STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555583	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MacLay Healthcare Center	12831 MacLay Street Sylmar, CA 91342

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to create and implement a comprehensive, person-centered care plan with measurable objectives and interventions for one of three sampled residents (Resident 1). The facility failed to develop and implement an individualized care plan with interventions addressing the following: Resident 1's orthostatic blood pressure monitoring.Resident 1's preference in using a slip-on rubber slipper while ambulating (walking).Resident 1's refusal in using an assistive device while ambulating. These deficient practices placed Resident 1 at risk for not receiving the necessary services and assistance that can result in resident injury and serious condition such as worsening of Resident 1's orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from sitting or lying position and may cause lightheadedness, dizziness or fainting), falls, and fractures (broken bones).Findings: During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted the resident on 2/10/2026 with diagnoses including orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from sitting or lying position and may cause lightheadedness, dizziness or fainting), difficulty walking, muscle weakness, history of falling, and restless leg syndrome (RLS - a nervous system disorder that creates an irresistible urge to move your legs, usually accompanied by uncomfortable sensations like crawling, itching, or pulling). During a review of Resident 1's Fall Risk Evaluation, dated 2/10/2026, the Fall Risk Evaluation indicated Resident 1 had a total score of 15. A total score of ten and above represented high risk for falls. During a review of Resident 1's Physician Order, dated 2/13/2026, the Physician Order indicated to monitor for side effects of mirtazapine (a medication used to treat depression [a mental health condition causing persistent sadness, loss of interest, and decreased energy that interferes with daily life] and frequently used for its sedative [medication that calms the mind and body] and appetite-stimulating effects) such as postural hypotension (also known as orthostatic hypotension, a sudden drop in blood pressure that occurs when standing up from a sitting or lying position). The Physician Order indicated for nursing staff to document observations using tally marks or hash marks (a system used for counting or keeping track of ongoing results with each mark representing one unit) on the Medication Administration Record (MAR - a legal document used by healthcare professionals to track and record every dose of medication given to a resident) every shift. During a review of Resident 1's Physician Order, dated 2/13/2026, the Physician Order indicated to monitor for side effects of anti-psychotic medications (used to manage symptoms of psychosis [a set of symptoms indicating a loss of contact with reality, where a person has trouble distinguishing what is real from what is not]), including drowsiness (a state of strong desire for sleep or extended, inappropriate sleeping during the day) and postural hypotension. The Physician Order indicated for nursing staff to document these side effects using tally marks on Resident 1's MAR every shift. During a review of Resident 1's Change in Condition (COC - when there is a sudden change in a resident's condition) Evaluation, dated 2/26/2026, the COC Evaluation indicated on 2/26/2026 at 4:30 a.m., Resident 1 was found sitting on the floor beside the resident's bed. The Functional Status Evaluation section that will indicate if Resident 1 had an orthostatic hypotension was not completed. During a review of Resident 1's Fall Risk Evaluation, (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 2/26/2026, the Fall Risk Evaluation indicated Resident 1 had a total score of ten. A total score of ten and above represented high risk for falls. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2026, the MDS indicated Resident 1's cognitive (refers to the mental processes involved in gaining knowledge, understanding, and thinking) skills for daily decision making were moderately impaired. The MDS further indicated that Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for mobility (movement) activities, including sit-to-stand (the ability to come to a standing position from sitting in a chair, wheelchair, or the side of the bed) transfers and walking 150 feet (ft - unit of measurement). The MDS indicated Resident 1 required set-up assistance (helper assists the resident prior to or following the activity) for walking 50 ft with two turns (once standing, the ability to walk at least 50 ft and make two turns). During a review of Resident 1's Change in Condition (COC) Evaluation, dated 4/25/2026, the COC Evaluation indicated on 4/25/2026 at 1:55 a.m., Resident 1 had a fall while ambulating in the hallway. The COC Evaluation indicated Resident 1 complained of severe pain in the left shoulder and entire left arm and did not tolerate the range of motion (ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point) on the left upper arm. The Functional Status Evaluation section indicated Resident 1 did not have orthostatic hypotension but there was no documented evidence that orthostatic blood pressure was taken. During an interview on 4/29/2026 at 6:30 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 1 wore a purple rubber slipper, one to two inches thick, and occasionally refused to use the wheelchair while ambulating. During a concurrent interview and record review on 4/29/2026 at 6:59 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 1's admission Record, Progress Notes dated 