STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555677	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne Healthcare & Wellness Centre, LP	11630 South Grevillea Ave. Hawthorne, CA 90250

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure its Payroll Based Journal (a mandated reporting system used by the Centers for Medicare & Medicaid Services (CMS) to collect auditable, employee-level staffing data from long-term care facilities) was submitted for the first fiscal year quarter.This deficient practice resulted in the facility's failure to provide required information regarding staffing levels necessary to ensure the provision of safe and comprehensive care for all residents in accordance with federal regulations. Findings:During a review of the facility's PBJ Staffing Data Report for Fiscal Year Quarter 1, dated 3/19/2026, the PBJ report indicated the facility failed to submit data for the fiscal year one quarter. During an interview, on 3/26/2026 at 3:02 p.m., with the Administrator (Admin), the Admin stated the facility's consulting group was responsible for submitting the PBJ fiscal year information timely. The Admin stated the PBJ was required to be submitted quarterly. During a concurrent interview and record review, on 3/27/2026 at 8;09 a.m., with the Admin, the Admin stated the CMS submission report for the PBJ validation report, dated 2/13/2026, indicated fiscal year 2 was submitted instead of fiscal year 1 which covers October 2025 through December 2025. The Admin stated the risk of not submitting the facility's PBJ in a timely manner could result in not being able to prove care services are being provided to the residents in the facility.During a record review of the State Operations Manual (SOM), dated 7/23/2025, the SOM indicates the facility is responsible for submitting staffing data through the CMS Payroll-Based Journal (PBJ) system. The facility's failure to submit PBJ data, as required, will be reflected on their CASPER report and result in a deficiency citation.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide adequate eating assistance for three of four residents (Resident 1, Resident 7, and Resident 18) by assigning only one staff member to a table where all four residents required assistance. This resulted in Residents 1, 7, and 18 experiencing delays while the staff member assisted another resident. This deficient practice violated the residents' right to be treated with respect and dignity and had the potential to negatively impact their self-esteem, cause emotional distress, and adversely affect their psychosocial well-being.During a review of Resident 1's Face Sheet, the face sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), long term (current) use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication, and muscle weakness.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/24/2025, the MDS indicated Resident 1 usually had the ability to make self-understood and usually had the ability to understand others. The MDS indicated Resident 1 was dependent on staff for eating, oral hygiene, toileting, bathing, lower body dressing, and personal hygiene. During a review of Resident 1's History and Physical (H&P) dated 1/29/2026, the H&P indicated Resident 1 could make needs known but could not make medical decisions.During a review of Resident 7's admission Record, the admission record indicated Resident 7 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including complete paraplegia (total paralysis of the arm, leg, and trunk on the same side of the body), type 2 diabetes, and dysphagia (difficulty swallowing.)During a review of Resident 7's H&P dated 1/27/2026, the H&P indicated Resident 7 did not have the capacity to understand and make decisions.During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 usually had the ability to make self-understood and usually had the ability to understand others. The MDS indicated Resident 7 was dependent on staff for eating, oral hygiene, toileting, bathing, upper and lower body dressing, and personal hygiene.During a review of Resident 18's Face Sheet, the face sheet indicated Resident 18 was initially admitted to the facility on [DATE] with diagnoses that included paraplegia, dysphasia, and personal history of traumatic brain injury.During a review of Resident 18's H&P dated 2/26/2026, the H&P indicated Resident 18 does not have the capacity to understand and make medical decisions.During a review of Resident 18's MDS dated [DATE], the MDS indicated Resident 18 usually had the ability to make self-understood and usually had the ability to understand others. The MDS indicated Resident 18 was dependent on staff for eating, oral hygiene, toileting, bathing, lower body dressing, and personal hygiene.During an observation on 3/24/2026 at 12:11 pm in the dining room, Resident 1, Resident 7, and Resident 18 were seated at a table, with covered food plates in front of them. There was a staff member seated at the table assisting a fourth resident with eating.During an observation on 3/24/2026 at 12:32 pm in the dining room, there was one staff member seated at the table assisting the same resident while Resident 1, Resident 7, and Resident 18 were seated at the table with covered food plates in front of them.During an observation on 3/24/2026 at 12:38 pm in the dining room, three staff members were sitting at the table to assist Resident 1, Resident 7, and Resident 18 with their meals.During an interview on 3/27/2026 at 8:50 am with Certified Nursing