

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555688	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Point		STREET ADDRESS, CITY, STATE, ZIP CODE 3415 W Ball Road Anaheim, CA 92804	
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of five sampled residents for unnecessary medications (Residents 2, 6, and 13), and three of 29 final sampled residents (Residents 3, 11, and 61) reviewed for informed consents were provided the right to self-determination regarding the use of the psychotropic medications and treatments. * The facility failed to ensure Resident 2's informed consent for the quetiapine (antipsychotic medication) was signed by the resident or resident's representative. In addition, the facility failed to ensure Resident 2's informed consent for the trazadone medication was verified by two licensed nurses when the resident's representative gave consent via telephone. * The facility failed to ensure Resident 3's informed consents for the duloxetine and escitalopram (antidepressant) medications showed whether the duloxetine and escitalopram medications were off-label use, and FDA-approved use. * The facility failed to ensure Resident 6's informed consent for the quetiapine medication included the diagnosis, manifested behavior, and duration for the use of the medication as per the physician's order. * The facility failed to ensure Resident 11's informed consent for the alprazolam (antianxiety) medication was signed by the resident or resident's representative. * The facility failed to ensure Resident 13's informed consent for the trazodone (antidepressant) medication was signed by the resident. In addition, the facility failed to ensure Resident 13's informed consent for the clonazepam (antianxiety) medication showed whether the clonazepam medication was off-label use and FDA-approved use * The facility failed to ensure Resident 61's informed consents for duloxetine (antidepressant) and trazodone medications showed the caution and warning summary to show whether the duloxetine and trazodone medications had any off-label use, FDA-approved use, and black box warning label. These failures posed the risk of the residents receiving the psychotropic medications without a valid informed consent resulting in a loss of autonomy and self-determination regarding treatment decisions, and the risk of the residents and their responsible parties not understanding the required information related to the use of psychotropic medications. Findings: 1. Review of the AFL 25-38.1, titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed effective 1/1/26, the Psychotherapeutic Drug Informed Consent Form or equivalent in-house form must be used for new residents, residents being prescribed a new psychotherapeutic drug, or residents having a psychotherapeutic drug dosage change. The Psychotherapeutic Drug Informed Consent Form Instruction Sheet showed, under the Caution and Warning Summary section, it is required to answer yes or no for each item (a) off-label use, (b) (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident 13 was administered the trazodone medication from 6/1 to 6/17/26, at 2100 hours; and - Resident 13 was administered the clonazepam medication on 6/2/26 at 0529 and 2050 hours, and on 6/3/26 at 1726 hours. On 6/18/26 at 0849 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 2. RN 2 verified the above findings. On 6/18/26 at 1505 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON verified the above findings. 2. Medical record review for Resident 61 was initiated on 6/16/26. Resident 61 was admitted to the facility on [DATE]. Review of Resident 61's Order Summary Report showed the following physician's orders dated 6/2/26: - To administer trazodone 50 mg one tablet by mouth at bedtime for depression manifested by difficulty sleeping; and - To administer duloxetine 60 mg one tablet by mouth one time a day for depression manifested by persistent feeling of sadness. Review of Resident 61's Psychotherapeutic Drug Informed Consent Form dated 6/2/26, for the trazodone medication, did not show the Caution and Warning Summary section was completed to show whether the trazodone medications had any off-label use, FDA-approved use, and black box warning label. Review of Resident 61's Psychotherapeutic Drug Informed Consent Form dated 6/2/26, for the duloxetine medication, did not show the Caution and Warning Summary section was completed. The form only showed the medication had a black box warning label but did not show whether the duloxetine medication was off-label use and FDA-approved use. Review of Resident 61's MAR for June 2026 showed the following: - Resident 61 was administered the trazodone medication from 6/1 to 6/17/26 at 2100 hours; and - Resident 61 was administered the duloxetine medication on 6/3 to 6/18/26 at 1800 hours. On 6/18/26 at 0835 hours, an interview and concurrent medical record review for Resident 61 was conducted with RN 2. RN 2 verified the above findings. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 2's H&P examination dated 5/5/26, showed Resident 2 was unable to understand and make treatment decisions due to dementia. Review of Resident 2's Order Summary Report, showed the following physician's orders: - dated 5/5/26, to administer quetiapine fumarate 150 mg one tablet by mouth at bedtime for psychosis as manifested by sudden angry outburst; and - dated 5/5/26, to administer trazadone 100 mg one tablet by mouth at bedtime for depression as manifested by inability to sleep. Review of Resident 2's Psychotherapeutic Drug Informed Consent Form dated 2/25/26, for the quetiapine medication, showed the informed consent was given by the resident but did not sign the consent and only one licensed nurse verified the informed consent. Review of Resident 2's Psychotherapeutic Drug Informed Consent Form dated 2/26/26, for the trazadone medication, showed the informed consent was given by the resident's representative via telephone. Further review of the informed consent form showed only one licensed nurse verified the informed consent. Review of Resident 2's MAR for June 2026 showed: - was administered with quetiapine medication from 6/1 to 6/18/26 at 2100 hours; and - was administered with trazadone medication from 6/1 to 6/18/26 at 2100 hours. On 6/19/26 at 1007 hours, an interview and concurrent medical record review for Resident 2 was conducted with the ADON. The ADON verified the informed consent form for the quetiapine medication showed the resident did not sign the consent. The ADON stated Resident 2 at times refused to sign the documents but gave the verbal consent. The ADON stated ideally if the resident gave the informed consent verbally, but refused to sign the form, two licensed nurses should verify it. The ADON also verified the informed consent form for the trazadone medication showed the resident's representative gave the informed consent via telephone; however, only one licensed nurse verified the informed consent. The ADON stated two licensed nurses were supposed to verify the informed consent when the consent was given via telephone. 5. Medical record review for Resident 6 was initiated on 6/16/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 8/15/25, showed Resident 6 had no decision making capacity. Review of Resident 6's Order Summary Report showed a physician's order dated 4/25/26, to administer quetiapine fumarate 25 mg one tablet by mouth at bedtime for schizoaffective disorder as manifested by striking out. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's Psychotherapeutic Drug Informed Consent Form dated 4/25/26, for the quetiapine medication, under the Reason for Use of Psychotherapeutic Drug and Benefits section, the form did not include the diagnosis and behavior manifestation related to the use of quetiapine medication. In addition, the form did not show the duration for the quetiapine medication. Review of Resident 6's MAR for June 2026 showed Resident 6 was administered with quetiapine medication from 6/1 to 6/18/26 at 2100 hours. On 6/19/26 at 1140 hours, an interview and concurrent medical record review for Resident 6 was conducted with the ADON. The ADON verified the informed consent for the quetiapine medication did not include the diagnosis and behavior manifestation related to the use of the medication, as well as the duration for the use of the medication. The ADON stated the informed consent for the psychotropic medications should show the diagnosis, behavior manifestation, and the duration for the use of the medication as per physician's order. 6. Medical record review for Resident 11 was initiated on 6/16/26. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's Psychotherapeutic Drug Informed Consent Form dated 5/13/26, showed for the alprazolam medication, the informed consent was given by the resident but did not sign the consent and only one licensed nurse verified the informed consent. Review of Resident 11's H&P examination dated 5/19/26, showed Resident 11 had no capacity to understand and make decisions. Review of Resident 11's Order Summary Report showed a physician's order dated 6/13/26, to administer alprazolam 0.25 mg one tablet via GT (gastrostomy tube, a small tube placed through the abdominal wall into the stomach, used to provide enteral feedings and/or administer medications) every 12 hours as needed for anxiety as manifested by verbalization of feeling anxious for 14 days. Review of Resident 11's MAR for June 2026, showed Resident 11 was administered with alprazolam medication on the following dates and time: - 6/3 at 2156 hours, - 6/4 at 2130 hours; - 6/6 at 2350 hours, - 6/8 at 0006 hours; - 6/9 at 0430 hours; - 6/10 at 2143 hours; and (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 6/14 at 0048 hours. On 6/18/26 at 1435 hours, an interview and concurrent medical record review for Resident 11 was conducted with the ADON. The ADON verified the informed consent form for the alprazolam medication showed the resident or resident's responsible party did not sign the consent. On 6/19/26 at 1418 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 2, 6, and 11.		

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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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents for unnecessary medications (Resident 6), and two of 29 final sampled residents (Residents 5 and 13) were free from the unnecessary psychotropic medications. * The facility failed to ensure the behavior manifestation related to the use of Risperdal (antipsychotic) medication was monitored for Resident 5. In addition, the resident's psychoactive summary sheet for May 2026 did not match the behavior monitored. * The facility failed to ensure Resident 6 was provided with nonpharmacological interventions when the resident exhibited the behavior manifestation related to the use of the quetiapine (antipsychotic) medication. * The facility failed to ensure Resident 13 was monitored for the behavior manifestation related to the use of the clonazepam (anxiety) medication as per the physician's order. These failures had the potential for the residents to receive unnecessary psychotropic medication and cause the provider to have incomplete information in determining the psychotropic medication dose adjustments. Findings: Review of the facility's P&P titled P-NP106 Behavior/Psychoactive Medication Management dated 1/30/26, the Policy Interpretation and Implementation section showed the following: - The licensed nurse collaborates with the healthcare practitioner, family, resident, resident representative, and/or IDT members, to identify the contributing factors related to the resident's mood/behavior and the non-medication interventions to be implemented; - The medication maintains or improves the resident's functional capacity; - The IDT will reassess the effectiveness of the psychoactive medication at least quarterly during the IDT care plan meeting, or psychoactive behavior management committee; and - Residents have the right to be free from chemical restraints. 1. Medical record review for Resident 5 was initiated on 6/16/26. Resident 5 was readmitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 6/18/25, showed Resident 5 had no capacity to understand and make decisions. Review of Resident 5's Order Summary Report showed a physician's order dated 3/30/26, to administer Risperdal one mg one tablet by mouth two times a day for psychosis as manifested by sudden angry outburst. Review of Resident 5's MAR for May and June 2026 showed Resident 5 was administered the Risperdal medication on the following dates and times: (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 5/1 to 5/31/26 at 0900 hours and 1700 hours; and - dated 6/1 to 6/17/26 at 0900 hours and 1700 hours, and 6/18/26 at 0900 hours. Review of Resident 5's Psychoactive Summary Sheet for May 2026 showed for the Risperdal medication and the behavior manifestation of sudden angry outburst, Resident 5 was observed with one behavior episode on 0700 to 1500 hours (morning) shift. Further review of Resident 5's medical record did not show if Resident 5 was monitored for psychosis as manifested by sudden angry outburst as the target behavior related to the use of the Risperdal medication as per the physician's order. On 6/18/26 at 1523 hours, an interview and concurrent medical record review for Resident 5 was conducted with the ADON. The ADON verified the above findings. The ADON stated when the physician's order for the Risperdal medication was updated, the monitoring for the target behavior should have been updated as well. The ADON stated the target behaviors for the specific antipsychotic medication should be monitored and documented in the MAR. The ADON further stated the monthly psychoactive summary sheet should match the target behavior being monitored as per physician's order. 