STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555589	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Hospital Medical Ctr D/P Snf	9080 Colima Road Whittier, CA 90605

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure proper food storage and infection control practices were implemented in accordance with the facility's Policy and Procedure (P&P) titled Standards for storing food and supplies, and Infection Control - Food and Nutrition Services by failing to: 1. Ensure thermometers were kept inside refrigerators 1 and 2. 2. Ensure a pitcher of pre-made iced tea was not left in the refrigerator beyond safe use by date of 6/8/2026. 3. Ensure Dishwasher (DW) 2 used the correct test strip to test for the quaternary ammoniumˆ(QUAT-a quaternary ammonium, a type of sanitizing solution used to sanitize food contact surfaces) sanitizer. 4. Ensure dishwashing machine temperature was checked for PM shift on 6/8/2026 and ensure the dishwashing machine thermometer is working appropriately. The deficient practice had the potential to place the facility's residents at risk to consume expired, spoiled and contaminated food and increased the risk for the facility's residents to develop food-borne illnesses (any sickness caused by eating or drinking food contaminated with harmful germs or toxic chemicals). 1. During a concurrent kitchen tour and interview on 6/9/2026 at 9:40 AM with the Director of Food and Nutrition Services (DFN), there was no thermometer visible in refrigerators 1 and 2. The DFN stated there should be thermometers inside the refrigerators because that was what the kitchen staff use to ensure the temperatures inside the refrigerators matches the external gauges and document them in the temperature logs. The DFN stated, by checking the temperature and maintaining the temperature logs, they can ensure that the refrigerators are working appropriately. During an interview on 6/9/2026 at 9:42 AM with the Dietary Supervisor (DS), the DS stated, they just replaced old refrigerators and forgot to put the thermometers back inside the refrigerators. 2. During a concurrent observation and interview on 6/9/2026 at 9:44 AM with the DFN in the kitchen, a pitcher labeled Iced tea only and labeled with a prepared date of 6/4/2026 and use by date of 6/8/2026 was observed in refrigerator 2. The DFN stated, today is 6/9/2026, and the pitcher should have been discarded on 6/8/2026. During an interview on 6/10/2026 at 11:05 AM with the DFN, the DFN stated, if expired food or drink was left in the refrigerator, there was a potential risk that the service staff could serve the expired food or drink to all of the residents in the facility. 3. During a concurrent kitchen tour and interview on 6/9/2026 at 10:23 AM with the DFN, there are two sink areas. The DFN stated, there is one three-compartment sink area where they clean and sanitize cooking pots and pans manually (by hands) and another separate area where they clean and sanitize the residents' dishes and utensils using the dishwasher. During a concurrent observation and interview on 6/9/2026 at 10:38 AM with Dishwasher 2 (DW2) and the Director of Food and Nutrition (DFN) in the threecompartment sink area, DW 2 demonstrated how he normally tested the pink chemical sanitizing solution in one of the sink compartments. DW2 removed a paper test strip from a bottle labeled Ecolab Chlorine Test Strip and dipped it into the sanitizing solution. The test strip did not change color. DW2 stated that the strip was supposed to turn purple as soon as it was dipped into the solution. During the same concurrent observation and interview, the DFN observed the testing bottle and stated that the testing bottle expired in 2019. The DFN added, the testing strip that DW 2 used is not the correct testing strip to use. The DFN stated they are currently out of the correct testing strips. During an (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 6/9/2026 at 10:47 AM with the DFN, the DFN stated, if the sanitizing solution is tested with the wrong testing strips, the facility cannot ensure that the solution is within the expected range. The DFN stated if the solution is not within the expected range, there could be potential for food contamination and the risk of food-born illnesses. 