4/1/2026 to 4/28/2026, Vital Signs Log dated 2/10/2026 to 4/28/2026, and Care Plan (document that outlines the specific healthcare and support needs of a resident, along with strategies and interventions to address those needs) initiated on 2/10/2026, were reviewed. LVN 2 stated Resident 1 refused to wear nonskid socks and preferred to wear personal purple rubber slippers approximately one to one and a half inches thick. LVN 2 further stated Resident 1 occasionally refused to use the assistive device while ambulating. LVN 2 stated there was no documented evidence in Resident 1's medical records that indicated Resident 1 was monitored for orthostatic hypotension. LVN 2 reviewed Resident 1's care plan for falls, initiated on 2/10/2026, which identified Resident 1 as high risk for falls due to impaired balance, decreased or poor safety awareness, orthostatic hypotension, history of repeated falls, and possible medication side effects. LVN 2 stated Resident 1's care plan interventions did not indicate the resident's orthostatic blood pressure monitoring, use of personal rubber slippers, and Resident 1's refusal to use assistive device while ambulating. LVN 2 stated that the use of slippers and refusal to use an assistive device while ambulating may have contributed to Resident 1's fall. LVN 2 stated Resident 1's care plan was incomplete. During an interview on 4/29/2026 at 1:26 p.m. with the Director of Nursing (DON), the DON stated Resident 1's preference to use a personal slipper and the resident's refusal to use assistive devices while ambulating should have been addressed and reflected in the resident's care plan. The DON stated Resident 1's care plan did not have interventions that included orthostatic blood pressure monitoring. The DON stated Resident 1's care plans were not complete. The DON stated that the facility failed to identify the use of open-toed and open back slippers while ambulating and the resident's refusal to use an assistive device as risks for falls. The DON stated the facility failed to create a care plan and implement the appropriate interventions to prevent Resident 1 from falling and sustaining injuries. During a review of the facility's policy and procedure (PnP) titled, Care Planning, last reviewed on 4/16/2026, the PnP indicated each resident will have an individualized, person-centered care plan developed and implemented by the Interdisciplinary Team (IDT - a collaborative group of professionals from different disciplines - such as physicians, nurses, therapists, and social workers - who work together to create and implement a single, unified care plan for a resident) that reflects the resident's needs, preferences, goals, and clinical conditions. During a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's PnP titled, Nursing Assessment, last reviewed on 4/16/2026, the PnP indicated all residents will receive timely, comprehensive, and ongoing nursing assessments to identify clinical needs, detect changes in condition, and ensure appropriate interventions are implemented in accordance with physician orders and professional standards. The PnP indicated nursing assessments must be communicated to the Interdisciplinary Team (IDT), reflected in the care plan updates.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to follow professional standards of nursing practice for one of three sampled residents (Resident 1) by failing to:Ensure licensed nurses monitored Resident 1's orthostatic blood pressure related to the resident's orthostatic hypotension. Resident 1's orthostatic blood pressure was not taken from 2/13/2026 to 4/28/2026.Ensure licensed nurses appropriately assessed Resident 1's risk for falls following the resident's fall on 2/26/2026. Ensure licensed nurses appropriately assessed and monitored Resident 1's medical status following the resident's Change of Condition (COC - when there is a sudden change in a resident's condition) on 4/25/2026 related to the resident's fall. These deficient practices had the potential to result in the failure to identify continued or worsening clinical deterioration and increase risk for falls, thereby placing Resident 1 at risk for adverse health outcomes and compromised safety.Findings: During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted the resident on 2/10/2026 with diagnoses including orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from sitting or lying position and may cause lightheadedness, dizziness or fainting), difficulty walking, muscle weakness, history of falling, and restless leg syndrome (RLS - a nervous system disorder that creates an irresistible urge to move your legs, usually accompanied by uncomfortable sensations like crawling, itching, or pulling). During a review of Resident 1's Physician Order, dated 2/13/2026, the Physician Order indicated to monitor for side effects of anti-psychotic medications (used to manage symptoms of psychosis [a set of symptoms indicating a loss of contact with reality, where a person has trouble distinguishing what is real from what is not]), including drowsiness (a state of strong desire for sleep or extended, inappropriate sleeping during the day) and postural hypotension (also known as orthostatic hypotension, a sudden drop in blood pressure that occurs when standing up from a sitting or lying position). The Physician Order indicated for nursing staff to document these side effects using tally marks on Resident 1's Medication Administration Record (MAR - a legal document used by healthcare professionals to track and record every dose of medication given to a resident) every shift. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2026, the MDS indicated Resident 1's cognitive (refers to the mental processes involved in gaining knowledge, understanding, and thinking) skills for daily decision making were moderately impaired. The MDS further indicated that Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for mobility (movement) activities, including sit-to-stand (the ability to come to a standing position from sitting in a chair, wheelchair, or the side of the bed) transfers and walking 150 feet (ft - unit of measurement). The MDS indicated Resident 1 required set-up assistance (helper assists the resident prior to or following the activity) for walking 50 ft with two turns (once standing, the ability to walk at least 50 ft and make two turns). During a review of Resident 1's Change in Condition (COC - when there is a sudden change in a resident's condition) Evaluation, dated 4/25/2026, the COC Evaluation indicated on 4/25/2026 at 1:55 a.m., Registered Nurse 1 (RN 1) was notified of Resident 1's fall. The COC Evaluation indicated Resident 1 complained of severe pain in the left shoulder and entire left arm and did not tolerate the range of motion (ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point) on the left upper arm. The COC Evaluation indicated Resident 1 was left on the floor until the paramedics (are highly trained healthcare professional who provide advanced medical care to individuals outside of a hospital setting) arrived. The Functional Status Evaluation section indicated Resident 1 did not have orthostatic hypotension but there was no documented evidence that orthostatic blood pressure was taken. During an interview on 4/28/2026 at 1:54 p.m., and a concurrent record review of Resident 1's MAR dated 4/1/2026 to 4/30/2026, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated there was no documented evidence Resident 1's orthostatic blood pressure was monitored. LVN 1 stated Resident 1 was prescribed anti-psychotic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications that required orthostatic blood pressure monitoring in accordance with the physician's order. LVN 1 stated that orthostatic blood pressure is assessed by obtaining blood pressure readings while the resident is lying, sitting, and standing. A review of Resident 1's vital signs (essential objective measurements of basic body functions such as body temperature, heart rate, respiration rate, and blood pressure) logs, dated 2/10/2026 to 4/28/2026, was conducted during the interview. LVN 1 stated that there was no documented evidence indicating that blood pressure readings were obtained while standing. LVN 1 further stated that she was not checking Resident 1's orthostatic blood pressures. LVN 1 stated that failure to monitor Resident 1's orthostatic blood pressure could result in an undetected episode of orthostatic hypotension, which may increase the risk for falls. LVN 1 stated Resident 1 had a fall on 4/25/2026. LVN 1 stated Resident 1 should be monitored every shift for 72 hours. LVN 1 stated Resident 1's Progress Notes, dated 4/25/2026 to 4/28/2026, indicated there was no documented evidence that the resident was monitored on the following shifts: a. On 4/26/2026 (3 p.m. to 11 p.m. shift and 11 p.m. to 7 a.m. shift) and b. On 4/27/2026 (7 a.m. to 3 p.m. shift). LVN 1 stated that failure to document Resident 1's medical status monitoring following a change of condition related to a fall could put Resident 1's safety at risk. During an interview on 4/29/2026 at 1:26 p.m. and a concurrent record review of Resident 1's Fall Risk Evaluation, dated 2/26/2026, with the Director of Nursing (DON), the DON stated Resident 1 had a total score of ten representing high risk for falls. The DON stated Resident 1 had history of multiple falls. The DON stated the Fall Risk Evaluation indicated Resident 1 had no falls in the past 90 days, the Gait Evaluation section was not completed and indicated there was no drop in orthostatic blood pressure between lying and standing. The DON stated there was no documented evidence of Resident 1's orthostatic blood pressure was taken. The Diagnosis Review section indicated Resident 1 had one to two present diseases and diagnoses that could contribute to falls. The DON stated Resident 1 had more than two diseases and diagnoses that could contribute to falls. The DON stated failure to accurately evaluate Resident 1's risk for falls could cause inadequate interventions required to prevent falls and injuries. The DON stated there was no documented evidence of monitoring on the identified shifts and Resident 1's orthostatic blood pressures. The DON stated care not documented was considered not provided. The DON stated failure to monitor Resident 1 every shift after a COC could result to the resident's missed signs of orthostatic hypotension that could lead to falls and injury. The DON stated the facility failed to identify, document, and monitor Resident 1's risk for falls. The DON further stated the facility failed to follow the physician orders to monitor Resident 1 for orthostatic hypotension. During a review of the facility's policy and procedures (PnP) titled, Nursing Assessment, last reviewed on 4/16/2026, the PnP indicated all residents will receive timely, comprehensive, and ongoing nursing assessments to identify clinical needs, detect changes in condition, and ensure appropriate interventions are implemented in accordance with physician orders and professional standards. The PnP indicated the purpose to ensure early detection of changes in condition, timely intervention and physician notification, prevention of avoidable decline, accurate and complete clinical documentation. During a review of the facility's PnP titled, Orthostatic Blood Pressure Monitoring, last reviewed on 4/16/2026, the PnP indicated the purpose is to identify and manage residents at risk for orthostatic hypotension to prevent falls and injury. The PnP indicated the facility will monitor orthostatic blood pressure (BP) for residents at risk and ensure timely intervention, documentation, and physician notification. During a review of the facility's PnP titled, Change in Condition, last reviewed on 4/16/2026, the PnP indicated, the facility will promptly recognize, assess, and respond to any changes in a resident's physical, cognitive, or emotional condition to ensure timely medical intervention and maintain resident safety. The Follow-up section indicated to monitor the resident until the condition stabilizes and adjust care plans and interventions as recommended by physician or Interdisciplinary Team (IDT).