Assistant (CNA) 3, CNA 3 stated there are three staff members who assist all the residents in the dining room with eating. CNA 3 stated other CNA's also assist residents in the dining room after they have passed food trays to residents who eat in their rooms. CNA 3 said the residents who are waiting for assistance could feel neglected because they all should eat at the same time.During an interview on 3/27/2026 at 9:13 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there are enough staff to assist the residents to eat. LVN 1 stated the residents who are (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	waiting for assistance may feel jealous because they are hungry and someone is eating in front of them.During a review of the Policy and Procedure (P&P) titled Dining Program, effective 2/20/2025, the P&P indicated residents at a given table should generally be served at the same time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure that sweet potatoes fries stored in Freezer 2 in the kitchen were labeled and dated to ensure proper food safety and storage practices. This deficient practice had the potential to place residents at risk for foodborne illnesses.Findings:During an initial observation tour of the kitchen on 3/24/2026 at 8:54 a.m., a clear bag of sweet potato fries stored in Freezer 2 was observed undated and unlabeled.During a concurrent observation and interview, on 3/24/2026 at 8:56 a.m., with the Dietary Services Supervisor (DSS), the DSS stated all food items should be labeled and dated. The DSS stated the risk of not dating and labelling food items could result in staff not being able to identify the food item and possible expiration. During a review of the facility's policy and procedures (P&P), titled Food Storage, dated 11/1/2014, the P&P indicated to Label and date all food items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure that a resident's soiled personal clothing was not placed inside the clean linen cart.This failure had the potential to result in cross contamination (a transfer of harmful bacteria from one place to another or one object to another) and place residents at risk for the spread of infection.Findings:During a concurrent observation and interview on 3/24/2026 at 9:25 a.m. with the Infection Preventionist Nurse (IPN) in the resident's hallway, one gray sweater was observed inside the clean linen cart. The IPN stated the soiled gray sweater belonged to a resident, but she did not know which resident it belonged to. The IPN stated residents' personal clothing whether it's clean or dirty should be bagged in a plastic bag and should not be mixed with the facility's clean linen cart. The IPN stated soiled items could contaminate and transfer bacteria to a clean linen. The IPN stated the facility must follow strict guidelines in infection control for residents' safety.During a review of the facility's policy and procedure (P&P) titled, Infection Control Policies and Procedures, dated 1/2012, the P&P indicated The facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate hospice documentation was accurate in the Minimum Data Set (MDS- a federally mandated resident assessment tool) for Resident 60.This deficient practice had the potential to negatively affect Resident 60's plan of care and delivery of necessary care and services.Findings:During a review of Resident 60's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 60 was admitted on [DATE] with diagnoses which included inflammatory polyneuropathy (autoimmune disorders where the immune system attacks peripheral nerves, causing damage to myelin or axons, leading to weakness, numbness, and tingling), chronic obstructive pulmonary disorder (COPD- a chronic lung disease causing difficulty in breathing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event).During a review of Resident 60's MDS active diagnosis assessment, dated 11/28/2025, Resident 60's assessment indicated Resident 60 was not on hospice care.During a review of Resident 60's history and physical form (H&P), dated 2/12/2026, the H&P indicated Resident 60 did not have the capacity to understand and make decisions.During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60's cognitive (thinking) skills were severely impaired. The MDS indicated Resident 60 was dependent on staff members with Activities of Daily Living (ADLs).During a concurrent interview and record review, on 03/25/2026 at 3:43 p.m., with the MDSN 2, the MDSN 2 stated Resident 60 had been placed on hospice on 11/21/2025. The MDSN 2 stated Resident 60 was receiving hospice services on 11/28/2025. The MDSN 2 stated Resident 60's active diagnosis for hospice was marked incorrectly on 11/28/2026 indicating Resident 60 was not receiving hospice services. MDSN 2 stated Resident 60's assessment was inaccurate. The MDSN 2 stated the risk of documenting an inaccurate resident diagnosis could result in the possibility of a residents' needs not being met according to inaccurate assessment coding. During a review of the facility's policy and procedures (P&P), titled RAI Process, dated 10/4/2016, the P&P indicated the purpose of the RAI process was To provide resident-assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission requirements.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) Level 1 screenings (a federally required preliminary screening for individuals seeking admission to a Medicaid-certified nursing facility) were completed and resubmitted for two of seven sampled residents (Residents 10 and 12) with diagnoses of mental illness and who were receiving psychotropic medications. This deficient practice had the potential to result in Residents 10 and 12 not being appropriately evaluated and, therefore, not receiving necessary specialized services for mental illness.Findings:A. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included paranoid schizophrenia (a chronic mental health disorder where a person experiences intense, irrational suspicion that is characterized by disturbances in thought), major depressive disorder ([MDD] - a mood disorder that cause a persistent feeling of sadness and loss of interest), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing).During a review of Resident 10's History and Physical (H&P), dated 10/5/2025, the H&P indicated Resident 10 can make needs known but could not make medical decisions.During a review of Resident 10's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 10's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 10 required set-up assistance (helper assists only prior to or following the activity) from staff with oral hygiene, lower body dressing, and personal hygiene.During a review of Resident 10's Order Summary Report (a document containing active orders), dated 3/25/2026, the Order Summary Report indicated the physician placed a telephone order on 3/3/2026 for Resident 10 to start on Quetiapine Fumarate (a psychotropic medication, used to treat certain mental/mood disorder) 50 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth at bedtime (9 p.m.) for other psychotic disorder manifested by increased agitation and verbal aggression and Mirtazapine (a drug used to treat depression) 7.5 mg by mouth at bedtime (9 p.m.) for major depressive disorder.During a concurrent interview and record review on 3/25/2026 at 2:08 p.m., with the Director of Nursing (DON), Resident 10's PASARR Level 1 screening completed by the facility on 11/10/2024, was reviewed. The DON stated the PASARR Level 1 screening indicated Resident 10 had no serious mental illness diagnoses. The DON stated Resident 10 had a new mental illness diagnosis of paranoid schizophrenia on 4/2/2025. The DON stated the facility should have completed and resubmitted a new PASARR Level 1 screening under Resident Review because of the new mental illness diagnosis. The DON stated by not resubmitting the PASARR Level 1 screening, there is a possibility that Resident 10 would not be able to avail the treatment services for his mental illness diagnosis of paranoid schizophrenia.B. During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 12's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/25/2025, the MDS indicated, Resident 12 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 12 required set-up assistance (helper assists only prior to or following the activity) from staff with oral hygiene, upper body dressing, and personal hygiene.During a review of Resident 12's History and Physical (H&P), dated 3/24/2026, the H&P indicated Resident 12 had fluctuating capacity to understand and make (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decisions.During a review of Resident 12's Order Summary Report (a document containing active orders), dated 3/26/2026, the Order Summary Report indicated, the physician placed a telephone order on 3/23/2026 for Resident 12 to start on Haloperidol (a psychotropic medication, used to treat certain mental/mood disorder) 10 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth two times a day (9 a.m., and 5 p.m.) for schizophrenia manifested by aggressive behavior for 30 days.During a concurrent interview and record review on 3/25/2026 at 2:22 p.m., with the Director of Nursing (DON), Resident 12's PASARR Level 1 screening completed by the facility on 3/18/2021, was reviewed. The DON stated the PASARR Level 1 screening indicated Resident 12 had no serious mental illness diagnoses and was not on prescribed psychotropic medications (any drug that affects brain activities associated with mental processes and behavior). The DON stated the PASARR Level 1 screening also indicated Resident 12's case was closed, and a PASARR level II mental health evaluation was not required. The DON stated the facility should have completed and resubmitted a new PASARR Level 1 screening under Resident Review because Resident 12 had a mental illness diagnoses of paranoid schizophrenia, MDD, and psychosis and Resident 12 was prescribed Haloperidol. The DON stated the facility did not follow the PASARR procedure for resubmitting a PASARR Level 1 screening under Resident Review.During a review of the facility's policy and procedure (P&P), titled Pre-admission Screening Resident Review, dated 6/12/2024, the P&P indicated The facility MDS coordinator will be responsible for accessing and ensure updates to the PASRR are completed per MDS guidelines.