident 18's medical record and verified the above findings. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/17/26 at 1435 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurse to complete the pain scale assessment and follow the physician's orders when medicating the resident for pain. On 2/18/26 at 1509 hours, an interview was conducted with the DON. The DON was informed and acknowledged of the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, medical record review, and facility P&P review, the facility failed to ensure the proper monitoring and documentation of the ongoing assessments before, during, and after dialysis treatments were conducted for one of one final sampled resident (Resident 108) reviewed for dialysis services. * The facility failed to ensure Resident 108's Hemodialysis Communication Records were complete. In addition, the facility failed to ensure Resident 108's AV (arteriovenous) hemodialysis site assessments were consistent as per the physician's order. These failures had the potential to delay the identification and response to complications related to the hemodialysis site, and delay of care and treatment for Resident 108.Findings: Review of the facility's P&P titled Dialysis Care dated 8/25/21, showed the facility will arrange transportation to and from the dialysis provider, as well as for meals (if necessary), medication administration, and a method of communication between the dialysis provider and the facility. The AV shunt site will be inspected for functionality and sign and symptoms of complications. Under the section Communication and Collaboration showed the nursing staff, dialysis provider staff, and the attending physician will collaborate on a regular basis concerning the resident's care as follows:i. Nursing staff will communicate the following information in writing to the dialysis staff: the resident's current vital signs; and changes of conditions specific to the resident with each treatment.ii. The dialysis provider will communicate in writing to the facility any problems encountered while the resident was at the dialysis provider and any ongoing monitoring required.iii. Nursing staff will keep the attending physician, the resident and the resident's family informed of any change in conditions.iv. The nursing staff may use the hemodialysis communication record.Further review of the P&P, under Documentation- Dialysis Communication Record showed the nursing staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis. The provider's dialysis nurse will be responsible for the documentation of the dialysis treatment. The documentation will be maintained in the resident's medical record. Medical record review for Resident 108 was initiated on 2/11/26. Resident 108 was admitted to the facility on [DATE]. Resident 108 had the diagnoses of End Stage Renal Disease (the final, permanent stage of chronic kidney disease where kidneys function at less than 10-15%, necessitating dialysis or transplant) and dependence on renal dialysis (life-sustaining treatment for kidney failure, filtering blood to remove waste and excess fluid). Review of Resident 108's Order Summary Report showed physician's orders dated 11/21/25, for hemodialysis treatments on Tuesday, Wednesday, Thursday, and Saturdays. Chair time at 0930 hours for four hours durations. a. Review of Resident 108's Hemodialysis Communication Records showed the following missing documentation:- the pre-hemodialysis treatment section dated 1/31/26, failed to show the licensed nurse's documentation of the assessment of Resident 108's AV shunt for bruit (a turbulent whooshing sound heard with a stethoscope over a blood vessel) and thrill (the palpable vibration felt with your fingers in the same location); and the post-hemodialysis treatment section failed to show the licensed nurse's documentation of Resident 108's dialysis site type, swelling, drainage, and pain.- the dialysis center section dated 2/4/26, failed to show the documentation of Resident 108's dialysis site type, swelling, drainage, and pain.- the pre-hemodialysis treatment section dated 2/7/26, failed to show the licensed nurse's documentation of Resident 108's dialysis site for swelling, drainage, or pain.- the pre-hemodialysis treatment section dated 2/10/26, failed to show the licensed nurse's documentation of Resident 108's dialysis site for swelling, draining and pain; and for the post-hemodialysis treatment section, failed to show the licensed nurse's assessment of Resident 108 after his return to the facility, including Resident 108's vital signs, assessment of the dialysis site for swelling, drainage, and pain, assessment of the presence of bruit and thrill, and any post-hemodialysis complications. On 2/17/26 at 1355 hours, an interview and concurrent medical record review for Resident 108 was conducted with LVN 5. LVN 5 verified the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	above findings. LVN 5 stated the licensed nurse was responsible for the assessment of the resident, including the hemodialysis access site, and the documentation on the Hemodialysis Communication Record before the resident left for the hemodialysis treatment. LVN 5 stated the dialysis center was also responsible for completing