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was cognitively impaired (refers to difficulties with thinking, learning, remembering, and using judgment, among other mental abilities) and had documented history of falls, (as indicated in Resident 1's admission Record), was free from preventable falls and injury, by failing to: a. Monitor Resident 1's orthostatic blood pressure (a change in blood pressure that occurs when a person stands up from a sitting or lying position) in accordance with physician orders. b. Ensure Resident 1 wore nonskid (slip-resistant) footwear while ambulating (walking). c. Ensure Resident 1 used the assistive device (a tool or equipment that helps a person with a disability or medical condition maintain or improve their independence, safety, and ability to perform daily tasks such as walking) while ambulating. As a result, on 4/25/2026 at 1:55 a.m., Resident 1 fell to the ground while ambulating in the hallway without the assistive device and while wearing personal slip-on slippers (a comfortable, indoor shoe designed to be easily put on and taken off but lacks the support, stability, and secure fit leading to potential risks of falls, tripping, and foot pain). Following the fall, Resident 1 reported severe pain (pain not measured in numerical value) to the left shoulder and entire left arm and was subsequently diagnosed with a closed displaced fracture of the proximal end of the left humerus (a common serious type of broken shoulder where the top part of the left upper arm bone is broken into two or more pieces that moved out of their normal position, but had not broken through the skin), and a closed displaced fracture of the left great toe proximal phalanx (broken big toe bone on the left foot but had not broken through the skin). Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) on 4/25/2026 for further evaluation and treatment.Findings: During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted Resident 1 on 2/10/2026 with diagnoses including orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from sitting or lying position and may cause lightheadedness, dizziness or fainting), difficulty walking, muscle weakness, history of falling, and restless leg syndrome (RLS - a nervous system disorder that creates an irresistible urge to move your legs, usually accompanied by uncomfortable sensations like crawling, itching, or pulling). During a review of Resident 1's History and Physical (H&P- a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 2/11/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Physician Order, dated 2/13/2026, the Physician Order indicated to monitor for side effects of mirtazapine (a medication used to treat depression [a mental health condition causing persistent sadness, loss of interest, and decreased energy that interferes with daily life] and frequently used for its sedative [medication that calms the mind and body] and appetite-stimulating effects) such as postural hypotension (also known as orthostatic hypotension, a sudden drop in blood pressure that occurs when standing up from a sitting or lying position). The Physician Order indicated for nursing staff to document observations using tally marks or hash marks (a system used for counting or keeping track of ongoing results with each mark representing one unit) on the Medication Administration Record (MAR - a legal document used by healthcare professionals to track and record every dose of medication given to a resident) every shift. During a review of Resident 1's Physician Order, dated 2/13/2026, the Physician Order indicated to monitor for side effects of anti-psychotic medications (used to manage symptoms of psychosis [a set of symptoms indicating a loss of contact with reality, where a person has trouble distinguishing what is real from what is not]), including drowsiness (a state of strong desire for sleep or extended, inappropriate sleeping during the day) and postural hypotension. The Physician Order indicated for nursing staff to document these side effects using tally marks on Resident 1's MAR every shift. During a review of Resident 1's Fall Risk (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Evaluation, dated 2/26/2026, the Fall Risk Evaluation indicated Resident 1 had a total score of ten (score breakdown not indicated) and indicated Resident 1 was a high risk for falls. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2026, the MDS indicated Resident 1's cognitive (refers to the mental processes involved in gaining knowledge, understanding, and thinking) skills for daily decision making were moderately impaired. The MDS further indicated that Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for mobility (movement) activities, including sit-to-stand (the ability to come to a standing position from sitting in a chair, wheelchair, or the side of the bed) transfers and walking 150 feet (ft - unit of measurement). The MDS indicated Resident 1 required set-up assistance (helper assists the resident prior to or following the activity) for walking 50 ft with two turns (once standing, the ability to walk at least 50 ft and make two turns). During a review of Resident 1's Change in Condition (COC - when there is a sudden change in a resident's condition) Evaluation, dated 4/25/2026, the COC Evaluation indicated on 4/25/2026 at 1:55 a.m., Registered Nurse 1 (RN 1) was notified of Resident 1's fall. The COC Evaluation indicated Resident 1 complained of severe pain in the left shoulder and entire left arm and did not tolerate the range of motion (ROM - the extent or limit to which a part of the body can be moved around a joint or a fixed point) on the left upper arm. The COC Evaluation indicated Resident 1 was left on the floor until the paramedics (are highly trained healthcare professional who provide advanced medical care to individuals outside of a hospital setting) arrived. During a review of Resident 1's Physician Order, dated 4/25/2026, the Physician Order indicated the facility transferred Resident 1 to GACH 1 via ambulance (a specially equipped vehicle used to transport sick or injured people to a hospital, usually for emergency medical care) due to the fall. During a review of Resident 1's GACH 1 Emergency Department (ED) Provider Notes, dated 4/25/2026, the ED Provider Notes indicated that x-rays (medical imaging test that uses a small amount of radiation through the body to create pictures of bones and organs) were performed on Resident 1's left humerus (the long bone located in the upper arm, extending from the shoulder to the elbow) and left foot. The ED Provider Notes indicated Resident 1 sustained a closed displaced fracture of the proximal end of the left humerus and a closed displaced fracture of the proximal phalanx of the left great toe. The ED Provider Notes further indicated that Resident 1's left arm required the use of a shoulder immobilizer (medical sling with extra straps that securely holds the arm against the chest to stop the shoulder from moving) and Resident 1's left big toe required a buddy tape (a method that wraps an injured finger or toe together with an adjacent healthy one that acts as a splint). During a concurrent observation and interview on 4/28/2026 at 9:03 a.m., with Resident 1, Resident 1 stated that on 4/25/206, at around 1:55 a.m., she (Resident 1) walked to the restroom and then to the sink (both located inside the resident's room) without using her front-wheeled walker (FWW - a mobility aid with wheels on the front two legs, designed to help a person walk with improved stability and easier maneuvering) or a wheelchair. Resident 1 stated she returned to sit on her bed, stood up again, and proceeded to walk outside of her room without an assistive device. Resident 1 stated she did not recall why she left her room or where she intended to go. Resident 1 stated the next thing she remembered was being on the floor in front of Nurse Station 4, experiencing severe pain in her left arm. Resident 1 stated she was wearing her personal purple slip-on slippers on 4/25/2026, the day of the fall. During an observation, Resident 1's purple open-toed and open-back slippers were observed in Resident 1's room. During an interview on 4/28/2026 at 1:54 p.m., and a concurrent record review of Resident 1's MAR dated 4/1/2026 to 4/30/2026, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated there was no documented evidence Resident 1's orthostatic blood pressure was monitored. LVN 1 stated Resident 1 was prescribed anti-psychotic medications that required orthostatic blood pressure monitoring in accordance with the physician's order. LVN 1 stated that orthostatic blood pressure is assessed by obtaining blood pressure readings while the resident is lying, sitting, and standing. A review of Resident 1's vital signs (essential objective measurements of basic body functions such as body (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	temperature, heart rate, respiration rate, and blood pressure) logs, dated 2/10/2026 to 4/28/2026, was conducted during the interview. LVN 1 stated that there was no documented evidence indicating that blood pressure readings were obtained while standing. LVN 1 further stated that she was not checking Resident 1's orthostatic blood pressures. LVN 1 stated that failure to monitor Resident 1's orthostatic blood pressure could result in an undetected episode of orthostatic hypotension, which may increase the risk for falls. During an interview on 4/29/2026 at 6:30 a.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 1 walks in the hallway while pushing a wheelchair as a walker for support but would occasionally refuse to use the wheelchair. CNA 2 stated on 4/25/2026, she (CNA 2) observed Resident 1 walking from her (Resident 1) room towards Nurse Station 4. CNA 2 stated Resident 1 was wearing purple rubber slippers, one to two inches (in- unit of measurement) thick and was not using an assistive device at the time. CNA 2 further stated that Resident 1 fell forward and subsequently complained of left shoulder pain. During an interview on 4/29/2026 at 6:59 a.m. and a concurrent record review of Resident 1's admission Record, Progress Notes dated 4/1/2026 to 4/28/2026, Vital Signs Log dated 2/10/2026 to 4/28/2026, and Care Plan (document that outlines the specific healthcare and support needs of a resident, along with strategies and interventions to address those needs) initiated on 2/10/2026, the records were reviewed with Licensed Vocational Nurse 2 (LVN 2). LVN 2 stated Resident 1's diagnoses included orthostatic hypotension, muscle weakness, and difficulty walking. LVN 2 stated Resident 1 refused to wear nonskid socks and preferred to wear personal purple rubber slippers approximately one to one and a half inches thick. LVN 2 further stated Resident 1 occasionally refused to use the assistive device while