2. Medical record review for Resident 6 was initiated on 6/16/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 8/15/25, showed Resident 6 did not have decision making capacity. Review of Resident 6's Order Summary Report, showed the physician's orders dated 4/25/26 for the following: - to administer quetiapine fumarate 25 mg one tablet by mouth at bedtime for schizoaffective disorder as manifested by striking out; and - to monitor target behaviors for the use of quetiapine due to schizoaffective disorder as manifested by striking out. Indicate the number of behavior occurrences followed by the nonpharmacological interventions (NPI) provided. If no behaviors select not applicable for NPI, then Yes or No for effectiveness every shift. NPI: 1=Music/TV; 2=Redirect/divert; 3=Call family/resident representative to talk or visit with resident; 4=Toilet; 5=1:1 Conversation; 6= Reassure/orient; 7=Assess pain/infection; 8=Offer drink/snack; 9=Quiet environment; 10 Walk/wheel resident; 11=Activity/Exercise; or 12 Massage/back rub. Review of Resident 6's MAR for May and June 2026 showed the following: - Resident 6 was administered with quetiapine medication from 5/1 to 5/31/26 at 2100 hours; - Resident 6 was administered with quetiapine medication from 6/1 to 6/18/26 at 2100 hours; (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate GT care and services were provided for two nonsampled residents (Residents 88 and 149). * The facility failed to ensure RN 1 checked the GT residual prior to flushing the GT with water for Resident 88. In addition, RN 1 failed to administer the water flush and diluted medications via GT by gravity flow as per the facility's P&P. * The facility failed to ensure LVN 2 put the TF (tube feeding) on hold prior to checking the GT residual and flushing the GT with water; and prior to administering the medications for Resident 149. In addition, LVN 2 failed to administer the diluted medications via GT by gravity flow as per the facility's P&P. These failures placed the residents at risk for complications related to GT use, including tube dislodgement or gastrointestinal injury. Findings: Review of the facility's P&P titled P-NP135 Enteral Tube Management: Gastrostomy Tube-Jejunostomy Tube revised 9/28/23, showed the following:- Enteral tubes should be verified for placement and patency prior to intermittent feeding, at every shift, and prior to administering medications, hydration, and nutrition via enteral feeding tubes; and- Check for correct placement of gastrostomy & jejunostomy feeding tube using the following method:a. Withdrawal of Gastric & Jejunum Contents;b. Connect the syringe to the end of the tube;c. Slowly pull back the syringe to aspirate contents;d. Note the characteristics of syringe contents: amount, color, and texture;e. Return aspirated contents to the stomach;f. If gastric or jejunum content cannot be withdrawn, ask the resident to lie on his or her left side and attempt to aspirate again;g. If gastric or jejunum contents still cannot be aspirated, wait one (1) hour and repeat aspiration procedure. Note the tube may become obstructed with gastric contents, feeding formula, or crushed medication, making aspiration difficult. The tube may be in the stomach but above the level of gastric contents making aspiration impossible; andh. If correct placement is not completely assured, do not administer feeding or medication. Contact Physician for further instruction. Review of the facility's P&P titled P-NP47 Feeding Tube-Administration of Medication revised 5/30/24, showed the following:- If continuous or intermittent feeding is infusing, stop the feeding as follows:a. If the medication can be given with food, stop the feeding immediately before administering medications.b. If the medications have to be given on an empty stomach, stop the feeding 30 minutes before administering medications.c. If the medications are incompatible with the feeding product stop the feeding 1 to 2 hours before administering medications and according to manufacture instruction;- Verify tube placement via aspiration method. Return aspirate to stomach;- Flush tube with 15 ml (unless a different amount is specified by the physician/prescriber) of water before administering medication. Medication should not be mixed because of the risks of physical and chemical incompatibilities, tube obstruction, and altered therapeutic drug responses;- Between each medication, the tube is flushed with 15 ml of water, keeping in mind the patient's fluid volume status (unless a different amount is specified by the physician/prescriber); and - Administer medication by syringe via gravity into the feeding tube. 1. On 6/17/26 at 0905 hours, a medication administration observation for Resident 88 was conducted with RN 1. The following were observed with RN 1:- RN 1 did not check the GT residual for Resident 88 prior to flushing the GT with 30 ml of water;- RN 1 attempted to flush the GT with 30 ml of water for the second time but water was not flowing down the GT. RN 1 used the syringe plunger to push the 30 ml of water into the GT rather than allowing gravity flow; and- RN 1 used the same technique of using the syringe plunger to push the multivitamins (supplements) and Senna (laxative) when the medications were not flowing down the GT. On 6/17/26 at 0940 hours, an interview and concurrent (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record review for Resident 88 was conducted with RN 1. RN 1 verified the findings above for Resident 88. RN 1 stated she should have checked the residual prior to attempting to flush the GT with water to make sure the residual amount was not on the amount where she would need to hold the GT feeding and medication administration. RN 1 stated it was also a way to verify the GT placement. RN 1 stated the medications should be allowed to flow by gravity and she should have checked the patency of the GT when the medications were not flowing down the GT. RN 1 stated Resident 88 was getting 40 ml of water flush via GT every hour. 2. On 6/17/26 at 0817 hours, a medication administration observation and concurrent interview for Resident 149 was conducted with LVN 2. The following were observed with LVN 2:- LVN 2 was observed checking the GT residual of Resident 149 and flushed back the aspirated 10 ml residual to the GT while the TF pump was still on;- LVN 2 was about to administer the first diluted medication via GT to Resident 88 while the TF pump was still on. LVN 2 was stopped and was asked if she needed to hold the TF. LVN 2 stated she should have put the TF on hold prior to checking the GT residual. LVN 2 put the TF pump on hold and proceeded with the medication administration;- LVN 2 administered the first medication, valproic acid liquid (antiseizure) without flushing the GT first with water; and- LVN 2 administered the diluted Namenda (medication for severe dementia) medication and added 5 ml of water to the GT but the medication did not flow down the GT. LVN 2 then added the diluted folic acid (vitamin) medication and added 5 ml of water. The medications were observed not flowing down the GT. LVN 2 used the syringe plunger to push the medications into the GT rather than allowing gravity flow. On 6/17/26 at 0855 hours, an interview and concurrent medical record review for Resident 149 was conducted with LVN 2. LVN 2 verified the above findings for Resident 149. LVN 2 stated the GT should be flushed with 15 ml of water before administering the medications. LVN 2 further stated she should have let the medications flow to the GT by gravity or have checked for the patency if the medications were not flowing down. On 6/17/26 at 1518 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 88 and 149 during the medication administration observation. Cross reference to F726.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for three of four sampled residents (Residents 8, 126, and 148) reviewed for respiratory care. * The facility failed to ensure Resident 8 and 148's oxygen were administered as per the physician's order. * The facility failed to ensure Resident 126's Yankauer suction tip was stored in a set-up bag when not in use. In addition, the facility failed to ensure Resident 126 was assessed and provided education on how to independently suction herself, and how to store the Yankauer suction when not in use. These failures posed the risk for the residents to develop complications related to oxygen and suction use. Findings: Review of facility's P&P titled Oxygen Therapy effective 10/31/25, showed in part, administer oxygen and obtain oxygen saturation as ordered by the provider. If the oxygen saturation falls below the level identified by the provider, the provider will be notified immediately. Humidification of oxygen is not necessary unless more the 4 liters per minute is ordered, or the resident requests humidification for liter flow of 4 liters per minute or below. Oxygen equipment shall be maintained. The tubing and mask should be changed at least every 7 days and labeled with the date of change. 1. On 6/16/26 at 1611 hours, during the initial tour of facility, Resident 8 was on her bed receiving oxygen at a rate of 3.5 liters per minute per nasal cannula using the oxygen concentrator. Medical record review for Resident 8 was initiated on 6/17/26. Resident 8 was initially admitted to facility on 6/4/25, and readmitted on [DATE]. Review of Resident 8's Order Summary Report dated 6/18/26, showed a physician order dated 6/13/26, for oxygen at a rate of 2 liters per minute via nasal cannula to keep oxygen saturation at 94% or above every shift. On 6/17/26 at 1015 hours, a follow up observation for Resident 8 and concurrent interview was conducted with LVN 5. LVN 5 verified the oxygen was set at a rate of 3.5 liters per minute. LVN 5 stated only the RN change the setting of the oxygen. 2. On 6/16/26 at 1514 hours, an observation on Resident 148's room was conducted. Resident 148 had oxygen per nasal cannula set at a rate of 1.5 liters per minute. Medical record review for Resident 148 was initiated on 6/17/26. Resident 148 was admitted to facility on 1/12/25, and readmitted on [DATE], with diagnosis of Acute Respiratory failure with hypoxia (medical condition where the body's tissues and organs do not receive enough oxygen to function properly). Review of Resident 148's Order Summary Report dated 6/18/26, showed a physician order dated 6/4/26, for oxygen at a rate of 2 liters per minute via nasal cannula to keep the oxygen saturation (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at/above 92% every shift for Acute Hypoxic Respiratory Failure. On 6/17/26 at 1220 hours, a follow up observation for Resident 148 and concurrent interview was conducted with the DSD. The DSD verified Resident 148 oxygen was set at a rate of 1.5 liters per minute. The DSD stated the physician order was to administer oxygen at a rate of 2 liters per minute. On 6/19/26 at 1425 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings for Residents 8 and 148. 3. Review of the facility's P&P titled Emergency Airway Placement and Oropharyngeal Suctioning revised 5/29/25, showed the suction equipment must be cleaned and stored according to manufacturer guidelines and facility protocol On 6/16/26 at 0919 hours, Resident 126 was observed asleep in bed. A Yankauer suction tip was observed underneath Resident 126's cloth underpads. On 6/16/26 at 1015 hours, an observation for Resident 126 and concurrent interview was conducted with RN 1. RN 1 verified the Yankauer suction tip was placed underneath Resident 126's cloth underpads. RN 1 stated she suctions herself; she wants it near her. Resident 126 stated the Yankauer suction was just changed. RN 1 was observed labelling a new set-up bag and placing the resident's Yankauer suction into the set-up bag. Medical record review for Resident 126 was initiated on 6/16/26. Resident 126 was readmitted to the facility on [DATE]. Review of Resident 126's Order Summary Report showed a physician's order dated 5/15/26, may suction as needed for increased secretions and congestion. Further review of Resident 126's medical record did not show Resident 126 was assessed and provided education on how to suction herself, and how to store the Yankauer suction when not in use. On 6/18/26 at 0906 hours, an interview and concurrent medical record review for Resident 126 was conducted with RN 2. When asked about Resident 126 suctioning herself, RN 2 stated she was sure an education was provided to Resident 126 on how to suction but RN 2 could not show any documentation. On 6/18/26 at 1510 hours, an interview for Resident 126 was conducted with the DON. The DON acknowledged the above findings. The DON stated the RN supervisors were assigned to change the Yankauer suction tip and the tubing with a set-up bag weekly. When asked about Resident 126's independent use of the suction, the DON stated they were working on getting an assessment and a physician's order for Resident 126 to self-suction.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review the facility failed to ensure food safety and sanitation guidelines were followed in the kitchen. * Proper hand hygiene was not followed,* Food preparation equipment was not clean, and* The kitchen floor was not intact.These failures posed a risk for food borne illness for 127 residents who received food prepared in the kitchen.Review of the facility's matrix dated 6/16/26, showed 127 residents received food prepared in the kitchen. 1. Review of the facility's P&P titled Dietary Department Infection Control for Dietary Employees dated 2022 showed, II. Proper Hand Hygiene A. Upon entering the kitchen, F. After handling soiled equipment or utensils. III. Hand Washing Facilities A. Kitchen sinks shall not be used for hand washing. Separate hand-washing facilities with soap, running water and individual towels shall be provided. During the initial tour of the kitchen on 6/16/26 at 0810 hours, an observation of the automatic dishwashing process was conducted. Wearing gloves, Diet Aide 1 loaded soiled dishes into the dish machine. Diet Aid 1 removed his gloves, rinsed his hand in water using the manual ware washing sink, then picked up clean dishes from the clean side of the dishwashing machine. On 6/16/26 at 1048 hours, Diet Aid 1 entered the kitchen, used hand sanitizer on his hands rather than washing his hands in the hand-washing sink then returned to work in the kitchen. On 6/16/26 at 1100 hours, an interview was conducted with the Dietary Services Supervisor (DSS). The DSS confirmed when kitchen employees enter the kitchen they must wash their hands. Use of a hand sanitizer is not to be used in place of handwashing. On 6/18/26 at 1400 hours, during a meeting with the DSS, DON, and Administrator, the above findings were confirmed. 