STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow professional standards of practice by failing to:1.Ensure two of four sampled residents (Resident 1 and Resident 2), who presented with skin rashes and itching, was tested to rule out scabies (a contagious skin infestation by a microscopic mite, sarcoptes scabiei).2. Ensure Resident 2 (Resident 1's roommate), was tested for scabies before the scabies treatment was administered.3. Ensure three of seven sampled facility staff (Treatment Nurse [TxN] 1, Licensed Vocational Nurse [LVN] 2, and Certified Nursing Assistant [CNA] 1), who provided care to Resident 1, were informed about Resident 1's positive scabies result. 4. Ensure one of three sampled residents (Resident 4), who was exposed to Resident 1 was assessed for scabies. These deficient practices had the potential for undetected and untreated scabies which could negatively impact the residents, visitors, and facility staff's health and safety.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 12/17/2024 and readmitted on [DATE] with diagnoses including dermatitis (conditions that cause inflammation of the skin), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and Parkinson's disease (a slow-progressing brain disorder that affects movement, causing shaking, stiffness, slow movement, and balance issues). During a review of Resident 1's admission Reassessment, dated 5/18/2025, the admission Reassessment indicated the resident was sent out with. rashes on the chest, bilateral lower extremities (BLE - both legs from hip to toes), and bilateral upper extremities (BUE - both arms from shoulder down to the fingertips). The admission Reassessment indicated Resident 1 returned to the facility on 5/17/2025 with rashes that spread to the resident's back and abdomen. During a review of Resident 1's Care Plan on skin integrity impairment, revised on 6/19/2025, the Care Plan indicated the resident had skin rash. The Care Plan indicated interventions including administer treatment as ordered, notify dermatologist of non-response. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was severely impaired. During a review of Resident 1's Change of Condition (COC) Interact Assessment Form, dated 1/16/2026, the COC Interact Assessment Form indicated Resident 1 was transferred to the General Acute Care Hospital (GACH) 1 for altered mental status and abnormal vital signs (reflect essential body functions, including the heartbeat rate, breathing rate, temperature, and blood pressure). The background section of the COC Interact Assessment Form indicated Resident 1 had body rash. During a review of the facility-provided Scabies Examination, dated 1/18/2026, the Scabies Examination indicated Resident 1 had a skin tissue specimen collected. The Scabies Examination result indicated Resident 1 was positive for scabies. During an interview on 1/26/2026 at 11:20 a.m. and concurrent record review of the facility-provided Scabies Case Contact Line List Form, dated 1/26/2026, reviewed with the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Staff Development (DSD), the Scabies Case Contact Line List Form indicated the names of Resident 1, Resident 2, and Resident 3 (roommates). The DSD stated she could not access the Infection Preventionist Nurse's (IPN) Scabies Case Contact Line List Form. The DSD created a new Scabies Case Contact Line List Form. The Scabies Case Contact Line List Form indicated three resident names (Residents 1, 2, and 3 were roommates). There was no documented evidence of assessments done on other residents exposed to Resident 1 except for Resident 1's roommates. During an interview on 1/26/2026 at 11:25 a.m. with TxN 1, TxN 1 stated she was assigned to provide care to Resident 1. TxN 1 stated the facility did not inform her that Resident 1 tested positive for scabies until she returned to work on 1/25/2026, three days after the facility was made aware of Resident 1's positive scabies result. During an interview on 1/26/2026 at 12:12 p.m. with CNA 1, CNA 1 stated she was assigned to provide care to Resident 1. CNA 1 stated she witnessed Resident 1 scratching all over the resident's body. CNA 1 stated she reported Resident 1's rashes to the TxN. CNA 1 stated the TxN informed her that Resident 1's rashes were treated with medications. CNA 1 stated the facility did not inform her that Resident 1 tested positive for scabies until she returned to work on 1/24/2026, two days after the facility was made aware of Resident 1's positive scabies result. During an interview on 1/26/2026 at 1:41 p.m. with the MDS Nurse (MDSN), the MDSN stated Resident 1 shared the same table with two residents in the activity room. During an interview on 1/26/2026 at 2:52 p.m. with Nurse Practitioner (NP) 1, NP 1 stated he got push backs from the facility management which consisted of the Administrator (ADM), the Director of Nursing (DON), and the Infection Preventionist Nurse (IPN). NP 1 stated the DON gave the most push back on ordering skin scraping (a procedure done to collect skin cells to diagnose skin conditions) for some residents. NP 1 stated the facility management informed him that skin scraping on residents may result in positive scabies results which may put the