ambulating. LVN 2 stated orthostatic blood pressure should be obtained by first measuring blood pressure while the resident is in lying and sitting positions using a battery-operated blood pressure machine, followed by repeat measurements after 15 to 30 minutes using a manual blood pressure machine. LVN 2 stated she did not obtain Resident 1's standing blood pressure due to LVN 2's fear that the resident might fall if the blood pressure decreased or dropped. LVN 2 stated on 4/25/2026 she (LVN 2) observed Resident 1 walking in the hallway in front of Nurse Station 4 from the resident's room without an assistive device. LVN 2 stated Resident 1 appeared groggy (a state of being weak, dizzy, and unable to think clearly or move properly). LVN 2 stated she did not witness Resident 1's actual fall but observed Resident 1 lying in a prone (lying flat, specifically face down) position on the floor with both arms positioned under the resident's body. LVN 2 further stated Resident 1 complained of left arm pain and was observed wearing purple rubber slippers at the time of the incident. LVN 2 reviewed Resident 1's care plan for falls, initiated on 2/10/2026, which identified Resident 1 as high risk for falls due to impaired balance, decreased or poor safety awareness, orthostatic hypotension, history of repeated falls, and possible medication side effects. LVN 2 stated Resident 1's care plan interventions did not indicate the resident's orthostatic blood pressure monitoring, use of personal rubber slippers, and Resident 1's refusal to use assistive device while ambulating. LVN 2 stated that the use of slippers and refusal to use an assistive device while ambulating may have contributed to Resident 1's fall. During a concurrent observation and interview on 4/29/2026 at 8:15 a.m., with the Maintenance Director (MDtr), the MDtr measured the distance from Resident 1's bed to Nurse Station 4, where Resident 1 had walked without an assistive device prior to the fall on 4/25/2026. The MDtr stated that the total distance measured was 71 ft. During an interview on 4/29/2026 at 9:30 a.m. and concurrent record review of Resident 1's Physical Therapy (healthcare specialty focused on treating injuries, illnesses or conditions that limit mobility and physical function) Treatment Encounter Notes, dated 3/31/2026, with Physical Therapist 1 (PT 1 - a licensed healthcare professional who diagnoses and treats patients of all ages with conditions limiting their ability to move and function), PT 1 stated Resident 1's vital signs were monitored due to the resident's history of syncope (temporary loss of consciousness [is the state of being aware of one's surroundings, sensations, thoughts, and existence] and muscle strength caused by a sudden drop in blood flow to the brain, usually lasting only a few seconds to minutes). PT 1 stated Resident 1 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was able to ambulate 150 feet within the facility by using the handle of the resident's wheelchair for support. PT 1 further stated Resident 1 was not trained to ambulate more than ten feet without the use of an assistive device. During an interview on 4/29/2026 at 10:04 a.m., and a concurrent record review of Resident 1's Physical Therapy Discharge summary, dated [DATE], with the Director of Rehabilitation (DOR), the DOR stated Resident 1's Physical Therapy Discharge Summary indicated the resident's treatment diagnosis as difficulty walking. The Discharge Recommendation and Status section indicated that Resident 1 may ambulate as desired within the facility using a FWW with staff supervision. The DOR stated she was not aware that Resident 1 refused to use an assistive device or that the resident preferred to wear slippers while ambulating. The DOR further stated that the physical therapy department did not recommend the use of slippers for Resident 1 due to the resident's increased risk for falls. During an interview on 4/29/2026 at 1:26 p.m., with the Director of Nursing (DON), the DON stated Resident 1 was at high risk for falls and had diagnoses that included orthostatic hypotension. The DON stated Resident 1's orthostatic blood pressure should be obtained while the resident is in lying, sitting, and standing positions. The DON further stated that obtaining Resident 1's standing blood pressure reading is crucial in identifying orthostatic hypotension and monitoring the resident's condition. The DON stated Resident 1's orthostatic blood pressure should have been monitored in accordance with the physician's orders and documented in Resident 1's medical records. The DON stated there was no documented evidence that Resident 1's orthostatic blood pressure was monitored. The DON stated Resident 1's use of slippers while ambulating and refusal to use an assistive device placed the resident at increased risk for falls and injury. The DON acknowledged and stated the facility failed to monitor Resident 1's orthostatic blood pressure in accordance with the physician order. The DON further stated the facility failed to identify Resident 1's risks for falls and failed to implement interventions to prevent a fall with injury. The DON stated that the facility failed to identify the use of open-toed and open back slippers while ambulating and the resident's refusal to use an assistive device as risks for falls. The DON stated the facility failed to create a care plan and implement the appropriate interventions to prevent Resident 1 from falling and sustaining an injury. During a review of the facility's policy and procedure (PnP) titled, Fall Management Program, last reviewed on 4/16/2026, the PnP indicated the facility is committed to minimizing the risk of resident falls through a structured Fall Management Program that includes prevention, monitoring, and