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan for two of 20 sampled residents (Residents 9 and 77) by failing to:Ensure a care plan was developed for Resident 9's use of Lorazepam (drug to relieve anxiety).Ensure a care plan was created for Resident 77's diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought).This failure had the potential to result in a lack of meeting necessary care and addressing medical needs for Residents 9 and 77. Findings: A.During a review of Resident 9's admission Record, the admission Record indicated, Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrolled fear or worry that interferes with daily life), epilepsy (chronic brain disorder characterized by recurrent unprovoked seizures), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 9's Minimum Data Set ([MDS] – a resident assessment tool), dated 1/29/2026, the MDS indicated, Resident 9's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated, Resident 9 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 9's History and Physical (H&P), dated 2/23/2026, the H&P indicated, Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's Order Summary Report (a document containing active orders), dated 3/26/2026, the Order Summary Report indicated, the physician placed a telephone order on 3/1/2026 for Resident 9 to start on Lorazepam 1 milligram ([mg.] – metric unit of measurement, used for medication dosage and/or amount) to give 1 tablet by mouth three times a day (9 a.m., 1 p.m., and 5 p.m.,) for anxiety disorder manifested by inability to relax. During a concurrent interview and record review on 3/26/2026 at 10:17 a.m., with Minimum Data Set Nurse 1 (MDSN 1), Resident 9's care plans were reviewed. MDSN 1 stated there was no comprehensive care plan to address Resident 9's use of Lorazepam. MDSN 1 stated it is important to have a care plan for medication in order to monitor the side-effects or the black box warning (drugs that have special problems, particularly ones that may lead to death or serious injury) of the medication. MDSN 1 stated it is the responsibility of the licensed nurses to develop a comprehensive care plan in order to be aware of each resident's individualized needs. MDSN 1 stated without a resident care plan, the facility staff would not be able to provide the care and services of the residents. B. During a review of Resident 77's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 77 was admitted on [DATE] with diagnoses which included metabolic encephalopathy (a change in how your brain works due to an underlying condition in the body), paranoid schizophrenia (a mental illness characterized by intense, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	irrational suspicions and delusions that others are plotting against or trying to harm an individual), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities) and epilepsy (seizures). During a review of Resident 77's history and physical form (H&P), dated 2/26/2026, the H&P indicated Resident 77 did not have the capacity to understand and make decisions. During a review of Resident 77's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 3/4/2026, the MDS indicated Resident 77's cognitive (thinking) skills were severely impaired. The MDS indicated Resident 77 was dependent on staff members with Activities of Daily Living (ADLs). During a review of Resident 77s' care plan, on 03/26/2026, there was no schizophrenia care plan noted. During a concurrent interview and record review, on 03/26/2026 at 10:14 a.m., with the MDSN 2, the MDSN 2 stated care plans were initiated to indicate what type of treatment staff would provide for the resident during their stay at the facility according to a resident's diagnosis and needs. The MDSN 2 stated psychiatric diagnosis were required to have a care plan. The MDSN 2 stated she did not see a schizophrenia care plan for Resident 77. The MDSN 2 stated Resident 77 required a care plan for schizophrenia. The MDSN 2 stated the risk of not initiating a care plan for a resident with a psychiatric diagnosis could result in a resident not obtaining the care and services needed according to their diagnosis. During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, dated 5/22/2025, the P&P indicated, The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a communication board was provided to Resident 58, who required assistance with communication. This deficient practice had the potential to result in ineffective communication, which could lead to unmet needs and decreased quality of care.Findings:During a review of Resident 58's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 58 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included aphasia (a disorder that makes it difficult to speak), (type 2 diabetes (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), cerebral infarction (stroke), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D).During a review of Resident 58's history and physical form (H&P), dated 6/24/2025, the H&P indicated Resident 58 had the capacity to understand and make decisions.During a review of Resident 58's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/12/2026, the MDS indicated Resident 58's cognitive (thinking) skills were cognitively intact. The MDS indicated Resident 58 was dependent on staff members with Activities of Daily Living (ADLs).During a review of Resident 58's care plan, on 3/24/2026, dated 5/2/2022, the care plan indicated to: Allow adequate time to respond. Repeat as necessary. Do not rush. Request clarification from the resident to ensure understanding. Face resident when CNA speaking. Make eye contact. Turn off TV/radio to reduce environmental noise. Ask Yes/No questions if appropriate. Use simple, brief, consistent words/cues. Use alternative communication tools as needed.Evaluate resident dexterity/ability to use communication board. During an observation, on 3/25/2026 at 3:23 p.m., in Resident 58's room, there was no communication board at the bedside. Resident 58 was nonverbal but attempted to use gestures to communicate.During a concurrent interview and record review, on 3/26/2026 at 10:14 a.m., with MDSN 2, MDSN 2 stated non-verbal residents are provided