facility on scabies outbreak and be fined. NP 1 stated he raised the scabies concerns to the facility management but was informed that a scabies outbreak may lead to less nursing staff taking care of the other residents. NP 1 stated the facility did not have a dermatologist (a medical doctor who specializes in diagnosing, treating, and preventing diseases and condition affecting the skin, hair, and nails). NP 1 stated he was not informed about Resident 1's positive scabies result. During an interview on 1/27/2026 at 11:06 a.m. and concurrent record review of Resident 1's Skin Rash Report, reviewed with LVN 2, LVN 2 stated she provided care to Resident 1. LVN 2 stated the Skin Rash Report indicated on 10/29/2025, 11/26/2025, and 12/10/2025, Resident 1 complained of itchiness. LVN 2 stated skin scraping should have been done on Resident 1 after the resident was observed and reported itching. LVN 2 stated there was no documented evidence that a skin scraping was done on Resident 1. LVN 2 stated there was no documented evidence a dermatologist was consulted for Resident 1's rashes. LVN 2 stated skin scraping confirms the presence of scabies and the type of scabies. LVN 2 stated the facility did not inform her that Resident 1 tested positive for scabies. LVN 2 stated she received a group text message from the facility on 1/26/2026, four days after the facility was made aware of Resident 1's positive scabies result. LVN 2 stated that unidentified scabies had the potential to spread to other residents, staff, family members, and visitors. During a follow up interview on 1/27/2026 at 3:27 p.m. with the DSD, the DSD stated on 1/26/2026, the residents that were seated beside Resident 1 in the dining room were added to the Scabies Case Contact Line List Form. The DSD stated she did not know if the facility staff that took care of Resident 1 before he was tested positive for scabies were notified. The DSD stated a skin scraping test identifies the presence and type of scabies on the resident. The DSD stated the two types of scabies had different treatments and isolation duration. The DSD stated untreated scabies had the potential to spread and infect other residents, visitors, family (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	members, and staff. During an interview on 1/28/2026 at 3:55 p.m. with the DON, the DON stated the facility corporate determined that Physician (MD) 1's group would handle skin and wound assessments and treatments in the facility. The DON stated meetings were held with NP 1 and the facility had discussed resident skin scraping. The DON stated NP 1 informed the DON there was no need for resident skin scraping to be done on any resident with rashes. The DON stated the facility did not have a dermatologist for two years. The DON stated that she and the ADM decided to bring the dermatology services back in the facility after Resident 1 tested positive for scabies. The DON stated the facility waited for the dermatologist, who was an expert in skin rashes, to determine the residents that needed skin scraping. The DON stated the residents exposed to Resident 1 in the dining room were not assessed for scabies. The DON stated the facility failed to consider timely skin scraping tests on residents. The DON stated the facility failed to perform assessments on the residents exposed to Resident 1 which may cause contamination of other residents and facility staff. During a review of the facility's policy and procedure (PnP) titled, Scabies Identification, Treatment and environmental Cleaning, last reviewed on 1/14/2026, the PnP indicated the purpose was .to treat residents infected with and sensitized to sarcoptes scabiei and to prevent the spread of scabies to other residents and staff. The PnP indicated secondary bacterial skin infections may result from untreated scabies. The PnP indicated the common locations of scabies included .b. around the waist; c. between fingers and palm of hand; d. on the inner thigh, groin, buttocks; e. anterior surfaces of the wrists and elbows; g. upper back of nursing home residents. The PnP indicated diagnosis may be established by recovering the mite from its burrow and identifying it microscopically. Failure to identify scrapings as positive does not necessarily exclude the diagnosis. The PnP indicated a resident sharing a room with someone infected with scabies should be examined carefully for scabies. If signs and symptoms are present, the resident should be treated in accordance with these procedures. If signs and symptoms are not present, daily assessments should be made until the case has resolved. During a review of the facility-provided Acute Communicable Disease Control (ACDC) Program titled, Scabies Prevention and Control Guidelines For Healthcare Settings, dated 7/2019, the ACDC Program indicated .evaluate patients/residents on affected units and immediately place patients/residents with suspected scabies in contact precautions.prepare a line listing of symptomatic patients/residents and healthcare workers (HCW) with a separate line list of their contacts. Evaluate contacts for scabies.provide prophylactic scabicide to all contacts of symptomatic cases. should all be accomplished within the same 24-hour