the assessment of the resident during the dialysis treatment; and when the resident returned to the facility, the licensed nurse should review the communication record and assess the resident, including obtaining vital signs and checking the hemodialysis access site. b. Review of Resident 108's Order Summary Report showed physician's orders dated 2/3/26, to monitor the AVF hemodialysis access site in the left upper arm, every shift. To monitor the access site for: R- Redness, S- Swelling, B- Bleeding, P- Pain. Review of Resident 108's MAR for 2/2026 showed the following licensed nurses' documentation for the monitoring of Resident 108's hemodialysis access site:- on 2/4/26, - for the day and night shifts and P for the NOC shift,- on 2/5/26, - for the day, night, and NOC shifts,- on 2/6/26, - for the day and night shifts, and 0 for the NOC shift.- from 2/8 to 2/10/26, +' for the day, night, and NOC shifts,- on 2/11/26, + for the day shift, and P for the night and NOC shifts,- on 2/12 and 2/15/26, - for the day shift, and P for the night and NOC shifts and- on 2/16/26, P for the day, night, and NOC shifts. On 2/17/26 at 1458 hours, an interview and concurrent medical record review for Resident 108 was conducted with the DON. The DON stated the residents receiving hemodialysis treatments should be assessed before leaving, during the hemodialysis treatment, and upon their return to the facility from the dialysis center. The DON stated the facility communicated with the hemodialysis treatment center using the Hemodialysis Communication Record and all areas on the record should be complete. The DON stated the licensed nurses were responsible for monitoring the resident's hemodialysis access site every shift and documented the assessment in the MAR. The DON reviewed Resident 108's MAR for 2/2026 and verified the above findings. When asked what the + and - meant, the DON stated she did not know. The DON further stated the documentation of P meant pain was assessed at the hemodialysis site. However, the DON reviewed Resident 108's medical record and stated there was no documentation the resident's pain was addressed or any pain medication were administered for the above dates the P was documented. On 2/18/26 at 1453 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure the accurate administration of the medication to one of one final sampled resident (Resident 28) and one nonsampled resident (Resident 97) observed for medication administration. * The facility failed to ensure the correct medication was administered to Resident 97. LVN 7 administered sodium bicarbonate (alkalinizing agent) 650 mg oral tablet instead of sodium chloride (electrolyte replenisher) oral tablet 1 gram as ordered by Resident 97's physician. * LVN 7 administered lactobacillus acidophilus (probiotic) oral capsule instead of lactobacillus rhamnosus GG (probiotic) oral capsule as ordered by Resident 97's physician. * The facility failed to ensure the administration of the controlled medication for Resident 28 was documented on the MAR. These failures had the potential to negatively affect the residents' health condition for possible complications.Findings: Review of the facility's P&P titled Medication Administration – General Guidelines revised 10/2017 showed medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The procedures section showed prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. 1.a. On 2/12/26 at 1610 hours, a medication administration observation for Resident 97 was conducted with LVN 7. LVN 7 took the medications from Medication Cart B, prepared, and administered Resident 97's medications which included the following: - one tablet of sodium bicarbonate 650 mg; and - one capsule of lactobacillus acidophilus. Medical record review for Resident 97 was initiated on 2/12/26. Resident 97 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 97's Order Summary Report showed the following physician's orders: - dated 11/25/25, to administer sodium chloride oral tablet, give 1 gram orally three times a day for hyponatremia; and - dated 11/25/25, to administer Culturelle (probiotic) oral capsule (lactobacillus rhamnosus GG), give one tablet by mouth two times a day for probiotic. Review of Resident 97's MDS assessment dated [DATE], showed the resident was cognitively intact. On 2/13/26 at 1652 hours, an interview and concurrent medical record review for Resident 97 was conducted with LVN 7. LVN 7 verified she administered sodium bicarbonate 650 mg oral tablet instead of sodium chloride 1 gram oral tablet to Resident 97. LVN 7 stated she administered the wrong (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication and did not double check if she was administering the right medication. LVN 7 further stated the wrong medication could harm Resident 97. LVN 7 stated she should have compared the label of the medication bottle with the MAR. On 2/17/26 at 0757 hours, an interview and concurrent medical record review for Resident 97 was conducted with the DON. The DON was informed and acknowledged LVN 7 administered sodium bicarbonate 650 mg oral tablet instead of sodium chloride oral tablet 1 gram to Resident 97. The DON stated the licensed nurse should have read the label completely to