4. During a review of the facility's record titled Dishwasher machine Temperature Log for June 2026, the log indicated there was no temperature check for PM on 6/8/2026. During a concurrent observation and interview on 6/9/2026 at 9:50 AM with Dishwasher (DW) 1 and the Maintenance Manager (MM), DW 1 demonstrated her usual method for checking the dishwasher's operating temperature. After running a wash cycle, DW 1 reported that the dishwasher thermometers showed a Wash temperature of 165 F and a Rinse temperature of 180 F. The MM stated that DW 1 had misread the gauges and clarified that the dishwasher thermometers indicated the actual temperatures were 135 F for Wash and 152 F for Rinse. The MM further stated that these temperatures were below the acceptable ranges of 150-165 F for Wash and 160-190 F for Rinse. The MM added that he would request maintenance service for the dishwasher machine from the supply company. During an interview on 6/9/2026 at 9:55 AM with DW 1, DW 1 stated, the temperatures had been below the accepted range for a while, and it usually took a few wash cycles for about more than 30 minutes to increase the temperatures to the accepted range. During an interview on 6/9/2026 at 10:20 AM with the Maintenance Manager (MM) and the Director of Nutrition and Food Services (DFN), the MM stated that the dishwasher machine should always be functioning properly. The DFN stated that she expected DW 1 to notify DFN immediately when DW 1 first noticed that the machine was taking more than 30 minutes to reach the acceptable temperature range. The DFN further stated that the dishwasher must operate correctly to ensure proper sanitization of residents' dishes and utensils, preventing contamination and foodborne illness. During a concurrent interview and record review on 6/10/2026 at 11:10 AM with the DFN, the facility's Dishwasher machine Temperature Log for June 2026, was reviewed. The DFN stated that the log is used to make sure the temperature of the dishwasher was at the accepted temperature to ensure sanitation for all washing cycles (wash, rinse and final rinse) before washing the dishes after each mealtime. The DFN stated that the cook was new, and he forgot to check the temperature before washing the dinner dishes. The DFN stated that the dishwasher machine temperatures need to be checked to make sure it is working appropriately and ensure all dishes and utensils are clean for residents' use. During a review of the facility's policy and procedures (P&P) titled, Standards for storing food and supplies, reviewed 3/2021, the P&P indicated: All leftover items are covered, labeled and dated. Prepared leftover items are used within 48-72 hours unless frozen for later use. Reliable thermometers are kept in visible areas in all refrigerators, freezers and dry rooms. Temperature logs are maintained. During a review of the facility's P&P titled Infection Control - Food and Nutrition Services, reviewed 5/2024, the P&P indicated: a) all utensils and equipment are cleaned and sanitized with diluted Ecolab Oasis 146 Multi-Quat Sanitizer daily. Sanitizer concentration should be between 150-400 PPM. Strips are used to determine the proper sanitation range of the sanitizer; b) Food and Nutrition Services will ensure proper maintenance and operation of equipment. Any necessary repairs are requested of Maintenance for follow up.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide privacy for one of one sampled resident (Resident 1) reviewed for dignity when Resident 1's nephrostomy bag (a clear bag thatcollects your pee (urine) from your kidney) was exposed. This deficient practice had the potential to cause psychosocial (mental and emotional well-being) decline, resident's individuality, self-esteem, and self-worth. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including urinary tract infection (an infection in any part of your urinary system) and epileptical spasm (a rare but severe type of seizure).ˆ During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), datedˆ4/05/2026,ˆthe MDS indicatedˆResident 1's cognition (ability to understand and make decisions) could not be assessed.ˆˆThe MDS indicated Resident 1ˆwas dependentˆ(helper does all) withˆeating, oral hygiene, toileting, shower, upper and lower body dressing. During an observation on 6/09/2026 at 10:29 AM in Resident 1's shared room (4 residents observed in the room), Resident 1 was observed lying in bed with privacy curtains pulled back leaving Resident 1 exposed to the other residents in the room. Resident 1's nephrotomy bag was observed hung on the right side of the bed without a dignity bag (a discreet, fabric or vinyl sleeve used to conceal the clear urine collection bag). During a concurrent observation and interview on 6/09/2026 at 10:31 AM in Resident 1' room with Registered Nurse Clinical Manager (RNCM), RNCM stated Resident 1's nephrostomy bag did not have a dignity bag leaving it exposed to the other residents and visitors in the room since Resident 1's privacy curtain was pulled back, leaving Resident 1 exposed to passersby. were pulled open as well. During an interview on 6/11/2026 at 12:42 PM with Chief Nursing officer (CNO), CNO stated the facility had purchased dignity bags to over Residents foley catheter (a thin, flexible, sterile tube inserted into the bladder to drain urine) and nephrostomy bags. CNO stated dignity bags should be placed over the urine drainage bag to protect the resident's dignity. CNO stated the facility had not developed a policy for placing a dignity bag over the urine drainage bag, but the use of a dignity bag was facility practice and should be implemented by all of the staff to ensure the residents privacy. ˆ