period to prevent reinfestation of treated or prophylaxed individuals. The Scabies Prevention and Control Program section indicated . healthcare workers who are trained to be suspicious of scabies in themselves or their patients/residents if unexplained rash or pruritus occurs and to report such occurrences to their supervisors. access to and use as needed of the diagnostic skills of a clinician and /or other healthcare consultant experienced in recognizing scabies to evaluate difficult or unusual cases or response to treatment. The Management of Symptomatic Cases section indicated None-the-less, it is recommended that efforts be made to confirm the diagnosis of scabies by skin scraping in at least one symptomatic individual. The Symptomatic Patients/Residents section indicated immediately place any patient/resident with suspected scabies infestation on contact precautions. for patients/residents with typical scabies, maintain contact precautions until treatment is completed. For patients/residents with atypical or crusted scabies, contact precautions should be maintained until treatment is completed and the signs any symptoms of infestation have abated. During a review of Resident 2's admission Record (undated), the admission Record indicated the facility admitted the resident on 1/27/2023 and readmitted on [DATE] with diagnoses including cerebral infarction (occurs as a result of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disrupted blood flow to the brain due to problems with the blood vessels that supply it), muscle weakness, and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 2's Physician Orders, dated 12/25/2025, the Physician Orders indicated dermatology consult and follow up treatment as indicated. During a review of Resident 2's Clinical Admission, dated 12/25/2025, the Clinical admission indicated the resident had no skin issues. During a review of Resident 2's Skin Reassessment, dated 12/26/2025, the Skin Reassessment indicated the resident had rashes on BUE, BLE, chest and back. The Skin Reassessment indicated Resident 2 did not complain of itchiness. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. During a review of Resident 2's Care Plan on skin integrity impairment, revised on 1/5/2026, the Care Plan indicated the resident had skin rash. The Care Plan indicated interventions including administer treatment as ordered, notify dermatologist of non-response. During a review of Resident 2's Physician Orders, dated 1/22/2026, the Physician Orders indicated permethrin external cream (medication used to treat scabies) five precent (% - unit of measurement) to be applied one time from the head to the toes for prophylaxis for possible exposure to rashes. During a review of Resident 2's Physician Orders, dated 1/22/2026, the Physician Orders indicated to place the resident on contact isolation precaution every shift, for one day for prophylaxis and possible exposure to rashes. During a review of Resident 2's Medication Administration Record (MAR), dated 1/1/2026 to 1/31/2026, the MAR indicated on 1/22/2026 at 8:45 p.m., Resident 2 received the permethrin external cream 5%. During a review of Resident 2's Skin Rash Report, dated 1/24/2026 and 1/26/2026, the Skin Rash Report indicated the resident complained of itching. During a review of Resident 2's Physician Orders, dated 1/26/2026, the Physician Orders indicated to perform skin scrape STAT (immediately without delay) for unspecified dermatitis. During a review of Resident 2's Treatment Administration Record (TAR), dated 1/1/2026 to 1/31/2026, the TAR indicated on 1/26/2026 at 6:15 p.m., a skin scrape was performed on Resident 2. During an observation on 1/26/2026 at 2:35 p.m. observed Resident 2's room with an enhanced barrier precaution (EBP - an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) signage on the wall. CNA 1 was observed inside Resident 2's room, not wearing personal protective equipment (PPE - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses), touching Resident 2's curtain and other items in the resident's room. During a concurrent observation and interview on 1/26/2026 at 2:40 p.m. with Resident 2, Resident 2 stated he had the rashes for a long time. Resident 2 stated the rashes was itchy all the time. Resident 2 was observed with small scattered red rashes on the top of both hands, in between the fingers, wrist, inner aspect of the lower and upper arms, and axillary area of both upper extremities. Resident 2 was observed with small red rashes on both shoulders and upper back. Resident 2 was observed with scabbed rashes on the upper right chest and abdomen. Resident 2 was observed with red and brown rashes on the lower abdomen, pubis, both inner thighs, inguinal area, lower back, and around the waist. Resident 2's black pants was observed with white dry skin flakes around the waist area. Resident 2 demonstrated how he scratches his body using his fingertips and palms, rubbing on both arms, abdomen, lower back and inner thigh areas. TxN 1 stated she this was the first time she saw Resident 2's rashes on the webs of the fingers. TxN 1 stated resident 2 received the permethrin cream treatment on 1/22/2026. TxN 1 stated the treatment nurses perform the