a communication board with pictures to indicate their needs or a marker to write what they would like to express. MDSN 2 stated Resident 58 was not provided a communication board. MDSN 2 stated Resident 58 used gestures to indicate her needs. MDSN 2 stated Resident 58's care plan indicated Resident 58 should have had a communication board instead of having staff translate her needs. MDSN 2 stated the risk of not providing a communication board could result in not understanding a resident or translating their needs correctly. During a review of the facility's policy and procedures (P&P), titled Accommodation of Residents' Communication Needs dated 2/24/2026, the P&P indicated The following are examples of adaptive devices or accommodations the staff may provide the Resident: A. Writing pad and pen; and B. Communication boards/charts.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled residents (Resident 70) was provided with assistance in obtaining community wheelchair transportation.This deficient practice placed Resident 70 at risk for missed medical appointments and social isolation. Findings:During a review of Resident 70's admission Record, the admission Record indicated, Resident 70 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 70's diagnoses included cerebrovascular accident ([CVA] - stroke, loss of blood flow to a part of the brain) with hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing), and diabetes Mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 70's History and Physical (H&P), dated 11/13/2025, the H&P indicated Resident 70 had the capacity to understand and make decisions.During a review of Resident 70's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/1/2026, the MDS indicated Resident 70 was independent (decisions consistent and reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 70 required supervision (helper provides verbal cues and/or contact guard assistance as resident completes activity) from staff with toileting hygiene, upper body dressing, and personal hygiene.During a review of Resident 70's care plan, titled The resident had a cerebrovascular accident, revised 3/16/2026, the care plan intervention included to monitor and document resident abilities for activities of daily living and assist resident as needed.During an interview on 3/24/2026 at 10:33 a.m., with Resident 70, Resident 70 stated he asked the Social Service Director (SSD) a month ago to help him complete the application for Access transportation service (a shared-ride, curb to curb transportation system designed for people with disabilities who cannot use traditional fixed-route buses or trains) and schedule an appointment but the SSD did not help him. Resident 70 stated he needed the Access transportation so he could visit his family, church friends, and schedule his own doctor's medical appointment.During an interview on 3/25/2026 at 10:41 a.m., with the SSD, the SSD stated one of the services provided by the facility is to assist and help resident to avail community wheelchair transportation such as the Access transportation services. The SSD stated he did help Resident 70 complete the Access application form and it was mailed out. The SSD stated he received and gave the approval notice of Resident 70's Access application form. The SSD stated he could not provide any documentation that he helped Resident 70 completing the application for Access transportation services. The SSD stated one of his responsibilities is to assist the resident with their daily needs.During an interview on 3/25/2026 at 11:17 a.m., with Resident 70, Resident 70 stated what he received from the SSD last month was a blank application form that was mailed to him by the Access Transportation services. Resident 70 stated he called and requested the application form for Access transportation services since no facility staff were willing to help him. Resident 70 showed an Access transportation application blank form which was not completed. Resident 70 stated he felt that he was not given good customer service and his needs were ignored. During a review of the facility's Social Service Coordinator Job Description, the Social Service Coordinator Job Description indicated one of the principal responsibilities of the Social Service Coordinator is to ensure the resident's psychosocial and care needs are identified and met in accordance with federal, state and company requirements.During a review of the facility's policy and procedure (P&P), titled Social Service Program, dated 5/22/2025, the P&P indicated, Responsibilities of the Social Service Department may include making referrals and obtaining services from outside referrals.

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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 ensure a recommendation from the Consultant Pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) was acted upon for one of eight sampled residents (Resident 9).This failure had the potential to result in Resident 9 experiencing a delay in treatment. Findings:During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrolled fear or worry that interferes with daily life), epilepsy (chronic brain disorder characterized by recurrent unprovoked seizures), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).During a review of Resident 9's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/29/2026, the MDS indicated, Resident 9's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 9 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, upper