2. Review of the USDA Food Code 2022 Section 4-601.11 Equipment, Food Contact Surfaces, Nonfood Contact Surfaces and Utensils (A) Equipment, food-contact surfaces and utensils shall be clean to sight and touch. On 6/16/26 at 1152 hours, an observation of the meal preparation for the lunch meal was conducted. [NAME] 2 was observed cooking onions in a fry pan with thick black residue on the inside of the pan. On 6/18/26 at 1400 hours, during a meeting with the DSS, DON, and Administrator, the above findings was confirmed. 3. During an observation of the kitchen on 6/16/26 at 1203 hours, the kitchen floor was noted to have two areas; one in the dish room and one near the grill where the tile was not intact exposing cement. On 6/16/26 at 1600 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Director stated he was aware of the condition of the kitchen floors but confirmed the Administrator had not received any quotes to repair the floors.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to protect the residents' clean linen from dust and contamination when the employee personal belongings were stored in the clean linen folding area. * The facility failed to ensure LVN 1 performed hand hygiene and changed gloves before administering the eye drop medications to Resident 25 after contact with potentially contaminated surfaces. * The facility failed to ensure RN 1 performed hand hygiene and changed gloves before administering the insulin medication to Resident 88. These failures posed the risk of infection, cross-contamination and the transmission of disease-causing microorganisms to highly vulnerable residents. Findings: 1. According to CDC, under the Linen and Laundry Management section dated 9/19/24, the best practices for management of clean linen included sorting, packaging, transporting, and storing clean linen in a manner that prevents risk of contamination by dust, debris, soiled linen or other soiled items. Review of the facility's P&P titled Laundry Services dated 1/1/12, showed when the facility operates its own laundry, the laundry is maintained in a clean and sanitary condition. On 6/16/26 at 1516 hours, an observation of the laundry area and concurrent interview was conducted with the Housekeeping Supervisor. The following were observed: - the clean storage area for blankets was observed with a black purse on top of a blanket, and also a book was observed on top of another folded blanket; and - the clean storage area for blue underpads was observed with a bag used to store the underpads; however, the bag used to store the underpads was worn and damaged. In addition, a white binder, sewing kit, small container of grape jelly, black plastic folder, roll of tissue and a small cup were observed stored within the storage area for blue underpads. The Housekeeping Supervisor verified the above findings. On 6/18/26 at 1527 hours, an interview was conducted the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Hand Hygiene revised 9/1/20, showed the facility considers hand hygiene as the primary means to prevent the spread of infections. Hand hygiene means cleaning your hands by handwashing (washing hands with soap and water), antiseptic hand wash or antiseptic hand rub (i.e. alcohol-based hand rub (ABHR) including foam or gel). Wearing gloves does not replace the need for hand hygiene. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/17/26 at 1012 hours, a medication administration observation for Resident 25 was conducted with LVN 1. LVN 1 touched the privacy curtain in Resident 25's room with his gloves on and proceeded in administering the eye drop medication to Resident 25. After administering Resident 25 all his oral medications, LVN 1 donned a pair of gloves without performing hand hygiene and proceeded to administer the second eye drop medication to Resident 25. On 6/17/26 at 1030 hours, an interview was conducted with LVN 1. LVN 1 acknowledged he did not perform hand hygiene and changed gloves before he administered the eye drop medications to Resident 25 after he touched the privacy curtain and administered all the oral medications. LVN 1 stated he should have performed hand hygiene and donned new pair of gloves for infection prevention. 3. On 6/17/26 at 0905 hours, a medication administration observation for Resident 88 was conducted with RN 1. RN 1 was observed administering the insulin injection to Resident 88's right upper arm immediately after she administered all the resident's medications via GT without performing hand hygiene and changing gloves. On 6/17/26 at 0940 hours, an interview was conducted with RN 1. RN 1 acknowledged she did not perform hand hygiene before administering the insulin injection to Resident 88. On 6/18/26 at 0948 hours, an interview was conducted with the IP. The IP stated the licensed nurses were expected to perform hand hygiene and change with new pair of gloves after touching the potentially contaminated surfaces in the resident's room before administering medications to prevent cross contamination. The IP was informed and acknowledged the above findings for Residents 25 and 88. On 6/19/26 at 1418 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 25 and 88.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, document review, and facility P&P review, the facility failed to ensure the kitchen and front dining room were free of pests. * The facility failed to ensure there was no cockroach the kitchen. * The facility failed to ensure there was no gnat flying in front dining room. These failures posed the risk of contamination of the food prepared in the kitchen and of the front dining room for 127 residents who received food prepared in the kitchen. Findings: Review of the facility's matrix dated 6/16/26, showed 127 residents received food prepared in the kitchen. According to the USDA Food Code 2022, 6-501.111, Controlling Pests, showed insects and other pests are capable of transmitting disease to humans by contaminating food and food-contact surfaces. Effective measures must be taken to eliminate their presence in food establishments. Review of the facility's P&P titled Pest Control revised 1/2012 showed to ensure the facility is free of insects, rodents and other pests that could compromise the health, safety and comfort of residents, facility staff and visitors, and the facility maintains an ongoing pest control program to ensure the building and grounds are kept free of insects, rodents and other pests. 1. Review of the facility's pest control reports dated 3/21, 4/23, and 5/26/26, showed the facility kitchen interior had been treated for cockroaches. Under the structural concerns the pest control reports showed the following: - dated 3/21/26 and 5/26/26, the rear door had a hole/gap that needed to be sealed off; and - dated 4/23/26, the rear door needs attention. Gaps on both right and left side of frame. Door sweep needed replacement to sit flush to the floor. On 6/16/26 at 1134 hours, during the lunch meal preparation observation in the kitchen, a cockroach ran across the kitchen floor next to the oven. [NAME] 2 verified she saw the cockroach. On 6/16/26 at 1600 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the facility had an outside pest control company who would treat the facility for cockroaches monthly. The Maintenance Director stated the kitchen employees could contact him if they saw any pests in the kitchen. The Maintenance Director stated he was not aware of any cockroaches in the kitchen nor had he been contacted by the kitchen employees regarding cockroaches in the kitchen. On 6/16/26 at 1611 hours, an interview was conducted with [NAME] 2. [NAME] 2 stated if she saw any pests in the kitchen, she would inform the DSS then he would contact the pest company. [NAME] 2 confirmed she had not informed the DSS of any cockroaches in the kitchen. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 6/16/26 at 1242 hours, during the dining observation in the front dining room, a gnat was observed flying around the dining room and subsequently landed on a resident's cup of ice cream. LVN 3 verified the above findings. LVN 3 was observed disposing the contaminated ice cream. On 6/18/26 at 1420, an interview and concurrent facility document review was conducted with the Maintenance Director and Administrator. When asked about the gnats in the dining room, the Maintenance Director stated there were no reports of gnats in the resident rooms nor in the dining room. The Maintenance Director stated the pest prevention company came on 5/20, 5/26, and 6/17/26, to which he showed the pest control company service reports. Review of the service reports conducted by the pest control company dated 5/20, 5/26, and 6/17/26, did not show an inspection by the pest control company was conducted in the front dining room.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to promote dignity and respect for one of 29 sampled residents. * The facility failed to ensure Resident 15's indwelling urinary catheter drainage bag was placed inside the dignity bag. This failure had the potential to affect the privacy and dignity of the resident. Findings: On 6/16/26 at 1240 hours, during the initial tour of the facility, Resident 15 was observed lying on his bed with the indwelling urinary catheter on left side of his bed. The indwelling urinary catheter drainage bag was observed not inside the dignity bag exposing a scanty yellowish urine. On 6/17/26 at 0932 hours, a follow up observation for Resident 15 and concurrent interview was conducted with IP nurse. The IP nurse verified the indwelling urinary catheter drainage bag was still not inside the dignity bag. Medical record review for Resident 15 was initiated on 6/17/26. Resident 15 was initially admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis of Neurogenic Bladder (nerve damage from underlying illness or injury causing loss of normal control of urinary bladder resulting to inability to empty urine). Review of Resident 15's Order Summary report dated 6/18/26, showed a physician's order dated 2/16/26, for indwelling urinary catheter size (FR#16) with balloon via gravity drainage for neurogenic bladder. On 6/19/26 at 1144 hours, an interview was conducted with the IP Nurse. The IP nurse stated she had in-service to staff on 12/10/25, regarding Care of Indwelling Catheter, to always place the indwelling urinary catheter drainage bag inside the dignity bag and not touching the floor. On 6/19/26 at 1427 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the findings.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide reasonable accommodation to meet the needs for two of 29 final sampled residents (Residents 52 and 90). * The facility failed to ensure Resident 52 and 90's call lights were within the residents' reach. This failure posed a risk in a delay in providing care to the residents with the potential to negatively impact on the residents' well-being. Findings: Review of the facility's P & P titled Communication-Call System revised 8/24/24, showed the call alert device will be placed within the resident's reach. 1. Medical record review of Resident 52 was initiated on 6/16/26 and 6/19/26. Resident 52 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 52's H&P examination dated 8/18/25, showed the resident had the capacity to understand and make medical decisions. On 6/16/26 at 1028 hours Resident 52 was observed lying in bed. Resident 52's call light was observed hanging behind the headboard of the bed. Resident 52 attempted to reach for the call light and was unable to reach it but refused to be interviewed. On 6/16/26 at 1112 hours, the DON was summoned to Resident 52's room. An observation for Resident 52 and concurrent interview was conducted with the DON. Resident 52's call light was hanging behind the headboard of the bed which was not within Resident 52's reach. When asked, the DON stated the call light should be within the reach of every resident, in case the resident needed assistance it will be available to call for help. 2. Medical record review for Resident 90 was initiated on 6/16/26. Resident 90 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 90's H&P examination dated 7/8/25, showed the resident had the capacity to understand and make medical decisions. On 6/16/26 at 1056 hours, Resident 90 was observed lying in bed. Resident 90's call light was observed on the floor on left side of the bed far from the resident's reach. Resident 90 stated having no idea where the call light was. Resident 90 further stated she needed to use the call light to call the staff then because she wanted pain medication. Resident 90 attempted to reach for the call light and Resident 90 stated she was unable to find the call light and unable to reach the call light. Resident 90 stated, I need my call bell now. On 6/16/26 at 1058 hours, CNA 2 was summoned to Resident 90's room. An observation for Resident 90 and concurrent interview was conducted with CNA 2. Resident 90 was observed lying in bed, and the call light was on the floor on left side of the bed away from the resident's reach. CNA 2 verified the findings and placed the call light back on the resident bed. On 6/19/26 at 1400 hours, an interview was conducted with the DON. The DON informed and acknowledged the above findings. The DON stated the call light should be within the reach of the resident to ensure the resident's safety and allowed the resident to communicate with the facility staff when assistance was needed.