make sure she had the correct supply and compared it to the MAR. b. On 2/17/26 at 0733 hours, an observation, interview, and concurrent medical record review for Resident 97 was conducted with LVN 8. LVN 8 verified Resident 97 had an order for lactobacillus rhamnosus GG medication and there was no lactobacillus rhamnosus GG medication in Medication Cart B. LVN 8 went to get lactobacillus rhamnosus GG medication in the stock room and came back with a bottle of lactobacillus acidophilus medication. LVN 8 stated she would ask the DON about the lactobacillus rhamnosus GG medication. On 2/17/26 at 0747 hours, an interview and concurrent medical record review for Resident 97 was conducted with the DON. The DON acknowledged LVN 7 gave lactobacillus acidophilus instead of lactobacillus rhamnosus GG to Resident 97. The DON stated the lactobacillus acidophilus was the only supply the facility had. The DON stated she would clarify the physician's order to the current over the counter supply on hand. On 2/18/26 at 1403 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Medication Administration – General Guidelines revised 10/2017 showed when PRN medications are administered, the following documentation is provided: - date and time of administration, medication, dose, route of administration (if other than oral), and, if applicable, the injection site; - complaints or symptoms for which the medication was given; - results achieved from giving the dose and the time results were noted; and - signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication. Medical record review for Resident 28 was initiated on 2/13/26. Resident 28 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 28's H&P examination dated 9/23/25, showed Resident 28 had the capacity to understand and make decision. Review of Resident 28's Order Summary Report showed a physician's order dated 11/25/25, to administer hydrocodone-acetaminophen (Norco, a controlled pain medication) 5-325 mg one tablet by (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth every six hours as needed for moderate pain (pain level of 4 -7 - using the 0-10 pain scale; zero meaning no pain and 10 meaning worst pain). Review Resident 28's Antibiotic or Controlled Drug Record (undated) showed the Norco 5-325 mg one tablet was dispensed and signed out on 2/2/26 at 1100 hours. On 2/13/26 at 1457 hours, an interview and concurrent medical record review for Resident 28 was conducted with LVN 3. Resident 28's MAR failed to show the documentation the Norco 5-325 mg was administered on 2/2/26 at 1100 hours. LVN 3 verified the above findings. On 2/17/26 at 1407 hours, an interview and concurrent medical record review for Resident 28 was conducted with the DON. The DON verified the Norco 5-325 mg tablet was removed on 2/2/26 at 1100 hours, but there was no documented evidence to show the medication was administered on that date and time. The DON further stated the process when the resident required pain medication, the licensed nurse would assess the resident, check the physician's order, removed the medication from the medication cart, sign the removal of the narcotic medication on the Antibiotic or Controlled Drug Record, administer the medication to the resident, then document on the MAR. The DON was informed and verified the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage of medications for one of four medication carts (Medication Cart B) inspected. * The facility failed to ensure the orally administered medications were stored separate from the externally used medications in Medication Cart B. This failure had the potential to negatively impact the residents' well-being, and the potential for the medications to lose stability and effectiveness. Findings: Review of the facility's P&P titled Medication Labeling and Storage revised 2/2023 showed medications for external use, as well as hazardous drugs and biologicals are clearly marked as such and are stored separately from other medications. On 2/13/26 at 1105 hours, a medication cart inspection for Medication Cart B and concurrent interview was conducted with LVN 1. The following was observed: - A bottle of sodium chloride tablet (supplement) for oral use was stored with four boxes of artificial tears lubricant eye drops in a storage compartment in the first drawer of the medication cart. LVN 1 verified the above findings. LVN 1 stated the medications should be stored separately to prevent accidentally mixing up the medications since the medications were administered by different routes. On 2/13/26 at 1110 hours, an interview was conducted with RN 2. RN 2 was informed and acknowledged the above findings. RN 2 stated the external and internal medications should be stored separately to prevent medication error.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure one of the kitchen employees (Dietary Aide 1) was competent in the position related duties. * Dietary Aide 1 failed to intervene when the low dishwashing machine failed to reach 120 degrees Fahrenheit. This failure had the potential for food preparation equipment, dishware, and utensils not to be cleaned and sanitized correctly. Findings: Review of the facility's P&P titled Warewashing revised 2/2023 showed all dishware, serviceware, and utensils will be cleaned and sanitized after each use. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines. Review of the facility's in-service titled Pots and Warewashing dated 7/29/25, showed Dietary Aide 1 attended the in-service. On 2/12/26 at 0845 hours, an observation of warewashing procedure and concurrent interview was conducted with Dietary Aide 1. The facility had a low temperature dishwasher. Dietary Aide 1 was observed putting the plate lids on the trays. The temperature of the dishwasher was showing at 104 degrees Fahrenheit during the cycle. Dietary Aide 1 completed the cycle and placed the trays in the dishwasher. Dietary Aide 1 verified the dishwasher temperature during the cycle was 104. Dietary Aide 1 stated the temperature when he checked at the start of the shift was 120 degrees Fahrenheit. On 2/12/26 at 0846 hours, an observation of the dishwasher thermometer gauge and concurrent interview was conducted with the DSS. The DSS verified the temperature of the dishwasher was at 104 degrees Fahrenheit during the cycle while the trays were being washed. On 2/12/26 at 0850 hours, an observation of the dishwasher thermometer gauge and concurrent interview was conducted with the Dietary Services District Manager. The Dietary Services District Manager stated the temperature was not reaching 120 degrees because the hot water was being used simultaneously for the residents' shower. The Dietary Services District Manager ran the dishwasher twice to reach the temperature of 120 degrees Fahrenheit. The Dietary Services District Manager advised Dietary Aide 1 to run the dishwasher twice and check to make sure the dishwasher temperature reached 120 degrees Fahrenheit prior to loading the dishwasher. The Dietary Services District Manager stated she would reload the plate lids and the trays to wash again.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menu and recipes were followed for one sampled resident (Resident 89) and one nonsampled resident (Resident 87) reviewed for meal observation. * The facility failed to ensure Resident 87 was served the pureed soup and dessert as per the menu. * The facility failed to ensure Resident 39 was served omelet, bread, jelly, and margarine for breakfast, as listed on the meal ticket. These failures posed the risk of negatively impacting the residents' satisfaction and dietary compliance.Findings: Review of the facility's Diet Type Report dated 2/12/26, showed 114 of 118 residents consumed the food prepared in the kitchen. Review of the facility's P&P titled Menus revised 10/2022 showed menus will be planned in advance to meet the nutritional needs of the residents in accordance with established nutritional guidelines. Menus will be served as written, unless a substitution is provided In response to preference, unavailability of an item, or a special meal. Review of the facility's P&P titled Dining and Food Preferences revised 10/2022 showed food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered in the resident's profile in the menu management software program. The individual tray assembly ticket will identify all food items appropriate for the resident based on diet order, allergies, intolerances and preferences. 1. Review of the facility's document titled Week at a Glance (undated), showed the lunch menu for Wednesday 2/11/26, was Vietnamese barbecued chicken breast, green beans with bean sprouts, steamed rice, beef rice soup, and cranberry crunch bar. Medical record review for Resident 87 was initiated on 2/11/26. Resident 87 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 87's H&P examination dated 10/17/25, showed Resident 87 had no capacity to understand and make decisions. Review of Resident 87's Order Summary Report showed a physician's order dated 2/5/26, for Resident 87 to have a Regular, pureed texture diet with moderately thick consistency. Review of the facility's document titled Diet Guide Sheet (undated) Week 3- Wednesday, under dysphagia puree, showed the following items: pureed Vietnamese barbecued chicken breast, pureed green beans with bean sprouts, pureed steam rice, pureed beef rice soup, and pureed cranberry crunch bar. On 2/11/26 at 1228 hours, during the meal observation in the dining room, the facility staff was observed assisting Resident 87 with his lunch. On Resident 87's lunch plate, the following were observed: a scoop of pureed barbecued chicken, a scoop of pureed green beans with bean sprouts, and a scoop of the pureed rice. Resident 87 was not observed with the pureed beef rice soup or the pureed cranberry crunch bar. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/26 at 1230 hours, an interview and concurrent observation for Resident 87 was conducted with RN 4. RN 4 verified the above findings and was observed going to the kitchen to retrieve the missing entrees for Resident 87. On 2/18/26 at 1453 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Menus revised 10/2022 showed menus will be planned in advance to meet the nutritional needs of the resident in accordance with established national guidelines. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. On 2/13/26 at 0807 hours, a meal observation and concurrent interview was conducted with Resident 39 in her room. Resident 39 was observed with breakfast tray at bedside. Resident 39 stated she was hungry. Resident 39 complained that her food was not enough because she only had two-rice bowls. Resident 39's breakfast tray was observed with two rice bowls. Resident 39's meal ticket showed cranberry juice 4 oz, congee 1-4 oz, breakfast omelet, bread and jelly, and margarine. On 2/13/26 at 0810 hours, an observation and concurrent interview for Resident 39 was conducted with CNA 1. CNA 1 verified Resident 39's breakfast tray only had two rice bowls; however, the resident's meal ticket showed cranberry juice 4 oz, congee 1-4 oz, breakfast omelet, bread and jelly, and margarine. CNA 1 stated she would go to the kitchen to inform the kitchen staff of the missing food items and get the food for the resident. Medical record review for Resident 39 was initiated on 2/11/26. Resident 39 was admitted to the facility on [DATE]. Review of Resident 39's H&P examination dated 1/9/26, showed Resident 39 had no capacity to understand and make her own decisions. On 2/13/26 at 0815 hours, an interview was conducted with LVN 6. LVN 6 stated she had checked the residents' breakfast trays when breakfast cart was delivered to the unit; however, she might have missed Resident 39's missing food items. LVN 6 further stated the CNA would get the missing food items from the kitchen.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to accommodate the drink preferences for two of 114 residents (Residents 55 and 114) who received food prepared in the kitchen. * The facility failed to ensure Resident 114 was served with his juice of choice for his lunch meal. * The facility failed to ensure Resident 55 was served with the preferred beverage as per the meal ticket. These failures had the potential to affect the residents' overall meal intake and nutritional status.Findings: Review of the facility's P&P titled Dining and Food Preferences revised 10/2022 showed individual dining, food, and beverage preferences are identified for all residents. Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered in the resident's profile in the menu management software program. The individual tray assembly ticket will identify all food items appropriate for the resident based on diet order, allergies, intolerances and preferences. 1. On 2/11/26 at 1215 hours, during the meal observation in the dining room, an observation and concurrent interview for Resident 114 was conducted with LVN 10. Resident 114 was observed sitting at the table and eating his lunch independently. Resident 114's lunch tray was observed with the pureed barbecued chicken, pureed green beans with bean sprouts, pureed rice, pureed beef rice soup, pureed cranberry crunch bar, and a cup of water. Review of Resident 114's lunch meal ticket (used to identify the resident's diet, allergies, and food preferences), under Special Requests showed four ounces of the juice of choice; however, Resident 114's tray was not observed with the juice. LVN 10 verified the above findings. LVN 10 stated Resident 114 should be served with what was listed on the meal ticket. LVN 10 was observed leaving the dining room and returning with a nectar thick apple juice. Resident 114 was observed picking up the juice and drinking it when LVN 10 placed the apple juice on his tray. Medical record review for Resident 114 was initiated on 2/11/26. Resident 114 was admitted to the facility on [DATE]. Review of Resident 114's H&P examination dated 2/11/26, showed Resident 114 had the capacity to understand and make decisions. On 2/18/26 at 1453 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 2/11/26 at 1240 hours, during the meal observation in the dining room, Resident 55 was observed with no beverage served. Resident 55's meal ticket dated 2/11/26, showed lunch beverages hot coffee six ounces. On 2/11/26 at 1242 hours, an interview was conducted with LVN 4. LVN 4 stated hot beverages listed on the meal ticket should be in the resident's meal tray from the kitchen. On 2/11/26 at 1243 hours, a meal observation and concurrent interview for Resident 55 was conducted with LVN 4 in the dining room. LVN 4 verified Resident 55 was not served with hot coffee. LVN 4 verified Resident 55's meal ticket dated 2/11/26, showed lunch beverages hot coffee six ounces. Resident 55 stated he would like to have coffee with his meal when asked by LVN 4. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 55 was initiated on 2/11/26. Resident 55 was admitted to the facility on [DATE]. Review of Resident 55's H&P examination dated 7/10/25, showed Resident 55 had no capacity to understand and make his own decisions. On 2/12/26 at 1115 hours, an interview was conducted with the DSS. The DSS stated the nursing staff should provide coffee to the resident as listed in the meal ticket in the dining room. The DSS further stated the coffee was provided when the meal cart was delivered to the dining room. On 2/18/26 at 1516 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and facility P&P review, the facility failed to ensure the food brought from the outside were handled safely. * The facility staff and residents' visitors were not educated on the safe food handling practices when food