STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555686	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: A. Ensure one of four sampled residents (Resident 10) who had intact skin upon admission on [DATE], was assessed as at risk for developing pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence), required assistance with turning while in bed and in a chair, and was incontinent of bowel and bladder (having no or insufficient voluntary control over urination or defecation) did not develop pressure ulcers while in the facility and received appropriate treatment and services to maintain skin integrity (the condition of the skin being intact, healthy and free from damage) by failing to: 1.Ensure Licensed Vocational Nurse 2 (LVN 2) and Treatment Nurse 1 (TN 1) assessed and reported to the Director of Nursing (DON) that Resident 10 developed skin peeling and redness between the buttocks on 7/24/2025. 2. Assess Resident 10 promptly upon Certified Nurse Assistant 2's (CNA 2) identification of an open sacrococcyx (tailbone) wound as indicated in the Daily Body Check Report, dated 7/28/2025. 3.Ensure Vitamin A and Vitamin D (A&D - a skin protectant used to treat and prevent diaper rash and minor skin irritations) was applied to the left and right foot callus (hard, thick patches of skin) as ordered on 7/28/2025 for Resident 10. 4. Conduct a timely Wound Risk Assessment (also known as Braden Scale - an assessment tool used to predict the risk of a resident developing pressure ulcers) for Resident 10 upon the development of Moisture Associated Skin Damage (MASD - inflammation [becomes reddened, swollen or hot] or skin erosion [breakdown of outer layers of skin] caused by prolonged exposure to moisture like urine, stool, sweat) on 7/31/2025 and the subsequent identification of wounds to the sacrococcyx and left buttock on 8/12/2025. 5.Ensure Certified Nurse Assistant 9 (CNA 9) completed body checks for Resident 10 on 8/8/2025, 8/9/2025 and 8/10/2025. 6. Ensure TN 1 removed Resident 10's incontinence brief on 8/11/2025 to assess the skin underneath during the administration of MASD treatment to the right and left buttocks. 7. Ensure TN 1 reported and obtained a physician's order prior to providing wound treatment to Resident 10 on 8/12/2025, when TN 1 applied a bordered gauze dressing (a wound care product designed to absorb wound drainage and protect the wound) to Resident 10's left buttock and sacrococcyx. 8. Administer Acetaminophen (also known as Tylenol, a medication used to relieve pain) as ordered to Resident 10 on 8/13/2025 prior to the administration of wound treatment. 9. Implement the facility's policy and procedure (P&P) titled Care and Prevention of Pressure Sores (also known as Pressure Ulcers), last reviewed on 4/16/2025 that indicated to provide appropriate facility interventions to manage and prevent pressure sores. These deficient practices resulted in the development of two facility-acquired pressure ulcers for Resident 10, as identified by Physician Assistant 1 (PA 1) on 8/13/2025. On 8/13/2025, PA 1 identified a Stage two pressure ulcer (partial thickness loss of skin, presenting as a shallow open sore or wound) on the left buttock and a Stage three pressure ulcer (full-thickness skin loss that extends through the skin into deeper tissue and fat but do not reach muscle, tendon or bone) on the sacrococcyx. B. Provide care consistent with professional standards of practice to prevent pressure ulcers for two of four sampled residents (Resident 16 and 33), who were at risk for pressure ulcer/injury, required assistance with turning while in bed and chair, incontinent of bowel and bladder, by failing to: 1. Provide heel protectors (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 0686 Level of Harm - Actual harm Residents Affected - Few	(devices designed to reduce pressure and friction on the heels, primarily to prevent or treat pressure ulcers) to Resident 16. This deficient practice had the potential to result in the development or worsening of pressure ulcers. 2. Ensure Resident 33 had their low air loss mattress (LALM - a special mattress designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) at the correct setting. This deficient practice had the potential to increase Resident 33's risk of skin breakdown and develop pressure ulcers. Findings: A. During a review of Resident 10's admission Record (AR), the AR indicated that the facility admitted the resident on 6/2/2025 with diagnoses including unspecified sequelae (the long-term conditions that happen because of an illness or injury) cerebral infarction (stroke - loss of blood flow to a part of the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), myocardial infarction type two (heart attack- occurs when the heart muscle doesn't get enough oxygen due to an imbalance between oxygen supply and demand, not caused by a blockage in the coronary arteries {blood vessel supplying blood to the heart}), generalized muscle weakness, and abnormalities of gait (manner of walking) and mobility (movement). During a review of Resident 10's History and Physical (H&P - comprehensive assessment conducted by a healthcare provider that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern), dated 6/2/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. The H&P indicated that Resident 10's integumentary (skin) was intact. During a review of Resident 10's admission Re-assessment, dated 6/3/2025, the admission Re-assessment indicated Resident 10 had left axilla (armpit) mass, and calluses on the right and left feet. During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 6/9/2025, the MDS indicated that Resident 10 has the ability to make self understood and has the ability to understand others. The MDS indicated Resident 10 required partial/moderate assistance from staff for bed mobility including rolling to the left and right. The MDS indicated Resident 10 was always incontinent of bowel and bladder. The MDS indicated Resident 10 had no unhealed pressure ulcer but was identified as being at risk for developing pressure ulcers. During a review of Resident 10's Braden Scale (a scoring tool used to predict resident's risk of developing a pressure ulcer, total score ranges from zero {0} to 18. A lower score indicating a higher risk of developing a pressure ulcer.) dated 6/3/2025, timed at 2:18 p.m., the Braden Scale assessment indicated a score of 17, which signifies that Resident 10 is at risk for developing pressure ulcer. During a review of Resident 10's Physician Orders dated 7/31/2025, the Physician Order indicated treatment for Resident 10's MASD to the right and left buttocks extending to the perianal (around the anal {near the anus – opening at the end of the digestive tract, through which solid waste – stool, is expelled from the body} area). The Physician Order indicated to cleanse with normal saline (a mixture of water and salt), pat dry, apply a skin barrier cream, leave open to air every day shift for 30 days. During a review of Resident 10's Physician Orders dated 8/12/2025, the Physician Orders indicated to administer Acetaminophen tablet 325 milligrams (mg - a unit of measurement), give two tablets by mouth every day shift prior to wound care and treatment. During an interview on 8/12/2025 at 2:26 p.m., with Resident 10, Resident 10 stated having a wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	on her (Resident 10) back. Resident 10 stated that she (Resident 10) did not have this wound upon admission to the facility. Resident 10 stated that the wound on her (Resident 10) back is starting to hurt, and that she (Resident 10) is in pain. Resident 10 further stated that a staff member (name unknown) applied something to the wound the previous day, but she (Resident 10) was unsure of what was applied. During an interview on 8/12/2025 at 2:30 p.m., with TN 1, TN 1 stated that Resident 10 does not have a wound treatment in place, because Resident 10 only has MASD. TN 1 stated that she (TN 1) has not yet performed the MASD treatment ordered for Resident 10. During a concurrent observation and interview on 8/12/2025 at 2:32 p.m., with TN 1, Certified Nurse Assistant 1 (CNA 1), and Certified Nurse Assistant 2 (CNA 2), at Resident 10's bedside (the place next to a resident's bed), CNA 1 and CNA 2 repositioned Resident 10 onto her (Resident 10) right side to change her (Resident 10) incontinence briefs. Two bordered gauze dressings were observed, one on Resident 10's left buttock and one on Resident 10's sacrococcyx area both without dates and staff initial. TN 1 removed the two bordered gauze dressings and stated Resident 10 has two open wounds. TN 1 stated that she (TN 1) does not know who applied the dressings on Resident 10. TN 1 then exited Resident 10's room. During a concurrent observation and interview on 8/12/2025 at 2:41 p.m., with CNA 1 and CNA 2, at Resident 10's bedside, CNA 1 stated that she (CNA 1) provided care for Resident 10 yesterday (8/11/2025), during the 3 p.m. to 11 p.m. shift, and observed bordered gauze dressings already in place on Resident 10's left buttock and sacrococcyx. CNA 1 stated that she (CNA 1) did not touch or remove the dressings. CNA 2 stated that she (CNA 2) cared for Resident 10 yesterday (8/11/2025), during the 7 a.m. to 3 p.m. shift, and observed a large open wound on Resident 10's sacrococcyx. CNA 2 stated that she (CNA 2) then documented the wound on Resident 10's Daily Body Check Report and notified the charge nurse (Licensed Vocational Nurse 1 {LVN 1). During a concurrent observation and interview on 8/12/2025 at 2:43 p.m., with TN 1, at Resident 10's bedside, TN 1 measured Resident 10's wounds and stated that Resident 10's sacrococcyx wound measured 4.5 centimeters (cm- a unit of measurement) in length by (x) three (3) cm in width, 80% wound bed granulation (the formation of new connective tissue and blood vessels that fill in a wound bed during the proliferative phase of healing), and 20% slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds). TN 1 stated that the wound edges were attached, with no signs of undermining (the destruction of tissue or ulcer extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface). TN 1 stated that the wound on Resident 10's left buttock measured two (2) cm in length x 0.4 cm in width and depth would be considered unstageable (a type of wound that occurs when pressure on the skin causes tissue damage that cannot be accurately assessed or staged due to the presence of necrotic {dead or dying} tissue) because the depth could not be determined. During an observation on 8/13/2025 at 8 a.m., Physician Assistant 1 (PA 1) and TN 1 were at Resident 10's bedside. During an interview on 8/13/2025 at 8:15 a.m., with TN 1, TN 1 stated that PA 1 evaluated Resident 10's wounds and performed excisional debridement (a surgical procedure involving the sharp removal of dead, damaged, or infected tissue from a wound to promote healing) on Resident 10's sacrococcyx wound. TN 1 stated that she (TN 1) then applied Santyl (also known as collagenase, a topical ointment that removes dead tissue from wounds so they can start to heal) to Resident 10's (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 8/13/2025 at 11:30 a.m., with Restorative Nursing Assistant 1 (RNA 1), Resident 10's Daily Body Check Report dated 8/4/2025 was reviewed. RNA 1 stated that on 8/4/2025 he (RNA 1) was working in the role of a CNA and was assigned to Resident 10. RNA 1 stated that on 8/4/2025 he (RNA 1) marked an X on the Daily Body Check Report to indicate that Resident 10 had a small, open, reddish pressure ulcer. RNA 1 stated that he (RNA 1) reported this finding to LVN 2 on the same day, and she (LVN 2) informed him (RNA 1) that she (LVN 2) would report it to TN 1. During an interview on 8/13/2025 at 2:47 p.m., with LVN 2, LVN 2 stated that the purpose of administering Acetaminophen to Resident 10 prior to wound treatment is for pain management. LVN 2 stated that TN 1 did not inform her (LVN 2) this morning (8/13/2025) that the wound treatment would be performed so she (LVN 2) did not administer the Acetaminophen. LVN 2 stated that Acetaminophen is given before wound treatment to help prevent Resident 10 from experiencing pain during the wound treatment. During a concurrent interview and record review on 8/13/2025 at 3:31 p.m., with LVN 1, Resident 10's Change of Condition (COC – when there is a sudden change in a resident's condition) Assessment form, Nursing Progress Notes (from 6/2/2025 to 8/13/2025), and Daily Body Check Report (from 6/2/2025 to 8/13/2025) were reviewed. LVN 1 stated that she (LVN 1) signed the Daily Body Check Reports on 7/28/2025 and 8/11/2025. LVN 1 stated that she (LVN 1) did not perform body checks on those dates (7/28/2025 and 8/11/2025) and does not have any documentation to support that the Daily Body Check Reports were completed. LVN 1 stated that the body checks are performed by the treatment nurse, and she (LVN 1) assumed the treatment nurse (TN 1) would complete them since Resident 10 has a treatment order for MASD. LVN 1 stated that the MASD began on 7/31/2025 and that she (LVN 1) should have checked Resident 10 on 7/28/2025. LVN 1 stated that if a new skin issue or wound is identified, she (LVN 1) would document the location, and if the wound was present, LVN 1 would complete a COC Assessment form. LVN 1 stated that she (LVN 1) does not recall whether she (LVN 1) reported Resident 10's new skin issue or wound to TN 1 on 7/28/2025. LVN 1 further stated that she (LVN 1) assumed TN 1 would inform her (LVN 1) of any changes in Resident 10's skin condition such as the development of a new wound or pressure ulcer, however no such information was relayed to her by TN 1. LVN 1 stated that the standard of practice requires documentation of any care or treatment provided. LVN 1 stated that if care or treatment is not documented, it is considered not to have been done. LVN 1 further stated that failure to document can result in a decline in the resident's condition. During a concurrent interview and record review on 8/14/2025 at 8:16 a.m., with CNA 2, the Daily Body Check Reports dated 7/28/2025, 7/31/2025, and 8/11/2025, were reviewed. CNA 2 stated that she (CNA 2) completed the documentation for the Daily Body Check Report. CNA 2 stated that the large, open wound on Resident 10's tailbone was the same wound site she (CNA 2) observed on 7/28/2025 and 7/31/2025. CNA 2 further stated that the wound on Resident 10's tailbone was the same size on both dates 7/28/2025 and 7/31/2025. CNA 2 stated that the smaller wound on Resident 10's left buttock, as observed on 8/12/2025 was open, red and had darkened edges. During a concurrent interview and record review on 8/14/2025 at 10 a.m., with TN 1, Resident 10's Braden Scale, dated 6/3/2025, 6/10/2025, 6/17/2025, and 6/24/2025, were reviewed. TN 1 stated that the Braden Scale determines how the facility would take care of residents and predict residents' risk of pressure ulcers. TN 1 stated Resident 10's Braden Scale indicated the following: -On 6/3/2025, Resident 10 had a score of 17 (at risk). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Daily Body Check Report was reviewed. CNA 9 stated that she (CNA 9) works 7 a.m. to 3 p.m. shift and was assigned to Resident 10 on 8/8/2025, 8/9/2025, and 8/10/2025. CNA 9 stated she (CNA 9) did not complete the Daily Body Check Report for Resident 10 on 8/8/2025, 8/9/2025, and 8/10/2025. CNA 9 stated that she (CNA 9) is responsible for completing the Daily Body Check Report daily. CNA 9 stated that she (CNA 9) sometimes completes the Daily Body Check Report, but at times does not complete it as required. CNA 9 stated that when she (CNA 9) identifies a skin issue on a resident, she (CNA 9) verbally reports the skin problem or concern to her (CNA 9) charge nurse. During a concurrent interview and record review on 8/14/2025 at 4:45 p.m., with TN 1, Resident 10's Care Plan (CP) titled, Risk for Developing Pressure Sore, dated 6/9/2025, was reviewed. TN 1 stated that the CP indicated goals for minimizing the risk of skin breakdown or pressure sore daily. The CP indicated interventions including assessing Resident 10's skin integrity during care, turning and repositioning as needed when in bed or wheelchair, administer/provide treatments as ordered, and assessing risk using Wound Risk Assessment on admission, quarterly, and as needed. During a concurrent interview and record review on 8/15/2025 at 9:52 a.m., with LVN 2, Resident 10's COC Assessment form, Nursing Progress Notes (from 6/2/2025 to 8/13/2025), and Daily Body Check Report (from 6/2/2025 to 8/13/2025) were reviewed. LVN 2 stated that she (LVN 2) signed the Daily Body Check Report for Resident 10 on 7/24/2025 and that she (LVN 2) was notified regarding Resident 10's skin peeling and redness between the buttocks on 7/24/2025. LVN 2 stated that she (LVN 2) verbally informed TN 1 to check on Resident 10. LVN 2 stated that she (LVN 2) did a body check on Resident 10 on 7/24/2025, but she (LVN 2) did not document the findings from the body check. LVN 2 stated that if residents had a COC related to skin condition, the treatment nurse is supposed to complete the COC form. During an interview on 8/15/2025 at 9:58 a.m., with TN 1, TN 1 stated that on 8/12/2025 she (TN 1) applied the bordered gauze dressing on Resident 10 without a physician's order. TN 1 stated that the facility's protocol requires staff to report any new skin issues to the physician, obtain a treatment order, and then initiate the prescribed treatment. TN 1 stated that obtaining an order prior to administering wound care is important to ensure that the appropriate treatment is provided to promote healing. TN 1 further stated that it is not acceptable to administer wound treatment without a physician's order, as doing so could potentially worsen the wound. During an interview on 8/15/2025 at 11:05 a.m., with TN 1, TN 1 stated that on 8/13/2025 prior to performing wound treatment, she (TN 1) has to verify with the charge nurse whether pain medication had been administered to Resident 10. TN 1 stated she (TN 1) does not recall if she (TN 1) confirmed Resident 10 received pain medication. TN 1 further stated that she (TN 1) proceeded with the wound treatment alongside PA 1 without verifying whether Resident 10 had received pain medication. During an interview on 8/15/2025 at 12:16 p.m., with the Director of Staff Development (DSD), the DSD stated that CNAs are expected to complete the Daily Body Check Report during the 7 a.m. to 3 p.m. shift. The DSD stated that she (DSD) does not have the Daily Body Check Report documentation for Resident 10 on 7/26/2025, 7/27/2025, 8/1/2025, 8/2/2025, 8/3/2025, 8/5/2025, 8/6/2025, 8/7/2025, 8/8/2025, and 8/10/2025. During an interview on 8/15/2025 at 12:48 p.m., with the DON, the DON stated that the Daily Body Check Report is completed during the morning shift (7 a.m. to 3 p.m.) by the CNAs, who are responsible for documenting any observed skin issues and reporting the skin issues to the charge nurse. The DON stated the charge nurse then co-signs the document. The DON stated that if a skin (continued on next page)

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Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0686 Level of Harm - Actual harm Residents Affected - Few	concern is identified during the morning shift and a treatment nurse is available, the charge nurse is expected to notify the TN to assess the area. The DON stated that the charge nurse is responsible for verifying whether the identified skin issue is new. The DON stated the verification process would include reviewing current physician orders, previous COC documentation and the resident's care plan. The DON stated that if the charge nurse reported a new skin issue to the treatment nurse, the treatment nurse would not acknowledge it unless there is a current physician order for treatment. The DON stated it is important for the Daily Body Checks Report to be completed to ensure timely identification of any skin issues or conditions of concern. The DON stated that when the body checks are not performed, there is a risk that wounds or skin breakdowns may not be identified promptly, potentially delaying necessary care. During an interview on 8/15/2025 at 1:00 p.m., with the DON, the DON stated that there must always be a physician's order in place to ensure correct and appropriate wound treatment is being provided. The DON stated that before initiating any wound care, the licensed nurse should notify the physician, obtain a treatment order, and complete a COC Assessment form. The DON also stated that Resident 10's most recent wound risk assessment (6/24/2025), as indicated in the Braden Scale was not accurate and did not reflect Resident 10's condition placing Resident 10 at risk for developing pressure ulcers. The DON stated that the Braden Scale assessment for Resident 10 was last completed on 6/24/2025 and was outdated, failing to account for Resident 10's present clinical status. During an interview on 8/15/2025 at 1:13 p.m., with the DON, the DON stated that pain medication should be provided to residents after residents' pain has been assessed and before wound treatment as ordered. The DON stated that pain medication is administered to residents to help minimize discomfort and manage pain during treatment procedures. During an interview on 8/15/2025 at 2:48 p.m., with the DON, the DON stated that all wound treatments for Resident 10 should be documented in the electronic health record (EHR – a comprehensive, digital collection of a resident's health information). The DON stated that the EHR is designed to alert the licensed nurse if a treatment was not done to ensure treatments are not missed. The DON stated that each treatment provided must be signed off and accurately recorded in the treatment record. The DON further stated that missed treatments can lead to a decline in the resident's wound condition. During an interview on 8/15/2025 at 2:53 p.m., with the DON, the DON stated that TN 1 should have assessed and visually examined Resident 10's wound while performing wound treatment. The DON stated that she (DON) could not verify the progression of the wound because wound conditions can change or regress within two hours. The DON stated that it is not possible to appropriately administer treatment without first assessing the area where the treatment is to be applied. The DON stated that TN 1 failed to assess and verify Resident 10's wound prior to treatment which resulted in the wound being missed. During an interview on 8/15/2025 at 2:58 p.m., with the DON, the DON stated that TN 1 demonstrated a lack of competency by failing to identify, report, and implement preventive measures for pressure ulcers. The DON stated that she (DON) discovered TN 1 had been dishonest in her (TN 1) documentation and communications. The DON also stated that TN 1 administered wound treatments without obtaining proper physician orders and failed to complete the COC Assessment form for Resident 10 on Monday (8/11/2025). The DON further stated that several required interventions were not carried out as expected. The DON stated that given Resident 10's comorbidities, lack of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	appropriate care contributed to the development and possible worsening of Resident 10's pressure ulcers (Stage Three on the sacrococcyx area and Stage Two on the left buttock area). During a review of the facility's P&P titled, Body Checks, last reviewed on 4/16/2025, the P&P indicated the objective is

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition for three of three sampled residents (Residents 67, 96, and 13) reviewed for informed consents (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to ensure: 1.Resident 67's Lorazepam (slowing activity in the brain to allow for relaxation) and Quetiapine (used to treat certain mental health conditions) informed consents indicated the name of the medication, dosage, and frequency of intake. 2.Resident 96's had an informed consent for Remeron (is a type of antidepressant medication used primarily to treat major depressive disorder in adults). 3.Resident 96's Depakote (mood stabilizer) informed consents indicated how the informed consent was verified, indicated the licensed nurses' signature and the date it was verified. 4.Resident 13's use of restraint left-hand mitten (is a soft, padded glove that covers the hands of a patient, particularly those who may be confused or prone to agitation) informed consent indicated the signature of the physician and the date the physician explained the risk and benefits of the use of restraint (devices that limit a patient's movement) left-hand mitten, and how the informed consent was verified by the licensed nurse. These deficient practices had violated the residents` right to be informed of the risk and benefits of the treatments provided to the residents. Findings: 1.During a review of Resident 67's admission Record, the admission Record indicated the facility admitted the resident on 3/8/2025, and readmitted the resident on 7/26/2025, with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that interferes with daily life), and dementia (a progressive state of decline in mental abilities). During a review of Resident 67's History and Physical (H&P), dated 7/26/2025, the H&P indicated the resident did not have the capacity to make complex healthcare decisions; however, the resident was able to decide for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and can make needs known. During a review of Resident 67's Minimum Data Set (MDS, a resident assessment tool), dated 8/2/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others. The MDS indicated the resident was on a high-risk drug class antipsychotic (medications used to treat psychosis, a condition where a person experiences a disconnect from reality) and antianxiety (a type of prescription drug that helps to reduce the symptoms of anxiety and fear, such as intense worry, nervousness, panic, and physical tension) medications. During a review of Resident 67's Order Summary Report, the order Summary Report indicated an order for: 8/10/2025 Lorazepam Tablet 0.5 milligrams (mg, a unit of weight). Give one (1) tablet by mouth every six (6) hours as needed for anxiety for 30 days monitor for behavior (m/b) recurrent outburst of anger, informed consent obtained by MD from RP after explanation of risks and benefits. ^ ^7/27/2025 Quetiapine Fumarate Oral Tablet (Quetiapine Fumarate). Give 12.5 mg by mouth two times a day for psychosis (a mental state where there's a disconnect from reality) m/b inability to cope with internal stimuli leading to episodes of stress and frustration. Informed consent obtained by MD from RP after explanation of risks and benefits. During a review of Resident 67's Care Plan (CP) Reports titled Seroquel (Atypical Anti-psychotic, have fewer and less severe side effects). Resident has episodes of psychosis, and Antipsychotic drug/dementia. At risk for complications, last revised on 3/31/2025, the CPs indicated interventions to involve the family in care if possible/available and encourage resident to discuss interest/concerns and notification of physician/responsible party of change of condition (COC). During a review of Resident 67's Informed Consents, dated 7/26/2025, the Informed Consents did not indicate the name of the medication, the dosage, and the frequency of medication intake the staff obtaining consents for. During a concurrent interview and record review on 8/13/2025, at 10:47 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m., with Registered Nurse (RN) 4, reviewed Resident 67's Order Summary Report, Care Plan, and Informed Consents. RN 4 stated there were two informed consents for psychotropic medications in the resident's chart, but it did not indicate the name of the drug, the dosage, and the frequency of medication intake. RN 4 stated it was important to indicate the name of the drug, the dosage, and the frequency of intake of the medication to know what treatment is being provided for the resident. During an interview on 8/15/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated Resident 67's Informed Consents should have the important information written on the consent for psychotropic medications. The DON stated they should include the name of the drug, dose, and frequency of intake of the medication to ensure the resident is well informed of their medication regimen. During a review of the facility's recent policy and procedure (P&P) titled Informed Consent, last reviewed on 4/16/2025, the P&P indicated before initiating the administration of psychotherapeutic drugs or physical restraints, facility staff shall verify that the patient's health record contains documentation that the patient has been given informed consent to the proposed treatment or procedure. ˆ 2.During a review of Resident 96's admission Record, the admission Record indicated the facility admitted the resident on 5/9/2011, and readmitted the resident on 6/7/2017, with diagnoses including anxiety disorder, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and mood disorder (a mental health condition characterized by significant and persistent disruptions in a person's emotional state, impacting their ability to function normally in daily life). During a review of Resident 96's H&P, dated 10/18/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 96's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (refers to a significant decline in a person's mental abilities, affecting their memory, thinking, reasoning, and judgment to the extent that it seriously interferes with daily life and independence). The MDS indicated the resident was on a high-risk drug class antidepressant medication. During a review of Resident 96's Order Summary Report, the Order Summary Report indicated an order for: 8/22/2022 Depakote Sprinkles (Divalproex Sodium). Give 125 mg via gastrostomy tube (g-tube, is a medical device that provides a way to get nourishment and/or medication directly into the stomach, bypassing the mouth and esophagus) in the evening for mood disorder m/b recurrent behavior fluctuations from calm & smiling to irritable & agitated and vice versa. 5/30/2025 Remeron tablet (Mirtazapine). Give 15 mg via g-tube at bedtime for depression m/b persistent weight loss/ loss of appetite. During a review of Resident 96's Informed Consent for Depakote, dated 5/27/2025, the Informed Consent did not indicate the verification of informed consent information (mode of verification, signature of the nurse verifying the consent, title, and the date of verification). There was no Informed Consent for Remeron on the medical chart of Resident 96. During a concurrent interview and record review on 8/12/2025, at 9:30 a.m., with RN 5, reviewed Resident 96's Order Summary Report and Informed Consents. RN 5 stated there was an informed consent for Depakote however, the mode of verification of the informed consent was not signed and dated by licensed staff. RN 5 also stated there was no informed consent for Remeron in Resident 96`s medical chart. RN 5 stated it was important to ensure the informed consents are obtained and complete to ensure the resident is well informed of what treatment they are getting, and they are aware of the risk and benefits of the proposed treatment. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated Resident 96's Informed Consents should have the important information written on the consent for psychotropic medications. The DON stated they should include the mode of how the licensed nurse verified if the physician explained the risk and benefits of taking the drug regimen. The DON also stated psychotropic medication should have informed consent prior to administering the medication to honor their right to agree or disagree to the proposed treatment. During a review of the facility's recent P&P titled Informed Consent, last reviewed on 4/16/2025, the P&P indicated before initiating the administration of psychotherapeutic drugs or physical restraints, facility staff shall verify that the patient's health record contains (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation that the patient has been given informed consent to the proposed treatment or procedure. 3.During a review of Resident 13's admission Record, the admission Record indicated the facility admitted the resident on 3/1/2019, and readmitted the resident on 5/29/2025, with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia, and history of falling. During a review of Resident 13's H&P, dated 5/29/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 13's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated that the resident had upper extremity impairment and was dependent on mobility and activities of daily living (ADLs). The MDS indicated the resident had limb restraints in bed and on chair. During a review of Resident 13's Order Summary Report, dated 5/30/2025, the Order Summary Report indicated an order to monitor behavior episodes of attempting to pull on life sustaining equipment every (q) shift and tally by hashmark. Left hand mitten use every shift. During a review of Resident 13's Informed Consent for left hand mitten, dated 5/29/2025, the Informed Consent did not indicate the physician's signature and date the physician spoke to the resident regarding the risk and benefit of applying the restraint and the verification of how the licensed nurse verified the informed consent with the resident or representative. During a concurrent interview and record review on 8/13/2025, at 1:31 p.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 13's Order Summary Report and Consent. LVN 5 stated the informed consent did not indicate the physician's signature and date the physician spoke to the resident regarding the risk and benefit of applying the restraint and the verification of how the licensed nurse verified the informed consent with the resident or representative. LVN 5 stated it was important to ensure the doctor signed and dated the consent to ensure the risk and benefits of applying the restraint was explained to the resident or representative. LVN 5 stated it is important to indicate how the licensed nurse verified the consent with the resident or representative to ensure the resident consented to the treatment plan. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated Resident 13's informed consent should have the important information written on the consent for the use of restraint left hand mitten. The DON stated they should include the mode of how the licensed nurse verified if the physician explained the risk and benefits of taking the drug regimen. The DON also stated the physician should sign and date the informed consent to attest that the physician obtained a consent on the use of the restraint left hand mitten by explaining the risk and benefit of the proposed treatment. During a review of the facility's recent P&P titled Informed Consent, last reviewed on 4/16/2025, the P&P indicated before initiating the administration of psychotherapeutic drugs or physical restraints, facility staff shall verify that the patient's health record contains documentation that the patient has been given informed consent to the proposed treatment or procedure.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the pad call light (a specialty alerting device that have ultra-sensitive touch surface for patients with limited mobility for nurses or other nursing personnel to assist a patient when in need) was within reach for three (3) of six (6) sampled residents (Residents 41, 148, and 158) reviewed under the environment task. This deficient practice had the potential to result in a delay of care and services and possible injury to residents when they are unable to call for assistance. Findings: a. During a review of Resident 158's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 6/6/2024, and readmitted in the facility on 4/7/2025, with diagnoses including dependence on respirator (also known as ventilator - a machine used to help a person breath when they are unable to do so on their own) status , contracture of muscle multiple sites, and type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 158's History and Physical (H&P) dated 4/8/2025, the H&P indicated Resident 158 was incapacitated (refers to a person's inability to manage their own affairs due to physical or mental limitations). During a review of Resident 158's Minimum Data Set (MDS, a resident assessment tool), dated 6/13/2025, the MDS indicated Resident 158 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS further indicated Resident 158 required supervision or touching assistance with eating and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 158's fall risk assessments dated 12/9/2024, 3/18/2025, and 4/7/2025, the fall risk assessments indicated Resident 158 was at a high risk for falls. During a review of Resident 158's care plan (CP) on risk for falls or injury initiated on 7/17/2024, the CP indicated to keep call light within easy reach and encourage resident to use it to get assistance as one of the interventions to reduce the risk of falls and injury daily. During a concurrent observation and interview on 8/11/2025 at 9:47 a.m. inside Resident 158's room, observed Resident 158 lying in bed, awake, alert, responding by mouthing words. Resident 158 stated he was unable to find his call light, and he did not know where it was placed. During a concurrent observation and interview on 8/11/2025 at 9:49 a.m. inside Resident 158's room with Licensed Vocational Nurse (LVN) 9, LVN 9 stated Resident 158's call light was placed under the draw sheet, and the resident was unable to reach for the call light. LVN 9 stated after providing care to the residents, the staff have to ensure the residents' call light, and all frequently used items are within the residents' reach at all times prior to leaving the room. LVN 9 stated Resident 158's call light should have been placed within reach so Resident 158 would be able to call for assistance when needed as it placed Resident 158 at risk for his needs not being attended and met timely. During an interview on 8/15/2025 at 9:50 a.m. with Registered Nurse (RN) 2, RN 2 stated staff are supposed to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room. RN 2 stated Resident 158's call light should have been placed within reach and not under the draw sheet as the resident was unable to see where the call light was. RN 2 stated if the call light was not within Resident 158's reach, the resident would not be able to call for assistance when needed and there could be a delay in providing assistance and meeting Resident 158's needs. During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed on 4/16/2025, the P&P indicated a purpose to assure resident received prompt assistance. The P&P further indicated that all staff shall ensure that the call light is within the resident's reach when in his/her room or when in the toilet and monitoring the lights and making sure that lights are answered promptly, regardless of who is assigned to each resident. b. During a review of Resident 148's admission Record, the admission (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record indicated Resident 148 was originally admitted in the facility on 12/13/2024, and readmitted in the facility on 2/15/2025, with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 148's History and Physical (H&P) dated 2/16/2025, the H&P indicated Resident 148 was incapacitated (refers to a person's inability to manage their own affairs due to physical or mental limitations). During a review of Resident 148's MDS assessment dated [DATE], the MDS assessment indicated Resident 148 was unable to understand others and make her needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 148 required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 148's fall risk assessments dated 3/5/2025 and 6/3/2025, the fall risk assessments indicated Resident 148 was at a high risk for falls. During a review of Resident 148's care plan (CP) on risk for falls or injury initiated on 3/24/2025, the CP indicated to attach call light to bed within access of resident as one of the interventions to reduce the risk of falls and injury daily. During an observation on 8/11/2025 at 10:56 a.m. inside Resident 148's room, observed Resident 148 lying in bed, asleep. Observed Resident 148's call light was placed on top of the overhead light. During a concurrent observation and interview on 8/11/2025 at 11:46 a.m. inside Resident 148's room, with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 148's call light was placed on top of the overhead light away from Resident 148 and was unable to reach for the call light. CNA 5 stated after providing care to the residents, the staff have to ensure the residents' call light, and all frequently used items are within the residents' reach at all times prior to leaving the room. CNA 5 stated Resident 148's call light should have been placed within reach so Resident 148 can call for assistance when needed as it placed Resident 148 at risk for her needs not being attended to and met timely. During an interview on 8/15/2025 at 9:50 a.m. with Registered Nurse (RN) 2, RN 2 stated staff are supposed to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room. RN 2 stated Resident 148's call light should have been placed within reach and not on top of the overhead light as the resident. RN 2 stated if the call light was not within Resident 148's reach, the resident would not be able to call for assistance when needed and there could be a delay in providing assistance and meeting Resident 148's needs. During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed on 4/16/2025, the P&P indicated a purpose to assure resident received prompt assistance. The P&P further indicated that all staff shall ensure that the call light is within the resident's reach when in his/her room or when in the toilet and monitoring the lights and making sure that lights are answered promptly, regardless of who is assigned to each resident. c. During a review of Resident 41's admission Record, the admission Record indicated the facility originally admitted the resident on 1/24/2023, and readmitted in the facility on 5/22/2025, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and neurogenic bladder (lack bladder control due to a brain, spinal cord or nerve problem). During a review of Resident 41's History and Physical (H&P) dated 7/9/2025, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a review of Resident 41's Minimum Data Set, dated [DATE], the MDS indicated Resident 41 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand others and make her needs known. The MDS further indicated Resident 41 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 41's fall risk (continued on next page)