body dressing, and personal hygiene.During a review of Resident 9's History and Physical (H&P), dated 2/23/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions.During a concurrent interview and record review on 3/26/2026 at 9:46 a.m., with the Assistant Director of Nursing (ADON), Resident 9's Consultant Pharmacist Medication Regimen Review ([MRR] - a structured, comprehensive evaluation of a resident's entire medication list, conducted by a pharmacist to ensure safety and effectiveness), dated 12/11/2025, was reviewed. The MRR indicated to please ensure to obtain a Comprehensive Metabolic Panel ([CMP] a blood test that measures 14 key substances in the blood, assessing electrolyte balance, kidney, liver function, and blood sugar), Complete Blood Count ([CBC] - a blood test that checks the overall health of the blood by measuring the number and types of cells), Carbamazepine level (a drug level blood test that measures the amount of seizure-control medication), lipid (a blood test that measures the amount of cholesterol [type of fat] in your blood), Folate level (a blood test that measures the amount of folate [vitamin B9] in your blood to check for deficiency), and vitamin B12 level (a blood test that measures the amount of cobalamin [Vitamin B12] in your bloodstream). The ADON stated the facility failed to take any action on the consultant pharmacist recommendation by not informing Resident 9's physician. The ADON stated there was no documentation by facility staff that the Consultant's Pharmacist MRR recommendation for Resident 9 was completed.During an interview on 3/26/2026 at 10:05 a.m., with the Director of Nursing (DON), the DON stated the MRR by the pharmacy consultant should be completed by the licensed nursing staff at the end of the month. The DON stated the facility's Consultant Pharmacist comes once a month to review residents drug regimen for any medication irregularities and drug interactions (a reaction between two or more drugs). The DON stated it is very important to address the Consultant Pharmacist recommendation in a timely manner for the welfare of the residents.During a review of the facility's policy and procedure (P&P) titled, Consultant Pharmacist Reports, dated 5/2022, the P&P indicated, Recommendations are acted upon and documented by the facility staff and or the prescriber.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor one of eight sampled residents (Resident 10) behaviors while prescribed psychotropic medications (any drug that affects brain activities associated with mental processes and behavior).This deficient practice had the potential to result in the use of unnecessary psychotropic medication that could cause harm to Resident 10.Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included paranoid schizophrenia (a chronic mental health disorder where a person experiences intense, irrational suspicion that is characterized by disturbances in thought), major depressive disorder ([MDD] - a mood disorder that cause a persistent feeling of sadness and loss of interest), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing).During a review of Resident 10's History and Physical (H&P), dated 10/5/2025, the H&P indicated, Resident 10 could make needs known but could not make medical decisions.During a review of Resident 10's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 10's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 10 required set-up assistance (helper assists only prior to or following the activity) from staff with oral hygiene, lower body dressing, and personal hygiene.During a review of Resident 10's Order Summary Report (a document containing active orders), dated 3/25/2026, the Order Summary Report indicated the physician placed a telephone order on 3/3/2026 for Resident 10 to start on Quetiapine Fumarate (a psychotropic medication, used to treat certain mental/mood disorder) 50 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) by mouth at bedtime (9 p.m.) for other psychotic disorder manifested by increased agitation and verbal aggression and mirtazapine (a drug used to treat depression) 7.5 mg by mouth at bedtime (9 p.m.) for major depressive disorder.During a concurrent interview and record review on 3/25/2026 at 2:50 p.m., with the Assistant Director of Nursing (ADON), Resident 10's Medication Administration Record ([MAR] - a daily documentation record used by licensed nurse to document medications and treatments given to a resident) from 3/3/2026 to 3/25/2026, were reviewed. The ADON stated there was no documented evidence of behavior monitoring of Resident 10's episode of increased agitation, verbal aggression, and depression. The ADON stated if a resident was prescribed with psychotropic medications, there should be an indication, dose, frequency and behavior manifestation. The ADON stated the behavior monitoring should be documented in the MAR by checking Yes or No. The ADON stated, monitoring of behaviors was important in order to keep track and determine if the psychotropic medications were effective and if the facility could attempt a gradual dose reduction ([GDR] - a structured, stepwise, and monitored decrease in medication dosage to determine if a resident can manage with a lower dose or discontinue the drug entirely). The ADON stated a lack of behavior monitoring of Resident 10's psychotropic medications would be considered as an unnecessary medications.During a review of the facility's policy and procedure (P&P) titled, Behavior/Psychoactive Drug Management, dated 3/24/2024, the P&P indicated, The facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting the health, safety, psychosocial, behavioral, and environment needs of residents.During a review of the facility's P&P titled, Behavior/Psychoactive Medication Management, dated 1/30/2026, the P&P indicated, Any order for psychoactive medications must include a specific behavior manifestation. The P&P did not disclose the frequency and the importance of monitoring resident's behavior.