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one (1) of five (3) sampled residents' (Resident 21) drug regimen was free from unnecessary medications (any medication in excessive dose, excessive duration, without adequate monitoring) in accordance with the facility's policy and procedure by failing to ensure: 1. Resident 21 had a specific, measurable target behavior related to the use of Sertraline (an antidepressant medicine used to treat depression [a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities]). 2. Resident 21 was monitored for the number of specific occurrences of behavior that was associated with the use of Sertraline. These deficient practices had the potential to place Resident 21 at risk for significant adverse effects (also known as side effects - undesired, unwanted, or dangerous effects that a drug may have, such as nausea and sleep problem) from the use of unnecessary antipsychotic drugs, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. During a review of Resident 21's admission Record (AR), the AR indicated that Resident 21 was admitted to the facility on [DATE] with diagnosis that included depression. During a review of Resident 21's [NAME] Data Set (MDS, a resident assessment), dated 4/26/2026, the MDS stated, Resident 21's cognition (ability to think, remember, and reason) is intact and Resident 21 was dependent (helper does all of the effort, resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to compete the activity) in eating, toileting hygiene and personal hygiene. The MDS indicated Resident 21 is taking high-risk drug class (a group of medications with a heightened potential to cause significant patient harm, severe side effects, or death if misused, miscalculated, or administered in error) for antidepressant. During a review of Resident 21's Order Summary Report (OSR), the OSR indicated that on 12/11/2025 the physician ordered staff to administer 125 mg (milligram, unit of weight) or 6.5 ml (milliliter, unit of volume) of Sertraline HCL solution (20 mg/ml) by mouth every night at 9 PM for a diagnosis of depression. The OSR did not identify the specific behaviors or symptoms exhibited by Resident 21 that were associated with the diagnosis of depression, and there was no order directing staff to monitor for any specific behavior associated with the condition. During a review of Resident 21's Interdisciplinary Team Review of Chemical/Physical restraints (IDTR), the IDTR indicated that IDT meeting was held on 4/17/2026 to review chemical restraint by the use of Sertraline. The ITDR indicated the outcomes of restraint use for the period of 1/17/2026 to 4/17/2026 was left blank. During an observation on 6/9/2026 at 12:05 PM in Resident 21's room, Resident 21 was lying in bed watching in his iPad. During a concurrent interview and record review on 6/10/2026 at 2:55 PM with the Registered Nurse Clinical Manager (RNCM), Resident 21's care plan (CP) was reviewed. The RNCM stated, there was no CP addressing the resident's depression or outlining how staff should monitor the specific behaviors associated with the condition. During an interview on 6/11/2026 at 10:22 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that she was the LVN in charge of Resident 21. LVN 1 stated, Resident 21 has been receiving Sertraline for his depression since his admission in 2025. LVN 1 stated Resident 21's depression presented as talking less than usual or refusing to get up into his wheelchair. LVN 1 stated, she only documented in Resident 21's medical record whether the resident was up in his wheelchair or not. During an interview on 6/11/2026 at 10:28 AM with LVN 2, LVN 2 stated that she is familiar with Resident 21 and has cared for him in the past. LVN 2 stated that her understanding of Resident 21's depression was that he would not want to wake up in the morning and would refuse care. LVN 2 stated, Resident 21 had not refused any care from her. During a concurrent record review and interview on 6/11/2026 at 10:34 AM with Registered Nurse (RN) 1, Resident 21's medical record for behavior monitoring was reviewed. RN 1 stated that when Resident 21 was depressed, he would refuse food and would not want to interact with her. RN 1 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also stated that there was no monitoring in place for any specific behaviors associated with Resident 21's diagnosis of depression. During a concurrent interview and record review on 6/11/2026 at 2:52 PM with the Chief Nursing Officer (CNO), the CNO stated that for each psychotropic medication used, there must be a clearly identified behavior that the medication is