post-fall evaluation. The Fall Prevention Strategies section indicated . implement individualized interventions based on risk level, which may include environmental modifications, mobility assistance and physical therapy. The PnP indicated all post-fall assessments, interdisciplinary team (IDT - a collaborative group of professionals from different disciplines - such as physicians, nurses, therapists, and social workers - who work together to create and implement a single, unified care plan for a resident) recommendations, and care plan updates must be documented in the Electronic Health Record (HER - a secure, digital, and real-time version of a resident's paper chart, containing comprehensive medical history, diagnostics [tests, methods, or procedures used to identify the cause, nature, and severity of a disease, injury, or technical problem], medications, and treatment plans). During a review of the facility's PnP titled, Nursing Assessment, last reviewed on 4/16/2026, the PnP indicated, all residents will receive timely, comprehensive, and ongoing nursing assessments to identify clinical needs, detect changes in condition, and ensure appropriate interventions are implemented in accordance with physician orders and professional standards. The PnP indicated the purpose is to ensure early detection of changes in condition, timely intervention and physician notification, prevention of avoidable decline, accurate and complete clinical documentation. During a review of the facility's PnP titled, Orthostatic Blood Pressure Monitoring, last reviewed on 4/16/2026, the PnP indicated the purpose to identify and manage residents at risk for orthostatic hypotension to prevent falls and injury. The PnP indicated the facility will monitor orthostatic blood pressure (BP) for residents at risk and ensure timely intervention, documentation, and physician notification. During a review of the facility's PnP titled, Care Planning, last reviewed on 4/16/2026, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the PnP indicated, each resident will have an individualized, person-centered care plan developed and implemented by the Interdisciplinary Team (IDT) that reflects the resident's needs, preferences, goals, and clinical conditions.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical records of three of three sampled residents (Resident 1, Resident 2, and Resident 3) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to:a. Ensure certified nursing assistants (CNAs) documented Residents 1, 2, and 3's percentage (% - per one hundred) of food eaten at the correct time. b. Ensure licensed nurses documented the accurate time Resident 1 arrived back at the facility from General Acute Care Hospital (GACH) 1 on 4/25/2026. These deficient practices resulted in inaccurate information on Residents 1, 2, and 3's medical records and had the potential for delayed and inaccurate medical interventions.Findings:During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted the resident on 2/10/2026 with diagnoses including orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from sitting or lying position and may cause lightheadedness, dizziness or fainting), difficulty walking, muscle weakness, history of falling, and restless leg syndrome (RLS - a nervous system disorder that creates an irresistible urge to move your legs, usually accompanied by uncomfortable sensations like crawling, itching, or pulling). During a review of Resident 1's Physician Order, dated 2/10/2026, the Physician Order indicated the resident had consistent carbohydrate diet (CCHO - a meal plan that limits carbohydrates to a specific, steady amount at each meal and snack to manage blood sugar levels).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2026, the MDS indicated Resident 1's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision making was moderately impaired.During an interview on 4/29/2026 at 12:32 p.m. and concurrent record review of Resident 1's Progress Notes, dated 4/25/2026, reviewed with Licensed Vocational Nurse (LVN) 3, LVN 3 stated on 4/25/2026 at 9: 30 a.m., Resident 1 returned to the facility from GACH 1. LVN 3 stated Resident 1's Progress Notes indicated the Assistant Director of Nursing (ADON) documented at 10:56 p.m. that Resident 1 returned to the facility at 9:30 p.m. on 4/25/2026. During an interview on 4/29/2026 at 11:58 a.m. and concurrent record review of Resident 1's Nutritional Task, dated 4/1/2026 to 4/28/2026, reviewed with CNA 3, CNA 3 stated the Nutritional Task section indicated the meal (breakfast, lunch, and dinner) intake amount the resident had eaten in percentage. Resident 1's Nutritional Task indicated the following:On 4/1/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 2:37 p.m.On 4/2/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 2:06 p.m.On 4/5/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 2:38 p.m.On 4/12/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 2:41 p.m.On 4/13/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 1:41 p.m.On 4/16/2026, Resident 1's documented breakfast meal intake was at 2:06 p.m. and lunch meal intake at 2:08 p.m., both at 76% to 100%.On 4/20/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 12:51 p.m.On 4/21/2026, Resident 1's documented breakfast meal intake was 0% to 25% at 2:19 p.m. and lunch meal intake was 26% to 50% at 2:20 p.m.On 4/22/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 1:39 p.m.On 4/23/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 12:53 p.m.On 4/24/2026, Resident 1's documented breakfast and lunch meal intake was 76% to 100%, both at 1 p.m.CNA 3 stated the documented times of Resident 1's percentages of meal intakes were inaccurate. CNA 3 stated Resident 1's meal intake should be documented after the meal had been consumed.During a review of Resident 2's undated admission Record, the admission Record indicated on the facility admitted the resident on 3/13/2025 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities but (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doctors cannot yet determine the exact underlying cause), muscle weakness, and essential hypertension (abnormally high blood pressure that was not the result of a medical condition).During a review of Resident 2's Physician Order, dated 7/29/2025, the Physician Order indicated the resident had regular diet (a balanced, everyday eating plan for healthy individuals with no restrictions).