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide a copy of the notification of the transfer/discharge to the office of the State Long-Term Care Ombudsman for one of the two final residents (Resident 9) transfer to the acute care hospital and one of three sampled residents (Resident 145) for closed record reviewed. * The facility failed to ensure the transfer/discharge notification was completed and a copy was sent to the Ombudsman when Resident 9 was transferred to Acute Care Hospital 2 (ACH 2) on 4/29/26. * The facility failed to send a copy of Resident 145's notice of transfer/discharge to the representative of the Office of the State LTC Ombudsman. These failures had the potential for the Ombudsman to not be aware of the residents' transfer/discharge status and not being able to provide information regarding the resident options or right to appeal. Findings: Review of the facility's P&P title Discharge and Transfer of Residents revised 2/27/25, showed prior to discharge, the facility will provide the resident/resident representative with Notice of Proposed Transfer and Discharge document. A copy of the Notice of Proposed Transfer and Discharge will be placed in the Resident's medical record and copy faxed to the ombudsman. 1. Medical record review for Resident 9 was initiated on 6/17/26. Resident 9 was admitted to the facility on [DATE], transferred to the acute care hospital on 4/29/26, and readmitted to the facility on [DATE]. Review of Resident 9's Order Summary Report showed a physician's order dated 4/29/26, to transfer Resident 9 to Acute Care Hospital 2 for further evaluation due to elevated WBC and bed hold for 7 days. Further review of Resident 9's medical record failed to show documented evidence of the Notice of Proposed Transfer/Discharge and if the Ombudsman was notified of Resident 9's transfer to the acute care hospital. On 6/17/26 at 0924 hours, an interview and concurrent medical record review for Resident 9 was conducted with the ADON. The ADON verified the Notice of Proposed Transfer Discharge was not found in Resident 9's medical record. The ADON stated the facility stop filling out the form because the Ombudsman informed the facility does not need to fax the Notice of Proposed Transfer Discharge form to the Ombudsman if the resident was to transfer to the hospital. The ADON further stated the facility should have sent the notice so the Ombudsman would have a record of the resident being sent to the acute care hospital. On 6/19/26 at 1310 hours, an interview was conducted with the DON and Administrator. The DON and Administrator was informed and acknowledged above findings. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Closed medical record review for Resident 145 was initiated on 6/16/26. Resident 145 was admitted to the facility on [DATE], and discharged on 4/5/26. Review of Resident 145's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. Review of Resident 145's Order Summary Report dated 4/5/26, showed a physician's order to transfer the resident to Acute Care Hospital 1 via 911 due to desaturation and SOB, and bed hold for seven days if admitted . Further closed medical record review for Resident 145 failed to show documented evidence of the notification to the LTC Ombudsman regarding the resident's transfer to the acute care hospital. On 6/17/26 at 1525 hours, an interview and concurrent closed medical record review for Resident 145 was conducted with the SSD. The SSD stated Resident 145 was sent to the acute care hospital. The SSD stated the social services did not do the notice of transfer for the residents that went to the acute care hospital. When the SSD was asked about who was responsible for sending a copy of the notice to the LTC Ombudsman, the SSD stated if the transfer was an emergency or the resident was sent to the acute care hospital the licensed nurse would do it. On 6/17/26 at 1548 hours, an interview and concurrent closed medical record review was conducted with RN 2. RN 2 verified the copy of the Notice of Proposed Transfer and Discharge form was not sent to the LTC Ombudsman. RN 2 stated she was not sure why the form was not sent to the LTC Ombudsman. RN 2 further stated when Resident 145 was transferred to the acute hospital, the medical records staff were responsible for faxing the copy of the Notice of Proposed Transfer and Discharge form to the LTC Ombudsman. RN 2 stated if a resident was discharged home the social services staff were the one responsible for faxing the copy to the LTC Ombudsman. On 6/17/26 at 1607 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the licensed nurses or the medical records staff used to fax the Notice of Proposed Transfer and Discharge form to the LTC Ombudsman. However, the LTC Ombudsman told the facility staff he did not need the notification of transfer and discharge, the facility staff stopped faxing the Notice of Proposed Transfer and Discharge form to the LTC Ombudsman's office.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and P&P review, the facility failed to develop the comprehensive plan of care to reflect the individual care needs for three of 29 final sampled residents (Residents 8, 79 and 126). * The facility failed to implement the care plan to address Resident 8's head of bed while the resident was on continuous oxygen. * The facility failed to develop a care plan problem to address Resident 79's use of bed bolster (a raised foam edges along the sides of bed mattress to support positioning and prevent patient from rolling out of bed) for safety. * The facility failed to develop a care plan problem to address Resident 126's self-use of suction equipment. These failures had the potential risk of not providing appropriate, consistent, and individualized care to these residents. Findings: Review of the facility's P&P titled Comprehensive Person-centered care planning revised 8/24/23, showed the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents to obtain or maintain the highest physical, mental, and psychosocial well- being. To ensure that a comprehensive person-centered care plan is developed for each resident. 1. Medical record review for Resident 79 was initiated on 6/18/26. Resident 79 was admitted to the facility on [DATE]. Review of Resident 79's Order Summary Report dated 6/18/26, showed a physician's order dated 5/17/26, for Low Air Loss Mattress with bolster for skin management every shift. On 6/16/26 at 1313 hours, during room visit, Resident 79 was observed on her bed with low air loss mattress with upper and lower bolster on each side. On 6/18/26 at 0838 hours, a review of Resident 79's comprehensive care plan dated 5/13/25, showed under Focus- at risk for impairment to skin integrity related to fragile skin, decrease mobility, DM (Diabetes Mellitus (increased sugar level in blood), incontinence of bowel. Under Intervention portion, initiated on 5/17/25, showed use of the low air loss mattress with bolster as ordered. On 6/18/26 at 0943 hours, an interview was conducted with LVNs 3 and 4. LVNs 3 and 4 stated the indication for low air loss mattress was for skin maintenance to prevent recurrence of pressure injury (localized damage to the skin and underlying soft tissue usually occurring over bony prominence). LVNs 3 and 4 stated and clarified that the bolster was for safety to prevent resident from sliding out of bed and not for skin maintenance. LVNs 3 and 4 verified there was no care plan for use of the bolster for safety to prevent resident from sliding out of bed. On 6/19/26 at 1415 hours, an interview was conducted with Administrator and DON. The DON verified (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the findings. 2. Review of the facility's P&P titled Person-Centered Care Planning, revised 4/24/25, showed the following: - Person-centered care plan means that the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what is important to each resident with regard to daily routines and preferred activities and having an understanding of the resident's life before coming to reside in nursing facility; and - The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident's rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following (1) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being; and On 6/16/26 at 0919 hours, Resident 126 was observed asleep in bed. A Yankauer suction tip was observed underneath Resident 126's cloth underpads. On 6/16/26 at 1015 hours, an observation for Resident 126 and concurrent interview was conducted with RN 1. RN 1 verified the Yankauer suction tip was placed underneath Resident 126's cloth underpads. RN 1 stated she suctions herself; she wants it near her. On 6/17/26 at 1006 hours, Resident 126 was observed independently dipping the Yankauer suction tip into a cup of water while the suction machine was turned on. Medical record review for Resident 126 was initiated on 6/16/26. Resident 126 was readmitted to the facility on [DATE]. Review of Resident 126's Order Summary Report showed a physician's order dated 5/15/26, may suction as needed for increased secretions and congestion. Review of Resident 126's MAR for June 2026 did not show Resident 126 was monitored for suctioning. Review of Resident 126's plan of care did not show a care plan problem was developed to address Resident 126's self-use of the suction equipment. On 6/18/26 at 0906 hours, an interview and concurrent medical record review for Resident 126 was conducted with RN 2. RN 2 verified Resident 126 independently suctions herself. RN 2 further verified Resident 126's plan of care did not show care plan problem was developed to address Resident 126's independent use of the suction equipment. On 6/18/26 at 1510 hours, an interview for Resident 126 was conducted with the DON. The DON was (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed and acknowledged the above findings. 3. On 6/16/26 at 1611 hours, during the initial tour of facility, Resident 8 was on her bed receiving oxygen at a rate of 3.5 liters per minute per nasal cannula using the oxygen concentrator. Resident 8's head of the bed was observed to be on a flat position. Medical record review for Resident 8 was initiated on 6/17/26. Resident 8 was initially admitted to facility on 6/4/25, and readmitted on [DATE]. Review of Resident 8's comprehensive care plan date initiated 6/5/25, showed a care plan problem to address Resident 8's had oxygen therapy related to ineffective gas exchange. The interventions included to position the resident to facilitate ventilation/ perfusion matching. Use upright, high fowlers position whenever possible to allow optimal diaphragm. Head of head elevated to 45 degrees if tolerated to promote lung expansion and improve air exchange by positioning with proper body alignment. On 6/17/26 at 1015 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 8's head of bed was in a flat position. LVN 5 tried to elevate the head of bed of Resident 8. On 6/19/26 at 1425 hours, an interview was conducted with the DON. The DON was made aware of the findings. The DON verified all the above findings.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive person-centered care plan was revised to reflect the residents' current care needs and interventions for one of 29 final sampled residents (Resident 11) and one nonsampled resident (Resident 133). * The facility failed to ensure Resident 11's care plan interventions for the alprazolam (antianxiety) and duloxetine (antidepressant) medications were revised to show the nonpharmacological interventions were included as per physician's order. * The facility failed to ensure the care plan for Resident 133 was updated to reflect Resident 133's dislike of the facility food, and the food brought daily from home. These failures increased the risk for the residents to not receive an individualized and person-centered care in accordance with their assessed needs. Findings: Review of the facility's P&P titled P-NP04-Person-Centered Care Planning revised 4/24/25, showed the facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Comprehensive care plans must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 1. Medical record review for Resident 11 was initiated on 6/16/26. Resident 11 was readmitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 5/19/26, showed Resident 11 had no capacity to understand and make decisions. Review of Resident 11's Order Summary Report, showed the following physician's orders: - dated 5/13/26, to administer duloxetine hydrochloride delayed release particles 30 mg one capsule via GT at bedtime for depression as manifested by persistent feeling of sadness; - dated 5/13/26, to monitor target behaviors for the use of duloxetine due to depression as manifested by persistent feeling of sadness. Indicate the number of behavior occurrences followed by the NPI (nonpharmacological interventions) # (number) provided. If no behaviors, select not applicable for NPI, then Yes or No for effectiveness every shift. NPI: 1=Music/TV; 2=Redirect/divert; 3=Call family/responsible party to talk or visit with resident; 4=Toilet; 5=1:1 Conversation; 6=Reassure/orient; 7=Assess pain/infection; 8=Offer drink/snack; 9=Quiet environment; 10=Walk/wheel resident; 11=Activity/Exercise; or 12 Massage/back rub; - dated 5/13/26, to monitor target behaviors for use of alprazolam due to anxiety as manifested by verbalization of feeling anxious. Indicate the number of behavior occurrences followed by the NPI # (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided. If no behaviors, select not applicable for NPI then Yes or No for effectiveness every shift. NPI: 1=Music/TV; 2=Redirect/divert; 3=Call family/responsible party to talk or visit with resident; 4=Toilet; 5=1:1 Conversation; 6= Reassure/orient; 7=Asses pain/infection; 8=Offer drink/snack; 9=Quiet environment; 10=Walk/wheel resident; 11=Activity/Exercise; or 12 Massage/back rub; and - dated 6/13/26, to administer alprazolam 0.25 mg one tablet via GT (every 12 hours as needed for anxiety as manifested by verbalization of feeling anxious for 14 days. Review of Resident 11's Care Plan Report showed a care plan focus problem to address the following: - the resident's depression and the use of duloxetine medication revised on 4/7/26. The interventions did not include the nonpharmacologic interventions as ordered by the physician; and - the resident's anxiety and the use of alprazolam medication revised on 5/14/26. The interventions did not include the nonpharmacologic interventions as ordered by the physician. On 6/18/26 at 1435 hours, an interview and concurrent medical record review for Resident 11 was conducted with the ADON. The ADON verified the findings for Resident 11. The ADON stated the licensed nurses and members of the IDT team could update or revise the resident's care plan as needed. The ADON further stated whatever interventions being provided to the resident should be reflected in the care plan. On 6/19/26 at 1418 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 11. 