intended to address. The CNO added that the behavior should be specific to Resident 21, as each resident may exhibit depression differently. The CNO further explained that staff should be aware of and monitor the same identified behavior to ensure consistency, noting that consistent monitoring and documentation are essential to determining whether the medication is effective and not causing more harm than benefit. The CNO stated that there should be a documented rationale to justify the continued use of Sertraline for Resident 21 and confirmed that the lack of specific behavior monitoring leads to inaccurate assessments and an inability to measure the effectiveness of psychotropic medications, potentially resulting in unnecessary use and greater harm than benefit to the resident. During a review of the facility's policy and procedures (P&P) titled, Psychotropic Medication Use in Pediatric Subacute, dated 6/2024, the P&P indicated the following: -The use of psychotropic medications for a specific behavior or manifestation of disordered thought process is to be identified in the patient's health record by the physician. -A physician's order is to be written for each specific psychotropic drug indicating the behavior for which the drug is being used. A new physician's order is required to continue the medication and must specify the number of days and rational for use. -The care plan of each patient will identify the specific behavior disorder, with type of psychotropic medication and common side effects to observe for. -Documentation of the effectiveness of the psychotropic medication and any adverse reaction or side effect will be noted in the nursing note and in the Behavioral/Intervention Flow Sheet each time the drug is given. Nursing will tabulate behaviors during the weekly summary report. -A summary of all the all the medications given and behaviors observed, the effectiveness of the drug will be noted weekly in the Weekly Summary.

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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, and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for one (1) of three (3) sampled residents (Residents 16) observed for medication administration by failing to: Administer Resident 16's Miralax (a medication used to treat chronic constipation) with 4-8 ounces of water as ordered by the physician. Administer all of Resident 16's multivitamin This deficient practice resulted in Resident 16 not receiving medications as ordered by the physician, which could negatively affect the residents' overall wellbeing. Findings: During a review of Resident 16's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertension (is when the pressure in your blood vessels is too high), pulmonary hypertension (high blood pressure in the arteries of the lungs). During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), datedˆ5/03/2026, the MDSˆindicatedˆResident 16's cognition (ability to understand and make decisions) could not be assessed.ˆˆThe MDS indicated Resident 6ˆwas dependentˆ(helper does all) withˆeating, oral hygiene, toileting, shower, upper and lower body dressing. During a review of Resident 16's Order Summary Report dated 6/11/2026, the Order Summary Report indicated a physician's order for: 1.Miralax 8.5 grams (unit of measurement) daily via G-tube (a medical device inserted through the abdomen directly into the stomach) for a diagnosis of constipation, mix with 4-8 ounces of water. 2. Multivitamin chewable tab pediatric 1 time a day via G-tube During a medication pass observation on 6/10/2026 at 9:52 AM with Registered Nurse (RN) 3, RN 3 was observed administering Miralax powder with 2 ounces of water and then proceeded to flush Resident 16's G-tube with water and then administering Multivitamin via G-tube. After administering the Multivitamin, the medication cup was observed with left over medication at the bottom and throughout the medication cup. During a concurrent interview with RN 3 on 6/10/2026 at 10:05 AM, RN 3 stated she did not administer all of Resident 16's multivitamin because it clumped up and was hard to give all of the medication via G-tube. RN 3 stated the reason she did not give Resident 16's Miralax with 4-8 ounces of water was because Resident 16 was on fluid restrictions. During a follow-up interview and record review of Resident 16's medical record on 6/11/2026 at 2:30 PM with Registered Nurse Clinical Manager (RNCM), RNCM stated there was no active or canceled order of fluid restrictions in Resident 16's medical record. During an interview on 6/12/2026 at 4:20 PM with the Chief Nursing Officer (CNO), the CNO stated all licensed nurses administering medications should follow the medication orders to prevent potential undesired side effects. CNO stated RN 3 should have rinsed the medication cup with extra water to ensure all of Resident 16's multivitamin was administered without any medications left over in the medication cup. CNO stated if RN 3 thought Resident 16 was on fluid restrictions she should have called Resident 16's physician to clarify the order to ensure Resident 16 was administered his medications as prescribed by the physician. During a review of the facility's Policy and Procedure (P&P) titled, Medication Pass, revised 5/2024, the P&P indicated, Administration preparation 1.The 6 rights of medication administration will be observed when administering medications to patients C. right dose of medications