skin scraping in the facility. TxN stated she observed and did a skin scraping procedure once in her nursing career. TxN 1 stated skin scraping was not ordered for Resident 2 During an interview on 1/27/2026 at 11:06 a.m. and concurrent record review of Resident 2's medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	records, reviewed with LVN 2, LVN 2 stated there was no documented evidence that a dermatologist assessed Resident 2. LVN 2 stated there was no documented evidence that Resident 2 had skin scraping done. LVN 2 stated she took care of Resident 2 for four months. LVN 2 stated she saw Resident 2's hands, neck and face. LVN 2 stated she had not assisted in changing Resident 2's disposable briefs and had not seen the resident's back and legs. During an interview on 1/27/2026 at 3:27 p.m. with the DSD, the DSD stated Resident 2 and Resident 1 were roommates. The DSD stated Resident 2 had generalized rashes and was exposed to Resident 1. The DSD stated Resident 2's skin scraping was done after the resident received the permethrin cream treatment. The DSD stated a skin scraping test identifies the presence and type of scabies on the resident. The DSD stated the two types of scabies had different treatments and isolation duration. The DSD stated untreated scabies had the potential to spread and infect other residents, visitors, family members, and staff. During an interview on 1/28/2026 at 3:55 p.m. with the DON, the DON stated the facility corporates determined that Physician (MD) 1's group would handle skin and wound assessments and treatments in the facility. The DON stated meetings were held with NP 1 and the facility had discussed resident skin scraping. The DON stated NP 1 informed the DON there was no need for resident skin scraping to be done on any resident with rashes. The DON stated the facility did not have a dermatologist for two years. The DON stated that she and the ADM decided to bring the dermatology services back in the facility after Resident 1 tested positive for scabies. The DON stated the facility waited for the dermatologist, who was an expert in skin rashes, to determine the residents that needed skin scraping. The DON stated the facility failed to consider timely skin scraping tests on Resident 2. During a review of the facility's policy and procedure (PnP) titled, Scabies Identification, Treatment and environmental Cleaning, last reviewed on 1/14/2026, the PnP indicated the purpose was .to treat residents infected with and sensitized to sarcoptes scabiei and to prevent the spread of scabies to other residents and staff. The PnP indicated secondary bacterial skin infections may result from untreated scabies. The PnP indicated the common locations of scabies included .b. around the waist; c. between fingers and palm of hand; d. on the inner thigh, groin, buttocks; e. anterior surfaces of the wrists and elbows; g. upper back of nursing home residents. The PnP indicated diagnosis may be established by recovering the mite from its burrow and identifying it microscopically. Failure to identify scrapings as positive does not necessarily exclude the diagnosis. The PnP indicated a resident sharing a room with someone infected with scabies should be examined carefully for scabies. If signs and symptoms are present, the resident should be treated in accordance with these procedures. If signs and symptoms are not present, daily assessments should be made until the case has resolved. During a review of the facility-provided Acute Communicable Disease Control (ACDC) Program titled, Scabies Prevention and Control Guidelines For Healthcare Settings, dated 7/2019, the ACDC Program indicated .evaluate patients/residents on affected units and immediately place patients/residents with suspected scabies in contact precautions.prepare a line listing of symptomatic patients/residents and healthcare workers (HCW) with a separate line list of their contacts. Evaluate contacts for scabies.provide prophylactic scabicide to all contacts of symptomatic cases. should all be accomplished within the same 24-hour period to prevent reinfestation of treated or prophylaxed individuals. The Management of Symptomatic Cases section indicated None-the-less, it is recommended that efforts be made to confirm the diagnosis of scabies by skin scraping in at least one symptomatic individual. The Symptomatic Patients/Residents section indicated immediately place any patient/resident with suspected scabies infestation on contact precautions. for patients/residents with typical scabies, maintain contact precautions until treatment is completed. For patients/residents with atypical or crusted scabies, contact precautions should be maintained (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to ensure three of three sampled facility staff (Treatment Nurse [TxN] 1, TxN 2, and Infection Preventionist Nurse [IPN]) were competent to provide nursing services to the residents by failing to ensure competency skill assessments that included skin scraping (a procedure done to collect skin cells to diagnose skin conditions) were completed upon hire and annually. This deficient practice had the potential to negatively impact the residents' safety and prevent the residents from