2. On 6/16/26 at 0935 hours, an interview was conducted with Resident 133's family member. Resident 133's family member stated Resident 133 was a vegetarian and she did not like the food provided by the facility so he would bring food daily for Resident 133. Resident 133's family member stated he got the food for Resident 133 from his church. On 6/18/26 at 1500 hours, a medical record review and concurrent telephone interview for Resident 133 was conducted with RD 2. RD 2 acknowledged the care plan for each resident should be resident centered. RD 2 confirmed the care plan for Resident 133 did not include the fact that Resident 133 did not like the food at the facility and Resident 133's family member was bringing food from the outside on a daily basis. RD 2 stated this information should have been in Resident 133's care plan.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services for one of 29 final sampled residents (Resident 51) and one nonsampled resident (Resident 149) reviewed for ADL care. * The facility failed to ensure Resident 51 was provided with showers on her scheduled shower days. * The facility failed to ensure Resident 149 was provided with oral care. Resident 149's tongue was observed covered with thick white residue. These failures had the potential for the residents' need not met and for the residents to experience physical discomfort. Findings: Review of the facility's P&P titled Oral Care revised 1/1/12, showed the following: - All residents receive appropriate oral care, including denture care if applicable, daily; - It is the responsibility of each staff member within the nursing department is to ensure good oral care for each resident; - For debilitated residents, use suction toothbrush to brush teeth, gums, tongue, cheeks, and palate; and - Document oral care on any pertinent observations in the resident's medical record. Review of the facility's P&P titled Showering and Bathing revised 1/1/12, showed a tub or shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors. Residents are given tub or shower baths unless contraindicated. 1. On 6/17/26 at 0817 hours, during the medication administration observation, a concurrent observation for Resident 149 and interview was conducted with LVN 2. Resident 149 was observed with her mouth open, and the tongue was sticking out. Resident 149's tongue was observed covered with thick white residue. LVN 2 stated the Resident 149 was non-verbal, needed total care with the ADL care, and on NPO. Medical record review for Resident 149 was initiated on 6/17/26. Resident 149 was readmitted to the facility on [DATE]. Review of Resident 149's H&P examination dated 6/2/26, showed Resident 149 had no capacity to understand and make decisions. Review of Resident 149's MDS assessment dated [DATE], showed Resident 149 needed substantial/maximal assistance for oral hygiene. Review of Resident 149's plan of care initiated on 7/30/21, showed a care plan problem addressing (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 149's dental health problems. The interventions included the following: - for the nurses to monitor document/report to the physician as needed the signs and symptoms of oral/dental problems needing attention: pain (gums, toothache, palate), abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken, eroded, decayed, tongue (black, coated, inflamed, white, smooth), ulcers in mouth, lesions; and - for the nurses and CNAs to provide good oral hygiene daily, report promptly redness, pain swelling or bleeding to the physician. On 6/17/26 at 1441 hours, an observation and concurrent interview was conducted for Resident 149 with CNA 1. CNA 1 stated she was familiar with Resident 149. CNA 1 stated Resident 149 needed total assistance with personal care. CNA 1 stated personal care included oral care. When asked if the resident received oral care and if she noticed something in the tongue, CNA 1 stated oral care was provided to Resident 149 ; however, the resident's tongue was already covered with thick white residue. CNA 1 stated Resident 149 could be resistive at times and the resident at times would roll her tongue backward, so it was hard to clean the tongue, and she did not want to force it. When asked if the nurse was aware of the tongue being covered with thick white residue, CNA 1 stated she did not report Resident 149 tongue's condition to the nurse because she thought the nurse knew about it. On 6/17/26 at 1457 hours, a follow-up observation and concurrent interview was conducted for Resident 149 with LVN 2. LVN 2 verified Resident 149's tongue was covered with thick white residue. LVN 2 stated she was not aware of Resident 149's tongue condition and the resident should not be left with that. LVN 2 stated the CNAs should inform the nurses if they needed help in providing oral care or any personal hygiene care to the resident. LVN 2 stated Resident 149's tongue being covered with thick white residue needed to be reported to the physician. On 6/17/26 at 1518 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 149. The DON stated they would report Resident 149's tongue condition to the physician for further assessment. 2. On 6/16/26 at 0909 hours, during the initial tour of the facility, Resident 51 was observed in bed. Resident 51 stated she was not given showers on her scheduled shower days and she did not refuse showers. Resident 51 stated she asked the staff, Where is my shower? Why is everyone getting a shower, and I do not? Resident 51 stated she felt frustrated, angry, and neglected. Resident 51 stated she was at the end of the room, and she felt forgotten. Medical record review for Resident 51 was initiated on 6/16/26. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's H&P examination dated 5/28/26, showed Resident 51 had the capacity to understand and make decisions. Review of Resident 51's MDS assessment dated [DATE], showed Resident 51 had moderate cognitive impairment, and was dependent on the facility staff for showering or bathing herself. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 51's CNA documentation under Task for Bathing: Shower/Bed bath every Wednesday and Saturday AM showed the following: - Resident 51's showers/bed baths were documented as not applicable on 5/30, 6/3, and 6/7/26; - Resident 51 received a bed/towel bath on 6/5/26, and - Resident 51 received showers on 6/6, 6/10, and 6/17/26; and Further review of the CNA task documentation failed to show if Resident 51 had showers or bed bath, or the resident refused showers or bed bath on 5/30, 6/3, and 6/13/26. On 6/17/26 at 1008 hours, an interview and concurrent facility document review was conducted with CNA 3. CNA 3 stated Resident 51 was scheduled to have showers on Wednesday and Saturday on the day shift. CNA 3 stated the residents could ask for a shower on the days they were not scheduled to shower, and he would try to accommodate it. CNA 3 stated the CNAs were supposed to fill out a skin inspection sheet every after the resident showered. CNA 3 was observed looking into a binder and showed the Shower Day Inspection Sheets. Review of Resident 51's Shower Day Inspection Sheet showed the following: - dated 6/6/26, refused body check. - dated 6/10/26, redness on the sacral area. - dated 6/16/26, open areas on the sacral area. Further review of Resident 51's medical record showed there were no Shower Day Inspection Sheets documented for 5/30, 6/3, and 6/13/26. CNA 3 verified the above findings. CNA 3 was observed going through the binder, and each page but did not locate the Shower Day Inspection Sheets documentation for 5/30, 6/3, and 6/13/26 for Resident 51. CNA 3 stated Resident 51 never refused showers. CNA 3 stated he showered Resident 51 yesterday (6/16/26), and a registry CNA was assigned to her last Saturday (6/13/26). On 6/18/26 at 0812 hours, an interview and concurrent medical record review for Resident 51 was conducted with RN 2. RN 2 stated the residents were scheduled to have showers twice a week, and the schedule was based on the room number, which will then determine the day and the shift, to which RN 2 showed the Shower Schedule for the day shift. Review of the facility's document titled Shower Schedule for 0700 to 1500 hours shift showed Resident 51's room number was under Wednesday and Saturday. RN 2 verified Resident 51 was scheduled to have showers on Wednesday and Saturday, and the CNAs would fill out a Shower Day Inspection Sheet after providing showers to the residents, then the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charge nurses will sign the shower sheets. If the resident refused shower, the CNA would have to inform the charge nurse. RN 2 further stated the CNAs would have to document under the Task documentation the resident refused showers or only provided bed bath. When asked about Resident 51's Shower Day Inspection Sheets, RN 2 observed going through the binder, and each page and located Resident 51's Shower Day Inspection Sheets dated 6/16, 6/10, and 6/16/26. RN 2 verified there were no Shower Day Inspection Sheets documented on 5/30, 6/3, and 6/13/26. When asked about the documentation of Resident 51's shower or bed bath under the Task documentation, RN 2 verified Resident 51's showers/ bed baths were documented as not applicable on 5/30, 6/3, and 6/7/26, and Resident 51 received a bed/towel bath on 6/5/26, and showers on 6/6, 6/10, and 6/17/26. On 6/18/26 at 1442 hours, an interview and medical record review for Resident 51 was conducted with the DON. When asked about Resident 51's shower, the DON stated the CNAs documented under Task if Resident 51 was provided with a shower or a bed bath. The DON verified Resident 51's showers/ bed baths were documented as not applicable on 5/30, 6/3, and 6/7/26, and Resident 51 received a bed/towel bath on 6/5/26, and showers on 6/6, 6/10, and 6/17/26. The DON verified there were no documented showers or bed bath provided to Resident 51 on 5/30, 6/3, and 6/13/26.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for one of 29 final sampled residents (Resident 61). * The facility failed to ensure Resident 61 was administered midodrine (antihypertensive) medication when Resident 61's systolic blood pressure (SBP) was less than 110 mmHg as prescribed by the physician. This failure had the potential to negatively affect Resident 61's health condition and well-being. Findings: Medical record review for Resident 61 was initiated on 6/16/26. Resident 61 was admitted to the facility on [DATE]. Review of Resident 61's Order Summary Report showed the following physician's orders dated 6/2/26:- to administer midodrine 10 mg one tablet by mouth every eight hours as needed for hypotension. Give if the systolic blood pressure is less than 110 mmHg; and- to monitor blood pressure every shift for the midodrine medication use. Review of Resident 61's MAR for June 2026 showed Resident 61's blood pressure was monitored every shift and Resident 61's systolic blood pressure was less than 110 mmHg on the following dates and shifts:- dated 6/2/26 on the evening shift, a blood pressure of 106/52 mmHg;- dated 6/3/26 on the night shift, a blood pressure of 101/50 mmHg;- dated 6/4/26 on the evening shift, a blood pressure of 103/61 mmHg, and on the evening shift, a blood pressure of 102/64mmHg;- dated 6/7/26 on the day shift, a blood pressure of 108/63 mmHg;- dated 6/8/26 on the day shift, a blood pressure of 99/52 mmHg, on the evening shift, a blood pressure of 103/57 mmHg, and on the night shift, a blood pressure of 108/63 mmHg;- dated 6/9/26 on the night shift, a blood pressure of 106/60 mmHg;- dated 6/10/26 on the evening shift, a blood pressure of 104/45 mmHg, and on the night shift, a blood pressure of 102/62 mmHg;- dated 6/12/26 on the evening shift, a blood pressure of 91/37 mmHg, and on the night shift, a blood pressure of 106/64 mmHg;- dated 6/13/26 on the evening shift, a blood pressure of 98/50 mmHg, and on the night shift, a blood pressure of 102/53 mmHg;- dated 6/14/26 on the night shift, a blood pressure of 104/63 mmHg;- dated 6/15/26 on the evening shift, a blood pressure of 99/51 mmHg, and on the night shift, a blood pressure of 96/46 mmHg; and- dated 6/16/26 on the night shift, a blood pressure of 92/47 mmHg. Further review of Resident 51's MAR did not show Resident 61 was administered the midodrine medication when the resident's systolic blood pressure was less than 110 mmHg as prescribed by the physician. On 6/18/26 at 0835 hours, an interview and concurrent medical record review for Resident 61 was conducted with RN 2. When asked about Resident 61's blood pressure monitoring, RN 2 stated the charge nurses checked the vital signs, including the blood pressure, every shift and would give the midodrine medication if the systolic blood pressure was less than 110 mmHg as prescribed by the physician. RN 2 verified Resident 61 was not administered the midodrine medication when the systolic blood pressure was less than 110 mmHg numerous times. On 6/18/26 at 1444 hours, an interview and concurrent medical record review for Resident 61 was conducted with the DON. The DON verified the above findings.