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the physician irregularities (includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) and to address the use of Sertraline (an antidepressant medicine used to treat depression [a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities] and other mental health conditions) on the medication regimen review (MRR, or Drug Regimen Review, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for one of five residents (Resident 21) in accordance with the facility policy. These deficient practices had the potential to place Resident 21 at risk for significant adverse effects (also known as side effects - undesired, unwanted, or dangerous effects that a drug may have, such as nausea and sleep problem) from the use of unnecessary antipsychotic drugs, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. During a review of Resident 21's admission Record (AR), the AR indicated that Resident 21 was admitted to the facility on [DATE] with diagnosis that included depression. During a review of Resident 21's [NAME] Data Set (MDS, a resident assessment tool), dated 4/26/2026, the MDS stated, Resident 21's cognition (ability to think, remember, and reason) is intact and Resident 21 was dependent (helper does all of the effort, resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to compete the activity) in eating, toileting hygiene and personal hygiene. The MDS indicated Resident 21 is taking high-risk drug class (a group of medications with a heightened potential to cause significant patient harm, severe side effects, or death if misused, miscalculated, or administered in error) for antidepressant. During a review of Resident 21's Order Summary Report (OSR), the OSR indicated that on 12/11/2025 the physician ordered staff to administer 125 mg (milligram, unit of weight) or 6.5 ml (milliliter, unit of volume) of Sertraline HCL solution (20 mg/ml) by mouth every night at 9 PM for a diagnosis of depression. The OSR did not indicate the specific behaviors or symptoms exhibited by Resident 21 that were associated with the diagnosis of depression, and there was no order directing staff to monitor for any specific behavior associated with the condition. During a review of Resident 21's Medication Regimen Review (MRR), dated 1/6/2026, 2/5/2026, 3/9/2026, 4/2/2026, 5/2/2026, and 6/4/2026, the MRR did not indicate any irregularities identified or reported to the physician and DON for Resident 21's use of Sertraline. The MRRs also indicated that there was no documented rationale supporting the continued use of Sertraline for Resident 21. During an observation on 6/9/2026 at 12:05 PM in Resident 21's room, Resident 21 was lying in bed watching his iPad. During a concurrent interview and record review on 6/11/2026 at 12:47 PM with the facility's Pharmacist (PHARM 1), Resident 21's MRR dated 1/6/2026, 2/5/2026, 3/9/2026, 4/2/2026, 5/2/2026, 6/4/2026, were reviewed. PHARM 1 stated that when completing monthly MRR, they rely solely on the attending physician's progress notes and the psychiatrist's notes. PHARM 1 that that the facility's pharmacy consultants only considered information from nursing staff if there are significant changes observed in the resident. PHARM 1 stated, the pharmacists were responsible to review the medications, and the physician was responsible to complete the rationale on whether to continue the medication or not. During a concurrent interview and record review on 6/11/2026 at 1:24 PM with the facility's Case Manager (CM), Resident 21's electronic health record and physical chart related to the use of Sertraline since admission on [DATE], was reviewed. The CM stated that the last time Resident 21 was seen by the psychologist was on 9/20/2026. The CM stated that she could not find any documentation from the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attending physician and the psychiatrist that justified the continuous use of Resident 21's Sertraline. During a concurrent interview and record review on 6/11/2026 at 2:52 PM with the Chief Nursing Officer (CNO), Resident 21's MRR dated 1/6/2026, 2/5/2026, 3/9/2026, 4/2/2026, 5/2/2026, 6/4/2026, were reviewed. The CNO confirmed that the pharmacist did not identify the lack of specific behavior monitoring for