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Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments dated 10/23/2024, 1/22/2025, 4/22/205, 7/8/2025, 7/22/2025, the fall risk assessments indicated Resident 41 was at a high risk for falls. During a review of Resident 41's care plan (CP) on risk for falls or injury initiated on 7/10/2024, the CP indicated to keep call light within easy reach and encourage resident to use it to get assistance as one of the interventions to reduce the risk of falls and injury daily. During a concurrent observation and interview on 8/11/2025 at 12:51 p.m., inside Resident 41's room with LVN 8, observed Resident 41 lying in bed and turned to the right side. LVN 8 stated Resident 41's call light was hanging over the left side rail and was not within the resident's reach as Resident 41 was facing away from the call light. LVN 8 stated after providing care to the residents, the staff have to ensure the residents' call light, and all frequently used items are within the residents' reach at all times prior to leaving the room. LVN 8 stated Resident 41's call light should have been placed within reach so Resident 41 can call for assistance when needed as it placed Resident 41 at risk for her needs not being attended to and met timely. During an interview on 8/15/2025 at 9:50 a.m. with Registered Nurse (RN) 2, RN 2 stated staff are supposed to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room. RN 2 stated Resident 41's call light should have been placed within reach and not over the left side rail. RN 2 stated if the call light was not within Resident 41's reach, the resident would not be able to call for assistance when needed and there could be a delay in providing assistance and meeting Resident 41's needs. During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed on 4/16/2025, the P&P indicated a purpose to assure resident received prompt assistance. The P&P further indicated that all staff shall ensure that the call light is within the resident's reach when in his/her room or when in the toilet and monitoring the lights and making sure that lights are answered promptly, regardless of who is assigned to each resident.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for five of seven sampled residents (Residents 76, 6, 148, 51, and 79) reviewed for physical restraints care area by failing to: 1.Ensure Resident 76's use of tab alarm (a simple device designed to alert staff when a resident attempts to get out of bed or a chair without assistance) was assessed quarterly for appropriateness of use per facility policy and procedure. 2.Ensure Resident 6 did not have rolled pillows tucked under the resident's fitted sheet on both sides. 3.Ensure Resident 148 had a physician's order, informed consent, complete a restraint assessment, and develop and implement a care plan for the use of left-hand mitten (a large, soft glove that covers a patient's hand to prevent from inadvertently dislodging medical equipment). 4.Ensure Resident 51 did not have a pillow under the fitted sheet to his right side and a wedge pillow (a triangular-shaped pillow that elevates one side of the body) under the fitted sheet to his left side while in bed. 5.Conduct a Physical Restraint Assessment for Resident 79, obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), and a physician's order prior to the use of a Geri chair (a type of adjustable, reclining wheelchair that may prevent a resident from rising independently) then, develop and implement a Geri chair care plan (CP, a written course of action that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs). The deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning and psychosocial harm of the residents. Findings: 1.During a review of Resident 76's admission Record, the admission Record indicated the facility admitted the resident on 12/19/2024, with diagnoses including presence of cardiac pacemaker (used to control or increase the heartbeat), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 76's History and Physical (H&P), dated 12/21/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool), dated 6/8/2025, the MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated that the resident had a bed and chair alarm (alert caregivers when someone at risk of falling tries to get out of bed or a chair without help). During a review of Resident 76's Order Summary Report, the Order Summary Report indicated an order for: -12/19/2024 Tab alarm when in bed and wheelchair to alert staff/remind resident to ask for assistance when transferring or ambulating. Ensure equipment is in place and functioning properly. Every shift. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-7/24/2025 Support & Safety Device- low bed (a bed frame or mattress set that is closer to the floor compared to standard bed frames) to decrease potential injury. Ensure equipment is in place and functioning properly. During a review of Resident 76's Fall Risk Evaluation, dated 7/24/2025, the Fall Risk Evaluation indicated the resident was at moderate risk for falls. During a review of Resident 76's Care Plan (CP) Report titled Tab Alarm, last revised on 1/9/2025, the CP indicated an intervention to assess need to use device quarterly or as needed. During a concurrent observation and interview on 8/11/2025, at 9:33 a.m., with Certified Nursing Assistant (CNA) 8, inside Resident 76's room, observed Resident 76's bed in the lowest position and had a tab alarm on. CNA 8 stated the resident`s bed had a tab alarm to prevent the resident from getting out of bed without assistance and to prevent falls. During a concurrent interview and record review on 8/13/2025, at 11:33 a.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 76's Medical Diagnosis, Order Summary Report, Fall Risk Evaluation, Restraint-Physical (Quarterly/Annual Evaluation), and Care Plan. LVN 5 stated the resident had an order for Tab Alarm. LVN 5 stated that the Tab Alarm was used to prevent the resident from getting out of bed without assistance. LVN 5 stated the use of Tab Alarm is a physical restraint. LVN 5 stated the Restraint-Physical (Quarterly/Annual Evaluation) was last done on 3/26/2025. LVN 5 stated the Restraint-Physical (Quarterly/Annual Evaluation) should have been done quarterly to ensure the Tab Alarm is still indicated for the resident as it keeps the resident in bed and had the potential for residents to physical deconditioning (the decline in physical fitness and function that occurs due to prolonged inactivity). LVN 5 also stated the CP indicated to evaluate the use of the restraint Tab Alarm quarterly. During an interview on 8/15/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated Resident 76's use of Tab Alarm should have been reassessed quarterly to ensure its appropriate use. The DON stated the Tab Alarm is the least restrictive form of restraint as it lets the resident move around in bed. However, it limits their movements in bed and not letting them get out in bed and walk as it will trigger an alarm when the resident pulls the cord attached to his gown. The DON stated the use of Tab Alarm should be assessed quarterly and as needed by licensed staff. The DON stated the facility missed one quarter of Restraint-Physical Evaluation. The DON stated the missed Restraint-Physical Evaluation could potentially result to resident physical deconditioning due to confining the resident in bed with minimal range of motion (ROM, how far you can move a joint or a body part, like an arm or leg, without pain or discomfort) and activity. During a review of the facility's recent policy and procedure (P&P) titled Resident Assessment, last reviewed on 4/16/2025, the P&P indicated the Minimum Data Set shall be completed for each resident regardless of payer status in facilities certified by the Medicare/Medicaid programs.ˆ Guidelines 3. Schedule and Completion of the MDS: Assessment (admission, quarterly, annual, significant change) will be completed as per RAI instructions/guidelines. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During a review of the facility-provided Information on Tab Alarm (TA) 1 copyright 2018, indicated TA 1 improves patient safety by alerting caregivers when a patient attempts to get out of a wheelchair or bed without assistance. WARNING: 1.Long pull cord can entangle the patient and be potentially dangerous. Use with care and supervision. 2.This product is not intended as a substitute for appropriate periodic visual patient/resident monitoring techniques. This product is only intended to supplement standard patient/resident monitoring techniques currently in use. 2.During a review of Resident 6's admission Record, the admission Record indicated the facility originally admitted Resident 6 on 3/11/2025 and readmitted on [DATE], with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 6's History and Physical (H&P) dated 6/5/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's MDS assessment dated [DATE], the MDS assessment indicated Resident 6 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and had impairment on BUE and BLE. During a review of Resident 6's Order Summary Report dated 7/31/2025, the Order Summary Report did not indicate a physician's order for the use of pillows tucked under the fitted sheet. During a review of Resident 6's fall risk evaluation dated 3/1/2025, the fall risk evaluation indicated Resident 6 was at a high risk for falls. During a review of Resident 6's care plan (CP) on risk for falls initiated on 3/24/2025, the CP indicated frequent visual monitoring as one of the interventions to reduce risk of falls and/or injury. During an observation on 8/11/2025 at 9:17 a.m., inside Resident 6's room, observed Resident 6 lying in bed with rolled pillows tucked under the fitted sheet. During a concurrent observation and interview on 8/11/2025 at 9:31 a.m. inside Resident 6's room with Licensed Vocational Nurse (LVN) 11, LVN 11 stated Resident 6 had rolled pillows tucked under the fitted sheet. LVN 11 stated rolled pillows are utilized for repositioning the residents and are supposed to be placed on top of the fitted sheet. LVN 11 stated the rolled pillows should not have been tucked under Resident 6's fitted sheet as the resident was unable to remove the pillows by himself and is considered a restraint. LVN 11 stated use of pillows tucked under the fitted sheet is (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not acceptable practice in the facility. During a concurrent observation and interview on 8/1/2025 at 9:35 a.m. inside Resident 6's room with Certified Nursing Assistant (CNA) 11, CNA 11 stated Resident 6 had rolled pillows tucked under the fitted sheet. CNA 11 stated rolled pillows are used to reposition the residents and are supposed to be placed on top of the fitted sheet. CNA 11 stated the rolled pillows should not have been tucked under Resident 6's fitted sheet as the resident was unable to remove the pillows by himself and is considered a restraint. CNA 11 stated use of pillows tucked under the fitted sheet is not acceptable practice in the facility. During an interview on 8/14/2025 at 11:16 a.m. with Registered Nurse (RN) 3, RN 3 stated pillows are used for the residents for turning and repositioning. RN 3 stated staff are supposed to place the pillows on top of the fitted sheet and not tucked under the fitted sheet. RN 3 stated placing the pillows under the fitted sheet is considered a restraint as the residents are unable to remove it by themselves. RN 3 stated the rolled pillows should not have been placed under Resident 6' s fitted sheet as the resident was unable to remove the pillows and is considered a restraint. RN 3 stated Resident 6's freedom of movement is restricted when pillows are placed under the fitted sheet on both sides. During an interview on 8/15/2025 at 11:45 a.m. with the Director of Nursing (DON), the DON stated that pillows are supposed to be placed on top of the fitted sheet for turning and repositioning of residents. The DON stated it is considered a restraint if the pillows are placed under the fitted sheet as the resident is unable to remove the pillows and is restricting the resident's freedom of movement. The DON stated the pillows should not have been placed under Resident 6's fitted sheet on both sides as the resident was unable to remove the pillows by himself and restricting Resident 6's freedom of movement. During a review of the facility's policy and procedure (P&P) titled, Physical Restraints, last reviewed on 4/16/2025, the P&P indicated: -Physical Restraints are any manual method, or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. -The licensed nurse shall be responsible for obtaining an order from the attending physician, which is to include: 1.Specific type of restraint 2.Purpose of the restraint 3.Time and pace of application 4.Approaches to prevent decrease functioning when applicable 5.Informed consent obtained from resident or from surrogate decision-maker. -The plan of care shall specify the reason for the use of the restraint, the type, when and where it is to be used. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A restraint shall be applied on such a manner that speedy removal is possible in the event of a fire of another emergency. 3.During a review of Resident 148's admission Record, the admission Record indicated the facility originally admitted Resident 148 on 12/13/2024 and readmitted on [DATE], with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 148's H&P dated 2/16/2025, the H&P indicated Resident 148 was incapacitated (refers to a person's inability to manage their own affairs due to physical or mental limitations). During a review of Resident 148's MDS assessment dated [DATE], the MDS assessment indicated Resident 148 was unable to understand others and make her needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 148 required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS further indicated that Resident 148 received antianxiety medications. During a review of Resident 148's Order Summary Report dated 7/31/2025, the Order Summary Report did not indicate a physician's order for the use of left-hand mitten. The Order Summary Report further indicated a physician's order dated 2/14/2025 for left freedom splint (soft splints that help restrict elbow and knee movement keep patients from accidentally pulling out important medical tubes) to prevent resident from attempting to pull on life sustaining tubes. During a review of Resident 148's fall risk evaluation dated 3/5/2025 and 6/3/2025, the fall risk evaluations indicated Resident 148 was at a risk for falls. During a review of Resident 148's care plan (CP) titled, Physical restraint in use, initiated on 12/14/2024, the CP did not indicate the use of left-hand splint. During an observation on 8/11/2025 at 10:56 a.m., 8/12/2025 at 7:40 a.m., and 8/13/2025 at 7:45 a.m., inside Resident 148's room, observed Resident 148 lying in bed with left-hand mitten on. During a concurrent observation and interview on 8/13/2025 at 7:45 a.m. with Registered Nurse (RN) 2, RN 2 stated Resident 148 had left-hand mitten on as the resident had multiple episodes of attempting to pull on life sustaining tubes. RN 2 stated the family was aware and the mitten was a family preference for Resident 148's safety. During a concurrent interview and record review on 8/13/2025 at 1:39 p.m. reviewed Resident 148's physician's order, informed consents, restraint assessments, and care plan with RN 3. RN stated Resident 148 did not have a physician's order for the use of left-hand mitten, there was no informed consent, care plan, and restraint assessment completed prior to application of the left-hand mitten. RN 3 stated Resident 148's daughter previously preferred left-hand mitten and now had changed preference to left freedom splint. RN 3 stated prior to the application of any restraint, the licensed nurse (LN) is supposed to obtain a physician's order, informed consent, complete a restraint assessment, and develop and implement a care plan. RN 3 stated the LN should have obtained a (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician's order, informed consent from Resident 148's family, complete a restraint assessment, and develop a care plan prior to the application of left-hand mitten on Resident 148 for safety. During an interview on 8/15/2025 at 11:45 a.m. with the DON, the DON stated prior to application of restraints, the staff are supposed to try the least restrictive measures first. The DON stated if the least restrictive measures did not work, the LN is supposed to obtain an order from the physician for the type of restraint needed and the reason for the restraint, confirm informed consent from the family with explanation of risks and benefits to give them a chance to decline or agree with the plan, complete a restraint assessment to ensure the appropriate type of restraint is used, and develop a care plan to ensure all the staff involved in the resident care is aware of the type of restraint to be used. During a review of the facility's policy and procedure (P&P) titled, Physical Restraints, last reviewed on 4/16/2025, the P&P indicated: -Physical Restraints are any manual method, or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. -The licensed nurse shall be responsible for obtaining an order from the attending physician, which is to include: 1.Specific type of restraint 2.Purpose of the restraint 3.Time and pace of application 4.Approaches to prevent decrease functioning when applicable 5.Informed consent obtained from resident or from surrogate decision-maker. -The plan of care shall specify the reason for the use of the restraint, the type, when and where it is to be used. -A restraint shall be applied on such a manner that speedy removal is possible in the event of a fire of another emergency. During a review of the facility's P&P titled, Informed Consent, last reviewed 4/16/2025, the P&P indicated the facility will verify that the patient's health record contains documentation that the patient has given informed consent before initiating a physical restraint. The P&P further indicated: -Before initiating the administration of physical restraints, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. -The attending physician is responsible for determining what information is necessary to obtain informed consent when a physician restraint is ordered. And disclosing the risks of the proposed treatment or procedure. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 4/16/2025, the P&P indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P further indicated: -The comprehensive person-centered care plan: 1.Includes measurable objectives and timeframes 2.Describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being including: (3) which professional services are responsible for each element of care -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision-making. -Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 4.During a review of Resident 51's admission Record, the admission Record indicated the facility originally admitted the resident on 9/7/2024 and readmitted the resident on 5/3/2025, with diagnoses including but not limited to, acute respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) and nontraumatic intracerebral hemorrhage (bleeding inside the brain tissue) in the brain stem (posterior stalk-like part of the brain that connects the cerebrum with the spinal cord).^ ^ During a review of Resident 51's History and Physical, dated 5/4/2025, the History and Physical indicated the resident was bedbound with limited function. During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 had severely impaired cognitive (relating to or involving the processes of thinking and reasoning) skills for daily decision making and was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 8/11/2025 at 9:31 a.m. with Licensed Vocational Nurse (LVN) 11 at Resident 51's bedside, Resident 51 had a pillow under the fitted sheet to his right side and a wedge pillow under the fitted sheet to his left side while in bed. LVN 11 stated pillows should not be tucked under the fitted sheet, they should be placed on top of the fitted sheet. LVN 11 stated the pillows under the fitted sheet could be considered a restraint as the resident is unable to remove them by himself. LVN 11 stated they just had an in-service where they reviewed restraints and not to put pillows under fitted sheets. During a concurrent observation and interview on 8/11/2025 at 9:35 a.m. with Certified Nursing Assistant (CNA) 11, CNA 11 stated the pillows should not be under the fitted sheet. CNA 11 stated they just had an in-service about not putting pillows or wedge pillows under the fitted sheet. CNA 11 stated they are considered a restraint as the resident cannot remove the pillow if it is under the fitted sheet. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Resident 51's medical record on 8/11/2025, the medical record did not indicate an order, assessment, or care plan for the use of pillows under the fitted sheet. During an interview on 8/15/2025 at 10:50 a.m. with the Director of Nursing (DON), the DON stated if a wedge pillow or bolsters (a supportive or cushioning device used for positioning patients) are used they should not be under the resident's fitted sheet. The DON stated if these pillows are under the resident's sheet, they are harder to remove and could restrict the resident's movement. The DON stated if they wanted to use pillows in that way, they would need a proper assessment and physicians order to use them. During a review of the facility's policy and procedure (P&P) titled, Policy: Physical Restraint, last reviewed 4/16/2025, the P&P indicated physical restraints include any material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. The P&P indicated a physical restraint assessment should be completed by a licensed nurse with input from the interdisciplinary team. The P&P indicated a licensed nurse should obtain an order from the attending physician for the specific restraint and informed consent from the resident or their representative. 5.During a review of Resident 79's admission Record (AR), the AR indicated the facility admitted the resident on 11/30/2021 and most recently readmitted the resident on 6/20/2025 with diagnoses that included cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left nondominant side, lack of coordination, muscle weakness, and history of falls. During a review of Resident 79's MDS dated [DATE], the MDS indicated the resident sometimes was able to understand others and sometimes was able to make themself understood. The MDS further indicated the resident was dependent on staff for toileting, bathing, dressing, personal hygiene, and mobility; and required substantial/maximal assistance for eating. The MDS indicated no chairs preventing rising were used as a physical restraint. During a review of Resident 79's History and Physical (H&P), dated 6/24/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 79's Restraint Physical Evaluation form regarding a low bed with floor mats, dated 6/20/2025, the Restraint Physical Evaluation form indicated the resident had an unsteady gait and attempts to self-transfer. During a review of Resident 79's Fall Risk Evaluation form, dated 7/24/2025, the Fall Risk Evaluation form indicated the resident had a history of 1 to 2 falls in the past three months and was a high risk for falls. During a concurrent observation and interview on 8/11/2025 at 11:45 a.m., observed Resident 79 in the dining room in a Geri chair. Observed the resident's feet and legs elevated to hip height with the back of the chair fully reclined placing the resident in a laying position. Resident 79 stated that he (Resident 79) was not comfortable. During a concurrent observation and interview on 8/13/2025 at 11:14 a.m., observed Resident 79 in the dining room in a Geri chair. Observed the resident's feet and legs elevated to hip height with the back of the chair fully reclined placing the resident in a laying position. Resident 79 stated he (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Resident 79) did not like being in the Geri chair in the reclining position with the feet up. Resident 79 stated Resident 79 wanted to sit up, but Resident 79 could not sit up. Observed Resident 79 was able to move the right leg and right arm. During an interview on 8/13/2025 at 11:21 a.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 stated Resident 79 was placed in the Geri chair in the reclined position with the legs up on 8/11/2025 and 8/13/2025 because the resident had left sided weakness and RNA 1 did not want the resident to fall. RNA 1 stated Resident 79 slides in the Geri chair and tries to put the right leg down. RNA 1 stated Resident 79 forgets that Resident 79 cannot stand up and Resident 79 tries to stand with the right leg. During a concurrent interview and record review on 8/13/2025 at 11:59 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 reviewed Resident 79's physician orders, informed consents, and Physical Restraint Evaluation forms. LVN 2 stated when a resident is physically restrained it can affect the resident by making the resident feel trapped resulting in psychosocial issues. LVN 2 stated the facility process[TRUNCATED]

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's drug regimen was free from unnecessary drugs for three of five sampled residents (Resident 125, 148, and 15) reviewed for unnecessary medications by failing to ensure: 1.Resident 125's Xanax 0.25 milligram (mg, a unit of weight) tablet every six (6) hours as needed for anxiety (a feeling of worry, nervousness, or unease, typically about an event or something with an uncertain outcome) had a 14-day stop date. This deficient practice had the potential to result in use of unnecessary psychotropic drugs (medications that affect your brain and change how you think, feel, and behave) for Resident 125, and can lead to side effect and adverse consequence (refers to the negative or harmful results that follow from a particular action or event) such as a decline in quality of life and functional capacity. 2.Resident 148's Ativan (an antianxiety [a type of psychotropic medications that help reduce feelings of anxiety, fear, and worry] medication) had a physician's order for monitoring for adverse side effects (unwanted or dangerous medication-related side effects). As a result, Resident 148 could have experienced adverse effects related to psychotropic medication (medications that affect brain activities associated with mental processes and behavior) therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. 3.Resident 15's antipsychotic medications Seroquel and Risperdal (medications used to treat mental illness) were used for a clear indication as diagnosed and documented in the resident's clinical record. 4.Resident 15's antipsychotic medications Seroquel and Risperdal were not used simultaneously without a clearly documented rationale. The deficient practices of failing to ensure antipsychotic medications were used to treat a resident's specific, diagnosed medical condition and that two antipsychotic medications of the same class were used concurrently without documented clinical rationale increased the risk that Resident 15 could have experienced adverse effects (unwanted or dangerous medication-related side effects) related to psychotropic medication (medications that affect brain activities associated with mental processes and behavior) therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: 1.During a review of Resident 125's admission Record, the admission Record indicated the facility admitted the resident on 8/1/2025, with diagnoses including anxiety disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that interferes with daily life), ataxia (a neurological condition that affects a person's coordination and balance, making it difficult to perform everyday movements like walking, speaking, or writing), and history of falling. During a review of Resident 125's History and Physical (H&P), dated 8/1/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 125's Minimum Data Set (MDS, a resident assessment tool), dated 8/8/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (normal mental abilitiesˆthat allow someone to effectively handle the day-to-day demands of life). The MDS indicated the resident was taking a high-risk drug class antianxiety medication (a drug used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress). During a review of Resident 125's Physician's Order Sheet, dated 8/5/2025, the Physician's Order Sheet indicated an order for Xanax oral tablet 0.25 mg (Alprazolam), give 0.25 mg by mouth every six (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(6) hours as needed for anxiety monitor for behavior (m/b) recurrent feelings of worrying regarding health. The Physician's Order Sheet indicated that informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) obtained by the physician from Responsible Party (RP) after explanation of risk and benefit. During a review of Resident 125's Care Plan (CP) Report titled Alprazolam (Xanax). At risk for adverse effect from black box med (are prescription drugs that carry the strongest safety warnings the Food and Drug Administration [FDA] can issue), initiated on 8/6/2025, the CP indicated an intervention of before prescribing alprazolam and throughout treatment, assess each patient's risk for abuse, misuse, and addiction; and to reduce the risk of withdrawal reactions, use a gradual taper to discontinue alprazolam or reduce the dosage. During a concurrent interview and record review on 8/13/2025, at 1:36 p.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 125's Medical Diagnosis, Order Summary Report, Physician's Order Sheet, Care Plan, and Consents. LVN 5 stated there was an order for Xanax oral tablet 0.25 mg (Alprazolam) every six hours as needed for anxiety, however there was no 14-day stop date on its use, and the physician did not create a progress note on why it did not have an end date. LVN 5 stated it was important to have a 14 day stop date on as needed (PRN) psychotropic medications to evaluate its effectiveness and to ensure the resident is not getting addicted to its use. During an interview on 8/15/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated Resident 125's Xanax oral tablet 0.25 mg (Alprazolam) every six hours for anxiety should have a 14 day stop date to force evaluation of the effectiveness of the medication and to prevent prolonged use. The DON stated the failure of the facility to indicate a stop date in the use of Xanax 0.25 mg PRN predisposed the resident to its adverse effects from a black box medication. During a review of the facility's recent policy and procedure (P&P) titled Psychotropic Medication Use, last reviewed on 4/16/2025, the P&P indicated under Policy Interpretation and Implementation 2. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: a. Anti-psychotics; b. Anti-depressants; c. Anti-anxiety medications; and d. Hypnotics. 11. Psychotropic medications are not prescribed on a PRN basis unless that medication is necessary to treat a diagnoses specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (2) For psychotropic medications that are antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 148's admission Record, the admission Record indicated the facility originally admitted Resident 148 on 12/13/2024, and readmitted in the facility on 2/15/2025, with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 148's History and Physical (H&P) dated 2/16/2025, the H&P indicated Resident 148 was incapacitated (refers to a person's inability to manage their own affairs due to physical or mental limitations). During a review of Resident 148's MDS assessment dated [DATE], the MDS assessment indicated Resident 148 was unable to understand others and make her needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 148 required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS further indicated that Resident 148 received antianxiety medications. During a review of Resident 148's Order Summary Report dated 7/31/2025, the Order Summary Report indicated the following physician's order: -8/1/2025: Ativan oral tablet 0.5 milligrams (mg – a unit of measurement) give one tablet via gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every six (6) hours as needed for anxiety for 14 days manifested by restlessness leading to shortness of breath. -4/30/2025: Monitor episodes of anxiety manifested by recurrent restlessness leading to shortness of breath and tally by hashmark for Ativan use every shift. During a review of Resident 148's care plan (CP) on periods of anxiety manifested by restlessness leading to shortness of breath at risk for side effects of medication usage initiated on 2/27/2025, the CP indicated to summarize effectiveness and side effects of drug monthly for the physician per psychotropic policy and observe for side effects and document occurrence of side effects per psychotropic policy as a few of the interventions to minimize the risk of adverse side effects of medication use. During a concurrent interview and record review on 8/13/2025 at 10:00 a.m., reviewed Resident 148's physician's order, informed consents, summary of episodes of anxiety, and care plans with Registered Nurse (RN) 3. RN 3 stated Resident 148 had a physician's order for Ativan and behavior monitoring for episodes of anxiety but there was no physician's order for monitoring of the adverse side effects. RN 3 stated if a resident had a physician's order for antianxiety medications, there should also be behavior episodes and side effects monitoring. RN 3 stated there should have been a physician's order for side effects monitoring for Resident 148's use of Ativan. RN 3 stated it was important that residents are monitored for side effects every shift for antianxiety medications to ensure Resident 148 did not experience adverse effects related to the use of Ativan which may lead to a decline in Resident 148's mental or physical condition. During an interview on 8/15/2025 at 11:45 a.m. with the Director of Nursing (DON), the DON stated if (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the licensed nurse received a physician's order for Ativan, a physician's order should have been obtained as well for monitoring behavior episodes and monitoring adverse side effects every shift. The DON stated she was made aware that there was no physician's order for adverse side effects monitoring for the use of Ativan on Resident 148. The DON stated there should have been a physician's order for monitoring adverse side effects for Resident 148's use of Ativan for the resident's safety that Resident 148 did not experience adverse side effects that were unmonitored which could lead to a decline in resident's physical, mental, or psychological functioning. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, last reviewed on 4/16/2025, the P&P indicated: -Psychotropic medication management includes indications for use, dose, duration, adequate monitoring for efficacy and adverse consequences, and preventing, identifying and responding to adverse consequences. -Residents receiving psychotropic medications are monitored for adverse consequences. 3. During a review of Resident 15's admission Record (a record containing diagnostic and demographic resident information), dated 8/13/2025, the admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including unspecified psychosis (a collection of symptoms indicating a disconnect with reality including auditory or visual hallucinations or delusions.) During a review of Resident 15's History and Physical (H&P- a record of a physician's comprehensive medical examination), dated 7/23/2025, the H&P indicated the resident did not have capacity to understand and make medical decisions. During a review of Resident 15's Order Summary Report (a summary of all active physician's orders), dated 7/31/2025, indicated he was receiving the following antipsychotic medications: 1.Risperdal one milligrams (mg – a unit of measure for mass) via gastrostomy tube (g-tube – a tube surgically implanted into the stomach for the administration of medication and nutrition) two times a day for psychosis manifested by inability to cope with daily living activities causing anger. 2.Seroquel 100 mg via g-tube at bedtime for psychosis manifested by inability to cope with internal stimuli leading to episodes of stress and frustration. During a review of Resident 15's clinical record, it did not contain any record or documentation of Resident 15 displaying symptoms of psychosis such as auditory or visual hallucinations, delusional beliefs, disorganized behavior, thinking, or speech, or lack of emotional expression. Further review of the clinical record indicated there was no documented rationale or clinical justification for the use of Seroquel and Risperdal simultaneously. During an interview on 8/13/2025 at 8:03 a.m. with the Licensed Vocational Nurse (LVN) 4 , LVN 4 stated she is one of the nurses, along with the Certified Nursing Assistants (CNA), who provide direct care to Resident 15 daily. LVN 4 stated common behaviors for this resident are yelling that he doesn't want to be here and resisting care like changing or blood sugar checks. LVN 4 stated sometimes she or the CNAs must come back multiple times before Resident 15 will allow care to be provided. LVN 4 stated Resident 15 is relatively new to this facility and was admitted near the end of July. LVN 4 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated these kinds of behaviors may be a result of him being in a new, unfamiliar setting. LVN 4 stated she has not ever heard this resident talking to people who aren't there, claiming he could see people who weren't there, or verbalizing paranoid beliefs such as people being after him. During an interview on 8/13/2025 at 10:58 a.m. with the Director of Nursing (DON), the DON stated psychosis itself is not a diagnosis, but a collection of symptoms that could stem from a diagnosis of mental illness such as schizophrenia or bipolar disorder, dementia, substance abuse, or possibly other medical issues. The DON stated symptoms of psychosis typically include auditory and/or visual hallucinations, paranoid delusions or delusions of grandeur, disorganized speech or behavior, or having little to no emotional expression or response. The DON stated Resident 15's use of Seroquel and Risperdal for unspecified psychosis is not a sufficient indication for the use of antipsychotic medication as the behaviors assigned to these medications, such as expressions of anger or frustration making his daily care difficult, do not align with symptoms of psychosis. The DON stated behaviors such as expressions of stress, frustration, or anger during the delivery of direct care could be explained by an environmental change, unfamiliar care givers, or simply lacking the capacity to understand his current situation. The DON stated it is inappropriate to use antipsychotic medications simply to make the delivery of direct care easier or more convenient for staff. The DON stated Seroquel and Risperdal are both antipsychotics in the same class. The DON stated it was not clear from Resident 15's clinical record why he needed to use both medications simultaneously. The DON indicated the clinical record did not contain any documentation or a clinical rationale which would explain the therapeutic duplication. The DON stated antipsychotics have a black box warning for use in the elderly to control behaviors because their use for that reason has resulted in residents' deaths. The DON stated the use of antipsychotic medications without an adequate indication or in therapeutic duplication could also cause Resident 15 to experience unnecessary adverse effects such as drowsiness, dizziness, dry mouth, constipation, urinary retention, or movement disorders possibly resulting in a decline in his quality of life.^ During a review of the facility's undated policy and procedure Psychotherapeutic Medications, the Policy and procedure indicated The use of psychotherapeutic medications shall be kept to a minimum in this facility. These medications are to be used only for specific behaviors by a resident, quantitatively and qualitatively documented by the facility, that cause: a. Danger to Self, b. Danger to other residents or staff, c. Psychotic symptoms (hallucinations, paranoia, delusion) that create frightful distress in the resident. A specific diagnosis, and a specific behavior or thought process justifying the need of psychotherapeutic medications are to be identified in the resident's health record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive care plan (CP, a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) by failing to:ˆ ˆ 1.Develop and implement a CP for the use of a Geri chair (a type of adjustable, reclining wheelchair that may prevent a resident from rising independently) for one of six sampled residents (Resident 79) reviewed during the Physical Restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) care area.