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the physician's orders to draw laboratory tests (a medical analysis of a body sample (blood, urine, tissue) to check health, diagnose diseases and monitor chronic conditions) for one of one sampled resident, (Resident 12).This deficient practice had the potential to result in the delay of the identification of medical concerns, delaying the care and services necessary for Resident 12.Findings:During a review of Resident 12's admission Record, the admission Record indicated, Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included hypothyroidism (a condition when the thyroid gland [a butterfly-shaped or H-shaped gland located in the neck below the Adam's apple] does not make enough thyroid hormones to meet your body's needs), urinary tract infection ([UTI] - an infection in the bladder/urinary tract), and diabetes mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 12's Minimum Data Set ([MDS] - a resident assessment tool), dated 12/25/2025, the MDS indicated, Resident 12 was independent (decisions consistent/reasonable) in cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 12 required set-up assistance (helper assists only prior to or following the activity) from staff with oral hygiene, upper body dressing, and personal hygiene.During a review of Resident 12's History and Physical (H&P), dated 3/24/2026, the H&P indicated, Resident 12 had fluctuating capacity to understand and make decisions.During a review of Resident 12's Order Summary Report (a document containing active orders), dated 3/26/2026, the Order Summary Report indicated, the physician placed a telephone order on 3/12/2026 for Resident 12 to have triiodothyronine 3 level ([T3] - a blood test that measures the level of active T3 hormone in the blood to evaluate thyroid function), Free Thyroxine ([FT4] - a blood test measuring the unbound, active form of T4 hormone produced by the thyroid gland to manage metabolism), and thyroid-stimulating hormone level ([TSH] - a test that measures the amount of TSH in your blood).During a concurrent interview and record review on 3/25/2026 at 2:36 p.m., with the Assistant Director of Nursing (ADON), Resident 12's laboratory results, were reviewed. The ADON stated Resident 12's order for T3, FT4, and TSH level were not completed, and results were not available. The ADON stated there was no documentation that the facility staff made a follow-up call to the laboratory provider to find out what happened with the laboratory results. The ADON stated for whatever reasons, if laboratory orders were not completed, the licensed nursing staff must document and notify the resident's physician. The ADON stated it is important to check Resident 12's T3, FT4, and TSH level for medication dose adjustment since Resident 12 was taking levothyroxine (a drug used to treat hypothyroidism).During an interview on 3/25/2026 at 3:10 p.m., with the Director of Nursing (DON), the DON stated it is important to check Resident 12's T3, FT4, and TSH level to evaluate the effectiveness of his levothyroxine medication and for the physician to provide new interventions if needed.During a review of the facility's policy and procedure (P&P) titled, Laboratory Services, dated 1/1/2012, the P&P indicated, The facility should provide laboratory services in an accurate and timely manner to meet the needs of residents per attending physician orders. The P&P also indicated the nurse documents the time when laboratory results were reported along with the attending physician's response in the resident's medical records.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow-up on dental service for new dentures for one of one sampled resident (Resident 30).This deficient practice had the potential to result in inability to chew food and weight loss for Resident 30.Findings:During a review of Resident 30's admission Record, the admission Record indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 30's diagnoses included dysphagia (difficulty swallowing), cerebral ischemia (a condition where blood flow to the brain is reduced or blocked), and epilepsy (chronic brain disorder characterized by recurrent unprovoked seizures).During a review of Resident 30's Dental Progress Note, dated 9/3/2025, the Dental Progress Note indicated the dentist recommended a denture for Resident 30.During a review of Resident 30's History and Physical (H&P), dated 2/13/2026, the H&P indicated Resident 30 did not have the capacity to understand and make decisions.During a review of Resident 30's Minimum Data Set ([MDS] - a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 30's cognitive (ability to think and reason) skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 30 required moderate assistance (helper does less than half the effort) from staff with toileting hygiene, upper and lower body dressing.During a review of Resident 30's Dental Progress Note, dated 2/5/2026, the Dental Progress Note indicated the dentist recommended a denture for Resident 