attaining or maintaining their highest practicable physical, mental, and psychosocial well-being.Findings: During a review of TxN 1's employee file indicated the hire date of 11/13/2024 and her most recent competency skills assessment was completed on 1/14/2025. There was no documented competency skills assessment done that included skin scraping procedures. During a review of TxN 2's employee file indicated the hire date of 2/11/2025 and his most recent competency skills assessment was completed on 2/12/2025. There was no documented competency skills assessment done that included skin scraping procedures. During a review of IPN's employee file indicated the hire date of 6/12/2024 and her most recent competency skills assessment was completed on 10/13/2025. There was no documented competency skills assessment done that included skin scraping procedures. During an interview on 1/27/2026 at 3:27 p.m. and concurrent record review of the facility's employee files, reviewed with the Director of Staff Development (DSD), the DSD stated TxN 1, TxN 2, and the IPN's skill competency assessment did not include skin scraping procedures. The DSD stated if skin scraping competency assessment was not done, the facility will not know if the licensed nurses did the skin scraping procedure correctly. The DSD stated the facility failed to ensure the facility staff were competent on performing skin scraping procedure. During an interview on 1/28/2026 at 3:55 p.m. with the Director of Nursing (DON), the DON stated there were no skin scraping competency assessments done on the licensed nurses. The DON stated the facility started the hands-on skin scraping competency assessments with the licensed nurses. The DON stated that without skin scraping competency assessments, the skin scraping procedure had the potential not to be done properly and may negatively affect the accuracy of the results. The DON stated the facility failed to train the licensed nurses on performing the skin scraping procedure. During a review of the facility-provided Acute Communicable Disease Control (ACDC) Program titled, Scabies Prevention and Control Guidelines For Healthcare Settings, dated 7/2019, the ACDC Program indicated .evaluate patients/residents on affected units and immediately place patients/residents with suspected scabies in contact precautions.prepare a line listing of symptomatic patients/residents and healthcare workers (HCW) with a separate line list of their contacts. Evaluate contacts for scabies. The Scabies Prevention and Control Program section indicated . healthcare workers who are trained to be suspicious of scabies in themselves or their patients/residents if unexplained rash or pruritus occurs and to report such occurrences to their supervisors. access to and use as needed of the diagnostic skills of a clinician and /or other healthcare consultant experienced in recognizing scabies to evaluate difficult or unusual cases or response to treatment. During a review of the facility's policy and procedure (PnP) titled, Competency Assessment, last reviewed on 1/14/2026, the PnP indicated . each employee must demonstrate competency requirement related to skills, technique, and training necessary to providing nursing and related care and services for all residents in accordance with resident care plans. Competency will be completed by the employee prior to an assignment.

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	555690	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical records of four of six sampled residents (Resident 1, Resident 2, Resident 5, and Resident 6) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to:1. Ensure TxN 1 documented the level of care provided to Resident 1 while the resident was in the facility when TxN 1 documented the level of care she provided to Resident 1 on 1/17/2026 but Resident 1 was discharged to the General Acute care Hospital (GACH) 1 on 1/16/2026.2. Ensure licensed nurses documented Resident 2's skin condition accurately when the resident was readmitted in the facility on 12/25/2025.3. Ensure Treatment Nurse (TxN) 1 accurately and timely documented Resident 2, Resident 5, and Resident 6's skin scraping procedures. Resident 2, 5, and 6's Treatment Administration Records (TARs) were signed two days after the procedures were done. 4. Ensure the licensed nurse that performed the skin scraping procedure signed the TAR. TxN 2 signed Residents 2, 5, and 6's TARs for the skin scraping procedure (a procedure done to collect skin cells to diagnose skin conditions) performed by TxN 1.These deficient practices resulted in incomplete and inaccurate information on Residents 1, 2, 5, and 6's medical records and had the potential for delayed medical interventions.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 12/17/2024 and readmitted on [DATE] with diagnoses including dermatitis (conditions that cause inflammation of the skin), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and Parkinson's disease (a slow-progressing brain disorder that affects movement, causing shaking, stiffness, slow movement, and balance issues). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was severely impaired. During a review of Resident 1's Physician Orders, dated 1/9/2026, the Physician Orders indicated a treatment order to apply clotrimazole-betamethasone external cream (a medication, applied on the skin, used to treat inflamed fungal skin infections) 1 - 0.05 percent (% - unit of measurement) to affected areas every day and evening shift for unspecified dermatitis (an itchy, inflamed skin rash that had not been given a specific diagnosis). During an interview on 1/28/2026 at 2:03 p.m. and concurrent record review of Resident 1's Change of Condition (COC) Interact Assessment Form, dated 1/16/2026, reviewed with TxN 1, TxN 1 stated Resident 1 was transferred to GACH 1 on 1/16/2026. TxN 1 stated Resident 1's Treatment Administration Record (TAR), dated 1/1/2026 to 1/31/2026, indicated her initials on 1/17/2026. TxN 1 stated she forgot to change the resident's chart code to hospitalized . TxN 1 stated the documentation was not accurate and had the potential for confusion amongst the care team. During an interview on 1/28/2026 at 3:55 p.m. with the Director of Nursing (DON), the DON stated Resident 1's TAR should indicate the resident was in the hospital. The DON stated TxN 1's documentation was not accurate. The DON stated that inaccurate documentation had the potential for inaccurate treatment and provision of care to Resident 1. The DON stated the facility failed to follow the process of timely and accurate documentation. During a review of the facility's policy and procedure (PnP) titled, Charting and Documentation, last reviewed on 1/14/2026, the PnP indicated all services provided to the resident. shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (a collaborative group of professionals who work together to provide comprehensive patient-centered care) regarding the resident's condition and response to care. The PnP indicated the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following information is to be documented in the resident medical records.c. treatments or services performed. The PnP indicated documentation in the medical record will be objective, complete, and accurate. The PnP indicated documentation of procedures and treatments will include care-specific details, including.the date and time the procedure/treatment was provided.the name and title of the individual(s) who provided the care. During a review of Resident 2's admission Record (undated), the admission Record indicated the facility admitted the resident on 1/27/2023 with diagnoses including cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), muscle weakness, and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. During a review of Resident 2's Physician Orders, dated 1/26/2026, the Physician Orders indicated to perform skin scrape STAT (immediately without delay) for unspecified dermatitis. During a review of Resident 2's TAR, dated 1/1/2026 to 1/31/2026, printed on 1/27/2026 at 4:43 p.m., the TAR indicated the skin scrape STAT for 1/26/2026 did not have a licensed nurse initial and time. During an interview on 1/28/2026 at 1:26 p.m. and concurrent record review of Resident 2's TAR, dated 1/1/2026 to 1/31/2026, printed on 1/28/2026 at 8:56 a.m., reviewed with TxN 2, TxN 2 stated on 1/26/2026, he was observing TxN 1 perform the skin scraping procedure on Resident 2 as he (TxN 2) had not done a skin scarping procedure before. TxN 2 stated he signed Resident 2's TAR on 1/28/2026, two days after TxN 1 performed the procedure on the resident. TxN 2 stated he does not remember what time the skin scraping procedure was done. TxN 2 stated he guessed the time the skin scarping procedure was done on Resident 2. TxN 2 stated it took 30 minutes to 45 minutes to complete the skin scraping procedure on one resident. TxN 2 stated he documented the time of the skin scarping procedures of nine residents at zero to 15 minutes per resident. TxN 2 stated inaccurate documentation of the time a procedure was done had the potential for confusion amongst the healthcare team. During an interview on 1/28/2026 at 2:03 p.m. with TxN 1, TxN 1 stated TxN 2 observed her perform the skin scraping procedure. TxN 1 stated she did not document the skin scraping procedure in Resident 2's TAR. TxN 1 stated the documentation on Resident 2's TAR was not timely and was not accurate. During an interview on 1/28/2026 at 3:55 p.m. and concurrent record review of Resident 2's Clinical Admission, dated 12/25/2025, reviewed with the Director of Nursing (DON), the Clinical admission indicated Resident 2's skin was warm, dry, normal skin color, and normal turgor. Resident 2's Clinical admission indicated there was no skin issues. The DON stated Resident 2's Skin Reassessment, dated 12/26/2025, indicated the resident had rashes on bilateral lower extremities (BLE - both legs from hip to toes), bilateral upper extremities (BUE - both arms from shoulder down to the fingertips), chest, and back. The DON stated on 1/26/2026, TxN 1 performed a skin scraping procedure on Resident 2. The DON stated TxN 2 documented Resident 2's skin scraping procedure on 1/28/2026, two days after the skin scraping procedure was completed. TxN 2 was not the licensed nurse that performed the skin scraping procedure on Resident 2. The DON stated the documentation was not accurate. The