ˆ ˆ 2. Develop and implement a CP for a resident wearing bilateral hand mitts (soft, padded mittens used in healthcare settings to prevent patients from interfering with medical devices, dressings, or treatment) for one of six sampled residents (Resident 66) reviewed under the Physical Restraints care area.ˆˆ ˆ 3. Develop and implement a CP for the use of an antianxiety medication (a type of psychotropic medications that help reduce feelings of anxiety, fear, and worry) for one (1) of the five (5) sampled residents (Resident 148) reviewed for psychotropic medications (a class of medications used to treat mental health conditions by aiming to alter mood, behavior, perception, and thought processes).ˆ ˆ 4. Develop and implement a CP for the resident's use of restraint bed placed against the wall for one of six sampled residents (Resident 96) reviewed for physical restraints.ˆ ˆ 5. Implement a CP for a resident who was identified at risk for pressure ulcer/injuries (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) for one of four sampled residents (Resident 10) reviewed for pressure ulcer. ˆ These deficient practices had the potential to result in miscommunication among interdisciplinary staff, residents, and resident representatives resulting in a delay of necessary care and services.ˆˆ ˆˆ Findings:ˆ a. During a review of Resident 79's admission Record (AR), the AR indicated the facility admitted the resident on 11/30/2021, and most recently readmitted the resident on 6/20/2025, with diagnoses that included cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left nondominant side, lack of coordination, muscle weakness, and history of falls.ˆ ˆ ˆ During a review of Resident 79's Minimum Data Set (MDS – resident assessment tool) dated 6/27/2025, the MDS indicated the residentˆsometimes was able to understand others and sometimes was able to make themself understood. The MDS further indicated the resident was dependent on staff for toileting, bathing, dressing, personal hygiene, and mobility; and required substantial/maximal assistance for eating. The MDS indicated no chairs preventing rising were used as a physical restraint.ˆˆ ˆ ˆ During a review of Resident 79's History and Physical (H&P), dated 6/24/2024, the H&P indicated the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident did not have the capacity to understand and make decisions.^^ ^ ^ ^ During a concurrent observation and interview on 8/11/2025 at 11:45 a.m., observed Resident 79 in the dining room in a Geri chair. Observed the resident's feet and legs elevated to hip height with the back of the chair fully reclined placing the resident in a laying position. Resident 79 stated Resident 79 was not comfortable.^ ^ ^ During a concurrent observation and interview on 8/13/2025 at 11:14 a.m., observed Resident 79 in the dining room in a Geri chair. Observed the resident's feet and legs elevated to hip height with the back of the chair fully reclined placing the resident in a laying position. Resident 79 stated Resident 79 did not like being in the Geri chair in the reclining position with the feet up. Resident 79 stated Resident 79 wanted to sit up, but Resident 79 could not sit up.^^^ ^ ^ During an interview on 8/13/2025 at 11:21 a.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 stated Resident 79 was placed in the Geri chair in the reclined position with the legs up on 8/11/2025 and 8/13/2025 because the resident had left side weakness and RNA 1 did not want the resident to fall.^^ ^ ^ During an interview on 8/13/2025 at 11:59 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 79 had a stroke and has been in a Geri chair ever since returning from the hospital on 6/20/2025.^^ ^ ^ During an interview and record review on 8/13/2025 at 4:01 p.m. with the Director of Nursing (DON), the DON reviewed Resident 79's CPs and the facility policy and procedures (P&P) regarding Geri chairs and care plans. The DON stated Geri chairs may be used in the facility, but there was a process to follow to ensure the correct use of the device and the safety of the residents. The DON stated a CP is developed and implemented for the Geri chair. The DON stated CPs are resident centered plans of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care developed by the interdisciplinary team and family that include interventions that are reviewed quarterly and as needed. The DON stated without a CP for the use of the Geri chair, staff may not be able to execute interventions for the use of the Geri chair affecting the resident's safety and mobility. The DON stated, for example, a resident may need a Geri chair for safety due to a lack of trunk control, but without a Geri chair CP, staff may put the resident in a regular wheelchair, resulting in a fall.ˆ The DON stated Resident 79 did not have a CP for the use of the Geri chair but should have. The DON stated that the facility P&P was not followed for Resident 79's use of the Geri chair potentially leading to a physical decline in the resident.ˆˆˆˆ ˆ ˆ During a review of the facility P&P titled, Geri Chair Use When Not a Restraint, last reviewed 4/16/2025, the P&P indicated geriatric chairs are not considered a restraint when resident has no voluntary or involuntary movement and cannot transfer independently. Complete CP entry for the use of Geri chair.ˆ ˆ ˆ During a review of the facility P&P titled, Care Plans, last reviewed 4/16/2025,ˆthe P&P indicated a comprehensive, person-centered CP that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The CP interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The CP includes:ˆ - measurable objectives and timeframesˆ -describes services that are to be furnishedˆˆ -includes the resident's stated goalsˆ -builds on the residents' strengthsˆ -reflects currently recognized standards of practice for problem areas and conditions.ˆ CP interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents is ongoing, and CPs are revised as information about the resident and the resident's condition change.ˆˆˆ b. During a review of Resident 66's admission Record, the admission Record indicated the facility originally admitted the resident on 5/22/2024, and readmitted the resident on 8/8/2024, with diagnoses including but not limited to, adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and early onset Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).ˆ ˆˆˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ ^^ ^ During a review of Resident 66's H&P, dated 8/8/2025, the H&P indicated the resident had cognitive (relating to or involving the processes of thinking and reasoning) impairment, The H&P indicated to monitor Resident 66 for safety.^^ ^ ^^ ^ During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had severely impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).^^^ ^ ^^ ^ During a review of Resident 66's Order Summary Report, the Order Summary Report indicated the following orders dated 6/30/2025: 1. Left hand mitten to decrease potential injury due to resident behavior of attempting to pull on life sustaining equipment. 2. Right hand mitten to decrease potential injury due to resident behavior of attempting to pull on life sustaining equipment.^^ ^ ^^ ^ During a concurrent interview and record review on 8/13/2025 at 2:56 p.m. with Minimum Data Set Nurse (MDSN) 2, Resident 66's care plan titled, Physical restraint in use.LEFT AND RIGHT HAND MITTENS, dated 8/13/2025, was reviewed. MDSN 2 stated she renewed this resident's care plan recently and the resident should have a care plan addressing the bilateral hand mitts. MDSN 2 stated the care plan needs to be there for the safety of the resident, because for example the staff would need to know to check how tight the mitts are and if there is too much pressure on the resident's skin.^^ ^ ^^ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During an interview on 8/15/2025 at 10:50 a.m. with the DON, the DON stated the care plan should be initiated at the time the hand mitts are ordered. The DON stated the care plan is the overall picture of care and gives the interventions needed for the hand mitts so it should be there when the mitts are applied to the resident. The DON stated the care plan is needed to communicate what the interventions for the hand mitts should be to staff.^^^ ^ ^ During a review of the facility's P&P^ titled, Care Plans, Comprehensive Person-Centered, last reviewed 4/16/2025, the policy and procedure indicated, A^ comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy and procedure further indicated, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.^^^ c. During a review of Resident 148's admission Record, the admission Record indicated the facility originally admitted Resident 148 on 12/13/2024, and readmitted in the facility on 2/15/2025, with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress).^^ ^^ ^ During a review of Resident 148's H&P dated 2/16/2025, the H&P indicated Resident 148 was incapacitated (refers to a person's inability to manage their own affairs due to physical or mental limitations).^^ ^^ ^ During a review of Resident 148's MDS assessment dated [DATE], the MDS assessment indicated Resident 148 was unable to understand others and make her needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 148 required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS further indicated that Resident 148 received antianxiety medications.^^ ^^ ^ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 148's Order Summary Report dated 7/31/2025, the Order Summary Report indicated the following physician's order:^^ -5/6/2025: buspirone hydrochloride (also known as Buspar, a type of antianxiety medication) tablet five (5) milligrams (mg – a unit of measurement) two (2) times a day for anxiety manifested by pulling on life sustaining tubes. Informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) obtained by the physician from the responsible party after explanation of risks and benefits.^^ ^^ -8/8/2025: buspirone hydrochloride tablet 5 mg three (3) times a day for anxiety manifested by pulling on life sustaining tubes. Informed consent obtained by the physician from the responsible party after explanation of risks and benefits.^^ ^ ^^ During a concurrent interview and record review on 8/13/2025 at 10 a.m., reviewed Resident 148's physician's order, informed consents, summary of episodes of anxiety, and care plans with Registered Nurse (RN) 3. RN 3 stated Resident 148 had a physician's order for Buspar but there was no care plan developed and implemented when the order was first initiated. RN 3 stated any services the facility was providing for the resident should have a care plan, especially high-risk medications such as psychotropic medications. RN 3 stated Resident 148's care plan addressing the Buspar use should have been developed and implemented as it is the plan of care on how to properly address resident's behavior, so the staff would be aware of the appropriate interventions necessary to prevent delay in meeting Resident 148's needs.^^ ^^ ^ During an interview on 8/15/2025 at 3 p.m. with theˆDON, the DON stated there should be a care plan for each resident to reflect the care the resident is receiving in the facility. The DON stated a care plan is a summary of the interventions, goals, timelines and that care plan is used to communicate interventions, goals to other healthcare providers to ensure residents are provided consistent and high-quality care. The DON stated Resident 148's care plan on the use of Buspar should have been developed and implemented as it placed Resident 148 at risk for a delay in the delivery of the necessary care and services the resident needs.^^ ^^ ^ During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 4/16/2025, the P&P indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P further indicated:^^ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The comprehensive person-centered care plan:^^ 1.Includes measurable objectives and timeframes^^ 2. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being including:^^ 3. Which professional services are responsible for each element of care^^ ^^ -Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision-making.^^ ^^ -Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's conditions change.^^^ d. During a review of Resident 96's admission Record, the admission Record indicated the facility admitted the resident on 5/9/2011, and readmitted the resident on 6/7/2017, with diagnoses including epilepsy (a brain disorder that causes recurring seizures), hemiplegia and hemiparesis (is weakness or a decrease in movement on one side of the body), and cerebral infarction.^ ^ ^ During a review of Resident 96's H&P, dated 10/18/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.^ ^ ^ During a review of Resident 96's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (refers to a significant decline in a person's mental abilities, making it challenging or impossible to carry out everyday tasks independently). The MDS indicated the resident was dependent to needing supervision on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily).^^ ^ ^ During a review of Resident 96's Order Summary Report, the Order Summary Report indicated an order for:^ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/28/2024 Bed against the wall secondary to RP preference. Informed consent obtained by MD from RP after explanation of risks and benefits. Every shift.^ 10/20/2023 [Falling Star Program] Frequent visual monitoring due to high risk for fall and injury. Document every (q) shift. Every shift.^ ^ ^ During a review of Resident 96's Restraint-Physical (Quarterly/Annual Evaluation), dated 5/20/2025, the Restraint-Physical (Quarterly/Annual Evaluation) indicated the reason for the restraint was for unsteady gait, agitated, aggressive behavior, with hemiplegia and hemiparesis. The Restraint-Physical (Quarterly/Annual Evaluation) also indicated bed against the wall per family preference.^ ^ ^ During a review of Resident 96's Fall Risk Evaluation, dated 5/20/2025, the Fall Risk Evaluation indicated the resident was at moderate risk for falls.^ ^ ^ During a concurrent observation and interview on 8/12/2025, at 10:42 a.m., with Certified Nursing Assistant (CNA) 6, inside Resident 96's room, observed Resident 96's bed was placed against the wall at the left side of the resident. CNA 6 stated the bed was placed against the wall per family request and the resident was at risk for falls.^ ^ ^ During a concurrent interview and record review on 8/13/2025, at 1:45 p.m., with LVN 5, reviewed Resident 96's Medical Diagnosis, Order Summary Report, Restraint-Physical (Quarterly/Annual Evaluation), Fall Risk Evaluation, and Care Plan. LVN 5 stated there was no comprehensive care plan developed and implemented on the use of restraint bed placed against the wall on Resident 96. LVN 5 stated the failure of the facility to develop a comprehensive, person-centered care plan on the use of restraint bed placed against the wall on the resident had the potential for delay in the necessary care and services to the resident.^^ ^ ^ During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated there should be a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive, person-centered care plan on the use of restraint bed placed against the wall on Resident 96 to ensure its safe use. The DON stated the care plan contains the goals, timelines, and the agreed upon interventions the resident needs to safely care for a resident on a restraint. The care plan helps the healthcare team members to provide consistent, high-quality care to residents.ˆ ˆ ˆ During a review of the facility's recent P&P titled Care Plans, Comprehensive Person-Centered, last reviewed on 4/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.ˆ e. During a review of Resident 10's admission Record (AR), the AR indicated that the facility admitted the resident on 6/2/2025 with diagnoses including unspecified sequelae (the long-term conditions that happen because of an illness or injury) cerebral infarction (stroke - loss of blood flow to a part of the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), myocardial infarction type two (heart attack- occurs when the heart muscle doesn't get enough oxygen due to an imbalance between oxygen supply and demand, not caused by a blockage in the coronary arteries {blood vessel supplying blood to the heart}), generalized muscle weakness, and abnormalities of gait (manner of walking) and mobility (movement). During a review of Resident 10's History and Physical (H&P – comprehensive assessment conducted by a healthcare provider that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern), dated 6/2/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. The H&P indicated that Resident 10's integumentary (skin) was intact. During a review of Resident 10's admission Re-assessment, dated 6/3/2025, the admission Re-assessment indicated Resident 10 had left axilla (armpit) mass, and calluses on the right and left feet. During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 6/9/2025, the MDS indicated that Resident 10 has the ability to make self understood and has the ability to understand others. The MDS indicated Resident 10 required partial/moderate assistance from staff for bed mobility including rolling to the left and right. The MDS indicated Resident 10 was always incontinent of bowel and bladder. The MDS indicated Resident 10 had no unhealed pressure ulcer but was identified as being at risk for developing pressure ulcers. During a review of Resident 10's Braden Scale (a scoring tool used to predict resident's risk of developing a pressure ulcer, total score ranges from zero {0} to 18. A lower score indicating a higher risk of developing a pressure ulcer.) dated 6/3/2025, timed at 2:18 p.m., the Braden Scale assessment indicated a score of 17, which signifies that Resident 10 is at risk for developing pressure ulcer. During a review of Resident 10's Physician Orders dated 7/31/2025, the Physician Order indicated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment for Resident 10's MASD to the right and left buttocks extending to the perianal (around the anal {near the anus – opening at the end of the digestive tract, through which solid waste – stool, is expelled from the body} area). The Physician Order indicated to cleanse with normal saline (a mixture of water and salt), pat dry, apply a skin barrier cream, leave open to air every day shift for 30 days. During a review of Resident 10's Physician Orders dated 8/12/2025, the Physician Orders indicated to administer Acetaminophen tablet 325 milligrams (mg - a unit of measurement), give two tablets by mouth every day shift prior to wound care and treatment. During an interview on 8/12/2025 at 2:26 p.m., with Resident 10, Resident 10 stated having a wound on her (Resident 10) back. Resident 10 stated that she (Resident 10) did not have this wound upon admission to the facility. Resident 10 stated that the wound on her (Resident 10) back is starting to hurt, and that she (Resident 10) is in pain. Resident 10 further stated that a staff member (name unknown) applied something to the wound the previous day, but she (Resident 10) was unsure of what was applied. During an interview on 8/12/2025 at 2:30 p.m., with TN 1, TN 1 stated that Resident 10 does not have a wound treatment in place, because Resident 10 only has MASD. TN 1 stated that she (TN 1) has not yet performed the MASD treatment ordered for Resident 10. During a concurrent observation and interview on 8/12/2025 at 2:32 p.m., with TN 1, Certified Nurse Assistant 1 (CNA 1), and Certified Nurse Assistant 2 (CNA 2), at Resident 10's bedside (the place next to a resident's bed), CNA 1 and CNA 2 repositioned Resident 10 onto her (Resident 10) right side to change her (Resident 10) incontinence briefs. Two bordered gauze dressings were observed, one on Resident 10's left buttock and one on Resident 10's sacrococcyx area both without dates and staff initial. TN 1 removed the two bordered gauze dressings and stated Resident 10 has two open wounds. TN 1 stated that she (TN 1) does not know who applied the dressings on Resident 10. TN 1 then exited Resident 10's room. During a concurrent observation and interview on 8/12/2025 at 2:41 p.m., with CNA 1 and CNA 2, at Resident 10's bedside, CNA 1 stated that she (CNA 1) provided care for Resident 10 yesterday (8/11/2025), during the 3 p.m. to 11 p.m. shift, and observed bordered gauze dressings already in place on Resident 10's left buttock and sacrococcyx. CNA 1 stated that she (CNA 1) did not touch or remove the dressings. CNA 2 stated that she (CNA 2) cared for Resident 10 yesterday (8/11/2025), during the 7 a.m. to 3 p.m. shift, and observed a large open wound on Resident 10's sacrococcyx. CNA 2 stated that she (CNA 2) then documented the wound on Resident 10's Daily Body Check Report and notified the charge nurse (Licensed Vocational Nurse 1 {LVN 1). During a concurrent observation and interview on 8/12/2025 at 2:43 p.m., with TN 1, at Resident 10's bedside, TN 1 measured Resident 10's wounds and stated that Resident 10's sacrococcyx wound measured 4.5 centimeters (cm- a unit of measurement) in length by (x) three (3) cm in width, 80% wound bed granulation (the formation of new connective tissue and blood vessels that fill in a wound bed during the proliferative phase of healing), and 20% slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds). TN 1 stated that the wound edges were attached, with no signs of undermining (the destruction of tissue or ulcer extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface). TN 1 stated that the wound on Resident 10's left buttock measured two (2) cm in length x 0.4 cm in width and depth would be considered unstageable (a type of wound that occurs when (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure on the skin causes tissue damage that cannot be accurately assessed or staged due to the presence of necrotic {dead or dying} tissue) because the depth could not be determined. During an observation on 8/13/2025 at 8 a.m., Physician Assistant 1 (PA 1) and TN 1 were at Resident 10's bedside. During an interview on 8/13/2025 at 8:15 a.m., with TN 1, TN 1 stated that PA 1 evaluated Resident 10's wounds and performed excisional debridement (a surgical procedure involving the sharp removal of dead, damaged, or infected tissue from a wound to promote healing) on Resident 10's sacrococcyx wound. TN 1 stated that she (TN 1) then applied Santyl (also known as collagenase, a topical ointment that removes dead tissue from wounds so they can start to heal) to Resident 10's sacrococcyx wound as ordered. TN 1 further stated that she (TN 1) was the staff member who applied the bordered gauze dressings to Resident 10's left buttock and sacrococcyx area yesterday (8/12/2025). During a review of Resident 10's Wound Care Consultation Notes (WCCN) dated 8/13/2025, the WCCN indicated Resident 10 had the following wounds: Sacral, Stage three pressure ulcer, size 4 cm x 2.7 cm x 0.2 cm, wound base granular (a wound in the process of healing) with exposed subcutaneous (under or beneath the skin), 40% slough, 60% granular, and excisional debridement. Left buttock, Stage two pressure ulcer, size 1 cm x 0.4 cm x 0.1 cm, wound base granular with exposed dermis (middle layer of skin in your body). The WCCN indicated the following recommendations: Wound #1, Sacral: to monitor/offload (removing or minimizing the pressure, weight, and force from a specific area of the body, such as a wound or a body part at risk of injury), foam, and Santyl. Wound #2, Left Buttock: to monitor/offload and foam; Zinc cream (medication used to treat and prevent skin irritation) for moisture control, A&D ointment for skin maintenance, every two hours turning at all times while in bed; and apply heel protectors (device used to protect the heel of a resident's foot from pressure ulcers or pain caused by impact and friction) or keep heels floating or with pillows under legs at all times while in bed. During an interview on 8/13/2025 at 8:17 a.m., with LVN 2, LVN 2 stated that she (LVN 2) has not yet started medication administration. LVN 2 stated that she (LVN 2) has not given any medications to Resident 10. LVN 2 further stated that she (LVN 2) plans to administer Resident 10's medications after Resident 10 has eaten and been changed. During an interview on 8/13/2025 at 9:15 a.m., with Resident 10, at Resident 10's bedside, Resident 10 stated that she (Resident 10) is able to move her (Resident 10) legs but is unable to roll her (Resident 10) body to the r[TRUNCATED]

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed nurses provided care in accordance with professional standards to three of three sampled residents (Residents 4, 13, and 35) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites for Residents 4, 13, and 35. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross-reference F760 Findings: 1. During a review of Resident 4's AR, the AR indicated the facility admitted the resident on 9/4/2024, and readmitted the resident on 10/27/2024, with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to dangerously low oxygen levels and/or dangerously high carbon dioxide levels in the blood), and dependence on respirator (means a person needs a machine to help them breathe). During a review of Resident 4's H&P, dated 10/27/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person with severely impaired cognition has very serious difficulties with memory, attention, thinking, learning, or making decisions). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (re essentially sugar-lowering drugs for individuals with diabetes). During a review of Resident 4's Order Summary Report, indicated an order for: 6/16/2025 Insulin Glargine-yfgn Subcutaneous Solution 100 unit per milliliters (unit/ml, describes the amount of a substance present in each milliliter of a liquid) (Insulin Glargine-yfgn). Inject 16 unit subcutaneously at bedtime for DM. Rotate site (hold if blood sugar (bs) less than [<] 100). 6/24/2025 Insulin Aspart Injection Solution 100 unit/ml (Insulin Aspart). Inject as per sliding scale (increasing administration of the preˆmeal insulin dose based on the blood sugar level before the meal): if 0 - 150 = 0 <70 may give 8 ounces (oz, a unit of volume) orange juice (OJ) and notify MD; 151 - 200 = 2 unit; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units >350 give 10 units and notify MD, subcutaneously every 6 hours for DM. Rotate Sites. During a review of Resident 4's Location of Administration Report of Insulin from 6/2025 to 8/2025, the Location of Administration indicated: -Insulin Aspart Injection Solution 100 unit/ml was administered on, 7/27/2025 at 12:31 a.m. on the Abdomen – Left Lower Quadrant (LLQ) 7/28/2025 at 5:06 a.m. on the Abdomen – LLQ (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Insulin Lispro Injection Solution 100 unit/ml was administered on, 6/14/2025 at 5:10 a.m. on the Abdomen - LLQ 6/15/2025 at 5:21 a.m. on the Abdomen – LLQ -Insulin Glargine-yfgn Subcutaneous Solution 100 unit/ml was administered on, 8/7/2025 at 9:08 p.m. on the Abdomen – Right Lower Quadrant (RLQ) 8/8/2025 at 8:14 p.m. on the Abdomen – RLQ During a review of Resident 4's Care Plan (CP) Report titled Resident is at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar), last revised on 9/10/2024, the CP indicated an intervention to administer medications as ordered. During a concurrent interview and record review on 8/13/2025, at 11:36 a.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 4's Medical Diagnosis, Order Summary Report, Location of Administration Report for Insulin from 6/2025 to 8/2025, and Care Plan. LVN 5 stated there were multiple instances where the licensed staff did not rotate the sites of administration of insulin on Resident 4. LVN 5 stated the staff should rotate insulin administration sites on residents to prevent hematoma (collection of blood outside of a blood vessel, often appearing as a bruise), skin irritation, and lipodystrophy on residents. LVN 5 stated injecting insulin on the sites where lipodystrophy occurred can result to malabsorption of insulin that can cause hyper or hypoglycemia on residents. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated the licensed staff should have rotated the insulin sites of administration for Resident 4 to prevent lipodystrophy on residents. The DON stated frequent repetition of insulin site administration could lead to lipodystrophy on residents which causes malabsorption of insulin producing hypo or hyperglycemia on residents. During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. ^ During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Lispro injection, for subcutaneous or intravenous use, with initial U.S. approval in 1996, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. ^ During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Glargine, U-300, injection, for subcutaneous use, with initial U.S. approval in 2015, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 13's AR, the AR indicated the facility admitted the resident on 3/1/2019, and readmitted the resident on 5/29/2025, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), dependence on respirator, and type 2 diabetes mellitus. During a review of Resident 13's H&P, dated 5/29/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 13's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. ^ During a review of Resident 13's Order Summary Report, dated 5/29/2025, the Order Summary Report indicated an order for: - Insulin Regular Human Injection Solution 100 unit/ml (Insulin Regular (Human)). Inject as per sliding scale: if 60 - 130 = 0 may give 8 oz of OJ for BS< 60; 131 - 160 = 2U; 161 - 200 = 3U; 201 - 250 = 4U; 251 - 300 = 6U; 301 - 350 = 8U; 351 - 400 = 10U BS >400 give 12U and call MD, subcutaneously every 6 hours for DM 2. - Insulin Glargine Subcutaneous Solution (Insulin Glargine). Inject 20 unit subcutaneously at bedtime for DM 2 (rotate injection sites) Hold if bs<100. During a review of Resident 13's Location of Administration Report for Insulin from 6/2025 to 8/2025, the Location of Administration Report indicated: -Insulin Glargine Subcutaneous Solution was administered on, 6/12/2025 at 9:22 p.m. on the Abdomen – Left Upper Quadrant (LUQ) 6/14/2025 at 9:02 p.m. on the Abdomen – LUQ -Insulin Regular Human Injection Solution 100 unit/ml was administered on, 6/29/25 at 12:09 a.m. on the Abdomen – LLQ 6/30/2025 at 12:22 a.m. on the Abdomen – LLQ 8/2/2025 at 2:57 p.m. on the Arm-Upper arm (rear) (right) 8/2/2025 at 7:39 p.m. on the Arm-Upper arm (rear) (right) 8/6/2025 at 2:59 a.m. on the Arm - left 8/7/2025 at 11:54 p.m. on the Arm – left 8/8/2025 at 8:57 p.m. on the Abdomen-LUQ (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/10/2025 at 10 p.m. on the Abdomen-LUQ 8/10/2025 at 5:10 p.m. on the Abdomen-RLQ 8/11/2025 at 5:35 p.m. on the Abdomen-RLQ During a review of Resident 13's CP Report titled Resident is at risk for hypoglycemia and hyperglycemia, last revised on 4/25/2025, the CP indicated an intervention to administer medications as ordered. During a concurrent interview and record review on 8/13/2025, at 11:45 a.m., with LVN 5, reviewed Resident 13's Medical Diagnosis, Order Summary Report, Location of Administration Report for Insulin from 6/2025 to 8/2025, and Care Plan. LVN 5 stated there were multiple instances where the licensed staff did not rotate the sites of administration of insulin for Resident 13. LVN 5 stated the staff should rotate insulin administration sites on residents to prevent hematoma, skin irritation, and lipodystrophy on residents. LVN 5 stated injecting insulin on the sites where lipodystrophy occurred can result to malabsorption of insulin that can cause hyper or hypoglycemia on residents. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated the licensed staff should have rotated the insulin sites of administration to Resident 13 to prevent lipodystrophy on residents. The DON stated frequent repetition of insulin site administration could lead to lipodystrophy on residents which causes malabsorption of insulin producing hypo or hyperglycemia on residents. During a review of the facility-provided Highlights of Prescribing Information on the use of Humulin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1982. the Highlights of Prescribing Information indicated to rotate injection sites to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Glargine, U-300, injection, for subcutaneous use, with initial U.S. approval in 2015, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. 3. During a review of Resident 35's AR (AR), the AR indicated the facility admitted the resident on 3/7/2022 and most recently admitted the resident on 7/26/2025 with diagnoses that included severe acute bronchitis (inflammation of the airway that carries air to and from the lungs) from respiratory syncytial virus (RSV, a respiratory virus that infects the lungs and breathing passages), sepsis (a life-threatening blood infection), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 35's MDS, dated [DATE], the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make themself understood. The MDS further indicated that the resident was dependent on staff for eating, bathing, dressing, oral and personal hygiene, toileting, and mobility. During a review of Resident 35's Care Plan (CP) titled, Resident is at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to diabetes mellitus, initiated 6/16/2022 and last revised on 10/31/2025, the CP indicated to administer medication as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's Order Summary Report, the Order Summary Report indicated the following order: -Insulin lispro (a fast acting insulin), inject per sliding scale (a method of managing blood sugar levels in people with diabetes where the amount of insulin given is adjusted based on the current blood sugar reading): if 150 - 199 = 1 unit (a measurement); 200- 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 - 399 = 5 units; 400 and above = 6 units and call the physician, subcutaneously before meals and at bedtime for DM, rotate injection sites, dated 7/26/2025. During a concurrent interview and record review on 8/13/2025 at 12:47 p.m. with LVN 5, LVN 5 reviewed Resident 35's physician orders, care plans, and Location of Administration Report for insulin lispro for 8/2025. LVN 5 stated the process for insulin administration is to check the resident's blood sugar and administer insulin according to the sliding scale. LVN 5 stated the standard of practice and physician order is to rotate insulin administration sites. LVN 5 stated insulin can be administered in numerous sites on the body including the upper, middle, and lower area of the abdomen; and right and left arm. LVN 5 stated it is important to always administer insulin in a different site to ensure the insulin is absorbed properly by the body and there is no bruising at sites used repetitively. LVN 5 reviewed the Location of Administration form for insulin lispro and noted the following administration sites: - On 8/1/2025 at 11:30 a.m. administered on the Abdomen-Left Lower Quadrant (LLQ) - On 8/1/2025 at 4:40 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/1/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/2/2025 at 11:30 a.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/2/2025 at 4:30 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/2/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/3/2025 at 9 p.m. administered on the Abdomen-Right Lower Quadrant (RLQ) - On 8/4/2025 at 6:30 a.m. administered on the Abdomen – RLQ, not rotated from previous site. - On 8/5/2025 at 4:30 p.m. administered on the Abdomen-LLQ - On 8/6/2025 at 6:30 a.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/6/2025 at 4:30 p.m. administered on the Abdomen-LLQ - On 8/6/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/8/2025 at 11:30 a.m. administered on the Abdomen-LLQ - On 8/8/2025 at 4:30 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/8/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 8/9/2025 at 11:30 a.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/9/2025 at 4:30 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/9/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/12/2025 at 11:30 a.m. administered on the Abdomen-LLQ - On 8/12/2025 at 4:30 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/12/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. LVN 5 further stated Resident 35 had a lot of sites that were used back-to-back and not rotated, but they should have been. LVN 5 stated the licensed nurses that administered Resident 35's insulin did not follow the physician's orders because the sites were not rotated. During an interview on 8/15/2025 at 11:37 a.m., with the DON, the DON stated the licensed staff should rotate the insulin sites of administration on residents. The DON stated frequent repetition of insulin site administration could lead to lipodystrophy causing malabsorption of insulin producing hypoglycemia or hyperglycemia in residents. During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Lispro injection, for subcutaneous or intravenous use, with initial U.S. approval in 1996, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the policy and procedure (P&P) titled, Subcutaneous Medication Administration, last reviewed 4/15/2025, the P&P indicated the purpose was to administer medication in the subcutaneous tissue in order to promote slow medication absorption and prolong medication action. Select an appropriate side for injection.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for 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 two of seven sampled residents (Residents 33 and 112) received appropriate services to prevent a decline in range of motion (ROM, full movement potential of a joint) by failing to: 1. For Resident 33, provide a safe and appropriate Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) order for wearing a left elbow splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint), left resting hand splint for no more than 30 minutes as determined by occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) and provide a safe and appropriate order for a left knee splint and left ankle foot orthosis (AFO, an orthotic device designed to correct or address problems with the ankle and foot) for no more than one hour as determined by physical therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function). 