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were intact.During an interview on 4/29/2026 at 11:58 a.m. and concurrent record review of Resident 2's Nutritional Task, dated 4/1/2026 to 4/28/2026, reviewed with CNA 3, CNA 3 stated the Nutritional Task section indicated the meal (breakfast, lunch, and dinner) intake amount the resident had eaten in percentage. Resident 2's Nutritional Task indicated the following:On 4/1/2026, Resident 2's documented breakfast meal intake was at 12:30 p.m. and lunch meal intake at 12:31 p.m., both at 76% to 100%.On 4/2/2026, Resident 2's documented breakfast meal intake was at 12:14 p.m. and lunch meal intake at 12:15 p.m., both at 76% to 100%.On 4/5/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 1:43 p.m.On 4/6/2026, Resident 2's documented breakfast meal intake was 76% to 100% and lunch meal intake was 51% to 75%, both at 1:46 p.m.On 4/7/2026 and 4/8/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 1:11 p.m.On 4/9/2026, Resident 2's documented breakfast meal intake at 1:18 p.m. and lunch meal intake at 1:19 p.m., both were 76% to 100%.On 4/12/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 1:41 p.m.On 4/13/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 12:53 p.m.On 4/14/2026, Resident 2's documented breakfast meal intake was 51% to 75% and lunch meal intake was 76% to 100%, both at 1:05 p.m.On 4/15/2026, Resident 2's documented breakfast meal intake at 12:59 p.m. and lunch meal intake at 1 p.m., both were 76% to 100%.On 4/17/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 12:07 p.m.On 4/19/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 1:06 p.m.On 4/20/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 1:11 p.m.On 4/22/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 1:46 p.m.On 4/23/2026, Resident 2's documented breakfast and lunch meal intake was 76% to 100%, both at 12:21 p.m.CNA 3 stated the documented times of Resident 2's percentages of meal intakes were inaccurate. CNA 3 stated Resident 2's meal intake should be documented after the meal had been consumed.During a review of Resident 3's undated admission Record, the admission Record indicated on the facility admitted the resident on 11/12/2025 with diagnoses including unspecified dementia, muscle weakness, and displaced intertrochanteric fracture of right femur (a broken bone between the two bony bumps at the top of the thigh bone that moved out of place).During a review of Resident 3's Physician Order, dated 1/22/2026, the Physician Order indicated the resident had regular diet.During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decision making were severely impaired.During an interview on 4/29/2026 at 11:58 a.m. and concurrent record review of Resident 3's Nutritional Task, dated 4/1/2026 to 4/28/2026, reviewed with CNA 3, CNA 3 stated the Nutritional Task section indicated the meal (breakfast, lunch, and dinner) intake amount the resident had eaten in percentage. Resident 3's Nutritional Task indicated the following:On 4/11/2026, Resident 3's documented breakfast meal intake was 0% to 25% and lunch meal intake was 26% to 50%, both at 12:53 p.m.On 4/20/2026, Resident 3's documented breakfast and lunch meal intake was 76% to 100%, both at 1:43 p.m.On 4/23/2026, Resident 3's documented breakfast and lunch meal intake was 76% to 100%, both at 1:42 p.m.On 4/24/2026, Resident 3's documented breakfast and lunch meal intake was 76% to 100%, both at 12:30 p.m.On 4/25/2026, Resident 3's documented breakfast meal intake was 76% to 100% at 2:32 p.m. and lunch meal intake was 26% to 50% at 12:33 p.m.On 4/28/2026, Resident 3's documented breakfast meal intake at 1:10 p.m. and lunch meal intake at 1:11 p.m., both were 76% to 100%.CNA 3 stated the documented times of Resident 3's percentages of meal intakes were inaccurate. CNA 3 stated Resident 3's meal intake should be documented after the meal had been consumed.During an (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 4/29/2026 at 1:26 p.m. with the Director of Nursing (DON), the DON stated CNAs should document the residents' (Residents 1, 2, and 3) amount of meal intake after the residents (Residents 1, 2, and 3) consumed their meals (breakfast, lunch, or dinner). The DON stated inaccurate documentation had the potential for inaccurate assessment that may lead to unidentified weight changes. The DON further stated the documentation in the resident's medical records should indicate the accurate date and time. The DON acknowledged and stated the facility failed to ensure the residents' (Residents 1, 2, and 3) medical records were complete and accurate.During a review of the facility's policy and procedure (PnP) titled, Charting and Documentation Policy, last reviewed on 4/16/2026, the PnP indicated all resident care, assessments, medications, treatments, and changes in condition must be documented in the medical record promptly, accurately, and according to facility and regulatory requirements. The PnP indicated to document care at the time it is provided of immediately afterward, use clear, legible, and factual entries.