30.During an interview on 3/24/2026 at 9:50 a.m., with Resident 30, Resident 30 stated she broke her dentures about 3 to 4 months ago. Resident 30 stated she had a hard time eating without her dentures.During an interview on 3/25/2026 at 10:56 a.m., with the Social Service Director (SSD), the SSD stated he was aware that Resident 30 was seen by the dentist on 9/3/2025 and 2/5/2026 but was not aware of the dentist treatment recommendation for Resident 30 to receive a denture. The SSD stated he did not follow-up with the dentist regarding the update of Resident 30's denture. The SSD stated it is important for Resident 30 to receive dentures for her to chew the food properly. The SSD stated the risk of not providing dentures to Resident 30 would result in gum discomfort and pain that would affect her quality of life.During an interview on 3/25/2026 at 11:31 a.m., with the Director of Nursing (DON), the DON stated he was not aware of the dentist treatment recommendations for Resident 30 to receive a denture. The DON stated it is important to follow up with the dentist regarding the status of Resident 30's denture for resident's comfort when eating.During a review of the facility's Social Service Coordinator Job Description, the Social Service Coordinator Job Description indicated to communicate needs and plan of care to resident, families, responsible parties and appropriate staff and to arrange ancillary services that have been determined necessary to maintain the resident's concrete needs.During a review of the facility's policy and procedure (P&P) titled, Oral Healthcare and Dental Services, dated 7/14/2017, the P&P indicated The facility will provide oral healthcare and dental services for preventive care and treatment.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility failed to ensure two out of two randomly selected Certified Nurse Assistant's (CNA] 1 and CNA 2) received mandatory effective communications training.This deficient practice had the potential to result in inadequate staff communication skills, which may negatively impact residents' quality of care.Findings:During a concurrent interview and record review on 3/26/2026 at 3:35 p.m. with the Director of Staff Development (DSD), CNA 1 and 2's personnel records were reviewed. The DSD stated CNA 1 was hired on 7/7/2025 and did not have evidence of effective communication training on file. The DSD stated CNA 2 was hired on 3/5/2026 and did not have evidence of effective communication training on file. The DSD stated she was responsible for providing effective communication training for all direct care staff. The DSD stated it was important to provide effective communication training for all direct care staff so staff could adequately interact with residents and other staff to ensure a good working environment and residents' safety.During a review of the Facility Assessment Tool, updated on 3/23/2026, the Facility Assessment Tool indicated the facility's current CNA training program sufficiently addresses their resident population as identified by the Facility Assessment.During a review of facility's Director of Staff Development, Job Description, the DSD Job Description indicated the Director of Staff Development was responsible for planning, implementation, direction and evaluation of the facility's educational programs for all employees. The DSD Job Description indicated the DSD was to coordinate and conduct an effective on-going in-service plan for all employees.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to revise and maintain an updated average daily census of the Facility Assessment Tool (a process for evaluating a facility's resident population and identifying the resources needed to provide care and services).This deficient failure had the potential to place residents at risk for not receiving care and services necessary to maintain their highest practicable physical, mental and psychosocial well-being.Findings:During a review of the facility census for 3/23/2026, the facility census indicated, 83 residents resided in the facility.During a review of the facility census for 3/24/2026, the facility census indicated, 83 residents resided in the facility.During a concurrent interview and record review on 3/25/2026 at 11:45 a.m., with the Administrator (ADM), the Facility Assessment Tool, updated 3/23/2026, was reviewed. The ADM stated she was responsible for updating the Facility Assessment Tool. The ADM stated the Facility Assessment Tool should be updated yearly or as needed if there is a change in the facility census or if there are special treatments or services provided to the residents. The ADM stated the assessment provided was the average daily census of 80 residents. The ADM stated the Facility Assessment Tool was not accurate because of the average daily census which was below the actual census of residents residing in the facility. The ADM stated there were three residents who were not accounted for on the Facility Assessment Tool. The ADM stated it is important to indicate the correct average daily census in the Facility Assessment Tool so the facility staff could adequately provide care and support to the residents.During a review of the facility's policy and procedure (P&P) titled, Facility Assessment, dated 4/15/2021, the P&P indicated The Administrator should review and update the Facility Assessment annually and as necessary whenever there is, or the facility plans, for any change that would require a substantial modification to any part of the assessment.