2. For Resident 112, provide a safe and appropriate RNA order for wearing a left knee splint and left AFO for no more than three hours as determined by PT and provide a safe and appropriate RNA order for wearing a left elbow splint and left hand splint for no more than four hours as determined by OT. These deficient practices had the potential for injury, pain, and skin integrity issues to Residents 33 and 112 when wearing the splints. Findings: 1. During a review of Resident 33's admission Record (AR), the AR indicated Resident 33 originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to acute and chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) and functional quadriplegia (difficulty moving both arms and legs). During a review of Resident 33's Minimum Data Set (MDS, resident assessment tool) dated 8/12/2025, the MDS indicated Resident 33 had severe cognitive impairment (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 33 had functional ROM limitations on both sides of the upper extremities (BUE, shoulder, elbow, wrist/hand) and functional ROM limitations on one side of the lower extremity (LE, hip, knee, ankle/foot). The MDS indicated Resident 33 required dependent assistance for oral hygiene, bathing, lower body dressing, sit to lying, and bed to chair transfers. During a review of Resident 33's physician's orders, the physician's orders indicated an order dated 7/10/2025 for RNA nursing program for passive range of motion (PROM, movement at a given joint with full assistance from another person) for BUE and BLE as tolerated followed by left resting hand splint, left elbow splint and left lower extremity AFO for four to six hours or as tolerated seven days a week. The physician's orders indicated an order dated 8/8/2025 for PT clarification order for skilled PT services three times a week for four weeks for orthotics (an external device to support, align, or correct a movable part of the body) and splint management. The physician's orders indicated an order dated 8/8/2025 for OT clarification order for skilled OT services three times a week for four weeks for splinting and orthotic management. The physician's orders indicated an order dated 8/13/2025 for RNA nursing program for PROM for BUE and BLE as tolerated followed by left resting hand splint, left elbow splint, and LLE AFO for four to six hours or as tolerated four times a week. During a review of Resident 112's Care Plan (CP) Report initiated 7/10/2025 and revised 8/12/2025, the CP indicated Resident 33 had limitations in ROM and contractures (loss of motion of a joint). The CP goal was to minimize complications related to decreased mobility or contractures through appropriate interventions through the next assessment. The CP interventions indicated RNA referral by rehab for PROM to BUE and BLE and splinting to left resting hand splint, left elbow splint, and LLE AFO for four to six hours or as tolerated four times a week. During a review of Resident 33's PT Evaluation and Plan of Treatment (EPT) dated 8/8/2025, the PT EPT indicated treatment approaches to include (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initial encounter of orthotic management and training and subsequent encounter of orthotics. The PT EPT indicated a PT short-term goal for Resident 33 to safely wear a foot drop splint and left ankle for up to two hours with minimal signs and symptoms of redness, swelling, discomfort or pain. During a review of Resident 33's PT Treatment Encounter Note (TEN) dated 8/8/2025, the PT TEN indicated PT analysis of Resident 33's response to wearing a left AFO for 30 minutes. During a review of Resident 33's OT EPT dated 8/8/25, the OT EPT indicated treatment approaches to include initial encounter of orthotic management and training and subsequent encounter of orthotics. The OT EPT indicated an OT short-term goal for Resident 33 to safely wear a resting hand splint on left hand for up to 30 minutes to promote improved joint mobility and ROM and more optimal positioning of left hand/digits with minimal signs and symptoms of redness, swelling, discomfort or pain. During a review of Resident 33's OT TEN dated 8/8/2025, the OT TEN indicated a precaution of left resting hand splint for less than 30 minutes. The OT TEN indicated OT assessed fit of Resident 33's left resting hand splint. During a review of Resident 33's OT TEN dated 8/11/2025, the OT TEN indicated a precaution of left resting hand splint for 30 minutes. The OT TEN indicated OT tried left resting hand splint for 30 minutes without redness or skin break down. During an observation and interview on 8/14/2025 at 9:45 a.m., Restorative Nursing Assistant (RNA) 3 performed RNA treatment with Resident 33 in Resident 33's room. Resident 33 was lying in bed on his back. RNA 3 performed PROM to BUE and BLE. Resident 33 was not able to fully straighten the right elbow or move the right arm to shoulder level. The left elbow was bent about halfway and able to fully straighten the left elbow. The left arm was able to lift to almost shoulder level. Resident 33's left and right legs could not fully straighten or bend. Resident 33's left ankle could not fully bend up. RNA 3 put on a left resting hand splint, left elbow splint, and left AFO. RNA 3 stated he will leave the splint for at least four to six hours, because the RNA order was to wear the splints for four to six hours. During an interview and record review on 8/14/2025 at 11:08 a.m., Physical Therapist (PT) 1 stated it was the responsibility of the PT staff to establish an individualized RNA program for each resident based on their medical condition and needs. PT 1 stated if a resident required splinting, the PT would evaluate and assess the resident for the benefits of a splint and if the resident could benefit from a splint, then PT would trial the splint and slowly increase the tolerance of the splint over time and keep checking the splint and resident for adverse effects. PT 1 stated for example, at first PT would put on a splint for 30 minutes, then check the skin and resident, then increase the time to one hour. If the skin had redness, then staff would take off the splint. PT 1 stated if a resident wore a splint for longer than the established safe wearing time, a resident could have skin issues, and the splint could limit the movement of the limb. PT 1 stated whatever the resident tolerated wearing the splint during PT treatment was how much the resident should wear the splint during the RNA maintenance program. In the same interview and record review, PT 1 reviewed Resident 33's PT EPT dated 8/8/2025 and stated she indicated the PT goals to increase Resident 33's left ankle ROM to prevent contractures and to assess a left foot drop splint (same as an AFO). PT 1 stated PT was still determining an appropriate RNA program for Resident 33. PT 1 stated Resident 33 was trialed to wear the left AFO for 30 min and for one hour during PT treatment and PT staff was still slowly increasing the wear time of the left AFO to make sure Resident 33 could tolerate the left AFO. PT 1 reviewed Resident 33's orders and stated Resident 33 had an order for RNA program to wear the left AFO for four to six hours. PT 1 stated PT staff was assessing the fit and wear time for the same left foot drop splint/AFO that the RNA was putting on Resident 33. PT 1 reviewed PT documentation and stated PT staff did not document or indicate that PT staff assessed Resident 33 could safely wear the left foot drop splint/AFO for four to six hours with RNA. PT 1 stated PT was the discipline responsible for assessing a safe wear time for residents wearing splints and not RNA or nursing. During an interview and record review on 8/14/2025 at 12:16 p.m., the Director of Rehabilitation (DOR) stated splints helped maintain a resident's ROM and prevent further tightness. DOR stated OT staff assessed a resident's tolerance and safe wearing time for a splint because splints could cause pain and skin (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	integrity issues. DOR stated OT staff will increase the time a resident can wear a splint and safely tolerate a splint during OT treatment. DOR reviewed Resident 33's OT EPT dated 8/8/2025 and stated the OT goal was to assess and safely determine the wear time of the left resting hand splint and left elbow splint. DOR reviewed Resident 33's OT TEN and stated OT had only assessed Resident 33 to tolerate the left resting hand splint and left elbow splint for 30 minutes. DOR reviewed Resident 33's orders and stated Resident 33 had an RNA order for put on the left resting hand splint and left elbow splint for four to six hours. DOR stated the RNA program should not put on the left resting hand splint and left elbow splint for four to six hours unless OT staff first determined it was safe to wear for that amount of time. DOR stated OT staff was the discipline that could safely assess the proper wear time of a resident and not RNA or nursing. DOR stated it would put Resident 33 at risk for skin integrity issues and pain if the splint was not put on for the appropriate time. During an interview at 8/14/2025 at 3:00 p.m., the Director of Nursing stated the RNA program was established by PT and OT and the RNA order should be what was safe and appropriate for each resident. During a review of the facility's policy and procedure (P&P) titled Restorative Nursing Services, last reviewed on 4/16/2025, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence.and are individualized and resident centered. During an interview and record review on 8/14/2025 at 8:58 a.m., the assistant DON stated the facility did not have any policies related to splinting or orthotics and therapy standards for splinting. 2. During a review of Resident 112's admission Record (AR), the AR indicated Resident 112 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including but not limited to adult failure to thrive and heart failure (condition in which the heart has difficulty pumping enough blood to keep up with demands of body). During a review of Resident 112's MDS dated [DATE], the MDS indicated Resident 112 had severe cognitive impairments. The MDS indicated Resident 112 had functional ROM limitations on one side of the upper extremity and functional ROM limitations on both sides of the lower extremities. The MDS indicated Resident 112 required supervision with eating, partial assistance with oral hygiene, and was dependent on staff for bathing, lower body dressing, sit to lying, and bed to chair transfers. During a review of Resident 112's Order Summary Report (OSR), the OSR indicated an order for RNA nursing program established for RUE and RLE active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) exercise, LUE and LLE PROM exercise as tolerated, followed by left knee extension splint, left AFO, left elbow splint, and left hand splint for four to six hours as tolerated followed by sitting edge of bed as tolerated seven days a week. During a review of Resident 112's Care Plan Report (CP), the CP dated 10/7/2024 indicated Resident 112 had limitations in ROM/contractures. The CP goal was to minimize complications related to decreased mobility or contractures through appropriate interventions through the next assessment. The CP intervention indicated RNA referral by Rehab for AAROM for RUE and RLE as tolerated seven days a week, PROM to LUE and LLE as tolerated seven days a week, left knee extension splint, left AFO, left elbow splint, and left hand splint for four to six hours as tolerated seven days a week, orthotic application and skin integrity management LUE and LLE, and sitting edge of bed as tolerated seven days a week. During a review of Resident 112's PT Treatment Encounter Note (TEN) dated 10/3/2024 indicated Resident 112 was able to tolerate splinting for three hours without skin irritation or signs of discomfort. During a review of Resident 112's PT Discharge summary dated [DATE], the DC indicated Resident 112 could safely wear a left foot drop splint and left knee extension splint for three hours with minimal signs and symptoms of redness, swelling, discomfort or pain. The PT DC indicated a recommendation for a RNP for splinting and AAROM to RLE and PROM to LLE. During a review of Resident 112's OT Treatment Encounter Note (TEN) dated 10/4/2024 indicated as a precaution that Resident 112 was able to tolerate a left resting hand splint and a left elbow extension splint for four hours. During a review of Resident 112's OT Discharge summary dated [DATE], the DC indicated Resident 112 could safely wear a left elbow extension splint and left resting hand splint for four hours (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with minimal signs and symptoms of redness, swelling, discomfort or pain. The OT DC indicated a recommendation for a RNP for splinting and AAROM and splint or brace care. During an observation and interview on 8/13/2025 at 10:06 a.m., Restorative Nursing Assistant (RNA) 2 performed RNA treatment with Resident 112 in Resident 112's room. Resident 112 was lying in bed on his back. RNA 2 performed PROM to Resident 112's LUE and LLE. Resident 112 was not able to straighten the left elbow, was able to lift the left arm to below shoulder level, and the left wrist could not fully straighten. Resident 112's left leg was rotated away from the body, and the left knee could not fully straighten. After completing ROM exercises on all extremities and sitting at edge of bed with Resident 112, RNA 2 put on a left elbow splint, left resting hand splint, left knee extension splint, and left AFO. Resident 112 stated he did not want to wear the splints for too long and said he wanted to wear the splints for only two hours. Resident 112 stated he would call RNA 2 if the splints hurt. RNA 2 stated sometimes Resident 112 did not want to wear the splints for very long. During an interview and record review on 8/14/2025 at 11:08 a.m., Physical Therapist (PT) 1 stated it was the responsibility of the PT staff to establish an individualized RNA program for each resident based on their medical condition and needs. PT 1 stated if a resident required splinting, the PT would evaluate and assess the resident for the benefits of a splint and if the resident could benefit from a splint, then PT would trial the splint and slowly increase the tolerance of the splint over time and keep checking the splint and resident for adverse effects. PT 1 stated for example, at first PT would put on a splint for 30 minutes, then check the skin and resident, then increase the time to one hour. If the skin has redness, then staff would take off the splint. PT 1 stated if the resident wore a splint for longer than the established time, the resident could have skin issues, and the splint could limit the movement of the limb. PT 1 stated whatever the resident tolerated wearing the splint during PT treatment was how much the resident should wear the splint during the RNA maintenance program. In the same interview and record review, PT 1 reviewed Resident 112's PT documentation and PT Discharge summary dated [DATE] and stated at the end of skilled PT treatment, Resident 112 could safely tolerate a left knee splint and a left AFO for a maximum of three hours. PT 1 reviewed Resident 112's current RNA treatment orders and stated the RNA order indicated to wear the left knee extension splint and left AFO for four to six hours. PT 1 stated Resident 112's RNA program orders for the left knee splint and left AFO should only be for two to three hours and not four to six hours because Resident 112 could only tolerate the left knee and left AFO for three hours during PT treatment. If Resident 112 was wearing the left knee splint and left AFO for longer then three hours, then Resident 112 could have discomfort, skin issues like itchiness. PT 1 stated PT was the discipline responsible for assessing a safe wear time for residents wearing splints and not RNA or nursing. During an interview and record review on 8/14/2025 at 12:16 p.m., the Director of Rehabilitation (DOR) stated splints help maintain a resident's ROM, prevent further tightness. DOR stated OT staff assessed a resident's tolerance and safe wearing time for a splint because splints could cause pain and skin integrity issues. DOR stated OT staff will increase the time a resident can wear a splint and safely tolerate a splint during OT treatment. DOR reviewed Resident 112's OT DC Summary dated 10/4/2024 and stated the maximum time OT indicated Resident 112 could safely tolerate the left elbow splint and left resting hand splint was four hours. DOR reviewed Resident 112's current RNA orders and stated Resident 112 had an RNA order to wear the left elbow splint and left resting hand splint for four to six hours. DOR stated OT staff did assess if Resident 112 could tolerate the splint for more than four hours, but it was not documented, and DOR could not confirm if OT staff assessed Resident 112 could safely wear the left elbow splint and left resting hand splint for five or six hours. DOR stated if Resident 112 was wearing the splint for longer than was determined by OT, then Resident 112 was at risk for injury. DOR stated OT staff was the discipline that could safely assess the proper wear time of a resident and not RNA or nursing. During an interview at 8/14/2025 at 3:00 p.m., the Director of Nursing stated the RNA program was established by PT and OT and the RNA order should be what was safe and appropriate for each resident. During a review of the facility's policy and procedure (P&P) titled Restorative (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Services, last reviewed on 4/16/2025, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence.and are individualized and resident centered. During an interview and record review on 8/14/2025 at 8:58 a.m., the assistant DON stated the facility did not have any policies related to splinting or orthotics and therapy standards for splinting.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment that is free from accident hazards over which the facility has control for six of seven sampled residents (Residents 66, 158, 124, 112, 40, and 125) investigated under the Accidents care area by: 1.Failing to ensure Resident 66's bed lock (a mechanism that prevents a hospital bed from rolling or having its position adjusted) was engaged while the resident was in bed. 2.Failing to ensure Resident 158's bed was at the lowest position. 3.Failing to ensure there were no furniture or equipment on top of Residents 40's floor mats (a cushioned floor pad designed to help prevent injury should a person fall). 4.Failing to ensure there were no furniture or equipment on top of Residents 125's floor mats. 5.Failing to ensure fall mats were provided for Resident 124 per the physician's orders and resident's plan of care. These deficient practices increased the risk of accidents such as falls with injuries. 6.Failing to ensure Resident 112's three bottles of eye drops (medication used to treat and prevent dry eyes) were not left unattended and readily available in the resident's shared room. This deficient practice had the potential to result in injury from residents obtaining medication without staff knowledge resulting in overuse with adverse effects or accidental ingestion causing harm to residents Findings: ˆ 1. During a review of Resident 66's admission Record, the admission Record indicated the facility originally admitted the resident on 5/22/2024 and readmitted the resident on 8/8/2024 with diagnoses including but not limited to, adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and early onset Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).ˆ ˆ During a review of Resident 66's History and Physical, dated 8/8/2025, the History and Physical indicated the resident had cognitive (relating to or involving the processes of thinking and reasoning) impairment and to monitor her for safety. During a review of Resident 66's Minimum Data Set (MDS – a resident assessment tool), dated 5/13/2025, the MDS indicated Resident 66 had severely impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 8/13/2025 at 2:52 p.m. with Licensed Vocational Nurse (LVN) 6 and Certified Nursing Assistant (CNA) 5 at Resident 66's bedside, Resident 66 was in bed, and the pedal brake was not engaged. Observed Resident 66's foot of bed moved side to side as LVN 6 removed Resident 66's hand mitt (a soft, padded mitten used in healthcare settings to prevent patients from interfering with medical devices, dressings, or treatment) to check her skin with the assistance of CNA 5. LVN 6 and CNA 5 completed care and walked away leaving the bed unlocked. LVN 6 stated the bed should be locked for the resident's safety. During an interview on 8/15/2025 at 10:50 a.m. with the Director of Nursing (DON), the DON stated the resident's bed should be locked to prevent it from rolling. The DON stated if the bed is not locked there is a risk of the resident falling or becoming injured. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents, last reviewed 4/16/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. During a review of the facility's P&P titled, Accident/Incident Prevention, last reviewed 4/16/2025, the P&P indicated the facility provides an environment that is free from accident hazards over which the facility has control and has procedures to prevent accidents. 2. During a review of Resident 158's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 6/6/2024 and readmitted in the facility on 4/7/2025, with diagnoses including dependence on respirator (also known as ventilator – a machine used to help a person breath when they are unable to do so on their own) status , generalized muscle weakness, and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 158's History and Physical (H&P) dated 7/9/2025, the H&P indicated Resident 158 was incapacitated (refers to a person's inability to manage their own affairs due to physical or mental limitations). During a review of Resident 158's Minimum Data Set (MDS, a resident assessment tool), dated 6/13/2025, the MDS indicated Resident 158 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand others and make her needs known. The MDS further indicated Resident 158 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 158's care plan (CP) on risk for falls or injury initiated on 7/17/2024, the CP indicated to provide resident with a safe and clutter-free environment as one of the interventions to reduce risk of falls and injury daily. During a review of Resident 158's fall risk evaluations dated 12/9/2024, 3/18/2025, 4/7/2025, the fall risk evaluations indicated Resident 158 was a high risk for falls. During an observation on 8/11/2025 at 9:45 a.m., outside Resident 158's room by the doorway, observed Resident 158 lying in bed placed in a high position without any staff present in the room. During a concurrent observation and interview on 8/11/2025 at 9:49 a.m. inside Resident 158'a room, with Licensed Vocational Nurse (LVN) 9 in the presence of Respiratory Therapist (RT) 1, LVN 9 and RT 1 stated Resident 158's was placed in a high position. LVN 9 stated residents should not be left unattended with the bed in high position. LVN 9 stated staff are supposed to place the bed at a low position after providing care as it placed the residents at risk for falls and injury. LVN 9 and RT 1 measured the height of Resident 158's bed from the top of the mattress to the floor. LVN 9 and RT 1 stated the height of the bed was measured at 31 inches (a unit of measurement). LVN 9 and RT 1 stated they were not sure what was the acceptable height of bed to be considered a low bed. LVN 9 and RT 1 stated that Resident 158 should not have been left unattended with the bed in high position and the bed should have been placed in a low position as it placed Resident 158 at risk for accidents such as falls and/or injury. During a follow up interview on 8/11/2025 at 10:05 a.m. with RT 1, RT 1 stated a bed is considered in low position if the top of the mattress measures 17 inches from the floor. RT 1 stated that Resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	158's bed should have been placed in a low position to prevent Resident 158 from incurring injury during a fall. During an interview on 8/11/2025 at 11:40 a.m. with the Director of Nursing (DON), the DON stated that residents should not be left unattended with the bed in a high position. The DON stated the staff are supposed to place the bed in a low position after providing care and/or prior to leaving the room to ensure resident safety. The DON stated resident 158 should not have been left unattended with the bed in a high position. The DON stated Resident 158's bed should have been placed in a low position after providing care and/or prior to leaving the room as it placed Resident 158 at risk for falls/accidents and could incur injuries from the fall. During a review of the facility's policy and procedure (P&P) titled, Accident/Incident Prevention, last reviewed on 4/16/2025, the P&P indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accidents/incidents and the provision of adequate care plans with procedures to prevent accidents. The P&P further indicated that in order to provide an environment that is free of accident hazards, the facility will provide care planning with implementation plans. During a review of the facility's P&P titled, Safety and Supervision of Residents, last reviewed on 4/16/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible and resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P further indicated: - Individualized, Resident-Centered Approach to Safety: 1. The individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 3. During a review of Resident 40's admission Record, the admission Record indicated the facility admitted the resident on 11/6/2023, and readmitted the resident on 1/31/2025, with diagnoses including encephalopathy (a disease or disorder that affects the brain, causing it to not function normally), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and history of falling. During a review of Resident 40's History and Physical (H&P), dated 2/1/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 40's MDS dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others. The MDS indicated the resident was dependent to requiring supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 40's Order Summary Report, dated 1/31/2025, the Order Summary Report indicated an order for [Falling Star Program] Frequent visual monitoring due to high risk for fall and injury. Document every shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's Interdisciplinary Team (IDT, group of people with different specializations (disciplines) who work together actively and collaboratively towards a shared goal, combining their knowledge and perspectives to achieve a more comprehensive solution than they would individually)- For Expected Behavior related to (R/T) Movement From Low Bed to Floor Mat, dated 2/13/2024, the IDT indicated a recommendation to continue with low bed (a bed where the mattress sits closer to the floor, often under 13 inches tall) and floor mat. During a review of Resident 40's Fall Risk Evaluation, dated 7/29/2025, the Fall Risk Evaluation indicated the resident was at high risk for falls. During a review of Resident 40's Care Plan (CP) Report titled Resident is at risk for falls/injury, last revised on 11/15/2023, the CP indicated an intervention to provide resident with a safe and clutter-free environment. During a concurrent observation and interview on 8/11/2025, at 11:16 a.m., with the Assistant Director of Staff Development (ADSD), inside Resident 40's room, observed Resident 40 had bilateral floor mat, on the right side of the floor mat there was a wheelchair on top of them. The ADSD stated there should be no wheelchair on top of Resident 40's floor mat to prevent falls with injury. The ADSD stated it defeats the purpose of having a floor mat at the resident's bedside because when they fall, they will hit the hard surface of whatever was on top of the floor mat causing injury. During a concurrent interview and record review on 8/13/2025, at 11:13 a.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 40's Order Summary Report, IDT, Fall Risk Evaluation, and Care Plan. LVN 5 stated the resident was high risk for falls with injury and the resident was on a Falling Star Program. LVN 5 stated the resident had bilateral floor mat as recommended by the IDT. LVN 5 stated the floor mat reduces the chances of falls with injury. LVN 5 stated there should be no furniture or equipment on top of Resident 40's floor mat to prevent falls with injury, LVN 5 stated by placing furniture or equipment on top of the fall mat it defeats the purpose of placing a soft mat where the resident can fall, the resident will hit the hard surfaces of whatever was on top of the floor mat causing injury to the resident such as abrasion, hematoma (a collection of blood outside of a blood vessel, often appearing as a bruise), or even fracture (a break in a bone). During an interview on 8/15/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated there should be no furniture or equipment on top of Resident 40's floor mat to prevent falls with injury. The DON also stated placing heavy objects on top of the floor mat creates a permanent dent on the floor mat reducing its ability to lessen the impact of the fall of the resident causing injuries. During a review of the facility's recent policy and procedure (P&P) titled Accident/Incident Prevention, last reviewed on 4/16/2025, the P&P indicated this facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accident/incidents and the provision of adequate care plans with procedures to prevent accidents. During a review of the facility-provided Instructions for Floor Mat (FM) 1, undated, the Information indicated when moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. Sharp objects may cause damage to the mat. Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 4/16/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 4. During a review of Resident 125's admission Record, the admission Record indicated the facility admitted the resident on 8/1/2025, with diagnoses including ataxia (a neurological condition that causes lack of muscle coordination and control, making it difficult to perform everyday movements like walking, reaching, or speaking), syncope (commonly known as fainting or passing out, is a temporary loss of consciousness due to a sudden and brief drop in blood flow to the brain), and history of falling. During a review of Resident 125's H&P, dated 8/1/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 125's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (means that an individual's thinking, reasoning, and other mental abilities are functioning at a normal or expected level for their age and without significant impairment). The MDS indicated the resident required substantial to supervision assistance on mobility and activities of daily living (ADLs). The MDS indicated the resident had a fall in the last month prior to admission in the facility. During a review of Resident 125's Order Summary Report, dated 8/1/2025, the Order Summary Report indicated an order for: - [Falling Star Program]. Frequent visual monitoring due to high risk for fall and injury. Document every (q) shift. -Support & safety device- Low bed with floor mat to decrease potential injury. Every shift. During a review of Resident 125's Fall Risk Evaluation, dated 8/1/2025, the Fall Risk Evaluation indicated the resident was high risk for falls. During a review of Resident 125's CP Report titled Resident is at risk for falls/injury, last revised on 8/11/2025, the CP indicated an intervention to provide resident with a safe and clutter-free environment. During a concurrent interview and record review on 8/13/2025, at 9:23 a.m., with LVN 5, reviewed Resident 125's Order Summary Report, Fall Risk Evaluation, and Care Plan. LVN 5 stated the resident was high risk for falls with injury and the resident was on a Falling Star Program. LVN 5 stated the resident had bilateral floor mat. On the right-side of floor mat there was a bedside drawer on top and on the left-side floor mat there was a side table on top. LVN 5 stated the floor mat reduces the chances of falls with injury. LVN 5 stated there should be no furniture or equipment on top of Resident 125's floor mat to prevent falls with injury, LVN 5 stated by placing furniture or equipment on top of the fall mat it defeats the purpose of placing a soft mat where the resident can fall, the resident will hit the hard surfaces of whatever was on top of the floor mat causing injury to the resident such as abrasion, hematoma, or even fracture. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated there should be no (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	furniture or equipment on top of Resident 125's floor mat to prevent falls with injury. The DON also stated placing heavy objects on top of the floor mat creates a permanent dent on the floormat reducing its ability to lessen the impact of the fall of the resident causing injuries. During a review of the facility's recent P&P titled Accident/Incident Prevention, last reviewed on 4/16/2025, the P&P indicated this facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accident/incidents and the provision of adequate care plans with procedures to prevent accidents. During a review of the facility-provided Instructions for FM 1, undated, the Information indicated when moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. Sharp objects may cause damage to the mat. Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 4/16/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 5. During a review of Resident 124's admission Record (AR), the AR indicated the facility originally admitted the resident on 11/5/2015 and most recently admitted the resident on 4/20/2022 with diagnoses that included seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), anoxic brain injury (a type of acquired brain injury that occurs when cells in the brain do not receive enough oxygen), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 124's MDS dated [DATE], the MDS indicated the resident was rarely / never able to understand others and was rarely / never able to make themself understood. The MDS further indicated that the resident was dependent on staff for bathing, lower body dressing, oral and personal hygiene, toileting, and transfers; the resident required partial / moderate assistance for rolling left and right. During a review of Resident 124's History and Physical (H&P) dated 10/22/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 124's Order Summary Report, the Order Summary Report indicated the following physician's orders: - [Falling Star Program], frequent visual monitoring due to high risk for fall and injury. Document every shift, dated 10/20/2023. -Low bed with floor mat to decrease potential injury. Ensure equipment is in place and functioning properly, every shift, dated 4/20/2022. During a review of Resident 124's care plan (CP) titled, Resident is at risk for falls / injury related to: impaired vision, impaired cognition, poor safety awareness / judgment, decreased strength and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	endurance,., history of falls,., revised 4/10/2019, and last reviewed 6/19/2025, the CP indicated a goal that the resident would have a reduced risk of falls and injury with interventions including to provide floor mats. During a concurrent observation and interview on 8/11/2025 at 9:25 a.m., observed Resident 124 lying in bed awake. Resident 124 did not respond to the surveyor. Observed the bed elevated and no floor mats. During an observation on 8/12/2025 at 2 p.m., observed Resident 124 sitting up in bed with no fall mats at bedside. During a concurrent observation and interview on 8/12/2025 at 3:30 p.m., with Certified Nursing Assistant (CNA) 10, observed Resident 124 sitting in bed awake. CNA 10 stood at the resident's doorway and stated there were no fall mats on either side of Resident 124's bed. CNA 10 stated Resident 124 was not at risk for falls. During a concurrent observation, interview, and record review on 8/12/2025 at 3:40 p.m., with Licensed Vocational Nurse (LVN) 10, LVN 10 reviewed Resident 124's physician orders and care plans. LVN 10 stated Resident 124 was at risk for falls and has a physician's order and care plan for floor mats, so fall mats should be in place. Observed LVN 10 enter Resident 124's room and stated the resident did not have fall mats. LVN 10 stated Resident 124 should have fall mats at all times while in bed to prevent an injury if the resident falls. During a concurrent interview and record review on 8/15/2025 at 12 p.m., with the Director of Nursing (DON), the DON reviewed the facility P&P regarding fall prevention. The DON Stated fall mats decrease the severity of injuries from falls. The DON stated the facility P&P was not followed when Resident 124 did not have fall mats potentially resulting in injuries like fractures (broken bones) to the resident. During a review of the facility policy and procedures (P&P) titled, Accident / Incident Prevention, last reviewed 4/16/2025, the P&P indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identification of each resident at risk for accidents and the provision of adequate care plans with procedures to prevent accidents. During a review of the facility P&P titled, Falling Star Program, last reviewed 4/16/2025, the P&P indicated residents at risk for falls will participate in the falling star program. Residents will be assessed for fall risk and appropriate interventions will be provided. During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 4/16/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. 6. During a review of Resident 112's AR, the AR indicated the facility originally admitted the resident on 7/17/2020 and most recently admitted the resident on 7/13/2024 with diagnoses that included (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	myocardial infarction (MI-heart attack), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), age related bilateral nuclear cataracts (a type of cataract [a clouding of the eye's lens leading to blurry or dim vision] that affects the central part of the lens), and presbyopia (gradual loss of eye's ability to focus on nearby objects). During a review of Resident 112's MDS dated [DATE], the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated that the resident required partial / moderate assistance from staff for oral hygiene; and was dependent on staff for bathing, lower body dressing, personal hygiene; and mobility. During a review of Resident 112's H&P dated 7/13/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 112's Order Summary Report, the Order Summary Report indicated a physician's order for hydroxypropyl methylcellulose ophthalmic solution (medication to relieve dryness and irritation caused by reduced tear flow), instill one drop in both eyes every four hours as needed for dry eyes, dated 8/18/2024. During a review of Resident 112's CP titled, Potential for alteration in visual function., initiated 7/22/2020 and last reviewed 6/4/2025, the CP indicated a goal that the resident would have a reduced risk of redness, irritation or infection daily with interventions including to provide treatment per physician orders and administer eye medication / drops as ordered. During a review of Resident 112's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 8/2025, the MAR indicated hydroxypropyl methylcellulose ophthalmic solution was not administered to the resident in 8/2025. During a review of Resident 112's Self-Administration of Drugs Assessment form, dated 7/13/2024, the Self-Administration of Drugs Assessment form indicated the resident was not safe for self-administration of medication. During a concurrent observation and interview on 8/12/2025 at 8:51 a.m., observed Resident 112 lay in bed. Observed on the bedside rolling table a bottle of pheniramine maleate and naphazoline hydrochloride eye drops (a medication to relieve itching and redness caused by allergens), a bottle of naphazoline eye drops (a medication for eye redness, dryness, and irritation), and a bottle of carboxymethylcellulose sodium ophthalmic (a medication for dry eyes). Resident 112 stated Resident 112 used the three bottles of eye drops approximately every ten minutes and would not be able to see without them. During an observation and interview on 8/11/2025 at 9:40 a.m., observed LVN 4 at Resident 112's doorway. LVN 4 stated LVN 4 would give Resident 112 medication. Observed the three eye drops remained on the resident's bedside rolling table. During a concurrent observation and interview on 8/12/2025 at 8:40 a.m., with CNA 8, CNA 8 entered Resident 112's room and placed the resident's breakfast tray on the rolling table. Observed the three bottles of eye drops remained on the rolling table. CNA 8 exited the room and did not remove the eye (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drops. Upon exiting the room CNA 8 stated CNA 8 did not know if the resident had any eye drops at bedside. CNA 8 re-entered Resident 112's room. CNA 8 confirmed Resident 112 had three bottles of eye drops at bedside. During a concurrent interview and record review on 8/12/2025 at 11:25 a.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 112's Self-Administration of Drugs Assessment form. The ADON stated medications should not be left at bedside to ensure medications are administered per physician's orders with the correct dose and at the right time to the residents. The ADON stated if a resident wants to self-administer medications, then the facility will assess the resident, get a physician's order, develop and implement a CP, and place the medications in a locked box. The ADON stated all staff are responsible to assess the resident environment to ensure medications are not left at bedside. The ADON stated the ADON was made aware Resident 112 had eye drops at bedside. The ADON stated Resident 112 was not safe to self-administer medications. The ADON stated when the eye drops were left at Resident 112's bedside there was the potential that the resident would not administer the eye drops per physician orders or that other confused residents would use t