DON stated it had the potential to cause inaccurate provision of care for Resident 2. The DON stated the facility failed to accurately document Resident 2's identified skin issues. The DON stated the facility failed to follow the process of timely documenting the treatment done on residents. During a review of the facility's policy and procedure (PnP) titled, Charting and Documentation, last reviewed on 1/14/2026, the PnP indicated all services provided to the resident. shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (a collaborative group of professionals who work together to provide comprehensive patient-centered care) regarding the resident's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition and response to care. The PnP indicated the following information is to be documented in the resident medical records.c. treatments or services performed. The PnP indicated documentation in the medical record will be objective, complete, and accurate. The PnP indicated documentation of procedures and treatments will include care-specific details, including.the date and time the procedure/treatment was provided.the name and title of the individual(s) who provided the care. During a review of the facility's PnP titled, Scabies Identification, Treatment and environmental Cleaning, last reviewed on 1/14/2026, the PnP indicated the purpose was .to treat residents infected with and sensitized to sarcoptes scabiei and to prevent the spread of scabies to other residents and staff. The Documentation section of the PnP indicated: the following information should be recorded in the resident's medical record: 1. The date and time that care was given, 2. The name and title of the individual (s) who assisted with the care. During a review of Resident 5's admission Record (undated), the admission Record indicated the facility admitted the resident on 7/17/2025 with diagnoses including unspecified dementia (a significant cognitive decline but the specific type had not been identified), essential hypertension, and age-related osteoporosis (a condition where bones become thin, weak, and brittle due to aging). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was severely impaired. During a review of Resident 5's Physician Orders, dated 1/26/2026, the Physician Orders indicated to perform skin scrape STAT for unspecified dermatitis. During a review of Resident 5's TAR, dated 1/1/2026 to 1/31/2026, printed on 1/27/2026 at 4:39 p.m., the TAR indicated the skin scrape STAT for 1/26/2026 did not have a licensed nurse initial and time. During an interview on 1/28/2026 at 1:26 p.m. and concurrent record review of Resident 5's TAR, dated 1/1/2026 to 1/31/2026, printed on 1/28/2026 at 9:01 a.m., reviewed with TxN 2, TxN 2 stated on 1/26/2026, he was observing TxN 1 perform the skin scraping procedure on Resident 5 as he (TxN 2) had not done a skin scarping procedure before. TxN 2 stated he signed Resident 5's TAR on 1/28/2026, two days after TxN 1 performed the procedure on the resident. TxN 2 stated he does not remember what time the skin scraping procedure was done. TxN 2 stated he guessed the time the skin scarping procedure was done on Resident 5. TxN 2 stated it took 30 minutes to 45 minutes to complete the skin scraping procedure on one resident. TxN 2 stated he documented 7:16 p.m. on both Resident 5 and Resident 6's TAR for the skin scarping procedure. TxN 2 stated inaccurate documentation of the time a procedure was done had the potential for confusion amongst the healthcare team. During an interview on 1/28/2026 at 2:03 p.m. with TxN 1, TxN 1 stated TxN 2 observed her perform the skin scraping procedure. TxN 1 stated she did not document the skin scraping procedure in Resident 5's TAR. TxN 1 stated the documentation on Resident 5's TAR was not timely and was not accurate. During an interview on 1/28/2026 at 3:55 p.m. and concurrent record review of Resident 5's TAR, dated 1/1/2026 to 1/31/2026, reviewed with the DON, the DON stated on 1/26/2026, TxN 1 performed a skin scraping procedure on Resident 5. The DON stated Resident 5's TAR indicated TxN 2 documented the resident's skin scraping procedure on 1/28/2026 two days after the skin scraping procedure was completed. TxN 2 was not the licensed nurse that performed the skin scraping procedure on Resident 5. The DON stated the documentation was not accurate. The DON stated inaccurate documentation had the potential to cause inaccurate provision of care for Resident 5. The DON stated the facility failed to timely and accurately document Resident 5's skin scraping procedure. The DON stated the facility failed to follow the process of timely documenting the treatment done on residents. During a review of the facility's policy and procedure (PnP) titled, Charting and Documentation, last reviewed on 1/14/2026, the PnP indicated all services provided to the resident. shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(a collaborative group of professionals who work together to provide comprehensive patient-centered care) regarding the resident's condition and response to care. The PnP indicated the following information is to be documented in the resident medical records.c. treatments or services performed. The PnP