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and the facility P&P review, the facility failed to monitor the fluid intake accurately for one of one final sampled resident (Resident 126) and one nonsample resident (Resident 25) reviewed for hydration and nutritional status. * The facility failed to provide Resident 25's Nephro (nutritional supplements) oral liquid 237 ml as ordered by the physician. * The facility failed to ensure Resident 126's fluid intake was monitored accurately by the charge nurses and CNAs. The CNAs fluid intake documentation did not match the charge nurses' documentation, and often exceeded the volume documented by the charge nurses. In addition, the daily fluid intake documentation was inconsistent and incomplete. These failures placed the residents at risk for undetected fluid imbalances or weight loss and negatively impact the resident's well-being. Findings: 1. Review of the facility's P&P titled Intake and Output revised 2/27/25, showed the fluid intake and output shall be recorded for each resident if ordered per physician. Review of the facility's P&P titled Fluid Restriction dated 5/26/26, showed the licensed nurse will complete the intake and output documentation. On 6/17/26 at 1006 hours, an observation for Resident 126 was conducted. Resident 126 was observed in bed, and a pitcher of ice and a cup of thickened water were observed at bedside. Medical record for Resident 126 was initiated on 6/16/26. Resident 126 was readmitted to the facility on [DATE]. Review of Resident 126's Order Summary Report showed a physician's order dated 5/15/26, for fluid restriction of 1200 ml per day for CHF exacerbation. There was no breakdown shown for the nursing and dietary departments. Review of Resident 126's MAR for June 2026 showed checkmarks and initials by the licensed nurses for each shift but did not show Resident 126's actual fluid intake. Review of Resident 126' POC Response History for June 2026 under Task for Nutrition - Fluids section, showed the following fluid intake by Resident 126 as documented by the CNAs: - dated 6/1/26, the total fluid intake was 970 ml; - dated 6/2/26, the total fluid intake was 1,020 ml; - dated 6/3/26, the total fluid intake was 760 ml; - dated 6/4/26, the total fluid intake was 800 ml; (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 6/5/26, the total fluid intake was 830 ml; - dated 6/6/26, the total fluid intake was 905 ml; - dated 6/7/26, the total fluid intake was 720 ml; - dated 6/8/26, the total fluid intake was 250 ml; - dated 6/9/26, the total fluid intake was 840 ml; - dated 6/10/26, the total fluid intake was 830 ml; - dated 6/11/26, the total fluid intake was 1,060 ml; - dated 6/12/26, the total fluid intake was 970 ml; - dated 6/13/26, the total fluid intake was 500 ml; - dated 6/14/26, the total fluid intake was 860 ml; - dated 6/15/26, the total fluid intake was 780 ml; - dated 6/16/26, the total fluid intake was 320 ml; and - dated 6/17/26, the total fluid intake was 730 ml. Review of Resident 126's Intake and Output Recording for June 2026 showed the following fluid intake by Resident 126 as documented by the licensed nurses: - dated 6/1/26, the total fluid intake was 1,100 ml; - dated 6/2/26, the total fluid intake was 820 ml; - dated 6/3/26, the total fluid intake was 700 ml; - dated 6/4/26, the total fluid intake was 1,050 ml; - dated 6/5/26, the total fluid intake was 1,180 ml; - dated 6/6/26, the total fluid intake was 1,050 ml; - dated 6/7/26, the total fluid intake was 730 ml; - dated 6/8/26, the total fluid intake was 740 ml; (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 6/9/26, the total fluid intake was 770 ml; - dated 6/10/26, the total fluid intake was 700 ml; - dated 6/11/26, the total fluid intake was 480 ml; - dated 6/12/26, the total fluid intake was 900 ml; - dated 6/13/26, the total fluid intake was 1000 ml; - dated 6/14/26, the total fluid intake was 600 ml; - dated 6/15/26, the total fluid intake was 560 ml; - dated 6/16/26, the total fluid intake was 580 ml; and - dated 6/17/26, the total fluid intake was 600 ml. On 6/17/26 at 1021 hours, an observation for Resident 126 and concurrent interview was conducted with CNA 3. CNA 3 verified Resident 126 was observed with a pitcher of ice and cup of thickened water at bedside. When asked about Resident 126's fluid restriction, CNA 3 stated Resident 126 was on fluid restriction so she was only given a pitcher of ice and a cup of thickened water at bedside. CNA 3 stated Resident 126's fluid intake from the cup of thickened water at bedside and the fluids from the meal trays were documented under the Task documentation. CNA 3 stated they do not count Resident 126's intake of ice. On 6/18/26 at 0906 hours, an interview and concurrent medical record review for Resident 126 was conducted with RN 2. RN 2 verified Resident 126 was on fluid restriction of 1200 ml per day, and there was no breakdown for the nursing and dietary department. RN 2 stated the resident's fluid intake from the dietary or meal tray were documented by the CNAs on the Task documentation. RN 2 stated the licensed nurses' documentation of the resident's fluid intake in the Intake and Output Monitoring record included the resident's fluid intake from the nursing and dietary. When asked about the monitoring of Resident 126's fluid intake, RN 2 verified the resident's fluid intake from the dietary under the Task documentation was inconsistent and exceeded the fluid intake documented in the Intake and Output Monitoring record, which should have been the total fluid intake from the nursing and dietary. RN 2 further verified Resident 126 was not monitored for fluid overload when the resident exceeded her fluid intake limit. On 6/18/26 at 1510 hours, an interview and concurrent medical record review for Resident 126 was conducted with the DON. The DON verified the above findings. 2. On 6/17/26 at 1012 hours, a medication administration observation for Resident 25 was conducted with LVN 1. LVN 1 prepared and administered Resident 25's medications by mouth, which included the following: (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- one tablet of cetirizine (antiallergy) of 10 mg; - one tablet of Plavix (anticoagulant) 75 mg; - one capsule of duloxetine (antidepressant) 30 mg; - two tablets of methocarbamol (muscle relaxant) 500 mg; - Miralax (laxative) 17 grams; - one capsule of Lyrica (medication for nerve pain) 100 mg; - pro-stat (liquid protein supplement) 30 ml; - two tablets of senna (laxative) 8.6 mg; and - one tablet of vitamin C and B-complex (supplements). Medical record review for Resident 25 was initiated on 6/17/26. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Active Order Sets dated 6/17/26, showed a physician's order dated 5/14/24, to administer Nephro oral liquid 237 ml by mouth one time a day for supplement. Review of Resident 25's MAR for June 2026 showed the Nephro oral liquid 237 ml supplement was scheduled to be administered at 0900 hours. On 6/17/26 at 1400 hours, an interview and concurrent medical record review for Resident 25 was conducted with LVN 1. LVN 1 reviewed Resident 25's MAR and verified the Nephro oral liquid supplement was scheduled to be administered at 0900 hours. LVN 1 verified the Nephro supplement was not administered during the medication administration observation. On 6/17/26 at 1518 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pain management care and services for two of 29 final sampled residents (Residents 13 and 90) reviewed for pain management. * The facility failed to ensure Resident 13's pain was assessed prior to the administration of hydrocodone (narcotic analgesic) medication. * The facility failed to accurately document the pain level for Resident 90 according to the physician's order when the resident was administered with hydrocodone (narcotic analgesic) medication. These failures posed the risk for the residents not to receive the appropriate and necessary interventions to manage the residents' pain. Findings: 1. Medical record review for Resident 13 was initiated on 6/16/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 6/9/26, showed Resident 13 had the capacity to participate in medical decision-making. Review of Resident 13's Order Summary Report showed a physician's order dated 5/20/26:- to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth every four hours as needed for severe pain (pain level of 7-10, at a scale of 10, 0=no pain and 10=worst pain); and- to monitor for pain every shift and chart intensity of pain using the following pain rating scale: zero for no pain; 1-3 for mild pain; 4-6 for moderate pain; and 7-10 for severe pain. Review of Resident 13's MAR for June 2026 showed the following: a. Resident 13 was administered the hydrocodone medication on the following dates and times, but was not assessed for pain prior to administering the hydrocodone medication:- dated 6/1/26 at 1135 hours;- dated 6/2/26 at 0832, 1442 and 2210 hours;- dated 6/3/26 at 0826 hours;- dated 6/4/26 at 0925 hours;- dated 6/5/26 at 0609 and 1220 hours;- dated 6/6/26 at 0640 hours;- dated 6/7/26 at 0752 and 2041 hours;- dated 6/8/26 at 0544 and 1609 hours;- dated 6/9/26 at 0839 and 2011 hours;- dated 6/10/26 at 0642 hours;- dated 6/11/26 at 0632 hours;- dated 6/12/26 at 1004 hours;- dated 6/13/26 at 0648, 1758, and 2254 hours;- dated 6/14/26 at 1317 and 2107 hours;- dated 6/15/26 at 1137 hours;- dated 6/16/26 at 1132 hours;- dated 6/17/26 at 0822 and 1529 hours; and- dated 6/18/26 at 0830 hours b. Under the monitoring for pain every shift, showed Resident 13 was assessed for pain on the following dates and shift:- dated 6/2/26 in the evening shift, with a pain scale of 7/10;- dated 6/9/26 in the evening shift, with a pain scale of 3/10; and- dated 6/13/26 in the evening shift, with a pain scale of 5/10. Further review of Resident 13's medical record review did not show Resident 13 was assessed for pain prior to administering the hydrocodone medication. On 6/18/26 at 0849 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 2. RN 2 verified the above Resident 13 was not assessed for pain prior to administering the hydrocodone medication. On 6/18/26 at 1505 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON verified the above findings. 2. On 6/16/26 at 1228 hours, an observation and concurrent interview was conducted for Resident 90. Resident 90 stated she had pain and had been receiving pain medications. Resident 90 stated the pain medication did help her pain but not completely taking the pain away. Medical record review for Resident 90 was initiated on 6/16/26. Resident 90 was readmitted to the facility on [DATE]. Review of Resident 90's MDS assessment dated [DATE], showed Resident 90 had moderate cognitive impairment. Review of Resident 90's Order Summary Report showed the following physician's orders:- dated 2/7/26, to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth every six hours for severe pain (7-10); and- dated 6/8/26, to administer hydrocodone-acetaminophen 10-325 mg one tablet by mouth three times a day for severe pain (7-10). Review of Resident 90's MAR for June 2026 showed Resident 90 was administered the hydrocodone (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication on the following dates and times and the noted pain level:- date 6/1/26 at 0000, 0600, 1200, and 1800 hours with pain level of 0;- dated 6/2/26 at 1200, and 1800 hours with pain level of 0;- dated 6/3/26 at 0000, 0600, 1200, and 1800 hours with pain level of 0;- dated 6/4/26 at 0000, 0600, 1200, and 1800 hours with pain level of 0;- dated 6/5/26 at 0000, 0600, 1200, and 1800 hours with pain level of 0;- dated 6/6/26 at 0000, 0600, 1200, and 1800 hours with pain level of 0;- dated 6/7/26 at 0000, 0600, 1200, and 1800 hours with pain level of 0;- dated 6/8/26 at 0000, 0600, 1200, and 1700 hours with pain level of 0;- dated 6/9/26 at 0100, 0900, and 1700 hours with pain level of 0;- dated 6/10/26 at 0100, 0900, and 1700 hours with pain level of 0;- dated 6/12/26 at 0000, 0800, and 1600 hours with pain level of 0;- dated 6/13/26 at 0000, 0800, and 1600 hours with pain level of 0;- dated 6/14/26 at 0000, 0800, and 1600 hours with pain level of 0;- dated 6/15/26 at 0000, 0800, and 1600 hours with pain level of 0;- dated 6/16/26 at 0000, 0800, and 1600 hours with pain level of 0; and- dated 6/17/26 at 0000 and 0800 hours with pain level of 0. On 6/17/26 at 1049 hours, an interview and concurrent medical record review for Resident 90 was conducted with the ADON. The ADON verified the above findings. The ADON stated the nurses should follow the physician's order and administer the pain medication per the pain level parameter. The ADON further stated Resident 90 should have not been given the pain medication when the pain level was 0. On 6/19/26 at 1314 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 90.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of three final sampled residents (Resident 62) reviewed for hemodialysis. * The facility failed to ensure Resident 62's fluid intake related to dialysis was monitored accurately. In addition, the facility failed to monitor Resident 62 and notify the physician when his access site was assessed with redness, pain, swelling, or tenderness. These failures had the potential to result in accurate assessment of fluid status, complications associated with fluid overload, and delayed intervention to the resident in the event of a dialysis access emergency. Findings: Review of the facility's P&P titled Dialysis Management revised 1/25/24, showed the following:- Diet and fluid restriction will be followed as ordered; and - Assessing, observing and documenting care of access sites daily, as applicable, such as evidence of infection at the surgical site, such as drainage, redness, tenderness. Review of the facility's P&P titled Fluid Restriction dated 5/26/26, showed the licensed nurse will complete the intake and output documentation. Medical record review for Resident 62 was initiated on 6/16/26. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 62's Order Summary Report showed the following physician's orders dated 8/31/24:- For fluid restriction of one liter per day. The fluid intake limit for dietary was 360 ml per day, while the fluid intake limit for nursing was 640 ml, which was broken down to 340 ml for 0700 to 1500 hours shift, 200 ml for 1500 to 2300 hours shift, and 100 ml for 2300 to 0700 hours shift.