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure six of seven sampled residents (Residents 11, 51, 41, 168, 4, 125, and 155) reviewed under the urinary catheter (a tube that is inserted into the bladder, allowing urine to drain) and urinary tract infection (UTI, a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) care area received appropriate treatment and services to prevent UTIs by: 1.Failing to ensure Resident 11, 51, 41, 168, and 4's catheter tubing did not have dependent loops or kinks (incorrect positioning of the catheter tubing that forms a U-shaped loop or low point that traps urine and creates back pressure). These deficient practices increased the risk of urine to backflow into the bladder which may lead to the development of a UTI. 2.Failing to ensure Residents 125 and 155's urinal bottles (portable container for collecting urine) were labeled with the name and room number of the residents. These deficient practices had the potential to lead to switching urinal bottles with other residents and cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). Findings: ˆ 1. During a review of Resident 11's admission Record, the admission Record indicated the facility originally admitted the resident on 1/22/2024, and readmitted the resident on 6/5/2025, with diagnoses including but not limited to, respiratory failure (a condition where the lungs cannot release enough oxygen into the blood), obstructive and reflux uropathy (a urinary tract blockage that allows urine to flow backward into the kidneys), and type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 11's History and Physical, dated 6/6/2025, the History and Physical indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS – a resident assessment tool), dated 7/29/2025, the MDS indicated Resident 11 had severely impaired cognitive (relating to or involving the processes of thinking and reasoning) skills for daily decision making and was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 11's Order Summary Report, the Order Summary Report indicated the following order dated 6/5/2025: Foley (indwelling) catheter attached to bedside drainage bag for wound management. During a review of Resident 11's care plan (a document that outlines a patient's healthcare needs, goals, and the interventions and treatments planned to achieve those goals, serving as a roadmap for their care and facilitating communication among the healthcare team), titled, Alteration in elimination and at risk for UTI secondary to Foley Catheter., dated 3/26/2025, the care plan indicated to maintain proper alignment of the Foley catheter to promote proper drainage. During a concurrent observation and interview on 8/11/2025 at 10:56 a.m. with Registered Nurse (RN) 3, at Resident 11's bedside, Resident 11's Foley catheter tubing had a dependent loop below the drainage bag with urine pooling in the tubing. RN 3 stated the catheter tubing should be placed so the urine can freely drain by gravity. RN 3 stated it should drain by gravity, so the urine doesn't back up and cause an infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 51's admission Record, the admission Record indicated the facility originally admitted the resident on 9/7/2024 and readmitted the resident on 5/3/2025 with diagnoses including but not limited to, acute respiratory failure (a condition where the lungs cannot release enough oxygen into the blood), nontraumatic intracerebral hemorrhage (bleeding inside the brain tissue) in the brain stem (posterior stalk-like part of the brain that connects the cerebrum with the spinal cord), and UTI.ˆ ˆ During a review of Resident 51's History and Physical, dated 5/4/2025, the History and Physical indicated the resident was bedbound with limited function. During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 had severely impaired cognitive (relating to or involving the processes of thinking and reasoning) skills for daily decision making and was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 51's Order Summary Report, the Order Summary Report indicated the following order dated 6/29/2025: Foley catheter attached to bedside drainage bag for neuromuscular dysfunction of bladder (when nerve damage prevents the bladder from working correctly). During a review of Resident 51's care plan, titled, Alteration in urinary elimination and at risk for UTI secondary to use of Foley Catheter., dated 9/16/2024, the care plan indicated to maintain proper alignment of the Foley catheter to promote proper drainage. During a concurrent observation and interview on 8/11/2025 at 9:31 a.m. with Licensed Vocational Nurse (LVN) 11 at Resident 51's bedside, Resident 51's Foley catheter tubing was looped. LVN 11 stated the urine cannot flow freely and may backflow and cause a UTI. LVN 11 stated the bag should hang towards the lower part of the bed so there would not be a dependent loop or kinks. During an interview on 8/15/2025 at 10:50 a.m. with the Director of Nursing (DON), the DON stated for residents with a Foley catheter, the tubing should not be looped, and the urine should be freely flowing down the tubing. The DON stated looped tubing can affect the flow of urine and the urine should not flow back towards the bladder because there is a risk of infection. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, last reviewed on 4/16/2025, the P&P indicated the purpose to prevent urinary catheter-associated complications including UTIs. The P&P indicated to check the resident frequently to be sure he or she is not lying on the catheter, and the tubing is free of kinks. The P&P indicated to always position the drainage bag lower than the bladder to prevent urine from flowing back into the bladder. 3. During a review of Resident 41's admission Record, the admission Record indicated the facility originally admitted the resident on 1/24/2023, and readmitted in the facility on 5/22/2025, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and neurogenic bladder (lack bladder control due to a brain, spinal cord or nerve problem). During a review of Resident 41's History and Physical (H&P) dated 7/9/2025, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 41's MDS dated [DATE], the MDS indicated Resident 41 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand others and make her needs known. The MDS further indicated Resident 41 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 41 had an indwelling urinary catheter. During a review of Resident 41's Order Summary Report, the Order Summary Report indicated the following physician's order: -7/8/2025: Foley catheter (FC – also known as urinary catheter) French (Fr – a unit of measurement) 16 per ten (10) milliliters (ml – a unit of measurement) attached to bedside drainage bag due to neurogenic bladder every shift. -7/8/2025: FC care every day shift. -7/8/2025: Monitor FC urinary drainage bag and indicate if the following abnormal is present: dark color, cloudy consistency with sediments, foul odor, hematuria (blood in the urine), bladder distention, burning sensation every shift. -7/8/2025: Secure FC tubing with anchor every day shift to minimize dislodging of catheter. -Change bedside drainage bag every Sunday and as needed. During a concurrent observation and interview on 8/11/2025 at 12:51 p.m. inside Resident 41's room with Licensed Vocational Nurse (LVN) 8, LVN 8 stated Resident 41's urinary catheter tubing had a loop preventing the urine from flowing freely into the bag. LVN 8 stated the urinary catheter tubing had urine in the loop with some white sediments. LVN 8 stated staff responsibility when it comes to care of urinary catheter is to ensure the bag is below the bladder, the bag had privacy cover, and there must be no kink or loop in the tubing. LVN 8 stated if there is a kink or loop the urine cannot flow freely and cause development of urine infection. LVN 8 stated Resident 41's urinary catheter tubing should not have a loop so the urine can flow freely and prevent backing up to the bladder which can cause development of UTI. During an interview on 8/15/2025 at 11:37 a.m., with the Director of Nursing (DON), The DON stated for urinary catheter care, the staff are supposed to ensure the drainage bag is not touching floor to keep the bag clean, monitor for signs and symptoms of UTI, application of a leg strap to anchor the tubing and prevent accidental pulling, and the urine should be free flowing. The DON stated the coil should not be kinked or coiled because it prevents the urine flow and the urine can back flow. The DON stated Resident 41's urinary catheter tubing should not have been coiled or kinked as it had the potential for the urine not to flow freely and flow back into the bladder which could lead to development or UTI. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, last reviewed on 4/16/2025, the P&P indicated a purpose to prevent urinary catheter0associated complications, including UTI. The P&P further indicated that to maintain unobstructed urine flow, check the resident frequently to be sure he or she is not lying on the catheter and tubing free of kinks. 4. During a review of Resident 168's admission Record, the admission Record indicated the facility (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted the resident on 8/5/2016, and readmitted the resident on 8/5/2025, with diagnoses including benign prostatic hyperplasia (BPH, a health issue that becomes more common with age), obstructive and reflux uropathy (refer to conditions where urine flow is blocked or reversed, respectively, potentially causing kidney damage), and clostridium perfringens (a common bacteria that can cause food poisoning). During a review of Resident 168's History and Physical (H&P), dated 8/6/2025, the H&P indicated the resident was alert to person only and did not have the capacity to understand and make decisions. During a review of Resident 168's MDS dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had moderately impaired cognition (it refers to a stage where thinking and memory problems are clearly noticeable and impact daily life). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had an indwelling catheter (including suprapubic catheter and nephrostomy tube [is a small tube placed directly into the kidney through a small opening in the back]). During a review of Resident 168's Order Summary Report, dated 8/5/2025, the Order Summary Report indicated an order for: - Suprapubic Catheter French Size (Fr, refers to the diameter, or thickness, of the catheter tube itself) 18/10 milliliters (ml, a unit of volume) attached to bedside drainage bag due to: Obstructive uropathy with urinary retention. Every shift. -Monitor Suprapubic Catheter urinary drainage bag and indicate if the following abnormal if present: dark Color, cloudy consistency with sediments, foul odor, hematuria (blood in the urine), bladder distention, burning sensation (+) = presence of signs and symptoms (S/S) of UTI, (0) = absence of S/S of UTI If '+' is documented, complete a progress note and specify the s/s of UTI noted and Notify MD. Every shift. During a review of Resident 168's Care Plan (CP) Report titled Alteration in urinary elimination and at risk for UTI secondary to use of suprapubic catheter, last revised on 5/9/2025, the CP indicated an intervention to maintain proper alignment of Foley (a catheter brand) catheter to promote proper drainage. During a concurrent observation and interview on 8/11/2025, at 9:43 a.m., with Certified Nursing Assistant (CNA) 5, inside Resident 168's room, observed Resident 168's suprapubic catheter tubing with urine and sediments on the looped suprapubic catheter tubing. CNA 5 stated that the suprapubic catheter should have no loops on them because it will hinder the free flow of urine. CNA 5 stated the tubing should be free flowing to prevent backflow of urine causing infection to residents. During a concurrent interview and record review on 8/13/2025, at 1:54 p.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 168's Medical Diagnosis, Order Summary Report and Care Plan. LVN 5 stated there is an order for suprapubic catheter placement on the resident and a care plan was developed on its use. LVN 5 stated there should be no kinks or loops on the resident's suprapubic catheter tubing to prevent backflow of urine to the bladder causing urinary tract infection to residents. During an interview on 8/15/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the staff should have kept the suprapubic catheter tubing of Resident 168 kink and loop free to prevent backflow of urine to the bladder causing UTI to residents. The DON stated it is the responsibility of licensed staff to ensure the catheter bag is not touching the floor, there are no kinked/looped catheter tubing, and had a leg strap or stat lock to anchor the tubing to prevent pulling and tugging of the catheter. During a review of the facility's recent policy and procedure (P&P) titled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, last reviewed on 4/16/2025, the P&P indicated the purpose of this procedure is to provide guidelines for the prevention of catheter-associated urinary tract infections (CAUTIs). Steps in the Procedure 6. Maintain unobstructed urine flow. a. Keep the catheter and tubing free of kinks. During a review of the facility's recent P&P titled Catheter Care, Urinary, last reviewed on 4/16/2025, the P&P indicated the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Maintaining Unobstructed Urine Flow 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. 5. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted the resident on 9/4/2024, and readmitted the resident on 10/27/2024, with diagnoses including neuromuscular dysfunction of the bladder (means that the nerves controlling the bladder are not working properly), respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to dangerously low oxygen levels and/or dangerously high carbon dioxide levels in the blood), and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4's H&P, dated 10/27/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (means a person has very serious trouble with their thinking abilities – so serious that it significantly impacts their daily life and independence). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs). The MDS indicated the resident had an indwelling catheter (including suprapubic and nephrostomy tube). During a review of Resident 4's Order Summary Report, the Order Summary Report indicated an order for: (continued on next page)

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Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/9/2025 Foley Catheter Fr (18) / (10) ml attached to bedside drainage bag due to: (Urinary Retention). Every Shift. 10/28/2024 Monitor Foley Catheter urinary drainage bag and document the following: Color, consistency, odor, hematuria, bladder distention, burning sensation (+) = presence of S/S of UTI, (0) = absence of S/S of UTI DOCUMENT: 'Y' if monitored and any of the above observed, Notify MD & document in nurses' progress notes. Every shift. 10/28/2024 Foley catheter care. Every day shift. During a review of Resident 4's CP Report titled Alteration in urinary elimination at risk for UTI secondary to use of Foley catheter, and Potential for unavoidable recurrent UTI, last revised on 9/10/2024, the CP's indicated an intervention to maintain proper alignment of foley catheter to promote proper drainage and catheter care as ordered. During a concurrent observation and interview on 8/11/2025, at 10:11 a.m., with Registered Nurse (RN) 2, inside Resident 4's room, observed Resident 4's indwelling catheter with a loop on the tubing with urine and sediments on them. RN 2 stated there should be no loop on the indwelling catheter tubing to prevent backflow of urine to the bladder causing UTI. During a concurrent interview and record review on 8/13/2025, at 1:57 p.m., with LVN 5, reviewed Resident 4's Medical Diagnosis, Order Summary Report, and Care Plan. LVN 5 stated there is an order for insertion of Foley/Indwelling catheter on the resident and had a care plan on its use. LVN 5 stated there should be no loops/kinks on Resident 4's indwelling catheter tubing to prevent backflow of the urine on the bladder causing UTI. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated the staff should have kept the Foley/Indwelling catheter tubing of Resident 4 kink and loop free to prevent backflow of urine to the bladder causing UTI to residents. The DON stated it is the responsibility of licensed staff to ensure the catheter bag is not touching the floor, there are no kinked/looped catheter tubing, and had a leg bag or stat lock to anchor the tubing to prevent pulling and tugging of the catheter. During a review of the facility's recent P&P titled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, last reviewed on 4/16/2025, the P&P indicated the purpose of this procedure is to provide guidelines for the prevention of catheter-associated urinary tract infections (CAUTIs). Steps in the Procedure 6. Maintain unobstructed urine flow. a. Keep the catheter and tubing free of kinks. During a review of the facility's recent P&P titled Catheter Care, Urinary, last reviewed on 4/16/2025, the P&P indicated the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Maintaining Unobstructed Urine Flow (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. 6. During a review of Resident 125's admission Record, the admission Record indicated the facility admitted the resident on 8/1/2025, with diagnoses including ataxia (a neurological condition that causes lack of muscle coordination and control, making it difficult to perform everyday movements like walking, reaching, or speaking) following nontraumatic intracerebral hemorrhage (means bleeding within the brain tissue that is not caused by an outside force or injury), muscle weakness, and history of falling. During a review of Resident 125's H&P, dated 8/1/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 125's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others, had impaired vision and intact cognition (means that an individual's thinking, reasoning, and other mental abilities are functioning at a normal or expected level for their age and without significant impairment). The MDS indicated the resident required substantial to partial assistance on personal and toileting hygiene. The MDS indicated that the resident was occasionally incontinent of urine and stool (feces). During a review of Resident 125's Order Summary Report, dated 8/1/2025, the Order Summary Report indicated an order for cranberry tablet 450 milligrams (mg, a unit of weight). Give 1 tablet by mouth one time a day for UTI prophylaxis (guard against disease by taking action ahead of time). During a concurrent observation and interview on 8/11/2025, at 9:23 a.m., with LVN 5, inside Resident 125's room, observed two (2) urinals hanging at the left side rails of the resident not labeled with the name and room number of the resident. LVN 5 stated the urinal bottles should be labeled with the name and room number of the resident to prevent accidental switching of urinals causing cross-contamination to residents leading to UTI. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated the urinal bottles of Resident 125 should have been labeled with the name and room number of the resident to prevent switching of urinals causing cross-contamination on residents. The DON stated it was the responsibility of the CNAs to ensure all urinals were labeled with the name and room number of residents to prevent UTIs on residents. During a review of the facility's recent P&P titled Disinfecting Bedpans & Urinals, last reviewed on 4/16/2025, the P&P indicated to provide guidelines for disinfection of bedpans and urinals. Disposable bedpans and urinals are for single resident use only. [NAME] the resident's name and discard upon discharge. During a review of the facility's recent P&P titled Infection Prevention and Control Program, last reviewed on 4/16/2025, the P&P indicated an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During a review of Resident 155's admission Record, the admission Record indicated the facility admitted the resident on 4/7/2025, with diagnoses including elevated white blood cell count (the body is fighting off an infection, inflammation, or other medical condition), abnormalities of gait (the walking pattern in humans) and mobility, and colostomy (surgical procedure that creates an opening (a stoma) in the colon, allowing stool to pass out of the body through the abdomen instead of the anus). During a review of Resident 155's H&P, dated 4/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 155's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had moderately impaired cognition. The MDS indicated the resident required partial assistance on toileting and personal hygiene. The MDS also indicated the resident was frequently incontinent of urine. During a review of Resident 155's Order Summary Report, the Order Summary Report indicated an order for: 4/21/2025 On enhanced barrier precaution (is an approach to the use of personal protective equipment (PPE) to reduce transmission of Multidrug-Resistant Organisms (MDROs) between residents in skilled nursing facilities [SNFs]) monitor for behavior (m/b) colostomy. 4/7/2025 Cranberry Tablet 450 mg. Give 1 tablet by mouth one time a day for UTI prophylaxis. During a review of Resident 155's CP Reports titled Colostomy. Resident is at risk for infection, last revised on 7/30/2025, and Enhanced barrier precaution, last revised on 8/9/2025, the CPs indicated interventions to provide colostomy/stoma care (how to change, empty, and clean the pouch system) daily and as needed and cleaning and disinfection of equipment as indicated. During a concurrent observation and interview on 8/11/2025, at 10:24 a.m., with LVN 5, inside Resident 155's room, observed Resident 155's urinal hanging at the right-side rail not labeled with the name and room number of the resident. LVN 5 stated the urinal should be labeled with the name and room number of the resident to prevent infection to residents. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated the urinal bottle of Resident 155 should have been labeled with the name and room number of the resident to prevent switching of urinals causing cross-contamination on residents. The DON stated it was the responsibility of the CNAs to ensure all urinals were labeled with the name and room number of residents to prevent UTIs on residents. During a review of the facility's recent P&P titled Disinfecting Bedpans & Urinals, last reviewed on 4/16/2025, the P&P indicated to provide guidelines for disinfection of bedpans and urinals. Disposable bedpans and urinals are for single resident use only. [NAME] the resident's name and discard upon discharge. During a review of the facility's recent P&P titled Infection Prevention and Control Program, last reviewed on 4/16/2025, the P&P indicated an infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) by failing to: Rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration sites for three of three sampled residents (Residents 4, 13, and 35) reviewed for insulin. This deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F658. Ensure one of four residents (Resident 48) observed for medication administration was not allowed self-administration of Breo inhaler when it was determined to be unsafe by the interdisciplinary team (IDT - a multi-discipline group of healthcare professionals involved in periodically meeting and planning care for individual residents). This deficient practice of allowing Resident 48 to self-administer medication without an IDT evaluation for safety increased the risk that she may have administered the wrong dose of Breo due to poor technique possibly resulting in medical complications resulting in hospitalization or death. Cross reference F554. Findings: 1.During a review of Resident 4's admission Record, the admission Record indicated the facility admitted the resident on 9/4/2024, and readmitted the resident on 10/27/2024, with diagnoses including Type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), respiratory failure (the lungs are not able to get enough oxygen into the blood or remove enough carbon dioxide), and dependence on respirator (if a patient is unable to wean off a ventilator and breathe independently). During a review of Resident 4's History and Physical (H&P), dated 10/27/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 6/11/2025, the MDS indicated the resident rarely to never had the ability to make self understood and understand others and had severely impaired cognition (refers to a significant decline in a person's ability to think, remember, learn, or make decisions, to the point where it substantially impacts their daily life and independence). The MDS indicated Resident 4 was on a high-risk drug class hypoglycemic medication (areˆdrugs that lower blood sugar levels). During a review of Resident 4's Order Summary Report, indicated an order for: 6/16/2025 Insulin Glargine-yfgn Subcutaneous Solution 100 units per milliliter (unit/ml, is the number of units of insulin in 1 milliliter) (Insulin Glargine-yfgn). Inject 16 unit subcutaneously at bedtime for DM. Rotate Site (hold if blood sugar [bs] less than [<]100). 6/24/2025 Insulin Aspart Injection Solution 100 unit/ml (Insulin Aspart). Inject as per sliding scale (the amount of insulin to be administered changes or slides up or down based on the person's blood sugar): if 0 - 150 = 0 <70 may give 8 ounces (oz, a unit of volume) orange juice and notify MD; 151 - 200 = 2 unit; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units >350 give 10 units and notify (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MD, subcutaneously every 6 hours for DM. Rotate Sites. During a review of Resident 4's Location of Administration Report of Insulin from 6/2025 to 8/2025, the Location of Administration indicated: -Insulin Aspart Injection Solution 100 unit/ml was administered on, 7/27/2025 at 12:31 a.m. on the Abdomen – Left Lower Quadrant (LLQ) 7/28/2025 at 5:06 a.m. on the Abdomen – LLQ -Insulin Lispro Injection Solution 100 unit/ml was administered on, 6/14/2025 at 5:10 a.m. on the Abdomen - LLQ 6/15/2025 at 5:21 a.m. on the Abdomen – LLQ -Insulin Glargine-yfgn Subcutaneous Solution 100 unit/ml was administered on, 8/7/2025 at 9:08 p.m. on the Abdomen – Right Lower Quadrant (RLQ) 8/8/2025 at 8:14 p.m. on the Abdomen – RLQ During a review of Resident 4's Care Plan (CP) Report titled Resident is at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar), last revised on 9/10/2024, the CP indicated an intervention to administer medications as ordered. During a concurrent interview and record review on 8/13/2025, at 11:36 a.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 4's Medical Diagnosis, Order Summary Report, Location of Administration Report for Insulin from 6/2025 to 8/2025, and Care Plan. LVN 5 stated there were multiple instances where the licensed nurse staff did not rotate the sites of administration of insulin on Resident 4. LVN 5 stated the staff should rotate insulin administration sites on residents to prevent hematoma (a collection of blood outside of a blood vessel, often appearing as a bruise), skin irritation, and lipodystrophy on residents. LVN 5 stated injecting insulin on the sites where lipodystrophy occurred can result to malabsorption of insulin that can cause hyper or hypoglycemia on residents. LVN 5 stated not rotating insulin administration sites is a medication error. During an interview on 8/15/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the insulin sites of administration to Resident 4 to prevent lipodystrophy on residents. The DON stated frequent repetition of insulin site administration could lead to lipodystrophy on residents which causes malabsorption of insulin producing hypo or hyperglycemia on residents. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent policy and procedure (P&P) titled Adverse Consequences and Medication Errors, last reviewed on 4/16/2025, the P&P indicated the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies as appropriate.ˆ (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Interpretation and Implementation 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled Physician's Orders: Follow up, last reviewed on 4/16/2025, the P&P indicated physician's orders will be noted by the charge nurse on duty at the time the order(s) is/are written. Subsequent transcriptions will be accomplished as indicated; e.g., transcription of medication on MAR, treatment Sheet, etc. ^ During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. ^ During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Lispro injection, for subcutaneous or intravenous use, with initial U.S. approval in 1996, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. ^ During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Glargine, U-300, injection, for subcutaneous use, with initial U.S. approval in 2015, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. 2.During a review of Resident 13's admission Record, the admission Record indicated the facility admitted the resident on 3/1/2019, and readmitted the resident on 5/29/2025, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), dependence on respirator, and type 2 diabetes mellitus. During a review of Resident 13's H&P, dated 5/29/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 13's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated Resident 13 was on a high-risk drug class hypoglycemic medication. ^ During a review of Resident 13's Order Summary Report, dated 5/29/2025, the Order Summary Report indicated an order for: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Insulin Regular Human Injection Solution 100 unit/ml (Insulin Regular (Human)). Inject as per sliding scale: if 60 - 130 = 0 may give 8 oz of orange juice (OJ) for BS< 60; 131 - 160 = 2 units (U); 161 - 200 = 3U; 201 - 250 = 4U; 251 - 300 = 6U; 301 - 350 = 8U; 351 - 400 = 10U BS greater than [>]400 GIVE 12U and call MD, subcutaneously every 6 hours for DM 2. - Insulin Glargine Subcutaneous Solution (Insulin Glargine). Inject 20 unit subcutaneously at bedtime for DM 2 (rotate injection sites) Hold if bs<100. During a review of Resident 13's Location of Administration Report for Insulin from 6/2025 to 8/2025, the Location of Administration Report indicated: -Insulin Glargine Subcutaneous Solution was administered on, 6/12/2025 at 9:22 p.m. on the Abdomen – Left Upper Quadrant (LUQ) 6/14/2025 at 9:02 p.m. on the Abdomen – LUQ -Insulin Regular Human Injection Solution 100 unit/ml was administered on, 6/29/2025 at 12:09 a.m. on the Abdomen – LLQ 6/30/2025 at 12:22 a.m. on the Abdomen – LLQ 8/2/2025 at 2:57 p.m. on the Arm-Upper arm (rear) (right) 8/2/2025 at 7:39 p.m. on the Arm-Upper arm (rear) (right) 8/6/2025 at 2:59 a.m. on the Arm - left 8/7/2025 at 11:54 p.m. on the Arm – left 8/8/2025 at 8:57 p.m. on the Abdomen-LUQ 8/10/2025 at 10 p.m. on the Abdomen-LUQ 8/10/2025 at 5:10 p.m. on the Abdomen-RLQ 8/11/2025 at 5:35 p.m. on the Abdomen-RLQ During a review of Resident 13's CP Report titled Resident is at risk for hypoglycemia and hyperglycemia, last revised on 4/25/2025, the CP indicated an intervention to administer medications as ordered. During a concurrent interview and record review on 8/13/2025, at 11:45 a.m., with LVN 5, reviewed Resident 13's Medical Diagnosis, Order Summary Report, Location of Administration Report for Insulin from 6/2025 to 8/2025, and Care Plan. LVN 5 stated there were multiple instances where the licensed staff did not rotate the sites of administration of insulin on Resident 13. LVN 5 stated the staff should rotate insulin administration sites on residents to prevent hematoma, skin irritation, and lipodystrophy on residents. LVN 5 stated injecting insulin on the sites where lipodystrophy occurred can result to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	malabsorption of insulin that can cause hyper or hypoglycemia on residents. LVN 5 stated not rotating insulin administration sites is a medication error. During an interview on 8/15/2025, at 11:37 a.m., with the DON, the DON stated the licensed staff should have rotated the insulin sites of administration to Resident 13 to prevent lipodystrophy on residents. The DON stated frequent repetition of insulin site administration could lead to lipodystrophy on residents which causes malabsorption of insulin producing hypo or hyperglycemia on residents. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent P&P titled Adverse Consequences and Medication Errors, last reviewed on 4/16/2025, the P&P indicated the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies as appropriate.ˆ Policy Interpretation and Implementation 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled Physician's Orders: Follow up, last reviewed on 4/16/2025, the P&P indicated physician's orders will be noted by the charge nurse on duty at the time the order(s) is/are written. Subsequent transcriptions will be accomplished as indicated; e.g., transcription of medication on MAR, treatment Sheet, etc. ˆ During a review of the facility-provided Highlights of Prescribing Information on the use of Humulin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1982. the Highlights of Prescribing Information indicated to rotate injection sites to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. ˆ During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Glargine, U-300, injection, for subcutaneous use, with initial U.S. approval in 2015, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. ˆ 3.During a review of Resident 35's admission Record (AR), the AR indicated the facility admitted the resident on 3/7/2022 and most recently admitted the resident on 7/26/2025 with diagnoses that included severe acute bronchitis (inflammation of the airway that carries air to and from the lungs) from respiratory syncytial virus (RSV, a respiratory virus that infects the lungs and breathing passages), sepsis (a life-threatening blood infection), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's Minimum Data Set (MDS – resident assessment tool) dated 8/25/2025, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make themself understood. The MDS further indicated Resident 35 was dependent on staff for eating, bathing, dressing, oral and personal hygiene, toileting, and mobility. During a review of Resident 35's Care Plan (CP) titled, Resident is at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to diabetes mellitus, initiated 6/16/2022 and last revised on 10/31/2025, the CP indicated to administer medication as ordered. During a review of Resident 35's Order Summary Report, the Order Summary Report indicated the following order: -Insulin lispro (a fast acting insulin), inject per sliding scale (a method of managing blood sugar levels in people with diabetes where the amount of insulin given is adjusted based on the current blood sugar reading): if 150 - 199 = 1 unit (a measurement); 200- 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 - 399 = 5 units; 400 and above = 6 units and call the physician, subcutaneously before meals and at bedtime for DM, rotate injection sites, dated 7/26/2025. During a concurrent interview and record review on 8/13/2025 at 12:47 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 reviewed Resident 35's physician orders, care plans, and Location of Administration Report for insulin lispro for 8/2025. LVN 5 stated the process for insulin administration is to check the resident's blood sugar and administer insulin according to the sliding scale. LVN 5 stated the standard of practice and physician order is to rotate insulin administration sites. LVN 5 stated insulin can be administered in numerous sites on the body including the upper, middle, and lower area of the abdomen; and right and left arm. LVN 5 stated it is important to always administer insulin in a different site to ensure the insulin is absorbed properly by the body and there is no bruising at sites used repetitively. LVN 5 reviewed the Location of Administration form for insulin lispro and noted the following administration sites: - On 8/1/2025 at 11:30 a.m. administered on the Abdomen-Left Lower Quadrant (LLQ) - On 8/1/2025 at 4:40 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/1/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/2/2025 at 11:30 a.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/2/2025 at 4:30 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/2/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/3/2025 at 9 p.m. administered on the Abdomen-Right Lower Quadrant (RLQ) - On 8/4/2025 at 6:30 a.m. administered on the Abdomen – RLQ, not rotated from previous site. - On 8/5/2025 at 4:30 p.m. administered on the Abdomen-LLQ - On 8/6/2025 at 6:30 a.m. administered on the Abdomen-LLQ, not rotated from previous site. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 8/6/2025 at 4:30 p.m. administered on the Abdomen-LLQ - On 8/6/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/8/2025 at 11:30 a.m. administered on the Abdomen-LLQ - On 8/8/2025 at 4:30 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/8/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/9/2025 at 11:30 a.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/9/2025 at 4:30 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/9/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/12/2025 at 11:30 a.m. administered on the Abdomen-LLQ - On 8/12/2025 at 4:30 p.m. administered on the Abdomen-LLQ, not rotated from previous site. - On 8/12/2025 at 9 p.m. administered on the Abdomen-LLQ, not rotated from previous site. LVN 5 further stated Resident 35 had a lot of sites that were used back-to-back and not rotated, but they should have been rotated. LVN 5 stated the licensed nurses that administered Resident 35's insulin did not follow the physician's orders because the sites were not rotated. During an interview on 8/15/2025 at 11:37 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should rotate the insulin sites of administration on residents. The DON stated frequent repetition of insulin site administration could lead to lipodystrophy causing malabsorption of insulin producing hypoglycemia or hyperglycemia in residents. The DON stated that not rotating insulin administration site is a medication error. During a review of the facility's recent policy and procedure (P&P) titled Adverse Consequences and Medication Errors, last reviewed on 4/16/2025, the P&P indicated the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies as appropriate. Policy Interpretation and Implementation 5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility-provided Highlights of Prescribing Information on the use of Insulin Lispro injection, for subcutaneous or intravenous use, with initial U.S. approval in 1996, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the policy and procedure (P&P) titled, Subcutaneous Medication Administration, last reviewed 4/15/2025, the P&P indicated the purpose was to administer medication in the subcutaneous tissue in order to promote slow medication absorption and prolong medication action. Select an appropriate side for injection. 4.During an observation on 8/12/25 at 9:53 AM, Resident 48 was observed self-administering Breo inhaler as prepared by the licensed vocational nurse (LVN 4.) During a review of Resident 48's admission Record, dated 7/12/2025, indicated the resident was admitted to the facility on [DATE]. During a review of Resident 48's History and Physical (H&P – a record of a comprehensive physician's assessment), dated 7/3/2025, indicated the resident had a diagnosis of shortness of breath. During a review of Resident 48's Order Summary Report (a monthly summary of all active physician orders), dated 7/31/2025, indicated the resident was prescribed Breo inhaler to administer one puff by mouth daily for shortness of breath to be clinician administered. During a review of Resident 48's Self-Administration of Medication Evaluation (an evaluation to determine if a resident has a desire or capacity to self-administer medication), dated 7/2/2025, indicated IDT has determined that it is not safe for resident to administer drugs due to cognitive impairment d/t physical/functional impairment secondary to multiple diagnosis. Resident prefers licensed nurses to administer medications. Further review of the assessment indicated Resident 19 was not approved for the self-administration of medications. During an interview on 8/12/2025 at 10:13 AM with LVN 4, LVN 4 stated she allowed Resident 48 to self-administer the Breo inhaler because this is what the resident prefers. LVN 4 stated the order for Resident 48's Breo indicated it should be clinician administered and not self-administered. LVN 4 stated Resident 48's medication self-administration assessment indicated she should not self-administer medication due to her cognitive impairment. LVN 4 stated allowing residents to self-administer medication should only be allowed once the IDT determines the resident can do so safely and competently. LVN 4 stated there is a risk that poor technique from this inhaler could lead to breathing problems for Resident 48 possibly leading to hospitalization.^ During a review of the facility's policy Self-Administration of Medications, dated April 2008, indicated Residents who desire to self-administer medication are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. During a review of the facility's policy Adverse Consequences and Medication Errors, revised March 2023, indicated A 'medication error' is defined as the preparation or administration of drugs. which is not in accordance with the physician's orders. or accepted professional standards. examples of medication errors include: . failure to follow. accepted professional standards.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to ensure the facility's policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption was followed for one of one sampled resident refrigerator by failing to: 1. Ensure Certified Nursing Assistant (CNA) 4 informed Resident 82 that the facility had refrigerator designated for residents' food brought from home.^ 2. Ensure the facility's resident refrigerator was within acceptable temperature range per facility's policy and procedure for refrigerator at 40 degrees Fahrenheit (F, a scale for measuring temperature) or below and freezer at 0 degrees F or below.^ 3. Ensure expired whole milk yoghurt (6 packs), with expiration date of 7/23/2025 was discarded.