Resident 21's use of Sertraline in the monthly written reports to the facility. The CNO stated, the behavior should be specific to Resident 21 because each resident will manifest depression differently. The CNO stated, there should be documented rationale to justify the continued use of Resident 21's prescribed Sertraline. The CNO confirmed that not having specific behavior monitoring and justification for the continued use of Sertraline will lead to inaccurate monitoring, inability to measure the effectiveness of psychotropic medications, potentially causing unnecessary use and more harm than benefit to Resident 21. During a review of the facility's policy and procedures (P&P) titled, Psychotropic Medication Use in Pediatric Subacute, dated 6/2024, the P&P indicated the use of psychotropic medications for a specific behavior or manifestation of disordered thought process is to be identified in the patient's health record by the physician. The P&P indicated a physician's order is to be written for each specific psychotropic drug indicating the behavior for which the drug is being used. A new physician's order is required to continue the medication and must specify the number of days and rational for use. The P&P indicated the care plan of each patient will identify the specific behavior disorder, with type of psychotropic medication and common side effects to observe for and to document the effectiveness of the psychotropic medication and any adverse reaction or side effect will be noted in the nursing note and in the Behavioral/Intervention Flow Sheet each time the drug is given. Nursing will tabulate behaviors during the weekly summary report. The P&P indicated a summary of all the all the medications given and behaviors observed, the effectiveness of the drug will be noted weekly in the Weekly Summary.

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	555589	A. Building B. Wing	06/11/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility's medication error rate was less than five (5) percent (%). Two (2) medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error, to yield an overall medication error rate of 8 % for one (1) of three (3) sampled residents (Resident 16) observed during medication administration (med pass). This deficient practice had the potential to result in adverse reactions (undesired effect of a drug or other type of treatment), ineffective treatment, worsening of Resident 16's condition, or potentially serious harm or injury. Findings: During a review of Resident 16's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertension (is when the pressure in your blood vessels is too high), pulmonary hypertension (high blood pressure in the arteries of the lungs). During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), datedˆ5/03/2026,ˆthe MDS indicatedˆResident 16's cognition (ability to understand and make decisions) could not be assessed.ˆˆThe MDS indicated Resident 6ˆwas dependentˆ(helper does all) withˆeating, oral hygiene, toileting, shower, upper and lower body dressing. During a review of Resident 16's Order Summary Report dated 6/11/2026, the Order Summary Report indicated the following physician's order: 1.Miralax 8.5 grams (unit of measurement) daily via G-tube (a medical device inserted through the abdomen directly into the stomach) for a diagnosing of constipation, mix with 4-8 ounces of water. 2. Multivitamin chewable tab pediatric 1 time a day via G-tube During a medication pass observation on 6/10/2026 at 9:52 AM with Registered Nurse (RN) 3, RN 3 was observed administering Miralax powder that was mixed in 2 ounces of water. After the administration of Miralax to Resident 16, RN 3 proceeded to flush Resident 16's G-tube with water and then administering Multivitamin via G-tube. After administering Resident 16's Multivitamin that was in a medication cup, the medication cup was observed with left over multivitamins at the bottom and around the medication cup. there was observed medication left in medication cup on the bottom and around the cup. During a concurrent observation and interview with RN 3 on 6/10/2026 at 10:05 AM, RN 3 stated she did not administer all of Resident 16's multivitamin because the multivitamin clumps up and was hard to administer all of the medication via G-tube. RN 3 stated the reason she did not give Resident 16's Miralax with 4-8 ounces of water was because Resident 16 was on fluid restrictions. During a follow-up interview and record review of Resident 16's medical record on 6/11/2026 at 2:30 PM with Registered Nurse Clinical Manager (RNCM), RNCM stated there was no active or canceled order of fluid restrictions in Resident 16's medical record. During an interview on 6/12/2026 at 4:20 PM with the Chief Nursing Officer (CNO), the CNO all licensed nurses administering medications should follow the medication orders to prevent potential undesired side effects. CNO stated RN 3 should have rinsed the medication cup with extra water to ensure of all Resident 16's multivitamin. CNO stated if RN3 thought Resident 16 was on fluid restrictions she should have called Resident 16's physician to clarify the order to ensure Resident 16 gets his medications as prescribed by the physician. During a review of the facility's Policy and Procedure (P&P) titled, Medication Pass, revised 5/2024, the P&P indicated, Administration preparation 1.The 6 rights of medication administration will be observed when administering medications to patients C. right dose of medications