- To monitor hemodialysis access for presence of bruit and thrill every shift. Use (+) or (-) signs;- To monitor hemodialysis access for redness, swelling, drainage, and pain, every shift. Notify the physician if (+). Document the following if necessary: R for redness, S for swelling, D for drainage, P for pain, or N for not applicable. a. Review of Resident 62's fluid intake as per the CNA and licensed nurses' documentation showed inconsistency. In addition, the CNA documentation of Resident 62's fluid intake has also exceeded the daily fluid limit and/or exceeded the amount of the resident's fluid intake documented by the licensed nurses in the Intake and Output Monitoring Record. For example: Review of Resident 62's Task documentation for June 2026, under Nutrition - Fluids section, showed the following Resident 62's fluid intake as per the CNAs' documentation:-6/2/26, there was no documentation of the resident's fluid intake for breakfast and lunch;-6/3/26, the total dietary fluid intake was 1,300 ml;-6/4/26, the total dietary fluid intake was 1,020 ml;-6/5/26, the total dietary fluid intake was 730 ml;-6/6/26, the total dietary fluid intake was 640 ml;-6/7/26, there was no documentation of the resident's fluid intake for breakfast and lunch;-6/8/26, there was no documentation of the resident's fluid intake for breakfast and lunch;-6/10/26, there was no documentation of the resident's fluid intake for breakfast and lunch;-6/11/26, there was no documentation of the resident's fluid intake for breakfast and lunch;-6/13/26, there was no documentation of the resident's fluid intake for breakfast, lunch, and dinner;-6/14/26, the total dietary fluid intake was 1,480 ml;-6/15/26, the total dietary fluid intake was 960 ml;-6/16/26, the total dietary fluid intake was 1,020 ml; and-6/17/26, the total dietary fluid intake was 1,190 ml. Review of Resident 62's Intake and Output Recording for June 2026 showed the following Resident 61's fluid intake as per the licensed nurses' documentation:-6/1/26, the total fluid intake was 660 ml;-6/2/26, the total fluid intake was 660 ml;-6/3/26, the total fluid intake was 660 ml, although the 24-total was not recorded;-6/4/26, the total fluid intake was 650 ml;-6/5/26, the total fluid intake was 650 ml;-6/6/26, the total fluid intake was 640 ml;-6/7/26, the total fluid intake was 720 ml;-6/8/26, the total fluid intake was 660 ml;-6/9/26, the total fluid intake was 660 ml, (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	although the 24-hour total was recorded as 360 ml;-6/10/26, the total fluid intake was 660 ml;-6/11/26, the total fluid intake was 675 ml;-6/12/26, the total fluid intake was 660 ml;-6/13/26, the total fluid intake was 650 ml;-6/14/26, the total fluid intake was 660 ml;-6/15/26, the total fluid intake was 670 ml, although the 24-hour total was not recorded;-6/16/26, the total fluid intake was 640 ml, although the 24-hour total was not recorded; and-6/17/26, the total fluid intake was 660 ml. b. Review of Resident 62's MAR for June 2026 showed Resident 62's hemodialysis access was assessed (+) for redness, swelling, drainage and pain on 6/1/26 in the day shift, on 6/6/26 in the evening shift, and on 6/10/26 in the evening shift. There was no documentation to show Resident 62 was assessed and monitored further nor was the physician notified when the resident's hemodialysis access was assessed (+) for redness, swelling, drainage and pain. Further review of Resident 62's medical record did not show the licensed nurses notified the attending physician, dialysis facility and/or nephrologist of Resident 62's fluid intake, and presence of redness, swelling, drainage and pain on the hemodialysis access site. On 6/18/26 at 0928 hours, an interview and concurrent medical record review for Resident 62 was conducted with RN 2. RN 2 stated the resident's fluid intake from the dietary or meal tray were documented by the CNAs on the Task documentation. RN 2 stated the licensed nurses' documentation of the resident's fluid intake in the Intake and Output Monitoring record included the resident's fluid intake from the nursing and dietary. When asked about the monitoring of Resident 61's fluid intake, RN 2 verified the resident's fluid intake from the dietary under the Task documentation was inconsistent and exceeded the fluid intake documented in the Intake and Output Monitoring record, which should have been the total fluid intake from the nursing and dietary. RN 2 verified the Intake and Output Monitoring record was incomplete as it did not show the 24-hour total of Resident 62's fluid intake. RN 2 further verified Resident 62 was not monitored for fluid overload, and the attending physician, dialysis facility and/or nephrologist were not notified of Resident 62's fluid intake. When asked about the hemodialysis access monitoring, RN 2 verified the licensed nurses documented + on the monitoring for redness, swelling, drainage and pain on the resident's hemodialysis access but there was no documentation if the physician or nephrologist nor the dialysis facility was notified. On 6/18/26 at 1456 hours, an interview and concurrent medical record review for Resident 62 was conducted with the DON. When asked about the residents on fluid restrictions, the DON stated the resident's fluid intake from nursing and dietary was documented by the licensed nurses in the Intake and Output Monitoring record because the nurses do the 24-hour calculation, and weekly intake and output evaluation. When asked about monitoring of the hemodialysis access, the DON stated if there was redness, swelling, drainage or pain, the licensed nurses could document the pain the pain assessment every shift, and also it would generate a change of condition. The DON verified the above findings.		

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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, facility document review, and facility P&P review, the facility failed to ensure two of two licensed nurses (RN 1 and LVN 2) reviewed for competency had specific competencies and standard of practice skill sets needed to provide safe and efficient nursing care. * The facility failed to ensure RN 1 and LVN 2 were able to competently administer the medications via GT. These failures had the potential to put the residents at risks to receive care not provided in a safe and competent manner. Findings: Review of the facility's document titled RN Staff Nurse Job Description (undated) showed the general duties and responsibilities of the RN are to provide nursing care as prescribed by physician/health care professional in accordance with the legal scope of practice, any Board of Licensing restrictions, and within established standards of care, policies, and procedures, and to administer professional services and provide care consistent with allowing residents to attain or maintain his or her highest practicable physical, mental, and emotional well-being utilizing the nursing process of assessing, planning, implementing, and evaluating patient care. One of the clinical duties of the RN is to prepare/administer medications as ordered by the physician and within the legal scope of practice. Review of the facility's document titled LVN Staff Nurse Job Description undated showed the general duties and responsibilities of the LVN are to provide nursing care as prescribed by physician/health care professional in accordance with the legal scope of practice, any Board of Licensing restrictions, and within established standards of care, policies, and procedures, and administers professional services and provide care consistent with allowing residents to attain or maintain his or her highest practicable physical, mental, and emotional well-being. Provides clinical data and observations to contribute to the nursing plan of care. One of the clinical duties of the LVN is to prepare/administer medications as ordered by the physician and within the legal scope of practice. 1. On 6/17/26 at 0905 hours, a medication administration observation for Resident 88 was conducted with RN 1. The following were observed with RN 1:- RN 1 did not check the GT residual for Resident 88 prior to flushing the GT with 30 ml of water;- RN 1 attempted to flush the GT with 30 ml of water for the second time but water was not flowing down the GT. RN 1 used the syringe plunger to push the 30 ml of water into the GT rather than allowing gravity flow; and- RN 1 used the same technique of using the syringe plunger to push the multivitamins (supplements) and Senna (laxative) when the medications were not flowing down the GT. On 6/17/26 at 0940 hours, an interview and concurrent medical record review for Resident 88 was conducted with RN 1. RN 1 verified the findings above for Resident 88. RN 1 stated she should have checked the residual prior to attempting to flush the GT with water to make sure the residual amount was not on the amount where she would need to hold the GT feeding and medication administration. RN 1 stated it was also a way to verify the GT placement. RN 1 stated the medications should be allowed to flow by gravity and she should have checked the patency of the GT when the medications were not flowing down the GT. RN 1 stated Resident 88 was getting 40 ml of water flush via GT every hour. 2. On 6/17/26 at 0817 hours, a medication administration observation and concurrent interview for Resident 149 was conducted with LVN 2. The following were observed with LVN 2:- LVN 2 was observed checking the GT residual of Resident 149 and flushed back the aspirated 10 ml residual to the GT while the TF pump was still on;- LVN 2 was about to administer the first diluted medication via GT to Resident 88 while the TF pump was still on. LVN 2 was stopped and was asked if she needed to hold the TF. LVN 2 stated she should have put the TF on hold prior to checking the GT residual. LVN 2 put the TF pump on hold and proceeded with the medication administration;- (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2 administered the first medication, valproic acid liquid (antiseizure) without flushing the GT first with water; and- LVN 2 administered the diluted Namenda (medication for severe dementia) medication and added 5 ml of water to the GT but the medication did not flow down the GT. LVN 2 then added the diluted folic acid (vitamin) medication and added 5 ml of water. The medications were observed not flowing down the GT. LVN 2 used the syringe plunger to push the medications into the GT rather than allowing gravity flow. On 6/17/26 at 0855 hours, an interview and concurrent medical record review for Resident 149 was conducted with LVN 2. LVN 2 verified the above findings for Resident 149. LVN 2 stated the GT should be flushed with 15 ml of water before administering the medications. LVN 2 further stated she should have let the medications flow to the GT by gravity or have checked for the patency if the medications were not flowing down. On 6/19/26 at 1418 hours, an interview and concurrent employee file review for RN 1 and LVN 2 was conducted with the DON. a. Review of RN 1's Feeding Tube: Administration of Medications Competency Validation dated 5/1/26, under the Procedure section showed the following:- Verify tube placement via aspiration method. Return aspirate to stomach. The Met column was checked, and the verification method was return demonstration; and- Administer medication by syringe via gravity into the feeding tube. (Note: Medication may be diluted if necessary.). The Met column was checked, and the verification method was return demonstration. b. Review of RN 1's Feeding Tube: Administration of Medications Competency Validation dated 5/1/26, under the Procedure section showed the following:- If continuous or intermittent feeding is infusing, stop the feeding. The Met column was checked, and the verification method was return demonstration;- Flush tube with 15 ml (unless a different amount specified by the physician/prescriber) of water before administering medication. The Met column was checked, and the verification method was return demonstration;- Between each medication, the tube is flushed with 15 ml of water, keeping in mind the patient's fluid volume status (unless a different amount specified by the physician/prescriber). The Met column was checked, and the verification method was return demonstration; and- Administer medication by syringe via gravity into the feeding tube. (Note: Medication may be diluted if necessary.). The Met column was checked, and the verification method was return demonstration. The DON stated she was involved in providing training and checking/validating the skills competency of the licensed nurses. The DON stated the skills competency validations for the licensed nurses included the medication administration via all routes. The DON stated the licensed nurses were evaluated of their skills competency and knowledge upon hire, three months after they got hired, annually, and as needed if there were issues identified. The DON further stated the Pharmacy Consultant would also assist in checking the licensed nurses' medication administration knowledge and skills. The DON was made aware regarding what RN 1 and LVN 2 did during the medication administration via GT observation and acknowledged the above findings. Cross reference to F693.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and facility document review, the facility failed to ensure the nurse staffing information was posted in a prominent place and readily accessible to residents and visitors. * The facility failed to post the DHPPD, CDPH Form 612 in a prominent place and readily accessible to residents and visitors. This deficient practice had the potential for residents and visitors to not have facility staffing information available at any given time. Findings: On 6/18/26 at 1041 hours, a facility observation was conducted and there was no CDPH Form 612, Nurse Staffing Information with actual hours worked for licensed and unlicensed nurses posted in any prominent areas in the facility that was accessible to residents and visitors. On 6/18/26 at 1109 hours, an interview and concurrent observation of the posting of actual nursing hours worked by the licensed and unlicensed nurses was conducted with the DSD. The DSD stated the facility had only the posting of the daily projected hours for licensed and unlicensed nurses. The DSD verified there was no posting of the actual hours worked for licensed and unlicensed nurses. The DSD further stated the facility will start posting the DHPPD, CDPH Form 612 properly signed and dated from now on. On 6/19/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was made aware and acknowledged the above findings.