^ These deficient practices had the potential to result in food-borne illnesses (food poisoning) of residents and can lead to other serious medical complications and hospitalization. Findings: 1.During a review of Resident 82's admission Record, the admission Record indicated the facility admitted the resident on 9/11/2023, with diagnoses including but not limited to Parkinson's disease (a progressive brain disorder that affects movement, balance, and coordination), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone and hyperlipidemia (a condition where there are abnormally high levels of lipids in the blood). During a review of Resident 82's History and Physical (H&P), dated 9/11/24, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 82's Minimum Data Set (MDS, a resident assessment tool), dated 6/18/2025, the MDS indicated Resident 82 had the ability to make self understood and understand others. The MDS indicated Resident 82's cognition was intact (mental processes that enable people to think, understand, make decisions, and complete tasks) and participated in the assessment and goal setting of healthcare management. During an interview on 8/13/2025, at 2:40 p.m., with Resident 82, Resident 82 stated nobody has told her that there is a refrigerator for residents' food from home. Resident 82 stated her family brought food from home but discarded leftovers as it would be spoiled the next day. Resident 82 stated that no one has explained to her about food storage for foods brought by her family. During an interview on 8/13/2025, at 3:02 p.m., with CNA 4, CNA 4 stated Resident 82 was informed that leftovers are discarded beyond 2 hours because there is no refrigerator for storage. CNA 4 stated she was not aware of a refrigerator available for residents outside food. During an interview on 8/13/2025, at 3:35 p.m., with the Director of Staff Development (DSD), the DSD stated food from home should be stored at the resident's refrigerator located at the dining area. The DSD stated the policy on residents outside food storage is communicated through in-service to staff and stated the signature is the confirmation. During a review of the facility's recent policy and procedure (P&P) titled Outside Food Resident/Freezer Storage, last review date on 4/16/2025, the P&P indicated: POLICY This policy was created to increase compliance with diet orders, promote food intake, and promote safe and sanitary storage, handling, and consumption of outside foods. PROCEDURE The facility will maintain one refrigerator and freezer for resident use. 2.During a concurrent observation and interview on 8/13/2025, at 3:57 p.m., with the Activities Director (AD), in the dining area, observed the resident' refrigerator for food brought from home with the temperature of 46 degrees F and six pack of unopened box of milk yoghurt. The AD stated that she is responsible for checking the temperature and food contents of the residents' refrigerator food brought from home. The AD stated that the temperature should be 40 degrees F and below and if it is above 40 degrees, they are supposed to report it to the maintenance supervisor. The AD also stated the food brought from home should be labeled with name, room number and the date it was received. The AD stated the six packs of milk yoghurt is expired, the expiry date was 7/23/2025. The AD stated that she should have reported to the maintenance supervisor that the temperature of the residents' refrigerator was not within normal range, and she should have discarded the expired six packs of milk yoghurt. The AD stated her failure to report the abnormal temperature of the residents' refrigerator and failure to discard the expired six (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	packs of milk yoghurt can cause food borne illness to residents. During an interview on 8/14/2025, at 3 p.m., with the Maintenance Supervisor (MS), The MS stated he is responsible for the weekly temperature check of the resident's refrigerator at the dining area the refrigerator at the dining area and the daily check are performed by the AD. The MS stated he did not get a report from the AD that the residents' refrigerator temperature was 46 degrees F. The MS stated if AD reported the abnormal temperature to him, he could have fixed it right away to prevent the food inside the residents' refrigerator from spoiling. The MS stated, there is a potential for residents to consume the expired food that can cause diarrhea. During an interview and record review on 8/14/2025, at 3:35 p.m., with the Director of Nursing (DON), reviewed the policy and procedure (P&P) for storing resident's food brought from home and photos of resident's refrigerator temperature and contents taken on 8/13/2025, at 4:03 p.m. The DON stated the temperature of the residents' refrigerator is 46 degrees F and there is expired six packs of milk yoghurt. The DON stated the AD is responsible for monitoring the temperature of the residents' refrigerator in the dining room daily and to report to the MS if there is an abnormal temperature. The DON also stated the AD should have discarded the expired six packs of milk yoghurt in the refrigerator with expiry date of 7/23/2025. The DON stated the failure of the AD to report the resident's abnormal refrigerator temperature to the MS and failure to discard the expired six packs of milk yoghurt could cause residents to have food borne illnesses. During a review of the facility's recent P&P titled Outside Food Resident/Freezer Storage, last reviewed on 4/16/2025, the P&P indicated: POLICY This policy was created to increase compliance with diet orders, promote food intake, and promote safe and sanitary storage, handling, and consumption of outside foods. PROCEDURE Activity staff/ designee will check the inside temperature of the Refrigerator and Freezer daily and will initial and record the temperature. If the temperatures are not within appropriate range activity staff/ designee will notify the Maintenance Supervisor and Administrator If the temperatures are not within appropriate range, food may be discarded. Recommended Refrigerator Temperature: 40 degrees F or lower /Freezer Temperature: 0 degrees F or lower. Food items that are expired or beyond the best buy date are discarded.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the binding arbitration agreement (a resident waives the right to sue the nursing home in court, and instead agrees to have any future disputes handled by a private arbitrator) indicated the resident or anyone else (e.g., resident's representative) were allowed to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman for three of three sampled residents (Residents 30, 85, and 101) reviewed for Arbitration Facility Task. The deficient practice had the potential for residents to be unaware of their rights pertaining to the Arbitration Agreement. Findings: a. During a review of Resident 30's admission Record, the admission Record indicated the facility admitted the resident on 7/14/2025, with diagnoses including but not limited to muscle weakness, dysphagia (difficulty swallowing), and overactive bladder (involuntary squeezing of the bladder muscles, leading to frequent urination). During a review of Resident 30's History and Physical (H&P), dated 7/15/2025, the H&P indicated the resident 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 7/21/2025, the MDS indicated Resident 30 had the ability to make self understood and understand others. The MDS indicated Resident 30 had moderately impaired cognition (decline in a resident's mental abilities that profoundly impacts their daily life and independence) and had an authorized representative participated in the assessment and goal setting of resident's healthcare management. During a concurrent interview and record review on 8/15/2025, at 10:55 a.m., with the Director of admission (DOA), reviewed Resident 30's Arbitration Agreement signed by the resident's representative on 7/14/2025. The DOA stated the signed agreement did not have the verbiage Allow residents to communicate with federal, state, or local officials and representatives of the Office of the State Long Term Care Ombudsman. The DOA stated the residents' arbitration agreement should have the above verbiage at the time of signing to ensure residents or family have better understanding when making decisions. During a concurrent interview and record review on 8/15/2025, at 10:55 a.m., with the DOA, reviewed Resident 30's Information Regarding the Resident Facility Arbitration Agreement Questionnaire signed by the resident's representative on 7/14/2025. The DOA stated the questionnaire and arbitration agreement forms are reviewed before signing. The DOA stated the questionnaire did not include a question regardingˆcommunication with federal, state, or local officials and representative of the Office of the State Long Term Care Ombudsman. During a concurrent interview and record review on 8/15/2025, at 11:58 a.m., with the Administrator (ADM), reviewed Resident 30's Arbitration Agreement. ADM stated the agreement form does not include a verbiage Allowing residents to communicate with federal, state, or local officials and representatives of the Office of the State Long Term Care Ombudsman. The ADM stated residents have the right to freely communicate with anyone including outside agencies, regarding decision-making and any information related to their care and condition. The ADM stated it is important to include the above verbiage as part of the arbitration agreement. ADM stated the facility does not have a policy on arbitration agreement. During a concurrent interview and record review on 8/15/2025, at 12:05 p.m., with the ADM, the facility's policy and procedure (P&P) titled Contact with External Agencies, last review date on 4/16/2025 was reviewed. The ADM stated the policy is only for internal employees and residents were not given a copy. The ADM stated this information should be added to the arbitration agreement form. During a review of the facility's recent P&P titled Contact with External Agencies, last reviewed on 4/16/2025, the P&P Indicated: Policy Interpretation and Implementation 1. Residents are not prohibited in any way from communicating with officials or agencies that are independent from or have oversight of the facility. These agencies/individuals include (but are not limited to): a. federal or (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	state surveyors. b. federal or state health department employees; and/or c. any adult protection or advocacy agency employees or representatives. 2. Residents are not restricted from contacting or communicating with federal, state or local individuals or agencies regarding any matter, whether the matter is subject to arbitration or to any other judicial or regulatory action. b. During a review of Resident 85's admission Record, the admission Record indicated the facility admitted the resident on 10/12/2023, with diagnoses including but not limited to heart failure (a condition where the heart cannot pump enough blood to meet the needs of the body), major depression (a low mood or loss of pleasure or interest in activities for long periods of time) and unspecified psychosis (a mental health condition where someone loses touch with reality). During a review of Resident 85's H&P, dated 10/11/2024, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 85's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicated Resident 85 had severely impaired cognition (significant decline in a resident's mental abilities that profoundly impacts their daily life and independence) and the family participated in the assessment and goal setting of resident's healthcare management. During a concurrent interview and record review on 8/15/2025, at 10:55 a.m., with the DOA, reviewed Resident 85's Arbitration Agreement signed by the daughter on 1/22/2021. The DOA stated the signed agreement does not have the verbiage Allow residents to communicate with federal, state, or local officials and representatives of the Office of the State Long Term Care Ombudsman. The DOA stated the residents' arbitration agreement should have the above verbiage at the time of signing to ensure residents or family have better understanding when making decisions. During a concurrent interview and record review on 8/15/2025, at 10:55 a.m., with the DOA, reviewed Resident 85's Information Regarding the Resident Facility Arbitration Agreement Questionnaire signed by the resident's representative on 1/22/2021. The DOA stated the questionnaire and arbitration agreement forms are reviewed before signing. The DOA stated the questionnaire did not include a question regardingˆcommunication with federal, state, or local officials and representative of the Office of the State Long Term Care Ombudsman. During a concurrent interview and record review on 8/15/2025, at 11:58 a.m., with the ADM, reviewed Resident 85's Arbitration Agreement. ADM stated the agreement form does not include a verbiage Allowing residents to communicate with federal, state, or local officials and representatives of the Office of the State Long Term Care Ombudsman. The ADM stated residents have the right to freely communicate with anyone including outside agencies, regarding decision-making and any information related to their care and condition. The ADM stated it is important to include the above verbiage as part of the arbitration agreement. ADM stated the facility does not have a policy on arbitration agreement. During a concurrent interview and record review on 8/15/2025, at 12:05 p.m., with the ADM, the facility's policy and procedure (P&P) titled Contact with External Agencies, last review date on 4/16/2025 was reviewed. The ADM stated the policy is only for internal employees and residents were not given a copy. The ADM stated this information should be added to the arbitration agreement form. During a review of the facility's recent P&P titled Contact with External Agencies, last review date on 4/16/2025, the P&P Indicated: Policy Interpretation and Implementation 1. Residents are not prohibited in any way from communicating with officials or agencies that are independent from or have oversight of the facility. These agencies/individuals include (but are not limited to): a. federal or state surveyors. b. federal or state health department employees; and/or c. any adult protection or advocacy agency employees or representatives. 2. Residents are not restricted from contacting or communicating with federal, state or local individuals or agencies regarding any matter, whether the matter is subject to arbitration or to any other judicial or regulatory action. c. During a review of Resident 101's admission Record, the admission Record indicated the facility admitted the resident on 3/11/2025, with diagnoses including but not limited to hypokalemia (a condition where the potassium levels in the blood are lower than normal), anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), and unspecified psychosis. During a review (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident 101's H&P, dated 3/11/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 101's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicated Resident 101 had intact cognition (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 101, and the family participated in the assessment and goal setting of resident's healthcare management. During a concurrent interview and record review on 8/15/2025, at 10:55 a.m., with the DOA, reviewed Resident 101's Arbitration Agreement signed by the son on 3/18/2025. The DOA stated the signed agreement does not have the verbiage Allow residents to communicate with federal, state, or local officials and representatives of the Office of the State Long Term Care Ombudsman. The DOA stated the residents' arbitration agreement should have the above verbiage at the time of signing to ensure residents or family have better understanding when making decisions. During a concurrent interview and record review on 8/15/2025, at 10:55 a.m., with the DOA, reviewed Resident 101's Information Regarding the Resident Facility Arbitration Agreement Questionnaire signed by the resident's representative on 3/18/2025. The DOA stated the questionnaire and arbitration agreement forms are reviewed before signing. The DOA stated the questionnaire did not include a question regardingˆcommunication with federal, state, or local officials and representative of the Office of the State Long Term Care Ombudsman. During a concurrent interview and record review on 8/15/2025, at 11:58 a.m., with the ADM, Resident 101's Arbitration Agreement, reviewed. ADM stated the agreement form does not include a verbiage Allowing residents to communicate with federal, state, or local officials and representatives of the Office of the State Long Term Care Ombudsman. The ADM stated residents have the right to freely communicate with anyone including outside agencies, regarding decision-making and any information related to their care and condition. The ADM stated it is important to include the above verbiage as part of the arbitration agreement. ADM stated the facility does not have a policy on arbitration agreement. During a concurrent interview and record review on 8/15/2025, at 12:05 p.m., with the ADM, the facility's policy and procedure (P&P) titled Contact with External Agencies, last review date on 4/16/2025 was reviewed. The ADM stated the policy is only for internal employees and residents were not given a copy. The ADM stated this information should be added to the arbitration agreement form. During a review of the facility's recent P&P titled Contact with External Agencies, last review date on 4/16/2025, the P&P Indicated: Policy Interpretation and Implementation 1.Residents are not prohibited in any way from communicating with officials or agencies that are independent from or have oversight of the facility. These agencies/individuals include (but are not limited to): a. federal or state surveyors. b. federal or state health department employees; and/or c. any adult protection or advocacy agency employees or representatives. 2. Residents are not restricted from contacting or communicating with federal, state or local individuals or agencies regarding any matter, whether the matter is subject to arbitration or to any other judicial or regulatory action.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to: 1.Ensure nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) oxygen tubing (flexible, hallow tube that connects the air compressor of a nebulizer to the medication cup) was not left on the floor for one of six of sampled residents reviewed during the Respiratory care area (Resident 35) and one of three sampled residents (Resident 16) reviewed during the Nutrition care area. 2.Ensure the padded side rails (safety features designed to help prevent falls and provide support for residents) were not disinfected with a chemical not intended for porous (something that has lots of tiny holes or openings, allowing liquids or air to pass through) surfaces. These deficient practices had the potential to spread communicable diseases resulting in respiratory infections in residents. Findings: a. During a review of Resident 35's admission Record (AR), the AR indicated the facility admitted the resident on 3/7/2022 and most recently admitted the resident on 7/26/2025 with diagnoses that included severe acute bronchitis (inflammation of the airway that carries air to and from the lungs) from respiratory syncytial virus (RSV, a respiratory virus that infects the lungs and breathing passages), sepsis (a life-threatening blood infection), dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 35's Minimum Data Set (MDS – resident assessment tool) dated 8/25/2025, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make themself understood. The MDS further indicated Resident 35 was dependent on staff for eating, bathing, dressing, oral and personal hygiene, toileting, and mobility. During a review of Resident 35's Order Summary Report, the Order Summary Report indicated the following orders: - Ipratropium bromide (a medication used to help control the symptoms of lung diseases) inhalation solution 0.02 percent (% - a unit of measurement), 2.5 milliliters (mL – a unit of measurement) inhale orally via nebulizer every eight hours for shortness of breath (SOB) for one week, dated 7/26/2025. - Ipratropium – albuterol (a medication used to help control the symptoms of lung diseases) solution 0.5 -2.5 milligrams (mg. – a unit of measurement) per 3 mL, inhale 3 mL orally via nebulizer every four hours as needed for SOB/wheezing/congestion, dated 7/26/2025. During an observation on 8/11/2025 at 9:10 a.m., observed Resident 35 lying in bed asleep. Observed a clear plastic bag containing an aerosol mask (mask that delivers medication to the respiratory system) and oxygen tubing. Observed the bag on the floor next to the resident's nightstand. Observed Certified Nursing Assistant (CNA) 6 inside Resident 35's room. During a concurrent observation and interview on 8/11/2025 at 2:55 p.m., with CNA 6 and Licensed Vocational Nurse (LVN) 4, observed the clear plastic bag containing an aerosol mask and oxygen tubing remained on the floor next to Resident 35's nightstand. Observed CNA 6 inside Resident 35's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. CNA 6 confirmed the bag containing Resident 35's mask and tubing were on the floor. CNA 6 stated Resident 35 used to get breathing treatments every day. CNA 6 stated the mask and tubing in the plastic bag should not be on the floor and CNA 6 should have seen the bag and notified the nurse, but CNA 6 did not. Observed LVN 4 entered Resident 35's room and stated the bag with mask and tubing should not be on the floor because there was a chance that the tubing and mask would be used causing a risk for infection. Observed LVN 4 removed the bag containing the mask and tubing from Resident 35's room. During a follow up interview on 8/13/2025 at 9:45 a.m. with LVN 4, LVN 4 stated when a CNA enters a resident's room, there should be an environment check done to identify and report any issues to the nurse. LVN 4 stated when oxygen tubing is left on the dirty floor, the tubing could become contaminated. LVN 4 stated the contaminated tubing could transfer bacteria to the resident when the resident breathes through the mask resulting in a respiratory infection. During an interview on 8/14/2025 at 4:22 p.m. with the Director of Nursing (DON), the DON stated all oxygen tubing, even if placed in a plastic bag, should be off the floor for infection control. The DON stated when oxygen tubing is found on the floor the tubing should be removed and replaced with new tubing. The DON stated all staff are responsible for identifying tubing on the floor during their rounds. During a follow-up interview and record review on 8/15/2025 at 12 p.m. with the DON, the DON reviewed the facility policy and procedure (P&P) regarding oxygen tubing. The DON stated when Resident 35's mask and tubing was left on the floor the facility P&P was not followed potentially resulting in a respiratory infection in the resident. During a review of the facility P&P titled, Oxygen Administration, last reviewed 4/16/2025, the P&P indicated oxygen tubing should be used in a manner that prevents it from touching the floor. During a review of the facility P&P titled, Infection Prevention and Control Program, last reviewed 4/16/2025, the P&P indicated an infection prevention and control program is established to maintain a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Important facets of infection prevention include to educate staff and ensure that they adhere to proper techniques and procedures. b. During a review of Resident 16's AR, the AR indicated the facility admitted the resident on 7/6/2018 and most recently admitted the resident on 7/15/2025 with diagnoses that included chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), dependence on supplemental oxygen, dementia, and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). During a review of Resident 16's MDS dated [DATE], the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make themself understood. The MDS further indicated Resident 16 was dependent on staff for bathing, dressing, oral and personal hygiene, toileting, and mobility. During a review of Resident 16's Care Plan (CP) titled, Resident is at risk for respiratory distress., initiated 7/2/2025, the CP indicated to administer breathing treatments as ordered. During a review of Resident 16's Order Summary Report, the Order Summary Report indicated the following orders: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ipratropium – albuterol solution 0.5 -2.5 milligrams (mg. – a unit of measurement) per 3 mL, inhale 1 vial orally via nebulizer every four hours for respiratory failure, dated 7/15/2025. During an observation on 8/13/2025 at 9:26 a.m., observed Resident 16 lying in bed. Observed an aerosol mask and oxygen tubing connected to a nebulizer placed on the nightstand. Observed the mask placed in a plastic bag with the oxygen tubing hanging from the nebulizer and touching the floor. During a concurrent observation and interview on 8/13/2025 at 9:35 a.m., with CNA 7 and Restorative Nursing Assistant (RNA) 2, entered Resident 16's room with RNA 2. Observed oxygen tubing remained on the floor next to Resident 16's nightstand. RNA 2 confirmed the tubing was on the floor. CNA 7 entered Resident 16's room and stated the oxygen tubing should not be on the ground, but it was. During a concurrent observation and interview on 8/13/2025 at 9:45 a.m. with LVN 4, LVN 4 stated when a CNA enters a resident's room, there should be an environment check done to identify and report any issues to the nurse. LVN 4 stated when oxygen tubing is left on the dirty floor, the tubing could become contaminated. LVN 4 stated the contaminated tubing could transfer bacteria to the resident when the resident breathes through the mask resulting in a respiratory infection. LVN 4 stated LVN 4 would change Resident 16's nebulizer mask and tubing. During an interview on 8/14/2025 at 4:22 p.m. with the DON, the DON stated all oxygen tubing, even if placed in a plastic bag, should be off the floor for infection control. The DON stated when oxygen tubing is found on the floor the tubing should be removed and replaced with new tubing. The DON stated all staff are responsible for identifying tubing on the floor during their rounds. During a follow-up interview and record review on 8/15/2025 at 12 p.m. with the DON, the DON reviewed the facility policy and procedure (P&P) regarding oxygen tubing. The DON stated when Resident 16's mask and tubing was left on the floor the facility P&P was not followed potentially resulting in a respiratory infection in the resident. During a review of the facility P&P titled, Oxygen Administration, last reviewed 4/16/2025, the P&P indicated oxygen tubing should be used in a manner that prevents it from touching the floor. During a review of the facility P&P titled, Infection Prevention and Control Program, last reviewed 4/16/2025, the P&P indicated an infection prevention and control program is established to maintain a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Important facets of infection prevention include to educate staff and ensure that they adhere to proper techniques and procedures. c. During an observation on 8/14/2025, at 9:23 a.m., observed Room A had Resident 3 with the upper bilateral side rail padded with foam/porous tube noodles. During a concurrent observation and interview on 8/14/2025, at 9:30 a.m., with Housekeeper (HK) 1, inside Room A, observed Resident 3's bed with upper side rails padded with foam/porous tube noodles. HK 1 stated they clean the padded side rails using the Disinfectant Chemical (DC) 1 to sanitize the side rails covered with porous materials. HK 1 stated she sprays the liquid chemical on a rag and uses the rag to sanitize the siderails padded with tube foam/porous foam. During a concurrent an interview and record review on 8/14/2025, at 11 am, with the Infection Preventionist (IP) and the Maintenance Supervisor (MS), reviewed the product label of DC 1 and DC 2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Both the IP and the MS stated DC 1 and DC 2 are to be used on hard, non-porous surfaces. Both the IP and the MS stated they should not be using DC 1 for porous surfaces. Both the IP and the MS stated that the foam/porous tube noodles they used to pad the side rails of the residents are porous and they can absorb the chemical and can be harmful to residents when it gets contact on the resident's skin and when ingested. During an interview and record review on 8/15/2025, at 11:37 a.m., with the DON, reviewed the product information provided by the facility for DC 1. The DON stated the product information indicated DC 1 is used for general cleaning of hard, non-porous inanimate surfaces. The DON stated the foam tube covering their siderails are made of porous materials that can absorb the chemicals that can be harmful to residents when they get in contact with them or ingested. During a review of the facility-provided Product Information on the use of DC 1, undated, the product information indicated that DC 1 is a one-step germicidal disinfectant cleaner and deodorant designed for general cleaning of hard, non-porous inanimate surfaces. During a review of the facility-provided Safety Data Sheet on the use of DC 1, undated, the Safety Data Sheet indicated: IF ON SKIN: Take off contaminated clothing and wash before reuse. Rinse skin with water. If Skin irritation persists: Get medical attention. IF IN EYES: Rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. If eye irritation persists: Get medical attention. IF INHALED: Remove person to fresh air and keep comfortable for breathing. If problem persists, call a Poison Center or get medical attention. IF SWALLOWED: Rinse mouth. Do NOT induce vomiting. Get medical attention immediately.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure self-administration of a Breo (a medication used to treat breathing problems) inhaler was evaluated and considered safe by the interdisciplinary team (IDT - a multi-discipline group of healthcare professionals involved in periodically meeting and planning care for individual residents) for one of four resident's observed for medication administration (Resident 48.) The deficient practice of allowing Resident 48 to self-administer medication without an IDT evaluation for safety increased the risk that she may have administered the wrong dose of Breo due to poor technique possibly resulting in medical complications resulting in hospitalization or death. Findings: During an observation on 8/12/2025 at 9:53 a.m., Resident 48 was observed self-administering Breo inhaler as prepared by the Licensed Vocational Nurse (LVN) 4. During a review of Resident 48's admission Record dated 7/12/2025, the admission Record indicated the resident was admitted to the facility on [DATE]. During a review of Resident 48's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 7/3/2025, the H&P indicated the resident had a diagnosis of shortness of breath. During a review of Resident 48's Order Summary Report (a monthly summary of all active physician orders) dated 7/31/2025, the order summary report indicated the resident was prescribed Breo inhaler to administer one puff by mouth daily for shortness of breath to be clinician administered. During a review of Resident 48's Self-Administration of Medication Evaluation (an evaluation to determine if a resident has a desire or capacity to self-administer medication) dated 7/2/2025, the evaluation indicated IDT has determined that it is not safe for resident to administer drugs due to cognitive impairment due to physical/functional impairment secondary to multiple diagnosis. Resident prefers licensed nurses to administer medications. Further review of the assessment indicated Resident 48 was not approved for the self-administration of medications. During an interview on 8/12/2025 at 10:13 a.m. with LVN 4, LVN 4 stated she allowed Resident 48 to self-administer the Breo inhaler because this is what the resident prefers. LVN 4 stated the order for Resident 48's Breo indicated it should be clinician administered and not self-administered. LVN 4 stated Resident 48's medication self-administration assessment indicated she should not self-administer medication due to her cognitive impairment. LVN 4 stated allowing residents to self-administer medication should only be allowed once the IDT determines the resident can do so safely and competently. LVN 4 stated there is a risk that poor technique from this inhaler could lead to breathing problems for Resident 48 possibly leading to hospitalization.^ During a review of the facility's policy and procedure (P&P) Self-Administration of Medications, dated April 2008, the P&P indicated Residents who desire to self-administer medication are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility: 1.Failed to ensure resident's medical records were updated to show documented evidence that advance directives (AD - a legal document indicating resident preference on end-of-life treatment decisions) were discussed with one (1) of four (4) sampled residents (Resident 32). This deficient practice violated the resident`s rights and/or representative's right to be fully informed of the option to formulate their advanced directives. 2.Failed to ensure that a current copy of resident's advance directive (a legal document indicating resident preference on end-of-life treatment decisions) was in the resident's medical record for one of four sampled residents (Resident 4). The deficient practice had the potential to violate the resident's right to self-determination when the resident is incapacitated to make decisions. Findings: a. During a review of Resident 32's admission Record, the admission Record indicated the facility admitted the resident on 9/25/2024, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 32's History and Physical (H&P) dated 9/26/2024, the H&P indicated Resident 32 was incapacitated (refers to a person's inability to manage their own affairs due to physical or mental limitations). During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 7/2/2025, the MDS indicated Resident 32 was able to understand others and make her needs known and had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 32 required supervision or touching assistance with eating and total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the family participated in the assessment and goal setting of care for the resident. During a review of Resident 32's Advance Directive Acknowledgment form, dated 9/26/2024, the Advance Directive Acknowledgment form did not indicate if the resident and/or RP was provided information regarding formulation of an AD, offered assistance, or declined assistance. During a concurrent interview and record review on 8/13/2025 at 3:01 p.m., reviewed Resident 32's Advance Directive Acknowledgement form with the Director of Social Services (DSS). The DSS stated she did not provide information regarding formulation of AD to the RP, offered assistance, or if the RP declined or not interested in formulating an AD. The DSS stated there was no documentation in Resident 32's medical record that the AD information was provided, assistance was offered, and if the RP declined assistance in formulating one. The DSS stated it was important to provide information to the RP, offer assistance in formulating one if interested and document in the medical record that formulation of an AD was discussed with the family or RP, as it placed Resident 32 at risk for not honoring the resident's wishes regarding life sustaining measures when unable to decide for herself. During an interview on 8/15/2025 at 11:37 a.m., with the Director of Nursing (DON), the DON stated AD is discussed with the resident and/or RP during quarterly meetings. The DON stated if the resident has an AD, the social services department is supposed to obtain a copy from the resident (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or RP and file in the residents' medical record. The DON stated the social services department should indicate in the Advance Directive Acknowledgment form or in the social services notes that the facility provided information regarding formulation of an AD, offered assistance if they agreed to formulate an AD, and given them an opportunity to decline. The DON stated the DSS should have provided information and offered assistance to the RP if interested to formulate an AD and document as it placed Resident 32 at risk for not honoring the resident's wishes regarding life sustaining measures when unable to decide for herself. During a review of the facility's recent policy and procedure (P&P) titled Advance Directive, last reviewed on 4/16/2025, the P&P indicated: -The facility must ensure compliance with Federal and State requirements regarding advance directives. At the time the resident is admitted to a nursing home, staff must determine whether the resident has executed an advance directive or has given other instructions to indicate what care he or she desires in case of subsequent incapacity. -If the resident has not executed an AD, the facility is required to advise the resident and family of the right to establish an AD as set forth in the laws of the State; to offer assistance if the resident wishes to execute one or more directive (s); and to document in the resident's medical record these discussions and any AD that the resident executes. -Social services staff will complete the AD acknowledgement form with residents or their responsible party upon admission. b. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted the resident on 9/4/2024, and readmitted the resident on 10/27/2024, with diagnoses including respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to dangerously low oxygen levels and/or dangerously high carbon dioxide levels in the blood), dependence on respirator (person cannot breathe adequately on their own and relies on a machine [the respirator or ventilator] to move air in and out of their lungs), and history of cardiac arrest (when the heart suddenly and unexpectedly stops pumping blood effectively). During a review of Resident 4's History and Physical (H&P), dated 10/27/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 6/11/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (means a person has significant trouble with their thinking abilities that significantly affects their daily life and independence). The MDS indicated the family participated in the assessment and goal setting of care for the resident. During a review of Resident 4's Advance Directive Acknowledgment Form, dated 10/2/2024, the Advance Directive Acknowledgment Form indicated the resident had executed an Advance Directive. During a concurrent interview and record review on 8/12/2025, at 9:07 a.m., with the Social Services Designee (SSD), reviewed Resident 4's Advance Directive Acknowledgement Form, and the Resident's Medical Records. The SSD stated the resident had been offered the Formulation of Advance Directive Information and the resident had indicated on the Advance Directive Acknowledgment Form that the resident had formulated an Advance Directive dated 10/2/2024. The (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SSD stated they should have obtained a copy of the Advance Directive to be placed on the resident's medical chart. The SSD stated it has not been followed up for several months already and should have been followed up immediately upon the resident's disclosure of the presence of an Advance Directive from the resident or resident representative. The SSD stated the failure of the facility to obtain a copy of the Advance Directive had a potential for the facility to not honor the resident's wishes regarding life sustaining measures when unable to decide for herself. The SSD stated she will follow up immediately with the family to get a copy of the Advance Directive. During a concurrent interview and record review on 8/13/2025, at 11:20 a.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 4's Medical Diagnosis and Advance Directive Acknowledgment Form. LVN 5 stated the Advance Directive Acknowledgement Form indicated the resident had executed an Advance Directive but there was no copy filed in the medical chart of the resident. LVN 5 stated it was the responsibility of the SSD to obtain a copy of the Advance Directive to be filed on the medical chart. LVN 5 stated the failure of the facility to follow up and obtain a copy of Resident 4's Advance Directive had failed the resident's wishes for life sustaining measures when unable to decide for herself. During an interview on 8/15/2025, at 11:37 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the SSD should have obtained a copy of the Advance Directive of the resident as soon as possible to honor the resident's wishes during end-of-life care (a type of care for people nearing the end of life that focuses on maximizing their comfort and quality of life rather than on curing their illness). The ADON stated they should have at least followed up the missing file during quarterly assessments of the resident. During a review of the facility's recent policy and procedure (P&P) titled Advance Directive, last reviewed on 4/16/2025, the P&P indicated the facility must ensure compliance with Federal and State requirements regarding advance directives. At the time the resident is admitted to a nursing home, staff must determine whether the resident has executed an advance directive or has given other instructions to indicate what care he or she desires in case of subsequent incapacity. If the resident or the resident's legal representative has executed one or more advance directive(s), or executes one upon admission, it is important that copies of these documents be obtained, incorporated and consistently maintained in the same section of the resident's medical record readily retrievable by any facility staff, and that the facility communicate the resident's wishes to the resident's direct care staff and physician.