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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, and record review, the facilityˆfailed toˆensureˆone of ten dishwashers were competent in their duties when Dishwasher 2 (DW 2) did not know the proper sanitizer test strip to use for the quaternary ammoniumˆ(QUAT-a quaternary ammonium, a type of sanitizing solution used to sanitize food contact surfaces) sanitizer and when DWˆ2 did not know the procedure for testing strength of the quaternary ammonium sanitizer. This deficient practice had the potential to result in unsafe and unsanitary food production and could affect residents who were served food from the facility kitchen. During a concurrent kitchen tour and interview on 6/9/2026 at 10:23 AM with the Director of Food and Nutrition Services (DFN), two sink areas were observed. The DFN stated, there is one three-compartment sink area where they clean and sanitize cooking pots and pans manually (by hands) and another separate area where they clean and sanitize the residents' dishes and utensils using the dishwasher. During a concurrent observation and interview on 6/9/2026 at 10:38 AM with Dishwasher 2 (DW) 2 and the DFN in the three-compartment sink area, DW2 demonstrated how he normally tested the pink chemical sanitizing solution in one of the sink compartments. DW 2 removed a paper test strip from a bottle labeled Ecolab Chlorine Test Strip and dipped the test strip into the sanitizing solution. The test strip did not change color. DW 2 stated that the strip was supposed to turn purple as soon as it was dipped into the solution. DW 2 also stated that he did not know how long he was supposed to keep the test strip in the solution. DW 2 stated, he could not remember the last time he received in-service training on testing the sanitizing solution. During the same concurrent observation and interview, the DFN observed the testing bottle and stated that the testing bottle already expired in 2019. The DFN stated, the testing strip that DW 2 used is not the correct testing strip to use. The DFN stated they are currently out of the correct testing strips, which is the QUAT sanitizer testing strips. The DFN stated, DW 2 is required to be competent in checking the sanitizing solution to make sure the sanitizing solution remains in the critical 150-400 parts per million (PPM-unit of concentration measurement) range because if the solution is too weak, it fails to kill pathogens, risking foodborne illness. During a concurrent interview and record review on 6/9/2026 at 11:05 AM with the DFN, the DFN stated that there was no skill check in place for verifying QUAT sanitizing solution. The DFN stated that she would provide in-service training to all staff on the proper procedure for checking QUAT sanitizing solution. During an interview on 6/9/2026 at 10:47 AM with the DFN, the DFN stated, if the sanitizing solution is tested with the wrong testing strips, the facility cannot ensure that the solution is within the expected range. The DFN stated if the solution is not within the expected range, there could be potential for food contamination and the risk of food-born illnesses (any sickness caused by eating or drinking food contaminated with harmful germs or toxic chemicals). During a review of the facility's policy and procedures (P&P) titled Dishwasher Job Description, dated 8/2018, the P&P indicated the dishwasher is responsible in cleaning and sanitizing of equipment, dishes, utensils, and physical environment of the department. Clean and sanitize utensils, cups, plates, pots, pans, and trays by hand and/or machine. During a review of the facility's P&P titled Infection Control - Food and Nutrition Services, reviewed 5/2024, the P&P indicated: All utensils and equipment are cleaned and sanitized with diluted Ecolab Oasis 146 Multi-Quat Sanitizer daily. Sanitizer concentration should be between 150-400 PPM. Strips are used to determine the proper sanitization range of the sanitizer.