from the outside was brought to the facility for resident consumption. This failure had the potential for unsafe food handling which could lead to food borne illness in the residents who resided in the facility. Findings: Review of the facility's P&P titled Food Brought in by Visitors revised 3/28/24, showed in part Family members and visitors will be educated to inform nursing staff of their desire to bring food into the facility. Family/visitors are asked to prepare and transport food using safe food handling practices. Review of the facility's in-service lesson plan and attendance record titled Safe Food Handling in a Skilled Nursing Facility dated 6/19/25, showed an in-service was conducted by the DSD. The in-service included implementation which reviewed the safe food handling in the facility; however, the safe food handling preparation and transport of food brought in from home was not included. On 2/17/26 at 1321 hours, an observation of the refrigerator used to store the residents' food brought into the facility from the outside and concurrent interview was conducted with LVN 4. When asked how the visitors were educated on safe food handling practices, LVN 4 stated she was not sure how the visitors were educated on safe food handling practices. When asked if she had received education on safe food handling, LVN 4 stated she could not remember. LVN 4 stated she was informed to make sure resident's food was labeled with the resident's name and the date it was brought into the facility. On 2/17/26 at 1333 hours, an interview was conducted with CNA 4. When asked how the visitors were educated on safe food handling practices, CNA 4 stated she was not sure how the visitors were educated on safe food handling practices. When asked if she had received education on safe food handling, CNA 4 stated she did not know about the safe handling of food. On 2/18/26 at 1038 hours, an interview and concurrent record review was conducted with the DSD. The DSD verified she had conducted the Safe Food Handling in a Skilled Nursing Facility dated 6/19/25, to the nursing staff. When asked how the visitors were educated on the safe food handling practices, the DSD stated the visitors were informed verbally by staff to make sure to bring the right diet texture for the resident and was educated regarding the facility's policy of bringing food in the facility. The DSD stated the facility did not provide safe food handling information in writing for the family members. On 2/18/26 at 1508 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain an accurate medical record for two of 24 final sampled residents (Residents 6 and 10) and one of three residents (Resident 22) reviewed for closed records. * The facility failed to ensure the POLSTs were complete for Residents 6, 10 and 122. This failure had the potential for the residents' care needs to not be met as their medical information was inaccurate.Findings: Review of facility's P&P titled Charting and Documentation revised dated 7/2017 showed documentation in the medical record will be objective (not opiniated or speculative), complete, and accurate. 1. Medical record review for Resident 6 was initiated on 2/12/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's POLST dated 12/17/25, showed under Section D - Information and Signatures, the following check boxes were left blank: Advance Directive, Advance directive not available, and No Advance Directive. The blank boxes indicated the information was not complete for this section. Review of Resident 6's H&P examination dated 12/18/25, showed the resident had no capacity to understand and make decisions. On 2/12/26 at 1615 hours, an interview and concurrent medical record review for Resident 6 was conducted with the Social Services Assistant. The Social Services Assistant stated the social services was responsible to review the POLST for completion. The Social Services Assistant verified and acknowledged Resident 6's POLST section D was incomplete. 2. Medical record review for Resident 10 was initiated on 2/12/26. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 10/22/25, showed the resident had no capacity to understand and make decisions. Review of Resident 10's POLST dated 12/2/25, showed under Section D - Information and Signatures, the following check boxes were left blank: Advance Directive, Advance directive not available, and No Advance Directive. The blank boxes indicated the information was not complete for this section. On 2/12/26 at 1620 hours, an interview and concurrent medical record review for Resident 10 was conducted with the Social Services Assistant. The Social Services Assistant stated the social services was responsible to review the POLST for completion. The Social Services Assistant verified and acknowledged Resident 10's POLST section D was incomplete. On 2/18/26 at 1305 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings. 3. Closed medical record review for Resident 122 was initiated on 2/13/26. Resident 122 was admitted to the facility on [DATE], and discharged on 12/16/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 122's H&P examination dated 10/19/25, showed the resident had no capacity to understand and make decisions. Review of Resident 