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a comfortable and homelike environment for one of five sampled residents (Resident 71) investigated under the facility environment task. This deficient practice had the potential to negatively affect Resident 71's quality of life. Findings: ˆ During a review of Resident 71's admission Record, the admission Record indicated the facility admitted the resident on 6/26/2024 with diagnoses including but not limited to, respiratory failure (a condition where the lungs cannot release enough oxygen into the blood) and dependence on a respiratory ventilator (a medical device to help support or replace breathing). During a review of Resident 71's Minimum Data Set (MDS - a resident assessment tool), dated 7/3/2025, the MDS indicated Resident 71 had severely impaired cognitive (relating to or involving the processes of thinking and reasoning) skills for daily decision making and was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 71's Order Summary Report, the Order Summary Report indicated the following order dated 7/1/2024: Padded side rails to decrease potential injury related to history of seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a concurrent observation and interview on 8/14/2025 at 12:34 p.m. with Registered Nurse (RN) 5 at Resident 71's bedside, Resident 71's foam padding to the bilateral upper side rails had several rips. RN 5 stated he would contact maintenance to replace the foam padding. RN 5 stated the foam padding should be replaced because of aesthetics. During an interview on 8/15/2025 at 10:50 a.m. with the Director of Nursing (DON), the DON stated the bed rail padding should be in good shape. The DON stated the resident should be in a homelike environment for their dignity. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed 4/16/2025, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment. During a review of the facility's P&P titled, Policy: Equipment, last reviewed 4/16/2025, the P&P indicated equipment will be cleaned, maintained, and replaced as needed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial (relating to the interrelation of social factors and individual thoughts and behavior) needs for one of four sampled residents (Resident 16) reviewed during the Pressure Ulcer / Injuries (PU/PI - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) care area by failing to obtain physician orders prior to administering a wound care treatment for a newly identified skin issue. This deficient practice had the potential for Resident 16 to experience adverse (unwanted, unintended result) reactions or a delay in wound healing. Findings: During a review of Resident 16's admission Record (AR), the AR indicated the facility admitted the resident on 7/6/2018, and most recently admitted the resident on 7/15/2025, with diagnoses that included chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), dependence on supplemental oxygen, dementia (a progressive state of decline in mental abilities), and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). During a review of Resident 16's History and Physical (H&P) dated 7/16/2025, the H&P indicated that the resident had a history of right foot osteomyelitis. During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 7/21/2025, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make themself understood. The MDS further indicated that the resident was dependent on staff for bathing, dressing, oral and personal hygiene, toileting, and mobility. The MDS indicated the resident had two unhealed stage four (4) PUs (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and two unhealed unstageable PUs (serious wounds that often signify severe tissue damage) present upon admission or readmission to the facility. During a review of Resident 16's Order Summary Report, the Order Summary Report indicated the following orders: -[treatment] Monitor pressure sore/ wound every day shift, dated 7/16/2025. -[treatment] Left great toe PU.: cleanse with normal saline (NS), pat dry, apply santyl ointment (a topical medication to help with wound healing), and calcium alginate dressing (a highly absorbent wound dressing), cover with bordered gauze ever day shift for 30 Days, dated 7/16/2025. -[treatment] Left hip PU: cleanse with NS, pat dry, apply santyl ointment and calcium alginate dressing, cover with bordered gauze ever day shift for 30 Days, dated 7/16/2025. -[treatment] Right first metatarsal (long bones found in the midfoot) head (rounded end of bone at toward the toe) PU: cleanse with NS, pat dry, apply santyl ointment and calcium alginate dressing, cover with bordered gauze ever day shift for 30 Days, dated 7/16/2025. -[treatment] Right fifth metatarsal head PU: cleanse with NS, pat dry, apply santyl ointment and calcium alginate dressing, cover with bordered gauze ever day shift for 30 Days, dated 7/16/2025. During a wound care observation on 8/14/2025 at 8:34 a.m., with Treatment Nurse (TN) 1 and TN 2, observed Resident 16 lying in bed. Observed TN 1 provide wound care to the PUs on Resident 16's left hip, left great toe, right first metatarsal head, and right fifth metatarsal head per physician's orders. TN 2 stated there was a newly identified PU on the top of Resident 16's right great toe. Observed TN 1 also provided treatment to the top of Resident 16's right great toe and applied a dressing. During a follow-up interview and record review on 8/14/2025 at 2:57 p.m. with TN 2 reviewed Resident 16's physician order for wound treatment to the right great toe dated 8/14/2025 at 12:34 p.m. and Change of Condition form dated 8/14/2025 at 11:06 p.m. TN 2 stated the facility process is to report any new skin issues to the physician, get an order for treatment, and then initiate the treatment. TN 2 stated it was important to get an order prior to administering a wound treatment because the physician determines the treatment and may have a way to quickly heal a wound. TN 2 stated TN 2 provided wound care to a newly identified skin issue on Resident 16's right great toe on 8/14/2025 at 8:34 a.m. without notifying the physician and obtaining an order for treatment. TN 2 stated TN 2 applied hydrogel (a water-based gel that promotes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound healing) and a gauze dressing to the newly identified skin issue. TN 2 stated it was not okay to step ahead of the physician's order and perform wound care, but TN 2 did. ˆ During a concurrent interview and record review on 8/15/2025 at 12 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedure (P&P) regarding wound care. The DON stated when a new skin issue is identified on a resident the process is to call the physician, get an order, then perform the treatment. The DON stated the DON was aware that TN 2 performed wound care on Resident 16's newly identified wound prior to notifying the physician and obtaining an order. The DON stated when TN 2 did not follow the facility P&P there was the potential to result in a delay of wound healing if the correct treatment was not applied. During a review of the facility P&P titled, Wound Care, last reviewed 4/16/2025, the P&P indicated the purpose of the procedure is to provide guidelines for the care of wounds to promote healing. Procedure: verify that there is a physician's order for this procedure. During a review of the facility P&P titled, Change of Condition, last reviewed 4/16/2025, the P&P indicated the purpose was to ensure proper assessment and follow through for any resident change of condition. A change of condition is a sudden or marked difference in residents with any new open or red areas, bruises, lacerations, blisters, rashes, or skin tears. The physician shall be called promptly.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure residents who required colostomy (an opening [stoma] on your abdomen [belly] that connects your colon [large intestine] to the outside of your body) received care consistent with professional standards of practice for one of one resident (Resident 155) reviewed for colostomy care by failing to empty a full colostomy bag (s a small pouch worn on the outside of the abdomen to collect stool after a surgical procedure called a colostomy) when the resident already have been complaining that it was full since shift change in the morning. This deficient practice had predisposed the resident to discomfort, skin excoriation (a scrape or scratch to the skin), and had the potential for the bag to become dislodged, resulting in leakage of the fecal contents onto the resident`s body and bed. Findings: During a review of Resident 155's admission Record, the admission Record indicated the facility admitted the resident on 4/7/2025, with diagnoses including colostomy, elevated white blood cell count (the body has too many infection-fighting white blood cells in the blood, often as a response to infection, inflammation, or an injury), and abnormalities of gait (the way someone walks) and mobility. During a review of Resident 155's History and Physical (H&P), dated 4/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 155's Minimum Data Set (MDS, a resident assessment tool), dated 7/15/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had moderately impaired cognition (refers to a noticeable decline in a person's thinking and memory skills that makes it harder for them to manage daily life independently). The MDS indicated the resident required partial/moderate assistance on personal/toileting hygiene. The MDS indicated the resident was at risk for developing pressure ulcer/injuries (an injury to the skin and underlying tissue caused by constant pressure, often over a bony area, that reduces blood flow). During a review of Resident 155's Order Summary Report, dated 4/8/2025, the Order Summary Report indicated an order to: -Change colotomy bag as needed if full, dislodged or leaking. -Colostomy site: Cleanse with normal saline (NS, a mixture of water and salt), pat dry, apply colostomy bag every day shift. -Monitor colostomy site and surrounding area for any redness, skin breakdown and signs and symptoms (s/s) of infection. Document: Y= yes N= no, every day shift. During a review of Resident 155's Care Plan (CP) Report titled Colostomy. Resident is at risk for infection or skin alteration, initiated on 7/30/2025, the CP indicated an intervention to provide colostomy/stoma care daily and as needed. During an interview on 8/11/2025, at 10:18 a.m., with Resident 155, inside Resident 155's room, Resident 155 stated that he is having discomfort from his colostomy bag because it is full and needs to be emptied. Resident 155 stated it had been full since the morning shift change (7 a.m.). Resident 155 stated he told the staff about it, but the staff never came back to change. Resident 155 stated he cannot remember which staff member he had spoken to. During an observation and interview on 8/11/2025, at 10:24 a.m., with Licensed Vocational Nurse (LVN) 5, inside Resident 155's room, observed Resident 155's colostomy bag full of fecal contents. LVN 5 stated Resident 155's colostomy bag is full and needed to be emptied or changed. LVN 5 stated the colostomy bag should be checked periodically by staff to ensure it is not full and to prevent the bag from getting dislodged leaking fecal contents onto the resident. LVN 5 stated she was not aware that the resident had complaint about it, and she will empty the bag right away. LVN 5 stated it was the responsibility of all staff caring for the resident to ensure the colostomy bag is emptied or changed regularly to prevent accidental leakage of the fecal contents on the resident's skin causing excoriation. During an interview and record review on 8/13/2025 at 1:37 p.m., with LVN 5, reviewed Resident 155's Order Summary Report, Medication Administration Record (MAR), and Care Plan. LVN 5 stated there was an order to change Resident 155`s colostomy bag as needed if full, dislodged or leaking. LVN 5 also stated the PRN colostomy bag change on the MAR had no initials recorded for 8/2025. LVN 5 stated the failure of the staff to empty or change the colostomy regularly (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	predisposed the resident to skin excoriation on the site and potential dislodging of the bag leaking fecal contents causing humiliation to the resident. During an interview on 8/15/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated Resident 155'a colostomy bag should have been emptied during shift change and as needed to prevent accidental dislodging of the bag and to prevent skin irritation at the site of the colostomy. During a review of the facility's recent policy and procedure (P&P) titled Incontinent Care, last reviewed on 4/16/2025, the P&P indicated to keep incontinent residents clean, dry, and free of odor, and to prevent skin breakdown. Key Points Steps: 1. Check to see if resident is in need of changing. ˆ During a review of the facility's recent P&P titled Physician's Orders: Follow up, last reviewed on 4/16/2025, the P&P indicated physician's orders will be noted by the charge nurse on duty at the time the order(s) is/are written. Subsequent transcriptions will be accomplished as indicated; e.g., transcription of medication on MAR, treatment Sheet, etc.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide respiratory care consistent with professional standards of practice for two (2) of six (6) sampled residents (Residents 6 and 169) reviewed for respiratory care by: 1.Failing to ensure Resident 6's oxygen tubing was changed timely per facility policy and procedure (P&P). This deficient practice placed the resident at risk for acquiring respiratory infections. 2.Failing to ensure Resident 169's oxygen therapy (a treatment that provides extra oxygen to breathe in) via nasal cannula (NC, a simple, two-pronged device that delivers extra oxygen to the nose) was applied in the resident's nostrils. This deficient practice had the potential for the resident to develop complications such as shortness of breath, desaturation (low levels of oxygen in the blood), and respiratory infections. Findings: a. During a review of Resident 6's admission Record, the admission Record indicated the facility origionally admitted Resident 6 on 3/11/2025, and readmitted on [DATE], with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 6's History and Physical (H&P) dated 6/5/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS – a resident assessment tool) assessment dated [DATE], the MDS assessment indicated Resident 6 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and had impairment on Bilateral (both) Upper Extremities (BUE) and Bilateral Lower extremities (BLE). The MDS indicated Resident 6 received oxygen therapy. During a review of Resident 6's Order Summary Report dated 7/31/2025, the Order Summary Report indicated the following physician's orders dated 6/4/2025: -Titrate (to carefully adjust the amount of oxygen a patient receives to achieve a specific, target level of oxygen saturation in the blood) oxygen to keep oxygen saturation level (02 sat- a measurement of how much oxygen the blood is carrying as a percentage) greater than (> - a unit of measurement) 92 percent (% - a unit of measurement) every shift and as needed. During a review of Resident 6's care plan (CP) on risk for respiratory distress initiated on 3/12/2025, and last revised on 6/14/2025, the CP indicated to apply oxygen as needed or as ordered to ensure Resident 6 will have no unrecognized signs and symptoms of respiratory distress. During a concurrent observation and interview on 8/11/2025 at 9:41 a.m. inside Resident 6's room, with Respiratory Therapist (RT) 2, RT 2 stated Resident 6's oxygen tubing connected to the ventilator (also known as respirator, a medical device to help support or replace breathing) indicated a date of 8/3/2025. RT 2 stated oxygen tubing is changed weekly for all residents on oxygen therapy per facility policy to prevent growth of bacteria (microorganisms that can cause disease) in the tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RT 2 stated Resident 6's oxygen tubing should have been changed on 8/10/2025. RT 2 stated not changing Resident 6`s oxygen tubing placed the resident at risk of developing infection from a possibly contaminated or old oxygen tubing. During an interview on 8/15/2025 at 11:45 a.m. with the Director of Nursing (DON), the DON stated the facility staff are reqquired to change the oxygen tubings once a week to prevent growth or build up of bacteria in the tubing. The DON stated if the date on Resident 6's oxygen tubing was 8/3/2025, the tubing should have been changed on 8/10/2025. The DON stated if the tubing was not changed timely, it placed Resident 6 at risk of acquiring infection from a possibly contaminated tubing. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, last reviewed on 4/16/2025, the P&P indicated: -The oxygen tubing should be changed weekly and as needed, including changing the mask, cannula, nebulizer equipment, etc. when not in use, the oxygen tubing should be stored in a clean bag. -The date, time and initials should be noted on oxygen equipment when it is initially used and when changed. b. During a review of Resident 169's admission Record, the admission Record indicated the facility admitted the resident on 12/5/2022, and readmitted the resident on 8/8/2025, with diagnoses including encephalopathy (any condition that affects the brain's ability to function properly), interstitial pulmonary disease (an umbrella term used for a large group of diseases that cause scarring (fibrosis) of the lungs), and heart failure (a condition where the heart can't pump enough blood to meet the body's needs). During a review of Resident 169's History and Physical (H&P), dated 8/2/2025, the H&P indicated the resident was alert and confused. During a review of Resident 169's Order Summary Report dated 8/8/2025, the Order Summary Report indicated an order to: -Administer oxygen (O2) at 2 liters per minute (L/min, indicates how much oxygen is flowing out of a device, like an oxygen concentrator or tank, each minute) via NC. May titrate (to carefully adjust the amount of something, often a medication or chemical, to find the best or most effective level) up to 5 L/min for O2 saturation (a measure of how much oxygen is carried in your red blood cells, compared to how much it could potentially carry) less than 90%. Every shift for shortness of breath (SOB). -Monitor O2 saturation every shift. During a review of Resident 169's Care Plan (CP) Report titled Resident is at risk for respiratory distress, last revised on 7/8/2025, the CP indicated interventions to monitor oxygen saturation as needed/ordered, medication as ordered, and apply oxygen as needed/ordered. During a concurrent observation and interview on 8/11/2025 at 9:13 a.m., with Treatment Nurse (TN) 1, inside Resident 169's room, observed Resident 169's oxygen tubing was resting on the resident`s chest, not in the resident's nostrils to deliver oxygen. TN 1 stated the oxygen via nasal cannula should be in the resident's nostrils to deliver the oxygen supplement as ordered by the physician. TN 1 stated she does not know how long the oxygen therapy was off the resident. TN 1 stated it could (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause the resident to have shortness of breath and desaturation. During a concurrent interview and record review on 8/13/2025, at 1:52 p.m., with Licensed Vocational Nurse (LVN) 5, reviewed Resident 169's Medical Diagnosis, Order Summary Report, and Care Plan. LVN 5 stated there was an order for Resident 169 to receive O2 at 2 L/min via nasal cannula to keep O2 saturation above 90%. LVN 5 stated the charge nurses are responsible for ensuring that the resident are receiving the oxygen therapy . LVN 5 stated charge nurses should round at least every 2 hours to check oxygen delivery. LVN 5 stated the failure of the charge nurse to ensure the oxygen therapy is on can lead to resident's shortness of breath, change in the level of consciousness, and desaturation. During an interview on 8/15/2025, at 11:37 a.m., with the Director of Nursing (DON), the DON stated Resident 169's is required to receive oxygen therapy at all times per physician's order. The DON stated it was the responsibility of the licensed staff and the Certified Nursing Assistants (CNA) to ensure the oxygen therapy was on the resident. The DON stated the staff should at least make rounds every 2 hours to check on the residents` status, to ensure the residents are receiving required therapies . The DON stated the failure of the staff to ensure the oxygen therapy is on the resident can lead to shortness of breath that can lead to respiratory distress. During a review of the facility's recent policy and procedure (P&P) titled Oxygen Administration, last reviewed 4/16/2025, the P&P indicated oxygen will be administered to residents as needed per attending physician's orders by licensed personnel. 2. Review physician's order(s) for oxygen use. 4. Administer oxygen as per physician's orders: a. Oxygen may be administered up to 2 liters per minute without humidifier b. Oxygen administered at 3 liters per minute or more requires humidifier

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to provide pain management for one of four sampled residents (Resident 10) reviewed for pressure ulcer/injuries (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) before providing wound treatment as ordered by the physician. This deficient practice had the potential to result in increased pain and discomfort. Findings: During a review of Resident 10's admission Record (AR), the AR indicated that the facility admitted the resident on 6/2/2025 with diagnoses including unspecified sequelae (the long-term conditions that happen because of an illness or injury) cerebral infarction (stroke - loss of blood flow to a part of the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), myocardial infarction type two (heart attack- occurs when the heart muscle doesn't get enough oxygen due to an imbalance between oxygen supply and demand, not caused by a blockage in the coronary arteries {blood vessel supplying blood to the heart}), generalized muscle weakness, and abnormalities of gait (manner of walking) and mobility (movement). During a review of Resident 10's History and Physical (H&P - comprehensive assessment conducted by a healthcare provider that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern), dated 6/2/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. The H&P indicated that Resident 10's integumentary (skin) was intact. During a review of Resident 10's admission Re-assessment, dated 6/3/2025, the admission Re-assessment indicated Resident 10 had left axilla (armpit) mass, and calluses on the right and left feet. During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 6/9/2025, the MDS indicated that Resident 10 has the ability to make self understood and has the ability to understand others. The MDS indicated Resident 10 required partial/moderate assistance from staff for bed mobility including rolling to the left and right. The MDS indicated Resident 10 was always incontinent of bowel and bladder. The MDS indicated Resident 10 had no unhealed pressure ulcer but was identified as being at risk for developing pressure ulcers. During a review of Resident 10's Braden Scale (a scoring tool used to predict resident's risk of developing a pressure ulcer, total score ranges from zero {0} to 18. A lower score indicating a higher risk of developing a pressure ulcer.) dated 6/3/2025, timed at 2:18 p.m., the Braden Scale assessment indicated a score of 17, which signifies that Resident 10 is at risk for developing pressure ulcer. During a review of Resident 10's Physician Orders dated 7/31/2025, the Physician Order indicated treatment for Resident 10's MASD to the right and left buttocks extending to the perianal (around the anal {near the anus - opening at the end of the digestive tract, through which solid waste - stool, is expelled from the body} area). The Physician Order indicated to cleanse with normal saline (a mixture of water and salt), pat dry, apply a skin barrier cream, leave open to air every day shift for 30 days. During a review of Resident 10's Physician Orders dated 8/12/2025, the Physician Orders indicated to administer Acetaminophen (also known as Tylenol, a medication used to relieve pain) tablet 325 milligrams (mg - a unit of measurement), give two tablets by mouth every day shift prior to wound care and treatment. During a review of Resident 10's Physician Orders, dated 8/12/2025, the Physician Orders indicated treatment for Resident 10's sacrococcyx pressure ulcer to cleanse with normal saline, pat dry, apply Santyl (also known as collagenase, a topical ointment that removes dead tissue from wounds so they can start to heal) ointment, cover with bordered gauze, every day shift for 30 days. During a review of Resident 10's Physican Orders, dated 8/12/2025, the Physician Orders indicated treatment for Resident 10's left buttock pressure ulcer to cleanse with normal saline, pat dry, apply hydrogel (medication used in wounds to keep them moist, promote healing, reduce pain, and aid in tissue repair), cover with bordered gauze. During a review of Resident 10's Care Plan (CP) Report focused on actual unstageable sacrococcyx pressure sore, dated 8/12/2025, the CP indicated the resident with goals of minimizing risk of complications and decline with interventions that included assessing for (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs and symptoms of pain or discomfort and to medicate as ordered. During an interview on 8/12/2025 at 2:26 p.m., with Resident 10, Resident 10 stated having a wound on her (Resident 10) back. Resident 10 stated that she (Resident 10) did not have this wound upon admission to the facility. Resident 10 stated that the wound on her (Resident 10) back is starting to hurt, and that she (Resident 10) is in pain. Resident 10 further stated that a staff member (name unknown) applied something to the wound the previous day, but she (Resident 10) was unsure of what was applied. During an interview on 8/13/2025 at 8:15 a.m. with TN 1, TN 1 stated PA 1 evaluated Resident 10's wounds and completed debridement on the resident's sacrococcyx wound and she put Santyl as ordered. TN 1 stated she was also the one who placed the bordered gauze dressings on the resident on 8/13/2025. During an interview on 8/13/2025 at 8:17 a.m., with LVN 2, LVN 2 stated that she (LVN 2) has not yet started medication administration. LVN 2 stated that she (LVN 2) has not given any medications to Resident 10. LVN 2 further stated that she (LVN 2) plans to administer Resident 10's medications after Resident 10 has eaten and been changed. During a concurrent interview and record review on 8/13/2025 at 9:18 a.m., with LVN 2, Resident 10's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 8/2025 was reviewed. LVN 2 stated that tramadol (a pain medication used to treat moderate to severe pain) was administered to Resident 10 on 8/13/2025 at 3:08 a.m., and the last dose of Acetaminophen was given to Resident 10 in 6/2025. LVN 2 stated that she (LVN 2) has not administered any pain medication to Resident 10 during her shift. During an interview on 8/13/2025 at 2:47 p.m., with LVN 2, LVN 2 stated that the purpose of administering Acetaminophen to Resident 10 prior to wound treatment is for pain management. LVN 2 stated that TN 1 did not inform her (LVN 2) this morning (8/13/2025) that the wound treatment would be performed so she (LVN 2) did not administer the Acetaminophen. LVN 2 stated that Acetaminophen is given before wound treatment to help prevent Resident 10 from experiencing pain during the wound treatment. During a review of Resident 10's Wound Care Consultation Notes (WCCN) dated 8/13/2025, the WCCN indicated Resident 10 had the following wounds: 1.Sacral, Stage three pressure ulcer, size 4 cm x 2.7 cm x 0.2 cm, wound base granular (a wound in the process of healing) with exposed subcutaneous (under or beneath the skin), 40% slough, 60% granular, and excisional debridement. 2.Left buttock, Stage two pressure ulcer, size 1 cm x 0.4 cm x 0.1 cm, wound base granular with exposed dermis (middle layer of skin in your body). The WCCN indicated the following recommendations: 1.Wound #1, Sacral: to monitor/offload (removing or minimizing the pressure, weight, and force from a specific area of the body, such as a wound or a body part at risk of injury), foam, and Santyl. 2.Wound #2, Left Buttock: to monitor/offload and foam; Zinc cream (medication used to treat and prevent skin irritation) for moisture control, A&D ointment for skin maintenance, every two hours turning at all times while in bed; and apply heel protectors (device used to protect the heel of a resident's foot from pressure ulcers or pain caused by impact and friction) or keep heels floating or with pillows under legs at all times while in bed. During an interview on 8/15/2025 at 11:05 a.m., with TN 1, TN 1 stated that on 8/13/2025 prior to performing wound treatment, she (TN 1) has to verify with the charge nurse whether pain medication had been administered to Resident 10. TN 1 stated she (TN 1) does not recall if she (TN 1) confirmed Resident 10 received pain medication. TN 1 further stated that she (TN 1) proceeded with the wound treatment alongside PA 1 without verifying whether Resident 10 had received pain medication. During an interview on 8/15/2025 at 1:13 p.m., with the DON, the DON stated that pain medication should be provided to residents after residents' pain has been assessed and before wound treatment as ordered. The DON stated that pain medication is administered to residents to help minimize discomfort and manage pain during treatment procedures. During a review of the facility's policy and procedure (P&P) titled, Care and Prevention of Pressure Sores, last reviewed 4/16/2025, the P&P indicated the purpose of this P&P is to provide appropriate facility interventions to manage and prevent pressure sores. The P&P indicated that All available measure shall be taken to prevent skin breakdown and pressure sores. If these conditions occur, treatment is (continued on next page)

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Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be initiated immediately, and preventative measure taken to prevent further deterioration of the skin. The P&P indicated if a pressure sore develops The Charge Nurse is to immediately contact the physician for an order. The Charge Nurse and treatment nurse shall be responsible for the application of any prescribed medication or treatment. During a review of the facility's P&P titled, Care and Prevention of Pressure Sores, last reviewed on 4/16/2025, the P&P indicated the purpose of this P&P is to provide appropriate facility interventions to manage and prevent pressure sores. The P&P indicated that All available measure shall be taken to prevent skin breakdown and pressure sores. If these conditions occur, treatment is to be initiated immediately, and preventative measure taken to prevent further deterioration of the skin. The P&P indicated the general skin care for residents included Any staff member who notices any reddened area or breakdown in a resident's skin should report it immediately to the Charge Nurse. The Charge Nurse shall check the resident to ascertain the cause. The P&P indicated if a pressure sore develops The Charge Nurse is to immediately contact the physician for an order. The Charge Nurse and treatment nurse shall be responsible for the application of any prescribed medication or treatment. All residents with pressure sores are to be assessed daily for signs of infection.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure Treatment Nurse (TN) 1 demonstrated clinical competency and skills to care for residents at risk for pressure ulcers / injuries (PU / PI - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) reviewed under the Sufficient and Competent Nurse Staffing task. This deficient practice resulted in TN 1 failing to provide the necessary care to Resident 10 to prevent the development of PUs, when on 8/12/2025, Resident 10 was identified with a sacral (tailbone) stage three PU (full-thickness skin loss that extends through the skin into deeper tissue and fat but do not reach muscle, tendon or bone) and a left buttock stage two PU (partial thickness loss of skin, presenting as a shallow open sore or wound). Cross reference F686 Findings: During a review of Resident 10's admission Record (AR), the AR indicated that the facility admitted the resident on 6/2/2025 with diagnoses including unspecified sequelae (the long-term conditions that happen because of an illness or injury) cerebral infarction (stroke - loss of blood flow to a part of the brain), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), myocardial infarction type two (heart attack- occurs when the heart muscle doesn't get enough oxygen due to an imbalance between oxygen supply and demand, not caused by a blockage in the coronary arteries {blood vessel supplying blood to the heart}), generalized muscle weakness, and abnormalities of gait (manner of walking) and mobility (movement). During a review of Resident 10's History and Physical (H&P - comprehensive assessment conducted by a healthcare provider that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern), dated 6/2/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. The H&P indicated that Resident 10's integumentary (skin) was intact. During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool), dated 6/9/2025, the MDS indicated that Resident 10 has the ability to make self understood and has the ability to understand others. The MDS indicated Resident 10 required partial/moderate assistance from staff for bed mobility including rolling to the left and right. The MDS indicated Resident 10 was always incontinent of bowel and bladder. The MDS indicated Resident 10 had no unhealed pressure ulcer but was identified as being at risk for developing pressure ulcers. During a review of Resident 10's Wound Care Consultation Notes (WCCN) dated 8/13/2025, the WCCN indicated Resident 10 had the following wounds: 1.Sacral, Stage three pressure ulcer, size 4 cm x 2.7 cm x 0.2 cm, wound base granular (a wound in the process of healing) with exposed subcutaneous (under or beneath the skin), 40% slough, 60% granular, and excisional debridement. 2.Left buttock, Stage two pressure ulcer, size 1 cm x 0.4 cm x 0.1 cm, wound base granular with exposed dermis (middle layer of skin in your body). The WCCN indicated the following recommendations: 1.Wound #1, Sacral: to monitor/offload (removing or minimizing the pressure, weight, and force from a specific area of the body, such as a wound or a body part at risk of injury), foam, and Santyl. 2.Wound #2, Left Buttock: to monitor/offload and foam; Zinc cream (medication used to treat and prevent skin irritation) for moisture control, Vitamin A and Vitamin D ointment (A&D - a skin protectant used to treat and prevent diaper rash and minor skin irritations) for skin maintenance, every two hours turning at all times while in bed; and apply heel protectors (device used to protect the heel of a resident's foot from pressure ulcers or pain caused by impact and friction) or keep heels floating or with pillows under legs at all times while in bed. During a concurrent observation and interview on 8/12/2025 at 2:32 p.m., with TN 1, Certified Nurse Assistant 1 (CNA 1), and Certified Nurse Assistant 2 (CNA 2), at Resident 10's bedside (the place next to a resident's bed), CNA 1 and CNA 2 repositioned Resident 10 onto her (Resident 10) right side to change her (Resident 10) incontinence briefs. Two bordered gauze dressings were observed, one on Resident 10's left buttock and one on Resident 10's sacrococcyx area both without dates and staff initial. TN 1 removed (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the two bordered gauze dressings and stated Resident 10 has two open wounds. TN 1 stated that she (TN 1) does not know who applied the dressings on Resident 10. TN 1 then exited Resident 10's room. During a follow-up interview on 8/14/2025 at 10:08 a.m., with TN 1, TN 1 stated that on 8/12/2025 at 2:32 p.m., when TN 1 was asked whether she (TN 1) had performed the MASD treatment for Resident 10 as there were two bordered gauze dressings observed (one on Resident 10's left buttock and one on Resident 10's sacrococcyx area), and TN 1 responded that she (TN 1) did not know who applied the dressings, TN 1 stated she (TN 1) had misunderstood what was said and that she (TN 1) did not hear the State Agency (SA) correctly. TN 1 stated that she (TN 1) already did the MASD treatment to Resident 10 and that she (TN 1) was the facility staff who applied the two bordered gauze dressings on Resident 10. TN 1 stated that when she (TN 1) saw the two open wounds she (TN 1) panicked and left the room. TN 1 stated that she (TN 1) observed Resident 10's pressure ulcers on the left buttocks and sacrococcyx area on 8/14/2025 before 12 p.m. TN 1 stated that she (TN 1) did not know how Resident 10's wound occurred and that she intended to speak with the DON. TN 1 stated that she (TN 1) provided MASD treatment to Resident 10 on 8/11/2025. TN 1 further stated that she (TN 1) treated Resident 10's wound on the left and right buttocks extending into the perianal area really fast because Resident 10's family was there. TN 1 stated Resident 10 wore adult briefs. TN 1 stated that during the treatment on 8/11/2025 she (TN 1) did not remove Resident 10's brief and did not check Resident 10's skin to determine whether a wound was present or not. TN 1 stated that she did not assess Resident 10's left and right buttocks during the treatment. TN 1 stated that she (TN 1) only applied the barrier cream (A&D) to the resident's perianal area. TN1 further stated that she (TN 1) would not perform treatment if there was bowel movement or urine. TN 1 stated that she (TN 1) is supposed to remove the briefs and assess Resident 10's skin but did not do so. During an interview on 8/15/2025 at 9:58 a.m., with TN 1, TN 1 stated that on 8/12/2025 she (TN 1) applied the bordered gauze dressing on Resident 10 without a physician's order. TN 1 stated that the facility's protocol requires staff to report any new skin issues to the physician, obtain a treatment order, and then initiate the prescribed treatment. TN 1 stated that obtaining an order prior to administering wound care is important to ensure that the appropriate treatment is provided to promote healing. TN 1 further stated that it is not acceptable to administer wound treatment without a physician's order, as doing so could potentially worsen the wound. During a concurrent interview and record review on 8/15/2025 at 9:47 a.m. with the Director of Staff Development (DSD - a licensed nurse that provides education and training designed to increase the professional knowledge and skills of staff members), the DSD reviewed TN 1's employee file and noted the following: 1.TN 1 became a licensed vocational nurse on 6/20/2012 and was hired by the facility on 2/1/2017. 2.There was no documented evidence that TN 1 completed a clinical skills competency assessment (process of evaluating a healthcare professional's abilities and knowledge in performing clinical tasks effectively and safely) specific for the care of residents with pressure injuries. During a concurrent interview and record review on 8/14/2025 at 2:30 p.m. with the Director of Nursing (DON), TN 1's employee file was reviewed. The DON stated TN 1 had a previous Performance Correction Notice on 8/26/2024 indicating TN 1 provided treatments to residents without a physician's order. The DON stated the DON was aware that TN 1 again provided care to Resident 10 without a physician's order, just like TN 1 did before. During a review of TN 1's Performance Correction Notice, dated 8/26/2024, the Performance Correction Notice indicated TN 1 failed to follow the facility policy and procedures. TN 1 discontinued and removed a resident indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) without a physician's order. TN 1 was placed on a Performance Improvement Plan to perform duties following professional standards of practice, follow physician's orders as required, and would not initiate any plan of care without a physician's order. During a follow-up interview on 8/15/2025 at 2:58 p.m., with the DON, the DON stated the lack of demonstration of skills and care provided by TN 1 to Resident 10 could have contributed to the development and worsening of PUs in the resident. The DON stated the DON identified TN 1 was not telling the truth and provided a PU treatment without obtaining a (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's order which could result in the wrong treatment being provided to the resident. The DON stated TN 1 was not a competent TN because TN 1 failed to identify, report, and prevent PUs in Resident 10. During a review of TN 1's LVN Job Description, signed by TN 1 on 2/1/2017, the job description indicated that the position is responsible for assuring physician's orders are followed and quality of care is provided on each shift. The Job description further indicated to assure each resident is given care to prevent formation and progression of pressure sores including carrying out physician's orders for treatment of PUs. The Job Description indicated to perform the job successfully, an individual should exhibit sound and accurate judgment, make timely decisions, follow policy and procedures, and the ability to apply common sense understanding to carry out instructions. During a review of the facility's policy and procedure (P&P) titled, Job Description and Performance Evaluation, last reviewed 4/15/2025, the P&P indicated each employee will receive a copy of his/her job description prior to his/her performance of assigned tasks. The primary purpose of job descriptions is to provide uniform standards for the implementation of job requirements. It is the responsibility of the director of human resources and or the respective department director to review with each employee a copy of the employee's job description to determine if the essential functions of the job can be performed.