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage of medication for one of 29 final sampled residents (Resident 13) reviewed for self-administration of medication. * The facility failed to ensure a box containing fluticasone propionate (corticosteroid) nasal spray was not left at Resident 13's bedside table. This failure had the potential to negatively impact on the resident's well-being, unsafe administration of the medications, and the potential for the other residents, staff, and visitors to have access to the medication. Findings: Review of the facility's P&P titled Medication - Self Administration revised 7/31/25, showed the following:- Self-administration of medications refers to a resident's ability to independently take their own prescribed medications without assistance from licensed nursing staff. This includes preparing, consuming, or applying the medication as directed by a physician;- For storage and safety, if the IDT and the attending physician approve self-administration of medications, the medications will be placed in a secured drawer or cabinet that is easily accessible to the resident. On 6/16/26 at 0819 and 0824 hours, during the initial tour of the facility, a box of fluticasone propionate nasal spray was observed on the bedside table in Resident 13's room. On 6/16/26 at 0828 hours, an observation for Resident 13 and concurrent interview was conducted with LVN 3. LVN 3 verified a box of fluticasone propionate nasal spray was observed on the bedside table in Resident 13's room. LVN 3 stated she is allowed to have the nasal spray at the bedside table; I am not sure. Medical record review for Resident 13 was initiated on 6/16/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 6/9/26, showed Resident 13 had the capacity to participate in medical decision-making. Review of Resident 13's MDS dated [DATE], showed Resident 13 was cognitively intact, without any impairment to upper extremities. Review of Resident 13's Order Summary Report showed a physician's order dated 5/20/26, to administer fluticasone propionate 50 mcg one spray in each nostril daily as needed for allergy relief, unsupervised self-administration. Review of Resident 13's Self Administration of Medication dated 6/16/26, showed Resident 13 was approved for self-administration of medications, and the resident may keep medications at bedside. On 6/18/26 at 0849 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 2. RN 2 stated Resident 13 was assessed to be fully capable of self-administration of the nasal spray. When asked about the storage of the nasal spray, RN 2 stated Resident 13 could keep the nasal spray at bedside, not in a locked box. RN 2 further stated normally, it was just kept at bedside that she can reach easily. On 6/18/26 at 1505 hours, an interview and concurrent medical record review for Resident 13 was conducted with the DON. The DON was informed and acknowledged the above findings.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interviews, facility P&P review, and facility document review, the facility failed to ensure one of 12 kitchen employees (Dietary Aide 1) had the appropriate competency and skill set to perform daily kitchen duties. These failures posed the risk of cross contamination in the kitchen which could lead to food-borne illness in the 127 residents who received food prepared in the kitchen. Findings: Review of the facility's matrix dated 6/16/26, showed 127 residents received food prepared in the kitchen. Review of the facility's P&P titled Dietary Department Infection Control for Dietary Employees dated 2022 showed, II. Proper Hand Hygiene A. Upon entering the kitchen, F. After handling soiled equipment or utensils. III. Hand Washing Facilities A. Kitchen sinks shall not be used for hand washing. Separate hand-washing facilities with soap, running water and individual towels shall be provided. Review of the employee file signed by Dietary Aide 1 on 7/7/25, showed Dietary Aide 1 was responsible to maintain a safe and sanitary work environment. a. Review of the employee file for Dietary Aide 1 showed on 7/7/25, Dietary Aide 1 met the standards for hand hygiene. During the initial tour of the kitchen on 6/16/26 at 0810 hours, an observation of the automatic dishwashing process was conducted. Wearing gloves, Dietary Aide 1 loaded soiled dishes into the dish machine. Diet Aid 1 removed his gloves, rinsed his hand in water using the manual ware washing sink, then picked up clean dishes from the clean side of the dishwashing machine. On 6/16/26 at 1048 hours, Dietary Aide 1 entered the kitchen, used hand sanitizer on his hands rather than washing his hands in the hand-washing sink then returned to work in the kitchen. On 6/16/26 at 1100 hours, an interview was conducted with the DSS. The DSS confirmed when kitchen employees enter the kitchen they must wash their hands. Use of a hand sanitizer is not to be used in place of handwashing. On 6/18/26 at 1400 hours, during a meeting with the DSS, DON, and Administrator, the above findings were confirmed. Review of the facility's document titled Inservice Sign In Sheet dated 2/19/26, showed Diet Aid was not in attendance. Cross reference to F812 example #1. According to the USDA Food Code 2022 Section 3-304.14 Wiping Cloths, Use Limitation, B. Cloths in-use for wiping counter and other equipment surfaces shall be: 1. Held between uses in a chemical sanitizer solution at a concentration specified under 4-501.114. According to the USDA Food Code 2022 Section 4-501.114 Manual and Mechanical Ware washing Equipment, Chemical Sanitation - Temperature, pH, Concentration, and Hardness. C. A quaternary ammonium compound solution shall 2. Have a concentration as specified under 7-204.11 and as indicated by the manufacturer's use directions included in the labeling. Review of the quaternary ammonium label used for the sanitizing solution showed, Instructions: Dip paper in quat solution, not foam surface, for 10 seconds. Don't shake. Compare colors at once. b. Review of the employee file for Dietary Aide 1 showed on 7/7/25, showed Diet Aid 1 met the standards for proper kitchen sanitation. During the initial tour of the kitchen on 6/16/26 at 0810 hours, an observation and concurrent interview was conducted with Dietary Aide 1. Dietary Aide 1 was asked to test the sanitizing solution in the red bucket used to store in-use cleaning cloths. Dietary Aide 1 dipped the sanitizing solution in the quaternary solution for three seconds then compared the test strip to the color-coded chart on the test strip container. The test strip read less than 200 ppm (parts per million). Dietary Aide 1 then dipped the same test strip into the sanitizing solution for two seconds and compared the test strip to the color chart on the test strip container. The test strip read less than 200 ppm. The Dietary Aide stated he was nervous. The facility was not able to provide evidence Dietary Aide 1 had attended an in-service training on testing the sanitizing solution. On 6/18/26 at 1400 hours, during a meeting with the DSS, DON, and Administrator, the above findings were confirmed.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to ensure nutritional needs were met for one of 127 residents (Resident 133) who had an option to received a vegetarian meal. * The facility failed to ensure Resident 133 was provided the vegetarian meal with the same amount of protein as the regular diet. This failure posed the risk for the resident's nutritional needs not be met which could lead to medical complications. Findings: Review of the facility's document titled Cooks Spreadsheet dated 6/17/26, showed for the lunch meal a Regular diet would receive taco casserole, seasoned fresh zucchini, fiesta salad and tangy glazed fresh fruit and milk. The Vegan Alternative Menu dated 6/17/26, showed for the lunch meal Regular diet would receive baked beans, seasoned fresh zucchini, fiesta salad and fresh fruit. On 6/16/26 at 1145 hours, an interview was conducted with the DSS. When asked about the vegetarian diets, the DSS stated three residents received a vegetarian diet. Tofu or a veggie patty would be served for the entree for those residents on a vegetarian diet. The DSS further stated the vegetarian diets were not on the cooks spread sheet. On 6/16/26 at 1610 hours, a follow up interview was conducted with the DSS. The DSS stated the facility did have a vegetarian menu but he did not follow the vegetarian menu provided. The DSS stated he provided a piece of paper to the CNAs every day so the residents on a vegetarian diet can tell the CNA what they want to eat. The DSS stated the residents on a vegetarian diet could select what they want. When asked if the Registered Dietitian (RD) was involved to ensure the resident's nutritional needs were met, the DSS stated the RD was not involved to ensure resident nutritional needs were met. On 6/17/26 at 1100 hours, a telephone interview was conducted with RD 2. RD 2 stated she was covering for RD 1 while she was on vacation. RD 2 stated she usually worked remotely. When asked about the vegetarian menu, RD 2 stated she was not aware the facility had a vegetarian menu. When asked how she would ensure the residents on a vegetarian diet had met their nutritional needs, RD 2 stated she planned to meet with the residents on a vegetarian diet to ensure their nutritional needs were being met. RD 2 stated she would contact RD 1 and ask her how she ensured residents' nutritional needs were met when receiving a vegetarian diet. On 6/17/26 at 1145 hours, an observation of the lunch meal was conducted. Resident 133 received one veggie patty, mashed potatoes, seasoned zucchini, fiesta salad and tangy glazed fresh fruit for lunch. Review of the taco casserole recipe served for regular diets on 6/17/26, and the nutrition facts provided by the facility for the ground beef, shredded cheese and pinto beans used in the taco casserole showed the one serving of the taco casserole provided 16 grams of protein. Review of the nutritional information provided by the facility for the veggie patty showed one patty provided seven grams of protein, less than half the amount of the protein provided in one serving of the taco casserole. On 6/17/26 at 1504 hours, a telephone interview was conducted with RD 2. RD 2 stated she had spoken with RD 1 via telephone and RD 1 stated she ensured the nutritional needs were met for residents receiving a vegetarian diet by providing nutritional supplements such as boost (a calorie and protein supplement) or Pro-Stat (a protein supplement). On 6/18/26 at 1500 hours, a medical record review for Resident 133 and concurrent telephone interview was conducted with RD 2. RD 2 verified Resident 133 was admitted to the facility on [DATE], with a physician prescribed diet order for a Regular Vegetarian diet. The nutritional assessment completed by RD 1 on 4/29/26 was reviewed and the nutritional assessment showed Resident 133 was on a regular diet and there were no documentation to show Resident 133 was on a vegetarian diet. RD 1 did not recommend a nutritional supplement and/or (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protein supplements to ensure Resident 133's nutritional needs were met. In addition, there were documentations noted by RD 1 on 5/21/26 and 6/8/26; however, no recommendations were noted for nutritional supplements and/or protein supplements.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555688	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2026
NAME OF PROVIDER OR SUPPLIER Anaheim Point		STREET ADDRESS, CITY, STATE, ZIP CODE 3415 W Ball Road Anaheim, CA 92804	
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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and facility P&P review, the facility failed to ensure visitors who brought food from the outside to the facility residents, and the staff who handled the food brought from the outside were educated on safe food handling practices. These failures posed the risk for unsafe food handling for the 127 facility residents who received an oral diet. Findings: Review of the facility's P&P titled Food Brought by Visitors dated 2022 showed for the staff to assist the family/visitors to understand safe food handling practices (such as safe food cooling/reheating processes, hot/cold holding temperatures, preventing cross contamination, hand hygiene etc.). On 6/16/26 at 0935 hours, an interview was conducted with Resident 133 and her family member. Resident 133's family member had brought into the facility ethnic food from outside for Resident 133 to eat. Resident 133's family member stated he brought food for Resident 133 every day and got the food from his church. The food from outside was stored in a previously used plastic butter container and three additional plastic containers. Resident 133 was eating the food brought from outside. When asked, Resident 133's husband stated he had not received any information regarding safe food handling practices from the facility. On 6/16/26 at 1524 hours, an interview was conducted with the DON. When asked how the facility educated visitors on safe food handling practices in regard to food brought from outside of the facility, the DON stated they reviewed the rules on the policy with the residents and visitors. The DON confirmed nothing in writing was given to the residents or visitors regarding safe food handling. On 6/16/26 at 1530 hours, an interview was conducted with the DSD. The DSD confirmed she educated facility staff on various topics. On 6/16/26 at 1625 hours, during a follow-up interview with the DSD, the DSD confirmed she had not given an in-service to facility staff regarding safe food handling.		