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility's failed to meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, and ensure the required committee members (Thedirector of nursing (DON), The Medical Director or his/her designee, The Infection Preventionist (IP), and at least three other staff, one of whom must be the facility's administrator, owner, board member) were inregular attendance of the facilities quality assessment and assurance (QAA) meetings. This deficient practice had the potential to affect all of the facilities 22 residents residing in the facility. Findings: During an interview on 6/11/2026 at 12:45 PM with Chief Nursing Officer (CNO), CNO stated she was covering for the facilities DON since the DON was on leave since May 2026. CNO stated the facilities last QAA meeting had been held in May but she was unable to attend due to scheduling conflicts. During a concurrent interview and record review on 6/11/2026 at 12:45 PM with CNO of the facility's QAA meeting attendance sign in sheets were reviewed. The sign in sheets indicated the following: 1.QAA meeting sign-in sheet dated 7/10/2025 did not indicate facilities DON or covering DON, Infection Preventionist (IP), or facility administrator or board member were in attendance. 2. QAA meeting sign in sheet 12/18/2026 did not indicate facilities DON or covering DON, Infection Preventionist (IP), or facility administrator or board member were in attendance 3. QAA meeting sign in sheet 5/07/2026 did not indicate facilities Infection Preventionist (IP), or facility administrator or board member were in attendance. During an interview and record review on 6/11/2026 at 12:50 PM with CNO stated she was the one who attended the facilities QAA meetings acting as the board member/administrator, but had been unable to attend the meetings that were held on 710/2025,12/18/2025 and 5/07/2025 due to scheduling conflicts. CNO stated she was aware QAPI committee meetings had to occur quarterly, but due to scheduling conflicts the facility was unable to schedule them on time that was why they were held past the indicated regulatory time of quarterly. CNO stated the facility must have the required members meet on time to ensure appropriate coordination and evaluation of facilities QAPI program, and to ensure implementation of QAPI meetings per the federal regulations. During a review of the facility's Policy and Procedure (P&P) titled Performance Improvement Plans, revised 2/2026, the P&P indicated the purpose was to serve as a framework to describe all performance improvement activities within the organization that foster safety and quality of care, treatment, and services. The P&P indicated methods used to gauge the organization through collection data and analysis that lead to prioritized improvement activities. The P&P authority and responsibility of the governing body was ultimately responsible and accountable for oversight and priority setting for the safety and quality of care, treatment, and services provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to review the infection prevention and control program (IPCP) annually in accordance with the facility's policies and procedures (P&P) titled, Pediatric Subacute Infection Prevention Program 2024-2025. The deficient practice had a potential for the IPCP to fail in ensuring quality and compliance with recommended guidelines and practices. During an interview on 6/10/2026 at 1:25 PM with the Infection Prevention Nurse (IPN), the IPN stated, the facility's infection control policies and procedures are reviewed every three (3) years. The IPN stated she could not remember the last time she reviewed the facility's infection prevention and control program (IPCP). During concurrent interview and record review on 6/11/2026 at 3:15 PM with the Chief Nursing Officer (CNO), the facility's Pediatric Subacute Infection Prevention Program 2024-2025, undated, was reviewed. The IPCP indicated the program was developed for the year 2024-2025. The CNO stated they are using an outdated IPCP, and the IPCP should be reviewed and revised in 2025 to be used for the period of 2025-2026. The CNO stated, the IPCP is required to be reviewed and updated to ensure quality and compliance with recommendation and practice guidelines. The CNO stated, she did not know that the IPCP is required to be reviewed annually. During a record review of the facility's policies and procedures (P&P) titled, Pediatric Subacute Infection Prevention Program 2024-2025, undated. The P&P indicated: -The infection prevention and control program is part of an overall commitment in quality. The purpose of the infection prevention and control plan is to identify infections, opportunities for disease transmission, implementation of prevention and control interventions and education to reduce the incidences of infection and provide a safe environment for the residents, families and staff on the Pediatric Subacute. -The Pediatric Subacute infection prevention and control plan will be reviewed annually and as needed to ensure quality and compliance with recommendation and practice guidelines.