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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. Based on observation, interview, and record review, the facility failed to accurately account for one dose of tramadol (a controlled medication used to treat pain) 50 milligrams (mg - a unit of measure for mass) affecting Resident 112 in one of five inspected medication carts (Station 3 Cart). This deficient practice increased the risk of diversion (any use other than that intended by the prescriber) of controlled mediations (medications with a high risk for diversion) and the risk that Resident 112 could have received too much or too little medication due to lack of documentation possibly resulting in serious health complications requiring hospitalization. Findings: During a concurrent observation and interview on 8/12/29 at 1:29 PM with the Licensed Vocational Nurse (LVN) 4, at Station 3 Cart, the following discrepancies were found between the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): 1.Resident 112's Controlled Drug Record for tramadol 50 mg indicated there were two doses left, however, the medication card contained one dose. During an interview on 8/12/2025 at 1:34 PM with LVN 4, LVN 4 stated she administered the missing dose of tramadol to Resident 112 today around 10:40 AM. LVN 4 stated she failed to sign the Controlled Drug Record at that time due to being busy with other tasks. LVN 4 stated she is required to sign the log immediately after the medication is removed from the bubble pack. LVN 4 stated failing to sign for the narcotics increases the risk of accidental overdose if it is given to the residents too often which could result in medical complications. LVN 4 stated failing to sign out used doses of controlled medications also increases the risk for diversion.ˆ During a review of the facility's policy and procedure (P&P) titled, Controlled Medications, dated April 2008, the P&P indicated When a controlled medication is administered, the licensed nurse administering the medications immediately enters the following information on the accountability record and the medication administration record (MAR): .Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one used single-dose vial of testosterone injection (a medication used to supplement testosterone) was discarded after use affecting Resident 170 in one of five inspected medication carts (Station 4 Cart.) This deficient practice of failing to discard used single-dose vial of testosterone increased the risk that Resident 170 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications such as infection resulting in hospitalization or death. Findings: During a concurrent observation and interview on [DATE] at 1:51 p.m. of Station 4 Cart with the Licensed Vocational Nurse (LVN) 6, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1.One opened single-dose vial of testosterone injection for Resident 170 was found in the medication cart with half the contents missing. According to the product labeling, single-dose vials of testosterone injection should be discarded after use. During a concurrent interview, LVN 6 stated the testosterone vials for Resident 170 are single-dose vials meaning that they must be discarded after each use. LVN 6 stated the open vial for Resident 170's testosterone should have been discarded after its last use and not kept in the medication cart. LVN 6 stated using medication from a single dose vial more than once increases the risk that the resident could develop an infection from the injection because the preparation is not preserved. LVN 6 stated this could cause medical complications possibly resulting in hospitalization.^ During a review of the facility`s policy and procedure (P&P) titled Medication Storage in the Facility, revised [DATE], the P&P indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications. are immediately removed from stock, disposed of according to procedures for medication disposal. During a review of the facility`s policy and procedure titled Vials and Ampules of Injectable Medications, revised [DATE], the P&P indicated Ampules and single-use vials (containing no preservative) are discarded immediately after use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 safe and sanitary food storage and food preparation practices in the kitchen when the facility failed to label one opened bag of mini tortillas with an opened date. This deficient practice had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in residents who received food from the kitchen. Findings: During a concurrent observation and interview on 8/11/2025 at 7:46 a.m. with the Dietary Supervisor (DS), the DS stated the one bag of mini tortillas with no opened date should have an open date. During an interview on 8/15/2025 at 3:18 p.m. with the DS, the DS stated they put an open date for open containers to monitor expiration date and for food safety and prevent contamination. During a review of the facility's policy and procedure titled, Dating and Labeling, last reviewed 4/16/2025, the P&P indicated it is the facility's policy To ensure food safety and prevent contamination within the facility, all food items should be properly covered, dated, and labeled in dry storage and refrigerator/freezer areas. The P&P indicated that All items should properly covered, dated, and labeled. Food items should have the following appropriate dates. b. Open date - opened containers of potentially hazardous foods (PHF-foods that require time-temperature control to keep them safe for human consumption).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were maintained in accordance with professional standards that are complete and accurately documented when the facility failed to: Ensure Resident 15's Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) Progress Note dated 8/1/2025 was not signed by an occupational therapist (OT, rehabilitative professional that provides services to increase and/or maintain a person's capability to participate in everyday life activities). This failure had the potential for incomplete and inaccurate medical documentation. Findings: During a review of Resident 15's admission Record (AR), the AR indicated Resident 15 was admitted to the facility on [DATE], with diagnoses including but not limited to metabolic encephalopathy (any damage or disease that affects the brain), and dysphagia (difficulty swallowing). During a review of Resident 15's Minimum Data Set (MDS, resident assessment tool) dated 7/30/2025, the MDS indicated Resident 15 had severe cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS also indicated Resident 15 required dependent assistance with oral hygiene, showering, dressing, rolling, and shower transfers. The MDS indicated Resident 15 received three days of Physical Therapy in the last seven days. During a review of Resident 15's Order Summary Report (OSR), the OSR indicated an order dated 7/25/2025 for Clarification of PT order four times a week for four weeks. During a review of Resident 15's PT Progress Report (PTPR) dated 8/1/2025, the PTPR indicated the PT progress report was signed on 8/1/2025 by the Director of Rehabilitation (DOR), who is an occupational therapist on behalf of Physical Therapist (PT) 2. During an interview and record review of Resident 15's PTPR dated 8/1/2025, the DOR stated PT 2 did not sign the PTPR, but DOR did on PT 2's behalf. DOR stated the standard of practice for medical documentation was that if the therapist completed a medical note or documentation such as a PTPR, the same therapist should sign the note. DOR stated another therapist should not have to sign another therapist's note or documentation, because there can be potential for inaccurate documentation and know who documented on the record. During a phone interview on 8/14/2025 at 1:29 p.m., PT 2 stated he completed Resident 15's PTPR dated 8/1/2025. However, PT 2 did not have time to sign the document and asked the DOR to sign the document on his behalf. PT 2 stated the professional standard for completing medical documentation was that the PT who completed the documentation should also be the same PT to sign the document. PT 2 stated it was not acceptable professional standards to have another therapist sign his notes and documentation on his behalf. During an interview on 8/14/2025 at 3:00 p.m., the Director of Nursing (DON) stated any staff that completed medical documentation should sign the same document. DON stated another staff member should not sign any medical documentation on behalf of another staff member. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed on 4/16/2025, the P&P indicated documentation in the medical record will be objective, complete, and accurate.and will include the signature and title of the individual documenting. During a review of the facility's Physical Therapist Job Description dated 11/23/2022, the PT Job Description indicated essential responsibilities and expectations include record weekly progress notes, 14-day progress notes per facility policy and procedure.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement its policy for antibiotic (medication used to treat infection) stewardship (efforts in long-term care facilities to ensure that antibiotics are used only when necessary and appropriate [means prescribing the right drug at the right dose at the right time for the right duration]) program and infection prevention and control program for one of one sampled resident (Resident 6) by: 1.Failing to complete the Surveillance Data Collection Form (a checklist used in nursing homes to help healthcare workers identify if a resident actually has a significant infection, rather than just having symptoms) for Respiratory Infections that the resident met the criteria for the use of antibiotic. 2.Failing to monitor Resident 6 for the adverse effects (undesired or harmful effects) of ceftriaxone (antibiotic medication used to treat infection) while receiving the medication. These failures had the potential to increase antibiotic resistance (when bacteria develop the ability to withstand the effects of antibiotics, making it difficult or impossible to treat infections) from unnecessary or inappropriate antibiotic use and had the potential for Resident 6 to experience an unmonitored adverse reaction. Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted in the facility on 3/11/2025 and readmitted in the facility on 6/4/2025 with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 6's History and Physical (H&P), dated 6/5/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 6/18/2025, the MDS indicated Resident 6 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), required total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily), and had impairment on bilateral (both) upper extremity (BUE - arms and hand) and bilateral lower extremities (BLE - legs and feet). The MDS indicated Resident 6 received antibiotic therapy. During a review of Resident 6's Order Summary Report, dated 7/31/2025, the Order Summary Report indicated the following physician's orders: -8/9/2025: Stat (immediately in healthcare context) complete blood count (CBC - a blood test to look at overall health to help determine conditions including infection and blood disorders), basic metabolic panel (BMP - a blood test that provides information about the body's chemical balance, metabolism, kidneys, calcium, protein, liver), and chest x-ray (CXR - a test that uses radiation to create an image of the heart, lungs and bones to determine health conditions). -8/10/2025: ceftriaxone sodium solution one gram (gm - a unit of measurement) intravenously (into the vein) one time a day for atypical pneumonia (a milder, less severe form of lung infection) for seven days. During a review of Resident 6's care plan (CP) on risk for possible side effects or adverse reactions related to antibiotic therapy, initiated on 8/10/2025, the CP indicated to assess for signs and symptoms of adverse reactions or side effects and notify the physician as indicated. During a review of Resident 6's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 8/13/2025, the MAR indicated Resident 6 received the first dose of ceftriaxone on 8/10/2025 at 8 a.m. and the last day to receive the antibiotic was scheduled on 8/16/2025. During a review of Resident 6's CXR result, dated 8/9/2025, the CXR result indicated one of the conclusions as atypical pneumonia. During a review of Resident 6's CBC result, dated 8/9/2025, the CBC result indicated a white blood count (WBC - a type of blood cell in the blood that helps the body fight infections and other diseases) result of 16.2 (the normal range for adult men is 4.5 to 11 uL [microliter - a unit of measurement for volume] and the normal range for adult women is four to 10 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uL) uL. During a concurrent interview and record review on 8/13/2025 at 10:57 a.m. with the Infection Preventionist (IP), Resident 6's physician's orders, Surveillance Data Collection Form for Respiratory Infections, care plan, CXR result, CBC result, MAR, SBAR/COC (situation, background, assessment, recommendation/change of condition - a communication tool used by healthcare workers when there is a change of condition among the residents), and licensed nurses notes were reviewed. The IP stated Resident 6's Survey Data Collection Form for Respiratory Infection was incomplete and was missing the three criteria required that the resident actually had an infection rather than a symptom. The IP stated the three criteria Resident 6 met in the surveillance form was that the resident had a CXR indicating atypical pneumonia, had desaturation (refers to low oxygen levels in the blood), and a WBC level of 16.2 which is above the normal value. The IP stated the Surveillance Data Collection Form should have been completed to ensure the antibiotic use on Resident 6 was appropriate which may lead to development of resistance to most antibiotics which makes the infections harder to treat. The IP stated the surveillance form should have been completed so all the staff involved in Resident 6's care were aware of the reason for the use of antibiotic. The IP stated nurses monitor residents for the adverse effects of antibiotics every shift until three days after the completion of antibiotic dose and should be documented in the licensed nurses' notes. The IP stated if residents were not monitored for the adverse effects of antibiotics, residents could have adverse reaction, which could result in delay in physician notification and delay in resident care. The IP stated there was no documented monitoring for the adverse effects of ceftriaxone in Resident 6's licensed nurses' notes on the following dates and times: -8/10/2025 and 8/12/2025 7 a.m. to 3 p.m. shift -8/10/2025, 8/11/2025, and 8/13/2025 3 p.m. to 11 p.m. shift -8/11/2025, 8/12/2025, and 8/13/2025 11 p.m. to 7 a.m. shift During an interview on 8/15/2025 , 3 p.m., with the Director of Nursing (DON), the DON stated the Surveillance Data Collection Form are completed by the licensed nurse (LN) who received the antibiotic order from the physician and the IP checks that the form was completed to ensure the antibiotic use on the resident is appropriate. The DON stated the LN are supposed to monitor the residents for signs and symptoms of side effects or adverse reactions for the use of antibiotics every shift and documented in the LN notes for the duration of the antibiotics plus another three days after completion. The DON stated the LN should have monitored Resident 6 for signs and symptoms of side effects or adverse reactions to ensure Resident 6 was tolerating the use of ceftriaxone so the physician can be notified immediately and prevent delay in the care the resident needs. The DON stated Resident 6's Surveillance Data Collection Form, dated 8/10/2025, should have been completed and checked by the IP to ensure the antibiotic use on Resident 6 was appropriate and that the resident had a true infection as it placed Resident 6 at risk for developing resistance to most antibiotics which makes the infections harder to treat. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic use and Outcomes, last reviewed on 4/16/2025, the P&P indicated: -Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for the improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. -All clinical infections treated with antibiotic will undergo review by the IP or designee. -The IP or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. -All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The info gathered will include: e. Start date of antibiotic i. stop date k. outcome l. adverse events During a review of the facility's P&P titled, Charting and Documentation, last reviewed on 4/16/2025, the P&P indicated: -All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition shall be documented in the resident's medical record. -The following information is to be documented in the resident medical record: b. Medications administered f. Progress toward or changes in the care plan goals and objectives

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain mechanical, electrical, and resident care equipment in safe operating condition for two of six sampled residents (Residents 44 and 92) reviewed under the environment task by failing to ensure the residents' bed controller (device used to change the height and angle of the bed) cord did not have frayed or exposed wires. This deficient practice had the potential to place the residents at risk of incurring injury. Findings: a. During a review of Resident 44's admission Record, the admission Record indicated the facility originally admitted Resident 44 on 10/5/2020 and readmitted in the facility on 4/10/2022, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 44's History and Physical (H&P), dated 5/10/2025, the H&P indicated Resident 44 did not have the capacity to understand and make decisions. During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 44 was not able to understand others and make his needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 44 required total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 8/11/2025 at 10:06 a.m. inside Resident 44's room with Licensed Vocational Nurse (LVN) 9, Resident 44 laid in bed with the bed control box next to the resident's right hand. LVN 9 stated Resident 44's bed control was placed next to the resident's left hand, and the base of the bed control had exposed wires. LVN 9 stated if staff observed any equipment in the resident room that is in disrepair, the maintenance department should be notified as soon as possible to have the bed control replaced. LVN 9 stated the maintenance department should have been notified by the staff to change Resident 44's bed control as soon as possible because the exposed wires placed Resident 44 at risk for electrocution which may lead to injury. b. During a review of Resident 92's admission Record, the admission Record indicated the facility originally admitted Resident 92 on 11/4/2019 and readmitted in the facility on 10/11/2024, with diagnoses including respiratory failure, tracheostomy, seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 92's H&P, dated 10/12/2024, the H&P indicated Resident 92 was incapacitated (refers to a person's inability to manage their own affairs due to physical or mental limitations). During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92 was sometimes able to understand others and make his needs known and had severely impaired cognition. The MDS further indicated Resident 92 required total assistance from staff with all ADLs. During a concurrent observation and interview on 8/12/2025 at 7:45 a.m. inside Resident 92's room with LVN 7, Resident 92 laid in bed with the bed control next to the resident's right side and the bed control cord, wrapped around the right-side rail, had exposed wires. LVN 7 stated the base of Resident 92's bed control box and the cord wrapped around the right siderail had the wires exposed. LVN 7 stated if staff observed any equipment in the resident room is in disrepair, the maintenance department should be notified as soon as possible to have the bed control and cord replaced. LVN 7 stated the maintenance department should have been notified by the staff to change Resident 92's bed control as soon as possible as the exposed wires placed Resident 92 at risk for accidents such as electric shock which may lead to injury. During an interview on 8/15/2025, at 11:54 a.m., with the Director of Nursing (DON), the DON stated there should be no frayed/exposed wires on all the residents' bed controller to prevent accidents such as electrical shock on the residents. The DON stated that the staff during their (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident rounds should identify hazards that can cause harm to residents and notify the maintenance department immediately. The DON stated upon observation of Resident 44 and Resident 92's bed control with frayed/exposed wires, the staff should have reported the incident to the maintenance department for immediate replacement as Resident 44 and Resident 92 can come in contact with the bed control and cause an accident such as electric shock which may lead to Resident 44 and/or Resident 92 incurring an injury. During a review of the facility's recent policy and procedure (P&P) titled Maintenance Service, last reviewed on 4/16/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P further indicated maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 4/16/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P further indicated: -Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. -Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. -Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: g. Electrical safety.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure five of 33 sampled residents received an accurate Minimum Data Set (MDS - a comprehensive resident assessment tool) by failing to: 1. Complete assessment Section I (active diagnoses), by failing to include diagnoses of mood disorder (a mental illness characterized by having rapid changes in mood from depression to mania) per information in the medical record for two of five residents sampled for unnecessary medications (Resident 15 and 107). 2. Accurately code Section O for therapy (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) minutes and days provided for one of six sampled residents (Resident 32). 3. Accurately code Section O for days of Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) range of motion (ROM, movement at a given joint) technique and application of splints provided for two of six sampled residents (Resident 85 and 6). The deficient practice of failing to accurately assess active diagnoses and complete MDS Section I increased the risk that Residents 15 and 107 may not have received care planning and treatment according to his needs possibly leading to a decline in his overall health and well-being. The deficient practices also had the potential to cause confusion, inaccurate care planning and delay in delivery of necessary care and services for Residents 32, 85, and 6. Findings: a. During a review of Resident 15's admission Record (a record containing diagnostic and demographic resident information), dated 8/13/2025, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including unspecified mood disorder. During a review of Resident 15's History and Physical (H&P, a record of a physician's comprehensive medical examination), dated 7/23/25, the H&P indicated the resident did not have capacity to understand and make medical decisions. During a review of Resident 15's Order Summary Report (a summary of all active physician's orders), dated 7/31/25, the Order Summary Report indicated the resident was receiving Depakote 250 milligrams (mg – a unit of measure for mass) via gastrostomy tube (g-tube – a tube surgically implanted into the stomach for the administration of medication and nutrition) twice daily for mood disorder manifested by recurrent behavior fluctuations from depressed behavior to manic behaviors and vice versa. During a review of Resident 15's Interdisciplinary Team (IDT – a team of healthcare professionals from various backgrounds that meets periodically to determine a resident's plan of care) conference documentation, dated 7/25/2025, the documentation indicated Depakote was prescribed pertaining to a diagnosis of bipolar disorder/mood disorder. During a review of Resident 15's MDS assessment Section I (active diagnoses), dated 7/30/2025, the MDS indicated he did not have an active diagnosis of bipolar disorder or mood disorder. b. During a review of Resident 107's admission Record, dated 8/13/2025, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including unspecified mood disorder. During a review of Resident 107's History and Physical dated 4/16/2025, the H&P indicated the resident had a mood disorder and did not have capacity to understand and make medical decisions. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of Resident 107's psychiatric note (a medical progress assessment written by a psychiatric care provider) dated 5/14/2025, the note indicated Resident 107's primary psychiatric diagnosis was unspecified mood disorder. During a review of Resident 107's Order Summary Report, dated 7/31/2025, the Order Summary report indicated the resident was receiving Depakote ER 250 mg by mouth three times daily for mood disorder manifested by recurrent behavior fluctuations from depressed behavior to manic behaviors and vice versa. During a review of Resident 107's MDS assessment Section I (active diagnoses), dated 7/23/2025, the MDS indicated the resident did not have an active diagnosis of bipolar disorder or mood disorder. During an interview on 8/13/2025 10:58 a.m. with the Director of Nursing (DON), the DON stated Section I of the facility's comprehensive admission assessment, dated 7/30/2025 for Resident 15, and 7/23/2025 for Resident 107 does not include mood disorder or bipolar disorder as a diagnosis despite record of such a condition in their clinical records. The DON stated this is an error in the MDS assessment and could possibly lead to care planning being incomplete, leading to a decline in their quality of life. During a review of the facility's undated policy and procedure titled Resident Assessment, the policy and procedure indicated .Assessment (admission, quarterly, annual, significant change) will be completed as per the RAI instructions/guidelines. Sources of information to complete the MDS/RAI: a. Review of resident's records. c. During a review of Resident 32's admission Record (AR), the AR indicated Resident 32 was admitted to the facility on [DATE], with diagnosis including but not limited to acute respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) and functional quadriplegia (loss of movement including legs, and arms). During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32 had intact cognition (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS Section O – Special Treatments, Procedures, and Programs for 0400 Therapies indicated zero and blank for minutes and days of Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) provided in the last seven days and indicated zero and blank for minutes and days of Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) provided in the last seven days. During a review of Resident 32's OT Discharge summary dated [DATE] indicated Resident 32 was receiving skilled OT services from 6/3/2025 to 7/24/2025. During a review of Resident 32's PT Discharge summary dated [DATE] indicated Resident 32 was receiving skilled PT services from 6/3/2025 to 7/24/2025. During an interview and record review on 8/14/2025 at 8:58 a.m., Minimum Data Set Coordinator (MDSC) and Minimum Data Set Nurse (MDSN 1) stated MDS staff did not input any therapy minutes or days in MDS, because they were told they did not have to unless the residents were on a certain type of insurance. MDSC and MDSN 1 stated MDS staff should follow the Resident Assessment Instrument (RAI) Manual to accurately code the MDS. MDSN 1 reviewed the RAI Manual and stated the MDS (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Section O400 Therapies indicated the MDS needed to record the total number of minutes of speech therapy (profession that identifies, assesses, and treats speech, language, cognitive communication and swallowing disorders), occupational therapy, and/or physical therapy was administered to the resident individually in the last seven days and the number of days the therapy was administered at least 15 minutes in the last seven days. MDSC reviewed Resident 32's medical records and stated Resident 32 was receiving both Physical Therapy and Occupational Therapy during the seven days prior to 7/2/2025 and the number of minutes of OT and PT and days provided should be recorded in the MDS. MDSC stated the MDS was not accurate and MDSC stated the facility should make revisions in the MDS. During an interview on 8/14/2025 at 3:00 p.m., the Director of Nursing (DON) stated the MDS needed to be accurate because it was an assessment that painted a picture of the resident including the diagnosis and what the facility was providing to the resident. DON stated the facility should follow the RAI Manual to complete the MDS accurately. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment, last reviewed on 4/16/2025, the P&P indicated the MDS assessment will be completed as per the RAI instructions/guidelines. d. During a review of Resident 85's admission Record (AR), the AR indicated Resident 85 originally admitted to the facility on [DATE], and readmitted to the facility on [DATE], with diagnoses including, but not limited to heart failure (condition in which the heart has difficulty pumping enough blood to keep up with demands of body), polyosteoarthritis (swelling and tenderness of a joint causing pain and stiffness), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 85's MDS dated [DATE], the MDS indicated in Section O – Special Treatments, Procedures, and Program 0500 Restorative Nursing Program indicated zero days of RNA performed in the last seven calendar days for at least 15 minutes a day for active ROM. The MDS indicated for Section O0500 Restorative Nursing Programs to record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last seven calendar days (enter 0 if none or less than 15 minutes daily). During a review of Resident 85's Order Summary Report (OSR) indicated an order dated 11/1/2023 for RNA nursing program established for active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) for both upper extremities (BUE, shoulder, elbow, wrist/hand) and both lower extremities (BLE, hip, knee, ankle/foot) as tolerated followed by sitting at edge of bed as tolerated five times a week. During a review of Resident 85's Care Plan Report (CP), the CP dated 11/1/2023 indicated Resident 85 had a limitation in range of motion (ROM, full movement potential of a joint)/contractures (loss of motion of a joint) and balance. The CP goal was to minimize complication related to decreased mobility or contracture through appropriate interventions through the next assessment. The CP intervention indicated RNA for AAROM to BUE and BLE as tolerated five times a week and sitting edge-of-bed as tolerated five times a week. During a review of Resident 85's July 2025 Documentation Survey Report (DSR) for RNA daily documentation, the DSR indicated Resident 85 received 15 minutes of AAROM for BUE and BLE on 7/25/2025, 7/28/2025, 7/29/2025, and 7/31/2025 (four days). (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation and interview on 8/12/2025 at 11:11 a.m., Resident 85 was lying in bed. Resident 85 was able to move both arms and legs a little in bed. During an interview and record review on 8/14/2025 at 8:58 a.m., Minimum Data Set Coordinator (MDSNC) stated it was important for the MDS to be accurate so that the facility could meet the resident's needs. MDSNC stated the facility should follow the Resident Assessment Instrument (RAI) Manual and follow the directions to accurately code and complete the MDS. MDSNC reviewed Resident 85's MDS dated [DATE] and stated under Section O 0500, the number of days AROM was performed with Resident 85 was zero. MDSNC reviewed Resident 85's July 2025 DSR RNA daily documentation and stated the DSR indicated Resident 85 received 15 minutes of AAROM for BUE and BLE on 7/25/2025, 7/28/2025, 7/29/2025, and 7/31/2025 and the MDS should have been coded as four days and not zero. MDSNC stated MDS staff should follow the RAI Manual instructions to accurately code the MDS and provide an accurate picture of the treatments and programs Resident 85 was receiving. During an interview on 8/14/2025 at 3:00 p.m., the Director of Nursing (DON) stated the MDS needed to be accurate because it was an assessment that painted a picture of the resident including the diagnosis and what the facility was providing to the resident. DON stated the facility should follow the RAI manual to complete the MDS accurately. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment, last reviewed on 4/16/2025, the P&P indicated the MDS assessment will be completed as per the RAI instructions/guidelines. e. During a review of Resident 6's admission Record, the admission Record indicated the facility originally admitted Resident 6 on 3/11/2025, and readmitted in the facility on 6/4/2025, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 6's History and Physical (H&P) dated 6/5/2025, the H&P indicated Resident 6did not have the capacity to understand and make decisions. During a review of Resident 6's MDS assessment dated [DATE], the MDS assessment indicated Resident 6 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and had impairment on BUE and BLE. The MDS assessment did not indicate Resident 6 received RNA PROM and application of bilateral hand splints, bilateral knee splints, and bilateral AFOs on BUE and BLE during the last 7 days from the assessment date of 6/18/2025. During a review of Resident 6' Order Summary Report dated 7/31/2025, the Order Summary Report indicated the following physician's order: -6/5/2025: Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility)/nursing program for PROM for BUE and BLE as tolerated followed by bilateral hand splints (a device that supports the hand), bilateral knee splints (a device that supports (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555686	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	the knees) and bilateral ankle foot orthosis (AFO - a brace that supports your foot and ankle to help improve alignment) for four (4) to six (6) hours or as tolerated. Every day seven (7) per week. During a concurrent interview and record review on 8/15/2025 at 8:55 a.m., reviewed Resident 6's MDS assessment dated [DATE], Order Summary Report, and RNA Documentation Survey Report v2 with the MDS Nurse Coordinator (MDSNC). The MDSNC stated Resident 6's RNA Documentation Survey Report v2 indicated Resident 6 received RNA/nursing program since readmission from the hospital on 6/5/2025. The MDSNC stated the MDS assessment dated [DATE] did not indicate Resident 6 received at least 15 min of RNA/nursing program. The MDSNC during the assessment period, the MDSNC checks the RNA documentation on how many minutes the residents tolerated during their RNA program. The MDSNC stated if the resident tolerated at least 15 minutes of the RNA program, it is counted as one day. The MDSNC stated Resident 6's MDS assessment should have indicated seven instead of zero (0) and was not coded accurately. The MDSNC stated the MDS assessment should be coded accurately as it presents a clinical picture of the resident and the type of care and services the resident is receiving in the facility. During a concurrent interview and record review on 8/15/2025 at 9:10 a.m., reviewed Resident 6's RNA Documentation Survey Report v2 form for 6/2025 with Restorative Nursing Assistant (RNA) 3. RNA 3 stated the RNA Documentation Survey Report v2 form for 6/2025 indicated Resident 6 received RNA PROM exercises for at least 15 minutes and application of splints for four (4) to six (6) hours as ordered by the physician since readmission from the hospital on 6/5/2025. During an interview on 8/14/2025 at 3:00 p.m. with the Director of Nursing (DON), the DON stated it was important for the MDS assessment to be accurate because the MDS is an assessment of the resident and paints a picture of who the resident is and the treatments and services the facility is providing to the resident. The DON stated the MDS staff should base their assessment according to the Resident Assessment Instrument (RAI – a comprehensive guide for completing the resident assessment and develop individualized care plans) manual and follow it to accurately code MDS. The DON stated if a resident received at least 15 min of RNA program prescribed by the physician, that is already considered 1 calendar day. The DON stated resident 6's MDS assessment should have been coded accurately to reflect the resident received the RNA program order by the physician during the assessment period to avoid confusion which may lead to delay in the care and services Resident 6 needed. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment, last reviewed on 4/16/2025, the P&P indicated the following: -Guideline: 3. Schedule and completion of MDS: Assessment (admission, quarterly, annual, significant change) will be completed as per the RAI instructions/guidelines. 4. Sources of Information to complete MDS/RAI: a. Review of resident's record c. Observe the resident

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of 65 resident rooms (room [ROOM NUMBER]) accommodated no more than four residents per room. room [ROOM NUMBER] measured 418.5 square feet (sq. ft. - a unit of area measurement) and had five beds inside the room. This deficient practice had the potential to result in inadequate usable living space for the residents and working space for the healthcare staff. Findings: During an observation on 8/11/2025 at 10:10 a.m., room [ROOM NUMBER] had five beds. room [ROOM NUMBER] had five residents residing in the room. room [ROOM NUMBER] had ample space for beds, overbed tables, dressers, equipment, and there was sufficient space for the provision of necessary care and services. Residents reported no issues regarding room size. During an interview on 8/11/2025 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated there were no concerns regarding room [ROOM NUMBER]'s size. During a review of a Letter regarding a written request for a continued room waiver, submitted by the Administrator on 8/15/2025, the Letter indicated that room [ROOM NUMBER] had five beds. During a review of the Client Accommodation Analysis Form, dated 8/15/2025, the Client Accommodation Analysis Form indicated room [ROOM NUMBER] had an approved capacity of five residents and measured 418.5 sq. ft. During a review of the facility policy titled, Bedrooms, last reviewed 4/16/2025, the policy indicated all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft. - unit of area measurement) per resident in multiple resident bedrooms for three out of 65 resident rooms (rooms [ROOM NUMBER]). room [ROOM NUMBER] had four beds and measured 290.93 sq. ft., room [ROOM NUMBER] had three beds and measured 215.2 sq.ft., and room [ROOM NUMBER] had three beds and measured 213.58 sq. ft. This deficient practice had the potential to result in inadequate useable living space for the residents and inadequate working space for healthcare staff. Findings: During a review of the Letter regarding a request for a room size waiver, submitted by the Administrator and dated 8/15/2025, the Letter indicated rooms [ROOM NUMBER] did not meet the 80 sq. ft per resident room requirement per federal regulation. The shape of the room, size, and location of the resident beds were in accordance with the special needs of the residents and would not adversely affect the residents' health and safety and did not impede the ability of residents in that room to obtain their highest practicable wellbeing. During a review of the Client Accommodation Analysis Form, dated 8/15/2025, the Client Accommodation Analysis Form indicated the following rooms provided less than 80 square feet per resident: -room [ROOM NUMBER], with 4 Beds, measured 290.93 sq. ft., equaling 72.7 sq. ft per resident -room [ROOM NUMBER], with 3 Beds, measured 215.2 sq. ft., equaling 71.7 sq. ft per resident -room [ROOM NUMBER], with 3 Beds, measured 213.58 sq. ft., equaling 71.2 sq. ft per resident The minimum square footage for a 3-bed room is 240 sq. ft. The minimum square footage for a 4-bed room is 320 sq ft. During the general observation of the residents' rooms on 8/11/2025 and 8/12/2025, the residents had ample space to move freely inside the rooms. There was sufficient space to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There was also sufficient space for beds, side tables, and resident care equipment. During interviews with staff on 8/15/2024 at 11:38 a.m., there were no concerns regarding the size of rooms 19, 22, or 23. During a review of the facility policy titled, Bedrooms, last reviewed 4/14/2025, the policy indicated all residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements. Bedrooms measure at least 80 square feet of space per resident in shared rooms, and at least 100 square feet of space in singles rooms.