122's POLST dated 10/21/25, showed Signature of Patient or Legally Recognized Decisionmaker section was not completed. In addition, the Completing POLST section showed to be valid a POLST form must be signed by (1) a physician, or by a NP or a PA acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. On 2/17/26 at 1511 hours, an interview and concurrent closed medical record review for Resident 122 was conducted with the Social Services Assistant. The Social Services Assistant verified the Signature of Patient or Legal Decisionmaker section of Resident 122's POLST was blank and not completed. The Social Services Assistant stated all the sections of Resident 122's POLST form should have been completed. The Social Services Assistant stated the form should be completed to avoid delay of care. On 2/17/26 at 1531 hours, an interview and concurrent closed medical record review for Resident 122 was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse or social services staff should have called Resident 122's representative to ensure the resident's preference for end-of-life care. On 2/18/26 at 1403 hours, and interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interview, the facility failed to maintain the essential equipment in a safe operating condition for one of three facility water heaters (Water Heater 1). * Water Heater 1 was observed leaking water from the check valve. This failure had the potential to cause water heater component damage, which posed the risk for the residents' water heater to malfunction. Findings: On 2/17/26 at 1010 hours, an observation was conducted of the facility's water heaters. Water Heater 1 was observed leaking water from the check valve. On 2/17/26 at 1500 hours, an interview was conducted with the Director of Maintenance. The Director of Maintenance stated he was aware the check valve on Water Heater 1 was leaking water. The Director of Maintenance stated Water Heater 1 provided water to the resident rooms throughout the facility. The Director of Maintenance stated the check valve functioned to prevent the backflow of water. The Director of Maintenance stated the facility was in the process of repairing the leak.

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	555473	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta Gardens Care Center	13075 Blackbird Street Garden Grove, CA 92843

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the PASRR level 1 contained accurate information for one of two final sampled residents (Resident 3) reviewed for PASRR. * Resident 3 had the diagnosis of major depressive disorder (mood disorder characterized by persistent sadness, hopelessness, and loss of interest in activities lasting at least two weeks) and was prescribed quetiapine (antipsychotic medication). However, the PASRR level 1 showed Resident 3 had no diagnosed mental illness and was not prescribed the psychotropic medication. This failure posed the risk for Resident 3 inappropriate placement in a long-term care nursing home when a PASRR level 2 evaluation was not done.Findings: Review of the facility's P&P titled PASRR Completion Policy revised 9/30/24, showed the facility will make sure all admissions have the appropriate PASRR completed. Medical record review for Resident 3 was initiated on 2/11/26. Resident 3 was admitted to the facility on [DATE]. Resident 3 had the diagnosis of recurrent major depressive disorder. Review of Resident 3's PASRR level 1 dated 5/22/25, showed Resident 3 had no diagnosed serious mental illness and was not prescribed any psychotropic medications. The form showed the level 1 screening was negative and a level 2 evaluation was not required. Review of Resident 3's H&P examination dated 5/23/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's admission MDS assessment dated [DATE], showed Resident 3 was taking an antipsychotic medication. Review of Resident 3's Order Summary Report dated 2/12/26, showed the following physician's orders:- dated 10/21/25, to administer quetiapine 50 mg give 1/2 (half) tablet by mouth two times a day for psychosis manifested by striking out.- dated 2/6/26, to administer divalproex (anticonvulsant medication, used as a mood stabilizer) 125 mg one capsule by mouth two times a day for mood stabilizer manifested by sudden verbal aggression without provocation, yelling, and cursing. On 2/12/26 at 1530 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON stated she, along with the RN Supervisor, were responsible for the coordination of the PASRR. The DON stated a PASRR level 1 screening was conducted at the acute hospital and transmitted to the facility prior to the resident's admission. The DON stated the facility was responsible for reviewing the PASRR level I screening for accuracy. The DON further stated the PASRR level 1 screening was conducted upon the resident's admission to the facility, and a resident review was conducted annually, or when the resident had a diagnosis of serious mental illness or was prescribed any psychotropic medications. The DON stated if the PASRR level 1 screening was positive, the level 2 evaluation would be conducted. The DON reviewed Resident 3's medical records and verified the above findings. The DON stated Resident 3's PASRR