indicated documentation in the medical record will be objective, complete, and accurate. The PnP indicated documentation of procedures and treatments will include care-specific details, including.the date and time the procedure/treatment was provided.the name and title of the individual(s) who provided the care. During a review of the facility's PnP titled, Scabies Identification, Treatment and environmental Cleaning, last reviewed on 1/14/2026, the PnP indicated the purpose was .to treat residents infected with and sensitized to sarcoptes scabiei and to prevent the spread of scabies to other residents and staff. The Documentation section of the PnP indicated: the following information should be recorded in the resident's medical record: 1. The date and time that care was given, 2. The name and title of the individual (s) who assisted with the care. During a review of Resident 6's admission Record (undated), the admission Record indicated the facility admitted the resident on 4/28/2017 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by chemical imbalance in the body), unspecified dementia, and essential hypertension. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was severely impaired. During a review of Resident 6's Physician Orders, dated 1/26/2026, the Physician Orders indicated to perform skin scrape STAT for unspecified dermatitis. During a review of Resident 6's TAR, dated 1/1/2026 to 1/31/2026, printed on 1/27/2026 at 4:38 p.m., the TAR indicated the skin scrape STAT for 1/26/2026 did not have a licensed nurse initial and time. During an interview on 1/28/2026 at 1:26 p.m. and concurrent record review of Resident 6's TAR, dated 1/1/2026 to 1/31/2026, printed on 1/28/2026 at 9:02 a.m., reviewed with TxN 2, TxN 2 stated on 1/26/2026, he was observing TxN 1 perform the skin scraping procedure on Resident 6 as he (TxN 2) had not done a skin scraping procedure before. TxN 2 stated he signed Resident 6's TAR on 1/28/2026, two days after TxN 1 performed the procedure on the resident. TxN 2 stated he does not remember what time the skin scraping procedure was done. TxN 2 stated he guessed the time the skin scraping procedure was done on Resident 6. TxN 2 stated it took 30 minutes to 45 minutes to complete the skin scraping procedure on one resident. TxN 2 stated he documented 7:16 p.m. on both Resident 5 and Resident 6's TAR for the skin scraping procedure. TxN 2 stated inaccurate documentation of the time a procedure was done had the potential for confusion amongst the healthcare team. During an interview on 1/28/2026 at 2:03 p.m. with TxN 1, TxN 1 stated TxN 2 observed her perform the skin scraping procedure. TxN 1 stated she did not document the skin scraping procedure in Resident 6's TAR. TxN 1 stated the documentation on Resident 6's TAR was not timely and was not accurate. During an interview on 1/28/2026 at 3:55 p.m. and concurrent record review of Resident 6's TAR, dated 1/1/2026 to 1/31/2026, reviewed with the DON, the DON stated on 1/26/2026, TxN 1 performed a skin scraping procedure on Resident 6. The DON stated Resident 6's TAR indicated TxN 2 documented the resident's skin scraping procedure on 1/28/2026 two days after the skin scraping procedure was completed. TxN 2 was not the licensed nurse that performed the skin scraping procedure on Resident 6. The DON stated the documentation was not accurate. The DON stated inaccurate documentation had the potential to cause inaccurate provision of care for Resident 6. The DON stated the facility failed to timely and accurately document Resident 6's skin scraping procedure. The DON stated the facility failed to follow the process of timely documenting the treatment done on residents. During a review of the facility's policy and procedure (PnP) titled, Charting and Documentation, last reviewed on 1/14/2026, the PnP indicated all services provided to the resident. shall be documented in the resident's medical record. The medical record should facilitate (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communication between the interdisciplinary team (a collaborative group of professionals who work together to provide comprehensive patient-centered care) regarding the resident's condition and response to care. The PnP indicated the following information is to be documented in the resident medical records.c. treatments or services performed. The PnP indicated documentation in the medical record will be objective, complete, and accurate. The PnP indicated documentation of procedures and treatments will include care-specific details, including.the date and time the procedure/treatment was provided.the name and title of the individual(s) who provided the care. During a review of the facility's PnP titled, Scabies Identification, Treatment and environmental Cleaning, last reviewed on 1/14/2026, the PnP indicated the purpose was .to treat residents infected with and sensitized to sarcoptes scabiei and to prevent the spread of scabies to other residents and staff. The Documentation section of the PnP indicated: the following information should be recorded in the resident's medical record: 1. The date and time that care was given, 2. The name and title of the individual (s) who assisted with the care.