level 1 screening was inaccurate and a resident review should have been conducted when Resident 3 was prescribed the divalproex medication. On 2/18/26 at 1453 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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the plan of care was revised for one of 24 final sampled residents (Resident 25). * The facility failed to ensure Resident 25's plan of care was revised to address the resident's fall on 1/4/26. This failure posed the risk for Resident 25 to not receive the person-centered care and services required to attain or maintain her highest level of physical and mental well-being. Findings: Review of the facility's P&P titled Care Plan Comprehensive dated 8/25/21, showed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, physical, mental and psychosocial needs shall be developed for each resident. Under the Procedure section showed assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change. Medical record review for Resident 25 was initiated on 2/11/26. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 12/28/25, showed the resident had no capacity to understand and make decisions. Review of Resident 25's Care Plan Report dated 12/11/25, showed the resident was at risk for falls/injury. Review of Resident 25's eINTERACT Change in Condition Evaluation - V5.1 dated 1/4/26, showed the resident had an unwitnessed fall and a small bump on the left cheek. Resident 25 stated she fell while attempting to get up from the bed. However, further review of Resident 25's medical record review failed to show documented evidence the resident's care plan was revised to address the resident's fall on 1/4/26. On 2/17/26 at 1413 hours, an interview and concurrent medical record review for Resident 25 was conducted with the MDS Nurse. The MDS Nurse verified Resident 25's medical record failed to show the resident's plan of care was revised to address the resident's fall on 1/4/26. The MDS Nurse stated Resident 25's care plan should have been completed to prevent further episodes of fall. On 2/17/26 at 1433 hours, an interview and concurrent medical record review for Resident 25 was conducted with the DON. The DON verified Resident 25's care plan was not revised to address the resident's fall on 1/4/26. On 2/18/25 at 1507 hours, a follow up interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure one of one final sampled resident (Resident 79) reviewed for respiratory services was provided with the appropriate respiratory care. * The facility failed to ensure Resident 79's nebulizer mask and tubing were labeled with the date and properly stored in a bag when not in use. This failure had the potential to affect Resident 79's respiratory health and well-being. Findings: Medical record review for Resident 79 was initiated on 2/11/26. Resident 79 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 79's H&P examination dated 1/10/26, showed Resident 79 had no capacity to understand and make decisions. On 2/11/26 at 0844 hours, an observation and concurrent interview was conducted with CNA 1 at Resident 79's bedside. Resident 79's nebulizer mask was observed undated and stored inside Resident 79's bedside drawer. The nebulizer mask was not inside a set-up bag. CNA 1 verified the above findings. On 2/17/26 at 1347 hours, an interview and concurrent medical record review for Resident 79 was conducted with LVN 5. LVN 5 stated Resident 79 was on room air and received the breathing treatments as needed, every six hours for shortness of breath or wheezing. LVN 5 stated when the nebulizer mask was not in use, it should be placed inside of a clear set-up bag. On 2/17/26 at 1448 hours, an interview was conducted with the DON. The DON stated the nebulizer mask and equipment including the tubing should be changed every seven days. The DON stated the nebulizer mask should be labeled with the date so the facility staff would know when it should be changed. The DON stated when the nebulizer mask was not in use, the equipment should be placed inside the clear set up bag for infection control purposes. On 2/18/26 at 1453 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 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment;2. A plan to maximize recruitment and retention of direct care staff; and3. A contingency plan for staffing needs. These failures had the potential not to meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed.Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility Assessment, which was reviewed by the facility on 7/29/25, did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; a plan to maximize recruitment and retention of the direct care staff; and a contingency plan for staffing needs. On 2/12/26 at 1216 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator reviewed the Facility assessment dated [DATE], and verified there were no direct care staff, direct care representatives, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no documentation of a plan to maximize recruitment and retention of direct care staff and a contingency plan for staffing needs in the Facility Assessment. The Administrator stated he was not aware of the current guidance. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.